

WOMEN DOCTORS IN THE BRITISH HEALTH SERVICES:
A SOCIOLOGICAL STUDY OF THEIR CAREERS AND OPPORTUNITIES

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ABSTRACT

This thesis is an examination of the careers of women in medicine in Britain from the 1860s to the 1970s. It begins with an analysis of some of the sociological literature on the medical profession and argues that much of this has been guided by inappropriate assumptions concerning the history and present position of women within the British medical profession. An analysis of statistical evidence on the numbers of women doctors follows which shows that the number of women within the profession has often been underestimated. The trends in women's entry to medical schools in Britain are examined in detail, showing fluctuation in their entry over the past century and the changing pattern of segregation into particular medical schools. This section includes a brief consideration of the development and significance of the practice of reserving 'quotas' of places for women in medical schools from 1947 to 1975.

Part Two consists of an historical analysis of the careers of women in medicine in successive periods over the past century. It begins with an analysis of the campaign for women's access to medical education in the late-nineteenth century, in relation to the contemporary women's movement and the professionalization of medicine. The following two chapters examine in detail the education and careers of women entering medicine before the First World War. The implications of the limitations of medical women's practice to women and children only are explored in relation to the contemporary organization of medical care. This limitation persisted until the First World War which brought about a marked increase in the numbers of women entering medicine, and wider opportunities for women to practise medicine, at least in the short-term. The subsequent reaction within medical schools and the profession is then analysed, as is the significance of the increasing state involvement in health service provision. The final chapter considers the implications of the development of the National Health Service for medical women's careers.

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ABBREVIATIONS

BCOG	British College of Obstetricians and Gynaecologists
BMA	British Medical Association
<u>BMJ</u>	<u>British Medical Journal</u>
CDCI	Civilian Doctors' Career Index
CMRC	Civilian Medical Recruitment Committee
DES	Department of Education and Science
DHSS	Department of Health and Social Security
DPH	Diploma in Public Health
EGA	Elizabeth Garrett Anderson Hospital
GMC	General Medical Council
LHMC	London Hospital Medical College
LKQCPI	Licence of King's and Queen's College of Physicians of Ireland
LSA	Licentiate of the Society of Apothecaries
LSMW	London School of Medicine for Women
L(RFH)SMW	London (Royal Free Hospital) School of Medicine for Women
MOH	Medical Officer of Health
MWF	Medical Women's Federation
NHS	National Health Service
NHW	New Hospital for Women
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RFH	Royal Free Hospital
RFHSM	Royal Free Hospital School of Medicine
RFHSM PC	Royal Free Hospital School of Medicine Press Cuttings

SHMO	Senior Hospital Medical Officer
SLH	South London Hospital for Women
SWH	Scottish Women's Hospitals
UCCA	Universities' Central Council for Admissions
UGC	University Grants Committee

CHAPTER I

INTRODUCTION

This thesis is a study of women in medicine in Britain from the time when women first sought access to formal medical qualifications to the time when formal restrictions on the numbers of women entering medical school were made illegal, that is, from the 1860s to the 1970s. It is, therefore a study of the lives of women who have shared an occupational qualification with each other, and with many more men. Most sociological literature on women's work and on medicine has assumed that medicine in Britain is an almost exclusively male-profession. By implication, women doctors are not just a small and unusually highly qualified group among women, just as men doctors are among men, but they are an exceptionally small, even a deviant, group.

In the 'second-wave' of organized feminism in Britain, in the 1970s and 1980s, many feminists have shared this view, though adding a more critical inference. There has been particular concern about the numbers of women in medicine, for two reasons. Firstly, in Britain, medicine is widely believed to be a profession in which overt and explicit discrimination has been exercised against women seeking entry. Medicine has been held up as a particularly extreme case of a general pattern by which women

are kept out of high status occupations.¹ Secondly, most feminists today see doctors as having a special relationship with women, through their control over biological reproduction and their role in mediating and transmitting ideas about women's biology. Male-dominated medicine, many feminists argue, is a key means for the social control of women. The overt exclusion of women from medicine is interpreted as part of this control. Many feminists have, therefore, seen medicine as a particularly important occupation for women to enter.²

This was the view I myself shared when I began studying the work of women doctors. Yet when I turned to the medical literature of the 1960s and 1970s, I found much discussion of the relatively 'high proportion of women now accepted in some British medical schools', and its implications, and many studies of women doctors' activity.³ The first substantive part of the thesis takes up this

1. C. Hakim Occupational Segregation: A comparative study of the degree and pattern of the differentiation between men and women's work in Britain, the United States and other countries Department of Employment Research Paper No 9. (London: Dept of Employment, 1979), p. 19.

2. See eg. B. Ehrenreich and D. English Complaints and Disorders: The Sexual Politics of Sickness (Old Westbury, The Feminist Press, 1973). On feminist views on the importance of more women doctors see M. Elston and L. Doyal Health and Medicine Unit 14, Open University Course U221, The Changing Experience of Women (Milton Keynes: Open University, 1983), pp. 44-45.

3. Royal Commission on Medical Education 1965-68: Report (London: HMSO, 1968) Cmnd 3569. para 302, p. 123. A. Maynard and A. Walker Doctor Manpower 1975-2000: Alternative Forecasts and their resource implications Royal Commission on the National Health Service. Research Paper No. 4. (London: HMSO, 1978), p.6; DHSS Medical Manpower- the next twenty years (London, HMSO: 1978). The views expressed in this thesis modify some of the arguments made in M. Elston 'Women in the Medical Profession: Whose Problem?' In Health and the Division of Labour, eds. M. Stacey et al. (London: Croom Helm, 1977), pp. 115-140.

apparent discrepancy. Rather than presume that what is sociologically significant about women doctors in Britain is how few there have been in the past, I have examined how many there have been, and the criteria by which we might judge this to be few or many. By certain statistical criteria, it might be argued that what is significant about medicine in Britain, is how many women there have been in the profession. While women have been a minority among British doctors and medical students throughout the past century, this minority has been larger than some have implied.

That there have been significant barriers to women entering the medical profession, barriers faced by all women pursuing high status occupations as well as ones specific to medicine is undeniable. Despite these, many women have obtained a medical qualification. But this is only the first stage in a medical career. A qualification in medicine is an occupational licence that may be used to pursue a variety of strategies within the medical labour market.⁴ What strategies are pursued by particular individuals will depend on their other resources and preferences and on the structure of opportunities that are available at any given time. The question then arises, what have women done with their qualifications? And why have those who have entered been so invisible in studies of the medical profession?

This is the theme of Part Two of the thesis, which analyses

4. 'On occupational' qualifications versus 'organizational' qualifications see R. Crompton and K. Sanderson 'Credentials and careers: some implications of the increase in professional qualifications among women', Sociology 20 (1986), 23-42.

the medical careers of women in successive periods—the multiple and changing ways in which individual women have become and practised as doctors. In undertaking this historical analysis of career patterns, I have been guided by Everett Hughes's insight into 'the making of a physician'.

'Career is, in fact, a sort of running adjustment between a man and the various facts of life and of his professional world...It is the sum total of these [individual] dispositions and turnings [individual actions] that gives us the kind of distribution of physicians we have among the various ways of practising and the various places and settings within which medicine may be practised, whether that distribution be good or poor.'⁵

This distribution in turn provides the context of opportunities and constraints in which individuals make their 'running adjustments', and in which certain decisions become more likely than others according to each individual's 'facts of life'. In my view, this passage is just as applicable to women as to men, although their 'facts of life', their professional worlds, and their dispositions may often have been different from men's.

The concept of career helps make intelligible the link between the experience of individuals and the social structure in which that experience takes place. Abrams has argued that the biography of even the most peculiar of individuals may be understood sociologically. It is 'rooted in a particular matrix of historical meanings and life chances... the analysis of any career,... is at root an analysis of the conditions governing recruitment to it, exclusion from it and especially, success or failure within it.' This matrix is two-dimensional—a con-

5. E.C. Hughes 'The making of a physician—general statement of ideas and problems', Human Organization 14 (Winter 1956), 25.

junction of life history and social history.

'Life histories are created by self and others to produce heroic or mediocre individuals ... in the setting of historically specific possibilities and impossibilities, opportunities and constraints.'⁶

My aim has therefore been, in a modest way, to study the lives of successive generations of women with medical qualifications in their historically specific settings of opportunity and constraint, especially within the complex and changing organization of medical work. For each period I have considered women's access to medical education and to the means of pursuing medical careers, the extent to which they have used their medical qualifications in Britain, the form and location of their medical work, and the significance of marriage and motherhood for women's medical careers in different periods.

In adopting this historical framework, and the emphasis on the organization of medical work, I am attempting to move beyond what has been described as the 'gender' model of explanation of women's work patterns, which considers these solely in relation to their femininity and their actual or potential domestic obligations. Such an approach is in marked contrast to the 'job' model that has often been used to explain men's careers, considering only features of medical work itself as the key determinants. This a priori use of different explanatory frameworks has recently been widely criticized as potentially misleading for the analysis of

6. M. Abrams Historical Sociology (Shepton Mallett: Open Books, 1982), pp. 281-2 & 297.

the work of both sexes.⁷ I have therefore attempted to look at the characteristics and attitudes that women have brought to medicine, including the significance of their domestic commitments, in relation to the organization of medical work, and how this has shaped their careers.

I use the term 'career' descriptively to refer to the movement of individuals through 'typical sequences of position' by negotiating formal and informal contingencies in a career line.⁸ My interest is not confined to those women who have had "careers" in the restrictive and prescriptive sense of a progressive and orderly advancement through a related sequence of full-time posts. But I am interested in the relationship between such prescriptive career lines within medicine and women's opportunities and work patterns. As has been widely recognized, such prescriptive career lines are associated with the kind of work that is normally done by men, although this does not mean that men's career trajectories

7. R.L. Feldberg and E.N. Glenn 'Male and female: job versus gender models in the sociology of work', Social Problems 26, 5 (1979), 524-538. S. Dex The Sexual Division of Work: Conceptual Revolutions in the Social Science (Brighton: Wheatsheaf, 1985), pp. 20-45. Both sets of assumptions are, of course, 'gender' models. Assuming that men's work lives take precedence over family roles, is based on tacit assumptions about masculinity, just as much as the converse is based on assumptions about femininity. But in studies of men, the assumptions more often remain tacit.

8. Contingency here refers not to random occurrences, but to significant conjunctures of uncertain outcome, decisive moments at which the career is framed and structured one way or another. Contingencies may operate assortatively, selecting certain kinds of people into the next stages of a career, while cooling others out or into different career lines. *ibid.*, 272-276; E.C. Hughes 'Institutional office and the person', Amer. J. Soc. 43 (1937), 409-410; R.M. Lee 'Redundancy, labour markets and informal relations', Sociological Review 33 (1985), 469-494.

in practice conform to such expectations. One of the weaknesses of many sociological studies of such "careers" is that they have taken the ideal-type for a description of what usually happens and regarded any departure from upward movement as a problem, when upward mobility might not be the statistical norm. The untoward results of this tendency to focus on orderly careers is exacerbated when only careers that do not cross organizational boundaries are studied.⁹

Women entering occupations where these expectations are institutionalized have often been shown to depart from them.¹⁰ This departure, their apparently 'disorderly' career trajectories, may be regarded as a problem by them (and by others). But we cannot assume that this is so, nor that women's trajectories within such occupations do not have their own regularities.¹¹ Nor should we treat the occupations with which "careers" are associated as an undifferentiated category or as internally uniform and unchanging in structure.

Medicine, at least since the end of the nineteenth century, has been an organized profession, that is, 'it provides the structural means to incorporate and regulate individual ambition

9. S. Spilerman 'Careers, labor markets strategies and socio-economic achievement', Amer.J.Soc. 83 (1977), 551-593. For a critique of the prescriptive approach to pregnancy careers see S. McIntyre Single and Pregnant (London: Croom Helm, 1977).

10. E.g. C. Epstein Woman's Place: Options and Limits in Professional Careers (Berkeley: University of California, 1970); I. Allen and P. Walters Women in Top Jobs- Four Studies in Achievement (London: George Allen & Unwin, 1971) and Women in Top Jobs: 1968-1979 (London: Heinemann, 1981).

11. S. Dex Sexual Division of Work, pp. 81-89; idem Women's Work Histories: an analysis of the Women and Employment Survey. Department of Employment Research Paper No. 46 (London: Dept. of Employment, 1984).

into a "career", an organized trajectory of individual advancement'.¹² But the kind of trajectories possible have been many and have changed markedly over the last century. Medicine in Britain has been transformed from a pattern of predominantly generalist work, in which advancement was pursued primarily through entrepreneurship, to one in which there is a complex internal cognitive division of labour, in some sectors of which advancement has become dependent on progress through a hierarchically ordered sequence of stages. In the course of these changes different opportunities for and barriers to women's advancement have been generated, and so have different opportunities for non-advancing trajectories, the kind of careers Crompton and Sanderson have recently termed 'practitioner' careers.¹³

Part Two begins by considering why women wished to enter medicine in the late nineteenth century, the struggle that they faced in doing so, and the implications the form of their entry and training had for their subsequent work in medicine. Women first entered medicine at a time when the division of labour within medicine was relatively fluid. The context for medical careers was primarily entrepreneurial, and barriers to combining practice with marriage relatively weak. By examining the careers

12. M.S. Larson The Rise of Professionalism (Berkeley: University of California Press, 1977), pp. 74 & 197-200. Quotation marks added.

13. Crompton and Sanderson 'Credentials and careers', 31. My thinking on this question, like that of Crompton and Sanderson, owes much to R. Brown 'Work histories, Career Strategies and the Class Structure'. In Social Class and the Division of Labour, eds. A. Giddens and G. MacKenzie (Cambridge: University Press, 1982), pp. 119-136.

of medical women before the First World War, I show how the mandate to be doctors for women and children, under which women entered medicine, channelled their work into particular fields. The obstacles that women faced in establishing medical careers in Britain led many to go overseas, and many of those at home to rely on the networks they themselves had created. Women were within the medical profession but largely outside its established structures.

The First World War brought many medical women into contact with male patients for the first time and into many new fields of work. It also brought many more women into medicine. But many of these new opportunities were short-lived. In the 1920s there was a reaction to an over-supply of medical women within the profession and to the employment of married women in general. At the same time, the organization of medical work was changing through two developments: the increasing emergence of organised specialties within medicine with their associated distinctive career paths; and growing state intervention in medical services; a development in which women played an important part. The result was a consolidation of some of the differences between men's and women's medical careers that had emerged before 1914.

These differences have remained under the National Health Service, at least up until the 1970s. Although the NHS brought formal equality of opportunity to medical education and most aspects of medical work, its initial impact on the organization of medical work was not always to promote this. At the same time, a larger proportion of (the increasing numbers of) women doctors have been marrying and having children, and doing so earlier in their careers than ever before. And, in common with married women

in Britain in general, they have tended to pursue discontinuous employment careers and to seek part-time work. But the form this work has taken, and the pattern of efforts to extend opportunities for part-time working, have been structured by the demand for medical women's services as well as by changes in women's attitudes or marriage patterns.

The history of the NHS has been characterised by a cyclical pattern of concern over alleged overall shortage alternating with concern over surplus of doctors, and by continual imbalances in recruitment between particular fields, and in the hospital career structure. There has been an uneven pattern of demand for doctors, and inequalities of opportunity for advancement between posts of different kinds. With the creation of the NHS the boundaries between general practice, hospital medicine and public health were drawn more sharply, making women's work in the latter field an increasingly marginal field of medical activity. A hierarchical career structure, founded on continuous full-time hospital employment in the training years, was instituted throughout the hospital service. Women have been under-represented in the career grades within hospital medicine, and the pre-NHS pattern of uneven representation of women in different specialties has been reinforced as more women have entered medicine.

There have, then, been consistent differences in the medical careers of women and men over the past century. These have served to render the minority of women within medicine less visible to sociologists who have, in my view, been overly pre-occupied with a particular vision of medicine, as a powerful, unified and scientific profession. For this reason they have been mainly concerned with a narrow range of fields within medicine or with

professional organizations and professional leaders, not with the whole range of medical activities and the whole range of individuals that the profession's leaders claim to speak for.¹⁴

Sources and Evidence

I have used primarily printed sources, except for the very earliest years. For the period before 1948, this means mainly contemporary journals and newspapers, and where possible, the writings of women themselves and the records of their professional association, the Medical Women's Federation. Such sources are inevitably biased towards those who were professionally active. But by identifying the concerns that were raised in public by these women, and the influences on their lives, one can at least determine some of the opportunities and constraints that all medical women experienced at the time. One of the problems that became apparent to me while undertaking this work, was how little historical research had been done on medical men's careers, as opposed to the development of the medical profession. I have been unable to make systematic comparisons between women's and men's medical careers before 1948.

For the more recent period, particularly from the 1960s, there is far more information available, particularly through the plethora of published surveys of medical women's activity, a phenomenon which I discuss in Chapter X. I draw on these and also on the material from the survey which initially prompted my

14. The notable exception is M.J. Peterson The Medical Profession in mid-Victorian London (Berkeley: University of California Press, 1978). But this only covers the very first part of the period I have been concerned with.

interest in women in medicine. This was the 'Medical Careers' survey, directed by M.L. Johnson, an investigation into the careers of the qualifiers from five English medical schools (two in London and three in the provinces) in 1954 and 1964. A postal questionnaire was sent in 1976 to the 704 qualifiers out of a total of 722 who could be traced as still alive, and 497 responded— 70 per cent. Of these, 97 were women, 40 qualifying in 1954 and 57 in 1964. Semi-structured interviews were carried out with ten per cent of respondents living in Britain.¹⁵

This survey therefore provides information about the careers of two cohorts of women, and their male peers, who qualified at times of quite different opportunities and constraints within medicine, even though only a decade apart. And, when surveyed, they were at different points in their professional and family careers. The older group, mainly in their mid-40s, had largely completed family-building, only one had a child of under pre-school age, while over half the younger cohort with children were in this situation. Though not a statistically representative sample, there is no reason to think that they were not typical of the qualifiers from English schools of the period.

15. A detailed account of the methodology is contained in M.L. Johnson and M.A. Elston Medical Careers: Final Report to the SSRC (1981). Some of the findings were reported in M. Elston 'Half our future doctors?'. In The Careers of Professional Women, eds. R. Silverstone and A. Ward (London: Croom Helm, 1980), 99-139.

Limitations of the Thesis

In this thesis there are many questions that I have left unexplored about women doctors' work and lives over the past century. I have not attempted to investigate the quality of their relationship with patients, nor whether they treated such patients in a distinctively different, feminine way.¹⁶ Nor, therefore, have I considered whether they had any greater or lesser effectiveness than their male colleagues. The case for (more) women doctors has nearly always been based on the claim that they would make a difference to the quality of patient care. But whether this has actually been the case needs to be investigated by means of different evidence from that which I have used.

Throughout the thesis, I am primarily concerned with those women doctors who have both trained and worked in Britain, indeed, in England, though with some reference to those who trained in Britain but worked overseas. I have not considered in detail the careers of overseas-trained medical women working in Britain. A study of women's medical careers is inevitably concerned with the relationship between medical education and subsequent careers, with the inter-relationship between family and professional careers, with women's attitudes to careers and to medicine and with sex discrimination. It was impossible to include, in a single study, those whose experience of all these things might be different, and for whom racial discrimination might also be important.

16. For a recent review of gender in doctor-patient relationships see C.S. Weisman and M.A. Teitelbaum 'Physician gender and the physician-patient relationship: recent evidence and relevant questions' Soc.Sci.Med 20, 11 (1985) 1119-1127.

PART ONE

WOMEN DOCTORS: AN INVISIBLE MINORITY

CHAPTER II

THE SOCIOLOGY OF THE MEDICAL PROFESSION

Introduction

The voluminous sociological literature on the medical profession in Britain and the United States can be categorized into studies that are concerned with medicine for its own sake, and those concerned with medicine as the paradigm of professions.¹ Most sociologists have held that, if any occupation warrants the title 'profession', it is medicine.² Indeed, because medicine has so often been taken to be the paradigm, to discuss whether medicine is a profession is almost meaningless, and I will not do so.

A second way of classifying the literature is into studies which focus on the organization and structure of the profession as a whole and studies of the socialization and careers of individual members. Although these two aspects are integrally related, in practice they have tended to be studied separately. This has been to the detriment of our understanding of both, as Olesen and Whittaker pointed out in a critical review of studies of

1. This division is suggested in G. Larkin Occupational Monopoly and Modern Medicine (London: Tavistock, 1983), p.1. 'Professions' here refers to 'a limited number of occupations which have particular institutional or ideological traits more or less in common', not to the broad stratum of occupations whose members have had higher education. E. Freidson 'The Theory of Professions: State of the Art' in The Sociology of the Professions: Lawyers, Doctors and Others, eds. R. Dingwall and P. Lewis (London: MacMillan, 1983), p. 23.

2. E. Freidson Profession of Medicine: A Study in the Sociology of Applied Knowledge (New York: Dodd Mead, 1970), p. 4; M.S. Larson The Rise of Professionalism, esp. p. 37.

professional socialization.

"The very substance of what is transmitted in the socializing process, the roles implicated, the definitions exchanged, the students recruited are shaped by professionalization, which we here extend to mean the broad changes in the occupation as well as those thrusting it to professional status...We must go on to observe that ... this admonition may be turned on its head, for the student of professionalization may well attend to what studies of professional socialization have to say about the processes which bring newcomers to the occupation, newcomers whose arrival, presence and definitions are influential on the course of professionalization as they come to create the very culture of the profession."³

Within each category of literature, different theoretical perspectives and value-orientations to medicine have been employed. Thus, while most British and American writers on the modern medical profession have shared the view that it is a uniquely powerful occupation they differ as to the basis of this power. Trait and functionalist approaches follow Durkheim, seeing professions as an altruistic force for social integration in modern society, whose status and power is based on their technical knowledge. Others have taken a more sceptical view. For symbolic interactionists, what distinguishes professions and professionals is not possessing distinctive skills or values, but the success of claims to a symbolically valued title, a public mandate for monopoly. Weberian and Marxist approaches have emphasized, respectively, occupational closure and monopolization of the market for health care, or medicine's agency for capitalism as the basis for professional power. This more sceptical perspective has predominated since the 1970s.⁴

3. V. Olesen and E. Whittaker 'Critical Notes on Sociological Studies of Professional Socialization' In Professions and Professionalization ed. J.A. Jackson (Cambridge: Cambridge University Press, 1970), p. 221.

4. Recent reviews of this literature include T.J. Johnson Professions and Power (London: MacMillan, 1972) and M. Saks 'Removing the blinkers? A critique of recent contributions to the

Among studies of medical socialization, functionalists have described medical schools as transmitting, more or less smoothly, the distinctive values, knowledge and skills of the medical community to the neophyte practitioner. In contrast, symbolic interactionists see medical education as a process of situational learning, in which subordinate students actively cope with faculty demands, as any other students do. Medical education is, for them, a process of 'acculturation' between two different cultures rather than 'assimilation'.⁵ Marxist and, more recently, feminist critics depict medical education as a process whereby class and patriarchal dominance in medicine is reproduced.⁶

Despite these differing theoretical perspectives and value orientations, most of this literature has had, until very recently, two features in common. First, it tended to depict the profession as socially, culturally and cognitively unified, and to study only orderly and successful careers; either those of professional spokesmen or those in discrete phases of early socialization within single institutions. Secondly, and perhaps,

sociology of the professions', Sociological Review 31 (Feb 1983), 1-21.

5. R.K. Merton, G. Reader and P. Kendall The Student Physician (Cambridge, Mass: Harvard University, 1957); H.S. Becker, B. Geer, E.C. Hughes and A. L. Strauss Boys in White (Chicago: University of Chicago Press, 1961). Both traditions are reviewed in P. Atkinson 'The Reproduction of the Professional Community'. In The Sociology of the Professions, eds. Dingwall & Lewis, pp. 241; idem The Clinical Experience (Farnborough: Gower, 1981). The distinction between 'assimilation' and 'acculturation' is made in Olesen and Whittaker 'Professional Socialization', p. 190.

6. J. Robson 'The NHS Company Inc.? The social consequences of the professional dominance in the National Health Service', International Journal of Health Services 3 (1973), 413-426. M. Campbell Why Would a Girl Want to Go into Medicine? (New York: Freemont Press, 1973).

relatedly, there was almost no explicit consideration within the general literature of the minority of women within British or American medicine. The small body of sociological writing on women in medicine and empirical studies of their work were not integrated into general discussions of the profession or of medical careers despite, or perhaps because of, their testimony of heterogeneity and 'disorderly' careers within the profession.⁷

More recently, particularly in the United States, there has been rather more interest in the small, but growing, minority of women within medicine. But, with the stimulus provided by the women's health movement, there has probably been even more interest in women's absence from medicine.

Women in Medicine: Absent or Invisible?⁸

The past lack of attention to women within medicine seems to have been due to sociologists holding one of two assumptions: either that doctors' gender was largely irrelevant in explaining the structure of the profession or individuals' careers; or that

7. E.g J. Williams 'Patients and prejudice: lay attitudes toward women physicians' Amer.J.Soc. 51 (Jan 1946), 283-287; idem 'The woman physician's dilemma', Journal of Social Issues 3 (1950), 38-44; J. Kosa and R.E. Coker 'The female physician in public health: conflict and reconciliation of the sex and professional roles', Sociology and Social Research 49 (1965), 294-305; M. Jefferys 'Marriage, Motherhood and Medicine'. Paper prepared for I.S.A. World Sociology Congress. Evian, France, 4-11th September, 1966; M. Jefferys and P.M. Elliott Women in Medicine: Results of an inquiry conducted by the Medical Practitioners' Union in 1962-63 (London: Office of Health Economics, 1966).

8. Lorber has also drawn attention to this neglect, J. Lorber 'Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients'. In Another Voice: Feminist Perspectives on Social Life and Social Science eds. M. Millman and R. M. Kanter (New York: Anchor Books, 1975), pp. 85-86. Such neglect was not, of course unique to the sociology of the medical profession, but characteristic of many fields of sociology prior to the 1970s. See e.g. S. Delamont The Sociology of Women (London: Allen & Unwin, 1980).

all, or virtually all, doctors were men until very recently. Although it is not always easy to determine which of these assumptions was held, the distinction is important because their implications are different. For example, under the first assumption, a change in the sex composition of medicine would have no implications. Under the second, the entry of substantial numbers of women might indicate or cause significant changes.

These assumptions might not matter if either could be demonstrated to be true. If gender can be shown to be irrelevant to the particular topic under investigation, failing to discuss it is hardly grounds for complaint. Failure to demonstrate its irrelevance might be. I hope to show in this thesis that ignoring gender divisions and the minority of women within medicine has, in some degree, vitiated sociological analysis of the British medical profession, but I would not claim that gender is salient to every aspect. Nor, when studying medical women can we assume a priori that gender is the sole or most important factor in explaining women's career development or their position in the profession.⁹

Studies of the medical profession that do not consider women in medicine explicitly are not necessarily irrelevant when studying their work. One test of the adequacy of accounts of medicine or of the development of medical careers is their ability to explain the position of women as well as men. Ignoring gender does matter if it leads to analyses that neglect important

9. E.g. M. Eichler The Double Standard: A Feminist Critique of Feminist Social Science (London: Croom Helm, 1980); R.M. Kanter 'Some effects of proportions on group life: skewed sex ratios and responses to token women', Amer.J.Soc. 82 (1977), 965-999.

features of medicine, or which purport to be general, but which, in fact, apply only to one sex, when both are present within the profession.

The second assumption has probably been the more common one. If women were mentioned at all in American sociological studies of medicine before the 1970s, it was generally to confirm their virtual absence. This absence might be attributed to the belief that though some were qualified, few practised. For example, Freidson stated that 'Even in the case of that most professional of professions, medicine, only a modest proportion of women in the United States qualified to practice actually do so.'¹⁰ He was referring (without quoting the precise findings) to a national survey of women graduating between 1925 and 1940 which found that, in the mid 1950s, 89 per cent of respondents were in practice (49 per cent full-time and 40 per cent part-time).¹¹ In most contexts, such a level is not thought modest. Freidson might well have commented on how high the activity rate of American women doctors was compared with that of other women graduates at the time. But his lack of attention to women within medicine is perhaps understandable as, at the time he wrote, women were about seven per cent of active medical practitioners in the United States. But in Britain they were 20 per cent.¹²

10. E. Freidson Profession of Medicine: A Study of the Sociology of Applied Knowledge (New York: Dodd, Mead & Co, 1970), p. 55.

11. R. A. Dykman and J.M. Stalnaker 'Survey of Women Physicians Graduating from Medical Schools, 1925-1940', Journal of Medical Education xxxii (1957) Part II, 1-38.

12. Census United States 1965, quoted in Hakim Occupational Segregation, p. 39; Census Great Britain, 1971. Freidson does, in fact, comment that both entry and wastage rates for women in medicine might be different in some European countries, but gives no clear account of why, and his hint has not been explored by

The two classic studies of American medical education, The Student Physician and Boys in White carried out in the 1950s and 1960s, both stated that there were too few women in their classes to warrant including, although they cautioned that their findings might only apply to men.¹³ The schools they studied were probably not untypical of American medical schools at the time. In 1957, the year The Student Physician was published, women were 6 per cent of all medical students in the United States.¹⁴ These two studies were concerned with those who had got in to medical school, not those who had not. But because they have so dominated subsequent sociological work on medical education in Britain and in the United States, their omission of women perhaps had unfortunate consequences. It conveyed an image of complete homogeneity among students and, by implication, within the profession.¹⁵

others in detail. Freidson op.cit., pp. 55-56, quoting J. Bui-Dang-Ha Doan and D. R. Levy 'Les femmes dans la medecine et les professions liberales', Cahiers de sociologie et de demographie medicales iv (1964) 123-136 and J. Bui-Dang-Ha Doan 'Quelques aspects de la feminisation dans les professions liberales et medicales', Le concours medicales, 87 (1965) 1480-1486.

13. Becker et al Boys in White, p. 148; Merton et al The Student Physician, p. 120. One American study of the 1960s that did include women but gave them little explicit attention was E. Mumford Interns: From Students to Physicians (Cambridge, Mass: Harvard University Press, 1970).

14. C. Lopate Women in Medicine (Baltimore: Johns Hopkins Press, 1968), p. 193.

15. Their focus on the 'total institution' of medical school, disregarding other aspects of students' life, was, in effect, employing a 'job model' of the determinants of professional life which was adopted by many subsequent studies of medical socialization in marked contrast to the consideration of the inter-relationship between professional and personal development employed in some studies of nurses' socialization. Atkinson 'Reproduction of the Professional Community', p.230; V. Olesen and E. Whittaker The Silent Dialogue: A Study in the Social Psychology of Professional Education (San Francisco: Jossey Bass, 1968); idem 'Studies of Professional Socialization', pp. 186-188.

In the United States, it was not until the mid-1970s, with the rise of the women's health movement and of the proportion of women medical students (to 25 per cent in 1979) that we find substantial studies of women in medical schools, or interest in the fact that the proportion of women in American medical schools was higher in 1900 than when Merton and Becker did their fieldwork.¹⁶ In Britain, in 1957, the year The Student Physician was published, women constituted 23 per cent of all medical students: still very much a minority but hardly a negligible one, or so one might have thought.¹⁷

This discrepancy, coupled with the discussions about the "high" proportion of women within the British medical profession contained in the medical literature before the mid-1970s led me to consider whether the commonly held view (or, at least my initial view) that there had been "hardly any" women in British medicine until recently was, in fact, correct. In Chapters III and IV, I examine the evidence on how many women doctors and medical students there have been in Britain since women first had access to formal medical training. I suggest that though women have always been a minority, their presence within the profession may have been underestimated partly because of the way official statistics record their work. Similarly, women have been a

16. See for example J. Lorber Women Physicians: Career Status and Power (London: Tavistock, 1985), p. x. J. Leserman Men and Women in Medical School: How They Change and How They Compare (New York: Praeger, 1981); L. Davidson 'Sex roles, affect and the woman physician: a comparative study of women and men professionals'. Unpublished Ph.D. dissertation, New York University, 1975. In 1900, women were 9 per cent of regular medical students in the United States. M. Roth Walsh Doctors Wanted: No Women Need Apply (New Haven: Yale University Press, 1977) pp. 268-283.

17. UGC Annual Report, 1957-58.

minority in medical schools, but examining their distribution within medical schools as well as their absolute numbers suggests that this may have contributed to their invisibility.

These statistics indicated to me that the assumption that doctors are, or have been until recently, virtually all male might have deflected the attention of most medical sociologists in Britain away from investigating their work within medicine and how this has varied over time. This was the task I set myself in Part Two. In the rest of this chapter I consider the extent to which sociological thinking about the medical profession may have masked the presence of women. I do this by examining two rather different accounts of the gender division of labour in formal health care.

Women in Medicine and the Gender Division of Labour in Health Care

When noted at all, the (relative) absence of women from medicine has generally been contrasted with the situation in nursing and other "para-medical" occupations, in which women predominate, at least numerically. Within formally organized health care there currently exists a complex division of labour in which one occupation, medicine, which is predominantly male, dominates others, which are predominantly female.¹⁸ Explanations of why women are well represented in the subordinate health care occupations and not in medicine have been of two main kinds. Both have implied women within medicine are exceptional and anomalous. The difficulty for my purposes with both these approaches is not that they do not explain why there are few women doctors. Rather,

18. E.g. Freidson Profession of Medicine, pp. 49-70.

they make it difficult to explain why there have been any at all.¹⁹

The first approach, characteristic of trait and functionalist perspectives contrasted "true" professions, of which medicine is the archetype, with "semi-professions" which have not (yet?) achieved the same high social status, a status derived from society's positive sanctioning of professionals' skills, not from the latent social status of recruits. Some semi-professions, such as nursing and teaching contained a high proportion of women members whereas professions did not. Professions were characterized by a high degree of self-control over their work. This work was based on a body of systematic theory, which in the case of medicine was applied science, acquired by long specialist training and governed by an ethical code requiring altruistic commitment to client service but a universalistic and affectively-neutral

19. The same is, to some extent, true of many recent attempts to explain the characteristic distribution of women within the labour force in general by adapting concepts originally developed for the analysis of the male workforce in productive industry. But such attempts also have difficulty in explaining why women are well represented among the personal service professions as a whole. For example, suggestions that women do not augment their human capital by gaining work-related qualifications, or that they constitute the secondary sector in an overall 'dual labour market' or 'a reserve army' of labour cannot explain why some women are in the primary sector, and why women are in general concentrated in human service occupations, but not necessarily in unskilled work. For detailed discussion of these issues see M. Stacey 'The Division of Labour Revisited or Overcoming the Two Adams'. In Development and Diversity: British Sociology 1950-1980, eds. P. Abrams et al. (London: George Allen & Unwin, 1981), pp. 172-190. On theories of women's work patterns in general see Dex Sexual Division of Work; V. Beechey Women and Employment Units 10 & 11, Open University Course U221 The Changing Experience of Women (Milton Keynes: Open University Press, 1983); I. Bruegel 'Women as a reserve army of labour: a note on recent British experience', Feminist Review, 3 (1979), 12-23; J. Wajcman 'Work and the Family: Who Gets "the Best of Both Worlds"?' and J. Siltanen 'A Commentary on Theories of Female Wage Labour'. In Women and Society: Interdisciplinary Essays. ed. Cambridge Women's Studies Group (London: Virago, 1981), pp. 9-25 & 25-40.

attitude to clients. Professional self-regulation was achieved through the internalization of a strong sense of occupational commitment and community. Recruitment was held to be based solely on criteria of technical competence.²⁰

In the case of semi-professions, 'training is shorter, their right to privileged communication less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision or societal control than "the" professions...' The work was depicted as involving humanitarian and caring skills rather than intellectual ones, a personal service motivation, not task orientation, and it was primarily located within and regulated by bureaucratic structures. 'It is difficult to determine if the semi-professional organizations have taken the form they have because of the high percentage of female employees, or if they recruit females because of organizational reasons; in all likelihood these factors support each other.'²¹

20. This is only intended as the briefest indication of different approaches not as an exegesis of functionalist and trait approaches to professions and ignores the differences between them. For examples of the trait approach see E. Greenwood 'Attributes of a profession', Social Work 2 (July 1957), 44-55; M.L. Cogan 'Toward a Definition of Profession', Harvard Educational Review xxiii (1953), 33-50. For functionalist approaches see for e.g. T. Parsons 'The Professions and Social Structure'. In Essays in Sociological Theory (New York: Free Press, 2nd edn 1954), p.34. (Originally published in Social Forces (1939) 17, 457-467; idem 'Introduction' to M. Weber The Theory of Social and Economic Organization (New York: Free Press, 1st published 1947); idem 'Professions' in The International Encyclopaedia of the Social Sciences edited by D. Sills (New York: MacMillan, 1968) pp. 536-47; idem Social System pp. 428-479. W.J. Goode 'Community within a Community: The Professions' American Sociological Review xxii (April 1957) 194-200.

21. A. Etzioni 'Preface' to The Semi-Professions and Their Organization (New York: Free Press, 1969), pp. v & xv. See also especially R.L. Simpson and I.H. Simpson 'Women and Bureaucracy in the Semi-Professions', in ibid., pp. 196-265. and H. L. Wilensky and C.N. Lebeaux Industrial Society and Social Welfare (New York: Free Press, 1965), pp. 283-384. There is persistent ambiguity in the discussions of "semi-" or "lesser" professions as to which

The reasons given why women were in semi-professions, and not in professions, centred on the 'presumptive primacy of expectation': that within middle-class American families, women will specialize in child-rearing and domestic tasks, and that they will give this priority over their employment roles. It was implied that few women sought the kind of occupational commitment demanded by a profession, because of its potential conflict with their family role and the danger of 'competition for status' with their husband. The role expectations of professional performance were ones that were especially incompatible with those that prevailed in the private world of the family. On the other hand, the continuity between the skills and qualities demanded of family tasks and semi-professional tasks, and the organization of work made

occupations might be included, and hence whether all show a numerical predominance of women. Thus Hearn claims that the distinction drawn between established and semi-professions, 'is of course really a distinction that draws on sex', and that professionalization is a patriarchal process. Unfortunately, it is not clear what exactly Hearn means. He appears to claim simultaneously that semi-professions are, by definition, occupations with a majority of women and, conversely, that professions are male-dominated, that the tasks done by "true" professions are inherently ones that oppress women, and that it is the presence of large numbers of women that keeps some occupations from becoming professionalized. 'Patriarchy' is both explicans and explicandum. J. Hearn 'Notes on Patriarchy, professionalization and the semi-professions', Sociology 16 (1982), 185. (Emphasis added) Hearn's specific reference is to A.M Carr-Saunders and P.A. Wilson The Professions (Oxford: Oxford University Press, 1933) which explicitly disclaims any attempt to define a distinction between established and other "professions", and includes estate agents, auctioneers and stockbrokers among the latter. Hearn only discusses health and welfare occupations with a majority of women as semi-professions, not including those paramedical occupations where men predominate. Hearn suggests that nursing is becoming professionalized because of the increasing entry of men. Presumably he would also argue that increasing numbers of women in medicine would render it a semiprofession. Parkin takes issue with this kind of 'machismo' theory of professionalization. F. Parkin Marxism and Class Theory: A Bourgeois Critique (London: Tavistock, 1979), pp. 89-110. On the development of paramedical occupations and the role of gender divisions see Larkin Occupational Monopoly.

semi-professions attractive to women recruits. Discrimination against women entering the professions was much less important a reason for their absence than the effect of women's family role obligations and was, in any case, a rational organizational response given the primacy of these obligations.²² In this approach, then, medicine was defined as applied science rather than personal service work. The qualities that made women generally less suited to this kind of health work made them especially suitable for other kinds. Only exceptional, and usually unmarried, "career" women became doctors, deviating from the normal expectations of the feminine role.

Trait and functionalist approaches in general have been widely criticized for taking the medical profession's ideological claims to, for example, a systematic knowledge base as the basis for its status and privilege, at face value. To do this, critics argue, obscures the power relations involved in medicine's acquisition of a public, state-backed mandate for self-regulation and a dominant position over clients and other workers within the health division of labour.²³ This has stimulated a number of

22. T. Parsons 'Age and Sex in the Social Structure of the United States'. In Essays in Sociological Theory, pp. 94-95; Simpson and Simpson 'Women and Bureaucracy'. For an outstanding discussion of Parsons's views of the family which rescues it from some misconceptions see C. Harris The Family and Industrial Society (London: Allen & Unwin, 1983), pp. 50-88.

23. For general criticisms see, for e.g. Freidson Profession of Medicine, pp. 71-84; Johnson Professions and Power; Saks, 'Removing the blinkers'; D. Klegon 'The Sociology of Professions: An Emerging Perspective', Sociology of Work and Occupations 5 (Aug 1978), 259-283; J. Roth 'Professionalism: the sociologist's decoy', Sociology of Work and Occupations 1 (Feb 1974), 17; A. Glasner 'Professional Power and State Intervention in Medical Practice', Australian and New Zealand Journal of Sociology 15 (1979), 20; E. Hughes 'Professions', Daedalus 92 (1963), 647-653 and Men and Their Work (Glencoe, Illinois: Free Press, 1958).

major studies of the professionalization of medicine in the nineteenth century: of the process by which its privileged position has been achieved in particular historical circumstances not necessarily available to other occupations subsequently. Few of these studies explicitly addressed the role of gender divisions in shaping this process, or the question of women's presence within medicine.²⁴

Since the 1970s, sociologists influenced by the women's health movement have scrutinized this gender division of labour in health care more critically. Some have criticized the tacit incorporation of stereotypes of masculine and feminine attributes into sociological conceptions of professions and semi-professions, and the conception of medicine as an "masculine" activity" — a conception which makes medical women either invisible or exceptional.²⁵ But much more common has been questioning not of the assumption that women were absent from medicine but of sociologists' tendency to take this for granted. Attention has been focussed on the very masculinity of medicine and on the power of

24. As noted in the introduction, in these different studies a range of factors are put forward to explain medicine's privileged position, including both characteristics of its members and wider power relations. Johnson op.cit.; Freidson op.cit; J. Berlant Profession and Monopoly: Study of Medicine in the United States and Great Britain (Berkeley: University of California Press, 1975); Larson Rise of Professionalism; Peterson Medical Profession in Mid-Victorian London; I. Waddington The Medical Profession in the Industrial Revolution (Dublin: Gill & MacMillan, 1984). Discussions which do consider, very briefly, the question of women within medicine include W.J. Reader Professional Men (London: Weidenfeld and Nicolson, 1966) pp. 167-182; N. C.A. Parry and J. Parry The Rise of the Medical Profession: a Study of Collective Mobility (London: Croom Helm, 1976).

25. L. Davidson 'Medical immunity? Male ideology and the profession of medicine' Women and Health 3 (1978), 3-9. Lorber 'Women and Medical Sociology', pp. 89-91.

men over women in the health division of labour. From the women's health movement there has developed a critique of (male-dominated) medicine as a crucial institution for the social control over women, through its control over reproduction and its promulgation of naturalistic ideologies legitimating subordination, and through its dominance over paid and unpaid health workers.

This critique brought together a number of distinct themes: the transfer of traditionally "women's work" to the market-place with the rise of industrial capitalism; the elimination from the market place of unqualified but not necessarily unskilled healers, many of whom were women; the subordination and denigration of women's roles within the formal division of labour in health care; the elaboration of medical ideologies to control middle-class women in the mid-nineteenth century and the contemporaneous opposition of doctors to women's entry to medicine. Nor is this special control by medicine over women patients and workers held to be confined to the past.

Thus, the second kind of explanation of the absence of women from medicine is that, to put it at its simplest, the professionalization of medicine was achieved 'on the backs of' women healers and women patients— 'professionalism is nothing more than the institutionalization of a male upper-class monopoly'.²⁶ The reason that there are few women in medicine is because they have been systematically excluded from an occupation that is not merely the paradigm of professions which happens to have a preponderance

26. B. Ehrenreich and D. English Witches, Midwives and Nurses: A History of Women Healers (Westbury, New York: Feminist Press, 1973, reprinted London: Writers and Readers Publishing Cooperative, 1976), p. 61). See also idem Complaints and Disorders.

of men. It is held to be a crucial fact about the nature of modern medicine that it is dominated by a masculine conception of healing and that the vast majority of its members are men.²⁷

This perspective has transformed sociological and historical analysis about women and medicine in a manner that it is impossible to discuss in detail here. It has stimulated an immense literature on the control of human reproduction and of medical ideas about women, and women's experience at the hands of male doctors.²⁸ New research has shed light on the work and history of the subordinated health workers. For example, studies of the history of midwifery have shown how prior to the seventeenth century, this was an exclusively female activity, with some highly educated 'gentlewomen' practitioners. Women were then progressively excluded from good class practice, by aspiring medical men by the early nineteenth century; and then, from the mid-nineteenth century, midwifery once again became the province of women, but increasingly under medical control.²⁹ Gamarnikow has shown how nineteenth/^{Century}nursing reform was premised on ideol-

27. In this literature the term 'masculine predominance' is often ambiguous as to whether it refers to numbers or power, or both. In subsequent chapters I shall suggest that the numerical predominance of men in British medicine has not been as absolute as some have supposed. I do not question that men have held the most powerful positions, only that this is not a reason for not studying what the subordinate minority actually did.

28. See Elston and Doyal Health and Medicine E.g. A. Oakley Women Confined (Oxford: Martin Robertson, 1980); H. Roberts (ed.) Women, Health and Reproduction (London: Routledge and Kegan Paul, 1981); L. Doyal The Political Economy of Health (London: Pluto, 1979).

29. J. Donnison Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights (London: Heinemann, 1977). A. Oakley 'Wisewoman and Medicine Man: changes in the management of childbirth'. In The Rights and Wrongs of Women, eds. J. Mitchell and A. Oakley (London: Penguin, 1976), pp. 17-58.

ogies of femininity and familial relationships transferred into the hospital environment.³⁰

There has also been some, relatively unsystematic, attention to what has been described as the 'counter-attack' that women launched to 'break back into orthodox medicine' in the middle of the nineteenth century, following their exclusion 'as an integral part of the process of professionalization'.³¹

Professionalization and the Exclusion of Women from Medicine

There are however a number of problems with some of these claims about the link between the professionalization of medicine and women's exclusion, and this idea of the 'counter attack'. The first problem is simply that the very existence of the counter-attack is anomalous under a strong version of the view of medicine as male control. If we accept some of the more polemical arguments about medicine's power to define women's social role and exclude and subordinate women healers it becomes extremely difficult to understand why women should have even been trying to enter the medical profession in the mid-nineteenth century, let alone that they succeeded in doing so in the 1870s. If medicine's control over middle-class women was as absolute as some accounts imply, then the very idea of women entering medicine would have been unthinkable. If medical men's opposition to women's entry was been absolute, they would never have succeeded in entering,

However, as has become clear in the analytic work stimulated

30. E. Gamarnikow 'Sexual division of labour: the case of nursing'. In Feminism and Materialism, eds. A. Kuhn and A.M. Wolpe (London: Routledge and Kegan Paul, 1978), pp. 96-123.

31. J. Leeson and J. Gray Women and Medicine (London: Tavistock, 1978), p. 24 & 20.

by some of the earliest polemical claims, the model of medicine as patriarchal control put forward has sometimes been, to use Larkin's phrase, 'over-muscular'.³² General accounts of the exclusion of women healers, particularly the arguments about witches, have been shown to be over-simplifications and poor history. By moving rapidly across centuries and continents, the degree of variation between countries, above all, between Britain and the United States has been obscured.³³ Early discussions of medical ideologies relied uncritically on prescriptive texts, or on individuals' arguments put forward as part of a polemic as indicating professional consensus. What doctors said about women was taken as a guide to what they did to women, and to women's experience at their hands. Clinical procedures that seem bizarre or cruel to the modern reader were sometimes taken out of context as evidence of misogynist attitudes, when sometimes they were also practised on men. Women were often regarded as passive victims of a medical conspiracy against them. The possibility that they might actively seek treatment or use invalidism manipulatively was sometimes ignored. The power and the unity of medicine at least before the twentieth century was often exaggerated, as was the extent to which health work was transferred to the public domain.³⁴ Ironically, in some of ^{the} early work in this field, many

32. Larkin Occupational Monopoly, p. 8. Larkin was referring to Freidson's analysis of the subordination of paramedical professions to medicine.

33. M. Versluysen "'Old Wives' Tales"? Women Healers in English History'. In Rewriting Nursing History, ed. C. Davies (London: Croom Helm, 1980), pp. 175-199.

34. For a good review of these problems in the American literature see R.M. Morantz 'The Lady and Her Physician'. In Clio's Consciousness Raised, ed. M. Hartmann and L.W. Banner (New York: Harper, 1974), pp. 38-53. On the inter-relationship of

of the claims of the medical profession to power and status were accepted at face value.

The few recent discussions of women's campaign to enter medicine do not entirely escape the charges of over-simplification and poor history. First, because the outline of this struggle is well-known through several well-established descriptive secondary sources, there seems to have been little attempt to go beyond these.³⁵ Secondly, when this has been done, a limited range of sources has been used, and not always very critically. And, unfortunately for my purposes, these articles have been mainly about the medical profession's beliefs about women and not about women's own beliefs and actions.³⁶

Any relationship between women's exclusion from their pre-industrial healing roles and the professionalization of medicine was certainly not a straightforward one. If, during the seven-

formal and informal health care see M. Stacey and C. Davies 'Division of Labour in Child Health Care: Final Report to the SSRC, 1983'. (Coventry: University of Warwick, 1983). Grant No. RB/19/14/3.

35. E.g. the discussion in Parry and Parry Rise of the Medical Profession, pp. 172-176 is superficial. A full list of secondary sources is given in Chapter V, note 1. The exception to this is C. Blake 'Women's Entry into the Medical Profession'. Unpublished M.A. dissertation, University of Essex, 1983, which gives a full narrative, though perhaps too reliant on the Lancet

36. E.g. L. Duffin 'The Conspicuous Consumptive: Women as Invalid'. In The Nineteenth Century Woman: Her Cultural and Physical World, eds. S. Delamont and L. Duffin (London: Croom Helm, 1978), pp. 26-56 relies on the Lancet, as representing 'the consensus of medical opinion in the late nineteenth century! She also draws freely on American material without comment. A fuller view that takes more account of women's views on medicine, but has only a little on women's wish to enter medicine is J. L'Esperance 'Doctors and Women in Nineteenth Century Society: Sexuality and Role'. In Health Care and Popular Medicine in Nineteenth Century England, eds. J. Woodward and D. Richards (London: Croom Helm, 1977), pp. 105-127.

teenth and early eighteenth century, women were being prevented from selling their healing skills by medical men, then these men were not members of a powerful unified medical profession. Nor were attempts to exclude the unqualified solely directed at women, or anywhere near complete success.³⁷ The incursion of men into midwifery during the eighteenth century was undoubtedly an important aspect of the emergence of the general practitioner in medicine. But it was highly controversial among the established orders of medical men, and did not guarantee its male practitioners a secure professional career.³⁸

There is no scope here for detailed discussion of these developments before the mid-nineteenth century. But one point is clear. The 'professionalization' of medicine as conventionally understood within the sociology of medicine could be said to have coincided not so much with women's exclusion as with their 'counter-attack', beginning at the end of the 1850s.³⁹ Most writers on the history of medicine have taken the 'professionalization' of British medicine to refer to the emer-

37. The fullest secondary accounts are Versluysen "Old Wives' Tales?"; J. Manton Elizabeth Garrett Anderson, (London: Methuen, 1964), pp. 55-67; A. Clark Working Life of Women in the Seventeenth Century (London: Cass, 1919: Republished 1968), pp. 236-289. Clark's account suggests that this exclusion of women was more to do with the general social changes whereby women were being excluded from public life and access to education than medical men's direct action.

38. Waddington Medical Profession in the Industrial Revolution, pp. 1-53; Donnison Midwives and Medical Men, pp. 1-61;

39. Leeson and Gray, Women and Medicine, p. 24. I am not suggesting that 'professionalization' was an instant process. But it may be that the exclusion of women and takeover of midwifery was more a precondition for medicine's emergence as a profession, or the product of the same social changes that provided these preconditions than the means by which successful professionalization was achieved.

gence of a unified occupation, basing its claims to status on occupational skill rather than social status, with state-sanctioned collegiate control over recruitment and standards, an effective monopoly over the market for its services and the ability to offer its members full-time secure careers. And they identify this process as beginning with the campaign for professional reform in the 1820s, but taking place mainly in the second half of the nineteenth century. The 1858 Medical Act brought legal unity to the three traditional orders of medical men, physicians, surgeons and apothecaries. And it established the General Medical Council as the means of self-regulation and the keeper of a register of duly qualified practitioners. Over the next fifty years there was a substantial reduction in the number of unqualified "medical" practitioners and a consequent rise in incomes. But neither of these changes happened overnight. It would be quite wrong to see the medical profession of the 1860s and 1870s as monolithically powerful or all of its members as financially and socially secure.⁴⁰

Any account of the entry of women into the medical profession should therefore consider whether there were any ways in which this was furthered by the efforts of medical men to raise the status of their occupation. Tentatively, I suggest there were several. First, one effect of the Medical Register and the move away from apprenticeship-based training towards hospital medical

40. E.g. Larson Rise of Professionalism; Waddington Medical Profession in the Industrial Revolution; Peterson Medical Profession in Mid-Victorian London. On the distinction between pre-industrial and modern professions see also P. Elliott The Sociology of Professions (London: MacMillan, 1972); D. Portwood and A. Fielding "Privilege and the Professions" Sociological Review 29 (1981), 749-773.

schools and subsequently universities was to formalize and codify examination requirements. While this did not lower the barriers that women faced, it did make these barriers more visible obstacles to be negotiated.⁴¹ Secondly, refusal by examining bodies to treat women according to the meritocratic principles they allegedly espoused, and which were the legitimation of their monopoly, was important in generating public support for women during the struggle for entry.⁴² Thirdly, it seems possible that public hostility to the growing power and autonomy of medicine may have generated some support for women's entry. This aspect has received little attention in most histories of the professionalization of medicine. For example, Larson has stressed the growing association between medicine and science as 'the cardinal system of ...legitimation' in the late nineteenth century but notes that in Britain this association was controversial within the profession, as in conflict with an earlier aristocratic ideal.⁴³ But it was also controversial among the public.

None of these factors, however, explain why women were trying to enter the British medical profession in the second half of the nineteenth century, nor why medicine was the first of the traditional professions to be 'invaded by women', not the last, as the "professionalization as patriarchal control" thesis might imply.⁴⁴ Chapter V attempts to do this, and to consider the relationship

41. Walsh Doctors Wanted, p. 14 makes this point in relation to women's entry to medicine in the United States in the mid-19th century. Larson Rise of Professionalism, pp. 90-92.

42. Larson, op.cit.; Berlant Profession and Monopoly.

43. Larson, op.cit. p. 102.

44. This point is made in Reader Professional Men, p. 181.

between the professionalization of medicine and women's campaign to enter the profession between 1858 and 1877.

Women in the Medical Profession

If historians of medicine and of feminism have given the struggle of women to enter medicine some attention, they have been almost completely silent on what happened subsequently.⁴⁵ The comment Drachman made about the United States, is even more applicable to Britain.

'Historians have focussed on the first part of this story—women's struggle to enter the medical profession. This interpretation might best be understood as the struggle/victory model: male doctors sought to bar women from medicine; in response female solidarity overcame male opposition, and women entered the medical profession... But there is a second more complex chapter to this story which the struggle/victory interpretation masks... the struggle to become a physician was simply their first battle in the more enduring struggle to be one.'⁴⁶

Given that there were some women in medicine, does this invisibility mean that the first of the two assumptions discussed at the beginning of this chapter was correct? Was gender irrelevant? Were women within the profession indistinguishable from

45. E.M. Bell Storming the Citadel (London: Constable, 1953) is the one major secondary source I have found. The two major studies that do consider how the development of medicine has shaped medical careers in the twentieth century do not consider women. R. Stevens Medical Practice in Modern England: The Impact of Specialization and State Medicine (New Haven: Yale University Press, 1966) and F. Honigsbaum The Division in British Medicine: A History of the Separation of General Practice from Hospital Medicine 1911-1968 (London: Kogan Page, 1979).

46. V. Drachman 'Female solidarity and professional success: the dilemma of women doctors in nineteenth-century America.' Journal of Social History 15 (1981-2) 607. On the history of women physicians in the United States see V. Drachman Hospital with a Heart: Women Doctors and the Paradox of Separatism at the New England Hospital 1862-1969. (Ithaca: Cornell University Press, 1984); Walsh Doctors Wanted; R.M. Morantz-Sanchez Sympathy and Science: Women Physicians in American Medicine (New York: Oxford University Press, 1985).

their male colleagues in their careers, attitudes and practice? Were they fully accepted and integrated into the profession once they had achieved entry? Were any initial differences in outlook eliminated as they passed through the powerful homogenizing institutions of medical education?⁴⁷ Or was it the case that, though women had entered the profession, they were invisible to sociologists and historians because of their absence from the institutions and activities that had been studied? These are the themes of Chapters VI to X.

When I turned to the small sociological, and rather larger empirical, literature on British medical women's careers in the past thirty years there was evidence that the second possibility might be the case. Gender did appear to make a difference to women's career outcomes in the mid-twentieth century medical profession. Although the vast majority were active, married women doctors were more likely to have discontinuous careers and to work part-time. Women were clustered in some fields of medicine and not in others. In particular, they were more likely to be in public or community health and general practice, and they were particularly unlikely to be in surgery and they were less well represented in positions of seniority and leadership.⁴⁸

47. For criticisms of the 'empty vessel' approach to medical socialization see Olesen and Whittaker 'Studies of Professional Socialization'. Women doctors have often been criticized from within the women's health movement for "failing" to resist these pressures. Ehrenreich and English Witches, Midwives and Nurses, p. 61.

48. Because this evidence is discussed in Chapter X, it is not reviewed in detail here. See Elston 'Women in the Medical Profession', and, for example, B.R. Bewley and T.H. Bewley 'Hospital doctors' career structure and the misuse of medical womanpower', Lancet (9 aug. 1975), 270-273; Jefferys and Elliott Women in Medicine; DHSS Women in Medicine, Proceedings of a

Attempts to explain these differences, or their superficially equivalent American equivalents, have taken two main approaches. The first is the 'gender' model which emphasises women's preferences or their actual or potential domestic obligations, and the cultural expectations of women's role in explaining the patterns of women's activity and their choice of field. Women were held to choose work that was compatible with their competing time demands or reduces sex-role conflict.⁴⁹ The second emphasises the formal and informal barriers and constraints that women have allegedly faced in a male-dominated profession. For example, following the seminal work of Hall on the informal organization of the medical profession, it has been suggested that American medical women's exclusion from informal networks and sponsor-protege relationships means that they are channelled into low status fields.⁵⁰

Conference organised by DHSS. 4-5 July, 1975. Sunningdale. A. Ward et al. 'Careers of Medical Women'. Report for DHSS. (Sheffield: Medical Care Research Unit, University of Sheffield, 1981).

49. E.g. J. Kosa and R.E. Coker 'The female physician in public health: conflict and reconciliation of the sex and professional roles' Sociology and Social Research 49 (1965) 294-305.

50. Lorber Women Physicians, pp. 6-7, 12-14, 31-34; P. A. Yokopenic, Bourque, L.B. and Brogan, D. 'Professional communication networks: a case study of women in the American Public Health Association', Social Problems 22 (1975) 493-509; O. Hall 'The informal organization of the medical profession', Canadian Jnl. of Economics and Political Science 12 (1946), 30-44; idem 'The stages of a medical career' Amer. J. Soc. 53 (1948), 327-336; idem 'Types of medical career' Amer. J. Soc. 55 (1949), 243-253; P.G. Bourne and N.J. Wikler 'Commitment and the cultural mandate: women in medicine', Social Problems 25 (1978), 430-440; J. Quadagno 'Occupational sex-typing and internal labor markets: an assessment of medical specialties', Social Problems 23 (1976), 442-452; C. Epstein 'Encountering the male establishment: sex status limits on women's careers in the professions' Amer.J.Soc. 75 (1970), 965-982; idem Women's Place, p. 159; Elston 'Women in the Medical Profession'.

My aim in this thesis is not to resolve the relative merits of these two approaches per se. My data is not sufficiently fine-grained for that. They are, in any case, not wholly incompatible. Each has merits in understanding how women (and men) make constrained choices in their professional and family careers.⁵¹ What I have tried to do is to indicate what the formal and informal barriers have been to women in medicine over the past century and how women responded to them. At the same time I have tried to show that the significance of marriage or motherhood for a medical career has not been constant, but has shifted with changing attitudes to married women's work and with developments in the organization of medicine. I have tried to indicate how it is that certain fields within medicine have been more accessible to women than others, and the differing ways in which women have interpreted their role as women who are also doctors, and doctors who are also women.

51. L.R. Davidson 'Choice by constraint: the selection of function of specialties among women physicians in training' Jnl. of Health Policy, Politics and Law 4 (1979), 200-220.

CHAPTER III

HOW MANY WOMEN DOCTORS?

Introduction

How many women have been able to have careers in British medicine since the 1870s? Have they been the tiny minority in an almost exclusively male profession that some imply? Or is their invisibility a product of sociological blinkers? This chapter and the following one examine statistical evidence on the numbers of women in the profession and in medical schools. I begin by considering the data on the numbers of doctors and then discuss the trends they show. Women have clearly been a minority within the profession throughout the past century. But, I shall suggest, it is less clear that they have been an exceptionally small minority.

Official Statistics on the Number of Doctors?

The number of doctors has long been a matter of concern to the profession, to politicians and to the public, albeit for different reasons. Because of this, there is for medicine more information about the stock of practitioners than for most occupations, though such information has proved notoriously inadequate for planning purposes under the NHS.¹ Most of this information is derived directly or indirectly from official sources.

1. See e.g. J. Parkhouse Medical Manpower in Britain (Edinburgh: Churchill Livingstone 1979); C. Ham Policy-making in the National Health Service (London: MacMillan, 1981), pp. 78-97.

Some sociologists have argued against the use of official statistics on the grounds that they are collected for interests, and under assumptions, incompatible with sociological concerns.² In my view, universal scepticism, regardless of the topic of inquiry, is unwarranted. Some of the more extreme sceptics are, in effect, arguing against the use of empirical evidence at all in sociology. Many of their claims would, if valid, be equally applicable to non-official statistics and qualitative data. Moreover, specific criticisms that apply to information derived from administrative procedures, may not apply to data obtained through censuses and surveys, and vice versa. But the methods of recording, classifying and processing data in official statistics do need to be carefully examined.³

Before using any source to answer the question 'How many women doctors were there?', we need to establish the answers to three prior questions: (i) Who counts as a doctor? (ii) Who counts as a British doctor? (iii) When do doctors cease to be doctors?⁴

In Britain, after 1858, there are at least three answers to the first question: those who have undergone a formal training in medicine, those who are 'registered medical practitioners' under the terms of the 1858 Medical Act, and those who describe

2. See M. Bulmer 'Why don't sociologists make more use of official statistics', Sociology 14 (November 1980), 506-8. C. Davies 'Making sense of the Census in Britain and the USA: the changing occupational classification and the position of nurses', Sociological Review 28 (August 1980), 581; B. Hindess The Use of Official Statistics in Sociology (London: MacMillan, 1973); Critics include A.V. Cicourel Method and Measurement in Sociology (Glencoe: Free Press, 1964).

3. Bulmer 'Official statistics', 508-9; C. Hakim 'Census Reports as Documentary Evidence: The Census Commentaries 1801-1951', Sociological Review New Series 28 (August 1980), 580.

4. Cf. Davies 'Making Sense of the Census', p. 595.

themselves as 'doctors'. My concern is with the first group, those with formal credentials.⁵

The second question arises because a qualification in medicine has proved highly portable. British trained doctors have worked overseas, and overseas trained doctors have worked here. Sources vary in their classification of both immigrants and emigrants. My interest is in women of British origins who trained in British medical schools, wherever they have practised, but these are not easy to identify. About a quarter of the doctors in the NHS in 1984 were born overseas, and there were proportionately fewer women among them than among British-trained doctors.⁶ Conversely, it is probable that between 1881 and 1931, more British trained women than men emigrated. There is little evidence of differences in emigration rates since then.⁷

The third question refers to the use of medical qualifications. How are those not using their qualifications classified in a given source, and how is this determined? This question is especially pertinent when women doctors are being considered. The classification of economic activity used in many official sources is based on 'a masculine conception of employment', leading to the under-recording of work that is not 'full-time, full-year-round employment outside the home'.⁸

5. For simplicity I am ignoring the fact that the term 'doctor' did not come into general use as a generic term for the legally unified occupation of medicine until the late nineteenth century. See e.g. M.J. Peterson Medical Profession in Mid-Victorian London.

6. DHSS Health and Personal Social Services Statistic for England & Wales (London: HMSO, 1985); D. J. Smith Overseas Doctors in the National Health Service (London: Heinemann, 1978)

7. See Chapters VI and X.

8. Beechey Women and Employment, Unit 10, p. 38; P. Allin

Figure 3.1. lists the major sources of statistics, indicating how they answer these questions and the information they give about the stock of British-trained women doctors. Only three sources, the Medical Register, The Medical Directory and the Population Census, cover the whole period.

The Medical Register

Since the mid-1870s, each annual volume of the printed Medical Register has included tables giving the total of registered doctors, new registrations and removals. These have been used by some as estimates of the size of the British medical profession.⁹ But there are a number of problems with the Register for my purposes. Self-evidently, the Medical Register only includes those who hold registerable qualifications who have applied to the GMC. Thus all those who continued to practise unregistered after 1858 were omitted, including the small number of women with European medical degrees in the early 1870s known to have been practising unregistered, and possibly more unknown.¹⁰

The question of which qualifications should be recognized for full or temporary registration by the GMC has been an issue of recurring controversy, particularly with regard to overseas qualifications. The history of the Medical Register reflects intra-occupational divisions as well as relations between doctors and the state.¹¹ The Register includes registered doctors, regardless

and A.Hunt 'Women in official statistics', in The Changing Experience of Women, eds. E. Whitelegg et al. (Oxford: Martin Robertson, 1982), pp. 337-351.

9. E.g. P.R. Jones Doctors and the BMA: A Case Study in Collective Action (London: Gower, 1981), p. 48; G. Forsythe Doctors and State Medicine (London: Pitman Medical, 1973), p.8

10. See Chapter V.

Sources of Data On Medical Practitioners						
<u>Source</u>	<u>Period</u> <u>Comparable Data</u>	<u>Interval</u>	<u>Whom Included</u> <u>(Qualification)</u>	<u>Geographic Area Covered</u>	<u>Coverage of Inactive</u> <u>Doctors</u>	<u>Tables published</u> <u>by Sex</u>
<u>Population</u> <u>Census</u>	1841-1981 (excluding 1941)	10 years	Those describing themselves as doctors, subject to enumerators & others' checking	Doctors resident in Great Britain	Varies - some included	Yes
<u>Medical</u> <u>Register</u>	1858 - (post 1970 not comparable)	Annual plus fortnightly updates	All those on General Medical Council Register	All doctors registered with GMC Great Britain	Yes, some reduction after 1970	No
<u>Medical</u> <u>Directory</u>	1858 -	Annual	All those returning form sent to all above	Summary tables identify various geographical locations	Yes, if form is returned	No
<u>The English</u> <u>Woman's</u> <u>Yearbook</u>	1876-1908	Annual	Registered Medical Women known to editor	World: 1897-1908 ordered by location	Yes	Women only
<u>CMRC/CDCI</u>	1963 -	Annual	Now based on doctors registered with GMC in Britain	Great Britain Excludes temporary registered doctors 1963-1975	Varies, 1963-1980 "unknown occupation" classed as active	Yes

FIGURE 3.1:

of where they live, but doctors known to be living overseas have not been included in the printed Register in recent years. Summary tables giving area of first registration are printed.

Finally, the Register lists registered doctors, not practising registered doctors. Before 1970, registration with the GMC occurred once (normally) in a doctor's career. Doctors' names were only erased on death, as a result of disciplinary proceedings or as a result of failure to respond to the occasional GMC circulars. Since the 1969 Medical Act, annual registration has been required, probably reducing the numbers of inactive doctors and out-dated addresses on the Register, but making comparisons over time more difficult.¹²

The major drawback of the Register for my purposes is that, until 1973, no distinction was made in the GMC's records between women and men doctors. No counts of the total names of each sex were prepared by the GMC until 1 March 1982.¹³ Interestingly, the first women on the Register were opposed to any official

11. On the conditions of registration, see the annual published Medical Registers; Report of the Committee of Inquiry into the Regulation of the Medical Profession (London: HMSO, 1975) (Merrison Report). On the history of the recognition of Indian qualifications see R. Jeffery 'Recognizing India's doctors: the institutionalization of medical dependency, 1918-1939' Unpublished paper, 1983. Separate lists are currently kept of overseas-trained doctors who have only been given temporary registration for specific posts.

12. In 1976, using the updated Register, Beaumont found 0.3 per cent of a sample of 3,000 women were misclassified by sex and an estimated 2 to 4 per cent of women eligible, as qualifying in the relevant years, were not on the Register. B. Beaumont 'Special provisions for women doctors to train and practise in medicine after graduation: a report of a survey' Medical Education 13 (1979), 285.

13. Personal communication, General Medical Council. Before this date counts of new registrations by sex were sometimes made for specific purposes, presumably relying on first names.

intimation of difference from their male peers. In 1878, a deputation of women doctors protested to the Privy Council about the Medical Act (Amendment) Bill's proposals for a separate section of the register for women. The women were supported by a memorandum against professional divisions from the BMA, concerned lest its campaign for equal status for all registered practitioners be compromised.¹⁴

Counting the names on the Register is no mean task. In 1900 there were 37,000 names in the published volume, and, by 1980, about 100,000. Before 1973, first names would be the only guide to doctors' sex; and, because place of training is not given, overseas-trained doctors cannot be reliably distinguished from British doctors. Fortunately, estimates of the number of women on the Register are available for some years before 1982. Between 1876 and 1909 the feminist journal The Englishwoman's Review and its companion The Englishwoman's Yearbook listed names and last-known addresses of women on the Register. In 1876 there were two. But in 1909, there were 848, and the list was discontinued because the task was no longer manageable. These lists include registered women living overseas. Of 848 names in the 1909 edition 29 per cent had addresses outside the United Kingdom. The Medical Women's Federation (MWF) founded in 1917 as a professional association for women doctors, has made a number of such counts.¹⁵

Churchill's Medical Directory is compiled from forms sent to

14. Times 8 May 1878; 3 Aug. 1878; Daily News 1 June 1878 (RFHSM PC Book I); J. Scott 'Women and the GMC' BMJ 289 (22-29 Dec. 1984), 1764-767; C. Newman The Evolution of Medical Education in the Nineteenth Century (Oxford: Oxford University Press, 1957).

15. Such counts were usually made for surveys or for mailing lists for GMC Elections. I am grateful to the MWF for searching for any unpublished counts in their files.

all whose names appear in the previous year's Register. Before 1970, addresses in the Directory were, therefore, more up to date than those in the Register, and the former was used as the main population list for the MPU survey of women doctors in Britain in 1962.¹⁶ Doctors' entries may include the place of training, and may also include the information that they are 'retired'. The list is arranged by area of residence, and includes an overseas section. The problem with the Directory, is that inclusion is voluntary, and possibly biased against inactive doctors. And, although totals of entries are tabulated, no separate totals for men and women are provided.

The difficulty of assessing the number of women from the Register or the Directory is illustrated by an exchange in the BMJ in 1954. A leader on 'Women in Medicine', reported 7,600 women on the Register, 6,000 of them active. It declared, that this 'impressive number lends force to the fact that women are now established in medicine and are accepted as a matter of course by their male colleagues and the public'. The secretary of the MWF pointed out that the BMJ had considerably underestimated the impressiveness of the number. She stated that there were 13,374 women in the Medical Directory for 1954, 12,500 of them active (75 per cent more in total and 100 per cent more active than the BMJ's figure). Her letter was accompanied by an editor's note that another estimate stated that, in January 1954, there were 10,800 women's names on the Register, 7,600 active. A member of the MWF commented, 'these figures are so at variance that I can only assume that one was made in error'. She described the procedures

16. Jefferys and Elliott Women in Medicine. GMC fortnightly lists and Ministry of Health information were also used.

adopted by the MWF in counting the Directory and drew attention to problems of the sort I have mentioned. The editor admitted the first figure (7600) was inaccurate, and explained some, but not all, of the discrepancy.¹⁷

The Central Recruitment Committee Index

The limitations of the Register for providing up-to-date information about doctors led those concerned with staffing the National Health Service in its early years to use a data source begun for quite different purposes. In the First World War, the BMA drew up a record of all registered civilian doctors available for medical work resident in Britain.¹⁸ Continued after 1918, this Index was counted for the Goodenough Committee on Medical Education in 1944. It listed 51,539 doctors aged less than 80 (7198 women), living in Great Britain and Northern Ireland compared with 57006 in the same areas in the Directory, and 69428 on the entire Register.¹⁹ The Willink Committee investigating the required numbers of medical students in 1955, counted some 60,800 names (11,000 women) on the Index and 85,594 on the Register.²⁰

Renamed the Central Medical Recruitment Committee Index (CMRC) and subsequently the Civilian Doctors' Career Index (CDCI),

17. BMJ (15 May 1954), 1143; (22 May 1954), 1210; (24 July 1954), 245.

18. 'Civilian' referred to doctors' status prior to the outbreak of war, i.e. only doctors in regular service with the Armed Forces prior to 1914 were excluded. This still continues. About 1400 armed forces doctors are excluded from 1980s figures.

19. Ministry of Health Report of an Inter-Departmental Committee on Medical Schools (London: HMSO, 1944) Cmd.7420, pp. 248-251.

20. Ministry of Health Report of Committee to Consider Future Numbers of Medical Practitioners and the Appropriate Intake of Medical Students (London: HMSO, 1957), pp. 3-4.

and now the responsibility of the DHSS, it has become a computerised data base of all civilian doctors, who are, or have been, registered with the GMC in Great Britain.²¹ It is now the best source available on the stock of doctors in Britain.

The Decennial Population Census

Given the limitations of these sources, it is not surprising that many sociological discussions of women doctors have used data from the Decennial Population Census, which provides tabulations for a wide range of occupations classified by sex.²² But the answers given in the Census to the three questions posed earlier are different from those derivable from the sources discussed so far. For example, the Census aims to enumerate all those and only those resident in the areas covered by the Census Offices on a given night, thus including all doctors in the country, wherever trained, and excluding British-trained doctors overseas. Census data between 1881 and 1931 probably underestimate British-trained women relative to men.

Who does the Census count as a doctor? In their discussion of professions, Carr-Saunders and Wilson cautioned that,

'The Census does not give any reliable indication of the

21. DHSS Advisory Committee for Medical Manpower, p.4; Parkhouse Medical Manpower, pp.51-60; DHSS Medical Manpower, pp.45. Information on doctors in the NHS is obtained by a count on 30 September each year, returns made during the year by employing authorities to the DHSS, or, for Scotland, the Common Services Agency. The DHSS also routinely collects information on doctors employed in the civil service and universities

22. E.g. M. Fogarty, R. Rapoport, R.N. Rapoport Sex, Career and Family (London: George Allen & Unwin, 1971), esp. pp. 20-2. NB. In the statistics that follow I have only considered the Censuses covering Great Britain, as those for the Republic and Northern Ireland are different. Figures for Great Britain between 1861 and 1996 are my summing of the separate figures for England and Wales and Scotland.

total number of persons practising any profession, since with a few exceptions such as patent agent and veterinary surgeon, it is open to anyone to assume any general designation he pleases. We have come to regard as professional men only those who are qualified..'²³

This passage alludes to two issues: the problem of inaccuracy in the self-reports which are the basis of Census occupational tables, and the process of professionalization, whereby the legitimacy of claims to certain occupational titles has come to depend on formal qualifications.

How many unqualified persons have claimed to be medical practitioners in successive censuses must remain unknown. But the Census commentaries, published between 1861 and 1951 show that the compilers of the Census were concerned to reduce the numbers of inappropriate claims. And the professionalization of medicine is reflected in the changing categories used to classify self-descriptions in order to produce occupational tables in successive Censuses. In these discussions, and in the published tables there are intimations that Census compilers were cautious about recognizing women's claims to be practitioners or students of medicine.²⁴

As Table 3.1 shows, in 1861, following the 1858 Medical Act, surgeons and apothecaries were separated from medical students and

23. A.M. Carr-Saunders & P.A. Wilson The Professions (Oxford: Clarendon Press, 1933), p. 505. (Emphasis added)

24. One result of reduced claims by the unqualified or the changing classification was a marked reduction in the number of "medical practitioners". In 1911 there were still fewer doctors in relation to the population than there had been fifty years previously. Waddington Medical Profession in the Industrial Revolution, p. 149. The census compilers were also much concerned with women's employment, as discussed in Hakim 'Census Reports as documentary evidence' and Davies 'Making Sense of the Census'. My discussion of Census data owes much to these two articles.

Table 3.1
1861 Census England & Wales:
Occupational Classification: Order III, Sub-Order 3

	M	F
Physician	2385	n/a ^a
Surgeon, Apothecary	12030	n/a
Medical Student, Assistant	3566	n/a
Dentist	1567	17
Chemist, Druggist	16026	388
Midwife	n/a	1913
Copper, Bleeder	10	58
Officer of Medical Society, Medical Agent, Clerk	2	n/a
Corn Cutter, Chiropodist	56	20
Professor of Hydropathy, Homeopathy	27	n/a
Patent Medicine Vendor, Herb Doctor	92	20
Others connected with medicine	215	30

Source 1861 Census England & Wales, Vol 2, pp. xliii & lvii.

^a The original tables, printed separately for each sex, noted 'When an Order or Sub-order consists of occupations inapplicable to both sexes it occurs only in the Table for the sex to which it is appropriate.' (Emphasis added)

assistants but not ranked with physicians. The 'Other' category for Females included 13 "'doctors'", 1 medical student, 5 mesmerists and 2 bonesetters. Thus the female medical student (who might have been Elizabeth Garrett) is not included in the official category 'medical student'.²⁵ The 'Other' category for males contained not "'doctors'" but 'quack doctors'. These women "doctors" might have included Mademoiselle Cavana of Nottingham, who, in 1863, advertised herself as the only female practitioner with a diploma practising in England.²⁶

25. Source as for Table 3.1. Scare quotation marks around "Doctors" in the original. Elizabeth Garrett had been an informal student at the Middlesex Hospital Medical School from August 1860 to June 1861. L.G. Anderson Elizabeth Garrett Anderson 1836-1917 (London: Faber and Faber, 1939), pp. 62-86.

26. The advertisement claimed she was "'effecting a revolution in medical practice, as evinced by the immense number of cures she has performed ... and the daily increasing number of patients, particularly females who are wisely availing themselves of her professional knowledge and skill, of which reports speak as being of high order... '". BMJ i (4 April, 1863), 362. Other than

By 1871, the printed tables classed physicians and surgeons together, 'the qualification having been much raised'. But this category and that of 'medical student' was still omitted from the women's occupational tables in England and Wales. The commentary noted that, '[Women] are also excluded wholly or in great part from the church, the law and medicine; whether they should be rigidly excluded from these professions or be allowed—on the principle of freedom of trade—to compete with men, is one of the questions of the day.'²⁷ Perhaps, by chance, the two women who were on the Register, and all the small number of English women studying medicine at the time, were not enumerated; or perhaps their entries were classified as 'Other'.²⁸ In Scotland, two women 'physicians and surgeons' and five medical students were recorded in the 1871 Census.²⁹ At the time, there were at least seven women students studying medicine at Edinburgh University. Even if these were not the women recorded in the Census, the very public presence of women medical students was unlikely to be ignored by Scottish Census officials. In 1881, women medical practitioners and students, and 'general practitioners' appear for the first time in the tables for England and Wales.

an entry in a contemporary street directory, Nottingham Record Office have been unable to trace any record of Mlle Cavanaia.

27. Census England & Wales, Vol 4, General Report, p.xli.

28. No breakdown of the 'Other' category was printed in 1871. It is possible that all the medical women were abroad on Census day 1871, failed to complete census forms or did not record their medical activity. This latter seems unlikely given their commitment to showing women could be doctors.

29. Census Scotland, C-380, p. 199.

Table 3.21881 Census: England & Wales:Occupational Classification: Class I (Professions) Order 3

	M	F
Physicians, Surgeons, General Practitioners	15091	25
Dentist	3583	n/a
Medical Student, Assistant	5991	64
Midwife	n/a	2646
Subordinate Medical Service	1972	35175

Source: 1881 Census: England and Wales. C3797.

The 1891 Commentary for England and Wales reported that,

'The persons entered as physicians, general surgeons or general practitioners, numbered 19,037 showing an increase of nearly 26 per cent upon the number returned in 1881. We regard, however these returns with much suspicions and think it probable that no few unqualified persons return themselves as medical practitioners... Among the 19,037 persons returned as practising medicine were 101 women and we think it possible there here also there may have been some exaltation of status, and that among the 101 there would be found some who were students rather than practitioners.³⁰

The Englishwoman's Yearbook showed 65 registered medical women with addresses in England and Wales in 1891. So there may have been some 'exalted' claims from students or assistants, many of whom will have been doing substantial amounts of medical work. But unqualified and qualified but unregistered women may also be included in the Census returns. There is no explicit reference yet to registration or qualification in the classification until 1911, when medical students began to be classified with other 'students'.

30. 1891 Census of England and Wales, Vol 1V General Report, C7222, (1893), p. 39; Englishwoman's Yearbook 1892.

Economic Activity and Retirement in the Census

The Census divides the enumerated adult population into two categories: from 1841 to 1961 into those normally occupied for pay or profit and those unoccupied; and since 1961, into those 'economically active' (in employment or actively seeking work) in the week preceding the Census and those not. Those engaged solely in domestic duties have been classified as unoccupied since 1891. From 1921 to 1951, schedule instructions specified that those engaged chiefly in domestic duties should be classified as unoccupied, even if working a few hours a week. Women's part-time work outside the home is known to be under-recorded in Censuses before 1971.³¹ Some women doctors working part-time may therefore be omitted from the Census.

Since 1911, tables showing numbers of 'retired' medical practitioners have been published. Adding the small numbers of retired women doctors to the active women given in Census tables from 1911 to 1951, raises these totals by between 4 and 7 per cent. Some of these may have been women 'inactive by reason of marriage'.³² Before the Second World War the term 'retired' was in general (and Census) use to describe women who had given up work on marriage, which reflected the fact that such withdrawal was then more likely to be permanent, than it is now. By 1961, the schedule contained specific instructions against including

31. K. E. Gales and P.H. Marks 'Twentieth-century trends in the work of women in England and Wales' Journal of Royal Statistical Society Series A 137 (1974), 60-74. Hakim 'Census Commentaries' p. 556-8; idem Occupational Segregation, esp 3-4.

32. In 1931, over half the three hundred retired women doctors were aged less than 55 and in 1951, over 60 per cent. In 1931 28 per cent of active and 60 per cent of retired women doctors in England & Wales were ever-married. Census figures.

inactive married women under their former occupations.³³

The Census, then, gives invaluable information about the numbers of women describing themselves as active medical practitioners in Great Britain. It does not tell us how many qualified women there were and how many trained in Britain. In the past it has probably underestimated medical women's activity. We cannot use its data for calculating wastage or marriage rates. Changes in the numbers of active women doctors recorded in the Census may reflect changes in the classification of women's activity as well as changes in that activity.³⁴

The Increase of Women in British Medicine

There is, then, no simple answer to the question 'How many British women doctors have there been?'. Table 3.3. gives data from some of the different sources between 1871 and 1981. Both the Census and the Register record the number of women doctors as doubling every decade up to 1931, and continuing to increase thereafter. Differences between estimates are as one would expect. In 1871, the figures for the Medical Register and the Census correspond, but probably do not refer to the same women. In 1881, slightly more women were recorded in the Census than on the Register. Thereafter, numbers on the Register in Great Britain are consistently greater than numbers recorded in the Census, because of the inclusion of inactive doctors. The CMRC/CDCI figures give some support to the suggestion that Censuses may have under-

33. Hakim Occupational Segregation pp 3-12.

34. The 1911 figures may understate active medical women very slightly. At least one is recorded as heeding the Women's Freedom League's call to women householders to refuse to complete their forms. E.L. Acres Helen Hanson: A Memoir (London: Atkinson, 1928), p. 74.

TABLE 3.3

Numbers of Women Doctors in Great Britain: 1871-1971

Year	Census ^a Active Doctors	Medical ^b Register	CMRC/CDCI ^c Index (Active)
1871	2	2	-
1881	29	25	-
1891	113	129	-
1901	277	456	-
1911	610	930	-
1921	1500	2100	-
1931	3330	5300	-
1941	-	6300	7198 (6064)
1951	7520	9500	11400 (8300)
1961	9440	12800	-
1971	11970	16000	(12596)
1981	19440	26100 *	22300 (20600)*

* United Kingdom Figures

Notes on Sources

- a Census Reports, England & Wales, Scotland & Great Britain, 1871-1981. From 1871 to 1901 no distinction was made between active and retired doctors.
- b 1871-1901 Englishwoman's Yearbook Names on Register for England and Scotland (ie include overseas residents).
 1911 Own count: names included as for 1871-1901.
 1921 Own count: names in Register, recorded address in Great Britain
 1931-1971 MWF: names in Register, with recorded address in Great Britain. '1941' figure is of 1940 Register. '1971' of 1972 Register. NB Change in criteria for inclusion in Register 1951 and 1971.
 1981 GMC Figure for United Kingdom
- c '1941' Report of an Interdepartmental Committee on Medical Schools, 1944. Count of BMA Index for 1944
 '1951' Report of the Committee to Consider the Future Numbers of Medical Practitioners and the Appropriate Intake for Medical Students, 1957. Count of BMA Index for 1955.
 1971 DHSS Medical Manpower: The Next Twenty Years, 1978, p.46.
 '1981' DHSS Report of the Advisory Committee for Medical Manpower Planning, 1985 p. 17. 1980 United Kingdom Figures.

estimated women doctors' activity in the past.³⁵

In 1971, Fogarty and the Rapoport's suggested that there was a common pattern in women's entry to a number of higher professions.

'There is a slow start, a rapid acceleration as the new development takes hold, then a tendency for the curve to flatten as a state of equilibrium is reached.'³⁶

Rather confusingly, they also describe these three phases in terms of rates of growth, as a 'sequence from breakthrough to acceptance onto a plateau suggesting stagnation.'³⁷ In the 1960s it appeared that that this plateau had been reached for women in higher professions as a whole.

'Between the Census years 1921 and 1931, in the decade immediately following the first opening of the doors to women in many professions, the numbers of women in higher professional work rose nearly twice as fast as the number of men, by 3 per cent a year as against 0.8 per cent. This was the classic decade of breakthrough. From 1931 to 1951 the two rates of growth were much closer together, though women still had a slight edge over men with an annual growth rate of 3.6 per cent against 3 per cent. But from 1951 to 1961 the number of men went on growing at 4.5 per cent a year while the number of women actually fell by nearly one per cent a year. The fall was mainly accounted for by a drop in the number of women professionally employed in religion. But the number practising medicine also fell ...'³⁸

Figure 3.2 plots the Census data on numbers of active medical women. There was indeed a 'slow start'—but this is a misleading term. The rate of increase in this early period was large. This

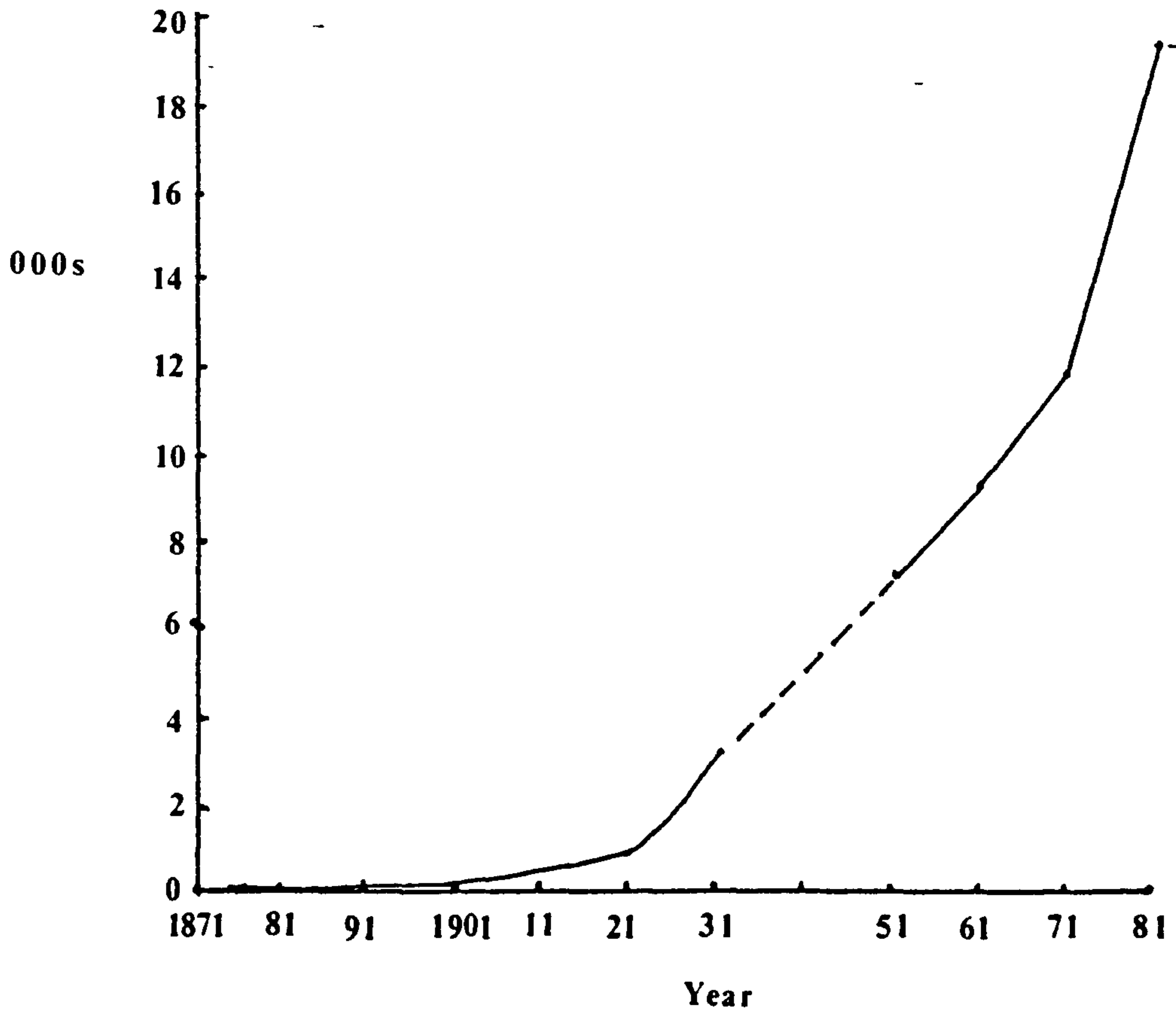
35. Prior to 1980, the CMRC regarded doctors of unknown occupation as active. In 1980 these doctors were classified as active/non-active in proportions derived from information on doctors' occupational movements in previous years. DHSS Advisory Committee for Medical Manpower Planning pp.55-6.

36. Fogarty, Rapoport & Rapoport Sex, Career and Family, p. 24. In this passage they are referring to numbers of women, at other times they confuse this with the trends in the proportion of women in the profession.

37. Fogarty et al., op. cit., p. 20.

38. Ibid., p.21. (Emphasis added)

FIGURE 3.2:
Active Women Medical Practitioners: 1871-1981
Census. Great Britain



Notes:

1881-1901 Figures include retired practitioners

1961 10 per cent sample, corrected for bias.

1971-1981 10 per cent sample.

is shown in Table 3.4. In medicine, the 'classic decade of breakthrough', the decade with the fastest rate of increase, was 1881-1891, not 1921-1931. There was, however, a considerable increase in active medical women in the decade after the First World War, the product of wartime disruption that will be discussed in Chapter XIII. The rate of annual increase in the number of active women doctors declined after 1931 and was lowest in the 1950s, producing the slight flattening of the curve in Figure 3.2. Whether we should see this as stagnation is doubtful. For rates of increase to slow as the numbers of active medical women grow is hardly surprising. The increase in the number of active women doctors between 1951 and 1961 was equivalent to the total number in 1931. The rate of growth between 1971 and 1981 is all the more significant, given the relatively large numbers to begin with.

Table 3.4 does not show the decrease in women doctors between 1951 and 1961 that Fogarty, Rapoport and Rapoport suggested, but indicates that women increased slightly more than men. This is because I have used the published Census figures of 8,300 active women doctors in England and Wales in 1961. They were quoting from an article which gives a total of 6,400 women doctors (23 per cent less than my figure) but a reduction of only 230 male doctors from the published figures. This article reclassified a sample of 1961 Census returns to the 1951 occupational classification, but this should not have affected medical practitioners.³⁹

I have been unable to determine the reason for this discrepancy. Perhaps a substantial number of women have been reclassi-

39. R. Knight 'Changes in the Occupational Structure of the Working Population' Journal of the Royal Statistical Society Series A, vol 137 (1967), 414.

Table 3.4:Growth in Active Medical Practitioners between Census Years:1881-1981: Analysis by Sex: Great Britain

Years	Average Annual Percentage Growth ^a		
	Women	Men	All Doctors
1881-1891	14.6	2.4	2.4
1891-1901	7.2	1.7	1.7
1901-1911	10.4	0.3	0.4
1911-1921	9.4	< 0.1	0.4
1921-1931	8.3	1.4	1.9
1931-1951	4.2	1.5	1.9
1951-1961	2.3	2.0	2.1
1961-1971	2.4	1.2	1.4
1971-1981	5.0	0.9	1.7

^a Average annual percentage growth calculated according to the

formula: $r = (m \sqrt[m]{X_n/X_r} - 1) 100$

R. Floud An Introduction to Quantitative Methods for Historians, (Methuen: London, 1973), 94. r is the desired growth rate, m the difference in years between the first and last period, and X_r and X_n the values for the first and last periods respectively.

fied as inactive or some doctors have been omitted (perhaps those in public health). If it is a mistake then the 'stagnation' of women in the higher professions as a whole between 1951 and 1961 may be overstated in Sex, Career and Family.⁴⁰

Table 3.5 shows the changing proportion of women active in the medical profession recorded in successive Censuses and Table 3.6 gives detailed information for the years 1965 to 1980 from the CMRC/CDCI. The percentage of women in the profession doubled every decade from 1881 to 1931. The Register records similar figures

40. The OPCS Census advisors confirmed my suspicion of this low figure and were unable to shed light on it. Knight definitely errs in attributing the relatively slow rate of growth in medicine as a whole between 1951 and 1961 to the Willink Report recommendations, which could not have directly influenced the number of active doctors by 1961. (Ibid.) It is impossible to recalculate the growth rates for the higher professions quoted in Sex, Career and Family, because totals for all professional occupations are not given.

over the same period; women being about one per cent of registered medical practitioners at the beginning of this century, and about 10 per cent in the 1930s. The Goodenough Committee found that women were 14 per cent of all doctors on the Index in the United Kingdom, aged less than 80 years, and 13 per cent of active doctors in 1944. Women were however 17 per cent of all doctors (15 per cent of active doctors) under the age of 50.⁴¹

After the Second World War there is more divergence between the Census and Register figures, with women being about 23 per cent of registered doctors in Great Britain in 1971 and about 30 per cent in 1981.⁴² This divergence is probably due to a combination of factors: the greater likelihood that women of working age will be inactive compared to men: the increasing proportion of women doctors over retirement age, as the large First World War intake reach this phase of their lives; and the growth in the number of active male doctors since the 1950s.

Table 3.6 shows that despite the considerable growth in men's already much larger numbers, the proportion of women active in medicine grew by 40 per cent over the fifteen years, according to these estimates. Little of this increase can be attributed to the formal abolition of quotas of places for women in medical school, following the the recommendation of the Committee of Vice-Chancellors and Principals in 1973 and the 1975 Sex Discrimination Act. It is, as we shall see, the product of increased output from medical schools before 1974-5, immigration, and a rise in qualified medical women's activity.

These admittedly limited data show that the number of British

41. Goodenough Report, pp. 253-4.

42. MWF Figures and Medical Register.

Table 3.5.Active Medical Practitioners 1881-1981: Analysis by Sex(Census: Great Britain) ^a

Year	Men	Women	Total	%Women
1881	16965	29	16994	<1
1891	21519	113	21632	1
1901	25391	227	25618	1
1911	26090	610	26700	2
1921	26260	1500	27760	5
1931	30060	3330	33390	10
1951	40710	7520	48220	16
1961	49760	9440	59200	16
1971	55920	11970	67890	18
1981	61230	19440	80670	24

^a Data for 1961 to 1981 based on 10 per cent sample.

Table 3.6:Active Medical Practitioners 1965-1980: Analysis by Sex(CMRC/CDCI: Great Britain)

Year	Men	Women	Total	%Women
1965	51279	9862	61141	16
1966	52239	10306	62545	16
1967	52868	10584	63452	17
1968	53488	11040	64528	17
1969	54772	11434	66158	17
1970	55766	12269	68035	18
1971	56311	12596	68907	18
1972	56137	13067	69204	19
1973	57643	14534	72177	20
1974	57981	15221	73202	21
1975	58600	16000	74600	22
1976	59200	16700	75900	22
1977 ^a				
1978 ^a				
1979 ^a				
1980	68000	20600	88600	23

Source 1965-1976 DHSS Medical Manpower, p. 46; 1980 DHSS Advisory Committee for Medical Manpower, p.17. Figures do not include temporarily registered doctors.

^a No figures found for these years.

registered medical and of active practitioners has increased considerably over the last century. Women have been taking a larger share of an expanding occupation. But they remained a minority. Does this indicate that medicine has been an occupation peculiarly closed to women?

Women as a Minority in Medicine

It sometimes implied that the fact that women constitute a minority of medical practitioners is, in itself, evidence of entry barriers specific to women; and that parity of numbers would represent a normal or a just situation. But if the sexes were equally numerous in the profession, this would not, in itself, show that there were no barriers, or that an aspirant's chance of success was unaffected by his or her gender. This would follow only if the proportions of equivalently qualified applicants were identical. There is no logical incompatibility between equal opportunity and having no women, or one hundred per cent women, and certainly no reason to expect the result to be equal numbers. (This is not to say that women applicants have not been and are not discriminated against, only that parity, in itself, would tell us little.)

The numerical predominance of men in medicine is typical of an occupational structure highly segregated by sex. In 1901, in 74 per cent of all occupations classified in the Census for England and Wales, more than 70 per cent of workers were men. In 1971, in 74 per cent of all occupations at least 64 per cent of the workforce were men. An occupation in which women were fifty per cent of the work force would be one in which women were over-represented relative to their presence in the labour market as a

whole. In 1901, women were 29 per cent of the total labour force, 37 per cent in 1971, 42 per cent in 1981.⁴³

How has the representation of women in medicine compared with their presence in other occupations regarded as 'higher' professions over the past century? Does medicine represent a paradigm of male dominance within an occupational category which has grown substantially in this time, especially since World War Two. As Halsey points out, 'the increasing numbers of higher-professional and managerial positions have largely gone to men...'. Using Census data adjusted for changes in classification, he shows that, in 1911, 1.5 per cent of all occupied males, and 1 per cent of females were 'Self-employed and higher-grade salaried professionals'. By 1971, the proportion of males in this category of professionals had increased by 400 per cent, to 6.1 per cent, but for women, the proportional increase had been less than 50 per cent, to 1.4 per cent.⁴⁴

This greater percentage increase in male professionals is not shown within medicine. The tiny percentage of all economically active males recorded as doctors in the Census doubled between 1911 and 1981 (from 0.20 to 0.35 in 1971 and 0.40 per cent in 1981). But for women it grew from 0.01 to 0.14 in 1971 and 0.2 per cent in 1981, 2000 per cent. For men, the percentage of all professionals who were medical practitioners halved over this period, from 13 per cent to 6 per cent. For women, medicine increased its share from 1 per cent to 10 per cent.⁴⁵

43. All figures on occupations besides medicine from Hakim Occupational Segregation, pp. 24-34; idem 'Job segregation in the 1970s' Employment Gazette (Dec. 1981), 521-529.

44. A.H. Halsey Change in British Society (Oxford: Oxford University Press, 1986) pp. 32-35.

In discussing the effects of the First World War on women's entry to the professions, the 1921 Census Commentary confirmed the point made earlier with respect to Sex, Career and Family: the chronology of women's entry to medicine is different: 'The admission of women commenced first and has proceeded furthest in medicine...' In 1921, though the only 'professions' distinguished in the Census with no women were the ministries of the Established and Roman Catholic churches, only in medicine was there more than a tiny number.⁴⁶ The difference between medicine and other professions in 1921 has been maintained. Hakim notes that, 'Women's participation in top jobs was minimal in 1971, hardly any higher than in 1911. The only notable increase was amongst doctors, where the proportion of women rose from two per cent to 20 per cent.'⁴⁷

Table 3.7 appeared in a popular sociological text to illustrate women's minimal presence in the professions.

The table shows that women were a small minority in all these occupations, but, in many contexts, a difference between zero and 14 per cent is considered significant.⁴⁸ The table would also

45. Census tables for 1911, 1971 and 1981. The small numbers are one reason for the large percentage rise of women. The total male economically active population grew by 20 per cent between 1911 and 1981 and the female total by over 80 per cent.

46. 1921 Census England & Wales, General Report (1927), p.125.

47. Hakim Occupational Segregation, pp. 34 & 41. (Emphasis added)

48. This 'comparatively great' number of women in medicine was recognized by the Royal Commission on Doctors' and Dentists' Remuneration (Pilkington Commission) in 1960. They selected ten "related" occupations for a pay comparability survey. For medicine, and one other occupation, university teaching, adjustments to tables were made because of the higher proportion of women in these two professions. Report of the Royal Commission on Doctors' and Dentists' Pay, 1957-1960 (London: HMSO, 1960)

Table 3.7Men and Women in Ten Selected Professions: 1977

<u>Profession</u>	<u>%women</u>	<u>%men</u>
Dentists	15	85
General practitioners	14	86
Veterinary surgeons	10	90
Barristers	6	94
Architects	5	95
University professors	2	98
Chartered surveyors	1	99
Civil engineers	1	99
Bank managers	Under 1	Over 99
Mechanical engineers	0	100

Source: A. Oakley Subject Women (Martin Robertson: Oxford, 1981) p. 154. taken from R. Miller Equal Opportunities (London: Penguin, 1978) pp.xxv-xxvi.

look very different if senior nurses, qualified social workers, paramedicals and junior hospital doctors were included. Within the division of labour in formal health care, medicine stands out as the one major occupation (apart from senior management) in which men predominate numerically. But one should not lose sight of the fact that, paradoxically, medicine has been one of the least sexually segregated of health care occupations during the NHS's history.⁴⁹

British women's representation in higher-level occupations as a whole in the 1960s and 1970s was lower than in many Western countries, but this ^{was} not always so in medicine, as Table 3.8 shows. The variation between countries suggests that women's place in medicine has been largely shaped by social, economic and

Cmnd. 939. para 122. The chosen occupations were accountants, actuaries, barristers, advocates, solicitors (England and Scotland), architects, surveyors, engineers, and university teachers.

49. L. Doyal and M. Elston 'Women, Health and Medicine' In Women in Britain Today Edited by V. Beechey and E. Whitelegg (Milton Keynes: Open University Press, 1986) pp. 200-202.

historical factors operating within particular societies, and not by women's abilities or the intrinsic nature of the work. What is needed is analysis of the specific organization of medicine and of the position of women in Britain.⁵⁰ This is taken up in Part Two.

I have suggested that, according to some statistical criteria, it is inappropriate to regard medicine as a profession in which women have been especially under-represented over the past century, even before the marked increase in numbers over the past fifteen years. This does not mean that their representation is satisfactory from their, or their patients' perspectives, or that there have not been major barriers to women's entry or to their subsequent practice. These are points that the data discussed here cannot illuminate.

These data referred to trends in the stock of women doctors, primarily to trends in the stock of active doctors in Great Britain as recorded in the Census. The size of this stock is determined by the balance between the numbers of doctors entering and leaving medical practice over time. The most important determinant of numbers entering is the number qualifying from British medical schools.⁵¹ This is the subject of the next chapter.

50. A point recognized by Myrdal & Klein Women's Two Roles, p. 76 and Hakim Occupational Segregation, p. 39.

51. Throughout the 1960s and most of the 1970s, the net inflow of overseas-trained graduates, was equivalent to half the British medical school output. Since then medical schools' output has expanded and immigration has been more strictly controlled. DHSS Medical Manpower: The Next Twenty Years, pp.65-69.

TABLE 3.8**PROPORTION OF WOMEN AMONG ACTIVE DOCTORS (SELECTED COUNTRIES)**

	1960-1966		1970-1975		1979-1981	
	%	Total	%	Total	%	Total
USSR (a)	75	(1963)	70	(1970)	(-)	
Poland (b)	38	(1960)	50	(1973)	(-)	
Finland (c, b, f)	23	(1960)	28	(1972-5)	28	(1979/80)
Fed. Rep. Germany (c, b, f,)	20	(1965)	22	(1974)	- 30	(1979/80)
Great Britain (c, g,)	18	(1966)	18	(1971)	24	(1981)
Sweden (c, b, f,)	17	(1965)	19	(1972-5)	25	(1979/80)
Denmark (c, b, f,)	16		25	(1972-5)	25	(1979/80)
France (c, f,)	13	(1965)			20	(1979/80)
Norway (c, b, f,)	10	(1960)	13	(1972-5)	14	(1979/80)
Japan (d)	9	(1965)			11	(1980)
USA (c, f,	7	(1965)			11	(1979/80)
Spain (b, e,)	3	(1965)			15	(1980)

* A + or - In this column indicates the trend in proportion of women since 1970- 1975, where no precise information available.

Sources:

- (a) M. Ryan The Organisation of Soviet Medical Care (Blackwell; Oxford 1978).
- (b) Proceedings of International Conference on Women in Health (USDHEW, 1975).
- (c) M. Galeenson Women and Work: an International Comparison
1LR Paperback No.13 (Cornell University; Ithaca; New York 1973) Table 5 p. 24.
- (d) S. Orpett Long 'Roles, careers and Femininity in Biomedicine: women physicians and nurses in Japan' Soc. Sci. Med., 22, (1986) p.83.
- (e) J. de Miguel 'Health Sector Structures: the case of Spain', Soc. Sci. Med., 22, 2 (1985).
- (f) P. Day Women Doctors (King's Fund; London, 1982) p. 105. (WHO Figures).
- (g) Census: Great Britain.

CHAPTER IV

HOW MANY WOMEN MEDICAL STUDENTS?

Introduction

Having a medical career depends on generating and sustaining the ambition to become a doctor, and, with the professionalization of medicine, on gaining access to formal medical training and passing a qualifying examination. This chapter's main purpose is to review the evidence on the numbers of women who have qualified from the 1870s to the 1970s, as an introduction to the subsequent, more detailed analysis of women's medical careers. It shows that women's presence in medical schools has not increased steadily since they first gained access to medical education. But it also shows that they have been a not insubstantial minority since the First World War.

The (relative) absence of women in British medicine in the past has often been attributed to medical schools' policies of exculsion, rather than to any lack of ambition on the part of women.¹ Thus, today, there are many confident predictions that the proportion of women medical students will soon be fifty per cent, and this is generally attributed to the outlawing of the much-publicised quotas of places for women within many medical schools, under the 1975 Sex Discrimination Act.²

1. E.g. J. Leeson and J. Gray Women and Medicine (London: Tavistock, 1978), pp. 44-47.

2. E.g. DHSS Report of the Advisory Committee for Medical Manpower Planning pp. 5. & 9. In 1984, women were 44 per cent of entrants to medical schools in Great Britain. (UCCA Statistics).

Most of the data discussed here, are concerned only with the successful, and as such, cannot determine whether admission policies or levels of female ambition have been the more important factors affecting the extent of women's presence in medical school. Indeed, this is, in many respects, a false dichotomy. Belief in the existence of discrimination, well-founded or otherwise, may act as a powerful inhibitor of ambition. It is indubitable that women as a whole have not had the same opportunities for medical education as men for most of the century since they first gained access. But the form of opportunities they have had has changed markedly over the past century. Overall trends conceal the changing pattern of gender segregation within medical education over the past century.

As this chapter shows, from the 1870s to 1914, the vast majority of women trained in single-sex institutions. From 1914 to 1948, there were three systems co-existing: one women-only school, a larger number of men-only schools, and co-educational schools—the majority of schools, but training a minority of students. The development of women-only schools, the beginning of co-education, and the implications of these for women's medical careers, are discussed in detail in Part Two. After the Second World War, all medical schools became formally co-educational. Subsequent trends are hard to analyse without reference to the quota system, the means by which co-education was implemented and controlled, and the changing context of medical education. These are therefore reviewed in the last section of this chapter.

A brief note on the changing structure of medical education in general, and on the different institutions involved, may help to clarify the subsequent discussion and the statistics presented.

The Structure of Medical Education

In 1858, the GMC recognized the qualifications offered by nineteen different examining bodies as registerable. These qualifications differed substantially in the knowledge and in the attendance at medical school or hospital required, as well as in their cost and status. Examining bodies did not necessarily provide medical training. A substantial minority of students still began, and in some cases, completed their studies, as pupils or apprentices of qualified practitioners, or took courses at several different institutions. Students within the same medical school might often be studying for different qualifications.³

Since 1858, the production of medical practitioners in Britain has become increasingly standardized. Today, the vast majority of medical students complete their medical training within a single institution studying for the same qualification as their peers. As medical schools have become gradually incorporated into the university system, this qualification is almost always the degree of the university in which they are enrolled. Curricula have become more standardized around a basic medical sciences foundation.

Recruitment has gradually become more formalized. The GMC ceased to recognize medical studies undertaken outside recognized medical schools in 1894, though most individual examining bodies had already taken this step. Preliminary examinations have been gradually removed from medical schools to secondary schools, and

3. On the history of medical education see C. Newman The Evolution of Medical Education in the Nineteenth Century (Oxford: Oxford University Press, 1957); Stevens Medical Practice in Modern England; Todd Report, pp. 171-214 & 292-303; Waddington Medical Profession and the Industrial Revolution.

entry requirements standardized and formally stated. This process culminated in the entry of medical schools from the mid-1960s into the centralized recruitment system established by the Universities Central Council for Admissions (UCCA), an entry which reflected and reinforced a growing tendency to rely on A-level grades in approved subjects for selection. Numbers taking '1st MB' examinations have fallen sharply in the past thirty years.⁴

Medical schools, in common with other forms of higher education, have also become progressively more dependent on state funds over the past century. Between 1908 and 1914, eighteen of the twenty-two medical schools in England applied for grants from the Board of Education, under its provision for 'technical education'. Medical education was included in the remit of the University Grants Committee (UGC) when it was established in 1919, and by 1930, all medical schools in Great Britain were in receipt of a grant.⁵ Government grants to medical students also increased after 1919. But the social background of most recruits to English medical schools meant that, except for those entitled to ex-service grants immediately after 1918, only a small minority were in receipt of such grants compared to students of other subjects before the Second World War. By 1956, two-thirds of medical students received some kind of government grant, a development which reflected changes in grant policy rather than in the social background of recruits.⁶

4. See Todd Report, pp. 123-127.

5. G. Newman Some Notes on Medical Education in England (London: Board of Education, 1918). Cd. 9124, p.5; UGC Annual Reports, 1919-1930.

6. In 1938-39, only 11 per cent of English students received grants, but 44 per cent of Scottish students. Goodenough Report, pp. 100-101; Parry and Parry Rise of Medical Profession, p. 215.

As I shall show, this formalization and the incorporation of medical training into the university system, and increasing dependence on state funding, have had an important bearing on women's access to medical education. Barriers to women became more visible, and hence more contestable, in institutions where meritocratic criteria were held to prevail.⁷ But these changes have developed unevenly within the medical education system. The differences between medical schools of very different origins and traditions have been progressively reduced but by no means eliminated. The 'hierarchical cast' of both the pre-1858 medical order, and of the educational system in Britain has persisted.⁸

Five main types of medical school can be identified, differing in the medical education they have provided, in the social status of their recruits and products, and in their policies in relation to women's admission.

In the elite English universities of Oxford and Cambridge, elements of the pre-1858 pattern of physician education have persisted, with students taking a three year degree, and then, until recently, mostly pursuing their clinical studies elsewhere, usually in one of the London hospital schools. A second, rather different, university-based system had developed in Scotland by the mid-nineteenth century, with strong links between the universities and their teaching hospitals.

A third group are the English provincial medical schools, with a variety of origins. Some began in the voluntary hospitals

7. This is the point made by Walsh I discussed in Chapter II. Doctors Wanted, pp. 14-15.

8. Larson Rise of Professionalism, pp. 80-103.

in the large provincial cities which were then absorbed into the "Redbrick" colleges developing for the professional and technical education of middle-class men in the late nineteenth century. Others were started almost a century later in the expansion of medical education in the 1960s. In these, standardization has been greatest, with most medical students completing their courses within a single institution and, from the time Royal Charters were obtained, studying for the degree of the provincial university.⁹

A fourth small group were the extra-mural schools, which, as their name suggests, existed on the periphery of the major institutions to prepare students for either external degrees or other qualifications. Although of small numerical significance throughout the twentieth century, and all now closed, the Scottish extra-mural schools and the short-lived extra-mural clinical school at the West London Hospital opened in 1938 played an important part in women's medical education.¹⁰

Finally there is the London system, with its varied and complex history.¹¹ Medical education in London began long before the establishment of London University. For the period I am concerned with, there have been twelve separate medical schools, affiliated to the University of London since 1900, but remaining at least semi-autonomous for most of this time. Nine of these developed from pre-existing voluntary hospitals, five providing

9. Durham was an exception to this pattern until its medical faculty was transferred to Newcastle University—and the Welsh system has been divided between clinical and preclinical schools.

10. Todd Report, pp. 303-305.

11. Todd Report, pp. 292-303 summarizes this history. Recent mergers among the twelve medical schools are not considered here.

both pre-clinical and clinical education throughout the period, and four clinical studies only for much of the time. In some, it was not until the 1930s that the majority of students took degrees, rather than the qualifications of the traditional medical corporations, mainly, after 1886, the "Conjoint" qualification of the Royal College of Surgeons and Royal College of Physicians. The custom of an individual's taking both a degree and "Conjoint" persisted for much longer. A slightly closer relationship with the University has prevailed in the medical faculties of its two original colleges, University College and King's College. These two have, for much of the last century, educated more pre-clinical students than could be accommodated in their associated, though partly independent, teaching hospitals.

The twelfth London school is the London School of Medicine for Women (LSMW) opened in 1874, renamed the Royal Free Hospital Medical School (RFHSM) in 1947, when the first men students were admitted. The relationship with the Royal Free Hospital began in 1877, when an agreement for the women students to have clinical training was negotiated. Thus, unlike all the other London schools, it had, initially, no formal association with the teaching hospital where its students did most of their clinical studies. I shall have much to say subsequently about the structure of medical education here. ¹²

12. I. Thorne Sketch of the Foundation and Development of the London School of Medicine (London: Privately printed, 1905). The LSMW's name was changed to the London (Royal Free Hospital) School of Medicine for Women (L(RFH)SMW) in 1899, as part of the school's incorporation prior to affiliation to London University.

Sources of Data on Medical Students

The changing structure of medical education has generated different sources of data on medical students and changes in classification within sources. There is no single source giving comparable data on male and female entrants or qualifiers over the past century. The GMC records the numbers commencing studies for a registerable qualification, and the number of new registrations each year, but separate totals for men and women have not been routinely prepared until recently.

The development of state funding for medical schools has generated official statistics on student numbers. Thus UGC Reports from 1919 contain details, tabulated by sex, on the numbers of students entering and enrolled and on the number of qualifications gained, at those schools in receipt of grants. However, the complex structure of medical education affects these data. Until the 1960s, it is not possible to distinguish entrants commencing preliminary or pre-clinical studies from those entering a new institution for clinical studies, or to identify the numbers of individuals qualifying, because of the practice of taking multiple qualifications.

Finally, the establishment of a centralized system for processing applications to medical schools through the UCCA scheme has generated additional information, including, for the first time, some information on applicants on a national basis.

Women in Medical Education: 1874-1914

From the mid-1870s, women had established, if limited, access to medical education and qualification. Chapter V analyses the complex struggle of women to achieve this. In 1874, instruction was secured (more or less) through the founding of the LSMW, as a last resort after all other avenues were closed to women. In 1876 women were admitted to the Licence of the King's and Queen's College of Physicians of Ireland (LKQCPI). In 1878, as a result of the campaign for women to have medical degrees, the University of London became the first university to admit women to all its degrees, including medicine, on the same terms as men.¹³ Women were not admitted to the medical faculties of the two colleges then in existence until thirty-nine years later.¹⁴

The medical schools and qualifications open to women before 1914 are given below. The list indicates the importance of the distinction between qualifications and medical schools. Students at the LSMW mainly prepared for LKQCPI, Scottish Triple, and, most of all, for the degrees of the University of London. Though all the Scottish universities' degrees were open to women from 1894, women were not admitted as medical students to Edinburgh University until 1916.

13. Opening all degrees to women came about because the supporters of women's right to medical education called the bluff of the medical graduates in Convocation. Earlier attempts had not met with such success. Jessie Meriton White had applied unsuccessfully to the University in 1856. In 1862 Elizabeth Garrett's application to be allowed to matriculate was twice turned down by the University Senate, by a single vote on each occasion. Burstyn Victorian Education and the Ideal of Womanhood, (London: Croom Helm, 1980), pp. 152-157.

14. Women were admitted to the Arts, Laws and Science Faculties of University College in 1878, but not the Medical Faculty until 1917. N.B. Harte 'The Admission of Women to University College, London: A Centenary Lecture' (University College, 1979) p. 17.

Examining Bodies Admitting Women by 1914

After	
1876	King's & Queen's College of Physicians of Ireland (LKQCPI)
1878	University of London
1879	Royal University of Ireland
1885	Royal College of Surgeons of Ireland
1886	College of Physicians and the College of Surgeons of Edinburgh and of the Faculty of Physicians and Surgeons, Glasgow (Scottish Triple)
1890	University of Glasgow
1893	University of Durham
1894	University of Edinburgh University of St. Andrews University of Aberdeen
1899	Victoria University, Manchester
1901	University of Birmingham
1905	University College, Leeds ^a
1906	University College, Bristol ^a
1907	University College, Liverpool ^a
1909	Royal College of Surgeons and Royal College of Physicians of London (Conjoint)
1910	University of Sheffield

Women's Medical Schools^b

1874	London School of Medicine for Women (LSMW)
1886	Edinburgh School of Medicine for Women (closes 1898)
1888	Medical College for Women, Edinburgh (merges with men's extra-mural school 1909)
1890	Glasgow School of Medicine for Women, (Queen Margaret College). (Becomes part of Glasgow University 1909)

Mixed Instruction^b

By 1900
Universities of Aberdeen, Dublin, Belfast, Cork, Galway, Durham, Manchester, College of Surgeons, Dublin. Partial courses at University College, Cardiff, St. Andrew's University, Dundee University.

By 1910
University Colleges in Bristol, Leeds and Liverpool. Sheffield

Source Englishwoman's Yearbook 1881-1914.

^a These were not independent examining bodies when they first admitted women but became so shortly afterwards,

^b This refers to the enrolling institution. Women in women's schools might attend mixed classes, and separate classes or teaching rounds were sometimes held in the mixed schools and teaching hospitals. (See Chapter VI).

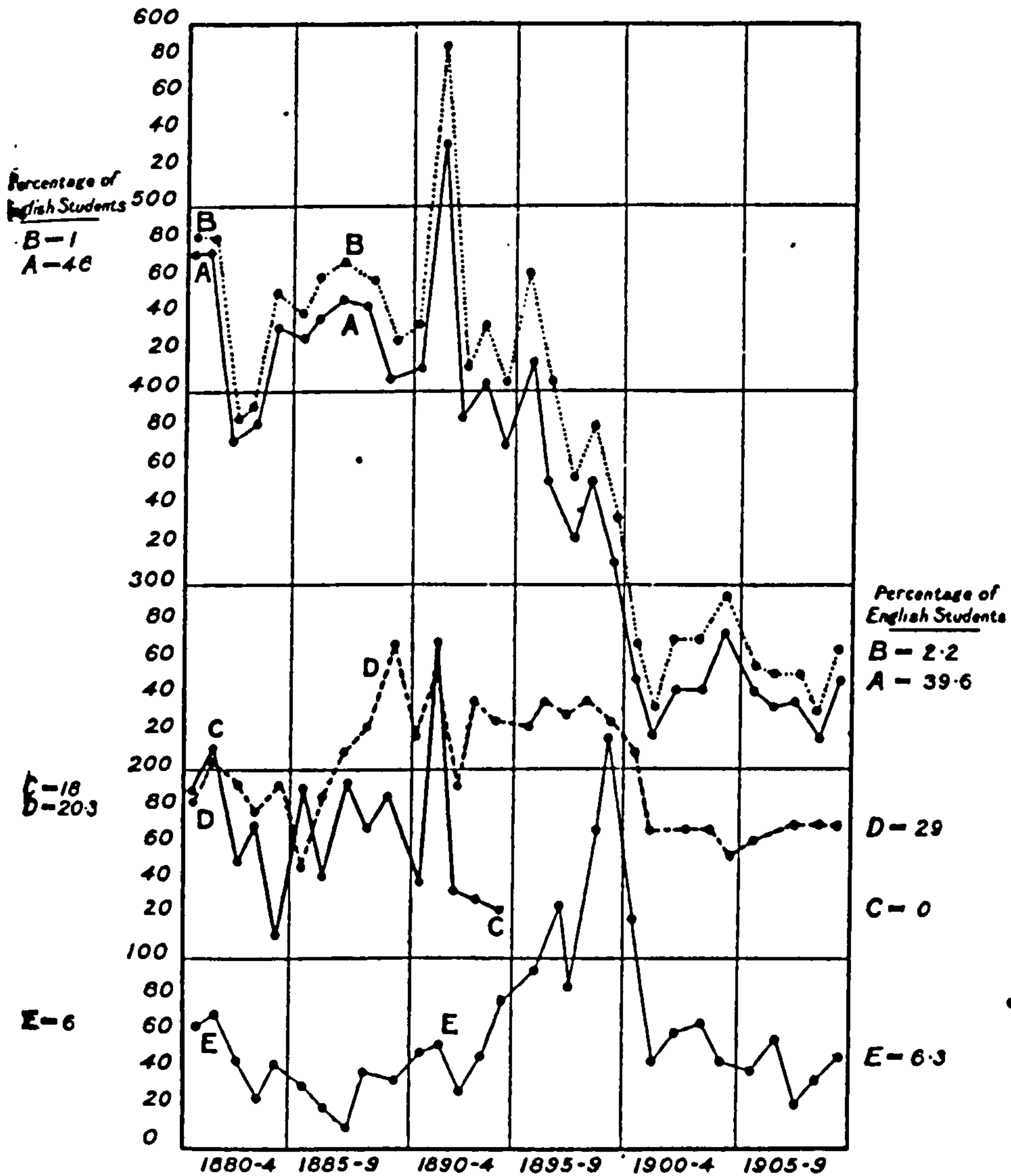
The list seems impressively long, but the omissions are also considerable—eleven of the twelve London schools, Oxford and Cambridge, Edinburgh University Medical School, and among the qualifications, Conjoint until the end of 1909. How many women were studying medicine in these schools and what proportion of the total did they represent? The information available is fragmentary, as the Royal Commission on University Education in London (Haldane Commission) noted in 1912. To get round the problem of multiple entry, they used the GMC's records of students' commencing medical studies, which do not easily permit identification of students' sex.¹⁵

Figure 4.1 shows numbers of students commencing in the different types of English school, between 1880 and 1910, indicating that women at the LSMW were between 1 and 4 per cent of all entrants in England in this time. The table also shows the peak of new registrations in medical schools in the 1890s, related to the abolition of pupillage in 1896. The decline in the proportion of students commencing studies in the London hospitals' schools was due to their greater expense and to the 'London grievance'. This 'grievance', one of the main concerns of the Haldane Commission, was that the matriculation requirements of London University were too high for male medical students, who were, therefore, unable to get degrees as opposed to Conjoint. In her evidence to the Commission, Miss Cock, Dean of the LSMW, pointed out that the matri-

15. Haldane Commission Fifth Report Appendix II, pp. 230-242. This contains a detailed discussion of the data. Comparing numbers of student registrations with entries to the Register six years later, showed a 23 per cent difference. Failure to complete studies was highest among those commencing as pupils and unqualified assistants. No information on the sex of those registering as qualified was given.

FIGURE 4.1:

Numbers of Medical Students Registering in English Medical Schools
1880 - 1909



- A - Number of Students registering in eleven London Schools.
 B - Plus Number of Students registering in London School for Women.
 C - Number of Students registering as pupils in England.
 D - Number of Students registering in eight Provincial Schools. (now Universities).
 E - Number of Students commencing in Local Hospitals, Technical Institutes & Secondary Schools etc. This curve shows how the number of this class of Students rose in the three years following the abolition of Pupilage. Since then it has fallen to its former percentage. (about 6 per cent).

Source: Royal Commission on University Education in London:
Appendix II to Fifth Report. 1912. Cd. 6312.

cultation requirements appeared to present no problems for women who had been debarred from Conjoint until 1910.¹⁶

About 30 per cent of all those commencing medical studies in Britain did so in Scotland, an average of 16 per cent in Edinburgh University alone between 1880 and 1910. Entrants to women-only schools in Scotland represented an average of 6 per cent of Scottish entrants annually between 1890 and 1909. Table 4.1 shows that the percentage of all entrants in Britain represented by the women-only schools rose from 0.5 per cent to just over 3 per cent. Figure 4.2 shows the numbers commencing in these schools over the same years. The fluctuation in numbers from year to year is partly because of the small numbers involved, but from 1904 to 1910, the overall trend was downwards. After 1911, new entrants to the LSMW rose to average 26 in the years 1911 to 1914. But the fall in Edinburgh students seems to have been maintained.¹⁷

Before 1893, these schools were the only ones open to women in Great Britain. Thereafter, the admission of women to some of the mixed schools, and, after 1909, the absorbing of the Scottish women's schools into men's institutions, makes it hard to determine the numbers of women students. The indications are that they were not many before 1910, and that numbers in individual schools were small. In 1893, Elizabeth Garrett Anderson reported that

16. Haldane Commission Fifth Report, pp. 125-129. See Chapter VI.

17. LSMW Register of new students. (Not precisely comparable to GMC figures. The total of women matriculated medical students in Edinburgh (all students of the extra-mural school) reached a peak of 137 in 1905, but by 1913 had fallen to 78. In both years this was about 7 per cent of all medical students Englishwoman's Yearbook 1906; A. L. Turner Story of a Great Hospital: The Royal Infirmary of Edinburgh 1729-1929 (Edinburgh, Oliver and Boyd, 1937), p.25.

TABLE 4.1:

**Medical Students Commencing in Women-only Schools
As a Percentage of all Students Commencing 1880-1910
Great Britain**

Average Number of Students Commencing in

Years	LSMR % of Total	Edinburgh % of Total	Glasgow % of Total	All	(N)
1880-84	0.5	-	-	0.5	1465
1885-89	1.2	0.3	-	1.5	1564
1890-94	2.0	1.0	0.7	3.7	1549
1895-99	2.6	1.1	1.2	4.9	1346
1900-04	1.9	1.8	0.9	3.6	1102
1905-09	1.4	1	1	3.4	1010
1910-11	2.1	n/a	n/a		944

Source: Royal Commission on University Education in
London Fifth Report Appendix II, 1912
cd 6312 pp 232-3.

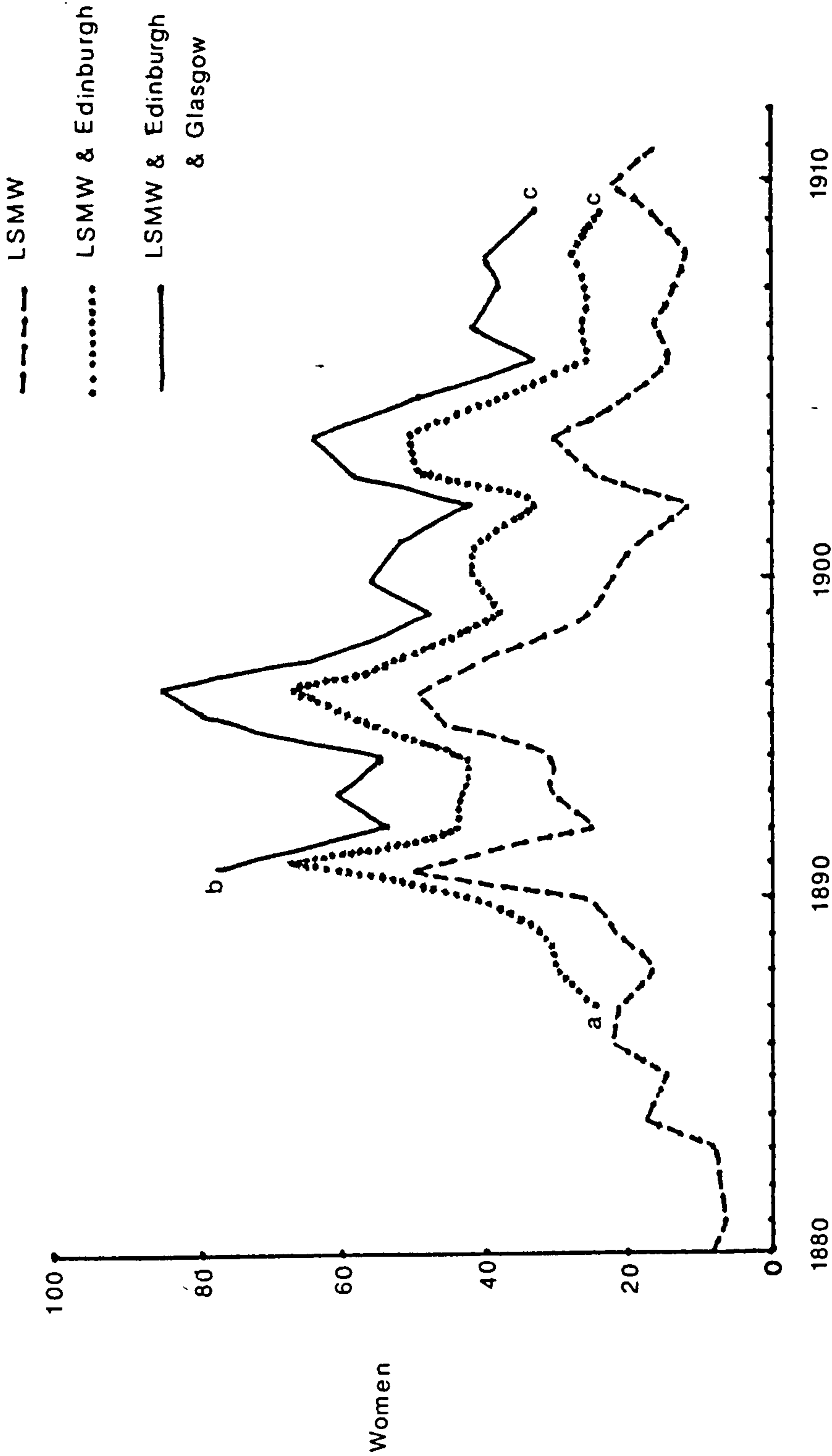


FIGURE 4.2:
 Women Registering as Medical Students in
 Women-only Medical Schools: Great Britain. (1880-1911).

Source: Royal Commission on University Education in London:

Appendix II to Fifth Report. 1912 Cd. 6312.

a. 1st Edinburgh School opens 1886

b. Glasgow School of Medicine for Women opens 1890.

c. Scottish extra-mural schools merge with men's 1909..

there was 1 woman studying in Durham among 243 women medical students enrolled in Great Britain (0.4 per cent). Fifty-nine per cent were at the LSMW and the rest at the Scottish schools. In 1900-1, there were fourteen women students in total enrolled at Durham, and the same number in 1910-11, seven per cent of all Durham students in both years.¹⁸ In 1909 there were sixteen women students in total at Manchester, about eight per cent, ten years after women were first admitted. In total, ten had qualified.¹⁹

Even if, by 1910, women were 10 per cent of entrants in those mixed schools to which they were admitted, a generous estimate, this would still mean that women could not have been more than 5-6 per cent of all entrants. Thus, the proportion of women enrolled in medical schools in Britain was possibly about five per cent in 1900, and not a lot higher, certainly less than 10 per cent, immediately before the First World War.²⁰ If so, this is less than the percentage of women in universities as a whole. The UGC estimated that women were about 16 per cent of all full-time university students in 1900-1, and 20 per cent in 1910-11. Within London University, LSMW students were about 9 per cent of all medical students in London in 1900-1, and 7 per cent in 1910-11. But women were 17 per cent and 19 per cent of all women full-time

18. E. Garrett Anderson 'History of a movement' Fortnightly Review (1893), 407. She reported 16 women at Irish mixed schools. Durham figures are from University Grants Committee Report for 1929-35, p. 52.

19. BMJ (Dec. 11 1909), 1710.

20. In 1916, there were 140 women medical students in their final year registered with GMC in the United Kingdom, eleven per cent of all final year students. But this proportion is probably inflated by the loss of male students to the armed forces and the inclusion of Irish students. GMC Student Census, 1916, quoted in Scott 'Women and the GMC', 1767.

university students in these years. In 1900-1, the 216 LSMW students represented 33 per cent of all London University's full-time women students, but by 1910-11, the number of women at the LSMW had fallen to 138, 13 per cent of the total. Male medical students in London fell from being about 60 per cent of all male students to about 45 per cent in the same period.²¹

Thus, there are indications that between 1900 and 1914 the total numbers of women entering medicine each year did not increase very much, if at all. This was happening although there were more schools formally open to them and places at the LSMW, for those who could afford a London medical education. The level of male entrants was also stable over this period. The entry of women into medicine was not keeping pace with expansion of their presence in higher education as a whole.

The schools women were entering were also changing. Entrants to the women-only schools fell overall during this period, and in 1909, two of the women's schools formally merged with men's schools. In 1900, probably not more than 10 per cent of all women entrants began in co-educational schools (and many of these would have subsequently studied at the LSMW). After 1910, the majority of new women entrants began their studies in what were formally mixed schools in Scotland and the English provinces. This caused concern at the LSMW, which had expanded its facilities in 1901.²²

21. UGC Report for 1929-35, p. 52. These figures include the small numbers of dentists and exclude the pre-clinical students at King's and University Colleges (all male) in both years.

22. The proposal to expand the School was controversial because of concern over provincial competition. The decision to go ahead despite her opposition, led to the resignation of Sophia Jex-Blake, the school's chief founder, as a trustee. (LSMW, Minutes of Governing Body January 1897).

The implications of the development of co-education are discussed in detail in Part Two. Two points are relevant here. First, though women's entry to mixed schools was increasing, the vast majority of women qualified before 1914 will have trained in women only schools.²³ Secondly, medical education in London was still rigidly segregated by sex, and looked set to continue being so. When the organization of medical education in London was reviewed by the Haldane Commission in 1912, the LSMW's view was forthright.

'We believe that it would be highly inimical to the interests of medical women at this time if the existing Medical School for Women were to disappear. This opinion might be modified in the future if effective co-education could be offered to women in other Medical Schools. This would involve, in our opinion, the direct representation of women on the governing body and the teaching staff of the Schools concerned, and the opening of all opportunities for work and experience, with absolute equality to women and men...

'We consider that it would be detrimental to the interest of women medical students that they should gain admission in small numbers to the poorer Schools for men, to which Schools their fees might be attractive, but where their interests are little likely to be safeguarded by effective representation on the executive or teaching bodies, and where they would form an isolated group of uninfluential aliens. It is improbable that women students would be admitted to the Metropolitan Schools for men except on motives of financial expediency, and we do not think that this is a basis likely to result in advantage to the women students so admitted.²⁴

The last prediction was about to be proved true as the First

23. Establishing a cumulative total of women qualifying in Britain between 1874 and 1914 is difficult, for reasons which will be clear by now. Information from individual schools, or examining bodies which permit identification of gender, has proved hard to obtain, especially from the institutions that no longer exist. But it seems unlikely ^{that} more than about 150 women could have qualified from mixed schools by 1914. By 1914, some 600 women who had ever registered at the LSMW had qualified. Assuming that about 70 per cent of commencing students at the Scottish women's schools before 1909 eventually qualified, this would mean about 400 women qualifying from these schools—giving a total of about 1100.

24. Haldane Commission Fifth Report, p. 124.

World War dramatically disrupted the trends I have just described.

Women in Medical Education: 1914-1947

Numbers of women medical students, and their proportion of all medical students, rose dramatically during the First World War, especially after 1915, as male medical students were called up. The GMC's wartime student census of 1916 recorded 636 first year women students (31 per cent of the total) compared to 295 second year students in the United Kingdom. Between 1916 and 1918, the total number of women medical students rose from 1379 to 2250, an increase of 63 per cent.²⁵ Part of this increase took place through a marked expansion of the LSMW.²⁶ The proportion of women in co-educational institutions also grew as the men left. And the number of co-educational schools increased.

In 1916, Edinburgh University finally permitted women to study medicine within the University's walls.²⁷ In London, the LSMW had more students than the RFH could accommodate for clinical studies and the men's teaching hospitals were short of dressers and clerks, and student fees. In July 1916, St Mary's Hospital agreed to take students from the LSMW for clinical studies. Three of the small clinical schools, Charing Cross Hospital, St. George's Hospital and the Westminster Hospital, also admitted women clinical students. More significant in affecting total

25. GMC Census quoted in Scott 'Women and the GMC', 1767; M. Malleson Mary Murdoch of Hull (London: Sidgwick & Jackson, 1919), p.2.

26. Entrants rose from 30 in 1913 to 56 in 1914, 80 in 1916, and 100 in 1918. LSMW Register.

27. The total of women matriculated in the Medical Faculty at Edinburgh University increased from 106 in 1914-15 to 240 in 1916-1917 and 413 in 1919-20, an increase from 10 per cent to 25 per cent, and falling in the last year to 21 per cent as the men began to return. Turner Story of a Great Hospital, p. 25.

numbers of women students were the decisions of University College and King's College to admit women to pre-clinical studies in 1917, and, in 1918, that of the London Hospital Medical College to admit women to the whole course.²⁸

These dramatic increases and most of these breaches of gender segregation in London were to prove short-lived. The background to them and the postwar reaction against them are analyzed in Chapters VIII and IX. But they had brought women into medicine in larger numbers than ever before by 1919. This is shown clearly in Figure 4.3, which plots the numbers of students of each sex enrolled in university medical schools between 1920 and 1948.²⁹ Figure 4.4 shows the percentage of women among full-time students in medical faculties and in university education as a whole.³⁰ These graphs omit the small numbers of women studying in extra-

28. Times 1 & 12 July, 1916; Elston 'Women in the Medical Profession' p. 118; W.R. Merrington University College Hospital and Its Medical School (London: Heinemann, 1976) pp. 237-9; BMJ (10 Aug 1918),

29. These figures probably understate the proportion of women medical students by up to 2 per cent in any year as they include overseas students, and dental students among whom the proportion of women was probably lower than among home students throughout the period. The number of medical and dental students was given separately in some years, suggesting that women were about 9 per cent of dental students in 1920, rising to 14 per cent in 1943.

30. Because of the problem of multiple entries and qualifications I have used UGC figures on total students enrolled. This has the effect of smoothing out the effect of the changes in entry in the 1920s. If wastage rates of male and female students did not differ markedly, the general pattern of qualifiers, though not the timing should be similar. There were suggestions just after World War One and in the Willink Report (p.31) in the early 1950s that women were more likely to drop out of medical training, but I have found no evidence on this for the inter-war years. A survey in 1963-4 found no significant differences in the withdrawal rates of men and women students. M. Jefferys, S. Gauvain, O. Gulesen 'Comparison of men and women in medical training' Lancet (26 June 1965), 1382.

mural schools, and a few from those schools which did not make UGC returns in the early post-war years.³¹ But this is unlikely to affect the overall pattern.

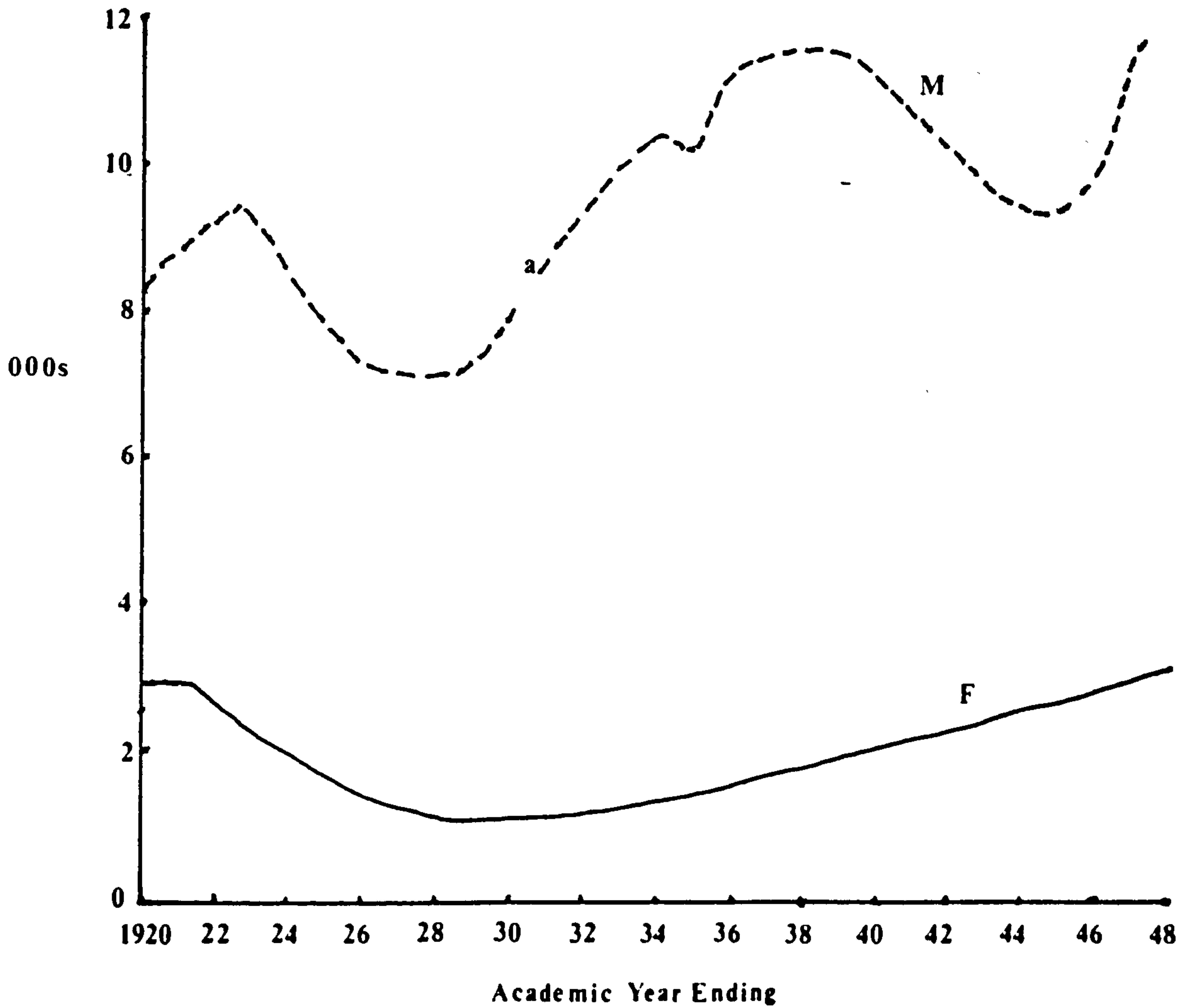
In the early 1920s, the number of women remained high as the large numbers admitted in the later years of the war completed their studies. But the percentage of women among medical students fell as the number of men increased, with demobilization and special grants for ex-service men. But in the mid-1920s there was a drop in enrollments which was common to the whole university system. Numbers within medicine began to rise slowly towards the end of the decade for men and a little later for women. Throughout the 1920s and 1930s women were a lower percentage of medical students than in university education as a whole.

New registrations of men and women with the GMC followed a similar pattern in the inter-war period. Between 1922 and 1925, 22 per cent of names added to the Register were women's. Thereafter the proportion dropped, to 16 per cent in 1927, down to 10 per cent in 1935, and 12 per cent in 1938.³²

During the Second World War, medical studies were a 'reserved' occupation, with the number of places set by a quota. Figure 4.3 shows that women medical students increased by about

31. In 1938-39, there were 1413 students in the extra-mural schools (11 per cent of all registered medical students) and 40 per cent were overseas students. Seven per cent of extra-mural students were women compared with 16 per cent in university schools. 38 of the 104 women extra-mural students were at the West London Hospital School, and were, therefore, from London, Oxford or Cambridge universities doing clinical training. (See Chapter VIII.) Between 1933 and 1937, 15 women and 270 men qualified from the Scottish extra-mural schools, under half the proportion of women at university schools. Goodenough Report, pp.260-261.

32. Calculated from Medical Register and information supplied to University of London and MWF by GMC. MWF Newsletter (March 1929), 42; (July 1939). 73. NB These are all new registrations.

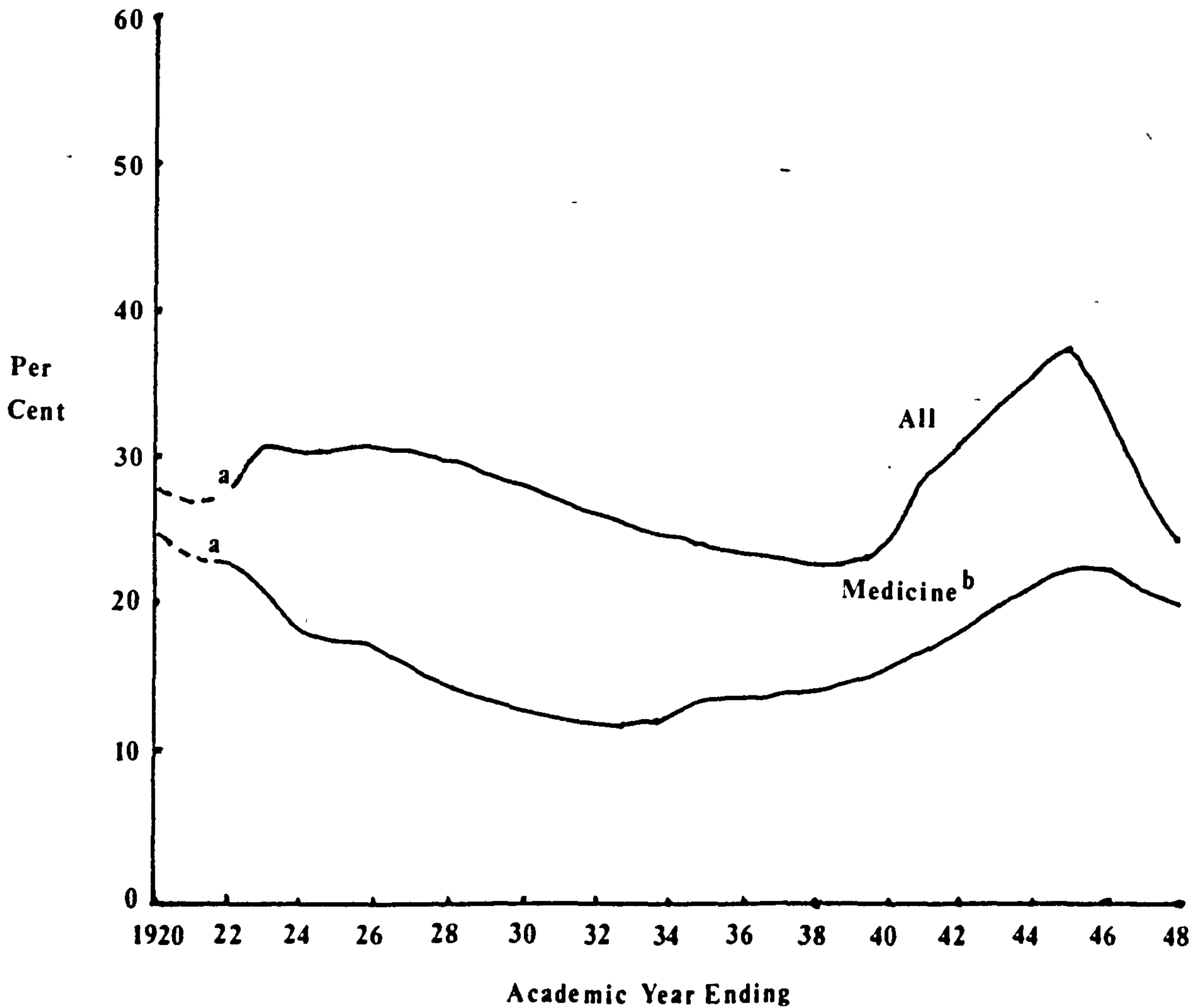
FIGURE 4.3:Students Enrolled in University Medical Schools:^b1920-1948. Great Britain.Source: UGC Annual Reports

a Guy's Hospital Medical School included for first time.

b Figures include dental students.

FIGURE 4.4:

Percentage of Women among Medical Students
and all University Students: 1920-1948. Great Britain.



Source: UGC Annual Reports.

a Oxford and Cambridge included for first time

b Dental students included.

forty per cent between 1937-8 and 1945-46, as some schools could not fill their quota of places for men. The proportion of women medical students^{rose} by about 6 per cent in this time as shown in Figure 4.4, which also shows how much less marked the impact of the war was on male medical students than on other male students.³³

Gender Segregation in Medical Education: 1920-1947

After the war, some but not all of moves to co-education were reversed. By 1929, all the London men's schools that had admitted women during the war had withdrawn this privilege, except for University College and King's College, which continued to admit women to pre-clinical studies, and a limited number of places for clinical studies at University College Hospital and King's College Hospital.³⁴ But Oxford and Cambridge began to admit women to preclinical medical studies, through the women's colleges.³⁵

The effect of the rise and fall in the numbers of women medical students and of changes in women's access to London men's schools can be seen in Figures 4.5 and 4.6. In the early 1920s, LSMW students represented slightly less than one-fifth of all women students in Britain and about 40 per cent of all women students in London. By the end of the 1920s the total number of

33. Goodenough Report, p. 99

34. See Chapter XI. The direct numerical effect of these withdrawals was quite small in the 1920s, because of the overall drop in women's entry to medicine.

35. Women were admitted to full Oxford degrees after 1920, and, in Cambridge, to only 'titular' degrees in 1921, and full degrees in 1947. J. Burstyn Victorian Education and the Ideal of Womanhood (London: Croom Helm, 1980), p. 166.

women students had fallen by 60 per cent from its 1922 peak, and the proportion studying at the LSMW rose to 60 per cent of all London medical students, (including those doing preliminary studies), and, until numbers outside London rose in the 1930s, one-quarter of all women students in Great Britain. No single men's school provided more than 10 per cent of male students in Great Britain in the period, but the concentration of male students into single-sex schools was greater throughout the period in London, and in Great Britain as a whole in the 1930s.

In Figure 4.6, the presence of one member of the minority sex was sufficient for a school to count as mixed, perhaps giving a misleading picture of the extent of co-education. For example, the London Hospital Medical College (LHMC) ceased to admit women in 1928, but until 1934 there were two women students completing their course. It is hard to imagine that they had a major impact on the approximately 370 male students in the LHMC.

Figure 4.7 indicates the cumulative distribution of women students in England and Wales, in schools with different proportions of women students. During the 1930s nearly half of all women students were studying in schools with less than 20 per cent women students. For a few years, Charing Cross Hospital Medical School had more women students than men. St. Mary's Hospital Medical School had more than 40 per cent of women for some years, having admitted women to the whole course between 1920 and 1924. Figure 4.8 shows the distribution of male students. The number who trained with more than 20 per cent of women was very

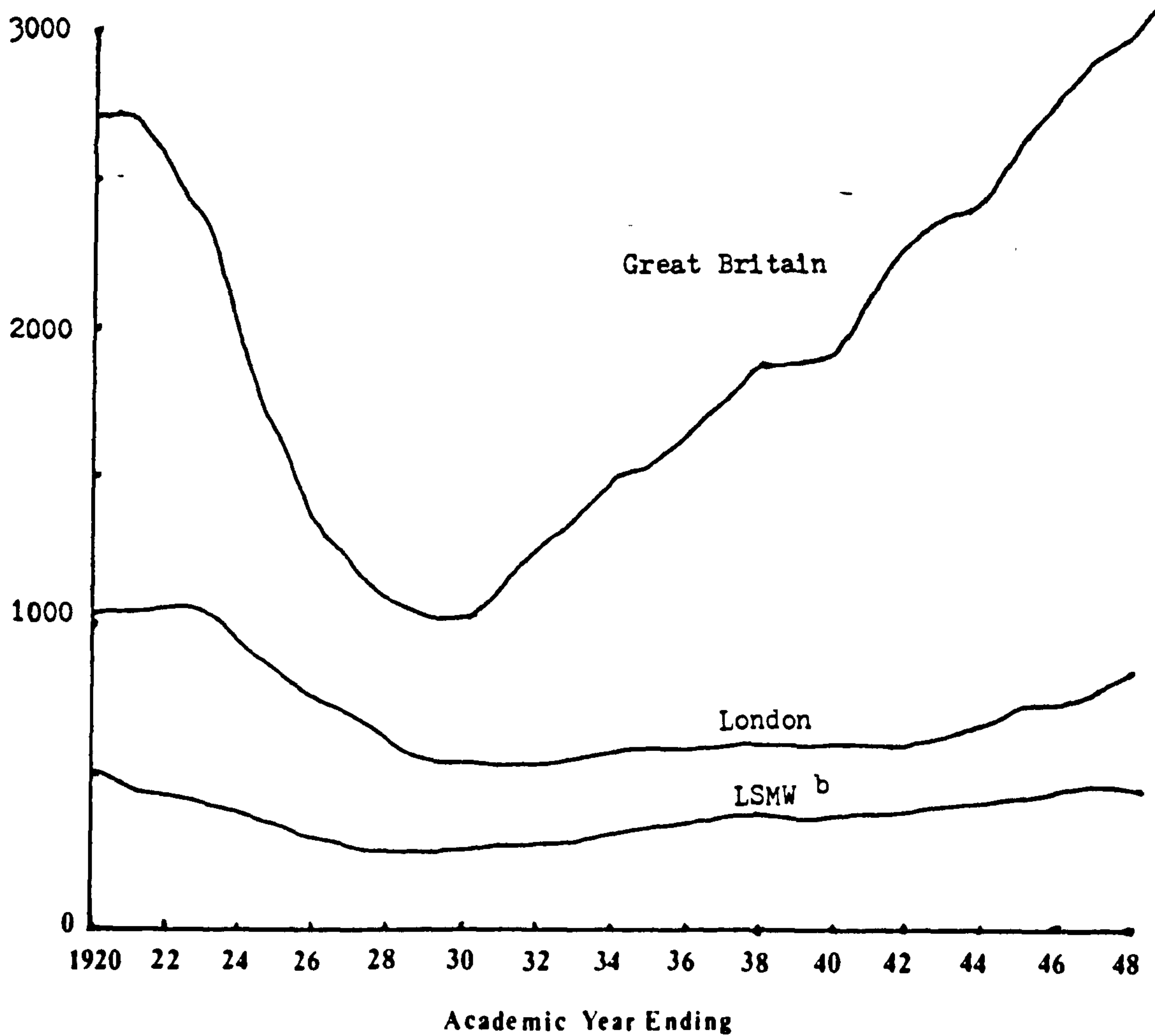
small, until the Second World War.³⁶ The two figures also show the ending of single-sex education in 1947, a development discussed in the next section.

Figure 4.9 shows the proportion of women in the different types of schools in England and Wales, showing very clearly the difference between most London schools, Oxford and Cambridge and the provinces. The effect of the fall of women students in London men's schools in the 1920s is clear. In 1944, nine English schools (all in London) did not admit women. But, at that time, of those schools that did admit women, only two, Oxford and Cambridge, had less than 20 per cent women. As two-thirds of all English and Welsh medical students trained in London and/or Oxbridge until the Second World War, their relative exclusion of women was numerically significant.³⁷

It was also socially significant. If, as many analysts of the medical profession have argued, the graduates of the large London Hospitals and of Oxford and Cambridge dominated the professional associations, especially the Royal Colleges, as well as their own hospital positions before 1948, then perhaps these figures help to explain the absence of women from positions of power, and the apparent invisibility of women within the profession. The vast majority of London and Oxbridge medical men training between 1876 and 1946 will have done so in virtually exclusively male company.

36. Totals and percentages in these figures exclude any students doing preliminary studies outside medical schools, and they do not, therefore, correspond precisely with those in Figures 4.5, 4.6, and 4.9.

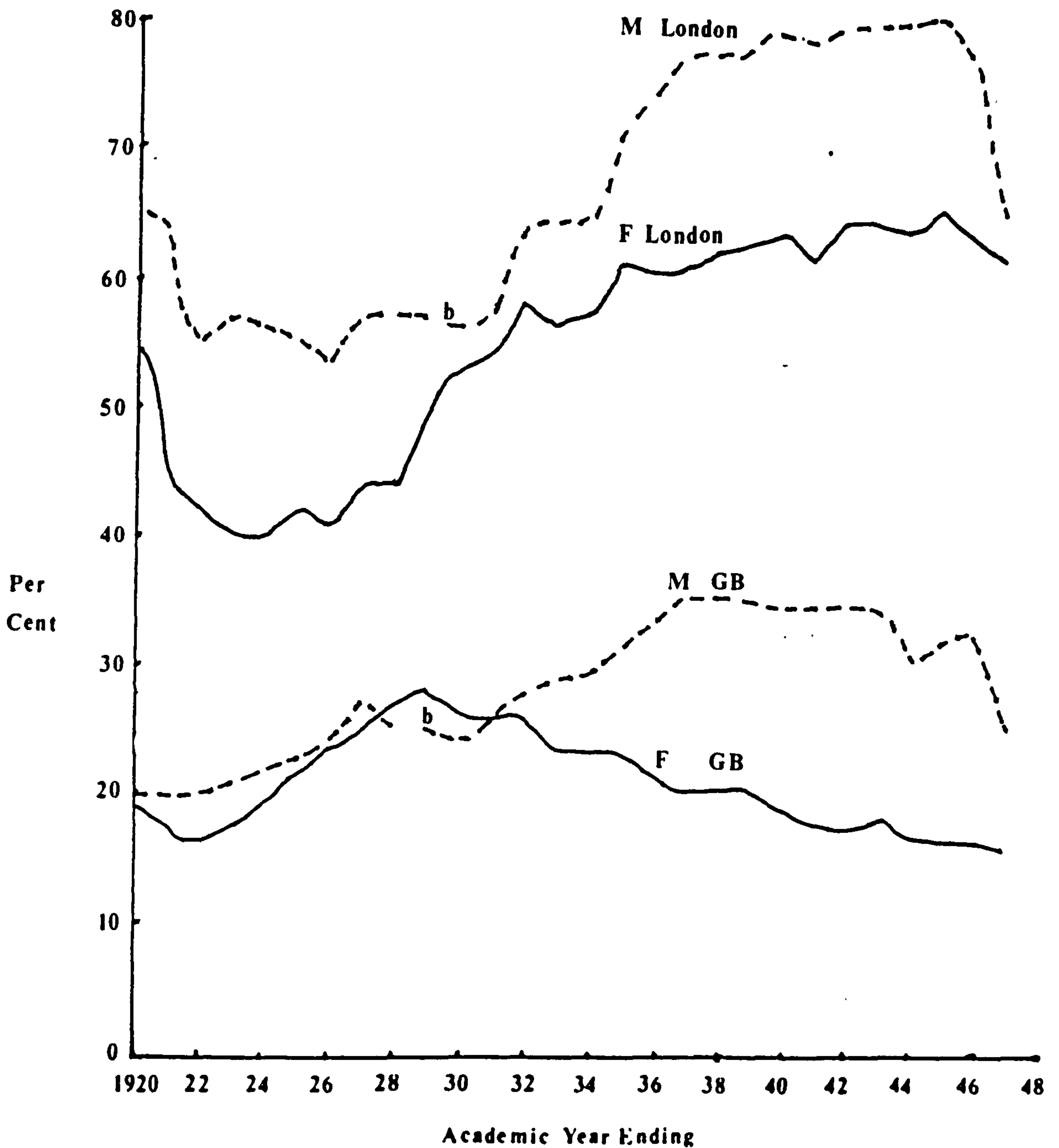
37. The proportion of women in Scottish schools was very close to the proportion in English provincial schools throughout, and would be difficult to show separately on this graph.

FIGURE 4.5:Women Medical Students in Great Britain: 1920-1948.^a

Source: UGC Annual Reports.

a Includes dental and preliminary students.

b London School of Medicine for Women.

FIGURE 4.6:

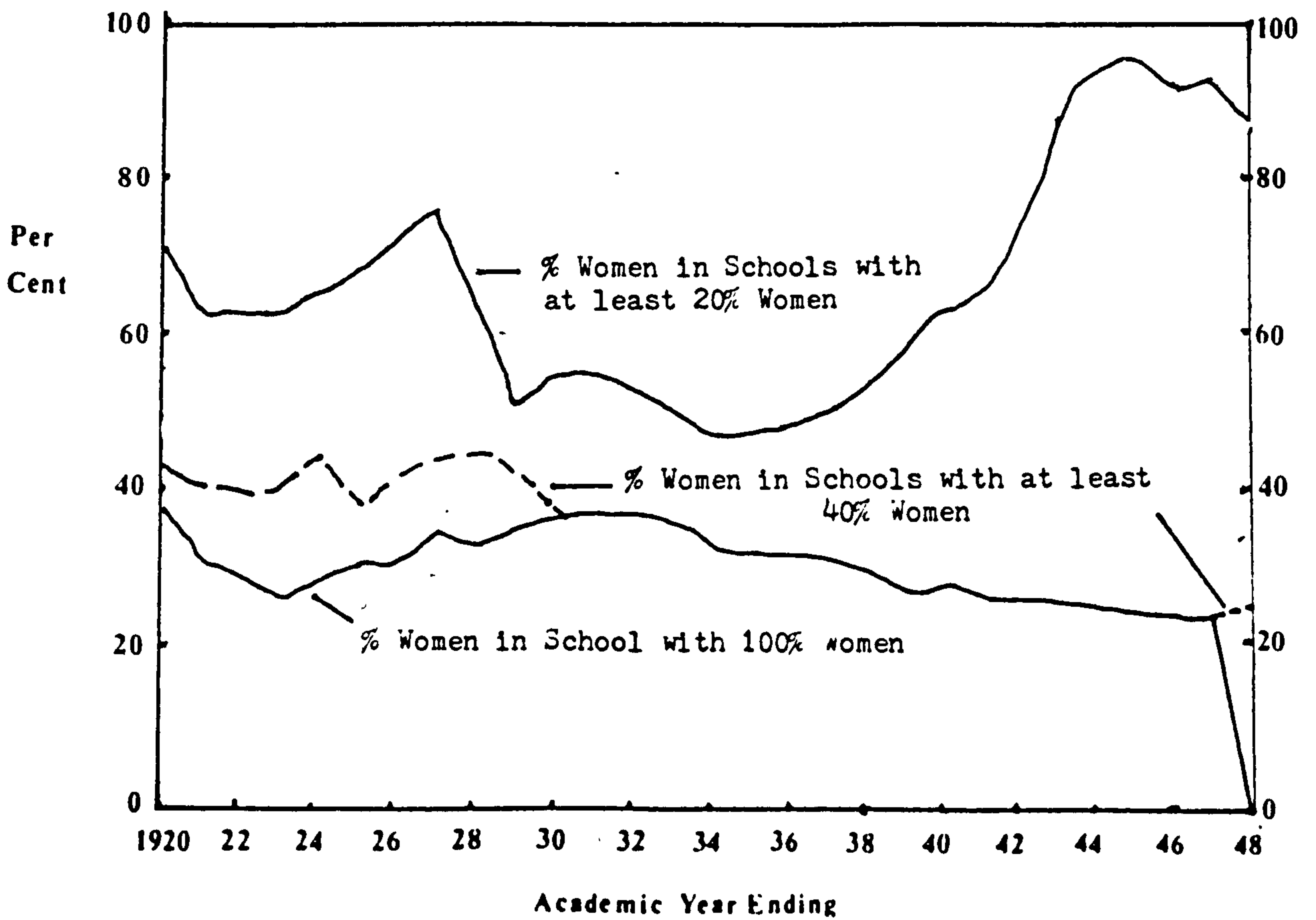
Percentage of All Male and Female Medical Students in Single-Sex Schools in London and Great Britain: 1920-1947.

Source: UGC Annual Reports.

a Includes preliminary and dental students.

b Guy's Hospital Medical School included for first time.

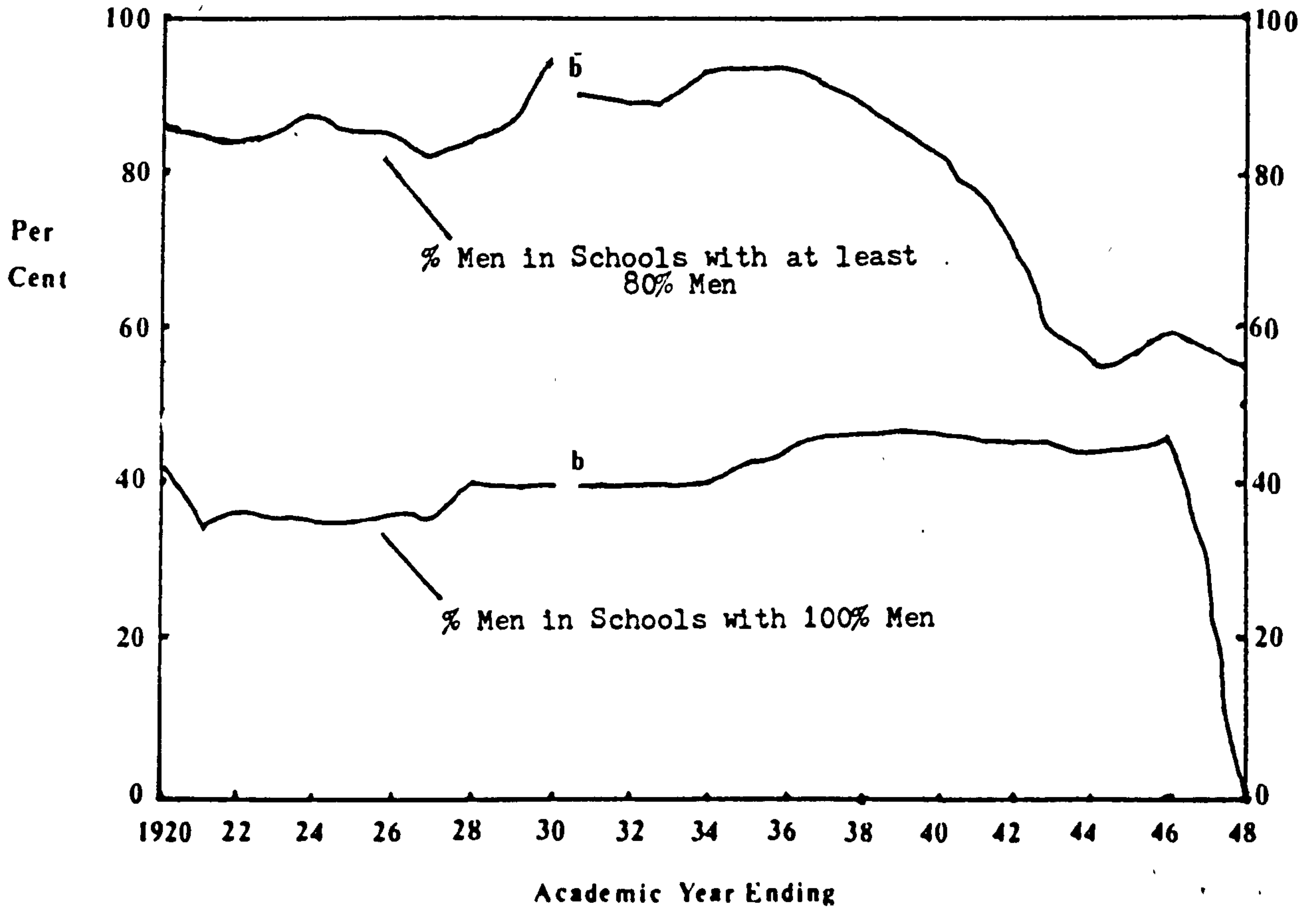
FIGURE 4.7:
Distribution of Women Medical Students: 1920-1948.
England & Wales.^a



Source: UGC Annual Reports.

^a Includes dental students.

FIGURE 4.8:
Distribution of Men Medical Students: 1920-1948^a
England & Wales.



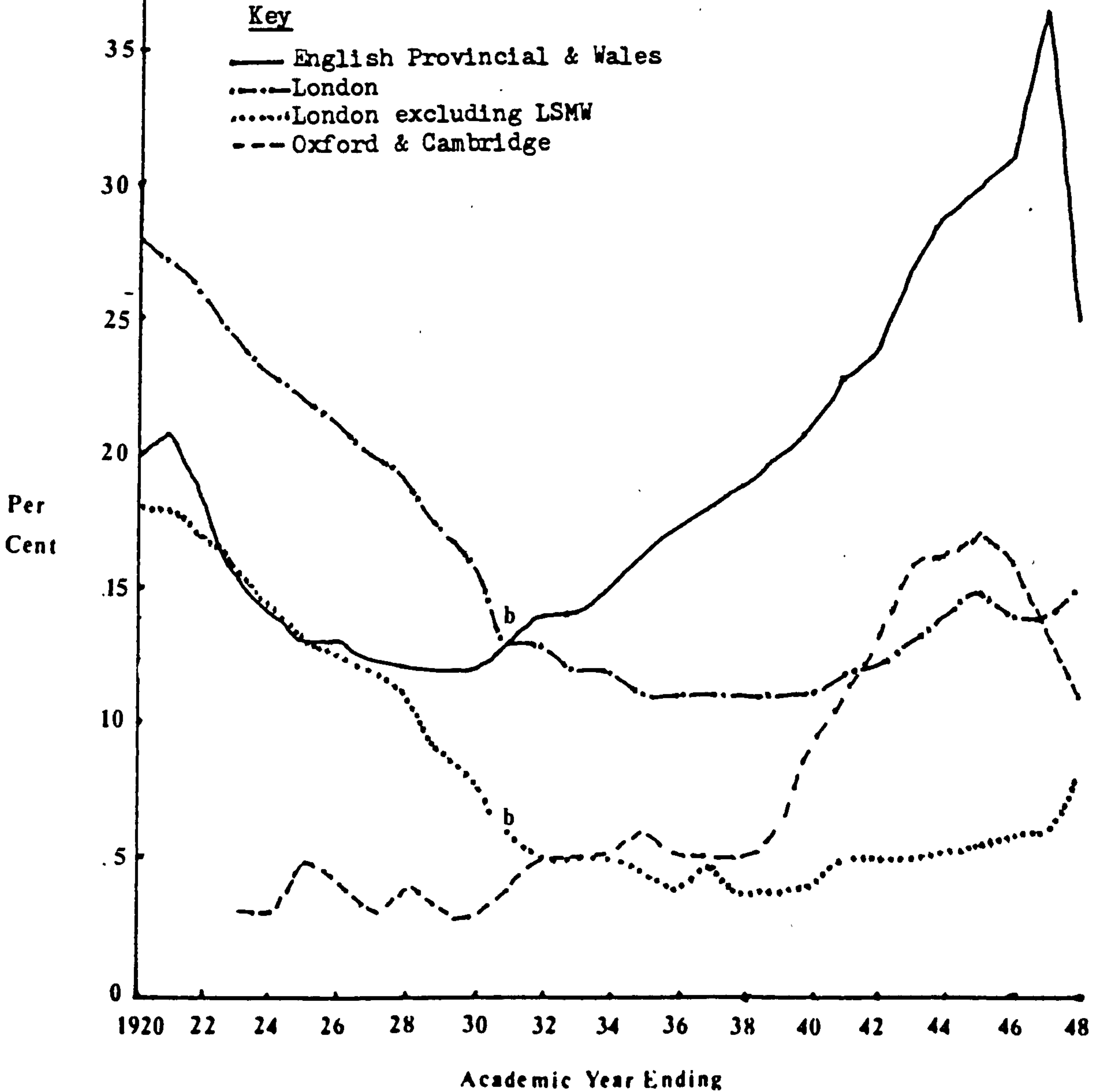
Source: UGC Reports.

a Includes dental students.

b Guy's Hospital Medical School included for first time.

FIGURE 4.9:

Percentage of Women in Different Types of
Medical School: 1920-1948. England & Wales.^a



Source: UCC Annual Reports.

a Includes dental and preliminary students.

b Guy's Hospital Medical School included for the first time.

Women in Medical Schools: 1948-1980

With the establishment of the NHS, virtually a monopoly employer of qualified doctors in Britain, the production of medical practitioners became a central concern of public policy: a matter of negotiation between the government, the profession and the universities, with their different interests. The result has been successive attempts to produce an appropriate structure of medical education and to adjust medical school places according to forecasts of national needs; forecasts which have been determined by fears fluctuating between expectation of a shortage of doctors and expectation of over-supply. These policy recommendations have had a major impact on the numbers of women in medical schools.

Immediately after the end of the war, the number of male medical students in university schools in Great Britain rose, with demobilization, and reservation of 90 per cent of university places for those whose education had been interrupted by the war. Then, from 1951 to 1961, the total number of male medical students fell gradually from 11,257 to 9,315. The total number of women had risen to just over 3,000 between 1947 and 1949. But there was no sustained fall thereafter. From 1951 until 1962, the numbers of women remained close to, or above, 2,900 (50 per cent more than in 1938-9). The result was a slight rise in the percentage of medical students who were women, from 20 per cent in 1948 to 24 per cent in 1961, a proportion equivalent to that achieved in 1920.

From 1948 to the late 1950s, the percentage of women studying medicine was only slightly below that of women among all first degree university students. From 1959 to 1963 it was the same. The proportions of all male and all female university students studying medicine was also close throughout: 17 per cent of men

and 15 per cent of women from 1949 to 1955, and falling to about 12 per cent for both sexes in the years 1959 to 1961. By these criteria, women do not appear to have been markedly under-represented in medicine within the university system during these years.³⁸

One factor in this small increase in female students relative to men was the Government's and UGC's partial acceptance of the following recommendation of the Goodenough Committee, set up in 1942, the first attempt to plan the scale and form of medical education for the National Health Service.

'In the interests of the public and the medical profession we believe that co-education should become the normal practice in every medical school. In this belief, and regarding the question as an important matter of public policy, we recommend for Government decision that the payment to any medical school of Exchequer grants in aid of medical education should be conditional upon the school being co-educational and admitting a reasonable proportion of women students. The proportion of women may well vary from school to school and from time to time, according to the quality of the students of both sexes applying for admission and to the public need for doctors. Further the schools at present admitting either men or women only may have to be allowed an interim period of varying length to adjust their arrangements on a co-educational basis....

'It is important that the number of women students in any school should be a reasonable proportion of the whole, say about one-fifth; otherwise the women will not form a sufficiently numerous body to ensure proper status and position. The grudging admission of a few women is unsatisfactory. The group must be large enough to feel itself to be an important but integral section of the whole, whose members are trained on a basis of complete equality with their male colleagues and given access to all the usual facilities, including staff appointments. There must be no sense of inferiority or of privilege.'³⁹

This is the origin of the post-war quota system, a public policy to ensure women's access to the full range of medical

38. All figures are UGC Statistics on total numbers of full-time medical students. (Dental students are excluded.)

39. Goodenough Report, p.99.

schools. The UGC recommended a minimum target of 15 per cent women, equivalent to the average proportion of women in all medical schools in the late 1930s. This recommendation was not welcomed by the single-sex schools, but, by the end of 1948, all had admitted at least one member of the minority sex.

But the fall in male students may also reflect another consequence of the introduction of the NHS. At the beginning of the NHS no central decision was made on the number of medical students although the Goodenough Committee had recommended an increase to 2,500 entrants per annum. By the 1950s, there was growing professional concern about a surplus of doctors, partly triggered by the evident imbalance in the middle ranks of the hospital career structure introduced at the beginning of the NHS. The Willink Committee set up to investigate this recommended, in 1957, a cut of 10 per cent in medical school places as soon as possible.⁴⁰ But entrants had already fallen by 8 per cent between 1954 and 1956. By 1964, the numbers qualifying per annum had fallen to 1500, the same level as in 1930. I was told by several deans and former students in interviews for the Medical Careers survey that some schools took in more women in the late 1950s, to keep student numbers up without adding to the surplus in the profession!⁴¹

But the Willink cuts were countermanded almost as soon as they had been implemented. By the early 1960s, professional and public concern turned to the apparent shortage of doctors to staff the expanding hospital sector, the allegedly increasing drain of British-trained doctors through emigration, and the growing dependence of the NHS on overseas doctors. Existing medical

40. Willink Report, p.33.

41. UGC Statistics. Todd Report, p. 127.

schools increased their intakes at government request, plans were made for a new medical school in Nottingham, and, in 1965, a Royal Commission on Medical Education appointed. In 1968, this recommended that expansion of medical schools was urgently necessary. A target of 4080 places by the mid-1980s was agreed and partly achieved (and, by the end of the 1970s, the claim that too many doctors were being trained was increasingly heard).⁴²

The expansion of medical education is shown clearly in Tables 4.2 and 4.3. Total numbers of students entering and qualifying in medicine have approximately doubled in this period. Women entrants grew by 250 per cent, and men by just over 50 per cent. Women qualifiers increased by nearly 200 per cent, and men by 60 per cent. Table 4.4 gives the percentages, indicating that by 1975 women were already 34 per cent of all entrants. Male entrants increased most rapidly during the early 1960s (producing a fall in the percentage of women), while the greatest rate of increase for women was between 1969 and 1974.

In the mid-1960s, places in universities as a whole were expanding much faster than in medicine, and the proportion of women entrants to university as a whole rose above that for medicine, being about 30 per cent from 1960-1 to 1969. Thereafter, they have risen together. The percentage of all male and all female university students studying medicine were similar throughout the period, though medicine's share of all university students continued to fall to 6 per cent of male students and 5 per cent of women students in 1980.⁴³

42. Todd Report, pp. 127-162; DHSS Medical Manpower-the next twenty years, p.27. In 1985 it was agreed to reduce places to the 1979 level of 3,900.

43. UGC Figures.

TABLE 4.2:

MEDICAL STUDENTS ADMITTED TO PRE-CLINICAL COURSES
ANALYSIS BY SEX (GREAT BRITAIN) 1961 - 1983.

Academic Year (ending 31 July)	Total	Men	Women
1961	2020	1528	492
1962	2103	1572	531
1963	2192	1669	523
1964	2281	1739	542
1965	2407	1871	536
1966	2478	1937	541
1967	2502	1933	569
1968	2560	1940	620
1969	2693	2009	686
1970	2695	1987	708
1971	2878	2066	812
1972	3032	2084	948
1973	3123	2149	974
1974	3276	2212	1064
1975	3281	2160	1121
1976	3468	2249	1219
1977	3654	2362	1292
1978	3778	2378	1400
1979	3944	2493	1451
1980	3979	2483	1496
1981	3987	2424	1563
1982	4010	2394	1616
1983	4072	2337	1735

Source: 1961 - 1980 UGC Returns

1981 - 1983 DHSS as quoted in RCOG Report of
 MANDOWER Advisory Committee, 1983.

TABLE 4.3:MEDICAL STUDENTS OBTAINING A FIRST REGISTERABLE
QUALIFICATION 1961-1983 ANALYSIS BY SEX (GREAT BRITAIN).

Academic Year (ending 31 July)	Total	Male	Female
1961	1844	1397	447
1962	1776	1342	434
1963	1844	1384	460
1964	1731	1322	409
1965	1805	1332	473
1966	1939	1458	481
1967	1933	1463	470
1968	2109	1567	538
1969	2126	1632	494
1970	2114	1621	493
1971	2190	1704	486
1972	2343	1739	604
1973	2289	1709	580
1974	2594	1896	698
1975	2644	1900	744
1976	2749	1895	854
1977	3045	2073	972
1978	3162	2146	1016
1979	3295	2215	1080
1980	3425	2278	1147
1981	3500	2304	1194
1982	3566	2314	1252
1983	3545	2240	1305

Source 1961 - 1978 UGC Returns

1979 - 1983 from DHSS as quoted in RCOG Report of
Mansoor Advisory Sub-Committee, 1983.

TABLE 4.4:

Percentage Women among medical students admitted to pre-clinical courses (Great Britain) 1961-1983

Percentage women among those obtaining a first registerable qualification (Great Britain) 1961 - 1983

**Academic Year
Ending 31 July**

% Women

1961	24.4
1962	25.2
1963	23.8
1964	23.8
1965	22.3
1966	21.8
1967	22.7
1968	24.2
1969	25.5
1970	26.3
1971	28.2
1972	31.3
1973	31.2
1974	32.5
1975	34.2
1976	35.1
1977	35.4
1978	37.1
1979	36.8
1980	37.6
1981	39.2
1982	40.3
1983	42.6

Source: As Table 4.2

**Academic Year
Ending 31 July**

% Women

1961	24.2
1962	24.4
1963	24.9
1964	23.6
1965	26.2
1966	24.8
1967	24.3
1968	25.6
1969	23.2
1970	23.3
1971	22.2
1972	25.8
1973	25.3
1974	26.9
1975	28.1
1976	31.1
1977	31.9
1978	32.1
1979	32.8
1980	33.5
1981	34.1
1982	35.1
1983	36.8

Source: as Table 4.3

Gender Segregation and Co-education in Medical Schools after 1947

How has this recent absolute and proportionate increase in women's presence in medical schools been distributed within medical schools? Did the Goodenough Committee's recommendation lead to a 'reasonable' proportion of women in the newly co-educational schools? Figures 4.10 and 4.11 show the trends in gender segregation from 1948 to 1980 in England and Wales.

Because the hitherto all-male schools admitted small numbers of women, the immediate effect of the move to universal co-education, was to increase the proportion of medical students studying in schools with just a few women.⁴⁴ Until after 1967 half of all male medical students based in England and Wales trained wholly or mainly in schools with less than 20 per cent women.⁴⁵ But only about one-third of women students were in this situation. On the other hand, the proportion of women students training where they were in the majority fell as the LSMW, now renamed the Royal Free Hospital School of Medicine (RFHSM) admitted its first men in 1947-8. The school initially set a target of 15 per cent, but the proportion grew slowly to 30 per cent in 1964-65 and 40 per cent in the following year. From 1972-73 to 1977-78 there were slightly more men than women at this school.⁴⁶ But from 1948 until 1971 it was the only school with 40

44. Figures from 1966 include dental students.

45. All the Scottish medical schools had at least 20 per cent women until the mid-1960s, and at least 30 per cent since 1968. UGC Annual Returns.

46. Jnl MWF (Feb. 1973), 39. Early male applicants to the RFHSM were reported as less well qualified than women applicants. A. Lawson and H.A.B. Simon 'The careers of men graduates from the Royal Free Hospital School of Medicine' Medical Education 10 (1976), 348.

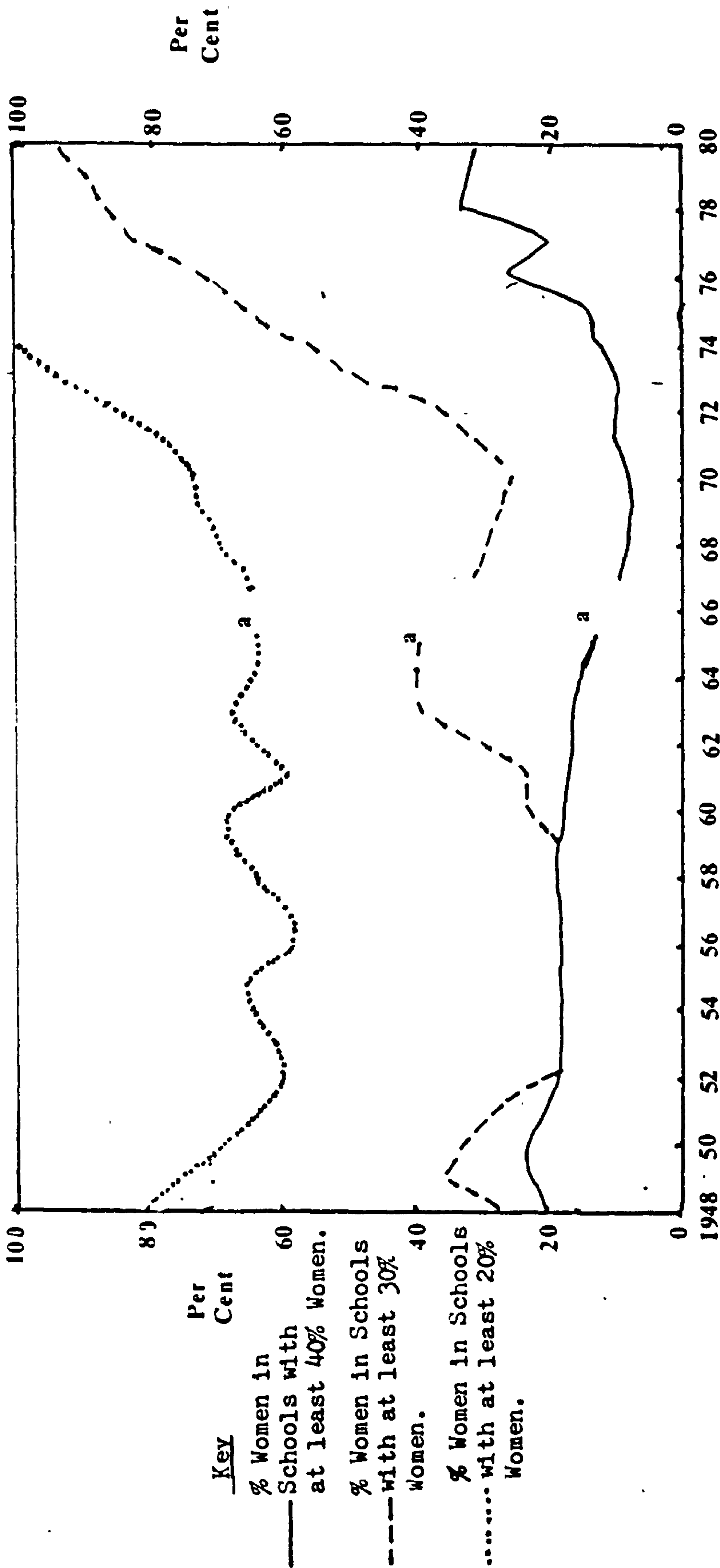
per cent women.

Figures 4.10 and 4.11 show that, as medical schools expanded after the mid-1960s, the proportion of either sex training with less than 20 per cent of women diminished. By 1975 the majority of male medical students were in schools with at least thirty per cent women, and the proportion in those with less than 20 per cent was negligible. Since then, segregation has diminished still further. Since 1973 the proportion of women training in schools with more than 40 per cent women has increased, and these women are no longer only in the RFHSM.

Figure 4.12 shows that the differences between types of medical school, with regard to the proportion of women among the students, persisted, though greatly diminishing in the 1970s. The proportion of all medical students in England training in London, Oxford and Cambridge fell from 67 per cent in 1960 to 58 per cent in 1968, and 50 per cent in 1976. This is partly because of the opening of three new provincial schools, Nottingham, Leicester, and Southampton, which, from the start, have had almost, or more than, 40 per cent of students women. Thus, even if the admission of women to the London "men's" schools and Oxford and Cambridge had not changed, the numbers and proportion of women students would have increased. However, as Figure 4.12 shows, from the late 1960s, the proportion of women among Oxford and Cambridge medical students has risen, as many colleges have become co-educational. The proportion of women also rose in the London schools from the late 1960s.

These were the schools to whom the Goodenough Committee's recommendations for co-education were specifically addressed. As they said, if, in 1938-9, '... the proportion of women students

FIGURE 4.10:

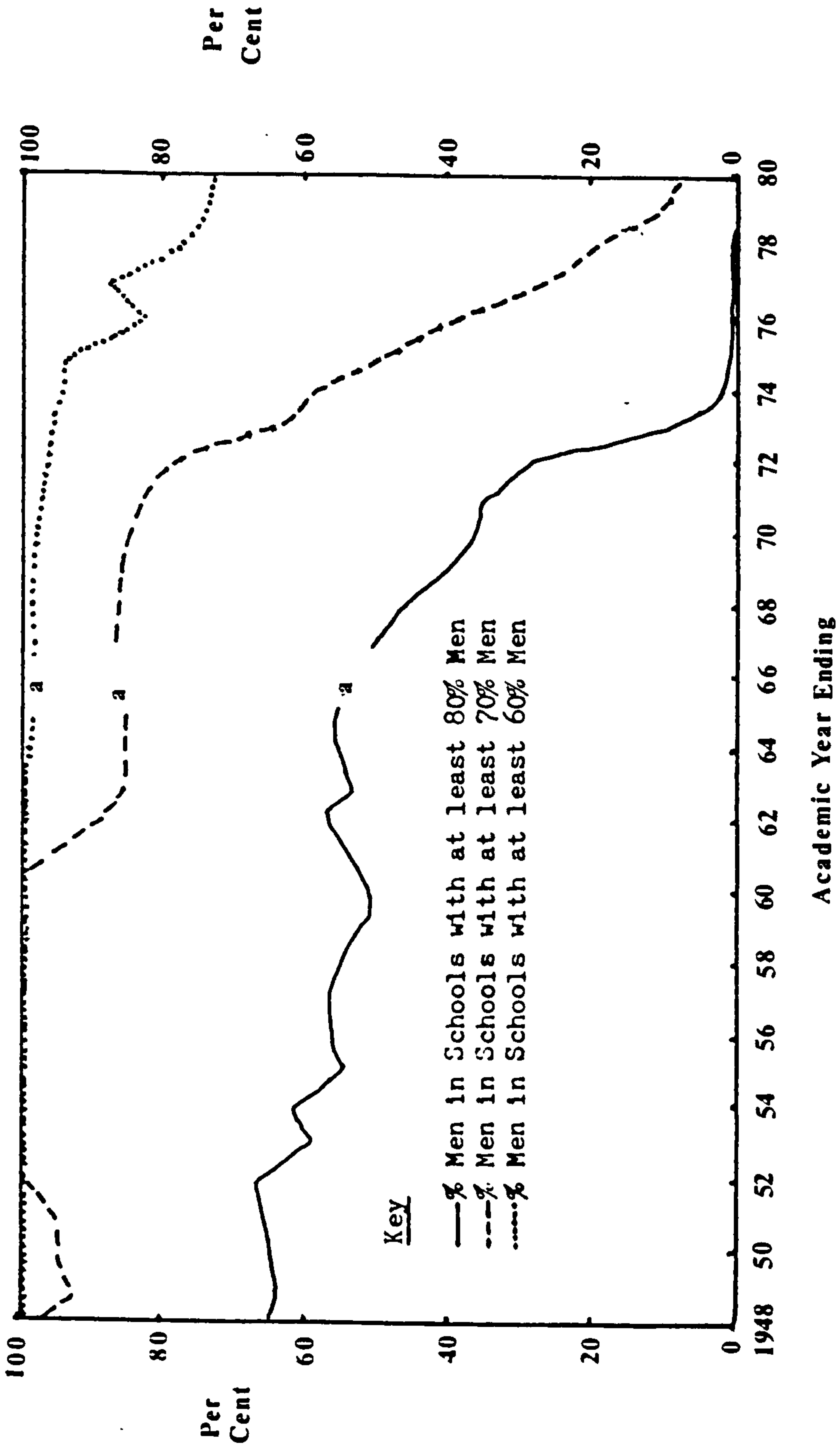


Academic Year Ending
Distribution of Women Medical Students: 1948-1980. England & Wales.

Source: UCC Annual Reports.

a. No figures available for 1966. Figures after 1966 include dental students.

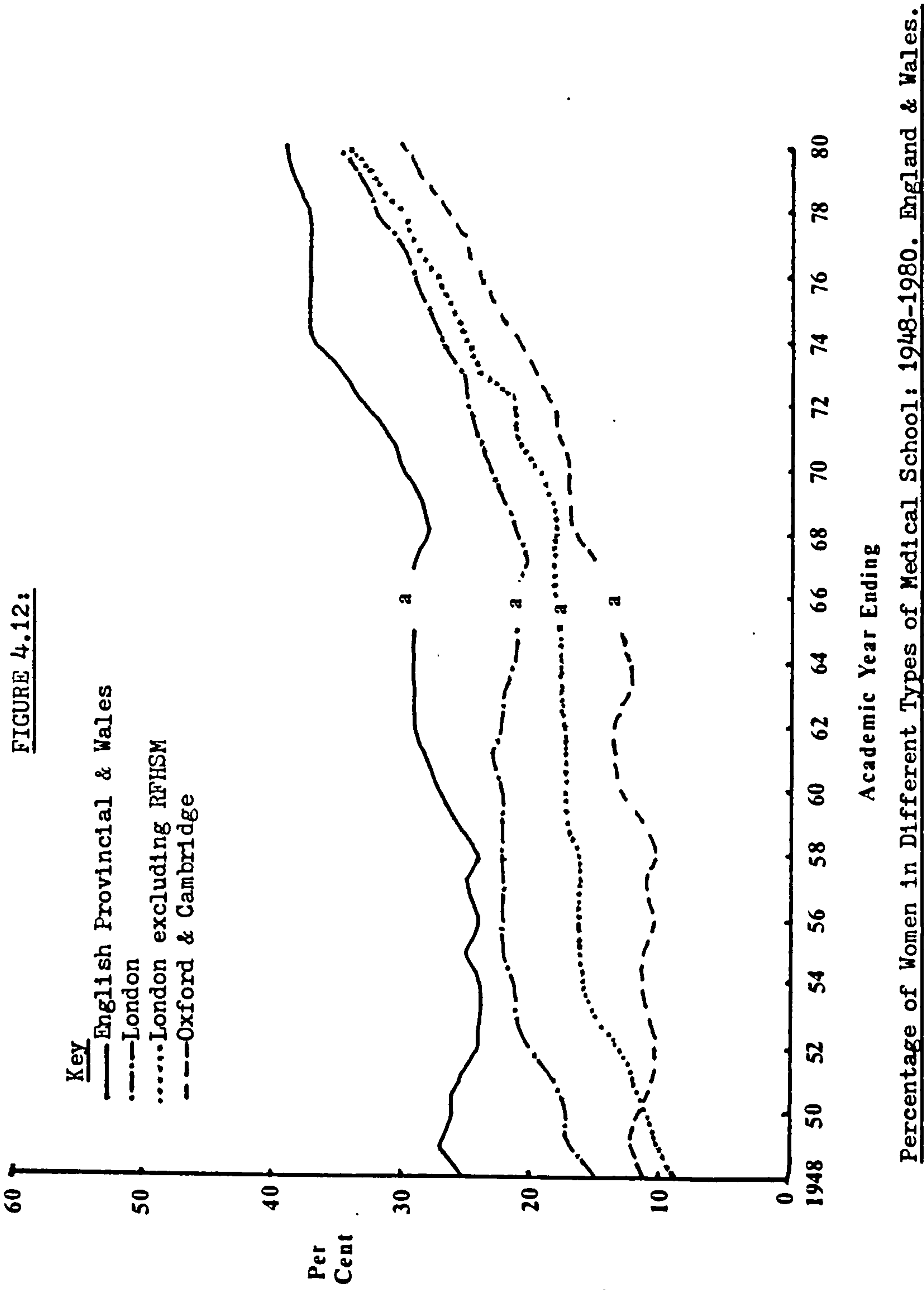
FIGURE 4.11:



Distribution of Men Medical Students: 1948-1980. England & Wales.

Source: UGC Annual Reports.

a. No figures available for 1966. Figures after 1966 include dental students.



Source: UGC Annual Reports.

a. No figures available for 1966. Figures after 1966 include dental students.

... had been the same in the London schools as in the universities in the English provinces and Wales or in the Scottish universities, approximately 450 more women would have been in training in London.⁴⁷ The Committee's recommendations ended categorical exclusion of women from any schools, but, as Figure 4.12 shows, the proportion of women in London schools was still less than in provincial schools in 1980.

The Goodenough committee recommended quotas of places for women as a means of ensuring their presence in "reasonable" proportions, and Figure 4.12 shows that, from 1954, the proportion of women in all the London schools excluding the RFHSM did reach the UGC's suggested level of 15 per cent, and stayed close to that level for the next fifteen years. Only Oxford and Cambridge, where men and women did not compete for the same places until recently did not achieve this level within ten years of the Goodenough Committee's report.

Did quotas subsequently become a means for keeping well-qualified women out of medical school, as some have claimed? Were they interpreted as a maximum rather than a minimum figure if the proportion of women among well-qualified applicants exceeded the places available to them? Detailed investigation of this lies outside the scope of this thesis but a few comments can be made.

There is much evidence, not least schools' own testimony, indicating that, at least in the mid-1960s, many medical schools considered women's applications more stringently than men's: a practice held to be justified by women's lower activity once qualified, or as a counter to the advantage bestowed on girls by

47. Goodenough Report, p. 98. 450 more women would have represented a 23 per cent increase in total numbers of women.

their being more mature than boys at school-leaving age.⁴⁸ Either higher entry qualifications were demanded, or a set proportion of places were set aside for women which, if women applicants as a whole were better qualified than men and sufficiently numerous, would have the same effect. There is at least indirect evidence that this was so for much of the 1960s.⁴⁹

The size of the quotas adopted varied between schools, from 15 per cent in one London school to one-third in several provincial schools. A survey of applicants to 24 medical schools in 1963-4 showed that although the proportion of males and females accepted was not dissimilar, the chances of women applicants being successful varied considerably between schools. Women's chances were lowest in the London schools, a finding which helps explain the pattern shown in Figure 4.12.⁵⁰ Since 1969, the proportion of applicants accepted overall has been higher for women than for men, indicating that they may still have been slightly better qualified, but the difference between the 'A-level' grades of male and female entrants disappeared. This happened before quotas were formally abolished, at a time when applications per place had

48. The quota policies of the five schools surveyed in the Medical Careers' survey were described in Elston 'Women in the Medical Profession', p. 134.

49. In October 1969 39 per cent of women and 23 per cent of men admitted to medical school had 3 B grades at A-level, or higher. UCCA Annual Report 1969-70. See also M.L. Johnson 'A comparison of the social characteristics and academic achievement of medical students and unsuccessful medical school applicants' British Journal of Medical Education 5 (1971), 260-263. In 1965, the Middlesex Hospital Medical School's policy was to admit 17-18 per cent of women, though they were 34 per cent of applicants. This quota was often exceeded as women offered places were more likely to achieve the required 'A-level' grades than men.' Jnl. MWF 47 (1965), 42.

50. Jefferys et al. 'Comparison of men and women in medical training', 1382.

reached record levels, and increasing reliance was being placed on 'A-level' grades in selection. This may be one reason why the proportion of women accepted rose in all types of school from the late 1960s.⁵¹

There is, then, at least indirect evidence to suggest that the operation of quotas had the effect of substantive discrimination against women in the mid-1960s. But it is important to bear in mind that belief in the existence of quotas could have produced these patterns, through its effect on women's applications, even if quotas were not, in practice, rigidly applied. The importance of their widely-publicized abolition (as formally acknowledged policies) may lie as much in its effect on applications as in its direct effect on selection. The development of a significant presence of women in the traditionally men's schools might prove as significant a development for their place in medicine as the rise in overall numbers. But this is for the future to reveal.

Summary

This chapter has attempted to establish three main points about the patterns of women's entry to medical schools in Britain. The first is simply that women have been present in medical schools in far from negligible numbers for much of the last sixty years, and have never been less than one-fifth of the total since the Second World War, despite the barriers that they have faced. Although for more than half that time the proportion of women in

51. UCCA Annual Reports. Elston 'Half Our Future Doctors', p.109; I.C. McManus and P. Richards 'Audit of admission to medical schools: I-Acceptances and rejects' BMJ 289 (3 Nov 1984), 1201-4. Since 1974, applications from British men have fallen.

medical schools has been somewhat less than their proportion in universities as a whole, it has been as high and generally higher than their proportion in "pure" science subjects, and much higher than their proportion in technological subjects. However, their presence in medical schools has not steadily increased since the 1870s, being greatly augmented by the impact of war, especially the First World War, after which there was a sustained fall.

Secondly, I have tried to set the issue of quotas in its historical context. Their formal abolition was only one factor in the marked increase of women medical students over the past twenty years. Abolition occurred against a background of rapidly rising numbers in an expanding medical education system. However, in considering the impact of the quota system, one must not lose sight of its most significant feature. Quotas were suggested as a matter of public policy in the first place, because of the expressed desire of relatively large numbers of women to enter medicine, and the belief of many that this was desirable. Their subsequent operation was so controversial, because others, notably the gatekeepers to some medical schools, did not agree.

Thirdly, I have shown the changing pattern of gender segregation within British medical education. Before the First World War, the vast majority of medical students trained in single-sex institutions. From 1918 to 1947 a substantial minority still did so in London. Before 1914, and for much of the inter-war period, most women outside the women-only schools trained in schools where they were a small minority—less than 20 per cent. From 1948 to 1972, the typical woman's medical training was in a school with 20-29 per cent women. Since then, they have been mainly in schools with 30 or even 40 per cent women.

I shall next consider who these women entrants to British medical schools were, and what they did after qualifying in medicine. First of all, I shall explore in more detail some of the questions raised by the discussion in this and the previous chapter. Why was medicine the profession 'in which the admission of women commenced first and proceeded furthest'?⁵² Why did women in the second half of the nineteenth century seek to enter medicine? What response did this meet with, and why was their main route to qualification through separate, women-only medical schools?

52. 1921 Census England & Wales, General Report (1927), p. 125.

PART TWO

WOMEN IN THE MEDICAL PROFESSION

CHAPTER V

WOMEN'S ENTRY TO THE MEDICAL PROFESSION, 1858-1877

Introduction

Parts of the story of women's struggle to gain access to medical education in the 1860s and 1870s have often been told, in descriptive, and generally celebratory, histories and biographies of "pioneer" women overcoming old-fashioned prejudices, with the aid of a few enlightened men.¹ More recently, as outlined in Chapter II, this struggle has featured in feminist accounts of the history of male control over women's health.² In Chapter II, I suggested that, although these studies have been invaluable in bringing about a revolution in the study of women and medicine,

1. Secondary sources include J. Manton Elizabeth Garrett Anderson, (London: Methuen, 1963); M. Todd [Travers] Sophia Jex-Blake (London: MacMillan, 1918); E.M. Bell Storming the Citadel: the Rise of the Woman Doctor (London: Constable, 1953). I. Thorne A Sketch of the Foundation and Development of the London School of Medicine for Women (London: Women's Printing Society, 1916); E. Lutzker 'Medical Education for Women in Great Britain' Unpublished M.A. Dissertation, Columbia University, 1959, and Women Gain a Place in Medicine (New York: McGraw-Hill, 1977); C. Blake 'Women's Entry into the Medical Profession in Britain, 1860-1880'. Unpublished M.A. dissertation, University of Essex, 1983; J. Donnison Midwives and Medical Men: a History of Inter-Professional Rivalries and Women's Rights (London: Heinemann, 1977). Contemporary accounts include S. Jex-Blake Medical Women: A Thesis and a History (Edinburgh: Oliphant, Anderson & Anderson, 1886); J. Stansfield 'Medical woman' Nineteenth Century 1 (1877) 888-901; R. Wilson 'Aesculapia Victrix' Fortnightly Review 35 (1886) 18-33; F. Hoggan 'Women in Medicine' in The Woman Question. Edited by T. Stanton (London: Sampson Lord, 1884) pp.63-85.

2. Eg. Duffin 'The Conspicuous Consumptive'; L'Esperance 'Doctors and Women in Nineteenth Century Society'.

they have, in some ways, been less helpful for studying women in medicine.

Many of the descriptive studies and the feminist accounts have given insufficient attention to the two-sided context in which the campaign took place: it involved both the middle-class women's movement and the changing and controversial world of medicine in the second half of the nineteenth century. Only by setting the struggle in this complex context can we see why the campaign for women to enter medicine aroused so much hostility as well as support from the public and within the profession, and how the conditions in which the first women entered structured the medical careers of them and of women subsequently.

Because the course of events is well-known, I do not propose to give an exhaustive narrative account of the struggle. I concentrate on setting the campaign in its context, and on identifying features that were significant for the careers of these pioneers, and those who followed them into medicine.

The first identifiable efforts of women to enter the qualified profession occur in the late 1850s. One woman, Elizabeth Blackwell MD, was entitled to be on the Medical Register, from its inception, having practised in Britain before 1858, with an American medical degree—an invaluable precedent. Her lectures

on the desirability of women doctors aroused much interest.³

In Britain, after 1858, 'it became a sine qua non that any woman desiring to practise medicine in this country, should obtain their education in such a way as would entitle them to demand registration.' The professional reforms that had led to the 1858 Act, and the establishment of the GMC, formalized the requirements for entry to the medical profession proper and placed control over entry firmly in the hands of the profession as represented by the GMC, and the nineteen examining bodies. Jex-Blake claimed that the 1858 Medical Act was 'wrested from its original purpose [of excluding the unqualified and incompetent] and made an almost unsurmountable barrier to the admission of women to the authorized practice of medicine.'⁴ The existence of the Medical Register made the campaign for women's entry to medicine in Britain very

3. Elizabeth Blackwell, (1821- 1910), British-born but brought up in the United States took an MD in 1848. She came to Britain several times before settling permanently in 1869. Though very active in many medical and moral reform movements she did little clinical work in England, partly because of ill-health. On Blackwell, see E. Blackwell Pioneer Work in Opening the Medical Profession to Women (London: Longmans, 1895. Reprinted Schocken Books, 1977); N.S. Sahli 'Elizabeth Blackwell, MD (1821-1910): A Biography' Unpublished Ph.D. Thesis, University of Pennsylvania, 1974. M. Forster Significant Sisters: The Grassroots of Active Feminism (London: Penguin, 1986), pp. 55-92.

4. Jex-Blake Medical Women p.64-66. Contemporary accounts including Jex-Blake's, do not suggest that the exclusion of women played any part in the debate over medical reform between 1820 and 1858. Waddington (personal communication) says that he found no reference to women in his study of the medical reform campaign culminating in the 1858 Act. They were simply "not on the agenda".

different from that in the United States.⁵

Women's Efforts to Enter Medicine

The first chapter in the history of women within the British medical profession, the struggle for entry, can itself be divided into two phases: from 1858 (with the passage of the Medical Act) to 1869, and from 1870 to 1877. Within these phases, the goals and many of the arguments were the same, but the tactics employed by both the women and their opponents were different.

In the first phase, there was a series of attempts by individual women to obtain medical education and join Elizabeth Blackwell on the Medical Register. One, Elizabeth Garrett, (1836-1917) succeeded in doing so. These individuals sought entry against a background of debate about middle-class women's role in public life and employment in general, and, more specifically, about their roles in health care. But it is perhaps inappropriate to describe this phase as a 'campaign', if this term should be taken to connote organized pressure-group tactics against publicly

5. In Jacksonian America, 'regular' doctors had no state backed monopoly over practice; nor had they state support for their claims to superior competence or for their qualifications. They competed with a variety of healers, male and female, for a largely rural clientele. For women in the United States, in the 1850s and 1860s, the institutionalized obstacles, especially for "inferior" and "irregular" training, were initially less formidable (though still considerable) than in Britain. But this meant that when, at the end of the nineteenth century, campaigns to eliminate inferior competitors and reform medical education gathered momentum, American women doctors lacked the protection afforded by unambiguous membership of the state-sanctioned professional community. See Walsh Doctors Wanted and Sanchez-Morantz Sympathy and Science on American women in medicine.

opposed positions.⁶

Garrett's tactics were essentially non-confrontational. She intended to advance the cause of women in medicine by setting an example. She wanted to demonstrate the possibility of women's obtaining medical education, by obtaining it for herself. To do so, she lobbied personally in medical schools and universities throughout the country, quietly aided by many supporters connected with the women's movement, by her friends and family, especially her father, and, so long as it did not threaten their own careers, by many individual medical men. Although her actions aroused considerable public interest and some petitions, including, for example, one for the admission of women to the University of London, the tone of her efforts and her response to setbacks was one of studied moderation. These efforts attracted opposition and hostility in some of the medical (and lay) press. The predominant tone was one of derision and amazement (feigned or otherwise) at the idea of women's practising medicine.

Her path to registerable qualification was cleared in 1861 by counsel's opinion that the charter of the Society of Apothecaries obliged the Society to examine all 'persons' who satisfied their formal requirements; requirements which, at that time, could be met through apprenticeship and private tuition. Eventually rejected by all the medical schools she tried, she followed this

6. The account that follows is based on the references given in Note 1, and on contemporary articles in Lancet, BMJ and The Englishwoman's Review. On Garrett, see also Manton Elizabeth Garrett Anderson; L.G. Anderson Elizabeth Garrett Anderson (London: Faber & Faber, 1939). Garrett took the name Garrett Anderson after her marriage, in 1871, to J.G.S. Anderson.

route—regarded by her as the last resort—to the low status Licence (LSA—known as 'Licence to Slay Anybody'). She qualified in 1865. Several other women attempted to follow Garrett's example, with private tuition from her and others. But, in 1868, Apothecaries' Hall closed its examinations to those who had not studied at a recognized medical school, and hence excluded women through an act of professional reform.

After 1868, some women continued to follow the quiet route through overseas training, returning to practice unregistered.⁷ But in October 1869, the immediate seeds for the second phase of the campaign were sown. Five women, including the indomitable Sophia Jex-Blake (1840-1912), matriculated at Edinburgh University to study medicine in separate classes arranged by themselves.⁸

This was to lead the Lancet's 'vitriolic campaign of "unprecedented malignity"' to reach its height.⁹ Subsequent placing of obstacles in the way of these women to prevent them from graduat-

7. The existence of this quiet route taken for example by Louisa Atkins and Frances Morgan Hoggan, was a factor in the public disagreement between Garrett Anderson and Jex-Blake in 1873, after the latter had lost her legal battle with Edinburgh University Senate. Garrett Anderson recommended women should seek training overseas and practice, until the medical corporations recognized that women in medicine were a fait accompli (Times 5 Aug. 1873). Jex-Blake argued this put medical education out of reach for almost all women and accepted current injustice (Times 23 Aug. 1873).

8. The others were Isabel Thorne, Edith Pechey, Helen Evans, and Matilda Chaplin, joined the following year by Mary Anderson and Emily Bovell. Jex-Blake Medical Women, p. 78. These seven were the 'Septem contra Edinem' in 1873. A. Sachs and H. Wilson Sexism and the Law (London: Martin Robertson, 1978), p.14. In total at least fifteen women matriculated at Edinburgh before 1873.

9. L'Esperance 'Doctors and Women', p. 118, quoting The Spectator 13 Dec. 1870.

ing inflamed the issue and provoked a frontal 'assault' on the 'citadel' of medicine, a public campaign for women's access to the Medical Register to constitute a right, rather than to depend on a concession to exceptional individuals.¹⁰ The obstacles led to lawsuits, mass meetings, and the public molestation of the women students by male students. The question became a major public issue, in Edinburgh and nationally, arousing the real ire of many medical men.

In 1873, seven women students lost their legal battle to graduate from Edinburgh, though they had almost completed the requisite study. As all other medical schools also seemed to be closed to women, Jex-Blake turned to a solution that had always been rejected when proffered by the opposition—that of a separate school for women. Garrett Anderson remained opposed to this venture until the last moment, agreeing in the end to join both the Executive Council and the teaching staff when the London School of Women for Medicine (LSMW) admitted its first students in 1874. Initially, the school had neither clinical facilities nor access to a registerable qualification. In 1877, the school obtained facilities for clinical training at the Royal Free Hospital, at first under an expensive and temporary arrangement.

With the failure in Edinburgh and the establishment of the LSMW, the public campaign became focussed on legislation as a means of granting women access to the Register, rather than on education per se. Between 1874 and 1876, a series of parliamen-

10. The terms are from Bell Storming the Citadel p. 62. Detailed accounts of events in Edinburgh are given in this, pp. 62-83; Blake 'Women's entry'; Jex-Blake Medical Women, pp. 63-165.

tary bills, attempting to compel the medical corporations to admit women or the GMC to recognize foreign degrees, failed. But the passage of Russell Gurney's Enabling Act, in August 1876, clarified the legal right of medical corporations to admit women to registerable qualifications, if they so wished.¹¹ The King's and Queen's College of Physicians of Ireland was the first to do so. In 1877, after a gap of twelve years, four women joined Blackwell and Garrett Anderson on the Medical Register. Women now had a foothold in the qualified and registered profession.

The strength of the opposition to women's entry to medicine has generally been explained in terms of the male profession's fear of the prospect of competition and its wish to retain patriarchal control. The difference in the two phases of the campaign has been generally attributed to the different personalities of Garrett Anderson and Jex-Blake. Undoubtedly, many, probably most, medical men were opposed to women's entering the profession. And there is ample evidence of 'chronic hostility' and a clash of temperaments between Jex-Blake and Garrett

11. Lutzker 'Medical education for women' contains a detailed discussion of the various bills.

Anderson.¹²

But these are only partial explanations. If most medical men were opposed to women in medicine, many were not. There is probably much truth in Jex-Blake's observation that the death, in 1870, of Sir James Simpson, the internationally famous Professor of Midwifery in Edinburgh, a staunch supporter of medical women, was 'a great and unexpected blow to the cause of women's medical education at Edinburgh'.¹³ Such was his status that he might have championed successfully the cause of women in the University against 'the whole opposition' in Edinburgh, which was, in Jex-Blake's published retrospective account,

'dictated by one man and his immediate followers. It is hardly necessary to say that that man was Sir Robert Christison whose great age and long tenure of office naturally gave him unusual weight, both in the University and among medical men in Edinburgh... [He] was the only Professor and the only medical man who had a seat in the University Court, and also the only person who had been a member of every important body, ... by whom our interests had to be decided...'¹⁴

There is also, probably, some truth in the claim by Frances Hoggan, MD, and her husband, George (a student in Edinburgh during

12. Elizabeth Blackwell to Kitty Barry Blackwell, 27 August, 1874 (Blackwell Family Papers, Schlesinger Library, Radcliffe College), quoted in Sahli 'Elizabeth Blackwell', p.217; Anderson Elizabeth Garrett Anderson, pp.210-211. In a recent "factional" book and television series, Garrett Anderson was portrayed as so demure and cautious, that it was difficult to imagine she could ever have even considered entering medicine. M. Allen and M. Elder The Walls of Jericho (London: BBC, 1981). Yet Manton Elizabeth Garrett Anderson esp. pp.112-184, makes it clear that her caution was learnt and tactical, often restraining her father.

13. Letter to Times 4 Sept 1873.

14. Jex-Blake Medical Women, pp. 74-75. On Christison, Professor of Toxicology, Physician to the Queen, see R. Christison The Life of Sir Robert Christison, Bart: Edited by his Sons (Edinburgh: Blackwood, 1885, 2 vols.) He died in 1880, five years before Jex-Blake wrote this.

the battles), that Jex-Blake's tactics alienated many, and may even have delayed the women's eventual success.¹⁵ When the plans for the LSMW were made public, Jex-Blake was induced 'not to let her name appear in any way for she is in such odium with the profession that her name would have damaged the school.'¹⁶

This is not to suggest that personalities, and the contingencies of their lives, dictated the course of the struggle, only that they played a part, given the changing course of the movement. The belligerent stance of Jex-Blake was, in itself, still shocking to many in the 1870s, arousing fears about the kind of women who might become doctors. But for a woman to behave in this way in the early 1860s, for her to address public meetings at all, let alone make statements leading to libel suits, was simply inconceivable. Such behaviour would have lost Garrett her battle to establish that women could learn medicine without loss of respectability—lost it before she began.

The significance of Jex-Blake's comments about Christison and Simpson lies in their indicating that one man might have made a difference in what was a very closely fought struggle. The ferocity and tenacity with which some medical men opposed women's entry may reveal the strength of public support for the women's case, not the power of a united, dominant profession. Although

15. Hoggan 'Women in medicine', pp. 63-85. For a critical response to this claim see S. Jex-Blake 'Review of The Woman Question in Europe' The Academy (4 Oct 1884)-(RFH Press Cuttings, Vol 2.)

16. Note by Elizabeth Blackwell, with 'Prospectus 1874-5 Session, London School of Medicine for Women' in Blackwell Family Papers/60. Schlesinger Library, Radcliffe College.

the women lost the legal battle in Edinburgh in 1873, they had clearly not lost the battle for public opinion nor all medical support.

To understand why this was so, and why the battle became so intense, we need to consider the place of the movement for medical women in the context of the contemporary women's movement, and the concerns of and about the medical profession in the 1860s and 1870s. These shaped the course of the immediate struggle and determined the terms on which women gained their foothold in medicine. We need to consider briefly why women sought to enter medicine; why they aroused both support and hostility; on what terms they succeeded; and what the implications for their entry were for the professionalization of medicine.

Medicine: A Suitable Profession for Women?

The efforts of women to enter the medical profession were one aspect of the many and diverse strands that constituted the middle-class women's movement of the second-half of the nineteenth century. In this movement, a number of different ideas about women and their place in public life co-existed, not always easily, even within individuals' writing and action. Two were particularly important and relevant here.¹⁷

The first was the demand for women's right to independent existence, to be autonomous agents, morally, legally, and

17.0. Banks Faces of Feminism (London: Martin Robertson, 1981) discusses these different perspectives, but exaggerates the extent to which these perspectives were actually discrete segments of the movement. See J. Lewis Women in England 1870-1950 (Brighton: Wheatsheaf, 1984), pp. 83-97.

eventually politically. For this, they needed education to realize their capacities, and, at least for single women, more rewarding employment than hitherto available. This is the tradition of Mary Wollstonecraft, and of liberal, or 'equal rights' feminism, in which the central demand is that the public world be opened to women on the same terms as to men.¹⁸

But a second strand of feminist thought was perhaps more important in the second half of the nineteenth century, and conditioned the public debate about women in medicine. In the public debate about women's entry in the 1860s and 1870s, there was no suggestion that women should compete on equal terms with men in medicine as a whole. Argument for the cause of woman in medicine was dominated by what Banks describes as 'welfare' feminism, and Lewis as 'social maternalism'. Women argued, not for equal rights to compete with men in the public sphere, but for access to it in order better to pursue their feminine interests and talents. This strand of feminism transformed the ideology that had arisen with the separation of home and work for the middle-classes—the ideology of separate spheres of influence for men and women: for men, the public domain of politics and commerce; for women, the private domain of the family and personal philanthropy. Women's special mission was their physical and moral guardianship of the home and those in it, that is women and children, who were to be defended against ill-health, dirt and sexual immorality. As many recent British and American historians have demonstrated, this

18.M. Stacey and M. Price Women, Power and Politics (London: Tavistock, 1981), pp. 49-78.

ideology was not a uniformly restrictive set of ideas imposed on women, but was continually interpreted and transformed by them.

The idea of middle-class women's mission to women and children was extended, in the 1850s and early 1860s, to embrace personal philanthropy to the disadvantaged. Ladies visited those less fortunate than themselves in public institutions, in the female wards of workhouses, in children's homes, in lock hospitals. By the late 1860s, the ideology was further transformed by such women as Frances Power Cobbe and Josephine Butler into a demand for the vote and for 'masculine philanthropy', that is, for societies and pressure groups demanding public action, and, if necessary, legislative changes, in order that women should be better able to exercise their role as agents of moral reform.¹⁹

Individualism was important in the movement for medical women. The women and their supporters argued for women's right to show that they were capable of being doctors. They did not enter into arguments about the abstract principle of equal rights, nor about women's intellectual ability. Allegations that women were biologically determined to be intellectually inferior or physically unsuitable were countered by pointing out that these matters

19. For general discussion see eg. A. Summers 'A Home from Home—Women's Philanthropic Work in the Nineteenth Century' in S. Burman (Ed.) Fit Work for Women (London: Croom Helm, 1979), pp. 33-63; F. Prochaska Women and Philanthropy in Nineteenth Century England (Oxford: Clarendon, 1980); J. L'Esperance 'Women's mission to women: explorations in the double standard and female sexuality in Nineteenth Century England' Social History-Histoire Sociale 12 (1979), 316-388. The phrase 'masculine philanthropy' is Butler's, and is exemplified in the essays in J. Butler (Ed) Woman's Work and Woman's Culture (MacMillan: London, 1869) including S. Jex-Blake 'Medicine as a Profession for Women', pp. 78-120.

were empirically testable. They rejected the claim that medicine was unsuitable for women, as inconsistent with the widely held view that women should be nurses and midwives.²⁰ They spurned offers of special qualifications and, initially, spurned separate educational institutions, or a special section of the Register, when proffered by the opposition, on the grounds that these would be branded as inferior. 'A fair field and no favour' was the constant refrain. As Jex-Blake wrote, at the height of the Edinburgh campaign,

'state clearly what attainments you consider necessary for a medical practitioner; fix your standards where you please...put no obstacles in our way; either afford us access to the ordinary means of medical education, or do not exact that we shall use your special methods; in either case subject us ultimately to exactly the ordinary examinations ...and, if we fail to acquit ourselves as well as your average students, reject us; if, ... in spite of all our difficulties, we reach your standard, and fulfill all your requirements, the question of "mental equality" is practically settled,... give us then the ordinary licence ... and leave the question of our ultimate success or failure in practice to be decided by ourselves and the public. I appeal to the justice, not the chivalry of the medical profession.'²¹

Her appeal to justice was through irony, through exposing the hollowness of medicine's claim that education was now based on merit and formalized standards. The necessary attainments were already clearly stated, regulations for 'ordinary examinations' clearly formulated. The women in Edinburgh had shown themselves

20. Blake 'Women's entry into the medical profession', pp. 76-79. She points out that some medical men were also vehemently opposed to improved training for midwives and nursing reform, as a threat, particularly to the general practitioner.

21. Lancet ii (1870), 887; quoted in Duffin 'The Conspicuous Consumptive' p.53-54.

capable, too capable, of satisfying the normal requirements so far. The failure of Edinburgh University to treat as equal individual students admitted under normal regulations, who had achieved the necessary standards, was to prove critical to the women's eventual success, because it mobilized public support and funds.²²

Appeal, on individualist grounds, for equal treatment and fair competition was vital in generating such public support as that arising from the incident of the Hope Scholarship; but vital only after women had made the first steps to enter medicine. It does not explain why some mid-Victorians thought that medicine was a suitable profession for women, or, rather, that medical care of women and children was a suitable field for women. It was the second strand of feminist thinking, and the ideology of 'separate spheres', that set the overall terms of debate.

22. In the spring of 1870, the Edinburgh University Senate voted (by a majority of one in each case) to withhold a Hope Scholarship for chemistry from Edith Pechey, on the grounds that she was not a member of the regular class, having been taught separately, and to award the women regular certificates of attendance for the chemistry class. This attracted national press attention, almost all unfavourable to the University, even among papers not generally favourable to medical women. The women gained public support, but the damage to its reputation was resented by many within the University. It was a critical incident for polarizing both "sides" into publicly opposed camps. Subsequent injustice perpetrated by Edinburgh University on these particular students led even the Lancet to condemn its actions, while continuing to oppose women doctors in principle. Jex-Blake Medical Women, pp. 82-83; Bell Storming the Citadel, pp. 72-74 & 80.

Women's Medical Mission to Women and Children

From the beginning until long after 1877, the public debate was, almost without exception, about the suitability of women to be doctors for women and children. In this, supporters and opponents were agreed, at least in public.²³ For some women seeking entry, this may have been a strategic argument rather than personal commitment; and strategic arguments reflect a perception of what will generate public support.²⁴ But for some women, and many of their supporters, it was undoubtedly a deeply held conviction. Only this can explain why the women's cause was supported by many with conservative and paternalist views about women's place.²⁵

The notion of women as traditionally healers, and as guardians of both physical and moral family health, was developed to the conclusion that women should be doctors to those whose lives were based in the family. This development was reinforced by a perception of the contemporary American example, and by recent controversies over man-midwifery. Women, it was argued,

23. An exception was C.V. Drysdale Medicine as a Profession for Women (London: Charlton Tucker, 1870), which argued against those 'Medical Fenians who would keep women to the diseases of women', (pp.17-18).

24. For example, both Garrett and Jex-Blake are recorded as having said privately they were willing to treat men were it not for the damage they would do to the cause. Garrett's remark of 1866 is reported by Lady Amberley, one of her patients in the 1860s. B. & F. Amberley The Amberley Papers (London: Allen & Unwin, Vol 1) quoted in Garrett Anderson Elizabeth Garrett Anderson, p.124. Jex-Blake considered serving in a military hospital in Serbia in 1876. Todd Sophia Jex-Blake, p. 433.

25. For example, Lord Shaftesbury supported medical women, at a time when he opposed women's suffrage, G. Finlayson The Seventh Earl of Shaftesbury 1801-1885 (London: Eyre Methuen, 1981).

had always been healers, often as skilled and knowledgeable as men, and not just practitioners of midwifery. Only recently had men monopolized access to formal training, and relegated women to inferior roles.

Medicine was held up as an activity that crossed the boundary between the public and private spheres, especially when women were the patients. Women doctors would bring new benefits to women, both through treatment and through their potential educational role. They would not be just doctors, but women doctors, bringing a distinctive vision to their work, one that drew on their distinctively female qualities. It was the private and personal aspects of medicine that were stressed. No such case could be made for the law, or the army, or other "traditional" professions, firmly located in the public sphere.²⁶

Thus, the public case for medical women was largely based on the right of women to have doctors of their own sex, and on women's imputed unmet need and demand for this; it being claimed that women refrained from seeking medical advice when this would involve intimate and invasive examination by a man. Some opponents

26. Eg. S. Jex-Blake 'Medicine as a profession for women'; E. Gamarnikow 'Nineteenth-century nursing reform and the sexual division of labour' Bulletin of the History of Nursing Group at the Royal College of Nursing, 4 (1984) pp. 10-19. Blake 'Women's entry into the medical profession'. The situation in the United States was publicised by articles in the feminist press and by individual American and English women, who crossed the Atlantic, such as Blackwell and Jex-Blake. The best discussion of the 'connecting link' between the ideas of feminine talent and public healing roles in the USA is R.M. Morantz "'The Connecting Link": the case for the woman doctor in 19th-century America' In J.W. Leavitt & R.L. Numbers (Eds.) Sickness and Health in America (Madison: University of Wisconsin Press, 1978), pp. 119-128.

queried whether this unmet need really existed, stressing that the growth of male midwifery indicated that, given a choice, women would prefer a male attendant.²⁷

The main question debated in public by the two sides became how woman's moral superiority and her capacity for moral influence was to be preserved, if these virtues depended on her modesty and delicacy. Opponents of medical women argued, sometimes undoubtedly from genuine conviction, that for women to be exposed to the degrading and disgusting details of reproductive anatomy and physiology was a development too horrendous to contemplate, especially if the exposure was to be in the lewd atmosphere of medical schools. Women so exposed, literally 'unsexed' by losing their feminine mystery and innocence, would pollute their patients.

Supporters turned the purity and delicacy argument on its head. If the intimate details of medicine were so shocking, then was it not an offence against the delicacy of women patients to have to submit to male treatment? Surely women, as guardians of the nation's morality, far from needing to be excluded, had a special role here? If modest women were not seeking treatment because medicine was monopolized by men, it was immoral to ignore this consideration. They thus appealed simultaneously to the immoral effects of monopoly and to the importance of preserving women's modesty—two important tenets of mid-Victorian middle-class values.

27. E. Davies 'Medicine as a profession for women' paper read at Social Science Congress 1862 (published 1863): Jex-Blake 'Medicine as a profession for women', p. 104. Lancet (7 May 1873) 159; Christison Sir Robert Christison ii, pp. 46-49.

They demanded to know, furthermore, how nurses were saved from corruption by this degrading knowledge and exposure. And how were medical students protected? If they were not affected, then this must be because the knowledge was not degrading and hardening. If they were, then they were unfit to attend women.²⁸ That much medical education, especially in anatomy, took the form of teaching 'indecent mnemonics' and was generally conducted in a boisterous, lewd manner, was generally common ground to both sides.²⁹ The debate was over whether this needed to be so, what effect it had on students, and how, if at all, women should be taught.

It was argued that knowledge of bodily functions, exposure to dead and living bodies and "disgusting" diseases, and the imposition of pain were in themselves hardening and desexing to women. This argument was countered in the language of natural theology: It was blasphemous to imply that the world of nature could be immoral. It was also claimed that women would be as much motivated by disinterested love of science as men allegedly were. It was argued above all that any untoward effects on women of learning medicine were as nothing compared with the degrading consequences of unwilling exposure to male doctors, especially if trained in an obscene manner. Finally, women were looked to to bring their moral influence to bear on medical education, and hence on the

28. Vigorous public airing of both sides on this question took place at the meetings of subscribers to Edinburgh Infirmary, in 1871, where women's admission to clinical teaching was raised. Jex-Blake Medical Women, pp. 97-99.

29. Newman Evolution of Medical Education, p. 302.

whole profession. The American precedent had, it was claimed, proved that this could happen without dire effects.³⁰

Even if medical knowledge was not in itself degrading, there remained the question of whether it could be taught with propriety in mixed classes. Some opponents undoubtedly proposed separate classes to make things more difficult and expensive for the women, just as some of the women's supporters proposed them in a spirit of compromise.³¹ But for many on both sides, there was clearly real concern about the question.

In 1869, there was no precedent for any kind of mixed university instruction. The cautious attempts to gain access for women to classes and examinations elsewhere had been entirely through single-sex institutions or classes. It was, after all, considered inappropriate for any young unmarried middle-class woman to spend time unchaperoned with a young man to whom she was not engaged in a private house. It is hardly surprising that it was a delicate matter—the prospect of intimate association, studying such subjects, in classes extending over months, if not years.³²

The women accepted separate extra-mural classes in 1869 as

30. Jex-Blake 'Medicine as a Profession for Women'. See Morantz "The Connecting Link" for American arguments.

31. Bell Storming the Citadel, pp. 68-71; But some opponents objected to separate classes for women on the grounds that the precedent might weaken the University's monopoly over men's education, leading to a return to the entrepreneurial schools of forty years earlier. Jex-Blake, pp. 164-165.

32. Harte discusses this and the tentative opening of mixed classes in the Slade School of Fine Art and in Political Economy at University College, London, in October 1871 (though women could not get degrees). 'The admission of women to University College, London', p. 14.

the only option, though they argued that there was, or should be, nothing, in what was to be taught, that could not be conveyed without impurity in mixed classes.³³ Their subsequent admission to some men's classes taught by their supporters in the Faculty led, according to at least one teacher, to a great improvement in the men's behaviour. But in other classes, allegedly, opponents "spiced up" their lectures to underline the annoyance which would be caused by the presence of women, and to instigate harrassment of the women students.³⁴

After October 1870, some of the male students began to be 'markedly offensive' to the women, partly in connection with mixed classes. This culminated in the "Riot" of Surgeon's Hall in November 1870, which amply demonstrated to the public that there was cause for concern about medical-school selection or the effects of medical education on men.³⁵ This shocking harassment of ladies, by those with pretensions to be gentlemen, was widely reported, strengthening the public support for the women, in Edinburgh and nationally. This strengthening of public support

33. Eg. Jex-Blake Medical Women, pp. 154-161.

34. Jex-Blake Medical Women, pp. 155-156; Scotsman 26 Dec. 1870, quoted *ibid.*

35. As the women approached Surgeon's Hall, to take an anatomy examination, the gates were slammed in their faces 'by a number of young men, who stood within, smoking and passing about bottles of whisky, while they abused us in the foulest possible language.' After the examination, the women walked defiantly back, escorted by a group 'gentlemen' students, and this was repeated for several days. Jex-Blake Medical Women, pp. 90-97; Bell Storming the Citadel, pp.76-79.

provoked an intensification of internal opposition.³⁶

Further polarisation resulted from Jex-Blake's thinly veiled allegation that these were not spontaneous outbursts of student feeling but were deliberately instigated by the women's opponents within the medical faculty. She lost a libel suit but won a moral victory, much favourable publicity, and ample public donations to repay her costs. This episode led to the formation of the 'Committee for securing the Complete Medical Education of Women in Edinburgh', whose chairman was the Lord Provost of the city.³⁷

Medical Opposition to Women Entrants

The precise forms taken within the profession by opposition and support for women's admission have been comparatively little studied.³⁸ Here, I can do no more than make a few tentative points. Differences between and within journals have not been systematically studied. But editorials in the British Medical Journal, for example, were consistently less obdurate against medical women than those in the Lancet. By 1870, BMJ editorials accepted the case for women's being doctors for women and children, if not the viability of such limited practice.³⁹

36. Jex-Blake recorded her 'painful' surprise that so many 'boys of a low social class, of small mental calibre, and no moral training', were admitted to study medicine at Edinburgh, though giving some honourable exemption from this charge. Jex-Blake Medical Women, pp. 156-160. The Lancet (17 Feb, 1872) attributed this kind of medical hooliganism to the fact that Edinburgh was recruiting 'a class of young men, inferior socially to their predecessors of ten years ago, because of the improved quality of the London schools. Quoted *ibid.* p. 157.

37. Bell Storming the Citadel, pp. 78-79.

38. Blake 'Women's entry into the medical profession' has some discussion.

39. Eg. BMJ (12 April 1870), 338-339.

Women's entry to the profession was defended by many medical men, by some on grounds of justice, by others on the grounds of suitability. Others perhaps followed Huxley (not a doctor) in seeing the importance of emancipating women from the 'mere ignorant parsonese superstition' in which most were sunk.⁴⁰ Other men were convinced of the importance of independence and opportunity for women; such men, for example, as Ernest Hart, the controversial editor of the BMJ, whose wife had studied medicine in Paris.⁴¹

From Garrett Anderson's first attempts until 1877, women found that individuals who supported them privately could or would express their views strongly in public only if their own position was secure; secure because unthreatened, sometimes by virtue of seniority, by the majority opinion prevailing within most medical

40. L. Huxley (ed) Life and Letters of Thomas Huxley (London: MacMillan, 1900) i., pp 211-2, 386-387, 417-418. Huxley resolutely refused to reduce standards for women for the sake of science, or to entertain the notion that there was any scientific basis for excluding women. He declared he 'was at a loss to understand on what grounds of justice or public policy a career which is open to the weakest and most foolish of the male sex should be forcibly closed to women of vigour and capacity.' *ibid.* 417.

41. Hart's personal views may have been behind the BMJ's less obdurate editorial stance. Garrett Anderson wrote, in an obituary in 1898, that though unfriendly to her first struggles, for thirty years he had given 'his hearty support to the movement for medical women', and from the foundation of the LSMW, had done 'all he could, consistent with his position as Editor of the Journal to befriend the movement ... [but] he felt that as Editor of the Journal he could not properly go against the expressed wish of the majority of members of the Association...'. His support then was largely private and behind the scenes, though significant. BMJ (15 Jan. 1898), 182. See also Manton Elizabeth Garrett Anderson, p.253.

institutions.⁴² Pressure was exerted on younger members of the profession (and on students) in Edinburgh, and elsewhere, and this recurred in the early years at the ISMW. Collective loyalty, the good of the profession, or for younger men, future prospects, were invoked against personal conviction.⁴³

This raises the question of why so many in the profession were so opposed to women. While genuine revulsion at the prospect of women's learning and practising medicine clearly did exist, no-one at the time believed this to be the main reason. Three groups seem to have been particularly opposed to women's entering the profession. The first and largest group, consisted of the rank-and-file general practitioners, and of students who envisaged careers as such. They probably feared economic competition and loss of the gains made over the previous thirty years, in professional reform and in the growth of the market for medical services. Not least through restricting numbers, some degree of prosperity had been given to ordinary general practitioners—to them and, they hoped, to their sons.⁴⁴

Midwifery, and the care of middle-class women and their

42. This may be one reason why so many experimentalists, whose reference group was different, supported the women. I have examined this in M. Elston 'Aping the Monstrous Males? Women Doctors and the Vivisection Controversy, 1876-1910.' On the research community see R. French Antivivisection and Medical Science in Victorian Society (Princeton: Princeton University Press, 1975).

43. Blake 'Women's entry into the medical profession' p. 81-82; Manton Elizabeth Garrett Anderson eg. pp. 108-109 & 153-154; Thorne London School of Medicine for Women.

44. Waddington Medical Profession in the Industrial Revolution, pp. 176-205.

children, were a major source of income for most general practitioners. Women doctors were perceived as a threat to this through direct competition and through an apprehended devaluation of the medical qualification and the status of the profession that would follow the entry of women. Even more than the training of midwives and nurses, the entry of women into medicine threatened general practitioners' newly-won and controversial authority over women patients.⁴⁵

The same concern fuelled opposition among those who sought to advance obstetrics as a consultant field within medicine through the Obstetrical Society, founded in 1858. In 1874, Garrett Anderson's application to join was rejected, despite nomination by two leading council members and great praise of her personal merits. The precedent of admitting even a registered woman might have undermined the Society's aims.⁴⁶ The same concern led leading members of the Obstetrical Society to resign rather than examine Jex-Blake, Pechey and Thorne for the Royal College of Surgeon's Licence in Midwifery.⁴⁷

The professionalization of medicine was central to the

45. Peterson Medical Profession in mid-Victorian London; Garmarnikov 'Nineteenth-century nursing reform'; Donnison Midwives and Medical Men, pp. 72-87; Blake 'Women's entry into the medical profession', pp. 68-82.

46. BMJ 28 Feb. 1874) 282-283, 289; (7 March 1874) 319-323; (14 March 1874) 355; (21 March 1874) 402. The full report given here shows how the issue was turned from an individual one into the broader question of admitting women.

47. Though a registerable qualification under the 1858 Act, this licence was normally only taken by those already having a qualification in either medicine or surgery. The RCS accepted the women as candidates, but the examiners refused to contemplate admitting such partial practitioners. Jex-Blake Medical Women, pp. 194-199; Mosciucci 'The Science of Women', pp. 200-201

opposition within the third group, the established members of the professional élite whom Christison typified and led.⁴⁸ Throughout the campaign Christison argued that there was no demand for women doctors in Britain, though, like his patient, Queen Victoria, he conceded the case for female medical missionaries to Muslim and Hindu societies. At the core of Christison's opposition to women's entry to medicine was the threat it posed to his vision of the autonomous, university-trained, scientific medical profession. For him, women doctors, far from being a means for the enlightenment of women, 'would be injurious to medicine as a scientific profession', women's scientific backwardness being irremediable.

He objected to the disruption, disrepute and risk suffered by the Edinburgh Medical Faculty, which he had spent his whole professional life promoting and improving. To him it was an institution founded for men and the furtherance of their learning. Women had no business there and the trouble they had caused showed that they were far from being a civilizing influence. If they wanted to learn medicine they should start their own institution, and not encroach on the autonomy of existing professional institutions, requesting such special privileges as separate classes which distracted teachers from their main task of teaching men. To compel lecturers to teach women was an affront to academic

48. Other élite opponents included Sir William Jenner, (Bell Storming the Citadel, p. 103, and, initially, less vehemently, Sir William Gull (Englishwoman's Review, 15 May 1877) and Sir Henry Acland, President of the GMC, 1874-1876 (Newman Evolution of Medical Education, p. 301). But as supporters the women could count, for example, Sir James Paget, President of the GMC, 1876-1881 and Regius Professor of Medicine Humphrey (Jex-Blake Medical Women, pp. 190-198).

freedom.

This was his main objection. Christison was a vehement opponent of any attempt at lay, including legislative, control over universities or the medical profession. He had been a key mover in the campaign to free Edinburgh University from city control in 1858. The public campaigns in Edinburgh, over women's access to the Infirmary, for example, constituted a double assault. It challenged medical control over access to the Infirmary and the University's autonomy from the city. In the same vein, he condemned Parliamentary Bills that sought to restrict medical research on animals or compel examining bodies to admit women.⁴⁹

Christison's views were not unique. Association of women with anti-science views, defence of the male "clubs" of medicine as unified communities of scientific professionals, and bitter opposition to lay control were the refrains of many established medical opponents of medical women. They did not fear economic competition, but were exercised by the issues raised by the women's efforts, issues that went beyond the question of admitting women.

By 1875, it was clear that the twin arguments of the need to preserve women's delicacy and of reducing the harmful effects to women of male monopoly commanded substantial public support. The government conceded that the medical education of women warranted attention. The Lord President of the Privy Council wrote to the

49. Christison Sir Robert Christison i. pp.43-51; Scott 'Women and the GMC', 1766; Jex-Blake Medical Women pp. 162-166. On Christison's opposition to any legislative control over vivisection see French Antivivisection.

GMC, asking for its views on Cowper-Temple's bill, which proposed the admission of women with foreign degrees to the Register, and on the general question of women's admission to the Register. Implicit in the request was the possibility that the Government might introduce legislation.

Cowper-Temple's proposals being against the raison d'être of the GMC, their rejection was a foregone conclusion; but three days of furious debate revealed that the GMC was divided on the general question of women doctors. A compromise resolution was agreed by 14 votes to 7:

'The council are of the opinion that the study and practice of medicine and surgery, instead of affording a field of exertion well-fitted for women, do, on the contrary, present special difficulties which cannot be safely disregarded; but the Council are not prepared to say that women ought to be excluded from the profession.'

It was recommended that, if the government desired that women should be admitted, their education and examination should, 'in the interests of public order', be entirely separate from, but equivalent to, men's, and under GMC supervision. There should be no legislative interference with the 'free action' of examining bodies to refuse to admit women if they so desired. Despite these qualifications, it is clear that the case for women was being conceded, subject to the maintenance of professional self-regulation.⁵⁰

The GMC therefore approved Russell Gurney's Bill to enable examining bodies to admit women if they chose to do so, and

50. 'Report of the General Medical Council to Privy Council', June 1875, quoted in Jex-Blake Medical Women, pp. 189-193 & Note 11 p. 91; Scott 'Women and the GMC', 1766; Bell Storming the Citadel p. 98.

requested only slight changes to emphasize its enabling, rather than mandatory, character. Thus, for the moment, was self-regulation preserved. And the women's supporters were satisfied. Either an examining body would agree to admit women, or if they all refused still, the case for compulsory measures would be even stronger.⁵¹

51. Jex-Blake Medical Women, pp. 193 & 200-203.

Monopolistic and Materialist Medicine

The movement for women's entry to medicine took place against the background of, and became entwined with, a movement against the direction of medical orthodoxy. The professionalization of medicine in the mid-19th century did not go uncontested. From the mid-1860s until the mid-1880s there was widespread concern within both the middle- and working-class about the power and form of "modern" medicine. Three worries predominated. The first was concern about medical monopoly, and the 'trade union' tactics of the profession or its leaders—exemplified by the exclusion of women. The second was outrage at the medical profession's growing claims to govern matters of personal morality in the name of 'health', trampling on personal rights and women's modesty in the process.

The third concern was over the changing basis of medical knowledge. The mid-1860s, in Britain, saw the beginning of the ascendancy of a new 'medical cosmology', a new set of concepts and associated institutional forms, structuring medical thought and practice. This was 'laboratory medicine' in which the concepts and methods of the natural sciences were applied to medical problems.⁵² This new cosmology was manifested in medical research, in the growth of experimental physiology involving vivisection, and in the beginnings of bacteriology, in the work, for example, of Koch and Pasteur. These ideas were to provide a new individualistic basis for medical intervention in public health and a change in the basis of medical education. From the late 1860s, the education committee of the GMC pressed for a shift

52. N. Jewson 'Medical knowledge and the patronage system in eighteenth-century England' Sociology 8 (Sept 1974) 369-385.

of emphasis in the early training of medical gentlemen away from the liberal arts and towards systematic training in experiment and observation, in the "pre-clinical" sciences.⁵³

These developments were controversial within the profession. But their implications were even more disturbing to many lay people. In common with contemporary developments in geology, and biology, this new materialist medicine displaced both God and vitalism from scientific theories of causality. In the case of medicine it also ruptured the association between health and morality that was so central to the sanitarian views of such health reformers of the past two decades as Chadwick and Florence Nightingale. The discovery of germs made the onset of disease appear a matter of chance encounter with microbes, and not the product of immorality and impurity.⁵⁴

These three concerns, about monopoly, abuse of personal rights, and materialism, coalesced in a number of anti-medical movements. Most important of these were the campaigns against the Contagious Diseases (CD) Acts, compulsory vaccination and vivisection. The CD Acts of 1864, 1866 and 1869, provided for the compulsory inspection of prostitutes in garrison towns, and for their compulsory hospitalization if diseased. These acts amounted, according to their critics, to state legitimation of

53. S.V. Butler 'Science and the education of doctors in the nineteenth century: A study of British medical schools with particular reference to the development and uses of physiology.' (Unpublished Ph.D. thesis, University of Manchester, 1981.

54. See eg. C.E. Rosenberg 'Florence Nightingale and Contagion: The Hospital as Moral Universe'. In C.E. Rosenberg (Ed.) Healing and History: Essays for George Rosen (New York: Dawson, 1976), pp. 117-136.

male vice. They deprived women of their rights and subjected them to degrading assault in the course of examination by speculum, which was increasingly resorted to. Organized action against them, begun in 1869, achieved their suspension in 1883. After their repeal in 1886, the campaign diversified, becoming a broader movement for social and sexual purity.⁵⁵

Lasting for twenty years, organized action against compulsory vaccination, viewed as an abrogation of personal and parental rights, began in 1871, when a Public Health Act compelled the appointment of vaccination officers in all areas.⁵⁶ Public concern over vivisection was apparent from the mid 1860s, but first took an organized form in 1875, around the issue of legislative control. The passage of the 1876 Cruelty to Animals Act fuelled rather than reduced protest.⁵⁷

Women were prominent among activists in all three campaigns. The power and content of medicine were of special concern to middle-class women, as guardians of family health, and as actual or potential patients of materialist doctors. There was some overlap of personnel, male and female, between all three movements and

55. J. Walkowitz Prostitution and Victorian Society: Women, Class and the State (Cambridge: Cambridge University Press, 1980); P. McHugh Prostitution and Victorian Social Reform (London: Croom Helm, 1980).

56. A. Beck 'Issues in the anti-vaccination movement in England' Medical History 4 (1960) 310-321; R. M. McLeod 'Law, medicine and public opinion: the resistance to compulsory health legislation, 1870-1907' Public Law (1967) 107-128, 189-211.

57. French Antivivisection; M. Elston 'Gender, medicine and morality in the late-nineteenth century: a study of the anti-vivisection movement, 1870-1904.' Unpublished M.A. thesis, University of Essex, 1984.

that for medical women.⁵⁸

The public behaviour of medical men towards the Edinburgh women was, to supporters of the other movements, confirmation of their concerns. Their callousness born of exposure to materialism, these monopolistic men were motivated only by self-interest, and not by the needs of their women patients. Medical men were accused of hypocrisy in their objection to medical women: they promoted ideas of women as delicate to generate custom, while destroying women's moral delicacy in their practice. For some, the link between supporting women in medicine and opposition to modern medicine went further: Women were looked to to preserve and restore the sanitarian tradition, the links between medicine and morality, through their specifically feminine approach.

Two women especially articulated this view, before and after 1877: the feminist and antivivisectionist, Frances Power Cobbe, and the first woman on the Medical Register, Elizabeth Blackwell.⁵⁹ For Blackwell and Cobbe, the answer to the question whether modern "scientific" medical education would harden and degrade women was an emphatic 'yes'. But for them, this was an

58. E.g., the same parliamentary spokesman, James Stansfield, Duncan McLaren, Russel Gurney, Cowper Temple spoke for all. Stansfield was Treasurer of the LSMW. The school's solicitor was William Shaen, chairman of the National Anti-Contagious Diseases Acts Association and an antivivisectionist. Josephine Butler, the dominant force behind the Ladies' National Association against the Contagious Diseases Acts was a patient of Elizabeth Garrett and an active supporter of the Edinburgh campaign. M.J. Shaen William Shaen: A Brief Sketch (London: Longmans, 1912); Manton Elizabeth Garrett Anderson pp. 171-179; Bell Storming the Citadel pp. 66-69.

59. On Cobbe See Elston 'Gender, medicine and morality'. On Blackwell, see *ibid*; Sahli 'Elizabeth Blackwell'; R.M. Morantz 'Feminism, professionalism and germs: the thought of Mary Putnam Jacobi and Elizabeth Blackwell.' American Quarterly 34 (1982) 459-78.

argument for their presence in medicine, a presence conducive to the reform of medical education and the profession, through their 'spiritual maternity'.⁶⁰

Space does not permit extended discussion of the connections between these different facets of public anxiety about professionalizing medicine. But it is clear that the cause of medical women gained some of its public support from its affinities with these other concerns. The vehemence of the opposition of such men as Christison arose partly from the inextricable association of the women's campaign with these concerns.

Not all of the would-be medical women of the 1860s and 1870s shared Blackwell's vision of what women's role in medicine should be, nor her commitment to the three other causes. The Edinburgh women medical students remained silent on the CD Acts, perhaps not wishing to add further cause for alarm. But Elizabeth Garrett supported the dominant professional view of the CD Acts, as a regrettable but necessary public health measure, to protect men and innocent women and children from disease. Her intervention caused bitter controversy in the women's movement. In subsequent years she was to be a firm defender of vaccination, and of a full scientific education for women medical students.⁶¹

60. E. Blackwell Erroneous Method in Medical Education (London: Bell, 1891) p. 8; See also Elston 'Aping the monstrous males?'

61. Todd Sophia Jex-Blake p.364; E. Garrett Anderson An Enquiry into the Character of the Contagious Diseases Acts of 1866 and 1869 (London: Association for Promoting the Extension of the Contagious Disease Act 1866 to the Civil Population, 1870: Reprinted from Pall Mall Gazette (25 Jan. 1870). On vaccination and vivisection see Manton Elizabeth Garrett Anderson pp. 178-180, 317-319, 319-320.

Women's Mission to Women Overseas

There was also another strand in the movement for women's entry to medicine, which in many ways represents the acme of the Victorian idea of women's special sphere of influence. By the mid-nineteenth century, women's work in overseas missions was well-established, women considered better suited to penetrate hearts and homes, especially in Hindu and Moslem countries, with their zenana or purdah systems, and above all in India. The mission movement increasingly augmented evangelising with the provision of practical services, especially medicine. And secular colonial administrations placed increasing importance on medical services for native populations.

These three developments come together in a movement for medical women overseas, a movement both secular and religious in inspiration, which began, in India and London around 1866, with some tentative individual efforts, initially as controversial within the missionary and colonial institutions as the parallel movement at home. But this movement also gained credence: The mid-1870s saw the opening of Madras Medical College to four Englishwomen; and experienced missionaries, seeking professional training, were among the first entrants to the LSMW.⁶² By the

62. On the development of mission work in general, see S.C. Potter, 'The Social Origins and Recruitment of English Protestant Missionaries in the Nineteenth Century', Unpublished Ph.D. Thesis, University of London, 1975. On the history of the medical women's movement in India see Bell Storming the Citadel pp. 111-125; M. Balfour and R. Young The Work of Medical Women in India (London: Oxford University Press, 1929) pp. 1-13; Jex-Blake Medical Women pp. 234-5; J.C. Pollock Shadows Fall Apart: The Story of the Zenana Bible and Medical Mission (London: Hodder & Stoughton, 1958); F. Hoggan 'Medical work for women in India' Englishwoman's Review (15 April & 15 May 1885), pp. 145-158 & 193-200; D.C. Wilson Palace of Healing: The Story of Dr Clara Swain, First Woman Missionary Doctor and the Hospital She Founded (London: Hodder and Stoughton, 1968).

early 1880s, the small-scale, largely individual, efforts were transformed into a public movement, accelerated, though not caused, by Queen Victoria's approval, much publicized following her reception of two LSMW qualifiers returning to work in India.⁶³

Both missionary and secular efforts to raise funds for training medical women and for hospitals gathered momentum, with many unco-ordinated and competing developments. Symbolically, the most important of these was the National Association for the Supply of Female Medical Aid to India, organized by the Countess of Dufferin, Vicereine of India from 1884 to 1887. With branches in India and the United Kingdom, it evolved into the organization eponymously known as 'The Countess of Dufferin's fund'.

These developments were of great significance at home, providing the LSMW, and later the Scottish schools, with a new public legitimacy, with students and scholarships, and with openings for early qualifiers. But from the start there were tensions within the movement, which became increasingly prominent over the next forty years. There was constant argument about the desirability of British versus Indian recruits, and about the potentially damaging effect on prospects for medical women in Britain, if this 'sidetrack' were promoted too zealously. Those in

63. In 1881, Elizabeth Bielby, a nurse and experienced missionary, who had completed medical training at the LSMW, delivered a plea for trained women for India from the Maharani of Poona to Queen Victoria. Pollock Shadows Fall Apart, p. 44. In 1883, Mary Scharlieb (1845-1930), not a missionary but one of those trained at Madras Medical College, completed her London MB. Before returning home, she too had an audience with the Queen, arranged by Sir Henry Acland, Regius Professor of Medicine at Oxford, despite opposition from Sir William Jenner. Englishwoman's Review (15 Feb. 1883), 74; M. Scharlieb Reminiscences (London: Williams & Norgate 1924), pp. 90-93. The Queen did not appear to change her opposition to medical women at home.

the mission movement experienced conflict between their proselytizing and medical obligations at both a personal and an institutional level. Women in both the secular and religious services would be constantly under pressure to be subsumed under the existing male services, and their professional autonomy diminished.⁶⁴

Epilogue: In the Profession but not in the Club

By the end of 1877, as we have seen, women had a precarious foothold in the profession. There were six women on the Register (and several other qualified unregistered women in practice), and women had access to the Register and clinical training. In 1877, the Englishwoman's Review carried an article on 'The Close of a Long Struggle'.⁶⁵ But it was only the end of the first stage.

As individuals, women had to convert the right to be doctors for women and children into successful practice; and this was not easy. Accounts of early years in practice by many pre-1914 entrants report the suspicion of potential patients and, often, of actual patients' families. Lady Frances Balfour's confession, at

64. Garrett Anderson, as Dean of the LSMW by 1883, was quick to capitalize on the movement publicly to promote the school, always stressing the importance of full professional training; Manton Elizabeth Garrett Anderson, pp269-70. She was criticized by Hoggan for underplaying the importance of developments in India and ignoring the dangers for the British medical women of service in poor conditions, subject to gross discrimination, and pressured to skimp on training. Hoggan was an ardent promoter of a secular service under women's control. Hoggan 'Medical women for India'. Garrett Anderson clearly shared many of these reservations. See also Balfour and Young Medical Women in India.

65. Englishwoman's Review (April, 1877) 145. James Stansfield, a prominent supporter of medical women, cautioned about the rocks still ahead in his contemporary account of the initial victory. Stansfield 'Medical women' 1877) 888-901.

the ISMW prizegiving in 1906, that, despite a lifetime's devotion to the cause, she had never consulted a medical woman, was one familiar to her audience.⁶⁶

The transformation of the ideology of separate spheres meant that there was no public mandate for women to be doctors for men. It would, indeed, have been improper. Women were not given public approval to compete fully with men in the public sphere. Much of their support and, for some, their personal motivation was for the preservation of a sanitarian tradition that was being undermined by professional developments. It takes little imagination to see that this limited mandate might come to be seen as restrictive by those who adhered to a more individualistic conception of the role of women doctors, even if they still saw themselves as primarily doctors for women. The disagreements between the first entrants (and some of their supporters) about tactics and about modern medicine, reveal a tension between the values of the professional community that women were entering and those of the movement that had nurtured their ambition, 'welfare' feminism.

Nor were the battles within the profession over. The limited nature of the mandate could still be used against medical women by their opponents.⁶⁷ And it had obvious practical consequences for

66. Standard 26 June 1906. (RFHSM Book III).

67. A separate register for women was proposed in an 1879 Medical Bill but averted largely due to a deputation of medical women led by Garrett Anderson to the Lord President of the Privy Council. In 1882, the Royal Commission on the Medical Acts recommended women be admitted to examinations on the same terms as men. Scott 'Women and the GMC'; Report of the Royal Commission appointed to inquire into the Medical Acts (London: 1882) para 67, quoted in Newman Evolution of Medical Education p.304.

the careers women might pursue. As the BMJ said in 1870,

'the obvious sexual limitation of the activity of female doctors excludes them from competing with men for all the ordinary and primary means of livelihood which are the support of the young man on entering the profession. It shuts them out from the army, the navy, the Poor Law Medical Service, from resident hospital appointments (except for women and children)... in fact, from the great bulk of the avenues from which the average practitioner enters practice'.⁶⁸

In 1877, women were just in, but in separate schools, without their own hospitals, with access initially only to one cheap, low status, qualification, the LKQCPI. There were no ways of compelling examining bodies to admit women. When, in 1888, the National Association for Promoting the Medical Education of Women (national successor to the Edinburgh Committee formed in 1871) wound itself up, women were still excluded from the majority of these qualifications.⁶⁹

Once it appeared that women were in the profession to stay, a Janus-faced attitude was displayed towards them by many medical men who 'felt it desirable that they should share, not only in the professional advantages but also in the internal discipline, and in the inoculation with esprit de corps that would make them more desirable and more sympathetic colleagues.'⁷⁰

In public, many former opponents declared their support for medical women now that they had proved themselves worthy, invoking

68. BMJ i (30 April 1870).444.

69. Englishwoman's Review (15 Feb. 1889), 59-60, quoting S. Jex-Blake 'Medical Women. A Ten Year's Retrospect' (Edinburgh: National Association for Promoting the Medical Education of Women, 1888), reprinted from Nineteenth Century (Nov 1887).

70. M. Scharlieb 'The medical woman: her training, her difficulties and her sphere of usefulness' Nineteenth Century 78 (1915), 1179. Scharlieb's point expresses Larson's argument about the significance of the professional community precisely

professional solidarity against lay criticism.⁷¹ In 1903, Julia Hickman, an LSMW graduate appointed as a Resident Medical Officer at the RFH in 1903, vanished and her body was not found for two months. Her disappearance and the verdict of suicide re-opened popular press speculation about the suitability of women for medicine. The medical press rejected the idea that this was anything but a particular individual's failure to live up to the demands of her chosen profession. For it to have been anything else would have been a slur on the standards of the profession.⁷²

The internal face many medical men turned to the women was very different. As Scharlieb implied, the other side of professional membership was conformity to professional etiquette. Women were now charged by their opponents with actual or threatened breaches of such standards, especially by undercutting fees.

Like Queen Victoria, many medical opponents saw no inconsistency between welcoming the developments in India and opposing them at home. Men maintained barriers to their professional associations. In 1881, medical women were barred from the International Medical Congress in London, allegedly at the insistence of Queen Victoria. The Association of Registered Medical Women (founded in 1879) protested, and then hosted a reception for 600 guests at the LSMW, making the excluders look ungracious.⁷³

71. Eg. Sir William Gull's speech at a meeting to establish a scholarship in memory of Helen Prideaux, MB. Englishwoman's Review (15 March 1886) 130-131.

72. Eg BMJ (21 Nov. 1903). RFHSM Book IV contains many cuttings from the lay and medical press indicating that the BMJ's stance was not unique.

73. Bell Storming the Citadel, p. 116; E. Pickard 'Ancient history' MWF Newsletter (April 1935), p. 44.

When women's admission to men's medical associations was opposed, familiar arguments about the effects of women's presence on professional life were heard; a fact instanced by the women's experience with the BMA. Garrett Anderson was elected to her local branch of the BMA in 1873, without objections, as was the unregistered Frances Hoggan MD 1870. But their attendance at the annual conference in Edinburgh in 1875, caused consternation. Christison, as conference president, declared the admission of women be an intolerable 'liberty'; but a motion to exclude women from the BMA could not be taken without notice.⁷⁴

Pressure to exclude women grew; but counsel advised the BMA Council that Garrett Anderson's membership was indubitably legal. Hoggan's, however, was not, because of a legal technicality which also annulled the membership of men elected at the same time.⁷⁵

At the annual conference in August 1878, Garrett Anderson made a speech denying that the objects of the Association, 'the promotion of medical science, ... the interests of the profession and of fellowship' would be harmed by admitting women. This speech was received with great acclaim. And a majority of the men promptly voted to exclude women in the future and to re-elect the

74. Anderson Elizabeth Garrett Anderson pp. 251-6; Manton Elizabeth Garrett Anderson, p.245-6. EGA's letters to her husband from Edinburgh reveal Hart's support, including a warning as to the danger of some of her "friends" including her association with Hoggan, by now a known active opponent of vivisection. EGA to JGSA 4 Aug. 1875. (Fawcett Autograph Letter Collection).

75. Polling the membership produced a 3 to 1 majority against the women, with 4,000 of 6,000 members voting. Sir William Jenner threatened to resign if women were members and several local branches passed resolutions for the exclusion of women. E.M. Little History of the British Medical Association: 1832-1932 (London: BMA, 1932), pp. 91-94.

men whose membership had been discovered to be void.⁷⁶ In the ensuing press debate, one 'practitioner of 23 years standing' may have spoken for many: Women doctors, separately educated, treating only women, were acceptable. But the BMA annual meeting was different, being

'looked forward to as a ... holiday where members may throw off all unpleasant restraint...this ... would be very much marred by the presence of medical sisters... [as women could read the British Medical Journal nothing is lost] beyond the pleasure of hearing themselves talk. Now as they never fail to avail themselves of the latter privilege on all other occasions, I think they might allow their poor tongue-tied brethren the opportunity of the only small modicum of club life which their habitual medical ties permit them to enjoy. With equal reason, might women insist on entering the Carlton or any other gentlemen's club.'⁷⁷

For 19 years, Garrett Anderson was the only woman in the BMA, assiduously attending meetings, braving the often hostile atmosphere and anti-woman speeches, until the exclusion clause was expunged, by a narrow majority, in 1892.⁷⁸

But other institutions held fast. In 1895, a petition, from the staff of the LSMW and RFH and over 30 distinguished medical men, to the Royal College of Physicians (RCP) and the Royal College of Surgeons (RCS), to end 'the serious inconvenience' resulting from women's exclusion from the London "Conjoint"

76. Anderson Elizabeth Garrett Anderson, pp. 257-262.

77. Standard (c. 18. Oct 1878) RFHSM Book I.

78. Anderson Elizabeth Garrett Anderson p. 262; English-woman's Review (15 Aug. 1887), 362. Little BMA p.94; MWF Newsletter (Nov 1926), 45-46, (Nov 1927), 82.

examination, was rejected by small majorities.⁷⁹ In 1909, women were eventually admitted to "Conjoint" and to the RCS Fellowship, though not with the same privileges as men. But they were excluded from the higher qualifications and from holding office in the RCP until 1925.⁸⁰

Outside the Royal Colleges, a proliferation of specialist medical societies at the end of the nineteenth century reflected a growing division of labour by specialism within the profession—a controversial development. Women did not automatically gain entry to these societies either, even when their applications were supported by prominent members.⁸¹ By 1895, only two societies, the Society of Anaesthetists and the Medico-Psychological Association,

79. The inconvenience lay in women's exclusion from a cheaper and easier qualification than the London MB degree, and from College membership and fellowship, increasingly important for appointments to honorary hospital staff positions. Stevens Medical Practice in Modern England, pp. 22-25. The failure of the 1895 petition was due to the opposition of the members, not the fellows, of the RCS, and the RCP would not act alone. Magazine of LSMW (1895), pp. 94-96; Englishwoman's Review (15 Jan. 1896), 40-42.

80. Englishwoman's Review (15 Jan. 1909), 61-62. (15 April 1909), 120-121, (15 Oct. 1909), 261; G. Clark A History of The Royal College of Physicians of London (Oxford: Clarendon Press, 1966) ii pp. 972-977.

81. The Medical Press (5 July 1893) (RFHSM Book III); E. Garrett Anderson 'Medical Ethics: Presidential address to Association of Registered Medical Women, 1897' Magazine of LSMW & RFH (1897) 179. Women applicants were refused entry to the Gynaecological Society of Great Britain in 1887, though nominated by prominent men. I.H. Flack Lawson Tait 1845-1899 (London: Heinemann, 1949), p. 97.

had admitted women to membership.⁸² Women were allowed membership of the Royal Society of Medicine at its foundation in 1907, but could not be fellows until 1910.⁸³

Sometimes the exclusion of particular women was legitimate in that they lacked sufficient expertise—expertise which they had few opportunities to gain.⁸⁴ More often, contemporary reports suggest a wish to bar women from the "clubs" and from decision-making; a practice of exclusion from men's hospitals and men's medical schools which was surely much more widespread than the specific incidents still retrievable by the historian.

From the start, the dominant public response of the earliest women practitioners to this combination of exhortation and ostracism by men was not to challenge professional ethics, but to defuse opposition through demonstrable conformity and co-ordinated

82. Magazine of the LSMW (1895) 94. In 1888, Jane Waterston, a South African-based missionary, obtained the certificate of the Medico-Psychological Association. MWF Newsletter (Jan 1933) 66-68. In 1893, the Association's Council voted 23:7 to admit women members. C. MacKenzie 'Women and psychiatric professionalization, 1780-1914' The Sexual Dynamics of History Edited by London Feminist History Group. (London: Pluto Press, 1983, p. 118.

83. M. Davidson The Royal Society of Medicine: The Realization of an Ideal (London: RSM, 1955), pp. 41 & 56.

84. Garrett Anderson to Edward Sharpey Schaefer. 1 Feb. 1886 (ESS/b.24/7. Sharpey-Schaefer Papers, Contemporary Medical Archives Centre.).

persuasion. The Association of Registered Medical Women was formed to overcome professional isolation, and to generate professional solidarity among the women—a minimal substitute for the schools and societies in which the professional community of men, and medical ethics, were forged.⁸⁵

In the next chapter, I examine these early female entrants to medicine and consider what kind of medical training they had. In the following chapter, I consider how the limited mandate, and the segregation of women from men, affected their opportunities and choices. And I consider how these changed over the first forty years of women's work within professionalized medicine.

85. Garrett Anderson 'Medical ethics.' p. 176. Garrett Anderson stresses the importance for women both to conform to professional etiquette and for women to organize themselves, lest individual effort jeopardize the position of them all.

CHAPTER VI

EARLY WOMEN ENTRANTS TO MEDICINE: 1860-1914

The "First Generation" and their immediate successors

In this chapter and the next, I examine the lives of women entrants to medicine before 1914.¹ The experience of the very first entrants, the "first generation", is compared with that of their immediate successors. I have taken as the first generation the 59 women identified as having a formal medical qualification by the end of 1886.² They include twenty "pioneers" who began, and in some cases completed, medical education before the founding of the LSMW, whose training was generally interrupted or obtained

1. I am not concerned with the impact the early medical women had on women's health nor with whether they practised in a distinctive way, as this would involve detailed analysis of case records. For an American example see R. M. Morantz and S. Zsoche 'Professionalism, feminism and gender roles: a study of the therapeutics of nineteenth century male and female doctors'. Journal of American History 67 (1980) 568-588.

2. Fifty-four were on the Medical Register by 1886, 1 registered in 1888, and 4 never registered. Englishwoman's Yearbook, 1888, pp. 196-197. The unregistered names are taken from the list of women with European medical degrees in Jex-Blake Medical Women Note RR, Appendix p.99.

almost entirely abroad.³ 39 were the first full students of the LSMW in its precarious first decade. Many began studies when access to the Register was in doubt, or under threat.

The second generation were the approximately a thousand women qualified from British schools between 1887 and 1914. (Here I am only concerned with their careers before the First World War.) 1886 was taken as a dividing point as, after the 1886 Medical Act, qualifications in medicine, surgery and midwifery were compulsory for registration.⁴ From 1886, women had new choices of medical schools and of qualifications. The Irish College of Surgeons opened its classes and examinations to women. The admission of women to the Scottish "Triple" by the Royal Colleges of Edinburgh and Glasgow led Jex-Blake to open the Edinburgh School of Medicine for Women in October 1886. This was followed by the rival Edinburgh Medical College for Women in 1889 and by Queen Margaret's College, Glasgow, in 1890.⁵ After 1900, a few were at

3. These included Garrett Anderson, Blackwell, those who had taken the "quiet route", and nine former Edinburgh students who eventually qualified. Thorne (Foundation of LSMW, p. 19). 12 of the 14 students at the LSMW in October 1874 had matriculated at Edinburgh, the other 2 being missionary students, Fanny Butler and Jane Waterston. 11 of the 14 qualified, one who did not was Mrs Thorne who became secretary of the LSMW in 1878. (Bell Storming the Citadel, p. 106.)

4. Before 1886, many registerable qualifications, including the LSA, LKQCPI and London MB did require examination in midwifery.

5. Jex-Blake Medical Women pp. 225-6. M. Lawrence Shadow of Swords: A Biography of Elsie Inglis (London: Michael Joseph, 1971) pp.52-58 describes the incidents which led to the establishment of the rival school. Jex-Blake's school closed in 1898. The 2 Scottish women's schools formally merged with men's in 1909.

English provincial schools.⁶

Most of the second generation, however, were at the LSMW. By comparison with their predecessors, but not with their male peers, these later LSMW students had a relatively well-established educational career line, though individuals' passage along this line was not necessarily smooth. At the Scottish women's schools, facilities were more precarious, at least until 1909, when they formally merged with the men's extra-mural schools.⁷

I have been able to trace the careers of 36 of the first generation in some detail, with some information for nineteen more.⁸ For the second generation, this is impossible. I have relied more on general sources, and detailed biographies. Inevitably, this information is biased towards those who were professionally most active but, at the same time, their lives reveal the 'particular matrix of historical meanings and life chances' that their less visible contemporaries faced.⁹

6. See Chapter IV.

7. Eg. Lawrence Shadow of Swords, pp. p.52-58.

8. My sources are primarily printed sources, and the archives and press cuttings of the Royal Free Hospital School of Medicine and the Medical Women's Federation. Some information on appointments is given in the Medical Register, Medical Directory, and the annual reports of the LSMW, I have used biographies and autobiographies and the Dictionary of National Biography (DNB), and contemporary periodicals, especially the The English Woman's Review, The Times, Lancet, British Medical Journal, and Medical Women's Federation Newsletter, provided many obituaries.

9. Abrams Historical Sociology, p. 281.

Background and Motivation of the Early Entrants

Chapter V indicated that the movement for medical women was far more than a search for respectable employment on the part of so-called "surplus women" from impoverished middle-class families in the second half of the nineteenth century. This is confirmed by early entrants' backgrounds and motivations for entering medicine. Though some were not well-off, others were rich. Most were single, sometimes undoubtedly by choice; but some were married and with children. Their attitudes probably differed from those of their male contemporaries. As Mary Scharlieb (1845-1930), MB 1882, wrote,

'The [early] women were all enthusiasts, they were all volunteers, far from entering the profession to fulfill a family tradition, or to inherit a family practice, they were endeavouring to qualify to please themselves generally with a view to philanthropic or missionary work.'¹⁰

The fathers of 22 of the first generation have been traced; all were successful businessmen, professionals or gentlemen. At least four were, in fact, the daughters of medical men. Others had strong medical connections.¹¹ At least eight were ministers' daughters. Many others, like Elizabeth Garrett Anderson, had the evangelical, non-conformist or radical backgrounds that figured largely in the women's and the medical reform movements of the

10. Scharlieb 'The medical woman' 1177.

11. Eg. Mary Anderson Marshall (1836-1910), MD Paris 1879, LKQCPI 1880, was the sister of Dr John Ford Anderson, a supporter of Garrett in her early practice (and of Skelton Anderson, who married Garrett in 1871). BMJ ii (20 Aug. 1910), 303.

1870s.¹² The fathers of at least ten of the 59 had died before they entered medicine—in six cases, in the women's childhood.

The second generation appear to have similar origins, though there were perhaps more from a missionary background; and there are some indications of the development of a "family tradition" involving daughters or other relatives of pioneer students, of prominent supporters of women's entry to medicine, or of medical and moral reform campaigners.¹³ The daughters of male doctors were still rare, except for the daughters of mission doctors. In any case, being a male doctor's daughter did not have the same significance as being a son, as a woman could not inherit a man's

12. Eg. Agnes McLaren (1837-1913), MD Montpelier 1878, LKQCPI (1878), daughter of Radical Edinburgh MP, Duncan McLaren, active campaigner against slavery and the CD Acts, and for the women students in Edinburgh from 1869—and initially against his own daughter's decision to take up medicine. K. Burton According to the Pattern: The Story of Dr Agnes McLaren and the Society of Catholic Medical Missionaries (New York: Longman, 1946), pp. 39-46.

13. Daughters of 1st generation students include Louisa Garrett Anderson, May Thorne and Mary Mears. Mona Geddes (Chalmers Watson) (1873-1936), first woman MD from Edinburgh University in 1896, was niece to Garrett Anderson and Mary Marshall. BMJ (15 Aug. 1936) 371. Daughters of medical reformers include Helen Wilson, MD 1889, daughter of Henry Wilson, Radical CD Acts repealer from Sheffield and Nancy Sheldon Amos (MB 1900), daughter of active antivivisectionist Professor Sheldon Amos. ('Elston 'Aping the Monstrous Males'). Mabel Campbell, MB ChB St. Andrews 1909 was said to one out four daughters of a Scottish clergyman entering medicine (out of eight daughters). BMJ (23 Nov 1939), 814.

practice.¹⁴

Few who faced the unrelenting opposition of their parents, especially of their fathers, would have been able to begin medical studies, at least while their fathers lived, given the combination of financial dependence and filial duty that prevailed among Victorian and Edwardian women. But there are many accounts of initial disapproval or long delayed fulfillment of ambitions.¹⁵ Some had strong support. Annie McCall, of the first group and Louisa Martindale of the second, attributed their entry to the wishes of their indomitable, long-widowed mothers.¹⁶

For some, expense rather than lack of parental approval was a major problem. Elsie Inglis, daughter of a retired Indian civil servant living in Edinburgh, was unable to pursue medical studies until classes in Edinburgh gave her the opportunity she longed

14. I. Emslie Hutton Memories of a Doctor in War and Peace. (London: Heinemann, 1960) p. 11. Among almost 400 qualifiers from the LSMW between 1887 and 1906 I have only identified 15 male doctors' daughters, and these did not all have an orderly entry into medical school. Elizabeth Davies-Colley (1874-1934), MB BS 1902, daughter and sister to established surgeons, decided on medicine after working for some years in an East End Settlement, studying in the evening for some years to pass Matriculation- and going on to become one of the outstanding woman surgeons of the second generation, and the first woman to pass FRCS by examination. MWF Newsletter (Jan 1935), 65.

15. In 1909, Helena Lowenfeld (later Wright) (1887-1981) acceded to her wealthy, disapproving father's pressure to "do" the London season for a year, but returned to medical school afterwards qualifying in 1914. B. Evans Freedom to Choose: The Life and Work of Dr Helena Wright: Pioneer of Contraception (London: Bodley Head, 1984), p. 67. See also Manton Elizabeth Garrett Anderson eg. pp.75-7 & 211. Todd Sophia Jex-Blake, pp. 67-72 & 210.

16. On Annie McCall (1859-1949) LKQCPI 1884, MD Berne 1884, see P. Barrass Fifty Years of Midwifery (London: Health for All Publishing Co., 1950). On Martindale (1875-1966) MB 1899), see L. Martindale A Woman Surgeon (London: Gollancz, 1951), p.24.

for.¹⁷ The medical studies of some were delayed or interrupted by caring for relatives (and others, no doubt, were prevented from ever beginning).¹⁸

Marriage precluded the first generation neither from taking up nor from continuing medical studies, though undoubtedly preventing many from doing so. At least four of the first 59 were married when they began medical studies, five were widowed, and at least five more married between beginning and qualifying. Marriage before qualification was rarer in the second generation, and accounted for some withdrawal from studies.¹⁹

Death of parents or husbands made an independent career possible for some, and, in many cases, more necessary. But financial resources on qualification varied greatly among both first and second generations. If most of the early entrants shared a wish to earn an independent living, for some the emphasis was on independence, rather than absolute need. Neither Garrett Anderson nor Jex-Blake would ever have had to work for a living, nor would Helena Lowenfeld Wright or Louisa Aldrich-Blake in the

17. On Inglis (1864-1917) (LRCP&S.Edin & Glasgow 1892) see Lawrence Shadow of Swords, p.51.

18. Eg. Mary Murdoch (1860-1916), LRCP & S Edin. 1892, H. Malleson Mary Murdoch of Hull (London: Sidgewick & Jackson, 1919), p. 17; and Florence Stanley Boyd, (?-1910) LKQCPI 1888, BMJ (25 June 1910), 1582.

19. 14 of 38 withdrawals (of 254 LSMW entrants) between 1874 and 1890, were because of marriage. Lancet (10 March 1894), 651.

second generation.²⁰ But others, such as Edith Pechey, Edith Shove, and Elsie Inglis, had limited resources for training and for setting up in private practice.²¹

Medicine was always an unlikely choice for the very poor, because of the expense of the training and of establishing practice. For the "pioneers", with their interrupted studies, the costs must have been huge. Once established, women's medical education was expensive, especially at the LSMW, costing more than most of the equivalent men's courses.²²

Among the least well-off were the missionary students. But with them, it is hard to disentangle cause from effect. Missionary motives brought in some less-well-off women to study medicine. But the scholarships provided through the movement for medical women in India, gave the less prosperous a way of entering medicine.²³ After 1900, concern over paying for women's medical

20. Manton Elizabeth Garrett Anderson, p.167; Todd Sophia Jex-Blake, p. 257. Evans Freedom to Choose, p. 62. Louisa Aldrich-Blake (1865-1925), MB 1892, Dean LSMW 1914 to 1925. See Lord Riddell Dame Louisa Aldrich-Blake (London: Hodder & Stoughton, 1926)

21. On Pechey (1845-1908), MD Bern and LKQCPI 1877, E. Lutzker Edith Pechey-Phipson, MD (New York: Exposition Press, 1973); On Shove (1848-1929), MB London 1882, Scharlieb Reminiscences, p.56.

22. See The Englishwoman's Yearbook, from 1880 to 1914. In 1901 Garrett Anderson advised that at least £1000 should be allowed for tuition and examination fees, and maintenance, and some allowance for establishing a practice. E. Garrett Anderson 'Foreword' In Medicine Vol IV in C. Osborn Manuals of Employment for Educated Women. (London: Walter Scott, 1901), pp.4-8. On the expense of the LSMW see Todd Sophia Jex-Blake, pp. 496-500; Haldane Commission Fifth Report Appendix, p.128.

23. Manton Elizabeth Garrett Anderson, p. 269; The Times 31 Oct.1881; Todd Sophia Jex-Blake, p.498.

education became more rather than less apparent, as it increasingly became a profession for "normal" unmarried middle-class daughters. The same process is manifested in the changing age distribution of entrants.²⁴

Before the First World War, women studying medicine were, on average, markedly older than contemporary male students. This difference diminished between the first and second generations; the second generation of women were younger, reflecting the greater institutionalization of both middle-class girls' secondary education and women's medical education. Most of the first generation were clearly older on entry than the LSMW's minimum of eighteen.²⁵ In 1911, the average of entry was still 'between 20 and 21'; about 10 per cent of LSMW students had previously studied at Oxford or Cambridge, and some at London University.²⁶ Some were still older entrants with varying experience.²⁷ In Scotland too, some of the second-generation entrants were mature. Kate Clark's experience sheds light on the realities of the gender division of labour at the turn of the century. She was a trained nurse, but 'the work was heavy and her older brothers became

24. Times 29 Nov 1909.

25. Of the 25 of the first 59 whose birth-dates are known, only one was under twenty and 2 twenty-one. Eighteen were over twenty-five, 3 of these being over thirty-five. From the biographical details available on others, few, if any, can have been in their teens when they began.

26. Haldane Commission Fifth Report Appendix, p. 127.

27. Eg. The Hon. Ella Scarlett was 28 when, after music studies at the Vienna conservatory, and several years of London society, she 'wearied of an existence of mere pleasure' and entered the LSMW, qualifying MB in 1900 aged 36. Undated press cutting c. 1896, in Haverfield papers.

anxious for her future, fearing that in her enthusiasm she might overtax her strength'; so they persuaded her to go to medical school in 1898, aged 32.²⁸ But many were young, reflecting the general pattern of Scottish education. The minimum age for entry to the Edinburgh Medical College for Women was 16. Isabel Emslie was 17 when she entered, in 1905, as, in her view, a naive and inexperienced girl. Looking back, she was grateful for the chance to 'start one's life's work and really begin to learn' aged 22.²⁹

Her comment reveals the difference of experience between the generations. The "pioneers" had spent their early years fighting for the opportunities to enter medicine, or taken it up as part, not the beginning, of a life's work of service.

Philanthropy, missionary work and financial independence, whether objectively essential or not, were the main personal motivations for the first generation. These were not mutually exclusive, as we have seen. Service to women was compatible with meeting the need for an income, with satisfying a desire for challenge, independence and a useful life; and service was informed by differing visions of what women's needs were.

Many did embrace some aspects of the public case for women doctors, as part of women's mission of moral reform and service. For these, as McCall wrote, 'It was not the bluestocking idea that made us steer our steps towards the humane professions. It was not just that we wished to establish our equality with men, by doing

28. Journal of MWF (Jan 1959), 41.

29. Hutton Memories of a Doctor, p. 35.

the things they could do', it was to serve.³⁰ Pechey was probably not unique among the first generation when she declared that her purely personal motives for entering medicine had been augmented by a passionate conviction that women should be freed from the care of 'such young ruffians' as had insulted her and her fellow students in Edinburgh.³¹ But we should be cautious about labelling all the early entrants as 'feminists'.

This is especially true of the many missionary students. In 1878, before the public campaign for women for India took off, eleven of the 45 LSMW students were missionary students, that is, sponsored by a religious society; many of them were experienced missionaries seeking professional training.³² There were also those like Mary Scharlieb with a secular mission. Determined to add an English degree to her Indian licence, she came to London in 1878 to study at the LSMW, bringing her children with her and leaving her barrister husband behind. She is one of those whose life's work exemplifies the conservative side of social maternalism, with an increasing commitment to medical women's professional equality.³³

In contrast, the beautiful and charismatic Anna Kingsford (1846-1888), MD Paris 1880, studied medicine primarily to further

30. Barrass Fifty Years of Midwifery, p.38. Blackwell had to earn a living after her father's death and left teaching for medicine at the request of a dying friend. Her public case for women's mission in medicine developed subsequently. E. Blackwell Opening the Medical Profession, p. 27. As noted earlier, neither Garrett Anderson or Jex-Blake expressed such high moral convictions publicly, or shared her opposition to materialism.

31. Letter to Scotsman 14 July 1871.

32. Thorne Foundation of LSMW, pp. 1-19. The Times 5 June 1878.

33. Scharlieb Reminiscences, pp. 29-48.

the cause of animals, to aid her antivivisectionist crusade. Determined to qualify without witnessing vivisection, she studied in Paris between 1874 and 1880 (with some classes at the LSMW), and submitted a controversial MD thesis on the merits of vegetarianism. She never registered but, in addition to work for antivivisection, specialized, until her death in 1888, in 'the treatment of complaints detrimental to beauty'.³⁴

Among the second generation, we find the same emphasis, in many accounts, on a mission to women, at home or overseas, as well as on independence. But this is increasingly combined with a more pragmatic approach to medicine as a career for unmarried middle-class daughters. And for some, there are signs of an interest in medicine for its own sake, rather than mainly as a mission to women (or animals).³⁵

Medical Education for Women: 1874-1914

The fragmented training of some of the very first entrants, Garrett Anderson, and the Edinburgh Seven, has been well studied. Less attention has been paid to the experience of those who followed them. As I have shown, the vast majority of both the first and the second generation were enrolled in single-sex institutions, and many brought distinctive motivations to their medical

34. Maitland Anna Kingsford i, pp. 17-28, 230. Advertisements for her beauty products are to be found in contemporary women's papers and antivivisection journals, for, as an unregistered practitioner she was free to promote herself.

35. Riddell Dame Louisa Aldrich-Blake, pp. 17-18. Evans Freedom to Choose, p. 53. C. St John Christine Murrell: Her Life and Work (London: Williams & Norgate, 1935).

studies. From the outset, the women's schools had three tasks: to provide women with a training not dismissable as inferior by medical opponents, to enable women to gain a registerable qualification, and to show that women could become doctors without being hardened and desexed.

Criteria for entry show these influences. The GMC required any students registering to study for a non-university licence to pass a preliminary examination in Arts. Degrees required matriculation, which, especially in London, involved the beginning of longer, harder, more expensive study.³⁶ Most of the first generation took the preliminary arts examination, preparing by private study, or in special classes after enrolment.³⁷ For the second generation, the examinations were passed before entry, and, thanks to Bedford and Royal Holloway Colleges and the new girls' secondary schools, were more often the examinations for matriculation.³⁸

Pre-1914 Deans of the LSMW stressed the importance of adequate intellectual ability, and good general education. To have insisted on exceptional brilliance would have been to accept that, while medicine was open to common-place men, it should be inaccessible to any but outstanding women. Health and stamina

36. The Englishwoman's Yearbook, 1880-1910. Garrett Anderson 'Foreword', pp. xi-xii. Malleon Mary Murdoch, pp. 25-27.

37. Todd Jex-Blake, pp. 232-7 & Evans Freedom to Choose, p. 43.

38. Self-selection probably accounted for the fact that between 1878 and 1883, 69 per cent of women (427 out of 619 entrants) compared to 52 per cent of men (3712 of 7208) passed London University Matriculation. Jex-Blake Medical Women, pp. 221-2.

were considered essential, because of the demands of the work and lingering concern about the effects of higher education on women's health.³⁹ To these requirements it was added that students must conduct themselves with appropriate demeanour, and that new entrants should not bring medical women into disrepute, by seeking to practice untrained, or by association with disreputable causes.⁴⁰

Once in medical school, the formal training of these women was not very different from that of male contemporaries working for the same qualifications. Professionalization entailed standardizing education; that made entry for women easier, and a distinctively female socialization more difficult. It meant conforming to the requirements of examining bodies.⁴¹

In the beginning, the women's schools were generally too poor, and their clinical facilities too precarious, to afford much extra teaching, even in the subjects considered most important for

39. Burstyn Higher Education pp. 149-151.

40. The former was mainly directed at missionary students. Englishwoman's Yearbook 1888 p. 193. An example of the latter is afforded by an incident in 1878, when two students and an applicant agreed to withdraw their names from the Council of the Malthusian League to promote birth control lest they discredit the school. LSMW Executive Council (EC) 10 Oct. 1878. The three were Juliet Swaagman-Mitchell (LKQCPI 1882), Alice Vickery Drysdale (1845-1929), LKQCPI 1880, and Kate Mitchell (LKQCPI 1882), all active in the early birth control movement.

41. For example, women had to learn about men's diseases even if they were never to practice with men, and had to have clinical training in a general hospital with at least 80 beds, approved by the GMC- hence the need for the arrangement with the RFH. If examination requirements changed, new provisions had to be made, often with difficulty. Eg LSMW Governing Body (GB) Minutes 7 May 1888.

women students.⁴² Moreover, the first generation, and the second generation outside the LSMW, were taught almost entirely by men who also taught in men's schools. Later, within the LSMW, the women teachers adhered strongly to professional norms, and the clinical teachers at the RFH remained mainly male.

Pressure to conform to externally set requirements and to professional values can be seen at the LSMW, in the teaching of physiology. After 1875, examining boards increasingly required knowledge of experimental physiology, knowledge obtained through vivisection; and leading London physiologists taught at the LSMW.⁴³ The hope of some of the women's supporters, and of some of the early women, that medical women would offset the materialist influence was vain. Committed antivivisectionists served on the LSMW's Governing Body, held honorary office, and in two cases did some teaching. But the physiologists were necessary to the school's survival.

Within the LSMW's own committees, the moral vision of

42. Englishwoman's Yearbook, BMJ and LSMW Prospectus for each year give course outlines. Jex-Blake Medical Women pp. 180-181; Scharlieb Reminiscences pp.55-65 describe the early years. Students could arrange extra tuition and clinical experience and many did. Financial pressure was eased but not eliminated by receipt of a Board of Education grant from 1909. G. Newman Some Notes on Medical Education (London: Board of Education, 1918), p.3.

43. Butler 'Science and the Education of Doctors.' Of the physiology teachers, the most important was Edward Sharpey Schaefer, later professor of physiology at both University College, London, and Edinburgh University. He lectured at the LSMW from 1877 to 1883, and chaired the school's curriculum committee from 1892 to 1897. A tireless promoter of experimental pre-clinical sciences in the LSMW, his influence was also felt by the women at Edinburgh. (LSMW EC Minutes, 30 May 1877, 10 Oct. 1878, 3 Feb. 1892. Hutton Memories of a Doctor pp.28-29.) Some of the LSMW staff were friends of the physiologists. Scharlieb shared a London house with the Schaeferes. Reminiscences, p. 146.

medicine with which women had been associated was pitched against the values of the "modern" scientific profession. The school did not permit vivisection on the premises until 1912 but the women attended demonstrations elsewhere. By 1900, the day-to-day teaching of the physiologists had clearly become the more potent influence on students. Antivivisectionists bitterly attacked the medical women for this alleged betrayal.⁴⁴

The vivisection controversy within women's medical education illustrates how issues of gender were intrinsic to the arguments about the project of professionalizing medicine through allegiance to science. But it also shows how the tension between ideas of women's mission and dominant professional values had to be resolved by both the school and individual women.

The LSMW, unlike many men's schools, did take the teaching of obstetrics and the diseases of women (gynaecology) seriously, and preferred it to be done, if possible, by women. But initially, it was a major problem even to comply with licensing bodies' minimal requirements for obstetrics experience. No obstetrics was practised at the RFH, and, at first, no major London lying-in institution would take the women. The earliest students went mainly to the Rotunda Hospital, Dublin, and later to Queen Charlotte's in London. By the end of the 1880s, some could gain

44. At least eight of the first generation (mostly among the first twenty) shared some of Kingsford's concern about vivisection. The teachers were Blackwell briefly, and Annie McCall, lecturer in midwifery. On medical women and vivisection see Elston 'Aping the Monstrous Males, and 'Women and Antivivisection in Victorian England: 1870-1900', in Historical Perspectives on Vivisection. Edited by N. Rupke (London: Croom Helm, f.c. 1987).

experience by working at one of several medical institutions staffed by medical women. Most important were the New Hospital for Women (NHW) started by Garrett Anderson, and the Clapham Maternity Mission, started by Annie McCall. After 1900, some out-patients obstetrics was based at the RFH.⁴⁵ Autobiographical accounts suggest that training in obstetrics for these women, as for men, consisted mainly of learning on the job from skilled midwives attending poor households; though some systematic instruction was given by Annie McCall from 1889.⁴⁶

In Edinburgh, to gain midwifery experience was also a problem for women, as most Edinburgh cases were reserved for men students. Again, the obstetrics out-patients of the two women's hospitals, the Bruntsfield and the Hospice, played a small part; but most students went to the slums of Glasgow. Hutton recalled that neither obstetrics nor gynaecology were seen as important parts of a student's medical education by the university.⁴⁷

Although the women took "men's" qualifications, the ones they

45. Obstetrics was at this date almost entirely an out-patients matter everywhere. Bell Storming the Citadel, p. 145-6; LSMW Executive Council (EC) Minutes 17 May 1881; GB Minutes 6 May 1889.

46. Eg. Evans Freedom to Choose, pp. 71-72; MWF Newsletter (Jan 1937), 60-61; Barass Fifty Years in Midwifery. In 1918, Newman, Chief Medical Officer at the Board of Education commended the LSMW's training, as part of his campaign to improve maternal and infant mortality through changing medical education. Newman Notes on Medical Education, p. 82. (On contemporary obstetrics training see J. Lewis The Politics of Motherhood esp. pp. 70, 119-120. In 1921, after the recommendations of the Haldane Commission, the L(RFH)SMW opened a full-time professorial obstetrics and gynaecology unit, the first in London, directed by Prof. Louise McIlroy. Bell Storming the Citadel, p. 176.

47. Hutton Memories of a Doctor, p. 57-74. Lawrence Shadow of Swords, pp. 73-77.

took and their performance in examinations were typically different. As Scharlieb said, of the early women,

"..They were also picked womenthe effort..ensured that those who survived the ordeal were both able and determined to succeed. In consequences not only was the percentage of university candidates greater but the percentage of graduation was greater and the women obtained honours, medals and scholarships in a much larger proportion than was the case in any other medical school."⁴⁸

The basic registerable qualification for the 55 of the first generation on the register, could not be Conjoint as it was for most of the London male students. For 45 of them it was LKQCPI, for two the LSA; two were the first to take the Scottish Triple, and five achieved the coveted and difficult London degree. But 35 of the 55 women had MD degrees (as did the four unregistered women). In the case of ten, these were European degrees taken before they could get a registerable qualification. But seventeen, a far higher proportion of the women than of the men, took a European MD after registration, usually at Brussels because it was cheapest. When Garrett Anderson became the first woman to take the Paris MD in order to supplement her low status LSA, she set a precedent that many were to follow. The early LSMW alumni were to be divided into the 'Brussels Sprouts' and the 'London Pride'.⁴⁹

In the second generation the emphasis on degrees is even more pronounced. The opening of the Scottish University degrees to

48. Scharlieb 'The medical women', p. 1177. Women's disproportionate success in examinations is amply documented. Eg Jex-Blake Medical Women, pp. 221-2; Malleson Mary Murdoch, p.20. Wilson 'Aesculapia Victrix', 25-26.

49. Manton Elizabeth Garrett Anderson pp. 185-195. Scharlieb Reminiscences, p. 140. Scharlieb describes the private tuition she[^] the other first London MB candidates obtained to get through.

women brought them 'flocking' to the Edinburgh and Glasgow schools.⁵⁰ In London, despite the London 'grievance', a far higher proportion of the women than of the men took the London degree. To a press report in 1911 that 20 per cent of women medical students failed their finals, the LSMW secretary replied that 86 per cent of entrants qualified, 75 per cent with the London MB.⁵¹

In her evidence to the Haldane Commission, Julia Cock, Dean of the LSMW, stressed the more systematic nature of the preparation at 'modern girls' schools' for University matriculation, as compared with men's public schools.⁵² But this bias towards gaining degrees was not merely a consequence of better initial preparation or individual ability. It was a strategy to rebuff the imputation that women's training was inferior and, as demand for post-graduate qualifications grew towards the end of the century, to offset the real disadvantages of exclusion from Conjoint degrees.⁵³ There were probably few hospitals like the Birmingham Hospital for Children, where, in 1903, the lay committee insisted, against the wishes of the male honorary staff, that, in order that women might be elected to the staff, the London MD and MS were to be regarded as equivalent to FRCS for

50. Lawrence Shadow of Swords p.72.

51. Standard 28 Nov. 1911 & 2 Jan. 1912. RFH Press Cuttings Book IV.

52. Haldane Commission Fifth Report Appendix, pp. 127-129.

53. M. McKenzie 'The use and abuse of hospitals' Contemporary Review 58 (1890), 501-519.

surgeons.⁵⁴

The teaching environment for the women differed between the two generations, and increasingly between the LSMW and the other schools. When the LSMW opened, the only woman among eleven lecturers was Garrett Anderson, lecturer in midwifery.⁵⁵ Women were subsequently appointed, at first to junior posts, if they met the necessary standards—a matter causing much discussion. By 1882-3, 5 of 15 staff were women, and after 1900, the majority of school posts were held by women.⁵⁶ In 1883, Garrett Anderson was elected dean, an office held by a woman for the next eighty years.⁵⁷ Entrants to the LSMW after 1900 thus began their studies in a more female environment at the staff level than their pre-

54. R. Waterhouse Children in Hospital: A Hundred Years of Childcare in Birmingham (Birmingham: privately printed, 1962) pp.35, 48 & 83. This hospital had a long history of both lay control and women on the house staff by then. Annie Clark MD (1844-1924) was an Honorary Physician at this hospital from 1883-1904. One obituary stated that Clark did not operate at the other hospital where she was on the honorary staff, the Birmingham and Midland Hospital for Women, because she did not have FRCS. Lancet (15 March 1924), 571-572.

55. The ten men were all teachers in medical schools recognized by the RCP and RCS. Blackwell was appointed lecturer in diseases of women in 1875, but did little teaching. Jex-Blake Medical Women Appendix, p. 88; Sahli Elizabeth Blackwell, pp. 220-221.

56. See for eg. LSMW: GB Minutes 12 June 1877 & 4 Feb 1878; EC Minutes 17 Dec. 1877. Numbers of women staff are from LSMW Annual Reports. An endowment in 1901 permitted permanent lectureships (but still part-time) in midwifery, anatomy and physiology to be established, providing appointing women was a priority. (LSMW EC Minutes 27 March 1901). Staff counts include those named as lecturers in clinical subjects in the school.

57. LSMW EC Minutes, 13 March 1883. Her appointment was opposed only by Jex-Blake, who proposed Pechey, resigning from the EC when Garrett Anderson was elected. Previously, Schaefer was informally invited to become Dean by Thorne, but refused. (Sharpey Schaefer Papers ESS/J.4. 26 June 1882).

decessors. But the uncompromising inaugural address from the then sub-Dean, Aldrich-Blake, in 1908, indicated the professional standards expected of them.

'If women are going to compete with men they must be equally efficient... You cannot have two standards of efficiency...The sooner women students get that idea out of their heads, if it is there, the better. We talk too much about competing with men...Why think about competition? If you are good at your work you are certain to succeed and if you are not you are certain to fail.'⁵⁸

Although the formal teaching of the women students may not have differed from that of men, the student culture and the public face of the LSMW were very different. It was a community of women. A model of female professionalism was set before the women students, as evidenced in Garrett Anderson's maxim, 'the first thing women must learn is to dress like ladies and behave like gentlemen'.⁵⁹

For women, life at medical school was expected to be decorous, in contrast with the notorious rowdiness of the male students, which reached new heights in disrupting women's suffrage activity in the 1900s. The women students, like their qualified sisters, who supported the campaign for the vote, had to strike a

58. Quoted in Evans Freedom to Choose p. 63.

59. Quoted *ibid.* (My interpretation is different from Evans's.)

delicate balance between professional reputation and personal conviction.⁶⁰

On ceremonial occasions, the women were constantly reminded of their femininity: with advice from women practitioners about what underwear to wear on nightcalls, ringing calls to women's spiritual qualities from prominent women philanthropists, or suggestions about women's special gifts within medicine from both men and women practitioners. But in time, the dominant element in this conception of female professionalism changed from social maternalism, with its emphasis on women's special qualities, to the achievement of professional equality with men, without becoming mannish. But it was still assumed that women would normally be, and prefer to be, doctors for women and children. At least at the LSMW, this expectation prevailed until 1914, and it was not merely an expectation imposed on women to restrict their opportunities.⁶¹

For the earliest students, the LSMW was a precarious community of women students in a male world, but it also provided a few of them with career opportunities in both pre-clinical and clinical teaching, status-enhancing adjuncts to private

60. A vivid picture of life at the LSMW in the 1880s is given in letters from Helen Wilson to her father. Fawcett Library Autograph Letter Collection. See also C. St. John Christine Murrell MD (London: Williams & Norgate, 1935), pp. 27-30. Murrell (1874-1933) qualified MB BS 1889, from the LSMW. On the suffrage and medical students see Harrison Separate Spheres, pp. 68, 197, 204. A poll in 1908 showed 538 medical women for women's suffrage and 15 against. Harrison 'Women's health and the women's movement', p. 51. Not all were active campaigners. Those that were were divided between the militant and constitutional suffragists.

61. This is based on reading the inaugural addresses (normally given by a medical practitioner) and the prize-giving addresses (normally a distinguished public figure) from 1874 to 1914.

practice—as in men's schools.⁶² In time, these women were role models and sponsors to their successors in an established community of women.

But the women at the LSMW provided only part of the women's training. The clinical teachers at the RFH before 1914 were almost entirely men. Before incorporation in 1897, the school had no say in RFH appointments, and only limited representation thereafter.⁶³ In 1877, senior staff of the RFH had not been wholly in favour of the women's admission, and the access granted was fairly limited. Initially, male patients were carefully screened to preserve women's delicacy, women's clinical experience thereby limited.⁶⁴

Until the 1890s, there were no opportunities for qualified women to gain clinical experience or a step on the career ladder in this general hospital. In the 1890s the situation changed minimally, when women were appointed as anaesthetists and surgical registrars. In 1900, two of the RFH's six general general houseposts were set aside for LSMW students. In 1902, the first senior woman honorary, Mary Scharlieb, was appointed as Gynaecological Physician, with a woman assistant, Ethel Vaughan Sawyer,

62. Ten of the first generation held lectureships at the LSMW.

63. After incorporation, there was still tension, especially about teaching in gynaecology, whether this should be primarily at the New Hospital for Women (done by women) or at the RFH. Eg. LSMW EC Minutes 11 May 1897 and School Committee Minutes 1 May 1901.

64. See letter from medical staff to LSMW in EC Minutes 18 May 1878. Thorne Foundations of LSMW, pp.22-23. In 1920, a retirement tribute from students to James Berry, Hon. Surgeon at the RFH from the 1890s, said 'It is entirely due to Mr Berry's complete disregard of what a really nice woman ought to know that we owe the careless freedom with which we now question [male] patients', rather than being limited to selected patients. Magazine of L(RFH)LSMW (Nov. 1920), 77.

who succeeded her. In 1914, all other senior honoraries were men.⁶⁵

Women staff were much less prominent in the Scottish women's training, with only small contributions from Jex-Blake and later Inglis as clinical teachers, and from some junior pre-clinical staff.⁶⁶ Accounts of the Medical College for Women between 1890 and 1910, suggest it was very different from the LSMW. In a world of men, women were much more obviously marginal throughout their studies.

After 1892, some classes and ward teaching in the Infirmary were mixed. Hutton recalled that the women were treated as inferior by most staff and with thinly veiled hostility by many male students—unless they were missionary students, and not a professional threat. Teaching the women was a useful step in the most junior men's careers. Junior women staff of the college had few prospects for advancement, and the students had no hope of houseposts in their "own" hospital.⁶⁷

65. In 1893 Aldrich-Blake was appointed Assistant Anaesthetist, and Anaesthetist in 1894, since when, 'anaesthetics has always been in the hands of women' at the RFH (written in 1905). Thorne Foundations of LSMW. Martindale Woman Surgeon p. 33. Evans op. cit., p. 69.

66. Englishwoman's Review 1886-1898; Todd Sophia Jex-Blake. The College for Women negotiated, in 1892, access to two wards in the male-staffed Edinburgh Royal Infirmary, thanks to a substantial endowment by the women's supporters. In Glasgow, the Infirmary was open from 1891 for mixed teaching thanks to the local 'great man', surgeon William McEwen. Lawrence Shadow of Swords, pp. 56-58; Turner Story of Great Hospital, pp. 250-252.

67. Hutton Memories of a Doctor, pp. 13-36; MWF Quart.Rev (July 1940). 70; F. Murray Women as Army Surgeons (London: Hodder & Stoughton, 1920), p. 52. Julia Pringle (MB ChB 1903) singled out by Hutton (p.33) as a brilliant assistant anatomist, made her career (whether through choice or constraint) in general practice in Dundee. Journal of MWF 42 (July 1960), 31.

The Scottish women shared (some of) the men's facilities. They could be seen to achieve men's standards (or better). But they were without the advantages of female support, role models and sponsors, and such opportunities as the LSMW provided.

This contrast between separate and mixed education was to become more marked as provincial schools opened their doors to women, increasingly in mixed classes, at least in the initial stages. Often, this was only a partial opening, women refused access initially to all or part of the main teaching hospitals.⁶⁸ And even where they were granted facilities as students, women were resolutely barred from houseposts in the general teaching hospitals after qualifying.⁶⁹

The relative merits of mixed and separate education were much discussed, especially at the LSMW. Separate schools had begun as a last resort; but the advantages of separate education, and female solidarity in the face of continued male obduracy, had quickly become apparent. So long as the men's institutions were demonstrably excluding women, women's schools could claim a raison d'être as a means to women's professional equality. But as other avenues appeared to open up for women, and concern for female delicacy was subordinated to professional ambition, the rationale

68. See Chapter IV. The first two women were admitted to the medical school at Leeds in 1905, but access to the Infirmary was not granted until 1910, and women were still excluded from male surgical out-patients until 1914. S.T. Anning The General Infirmary at Leeds Vol II: 1869-1965 (Edinburgh: Livingstone, 1966), p. 89.

69. Ibid., pp. 90-91. On women's exclusion from Manchester Royal Infirmary, see BMJ (11 Dec. 1909), 1710. ✓

for their existence was weakened. .

The Scottish women's schools, never such separate institutions as their English counterparts, merged formally with men's schools in 1909. There was growing concern among senior LSMW staff that the school might seem outmoded to younger women, unaware of or unconcerned with the past and attracted by the professional and social opportunities of a mixed provincial school. But the apparent immovability of the London men's schools, meant that its continued existence was defensible and assured.⁷⁰

Conclusion

Bringing to medicine experience and motivation different from men's, the earliest women entrants exhibited significant divergencies from their male counterparts; divergencies which diminished as medicine gradually became institutionalized as a career for women. Conducive to the diminution were the attitudes of the women's teachers, and the structure of medical education in which the women's institutions were set. But their informal experience remained very different from the men's, as did their opportunities when qualified. It is to these that I now turn.

70. LSMW Governing Body (GB) Minutes 6 May 1889; Garrett Anderson The Times 24 Nov. 1900. Scharlieb Reminiscences, pp. 232-3; Lawrence Shadow of Swords, p. 66; Haldane Commission Fifth Report Appendix pp. 124-126.

CHAPTER VII

THE CAREERS OF MEDICAL WOMEN: 1865-1914.

The Medical Career Structure: 1870-1914

Women first entered medicine when a new division of labour and a new career structure were emerging and, in the 1870s and 1880s, not yet established. As they have been described elsewhere, I shall give only an outline of these developments.¹

The first aspect of the change in division of labour was the gradual replacement of the old tripartite hierarchy by a bipartite one involving a division between elite consultants and general practitioners; the consultants practising general medicine or general surgery, and the general practitioners medicine, surgery and obstetrics. Consultants provided second, expert, opinions, or surgical skills to other men's private patients. Before the 1890s, the few doctors who were primarily consultants were virtually confined to London. Even these were usually general

1. See Waddington Medical Profession in the Industrial Revolution; Peterson The Medical Profession in mid-Victorian London, pp.259-82; Stevens Medical Practice in Modern England pp. 11-37; Parry & Parry Rise of the Medical Profession B. Abel-Smith The Hospitals 1800-1948: A Study in Social Administration in England and Wales (London: Heinemann, 1964) pp. 32-172. C. Davies 'Hospital Centred Health Care: Policies and Politics in the NHS'. In Prospects for the National Health. Edited by P. Atkinson, R. Dingwall and A. Murcott (London: Croom Helm, 1979) pp. 53-72.

practitioners to wealthy patients. The referral system to ease competition between the general practitioner and consultant over first access to patients was not fully established in London until the end of the nineteenth century.

Becoming a consultant required an honorary appointment at a major voluntary hospital. This did not, in itself, confer the status of consultant, but was evidence of professional skill, and gave access to unrivalled opportunities for clinical experience with the working-class patients on the wards. Achieving such positions normally involved remaining within the orbit of a teaching hospital for many years, obtaining seniors' patronage, barely paid houseposts and teaching opportunities and higher qualifications from the London Royal Colleges. Considerable capital was required.

Most medical men in this period were general practitioners. But appointments to the honorary staff of local voluntary hospitals, especially in the provinces, were sought after as a source of prestige; prestige which would attract paying patients and lead to at least local status as a "GP consultant". The practice of a doctor thus established might evolve into one of a primarily consultant character. Establishing successful general practice usually involved some financial outlay.

Taking up initial opportunities to acquire clinical experience in resident hospital posts, or as assistants to established practitioners, involved acceptance of minimal payment. Those without a practice to inherit, had to buy an established practice or put up a "plate" and wait for patients. Earnings would often be supplemented by part-time work for the public-health or poor-law medical services, or for dispensaries; or by

contract-club practice for working-class patients. Some regular payment was thereby guaranteed, though lay control was risked. This was the situation onto which the National Health Insurance panel scheme was grafted in 1911.²

The second aspect of the change in division of labour was consequential to the emerging differentiation of medical specialties. The embryonic division between consultants and general practitioners was increasingly cut across by these divisions and by the proliferation of special hospitals, initiated largely by medical men, with the aid of lay committees. These were mainly small, often with less than ten beds, in dilapidated premises, and hence comparatively cheap to establish.

The motives of those establishing most of these hospitals were mixed: to cater for the sick poor, such as children and pregnant women, excluded from general hospitals; to provide either improving environments for the moral regeneration of the indigent, or more respectable environments than in existing hospitals for the deserving poor, especially women. And they constituted means of promoting the careers of ambitious medical men frustrated by their exclusion from general voluntary hospitals.

In some cases, these individual efforts were part of a wider movement through which new specialisms within medicine were pursuing distinctive identities through entrepreneurship and the founding of specialist societies. Some men were attempting

2. Parry and Parry Rise of Medical Profession, pp.149-154 & 187-195; F.Honigsbaum The Division in British Medicine: A History of the Separation of General Practice from Hospital Care 1911-1968 (London: Kogan Page, 1979) pp. 9-22.

specialist careers outside and in opposition to the generalist tradition, and the dichotomy of medicine and surgery still prevailing within the major voluntary hospitals. These men's claims to consultant status were based on specialized technical knowledge rather than on social status.

This is exemplified by the beginnings of gynaecology as a specialty in the second half of the nineteenth century. Some obstetricians, wishing to extend their operative work to non-parturient women but excluded from general hospitals, and some ambitious surgeons whose advancement was blocked, constituted a small group which challenged the monopolies of physicians over the diagnosis of women's diseases, and of general surgeons over all abdominal surgery in hospitals. They sought to link medicine and surgery in a single field of women's diseases: a proposal bitterly opposed by general surgeons, and controversial among the lay public, because of the alleged indelicacy of their interventionist approach.

Special hospitals for women were founded by these specialists to gain experience in interventionist, surgically biassed treatment of women's diseases. From the 1860s, these hospitals were increasingly promoted as more suitable places than general hospitals for respectable (but working class) women; they were among the first to incorporate pay-beds. Divisions of social status and professional outlook led to increasing divergence between obstetricians and gynaecologists from the mid-1870s. There was no established single "specialty" of obstetrics and

gynaecology until the 1920s.³

The development of the referral system, and the growth of specialisms under the impetus of doctors' ambitions, began to coalesce by the end of the century, as special departments within general hospitals also developed. The meaning of being a 'pure' physician or surgeon slowly changed to that of technical specialist. The 'gynaecologist', qualified in both medicine and surgery, appeared on the honorary staffs of general hospitals, at least in London. At the same time, the idea of hospitals, or nursing homes, as appropriate places for those who could afford to pay, was beginning to spread. The foundations of the 'hospital-centred' medicine of the twentieth century were being laid.

But until after 1948, it was only in London and the major provincial cities with their teaching hospitals, that many medical men undertook purely consultant careers, with no direct access to private patients. The vast majority of voluntary hospitals' honorary staffs were still general practitioner 'consultands'. Many more general practitioners were involved with small cottage hospitals where they could admit their own patients.

Doctors with very limited resources might pursue, at least initially, organizational rather than entrepreneurial careers, mainly through the state medical services. These were often first steps to gain experience before undertaking an entrepreneurial career. Before the 1870s, such opportunities lay mainly in the army, navy or colonial (especially Indian) services. (Some men

3. Mosciucci 'The Science of Women' has analyzed these developments in detail. See also Peterson Medical Profession in mid-Victorian London pp. 260-270.

also took up mission work.)

From the 1870s, there were more opportunities for organizational careers, or part-careers at home, in the larger cities, for medical officers of health under local health authorities, or in connection with the expanding poor law institutions and services, or the growing network of public asylums. But full-time career posts were still few compared with the total number of practitioners, and generally low in status. In the early years of the twentieth century, state provision of both preventive and curative health services received new impetus in the context of growing concern about the population's health, especially that of infants and children.⁴

Between 1870 and 1914, this new division of labour was in the process of crystallizing; although lines were very blurred compared with those of today's picture, career trajectories became increasingly distinct: those of general practitioners, specialist-consultants, public health servants. This constituted the changing context in which these two generations of medical women were to make their careers, under their limited mandate.

The first question I shall consider is whether these early women used their hard-won professional qualifications.

4. J. Brand Doctors and the State: The British Medical Profession and Government Action in Public Health, 1870-1912 (Baltimore: Johns Hopkins, 1965); D. Watkins 'The English Revolution in Health, 1889-1911.' Unpublished Ph.D. thesis, University of London, 1984.

Wastage, Marriage and Motherhood

During the campaign for entry, the question whether women would use their qualifications was secondary to the question of delicacy and women's needs. But even if women doctors were, in principle, acceptable, as meeting such needs, they were faced with a paradox: The mysteries of medicine were only suitable for married women; but they would be unable to practise, it was alleged, because of their domestic commitments. Garrett's marriage in 1871 aroused interest in the medical press. She was acutely conscious of the onus on her to prove that marriage and motherhood, were compatible with medicine.⁵

Allegations of wastage become more common after 1877. In 1894, the LSMW reported that 14 per cent of entrants between 1874 and 1890 had failed to qualify. Of the 166 qualifiers, nine had died, 129 were known to be in practice and 28 (18 per cent of those still alive) had relinquished the profession.⁶

It seems that the majority did use their qualifications, at

5. Anderson Elizabeth Garrett Anderson pp. 163-205; Manton Elizabeth Garrett Anderson pp. 210-221.

6. Letter from Frances Dickinson Berry Lancet (10 March, 1894), 651. This item cites a report that of 1,000 students at St. Bartholemew's, 8 per cent never qualified, and 8 per cent left the profession within 12 years. Berry notes this is less than for women but suggests that, given the claims of marriage and relatives on women, women are not lacking in 'steadfastness'. In 1907, a similar estimate of withdrawal was given. Daily News 10 Oct. 1907. (RFH Press Cuttings Book 4).

least for a while.⁷ I have not identified anyone in the first generation who never practised, and only six who might not have done. But some do not have long careers in clinical medicine. By 1901, eight were dead, seven definitely retired from active clinical practice because of ill-health or age, and one erased from the Register for advertising. By 1914, 30 years after their mean date of qualifying, at least twenty were dead; and only eight definitely still in active clinical practice, this reflecting their age on qualification.⁸

Ill-health, then, is an important cause of 'wastage' in the first generation. Three died from tuberculosis within a decade of qualifying. The brilliant Helen Prideaux died of diphtheria one month after she had been elected house surgeon to Paddington Children's Hospital, the first woman to get a job in open competition in a London voluntary hospital. Others retired as a

7. Some of those not in 'clinical practice' made use of their qualifications. Arabella Kenealy, LKQCPI, 1883, left private practice in 1894 after diphtheria, becoming a well-known novelist (using medical plots), populariser of medical knowledge and anti-feminist. Elston 'Aping the Monstrous Males; DNB; Lewis Women in England p. 101. Among the second generation, Violet McLaren Kelynack MB ChB 1903 never 'practised' but for 19 years she was medical secretary to the Medical Women's Federation, as well as a medical wife. MWF Quart.Rev. (April 1940) 70.

8. Deaths and retirements are underestimates based on known dates of death or retirement, not disappearance from the Register or Directory. The doctor erased in 1893 was Eliza McDonagh Frikart, MD Zurich, 1877 LKQCPI 1879. (LSMW Register entry). Among the second generation there are many examples of premature death or withdrawal through ill-health, both in Britain and overseas, but my information is too selective to generalize from.

result of infections caught in practice.⁹

But, to balance the picture, others had long and active medical careers. Jane Walker, was still medical superintendent of her tuberculosis sanatorium at the age of eighty. Scharlieb who had 'never had an operating knife in her hand till she turned 40 years of age', was still performing major operations in 1928, aged 83.¹⁰

The loss of medical women overseas was substantial. Between 1887 and 1909, one third of those listed in the Englishwoman's Yearbook were abroad.¹¹ Among the 59 first-generation women, fifteen might be described as permanent emigrants, spending at least ten years after qualification in India, China, or Africa, or, in five cases, dying there. A further five spent some time in practice in these countries but returned to practise in Britain. Four spent at least some of their post-qualification lives in Europe, other than for post-graduate study.

Among the second generation too, about a third spent at least some of their careers abroad, mostly in mission or similar secular work. But the search for adventure, patriotism and contingencies made for some chequered careers. Soon after qualifying, Ella Scarlett worked briefly in the Imperial Household of Korea. On her

9. Deaths from TB were Kingsford (Maitland Anna Kingsford ii p. 328); Matilda Chaplin Ayrton (BMJ (11 Aug. 1885)); Emily Bovell Sturge (Englishwoman's Review (15 May) 1885, 236). On Prideaux and other early losses see Scharlieb Reminiscences p.56.

10. On Walker (1859-1938), KQCPI 1884, see MWF Quart. Rev (July 1951) 17-20; BMJ (26 Nov. 1938) 1120; Scharlieb had retired from her honorary post at the RFH in 1908 BMJ (29 Nov.1930), 935.

11. Most of these were in India.

return, she went out to South Africa as medical officer to a refugee camp for Boer women and children in the war. While there, she joined a Women's Liberal Federation inspection of these camps led by Millicent Fawcett, during which she married a British officer. She then settled in Canada where she was in successful practice for many years.¹²

Women's overseas work was also a source of real wastage, taking a heavy toll through disease and accident. Garrett Anderson's recognition of the financial importance of the missionary movement to the school, was tempered by warnings of a life of exile, penury and a bad climate, leading to illness, early death or return 'as shadows of their former selves'.¹³

Turning to marriage and its effect on medical practice, it is clear that, though the first generation were less likely to marry than women in general, a substantial proportion did marry at some time in their lives. Not all saw this as incompatible with medicine. As some contemporaries recognized, Garrett Anderson was not alone in combining marriage, motherhood and medicine.

In 1886, a male medical supporter claimed that the majority of English medical women married before or soon after qualifying, but denied that this was a reason against training them. He argued that medical women's skills made them attractive marriage prospects; and that, in finding medical work to be compatible with

12. BMJ (6 July 1901), 57; M.G. Fawcett What I Remember (London: Fisher Unwin, 1924) pp. 153-158, and Haverfield Papers. Scarlett returns to Europe briefly in 1917, with the Red Cross.

13. Garret Anderson 'History of a Movement', 416.

domesticity, such women were in a situation analogous to that of 'many artistic, literary and political ladies', the income making it easier for a lady physician, 'married or single, to adjust her work to her family claims', and to support her family in adversity.¹⁴

Jex-Blake rejected his claim about marriage rates, with its implications of potential waste, pointing out that two-thirds of the 50 registered women in 1885 were then unmarried.¹⁵ However, some of those single in 1885 might, and did, marry later. In addition to those married before qualifying, at least twenty married subsequently and thirteen more might have done. At least 58 per cent of this tiny first generation married at some time.¹⁶

Marriage did not necessarily terminate their medical work (or, as we have seen, prevent it from beginning). At least two lived apart from their husbands for some time, at least partly to pursue their careers.¹⁷ Garrett Anderson and Pechey-Phipson both married businessmen when their careers were well-established, and

14. Wilson 'Aesculapia Victrix', 1833.

15. Jex-Blake Medical Women, p.211.

16. This includes the five widowed before commencing medicine. In 1891, 87 per cent of women in England & Wales aged 45-49 were ever-married, and in 1901, 86 per cent. Census figures quoted in Lewis Women in England, p. 3.

17. Kingsford's sharing a house ^{with} a man other than her husband caused scandal in the 1880s. Maitland Anna Kingsford ii. pp. 44-5. Scharlieb lived apart from her husband for three years as a student, and for three years on her return from England, but he died in 1891. BMJ (29 Nov. 1930) 935.

combined marriage and full-time successful practice.¹⁸ At least twelve combined medicine and marriage in some form from soon after qualifying, though marriage sometimes did affect medical work.¹⁹

At least seven married medical men, and worked with them in some ways. Isabella Bartholomew (1853-1956) LKQCPI 1881, married her anatomy teacher, William Pope Mears in 1879. She was in general practice for nine years while he taught at Durham School of Medicine. In 1889, she and her husband went as missionaries to China, returning in 1893 because of his illhealth. They opened a TB sanatorium in Edinburgh which she continued after his death in 1902.²⁰

Perhaps it is such a career that Garrett Anderson had in mind, when writing, in 1898, that 'a good many medical women marry after graduation; their husbands are usually medical men and the wife, as a rule, both practises independently after marriage and helps her husband'.²¹ In 1895, Jex-Blake told a younger colleague

18. Garrett Anderson was 35 when she married. Manton Elizabeth Garrett Anderson p.217. Pechey was 44 when she married wine merchant Herbert Phipson in Bombay. E. Lutzker Edith Pechey-Phipson MD (New York: Exposition Press, 1973) p. 138.

19. E.g. Iszet Mead (Scottish Triple 1886) had been a medical missionary for five years when she married Rev.J. Haythornthwaite, Principal of St. John's College, Agra in 1892. Five children limited her medical practice to local missionary families. In World War I, when, a widow in her 50s in England, she took a variety of short term posts. MWF Quart.Rev. (Jan. 1947) 38.

20. BMJ (21 Nov. 1936) 1063. Other examples include Frances and George Hoggan BMJ (19 Feb. 1927) 132. Vickery Drysdale's worked life with her husband in the Malthusian League. R. Ledbetter A History of the Malthusian League (Columbus: Ohio State University Press, 1976) pp. 71-72.

21. Medical Press (23 Feb. 1898). RFH Press Cuttings Book III.

that babies, not husbands, were the obstacles to practice.²² Most of the early medical women, did not question the primacy of women's roles as wives and mothers. For some, the practice of medicine as a mission to wives and mothers was not incompatible with these other roles, and the flexible structure of late-nineteenth century medicine provided some opportunities for this.²³

In the mission field, medicine could be part of the normal incorporation of wives into male missionaries' work—medically qualified wives were rarely if ever given independent positions. At home, practitioner strategies, limiting the number or type of patients, were possible, within the primarily entrepreneurial career structure.²⁴

Combining medicine and marriage was not the preferred option for all. For Blackwell, medical women's 'spiritual maternity' was best cultivated by those who were free of the mundane demands of domesticity. For others, such as Jex-Blake, it is clear that spinsterhood was a valued choice. Marriage was seen as incompatible with their own ambitions, but their emotional lives

22. 'If a woman becomes a mother, I certainly think nothing outside her home can have, or ought to have, so much claim on her time.' Todd Sophia Jex-Blake p. 503. I have only identified 7 of the first generation as ever having children, all of whom did continue in some practice. Late marriage may be a factor here.

23. It seems likely that this highly selected first generation also had highly selected husbands.

24. E.g. Scharlieb Reminiscences pp. 144-146, 159-161. Marriage would have barred women, as it did men, from resident houseposts, (but hardly any were open to first generation women). Marriage was a major contingency in medical men's careers, the right wife being crucial to professional success. See Peterson Medical Profession in mid-Victorian London, pp. 106-107.

were filled by passionate friendship with women.²⁵

Among the second generation before 1914, there are many examples of women, with or without medical husbands, combining the careers of wife and doctor. But after the tiny, "atypical" first group, it is possible that there was a decline in the numbers marrying. Statistical information is hard to obtain, but perhaps only 30 to 40 per cent ever married, and more of the wives probably retired from practice.²⁶

In 1911, the Census showed that 80 per cent of women active as doctors in England and Wales had never married, but most of these would not have been long qualified. Comparing age-cohorts in successive Censuses, suggests that more subsequently married, some remaining active.²⁷

Several factors may have contributed to greater divergence between the typical careers of single and (early) married women doctors towards 1914, and possibly to more withdrawals on marriage, temporarily or permanently. Women's attitudes to

25. Sahli 'Elizabeth Blackwell'; Todd Sophia Jex-Blake. See also M. Vicinus Independent Women: Work and Community for Single Women 1850-1920 (London: Virago, 1985).

26. In 1920, 234 of 750 LSMW qualifiers were known to have married (30 per cent). LSMW Annual Report 1920. This total of 750 suggests the figure refers to qualifiers up to about 1916. Of 212 obituaries traced of women qualifying between 1886 and 1906, 25 per cent were described as married, but these will be biased towards the most active. A 1931 survey of women qualifying from Manchester between 1899 and 1923 found that 44 per cent of 178 qualifiers were married, half of whom had retired from practice. (Most of the 178 will have qualified after 1914 and the war diminished the younger members of the second generation's chance of marrying.) MWF Newsletter (March 1931) 38.

27. N.B. earlier warnings about Census data. In 1911, 76 of 477 were married and 19 widowed. In 1921, of 561 active women doctors aged 35-54, 31 per cent (174) were married (35 per cent ever-married). In 1931, 28 per cent of those aged 45-59 were married (124 of 436) and 44 per cent ever-married.

marriage may have been changing, as professional ambition replaced ideals of service.²⁸ The majority of senior role models were unmarried after 1900. As the possibility of specialist careers for (a few) women grew, so did problems of combining marriage with hospital training.²⁹

Among feminists in general, commitment to celibacy and independence became more pronounced between 1890 and 1914. At the same time, an ideology of motherhood as incompatible with careers and as the key to society's well-being was being actively promoted by doctors and eugenicists. The promotion took institutional form in the movement for infant and maternal welfare and in marriage bars in the expanding public service employment for women. Medical women were involved in all of these developments.³⁰

28. Women missionary students were more inclined to marry (other intending missionaries) than those intending careers in Britain according to Hutton Memories of a Doctor p. 39.

29. Two of 9 named clinical women LSMW lecturers in 1904 and 1909 were married. LSMW Annual Reports. After Garrett Anderson's retirement in 1903, LSMW Deans were unmarried until 1926. In 1904, 3 of 6 senior honoraries at the NHW were married, and in 1909 3 out of 9. Englishwoman's Yearbook 1904, 1909. All honorary staff at the South London Hospital for Women (SLHW) were single when it opened in 1912. One important married role model was Frances May Dickinson Berry (1857-1934) MB 1889, anaesthetist to her husband James Berry. Evans Freedom to Choose, p.68.

30. See Lewis Women in England pp. 97-104. Eg. Mary Howie, MB BS 1902, was a general practitioner's wife for ten years until his death in 1912. For 17 years she was senior child welfare officer in Durham County, a position barred to a married woman. Journal MWF (Oct 1946) 57-58.

'Sir, Gout is in My Field, but Gentlemen are not.' The Careers of the First Generation.'

This characteristically concise response is said to have been made by Garrett Anderson, around 1880, to a gentlemen who, despairing of his usual medical advisers, inquired, 'Madam', 'Is gout within your province? If so, will you see me tomorrow?'³¹ Her reply shows that, even as a successful London practitioner, she refused male patients, though, at the outset of her career, she had privately intimated her willingness to treat men.

Before the 1890s, it was exceptional for women to attend men at all, except in a carefully controlled manner as students, and remained rare and controversial for much longer. Records of occasions when members of the first generation did treat men suggest that it occurred almost entirely in family contexts or bizarre circumstances.³² I have found only three examples of first generation women attending, or being in charge of, sick men. These incidents occurred in the tuberculosis sanatoria taking patients of both sexes, which three of them helped to found after the 1890s.³³

Garrett Anderson's comment also reveals the typical form taken by the early women's practice. She declares herself compe-

31. Versions of the story are quoted in, inter alia, St. Stephen's Review (27 Dec 1884) (RFH Press Cuttings) and Manton Elizabeth Garrett Anderson p.262.

32. E.g. press reports of Garrett Anderson's attending her brother-in-law, Henry Fawcett when dying. Englishwoman's Review (15 Feb 1883) p.73 Scharlieb records an Indian farmer refusing to accept that she only treated women, and giving her a cow and some honey for extracting two teeth. Scharlieb Reminiscences p. 114.

33. See below and F.R. Walters Sanatoria for the Tuberculous (London: Allen & Co, 4th edn. 1913) Appendix 1.

tent to treat a disorder characteristic of men. She is not a specialist in the diseases unique to women (or children). Fifty years later, Mary Scharlieb recalled the situation when she began,

'We pioneer medical women were never able to be what is called pure physicians and pure surgeons. We had, of necessity in those early days to be willing to give advice to women as to their health, whether from the medical, surgical or obstetric point of view.'³⁴

The main reason for this is clear from the earlier discussion of men's careers. At the time, very few male doctors were pure physicians or surgeons attending both male and female patients, let alone only female patients. The ideal route to the elite of generalist consultant was clearly closed to women by exclusion from teaching-hospital posts and membership of the Royal College. To accumulate a prosperous clientele and reputation would take time. But it would be wrong to see the earliest women as being uniquely marginalized in a clearly defined career structure.

Nor, initially, as I have shown, was there much institutional provision, or an established clientele, for specialists in the diseases of women or children (paediatrics did not exist as a distinct specialty either). If, in practice, much of the first generation's medical work was in what we should now call 'gynaecology', they were not, initially, 'gynaecologists'.³⁵ However, the special hospitals and the development of gynaecology were

34. Scharlieb Reminiscences p.141.

35. In 1890, an American journalist inquiring if British medical women specialized in obstetrics and gynaecology, was told, 'No, their work lies naturally among women and children but they take all cases of general medicine. We have no-one in practice as a general surgeon but much of Mrs Garrett Anderson's practice is surgical.' New York Herald 12 Oct. 1890. (RFHSM PC Book III).

important in early medical women's careers.

As I indicated in Chapter IV, public concern about the growing medical intervention in women's bodies was one factor in generating support for the idea that there should be women doctors. Secondly, some of the special hospitals were important sources of early hospital experience for the women. More generally, the development of a market for gynaecological services created, in time, a few opportunities for medical women. These included their first, and until after 1918, their only place on the honorary staff of a general hospital, as gynaecologists at the RFH, beginning with Scharlieb in 1902. But to become a specialist gynaecologist necessitated, above all, surgical skill, which was hard for women to obtain.³⁶

As for male contemporaries, general practice was to be the mainstay of the careers of most of the first generation, supplemented in some cases by prior institutional or post-graduate experience, and subsequently by honorary appointments, which led a few to develop specialist interests. But women's general practice was with women and children only. They could neither buy nor inherit nor act as assistant in a man's mixed practice. 'Goodwill' could not be transferred from men to women or, indeed, conversely

36. Scharlieb 'The medical woman', 1177. I stress that I am not suggesting that women were welcomed by all male would-be gynaecologists or in all hospitals for women and children. As I have argued in Ch V, they were not, either before or after qualifying. Eg. Jex-Blake was refused access to advertised study opportunities at the Soho Square Hospital for Women in 1878. Jex-Blake Medical Women Note QQ, Appendix, pp. 98-99. My point is about the creation of possibilities. In time, women's concentration in this field would come to be seen as limiting by some, and even the limited opportunities in gynaecology for women were not sustained.

for many years.

Thus, without any post-qualification hospital experience, Garrett Anderson had no option when she qualified in 1865, but to put up her plate and wait for patients. With her father's subsidy, she set up 'on the fringe of fashionable medical London'; but private patients did not immediately flood in.³⁷ Being the first of its kind, her career was unique in many ways; but the path she trod is understandable in terms of its particular historical location. Some of her successors followed a similar path, sometimes under her patronage and sponsorship.³⁸ At least five more of the 59 also put up their plates with no previous experience, and at least fifteen with some previous institutional experience.³⁹ I have found only two cases where first-generation women took over existing small practices from other women. The earliest women did act as locums for each other, as part of an embryonic medical women's network; but initially, women's private practice provided no basis for assistants or partnerships.⁴⁰

37. Manton Elizabeth Garrett Anderson pp. 167-176.

38. Because Blackwell's clinical practice in Britain was minimal, I have not considered it here.

39. In 1886, Wilson noted that women were more likely to put up their plates than men, and, he suggested, were generally more successful than men in doing this. 'Aesculapia Victrix', 30. Data on earnings is fragmentary. There is general consensus that Garrett Anderson was eventually outstandingly successful and several others also established a large income in time. eg. Scharlieb Reminiscences. pp.128-130.

40. In 1883, Edith Pechey invited Alice Ker to take over her Leeds practice when she went to found a hospital in Bombay. Lutzker Edith Pechey-Phipson, p. 68. The Mitchell sisters took over Matilda Chaplin Ayrton's practice in Sloane St. London, when she died in 1883. Beauty's Queen 1898 (RFHSM PC Book III).

Six months after setting up in practice, Garrett did what many young doctors did: she gained clinical experience through philanthropy to the urban poor which, organized by the middle-classes, was burgeoning. She established the St. Mary's Dispensary for women and children, supported by a committee of prominent reformers and some eminent male consultants.⁴¹

Eight of the next twenty women on the Register were involved in the establishment of dispensaries early in their careers. At least seven more of the 59 worked in existing ones for a time to supplement their experience, sometimes in Garrett Anderson's. Starting or working in dispensaries was recommended to LSMW students in the 1880s as a good way to start practice, and many of the second generation did this as well.⁴² This was another way in which the first women's initiatives provided a small network of opportunities for those who came after them.⁴³

Some of these dispensaries developed out of existing philanthropic or religious missions. Annie McCall was the driving force behind the Clapham Dispensary for Women and Children opened in

41. Manton Elizabeth Garrett Anderson, pp. 172-176. On late-19th century philanthropy in London see G. Stedman Jones Outcast London (London: Peregrine, 1976).

42. Times 2 Oct. 1887.

43. By 1886 these included the Bristol Dispensary founded by Eliza Dunbar Walker in 1874 (The Times 11 May 1878); Jex-Blake's Dispensary started in Edinburgh in 1878; the Portobello Road Provident Dispensary in London and ones in Leeds and Manchester. As an indication of the balance of work involved, and the need for assistance in dispensary work, Jex-Blake reports that in her first year of practice in Edinburgh she had 574 private patient visits, and 2464 to her dispensary. Jex-Blake Medical Women, pp. 229-231. Hoggan and Atkins worked in Anderson's dispensary before registering. Manton op.cit. pp. 176 & 226.

1887. This grew out of the philanthropic mission to which she had been the resident medical officer for fifteen months, on a salary of £100 a year. She had taken her MD in Berne and studied obstetrics in Vienna immediately after qualifying in 1884. McCall did not have the resources of Garrett Anderson to set up in private practice in an expensive area, and her strong commitment to medicine as moral and, above all, hygienic reform, attracted her particularly to the mission field.⁴⁴

Unlike Garrett, McCall had some post-qualification experience before setting up a practice and a dispensary. Her way of getting such experience was not untypical for the first generation. Many went to Europe, particularly to Vienna for obstetrics studies, as well as taking MDs. Several found salaried resident posts in charitable institutions for women and children not designated as hospitals, or in the established women's dispensaries.

A minute number, nine, did hold at least one appointment as resident medical officer or clinical assistant (paid but normally non-resident) in existing hospitals, that is, in special hospitals, for children, or, in one case, for women. In 1872, the Birmingham and Midland Hospital for Women, opened in 1871, advertised for a resident medical officer, explicitly stating that women with medical degrees or diplomas were admissible. This development was noted as 'novel' by the BMJ and deplored by the Lancet. The actual appointment of the unregistered Mrs Louisa

44. Englishwoman's Review (14 Aug. 1886), 370-372. McCall was strongly personally influenced by Blackwell, and had written an MD thesis on prevention through adherence to 'the hygienic laws of life.' Barrass pp. 29-40.

Atkins (1859-1938) MD Zurich 1872, not one of the two registered male candidates, was also not warmly welcomed by the Lancet.⁴⁵

After Atkins, the post was filled by four of the first generation over the next eight years. One of these, Annie Clark, stayed in private practice in Birmingham, working for many years as assistant to the senior surgeon and anaesthetist in private practice, and in the hospital, as did a leading second-generation Birmingham general practitioner, Mary Sturge.⁴⁶

One influence behind these appointments in Birmingham was undoubtedly the controversial and flamboyant figure of Robert Lawson Tait, the senior surgeon, one of the leaders of the nascent specialty of gynaecology. The hospital was his initiative, a response to his exclusion as a provincial and would-be specialist surgeon from the London establishment. Tait is a paradoxical figure today, recalled by some as a pioneer of scientific gynaecology, and commemorated by an extant anti-vivisection trust, named after him because of his criticisms of some vivisection experiments as misleading.

Accused in his lifetime of over-zealous operating on women, and of seducing a nurse, he has been cited as an example of the misogynist gynaecologist by several historians recently. Yet he was the first medical man to employ medical women, proposing

45. BMJ (8 June 1872, 616; Lancet (22 June 1872), 885; Lancet (3 & 24 Aug. 1872), 171 & 279. Atkins had begun training for the LSA with Garrett Anderson before this route was closed, and then took the quiet route in to medicine via a European degree. She registered via the LKQCPI in 1877. BMJ (1 Nov. 1924), 836-837.

46. British Medical Journal, i (15 March 1924) pp.502-3. On Sturge MWF Newsletter (July 1925) 12-15.

(unsuccessfully) their membership of the British Gynaecological Society at its foundation in 1885; and he was regarded by some contemporary medical women as a 'friend'.⁴⁷

These apparent inconsistencies are resolved if we remember that, first, (this is the point made in Chapter V), conservative attitudes towards many aspects of women's lives, were not necessarily incompatible with support for medical women. Second, it seems possible that the idea of female chaperonage to give respectability to a young gynaecologist may have played a part. Finally, in Tait's support for medical women, there are strong hints of paternalism; women were essentially his assistants rather than his colleagues.

A second factor in these appointments was local support for medical women, stimulated by the contemporaneous events in Edinburgh. Tait's hospital had been supported by prominent local Liberals, notably the Chamberlain brothers. The hospital's lay governors approved Atkins's appointment. In 1873, there was a well-publicized effort for women's admission to medical classes at Queen's College, resisted by staff and students. The early support for medical women at the Birmingham Hospital for Children, has already been mentioned.⁴⁸

47. Biographies of Tait include J.A. Shepherd Lawson Tait, The Rebellious Surgeon, Kansas, Coronado, 1980; I.H. Flack Lawson Tait 1845-1899 (London: Heinemann, 1949); W. Risdon Lawson Tait: A Biographical Study (London: National Anti-Vivisection Society, 1967). Citations of his misogyny include Lewis Women in England, p. 98 and Burstyn Victorian Education, pp. 85-86. On Tait's support for medical women see Flack Lawson Tait p. 97; MWF Newsletter (Nov. 1926), 45-46.

48. Englishwoman's Review (15 July 1873), 227; BMJ (15 March 1924) 502-3. See also Ch. V. 2 women held posts at both Birmingham Hospitals.

Hospitals for children were another aspect of the proliferation of doctor-initiated special hospitals in the second half of the nineteenth century. The same mixture of motives were apparent: of gaining clinical experience, of meeting unmet needs, and of philanthropic supervision of the poor as in women's hospitals. In children's hospitals, the last was perhaps more important, and there was less impetus for a distinctive hospital-based specialty of children's illnesses.⁴⁹ If any hospital work was suitable for women, this was. In 1870, Garrett Anderson was appointed visiting physician at the East London Children's Hospital at Shadwell, begun in 1868 by her mentor from the London Hospital, Nathaniel Heckford, and his philanthropist wife.⁵⁰ In total, six first-generation women held subordinate resident appointments, and three more eventually held honorary appointments at small hospitals like the East London. Again, this was not always without controversy.⁵¹

49. Abel-Smith Hospitals, pp. 24-25.

50. Her appointment aroused some opposition. She resigned in 1873, because of the birth of her first child, regretting that no woman honorary was appointed in her place. Manton Elizabeth Garrett Anderson, pp. 193-199, 235. The next woman honorary was Hazel Chodak Gregory, appointed in 1923. Journal MWF (April 1952), 52-53. In 1886, the first woman clinical assistant, Jane Walker, was appointed. BMJ 26 Nov. 1938) 1120.

51. In 1873, the then unregistered Eliza Dunbar Walker (1845-1925) MD Zurich 1872, LKQCPI 1877 was appointed house-surgeon to Bristol Royal Hospital for Sick Children. Shortly afterwards, a senior consultant resigned, accusing her, according to the Lancet, of neglecting patients and of impertinence, one of the first of many charges against medical women of breaches of professional decorum. Though the lay committee refused to request her resignation, she resigned after a month to set up in private practice in Bristol. Lancet (16 Aug. 1873), 241 & (27 Sept. 1873), 464. A different account is given in Englishwoman's Review, Jan 1874, pp. 54-55.

The significance of these few hospital appointments lies not in their scale but in their constituting evidence that there were, in the special hospitals movement, small spaces for medical women to pursue their mission of care (and control) of women and children. This movement was one of medical entrepreneurship in the context of a general increase in institutional care for the sick, the mad, the bad and the destitute, provided by both philanthropists and the state.

Many of these institutions were strictly ordered by gender, creating the possibility of medical care along gender lines, and hence a few opportunities for medical women. In providing initial career steps this was to be important for the second generation. But among the first generation we see the earliest of miscellaneous honorary appointments—as medical officers to homes for orphans and fallen women and girls' reformatories, as inspectors of boarded-out children, and for school boards and the like; appointments that characteristically complemented pre-1914 medical women's private practice.⁵²

The expansion of women's employment opened up another potential space for the woman doctor. In 1883, Henry Fawcett, Garrett Anderson's brother-in-law, then Post-Master General, appointed Edith Shove as a fulltime medical officer to monitor the health of the growing numbers of women post office workers. This was the first public appointment held by a medical woman. Three more first-generation women later held part-time posts with the

52. These are listed in successive Englishwomen's Yearbooks.

GPO in Manchester or Liverpool. ⁵³

Nor were all these opportunities with working-class patients. From the 1880s onwards, some of the new middle-class girls' secondary schools appointed medical women. They taught hygiene and often remedial gymnastics, and monitored the effects on health of the controversial educational development which these schools embodied. They were also perhaps role models for the girls.⁵⁴ Julia Cock, who was later to commend the efficiency of these schools in producing women medical students, was for many years medical officer to North London Collegiate School and Camden School for Girls, taking over from other first generation women in both.⁵⁵

These, then, were the few opportunities that the first generation found in existing institutions for women and children, for either initial experience, or as complements to general practice. But more important, for this generation, and in the long run, were the opportunities the women themselves created in their own hospitals. This returns us to Garrett Anderson and her dispensary.

53. Manton Elizabeth Garrett Anderson p. 265. This sole full-time salaried appointment among the first generation, was held by one of the poorest students. Scharlieb Reminiscences, p.56.

54. D. Gorham The Victorian Girl and the Feminine Ideal (London: Croom Helm, 1982), pp. 90-91. R.M. Scrimgeour (ed) The North London Collegiate School 1850-1950, Oxford, Oxford University Press, 1950, p. 127. S.A. Burstall & M.A. Douglas (eds) Public Schools for Girls, London. Longmans, 1911, pp.220-1; P. Atkinson 'Fitness, Feminism and Schooling' In The Nineteenth Century Woman. Edited by Delamont & Duffin esp. pp. 110-3.

55. Cock (1868-1914), LKQCPI 1882, Lancet (14 Feb 1914), 117.

The First Hospitals Run by Women for Women

By 1871, working-class women from all over London were attending Garrett Anderson's dispensary, suffering from conditions for which surgery was becoming the approved treatment. The logical development of this philanthropic venture was therefore a hospital run by women, which would preserve these women's modesty while increasing medical women's experience. The New Hospital for Women began in 1872, as 10 beds above the dispensary, with Garrett Anderson as honorary physician, assisted by the unregistered Hoggan (then Morgan). In 1874, it moved to the Marylebone Road, with the grand total of 26 beds, and remained there until 1890, when it moved to its Euston Road site, where there were 42 beds. It became the Elizabeth Garrett Anderson Hospital in 1917.⁵⁶

At the NHW, Garrett Anderson began to perform major surgery, sometimes with the assistance of experienced men. Undertaking ovariectomies, from 1876, aroused concern from among her lay committee and led to Hoggan's resignation.⁵⁷ This was partly because of her inexperience and the objective risks of the operation, but also because ovariectomy symbolized the new interventionist gynaecology. To its critics it was 'spaying' or 'vivisection', reducing women to objects by desexing them, based on a dehumanizing and materialist approach to medicine. In undertaking it, Garrett Anderson was rejecting the idea of women's medicine as

56. Manton Garrett Anderson, pp. 226-230; Anderson Elizabeth Garrett Anderson pp. 241-250.

57. Manton op.cit, pp. 227-229; Bell Storming the Citadel, p. 144 describe the incident, not its wider significance. Hoggan became alienated from Garrett Anderson and the LSMW.

moral hygiene that Blackwell and Hoggan commended.⁵⁸

This hospital work was what enabled Garrett Anderson to develop the extensive, but not exclusively, surgical private practice that I have already referred to. She was the only woman in England to do major surgery in any setting before the late 1880s. But the NHW was important for far more than its impact on her professional career. It was the main source of hospital experience for the first 59. In total, twenty worked there at some time.

Behind this was, first, Garrett Anderson's association with those who took the 'quiet route' into medicine and then the close ties between the NHW and the LSMW. From 1874, LSMW students were welcomed at the hospital of their only woman lecturer, initially their only source of clinical experience. As its work expanded, it could offer one or two resident posts a year, clinical assistantships and, eventually, a few honorary positions for those established in London practice. This in turn provided opportunities for women to be (part-time) clinical teachers of the LSMW students. Of ten first generation women who lectured at the LSMW, seven held honorary posts at the NHW for at least ten years.

These were the women who were the educators, sponsors and role models of the next generation. Their careers had generally been chequered before they reached these positions. Neither the hospital nor the school could provide opportunities for orderly

58. Mosciucci 'The Science of Women' discusses the controversy over ovariectomy but not in relation to medical women. On Blackwell's criticisms of excess surgery by medical women see Sahli 'Elizabeth Blackwell', pp. 348 & 366-368.

careers before the 1890s. The first women honoraries at the NHW were not specialists, but acted as consultants to their women colleagues and ex-students in private practice. They built up the work of the hospital, and sought opportunities for their juniors.

Foremost among them was, of course, Garrett Anderson, as both Dean and senior physician. One of many examples of her patronage in this tiny world was her careful paving of the way for Scharlieb, on her return from India in 1887, to take over her surgical work at the enlarged NHW in 1890, through junior appointments at school and hospital and in her private practice.

But the choice of Scharlieb revealed the limited scope for surgical training that a hospital with 26 beds could provide. She had gained her experience by means of the 'unlimited opportunities' in India, not in England. Scharlieb's appointment, and the enlargement of the hospital, brought about a major development in the surgical work, especially gynaecological surgery, at the NHW.⁵⁹

Garrett Anderson's example in founding a hospital to be run by women for women (or children) was followed by others of the first generation in Britain. Jex-Blake added 'a few beds' to her dispensary in 1885, to create the Edinburgh (later Bruntsfield) Hospital for Women and Children. Four of the first generation held

59. Scharlieb *Reminiscences*, pp. 132-137. Another example of an NHW honorary/LSMW lecturer whose Indian experience had given her special expertise was Charlotte Ellaby (1854-1900) MD Paris 1884, LSA 1889, who was the NHW's first ophthalmic surgeon from 1890. BMJ (29 May 1909).

short-term posts here.⁶⁰ In 1895, Dunbar opened the 12-bedded Bristol Private Hospital for Women. Reflecting, as the name suggests, general trends in hospital development, this hospital aimed to bring 'hospital treatment for women by women within reach not only of the so-called poor, but of women higher in the social scale yet to whom the advantages ... are equally needful.'⁶¹

Three more first generation women established special hospitals in Britain. The role of the Clapham Maternity Hospital and School of Midwifery's in teaching LSMW students has already been mentioned. Evolving from McCall's dispensary, it embodied her efforts to 'initiate a service for women and children by skilled women' (doctors, nurses or midwives) and to 'wipe out the attitude of leaving the twin problems of health and hygiene to chance'. Here sanitarian and social maternalist ideas of medical women as agents of moral and health reform evolved into the idea of training female experts to educate mothers. Opposition to excessive intervention in obstetrics, and a strong reliance on the preventive and curative powers of vis medicatrix naturae, were combined with an authoritarian approach in which professionalism was uppermost.⁶²

Discipline and hygienic living were also the basis of treat-

60. Todd Sophia Jex-Blake, pp. 456-459.

61. Englishwoman's Review (15 Jan. 1896) 42-43. The hospital was later renamed the Walker Dunbar Hospital. MWF Quart. Rev. (Oct. 1938), 83. The NHW opened pay-beds in 1900. Daily Telegraph 25 Dec. 1900 (RFHSM PC Book IV).

62. Barrass Fifty Years of Midwifery, p.57. See also Bell Storming the Citadel, pp. 145-146. The hospital was renamed the Annie McCall Hospital in 1936.

ment in open-air TB sanatoria, with their highly structured regimen of exercise, food, air and water, and occupational therapy. Medical women pioneered their introduction to Britain. McCall herself opened two small sanatoria in the 1890s, influenced by her friend Jane Walker, for many years honorary physician at the NHW, who had opened the first in Britain, in 1892, followed by Naylands Sanatorium, Suffolk, in 1901.⁶³

The very first hospitals run by women for women, the NHW, the Edinburgh and the Clapham, did not spring merely from unprecedented feminist responses to women's exclusion from male hospitals. They developed in a context in which many hospitals, including ones for women, were being founded by male doctors motivated by a complex mixture of philanthropic, professional and entrepreneurial impulses. Hospitals run by women for women were the logical extension of the case for medical women, providing institutional care that did not violate women's modesty.

But they have great significance, particularly the NHW, for the careers of the early professional women. They were institutions where women could develop professional skills, and achieve positions of responsibility from which they were otherwise largely excluded, both by overt opposition and by the limited mandate. As we shall see, this function became increasingly evident as more women entered medicine. But the opportunities

63. Bell Storming the Citadel, p. 146; Barrass Fifty Years in Midwifery, p. 85. The third sanatorium started by a first generation woman was Woodburn near Edinburgh, started by Isabella Mears and her husband. BMJ (21 Nov. 1936), 1063. On Walker see BMJ (26 Nov. 1938), 1120; MWF Quart.Rev. 1939, 17-25. I am grateful to Linda Bryder and Michael Worboys for information on early women's work in TB institutions.

these institutions could offer to larger numbers of women seeking professional equality were few, and, as with the separate schools, the paradox remained of seeking professional equality through segregated institutions.

Many more first generation women were involved in establishing or working in hospitals for women in India, as mission institutions, as local secular initiatives, and through the Countess of Dufferin's Fund. By 1900, the latter's annual report claimed 235 hospitals, dispensaries and wards officered by women, for women, with 35 first grade women doctors and 73 assistant surgeons, most of whom were British trained.⁶⁴

While in a narrow professional sense, women in India had more opportunities to develop their skills than those in Britain, they mostly occupied very different positions. They were pursuing organizational careers, subject to much more extensive control by sponsoring bodies, notably the Dufferin Fund, where women were formally subject to inspection by male, often inexperienced, civil surgeons.

Detailed accounts of the early women's careers in both lay and religious hospitals are full of arguments over equal status

64. The Indian Magazine, (Oct 1900) p. 267,
 Most of these institutions had nothing to do with the Fund, whose claiming credit where none was due was one source of annoyance to medical women in India after the 1880s. Space does not permit detailed discussion of individuals' careers. For a brief accounts see Bell Storming the Citadel pp. 111-125 and Balfour and Young Medical Women in India. NB. Bell's figure of 183 hospitals staffed by women in Great Britain in 1927 (op.cit, p. 148) is in fact the Dufferin fund's claim for India in that year. Balfour & Young op.cit, p.182.

and professional autonomy.⁶⁵ This becomes more pronounced over time, and among members of the second generation, who perhaps saw themselves primarily as professional women, rather than as women who happen to be doctors. This came to a head in 1910 with a press campaign at home and abroad for an autonomous, fully professional women's medical service for Indian women and children.⁶⁶

To summarize, the tiny first generation of women found no existing market for their services except, in a highly constraining way, in India. Those who made their careers in Britain had to build up professional reputations as individuals in an essentially entrepreneurial system of medicine. They took what opportunities they could find on the margins of contemporary medicine, or in institutions for women and children, or created their own. In doing this they were setting patterns and creating opportunities for those who came after them.

The Careers of the Second Generation

For women qualifying in medicine between 1887 and 1914, there were still, as we have seen, many institutional barriers to their full entry to the medical club. But the major battles to get any kind of medical education were over. By the mid-1890s a small

65. For an account of Beilby's conflicts with her mission authorities over private practice see Pollock Shadows Fall Apart, pp.96-100. See also Lutzker Pechey Phipson; Burton According to the Pattern.

66. Such a service was established in 1916. But by this time, work in India was very unpopular with British trained women. See Balfour & Young Medical Women in India, pp. 44-53.

group of the first generation had achieved considerable professional success. The struggle now was to establish opportunities for a larger number of qualified women, to demonstrate that the early entrants were not exceptional women.

As for the first generation, the problem these women faced was how to get started, how to get any post-qualification experience, whatever their intended career, given that so many opportunities were closed to them. Initially the numbers qualifying each year were small, ten or twelve a year; but by 1910, they had increased at least five-fold. The problem became more acute, not less, particularly for women who were not well-off. Those who could afford to, could wait for a good opportunity, or study abroad. The majority 'could not afford to be exigent and grasped whatever posts were available'.⁶⁷

This was not just a problem for those intending careers in Britain. Those intending missionary careers were constantly urged to prepare themselves adequately for their gruelling work in professional isolation. But this was not easy. Some went to resident posts in India. Others struggled at home to piece together appropriate experience.⁶⁸

67. Hutton Memories of a Doctor, p. 102.

68.E.g. Ellen Farrer (1865-1959) MB BS 1890 canvassed in vain for opportunities at the RFH but did achieve a few weeks observation at Great Ormond St. Children's Hospital and an eye clinic, about ten days work at a medical mission in Kentish Town, and 4 months as resident medical officer at the NHW.

Hospital Work for Medical Women: 1887-1914

The most desirable post-qualification opportunities were still afforded by the junior posts in hospital. Table 7.1 presents an estimate of the number and type of such hospital posts held by newly registered women in 1889, 1899 and 1908 in Great Britain. Probably not more than a third of all qualifiers ever held such a post.⁶⁹ For those that did, the importance of the hospitals run by women throughout the period is clear, as is that of voluntary hospitals for women and children. There were women in posts in general hospitals, but, apart from the RFH, these were almost all state institutions. The other development is the small number of posts in lunatic asylums.

The five women in houseposts in 1889 were drawn from the twenty, all LSMW qualifiers, whose names were added to the Register between 1887 and 1889.⁷⁰ The only appointment outside the women's hospitals was Sarah Gray's appointment to Homerton Fever Hospital, the first appointment of a woman to a general hospital in Great Britain, and this post was to be regularly filled by LSMW students for many years.⁷¹

This was the first of several poor law institutions which

69. In the text I use 'housepost' to cover all the posts identified in the table, that is posts normally held by a newly qualified doctor. I have endeavoured to include only posts that women held during the given year and not past posts but a few of these may be included. Numbers for 1908 are probably underestimates, but there is no reason to suppose that the overall pattern would be different if more data were available.

70. Six went directly to India, seven to study abroad (three took British houseposts later). One was a demonstrator at the LSMW, later holding houseposts, two have no appointments that I have traced, perhaps entering directly into private practice.

71. Englishwoman's Review (15 March 1889) 143).

TABLE 7.1

"Houseposts"^a Held by Medical Women
Qualified For Less than Four Years

	1889	1899	1907
Hospitals run by Women	3	12	24
Voluntary Hospitals for Women/Children	1	15	12
Royal Free Hospital	0	3	6
Poor Law & Metropolitan Asylums Board	1	7	13
Lunatic Asylums	0	10	8
Dispensaries for Women & Children	0	4	2
Other General Hospitals	0	0	3
	4	51	66

Sources: Englishwoman's Yearbook; Medical Directory

a. Includes posts described as 'resident medical officer'; 'house surgeon'; 'house physician'; 'anaesthetist'.

regularly appointed women from the 1890s, as a specific policy adopted by particular medical superintendents or boards. Similarly a few large asylums (public and private) appointed women regularly from the late 1880s.⁷² After 1889, women students were advised to seek such openings.⁷³

These appointments did not necessarily mark a radical break with the idea of women as doctors for women and children. The appointments were usually to the women's sides of infirmaries, or to women's asylums, like Holloway. When, as sometimes happened, a woman's appointment to a mixed institution was challenged, a high proportion of women and children among the patients might be cited as justification for appointing her.⁷⁴ Objections raised included lack of suitable facilities for lady doctors, male medical staff's difficulty in consulting lady colleagues, and the impropriety and ill-discipline that would arise if women saw male patients when their male colleagues were absent. Some pointed out the grave disadvantage to young male residents for subsequent promotions if they were deprived of the valuable experience on the women's

72. Two institutions in or near London that appear frequently, besides Homerton Fever Hospital are Camberwell and Tottenham Infirmaries and Claybury Asylum. In Scotland, in the early 1900s, Stirling Asylum was regular source of experience for the Edinburgh students, under G.M. Robertson's superintendence. Hutton Memories of a Doctor. p.45.

73. The number of such appointments increases for a time around the turn of the century, possibly due to a shortage of young male doctors due to the Boer War. Daily Telegraph 30 June, 1899; Globe 8 Aug. 1901 (RFHSM PC Book III).

74. E.g. Liverpool Mercury 12 Oct. 1901; Lincoln Echo 17 Oct 1901. (RFHSM PC Book III)

wards.⁷⁵ A state of affairs analogous to that seeming to threaten these young men was to disadvantage women within the public asylum service for many years: lack of experience on male wards barred promotion.⁷⁶

Appointments to voluntary general hospitals were less likely than to poor law hospitals partly because competition from men was likely to be stronger. Voluntary general hospitals (other than teaching hospitals) were also usually smaller, and unlikely to have child patients. The case for having separate women housestaff, for women and children only, could less easily be made, and medical staff and lay governors could object to the inconvenience more strongly than in state institutions.

There were a few isolated appointments of women to general hospitals from 1891. But, until 1914, the posts at the RFH for women were the only ones in general voluntary hospitals regularly filled by women. The RFH was a very small teaching hospital, of about 165 beds until 1914. When women were eventually appointed, the work of the housestaff had to be re-arranged to permit women to be in charge of female wards only. Until the late 1890s, posts at the NHW were undoubtedly the 'mecca' for newly qualified medical women, giving unrivalled clinical experience (for women) and the patronage of established women. This was as true for women from outside the LSMW as for those who had studied there, though few of the former were appointed. But, after 1900, the RFH

75. E.g. Daily News 26 Nov 1903; Westminster Gazette 16 Feb 1904 (RFHSM PC Book III; Common Cause (29 Sept & 10 Oct. 1910).

76. MacKenzie 'Psychiatric professionalization', p.118.

posts were even more prized by LSMW students.⁷⁷

As women were admitted as students to provincial teaching hospitals, arguments about their admission to houseposts became intense. In their search for professional equality, women no longer felt publicly bound by the delicacy arguments. In 1909, the continued refusal of the governors of the Manchester Infirmary to accept the medical staff's recommendation that women be offered such posts provoked considerable local controversy. The governors argued that few women and no men wanted women doctors, that there were many things a woman doctor could not do or ask a man, and that their numbers did not justify re-arranging the existing system to provide women-only hospital experience. The Northern Association of Medical Women protested that there were no reasons why women should not treat men and therefore no need for any re-organization to give women the same opportunities as men. But the governors were unmoved.⁷⁸

Until 1914, therefore, it was still the special hospitals for women and children that provided most (of the few) housepost opportunities. Among those not run by women, hospitals for

77. In 1891 two women from the Edinburgh School were appointed to Leith General Infirmary (their teaching hospital). But this did not become a regular source of posts for women. Also in 1890, Dr Helen Wilson (MB 1889), was house physician to the London Temperance Hospital. MWF Quart. Rev (July 1931) 79-80. In 1901, the honorary staff of Macclesfield Infirmary resigned when the lay governors appointed Annabel Clark (MB ChB Glasgow 1901) as house physician, not their nominee. Daily Telegraph 27 Nov. 1901; 7 Dec 1901; 31 Jan 1901. On women housestaff at the RFH see Malleson Mary Murdoch, p. 26; Lawrence Shadow of Swords, p. 61. Jnl.MWF (Oct 1952), 72-74. Magazine of L(RFH)SMW (1919), 125.

78. BMJ (11 Dec. 1909), 1710; BMJ (18 Dec. 1909), 1774; BMJ (25 Dec. 1909), 1909.

children were the largest source of posts. Again, the same few institutions appear year after year, Birmingham, East London, Victoria Hospital in Hull, and, most prestigious, from 1890, the Belgrave Hospital, Kennington. These appointments can generally be attributed to particular medical men and women, whose ability to exercise patronage on behalf of the women was often limited by their junior status, or by the opposition of colleagues or lay boards.⁷⁹

Between 1899 and 1907, the number of women holding houseposts in hospitals run by women doubled. This was partly because existing hospitals had expanded a little. The NHW had 60 beds by 1907—by far the largest. The Edinburgh Hospital had opened on its Bruntsfield site in 1899, with ten ward beds and three private rooms, expanding to 40 beds in 1911.⁸⁰ But the number of such hospitals had also grown. Between 1899 and 1916, there opened at least ten small hospitals for women or children, and at least three tuberculosis sanatoria run by women.⁸¹

Like the ones described earlier, the origins and aims of

79. Mr Clinton Dent, appointed Frances Dickinson (later Berry) first woman house surgeon to the Belgrave. He was asked not to repeat the invitation he extended to her to attend his operations at George's, 'and though a man who disliked being dictated to, he had to comply.' MWF Newsletter (March 1928), 17-18. Berry's husband, honorary surgeon at the RFH, was one of many RFH staff who individually advised the women but who could exercise little patronage until after 1900. Eg. Scharlieb Reminiscences p.167-168.

80. Daily Telegraph 25 Dec. 1907; M.W.M. Campbell 'Three Scottish Women's Hospitals from their foundation until 1948'. Lecture delivered to Scottish Society for the History of Medicine, 28. Nov. 1981. The Clapham and Naylands had also grown.

81. There were also several nursing and convalescent homes and small short-lived private asylums not included here.

these varied. One, and the beginnings of a second, were clearly part of the women's philanthropic mission to the slums of London. The Canning Town Hospital for Women, opened in 1900 when a few beds were added to the Canning Town Women's Settlement Dispensary, which had opened in 1891.⁸² Other general hospitals founded by women were also associated with existing dispensaries but opened in respectable areas of cities. These were the initiative of established local women doctors, excluded from appointments at local voluntary hospitals and seeking beds for their patients.

In Edinburgh, the Medical Women's Club's Hospital was founded in 1899, by local medical women, as an alternative to the Bruntsfield. It had three private rooms at one guinea a week and four beds in a ward for half-a-crown a week. It closed in 1904, when Elsie Inglis opened her Hospice, which was intended primarily to provide surgical, gynaecological and obstetrics in- and out-patients services for working-class women. In 1910, the Hospice and the Bruntsfield were amalgamated administratively. In 1903, the Glasgow Private Hospital for Women, opened with eight beds, followed soon after by a similar one in Dundee. These two for better-off women.⁸³

The New Sussex Hospital for Women was another general hospital that was developed by women doctors and a lay committee

82. Bell Storming the Citadel, p. 147. Missionary motives led Selina Fox (?-1959) MB BS 1899, to found the Bermondsey Medical Mission in 1904, which became a small hospital for women and children in 1921. Jnl. MWF 41 (April 1959), 72.

83. Lawrence Shadow of Swords, pp. 74-77, 86-87; Campbell 'Three Scottish Women's Hospitals.'

associated with a dispensary founded in 1898. But its immediate cause was the persistent refusal of the Royal Sussex County Hospital to appoint women, specifically Martindale, to its staff. It opened in 1912, initially with twelve beds at three guineas a week for private rooms, and seven shillings and sixpence for a ward bed.⁸⁴

Brighton was also the site of one of the special hospitals founded by second generation women. The Lady Chichester Hospital for the Treatment of Early Nervous Diseases (of women), which opened in 1905 with ten beds, was the first hospital specifically for the treatment of neurosis in Britain. Boyle had begun her medical career at the Canning Town Mission, and then worked for two years as assistant medical officer in the London County Council's Claybury Asylum. She visited clinics on the continent before settling in Brighton to establish this hospital and private practice.⁸⁵

Although one area considered suitable for medical women was the care of children, women were not welcomed in all children's hospitals. Failure to get a post at the Manchester Children's Hospital led Catherine Chisholm, one of the first two women to graduate from Manchester in 1904, to establish the Manchester Babies' Hospital in 1912 with twelve beds, which was to train many

84. Martindale Woman Surgeon, pp. 127-130.

85. Helen Boyle (1870- 1957) LRCP&S Edin: 1893 R. Dingley 'Hospitals started by women doctors' Jnl. MWF 49 (April 1967), 109; Jnl. MWF 40 (Jan. 1958), 73-74.

of 'Dr Chisholm's young ladies' in the future.⁸⁶ Another special hospital for children opened by women doctors was the Harrow Road Hospital. This opened in 1911, owing largely to the efforts of Flora Murray and Louisa Garrett Anderson, the latter well established in private practice with an appointment at the NHW and close connections with the LSMW. Here from the start, giving training opportunities to women doctors was a major explicit aim.⁸⁷

This was also true for the last, and largest, of the women's hospitals founded in this period, the South London Hospital for Women. This was the initiative of Maud Chadburn and Elizabeth Davies-Colley, two women with established reputations as surgeons and honorary appointments at the NHW. They were conscious of the demand by qualified women for training facilities, and of the large number of women seeking treatment who were being turned away from the small NHW. After an extraordinarily successful fund-raising campaign, a hospital with 80 beds was opened by the Queen in 1916.⁸⁸

These, then, were the hospital opportunities open to newly

86. Chisholm (?-1952) had earlier worked in houseposts at the Clapham Hospital. Jnl. MWF (Oct 1952), 72-74. In 1935 the hospital was renamed the Duchess of York's in 1935, and began appointing men to the staff.

87. Murray (?-1923) (MB BS 1900); Anderson (1873-1943) MB BS 1897. F. Murray Women as Army Surgeons (London: Hodder & Stoughton, 1920) p. 258.

88. Chadburn (1868-1957) MB 1894. The success of the fund-raising was largely attributable to the intemperate opposition of a medical man, and ensuing correspondence in the Times. M.E. Ridler 'The South London Hospital for Women' MWF Newsletter (July 1933), 19-25.

qualified women before 1914—opportunities in sexually segregated public institutions, in a few voluntary hospitals for women and children, and in these few hospitals run by the women themselves. For most of the minority of women who did hold such posts, whatever the type of hospital, they were means of getting experience and testimonials, but not entry points into an orderly career line.

For example, one 1895 graduate, with very limited resources, her father having three sons to set up, was fortunate in obtaining, through [Garrett Anderson's] patronage, a resident post at a hospital for women and children. Determined on more experience before entering private practice, she spent a second year in a similar hospital and two years in a poor law infirmary as resident physician. Several months as medical attendant to a wealthy Army officer's wife gave her free overseas travel. After all this, some four years after qualifying, she had £300 saved, after careful economy.

'Long I debated the point—public appointment versus private practice. Ambition favoured the latter, prudence the former...private practice meant big initial expenses and ... little or no income for the first year at least. ...I cast my eye over the list of possible appointments... I thought of the salaries, varying from £100 to £450 or £500 a year but could not be content with anything similar just then.'⁸⁹

The consequence was that, in 1899, she took an appointment in Egypt, for £100 a year, travelling expenses and 'liberty to secure private practice'—another woman lost from British medicine. This

89. Anonymous 'What it means to be a lady doctor' Home Chat (18 Nov. 1899, 485–486. (RFHSM PC Book IV). The context makes it clear the patron is Garrett Anderson. The author appears to be Henrietta Cornford MD, who, as Mrs Trevithick, was still in Cairo in 1909, according to Englishwoman's Yearbook, 1909.

kind of disorderly experience was probably typical, though most of her peers opted for the slow process of building up private general practice in Britain, perhaps developing hospital links or gaining other appointments subsequently.

Table 7.2 gives an estimate of the number and type of posts in public and private institutions held in Great Britain by medical women qualified for at least five years in 1889 (when all the women recorded were of the first generation), 1899 and 1909. The vast majority will have been part-time and honorary (except for teaching and public service) posts, held in addition to private practice. Some of the posts will have been quite lowly or only requiring a few days work a year. Many women held more than one such post, as one sign of public recognition led to others.

The number of posts held increased considerably over the 30 years, though the growth is less impressive when the increase in number of women qualifying is considered.⁹⁰ But the type of posts held remained remarkably constant, still involving, almost exclusively, work with women and children. The largest concentration of posts remained at the LSMW and the NHW, but a growing number held minor posts at the RFH. The effect of the growth in hospitals run by women is shown (though several of those discussed earlier were started after 1909). Other voluntary hospital

90. These are underestimates of numbers of posts, particularly for 1909, but the distribution of posts is probably a reasonable approximation. The information is insufficient to calculate whether the overall increase in posts held is proportionate to the increase in numbers of women qualified, but it seems unlikely that hospital appointments were keeping pace.

TABLE 7.2Positions held by Established Medical Women in Great Britain^a

	1889	1899	1909
NHW/LSMW	8	34	48
RFH	0	2	17
Other Women's Hospitals and Medical Schools ^b	3	8	21
Voluntary Hospitals for Women/Children	5	22	27
TB Sanatoria	0	0	9
Other Voluntary Institutions for Women/Children	10	36	45
Asst. MOH, School Medical Inspectors	0	0	30
Lectureships in Hygiene, Home Nursing, etc.	0	0	12
Other Institutions	0	19	20
<hr/>			
Total Positions ^c	16	121	229
<hr/>			

Sources: Englishwoman's Yearbook; Medical Directory

- a. Includes women qualified for five years or more
- b. Excludes TB Sanatoria run by women.
- c. A given woman may hold more than one post.

appointments were few and still concentrated in hospitals for women or children.

Behind these cross-sectional figures are a few "specialist" careers. For several, like Helen Boyle, resident posts in asylums led to careers in the field of mental illness, despite the lack of promotion prospects for women in the public asylum system. Boyle pursued her career by entrepreneurship. Hutton had a male sponsor to help her overcome opposition to women's promotion in asylum work in Scotland. She was appointed physician in charge of the women's side at the Edinburgh Royal Mental Hospital in 1912.⁹¹ Others moved from resident posts at Naylands or other sanatoria to found their own, and tuberculosis medicine continued to be a field in which women were prominent.⁹²

By 1900, there were also a few women who had made relatively orderly progress towards a true consultant career, achieving senior honorary positions and reputations within ten years of qualifying. Such careers were, not surprisingly, centred on the NHW, often in association with the LSMW. Junior posts at the NHW or the RFH were clearly crucial first stages in these careers, appointments to such indicating the confidence of teaching staff

91. Hutton Memories of a Doctor, pp. 115-128. At least three others can be identified as mental health specialists, who were to form a nucleus for women's interest in the field in the 1920s.

92. Walters Sanatoria, Appendix 1, lists six sanatoria staffed by women in 1913, in addition to the ones founded by the first generation. Most of these women started at Naylands. One who did not was Esther Colbrook Carling (?- 1957) LSA 1896, founder of Maitland Hospital, Peppard, Berkshire, and a rival to Jane Walker as the leader of the women in this field. Jnl. MWF 39 (July 1957), 228. (I am grateful again to Lynda Bryder for information about the relationship between these two women.)

and leading to opportunities for professional experience. But not all who held such houseposts went on to achieve or even attempt consultant careers. Not all honoraries at the NHW by 1914 had such orderly careers; but it is significant that a few had.

The tightening of the referral system in London, the growth of the market for women-only medical services, and of training opportunities for women, had made possible this tiny group of women, mainly surgeons and gynaecologists, for whom substantial hospital experience was more crucial than for physicians.⁹³ They gave second opinions for their women colleagues and ex-students in general practice. And they were gradually taking over from the first generation as the teachers of women medical students. These were the women who were to transmit the new image of female professionalism.

Outside London, or cities with medical schools, opportunities for this kind of career were scarce for women (or for men) by 1914. Appointments at most voluntary hospitals would still have been combined with general practice. And this was true for those who started their own hospitals outside London. This rarely meant abandoning general practice, or not for many years. When the New

93. Examples of surgeons were Aldrich-Blake, Chadburn, and Elizabeth Bolton (1878-1961) MB BS 1904, consultant surgeon at the NHW from 1910 to 1940, and Dean of the LSMW from 1931 to 1945. Jnl MWF (July 1961), 433. (Almost all the surgeons were unmarried). Gynaecologists were Ethel Vaughan Sawyer, (?-1949) MB BS 1896, senior gynaecological physician at the RFH after Scharlieb. Jnl MWF (April 1949), 45-46. One of the few moving outside London was Frances Ivens Knowles, (?-1944) MB BS 1900, who after a series of appointments at the RFH took charge of the gynaecological department at the Stanley Hospital for Women, Liverpool. Jnl MWF (April 1944), 40-43. Both these women married quite late in life, Miss Ivens moving to Cornwall on doing so.

Sussex Hospital opened in 1912, Martindale, as senior surgeon, began doing more consultant surgical work, but she retained a substantial private general practice until 1921. Then she moved to London to establish herself as a consultant gynaecological surgeon, retaining her honorary post at the New Sussex and using nursing homes for her London private patients.⁹⁴

As these examples show, there were a few women doing major surgery (and many doing minor surgery as part of general practice). Much of this work was gynaecological, since their patients were women who had specifically selected a woman doctor. Though the RFH remained the only general hospital with a senior woman gynaecologist, there were a few women holding senior appointments in provincial hospitals for women. But the barriers to women's obtaining senior surgical posts were still immense, with their limited hospital opportunities, and exclusion from the RCS. Given their lack of experience it is not surprising that many women clearly had doubts about undertaking this kind of work, especially given the image of the work.

Opponents of women surgeons argued that because major surgery required strength, courage, quick decision-making and ability to bear great responsibility, it was unsuitable for women, incompatible with femininity. A reluctance to believe that women could exercise responsibility, or to submit to a woman's authority, is indicated by accounts of the opposition to women seeking senior appointments to the staff of hospitals for women

94. Martindale Woman Surgeon, pp. 128, 185-191

with mixed staffs.⁹⁵ Those women who did do major surgery were often not credited with the masculine qualities of the surgeon. Rather, 'the small hands and delicate touch of women' that made for a good needlewoman equipped them for conservative surgery. 'Whoever has seen Mrs Scharlieb quietly knitting at a committee of both men and women could doubt that?'⁹⁶

But perhaps more compatible with femininity was another way in which women might be involved in hospital surgery—the giving of anaesthetics. Before 1914, these were generally administered by house-surgeons, as a normal part of their work, or by general practitioners holding assistant surgeon or clinical assistant posts. Major hospitals might have special house and junior honorary posts specifically termed 'anaesthetist'. In all cases it was a subordinate task.

It is, therefore, not surprising that anaesthetics provided the first regular opportunities for women at the RFH, or that many other young women started their hospital work by doing this. So did many men. But the proportion of young men for whom these posts were steps to a surgical career was probably greater. In 1909, probably half of the honorary posts held by women in hospitals with mixed staffs involved administering anaesthetics for male surgeons. Few made the transition from assistant to full surgeon. The nature of the social relations of the operating theatre was

95. Eg. MWF Quart. Rev (April 1941), 59.

96. Illustrated London News (12 May, 1900) RFHSM PC Book IV; BMJ, Nov 29, 1930. It is possible that this had some bearing on the interest a number of early women had in ophthalmic surgery, but this probably stems from the importance of this work in India.

possibly an early factor in making anaesthetics a field suitable for women.⁹⁷

The other rows in Table 7.2 show how second generation women were also heavily involved in a range of activities concerned with the medical treatment, inspection and education of women and children, usually as complements to their general practice. The last two rows indicate, that by 1909, some of this was being done under state sponsorship. Before discussing this, I want to consider general practice in its own right, rather than as the basis for hospital attachment.

97. The point, which I put forward only tentatively, is not that women were more likely to do anaesthetics than men, but that doing it was less likely to be a stage in an upward career, becoming in some cases a "career" in itself. See MWF Newsletter (July 1925), 14; MWF Newsletter (March 1928), 16-24.

General Practice for the Second Generation before 1914

It is clear that the majority of women doctors active in Britain were, like their male contemporaries, primarily general practitioners. And once medical women were no longer such a novelty that their very existence is worth reporting, it becomes harder for the historian to trace those whose lives were spent in this routine way, as the majority of these women's professional lives probably were. Those whose lives were recorded in any detail become those who have more specific claims to distinction. But it is possible to make some general comments.

It has been shown that second generation women still faced major problems in getting initial experience with which to begin private practice. The openings available to them were far fewer than for men, and may have declined relatively as numbers of women qualifying increased. Probably fewer of the second generation had capital, many coming from families where resources were channelled to sons. A few set up with or joined their husbands in practice.⁹⁸ But for most, putting up a plate as a single-handed practitioner, with or without previous experience, was still the way into general practice. Instant success was rare, it being common to wait three or four years to cover costs.⁹⁹

The patients waited for were still almost entirely women and

98. I have found very few references to formally joint husband-and-wife practices at this time, but plenty of medically qualified wives' assisting their husbands generally including some medical work, and a number of women described as being in separate practice from their husbands.

99. See eg. St. John Christine Murrell; Martindale A Woman Surgeon p.106.

children. In 1870, the BMJ, had warned that such partial practice was only viable in large towns, and this was clearly believed by most of those starting up on limited resources. Practice in the country and small towns required more capital and introductions; and the inhabitants were thought to be more conservative. It was probably attempted mainly by those with substantial capital or family connections including husbands' commitments.¹⁰⁰

Most women had two choices in Britain: to remain in the vicinity of their medical schools, all located in large cities, where there was some established market for their services and the hope of hospital attachments; or to go to underprovided areas where the competition from men (and other women) would be weak and the number of potential patients large. The result was a marked concentration of pre-1914 medical women in London and Edinburgh, Glasgow, and the industrial towns of the midlands and north, Within the large cities, women without capital usually established

100. E.g. Grace Stewart Billings whose husband's work took him to Cheltenham, where she put up her plate in 1895. Journal MWF (39 (Oct 1957)); New York Herald, (12 Oct 1890). RFHSM PC Book II. One exception to this concentration in towns were a small number of women taking salaried posts as medical officers in the Scottish islands, another underdoctored area. See Hutton Memories of a Doctor, p. 102.

themselves initially in poorer areas.¹⁰¹

Deciding where to establish practice was often, therefore, a matter of realistic appraisal of chances. Ethel Williams selected Newcastle to put up her plate in 1895, on the grounds that only cities with a population of over 250,000, could support a woman general practitioner, and Newcastle had fewer doctors per head than any other city of this size. For Mary Murdoch, another doctor with no capital, it was the contacts made in her two years as house-surgeon at the Children's Hospital in Hull that made her settle there, the first woman private practitioner to do so.¹⁰²

Initially, many medical women were isolated from each other. Professional etiquette and female solidarity made setting up close to another woman practitioner a sensitive matter, especially for those who were establishing themselves in small towns.¹⁰³ But this

101. BMJ (30 April 1870) 444. This is shown in Englishwoman's Yearbooks; Harrison 'Woman's health and the woman's movement' p. 52. In London, one noted exception to women's setting up in poorer areas was the joint practice begun by Christine Murrell (1874-1933) Mb BS 1889, and Honor Bone (1875-1950) MB BS 1896 in Bayswater in 1903, both women contributing £1,000 each, very necessary as the joint fees at the end of the first year amounted to £87, though they were eventually very successful. Conscious of the difficulties women faced in establishing practices, Murrell was to "repay" her capital loan from her grandfather in the form of a loan fund bearing his name to aid young women doctors wishing to enter general practice. St. John Christine Murrell p. 37-38.

102. A. Gillie 'The scope of general practice for medical women' Journal of MWF 42 (1960) 74. On Ethel Williams (1863-1948), MB London 1891, MD 1895 see Journal of MWF (April 1948) 32-33. Malleson Mary Murdoch, p.26. Murdoch's subsequent appointment to the honorary staff of the Victoria Hospital was behind the regular appointment of women housestaff there.

103. E.g. Martindale asked the two women doctors in the vicinity, if they objected to her setting up in her home town. They replied that they would prefer her to start in Brighton, not Hove, where they lived. Martindale A Woman Surgeon p. 127.

feeling diminished as the number of women established in general practice grew. Those who had built up successful large practices in industrial towns might take on women assistants, and occasionally partners.¹⁰⁴ As women's practices appeared to be viable, setting up with a partner meant being able to share initial capital costs, and therefore, perhaps, a more prestigious address. It provided access to a second woman's opinion and skills. Disadvantages were the sharing of professional income and the possible strains that might arise in any business partnership.¹⁰⁵ And, as time passed, the chances of being able to buy established practices from retiring women grew.

Thus, there emerged identifiable and enduring women's practices, in which goodwill, if not actual premises, were handed down over generations. In 1958, Ethel Williams's original practice was still identifiable as one run by 'three busy women.' The London practice of Annis Gillie, first woman President of the Royal College of General Practitioners (from 1964 to 1967) was descended from one begun by Mrs Caroline Keith in 1896.¹⁰⁶

As small groups of women doctors (and medical students) grew

104. Hutton Memories of a Doctor, p. 102. Martindale began her professional life, after studies abroad, as salaried assistant to Murdoch in Hull for 5 years, gaining 'excellent experience' but little financial reward, a tenth of practice income each year. Woman Surgeon, pp.101-103. Occasionally women acted as temporary assistants to men. St. John Christine Murrell p.30.

105. See E.g. Lawrence Shadow of Swords, p.69.

106. Gillie 'The scope of general practice'. 74. These are just two of many whose continuity can be traced for at least sixty years- another was Jex-Blake's Edinburgh practice. MWF Quart.Rev. (April 1940), 70. (This continuity is not unique to women's practice, but specifically women's practices lasted long after women began to join mixed practices.)

in the large cities, they developed their own institutions, to overcome their professional isolation and to support each other. These were in addition to the London Association of Registered Medical Women, which had 147 members in 1903, and 200 in 1910, including some provincial members. The Edinburgh Medical Women's Club began in 1894, with Inglis as secretary, was founded in 1894. By 1905, there were also medical women's societies in Manchester, Liverpool, and Glasgow.

Initially, such societies were mainly concerned with self-education through clinical discussions and the promotion of medical women's interests locally, including, in the case of the Edinburgh Club, starting its own hospital in 1899. But by 1913, the local associations were increasingly amalgamating into larger ones, and affiliating with the London Association, and discussions became more concerned with the professional interests of medical women in general. Though not all medical women were members of such groups, it is clear that there was growing pressure for a body to represent medical women's interests in medical politics. The First World War prevented immediate action while demonstrating starkly the need for such a body, and seven local associations formed the Medical Women's Federation in 1917.¹⁰⁷

The move for a women's pressure group was due to more than the growing numbers of women. The growth of state intervention in medicine was making the value of such a body apparent, as more doctors engaged in work where payment and conditions of service

107. MWF Newsletter (April 1935), 42-46; Jnl. MWF (1967), 70-75; Notes on Local Associations, MWF Archives.

were externally determined. Professional medical associations in general were increasingly engaged in negotiations with the state, and growing in power and in their importance to members as they did so.¹⁰⁸ Women had small voice in existing associations; and, sometimes, their interests were clearly different.

One major development for general practitioners was the 1911 National Health Insurance (NHI) Act. Years of complex negotiations with the BMA brought increased financial security for many rank-and-file practitioners, through capitation fees for insured patients and greater autonomy from contract practice; and there was increasing social division between "panel practitioners" and 'GP-consultants', disproportionately drawn from those who did not join NHI.¹⁰⁹ Histories of the introduction of NHI have been silent on the attitudes of women practitioners towards the NHI and its effect on them. So are their sources, in the absence of a women's pressure group or prominent women within the BMA.

One generalization can be made. Women general practitioners as a group were less affected by the introduction of NHI than men. Scarcely involved in the club and contract practice run by friendly societies for working men, which caused their male colleagues so much frustration, women doctors found far fewer of their patients covered by NHI. Children and dependent wives of insured men were excluded (except for maternity benefit). They had

108. Parry and Parry Rise of Medical Profession, esp. pp. 153-160; Stevens Medical Practice in Modern England, pp. 34-37.

109. Honigsbaum Division in British Medicine, pp. 9-21; B. Gilbert The Evolution of National Insurance in Britain (London: Michael Joseph, 1966).

to continue paying for medical care, getting free treatment from dispensaries and hospital out-patients, or going without.¹¹⁰

However, not all working-class women were excluded. Some medical women did benefit from the capitation fees and maternity benefit, though, judging from published biographies, many of the best known women general practitioners before 1914 did not 'join the panel'. The right of an insured woman to choose a woman doctor if one were available was specified in the Act. This could include, if necessary, the making of special arrangements with women doctors who did not otherwise take panel patients, if no other medical women were available.¹¹¹ But before 1914, most insured women would not have been able to exercise this choice since there were still so few women practitioners.

By 1911, there was another form of state provision of personal health services that some women general practitioners, and many other medical women were becoming involved with. Or, as it could equally well be described, the state was becoming more involved in the services that many medical women were providing, as inspectors and health educators to women and children.

110. Exclusion of children and many women from NHI made the dispensaries and general outpatient facilities for women and children at hospitals, including those run by medical women, important for many years after they had ceased for men. See Abel-Smith Hospitals, p. 246. The effects of exclusion on working-class women's use of services and their health, especially in the Inter-War period, are discussed in, inter alia Lewis Politics of Motherhood, pp. 16-17, 44-51.

111. Malleon Mary Murdoch, pp. 104-105.

Medical Women's Mission to Women and Children Transformed

As I have shown, from the beginning, the movement for medical women had its roots in a wider movement to extend middle-class women's philanthropic mission to other women. Though not all the first generation shared Blackwell's grand moral vision and sanitarian beliefs, they did see raising the level of women's knowledge about health and hygiene as a major part of their work. This was to be equally true for many of the second generation, though in a changing setting, and with a growing, but not exclusive, emphasis on the benefits of such knowledge for women's children rather than for women themselves.

From the 1870s, medical women were rarely "just" treaters of individual women and children, but involved in preventive and educational work in a variety of institutions for women and children, largely on a voluntary basis. Many were drawn into local public life as uniquely qualified to present a professional woman's perspective on health and social questions. They often lent their medical expertise to the feminist and suffrage movements when medical "science" was invoked against the extension of women's rights.¹¹² Many gave public lectures and wrote health

112. Garrett Anderson's election to the new London School Board in 1870 and her rebuttal of Maudsley's claims about the ill effects of girls' schooling in 1874 were perhaps the first of these. Manton Elizabeth Garrett Anderson, pp. 203-208, 236-237.

handbooks for women.¹¹³ In this way, as well as through their curative work, medical women were involved in the nascent 'intermediate zone' between public institutions and the family in the late nineteenth century.¹¹⁴

From the beginning of the twentieth century this work took on new significance. In the context of imperialist ambition, and concern about industrial efficiency, the quantity and quality of infant and child health were becoming major public pre-occupations. Evidence of falling birth-rates, high infant mortality rates, and the poor health of army recruits in the Boer War, aroused new professional, political and public concern, though this evidence was not new.

In the years immediately before the First World War, this pre-occupation was expressed in a mass of diverse and overlapping voluntary and state initiatives to promote and monitor the health of the young. Analysis of these developments, and the different ideologies of welfare and public health put forward, has revealed an over-riding concern with the contribution of mothers to the

113. Space does not permit analysis of medical women's writing for popular or professional readerships. Though these women shared a commitment to their role as educators of women, their views were by no means identical, or necessarily different from all men's. One can find essays promoting the value of exercise for women, such as F.E. Hoggan 'Swimming and its Relation to the Health of Women' (Lecture to the Women's Union Swimming Club, 1884) and dire warnings against the consequences of excess exercise such as A. Kenealy 'Woman as athlete' Nineteenth Century 45 (1899), 636-645. The changing concerns about women's health, shifting towards an emphasis on motherhood after the 1890s, are well illustrated by comparing A. Ker Lectures to Women (Manchester, 1884) and idem Motherhood: A Book for Everywoman (Manchester: John Heywood, 1891 and 2nd edn. 1896).

114. Stacey and Davies 'Division of Labour' p.10.

health and welfare of their children. Promoting the efficiency of motherhood was the core activity, mainly by educating mothers (and potential mothers) and inspecting their homes and their children.

The routine aspects of such work, though not always its supervision, were held to be pre-eminently suitable for women. New opportunities for women's employment were created, as part of the gradual transformation of middle-class women's unpaid philanthropic mission into tasks for trained, paid women.¹¹⁵ Some of these opportunities were for medical women. They were involved in the movement in a variety of ways, some of which revealed their ambiguous position as women within a predominantly masculine profession, and as highly trained professionals in women's work.

The formal organization of the movement took different forms according to the age of the children. Though local initiatives preceded legislation, promotion of the health of school children was made a matter of central policy direction, from 1906 when provision was made for free school meals. This was augmented in 1907 by the introduction of school medical inspection, under the co-ordination of the new medical department of the Board of Education, under Dr. George Newman. Besides a small central staff, opportunities were created for full- and part-time employment with the 317 local education authorities in England and Wales to

115. On the transformation of women's mission see Davies and Stacey 'Division of Labour' On the movement for infant health see especially Lewis Politics of Motherhood; Honigsbaum Division in British Medicine; A. Davin 'Imperialism and motherhood' History Workshop 5 (1978), 9-65. On the movement for national efficiency see Gilbert Evolution of National Insurance; G.R. Searle The Quest for National Efficiency (Oxford: Oxford University Press, 1971). On the public health context see Brand Doctors and the State; Watkins 'The English Revolution in Public Health'.

perform medical inspection and promote the teaching of hygiene and "mothercraft" in schools.

Before 1914, most infant welfare work was formally in the hands of local branches of the many national voluntary societies. These involved 'doctors, clergymen, social workers, medical officers of health, councillors, teachers, nurses and health visitors, but, most of all, ladies whose work was voluntary and who would have no other job'.¹¹⁶ The involvement of medical officers of health, full-time salaried officials with responsibility for local health conditions, linked the voluntary bodies to local health authorities, some of which also established their own provision.

Towards 1914, State subsidies and state involvement in these initiatives increased, with several different state agencies involved. The Board of Education took a growing interest as an extension of its work with school children. The Local Government Board (LGB), acting through the 1800 local sanitary authorities was increasingly involved in the provision of maternity and child welfare centres, with salaried (not necessarily full-time) staff.

Honigsbaum has drawn attention to the result of this overlap, in the context of the variety of curative health service provision. As he says, in 1914, 'one working-class family might receive care from as many as 9 different doctors working under 5 different departments'.¹¹⁷ But in many cases, particularly when

116. Davin 'Imperialism and motherhood', 12.

117. Honigsbaum Division of British Medicine, pp. 25-26.

women and children were the patients, it might be the same doctor working under five different departments, sometimes charging a fee direct, sometimes as a sessional paid worker, and sometimes as a volunteer. This complexity on the ground, so to speak, makes it extremely difficult to assess the scale and precise form of medical women's involvement in this movement before 1914.¹¹⁸

How, then, were women doctors involved in these new developments, given their long, largely unsung, involvement in preventive work with women and children?¹¹⁹ First, many were involved in a wholly voluntary capacity in promoting the infant welfare movement in particular. How many, and whether proportionately more medical women than men were so involved; is hard to say, partly because too much credit for initiatives may have been given in the past to the role of male medical officers of health.¹²⁰

Many established medical women were prominent writers and speakers in the national movement for infant welfare.¹²¹ They were

118. Detailed analysis of local initiatives would be valuable in this period. On similar problems in studying medical involvement in maternal and child welfare work in the 1920s, see C. Davies "Little credit and less cash": the maternity and child welfare doctors of the interwar years.' Unpublished paper, 1981.

119. Many of the local initiatives that developed after 1900 were not completely novel ideas, but the climate of opinion gave them a new significance. Thus the well-known "pioneering" St. Pancras 'Babies' Welcome' founded in 1907 had been preceded by others such as Annie McCall's, begun in 1888. Barrass Fifty Years of Midwifery, p.43. (On St. Pancras Babies' Welcome and School for Mothers see Davin, 'Imperialism and motherhood', 39-43.

120. Stacey and Davies 'Division of labour', p.23.

121. Three women often cited, who held very different political views, are Scharlieb, Alice Vickery Drysdale and Dr Ethel Bentham (?-1931) MB 1896, who became Labour MP for Islington (1929-1931). Lewis Politics of Motherhood passim.

also often among the organizers of local voluntary initiatives. Sometimes this was as 'ladies', with no other paid work but with claims to expertise.¹²² More often it was as local general practitioners. Voluntary effort often extended to acting as medical officers to these initiatives, or as lecturers in health and hygiene for both voluntary agencies, and local health authorities.

For example, in 1907, the St. Marylebone Health Society opened a second centre for Infant Consultations. This followed the success of one opened in 1906 with Dr Eric Pritchard, a central figure in the national movement, as medical officer, supported by, among others, the newly qualified Flora Murray. At the second centre, the presiding medical officer was Christine Murrell, prominent local woman general practitioner and London County Council lecturer.¹²³

Increasing state involvement meant that there were also opportunities for paid work for women doctors. Some local authorities became directly involved in advising mothers and inspecting their homes through the appointment of paid and trained women health visitors or sanitary inspectors to replace women volunteers

122. Clara Stewart, MB BS 1908, gave up fulltime work in 1911, on marrying her senior pathologist, and became active in the Leeds' Babies' Welfare Association. When this was taken over by the local authority during the First World War, she became a part-time employee of the local authority staff. (Jnl. MWF 51 (1969), 37.

123. St. John Christine Murrell, pp. 40 & 47-48.

as the 'mother's friend'.¹²⁴ To supervise this essentially women's work, some authorities appointed especially well-qualified women. In 1906, St. Helens Health Committee appointed Dr. Frances Harper as 'lady Assistant Medical Officer',

'with the idea that her duties should practically place her at the head of the lady sanitary inspectors. She will undertake work which medical men could not do. She will educate midwives, teach women at mothers' meetings, and give instruction in day schools and to women teachers.'¹²⁵

As local-authority subsidy of voluntary clinics developed, some women found themselves being paid for the same work as done previously in a voluntary capacity, often in the same place, and usually part-time. This development accelerated during the First World War when Local Government Board grants for 50 per cent of the costs of infant welfare centres became available.¹²⁶

The largest number of opportunities for paid work before 1914 were with the school medical service. Such posts were recommended

124. C. Davies 'The health visitor as mother's friend', unpublished paper, 1981. See also R. Dingwall 'Collectivism, regionalism and feminism: Health visiting and British social policy', Journal of Social Policy, 6 (1977), 291-315.

125. Englishwoman's Review (15 Oct. 1906), 266. Emphasis added. A well known example of this was Huddersfield where two medical qualified "health visitors" were appointed to supervise a staff of eighty women. Davin 'Imperialism and motherhood', 37.

126. Dora Bunting, first medical officer at the St. Pancras School for Mothers when it opens in 1907 became assistant medical officer of health in Southampton in 1912. Jnl. MWF (April 1946), 39. 2 young women doctors who had been doing one voluntary session a fortnight at the Tottenham School for Mothers since 1912 became part-time officers of the Tottenham local health authority in 1915. L. Kent-Parsons 'Pioneer work in maternity and child welfare, Tottenham, from 1911'. Manuscript c. 1917, kindly lent to me by Victoria Bailey.

to and regularly taken by LSMW qualifiers from 1907.¹²⁷ Although by no means all authorities appointed women as school medical inspectors, some did so as a matter of principle, notably the London County Council. Most of these posts were part-time, but might be taken by women at very different stages in their careers. Thus, in 1910, among the part-time LCC women school medical inspectors, were Christine Murrell, an established general practitioner, Helen Hanson, recently invalided home from mission service in India, and the inexperienced Laetitia Fairfield, before she began continuous full-time service with the LCC from 1911 to 1948, broken only by the First World War.¹²⁸

Some combined work for local health and education authorities in a single full-time appointment. Sophia Seekings was appointed Assistant Medical Inspector for Schools, and Assistant Medical Officer of Health, for Tottenham in 1909. In 1912 she was appointed Acting Medical Officer of Health because of the illness of her chief, the first woman to occupy such a post. And in 1913, she was the first of many women "acting up" to find a man appointed to the permanent position over her. While she was MOH she initiated the voluntary Tottenham School for Mothers.¹²⁹

127. Times 3 July, 1909. In 1918, just before he moved to the Ministry of Health, Newman told the LSMw students that he had 'an admirable staff of 122 women doctors in the school medical service.' It is impossible to determine how many of these were full-time. Magazine of L(RFH)SMW (July 1918), 106.

128. Fairfield (1885-1978) MB ChB Edin. 1907 MWF Newsletter (Jan. 1934), 70. Hanson MB 1901 also became a full-time officer for the LCC. See Acres Helen Hanson passim.

129. Sophia Seekings Friel (? -1954), MB BS 1906, Kent-Parsons 'Pioneer Work in Tottenham'; Jnl. MWF (Oct 1954), 84.

Of the few appointments of medical women to the central state institutions before 1914, the best-known is probably that of Janet Campbell, an outstanding LSMW graduate, holder of RFH and Belgrave houseposts. In 1908, she accepted a senior post at the Board of Education, having turned it down the previous year when offered to her at a lower salary than for men in the same grade. This was the beginning of Campbell's formal career in maternity and child welfare, consolidated when she moved, with Newman, from the Board of Education to the new Ministry of Health in 1918, to head a team of five women responsible for Maternity and Child Welfare.¹³⁰ Posts at the centre were sometimes combined with a variety of other tasks. In 1912, Janet Lane-Clayton, another of the LSMW's outstanding students, was appointed assistant medical inspector for the IGB, combining this for some years with being Dean of King's College for Women, a major centre of training of domestic science teachers, and lecturing at Battersea Polytechnic.¹³¹

These examples of the different ways in which medical women became involved in infant and child health before 1914 show why it is hard to make an overall assessment of the scale of their involvement. Though it was never exclusively a women's field, it seems likely that proportionately more medical women than men were directly engaged in infant welfare and school health work, often under the direction of men.

130. Bell Storming the Citadel, p. 180; Dame Janet Campbell (1877-1954) MB BS 1901. Jnl MWF (1955), 60-62; Who was Who Vol V.

131. Janet Lane-Clayton (1877-1967) MB BS 1906. BMJ (29 July 1967), 314; Who Was Who Vol VI.

In 1911, there was one indication that public health was becoming a field in which women were slightly over-represented. The Census enumerated 1267 men and 80 women as medical officers with local authorities in England and Wales. Women were 2 per cent of all active doctors but 6 per cent of local authority doctors. Six per cent of medical men and 17 per cent of women enumerated as active recorded their main medical work as "public health".¹³²

One implication of this was that more medical women were becoming subject to bureaucratic conditions of employment. An increasingly salient question was whether they were employed primarily as women, expected to receive lower pay, and perhaps subject to dismissal on marriage, or as doctors, sharing equal status and prospects with their male colleagues. Janet Campbell's refusal to accept a salary lower than men was an early skirmish in a long battle.

Some of the first medical women given public appointments in the 1880s had been appointed on the same salaries as male colleagues.¹³³ But as such appointments increased so did the practice of advertising posts for women as assistant medical

132. Census England and Wales: Report to Vol. 10, p. xx. Some of these doctors of both sexes will have been asylum and county hospital doctors. About 25 per cent of doctors of both sexes were aged less than 35 suggesting the difference was not entirely due to women being younger and hence more likely to be in resident posts. Small numbers of women begin to take the DPH from the 1880s, which was not yet a prerequisite for appointments as assistant MOsH. 18 women listed in Englishwoman's Yearbook for 1909 (pp. 132-146) held this qualification, not all of whom were working in public health.

133. For example Edith Shove's appointment at the Post Office, and the LCC's appointments of women to asylums in the late 1880s. Bell Storming the Citadel, pp. 179-180.

officers of health and medical inspectors at salaries lower than for men. Medical women, through their local associations, sometimes supported by the BMA, called on their colleagues to refuse to accept this 'undercutting', either by resigning or refusing to take up appointments. This sometimes met with success, but some women could not afford to sacrifice their jobs for the principle of equal pay.¹³⁴

Though formal restrictions on the employment of married women were not universal in local-authority employment before 1914 (or after) they became increasingly common from the 1890s. Their spread was yet another aspect of the same movement which sought to ensure the health of the future population by promoting motherhood as married women's central role.¹³⁵ The ideas that many medical women were engaged in promoting increasingly implied that marriage and motherhood were incompatible with a major commitment to professional practice. So long as much of the work remained voluntary then it might be appropriate work for married medical women. But its incorporation into local authority employment meant that it increasingly became work for single women.

The infant welfare and child health movement were clearly creating new opportunities for women's medical work at a time when more women were seeking professional advancement and equality within the profession. But these new opportunities incorporated a

134. Common Cause (12 March 1915).

135. Lewis Women in England, p. 102. In 1906, the LCC introduced standing order No. 346, which prohibited the employment of married women; but exempted doctors, teachers and charwomen from its provisions. MWF Newsletter (July 1931), 19.

paradox in the very conception of the work. Was it "medical" work or women's work that they were being called upon to do? It was teaching, inspecting, advising, and above all, work with and through other women. The work that 'medical men could not do' was, in the eyes of many men within the medical profession, not proper medical work. It was work that had had a marginal status within public-health work as a whole, and, as public health work, within the medical profession as a whole.

By 1914, some women were beginning to express their doubts, not about the value of the work per se but about the opportunities it was providing for professional careers. Initially, as I have shown, many medical women became involved in infant welfare as a voluntary complement to private practice or domestic obligations. They were clearly enthusiasts for the cause, as were many of the women taking paid positions. But, just as women working on the women's side of lunatic asylums found their "narrow" experience a barrier to promotion so did women in school medical service and local health authority employment. As a woman with seven years experience in the public health service wrote bitterly in 1915,

'The posts of "School M.O." where the work is much less monotonous than the routine as Assistants are almost always closed to women, and I am not aware of a single post as Medical Officer of Health open to them. Women have been carefully excluded from the posts of Chief Tuberculosis Officer.'¹³⁶

This last reference is significant because senior administrative experience in the rapidly expanding field of local-

136. Common Cause (15 March 1915). I have only identified 3 women County School Medical Officers, including Dr Frances Harper for Lancashire Englishwoman's Review (15 Jan. 1909), 59.

authority tuberculosis medicine was recognized as an important step in the career path to posts as medical officers of health. Even though women had been running tuberculosis sanatoria since the 1890s, some of which were taken over by local authorities under the provisions of NHI, the claim that tuberculosis medicine was unsuitable for women was to have remarkable tenacity.

All these issues become even more salient after 1918, with the expansion of medical women's employment in maternity and child welfare services, and I shall return to them in the next chapter.

Conclusion: An Emerging Gender Order Within Medicine, 1870-1914?

It has been shown that gender segregation within medicine was all-pervasive before 1914. Throughout the period discussed in this chapter, women's medical practice was almost exclusively concerned with women and children. This state of affairs did not arise only from the efforts of men to restrict women's opportunities for professional development. Women themselves sought to develop medical services specifically for women and children, and to create roles within the profession specifically for women.

Before 1914, career lines were still relatively fluid. Boundaries were only loosely drawn between what we now see as distinct specialties within medicine, locations of practice or even "medical" and "non-medical" work, as in the infant welfare movement. But at the same time, the situation changed over forty years. I have tried to indicate the nature of the changes and their implications for early medical women's careers, and for the subsequent development of a gender-influenced pattern of medical specialties.

The women who entered medicine in the 1870s and early 1880s sought ways of interpreting their special philanthropic mandate. They worked to create a market for their services as general practitioners for women and children in a primarily entrepreneurial context. Among those that followed them, there was increasing differentiation of ways to become doctors for women and children; a differentiation arising not only from the growth in numbers of women and the market for their services, but also from the changing context of medical work.

Increased state involvement in medical services from the end of the nineteenth century did create some new opportunities. But the very nature of many of these opportunities, and their location in bureaucratic structures, posed new questions about the medical work of married women. The exclusion of women from the major general hospitals was increasingly felt as their numbers grew and as medicine and surgery became more hospital centred. Hospitals run by women for women provided opportunities for a few. But these institutions represented the same paradoxical solution to the problem of promoting professional equality as did separate medical schools for women.

By 1914, there were two potentially opposed tendencies apparent. Younger women, increasingly trained to see themselves firstly as professionals, were becoming aware of the limitations of sexually segregated work in medicine. Even if they still expected their work to be mainly concerned with women and children, they claimed this to be no ground for excluding them from important avenues to success. At the same time, the idea of medical women's having a special mandate was being reformulated to define a distinctive area of women's medicine within public

health. In the next chapter I shall consider the impact of World War I and its aftermath on these two developments.

CHAPTER VIII

MEDICAL WOMEN IN TOTAL WAR 1914-1918

Introduction

Historians of the First World War and of women's lives in the twentieth century are agreed that the years 1914 to 1918 had a dramatic impact on the lives of most women in Britain. Few were untouched by the consequences of total war, socially, economically and personally. Two interconnected features of women's participation in the public sphere in these years have received particular attention. First, thousands of women were drawn into the labour force (paid and voluntary) on a scale never previously experienced, as workers directly contributing to the war effort, and as substitutes for men serving with the armed forces. Secondly, the majority of women active in the pre-war suffrage campaign suspended their direct campaign, joining the war effort, often with the explicit aim of demonstrating women's worth as citizens.¹

Historians have been less agreed about the long-term effects of the war and of these two developments on women's lives, and on

1. For general accounts of women's work in the First World War see A. Marwick The Deluge: British Society and the First World War (London: Methuen, 1965); idem Women at War: 1914-1918 (London: Fontana, 1977). On women's employment see G. Braybon Women Workers in the First World War (London: Croom Helm, 1981). On the suffrage campaigners and war-work D. Mitchell Women on the Warpath (London: Cape, 1966); R. Strachey The Cause (London: Bell, 1928).

their position in British society. Some have argued that public recognition of women's war work and their entry into previously male preserves brought major changes in the social position of women, as shown by the "rewards" of partial suffrage in 1918 and the Sex Disqualification (Removal) Act of 1919.² Others emphasize the continuity in attitudes to women's employment and the primacy of married women's motherhood role during the war, the rapidity with which women disappeared from the labour market into the home after 1918, and the failure of the legislation to secure professional women's right to employment.³

Assessing the consequences of the war for British women as a whole involves 'working out a very complicated sum', which must balance short-term gains and losses against long-term ones.⁴ This is equally true when the consequences for medical women are in question. They too were involved in the war effort directly and as substitutes for men. Some saw medical women's war work as an opportunity to demonstrate the validity of their claims to professional and civil equality. The war brought great changes in their numbers, and brought large numbers of medical women into contact with male patients for the first time. But their war work met with much resistance. Many of the changes were short-lived.

2. This is the position implicit in Fogarty, Rapoport and Rapoport Sex, Career and Family discussed in Ch. III. The Sex Disqualification (Removal) Act did open a number of occupations and institutions to women for the first time, notably the legal profession, and gave women the right to be jurors and magistrates. Strachey The Cause, pp. 375-377.

3. Braybon Women Workers in the First World War; see also Lewis Women in England, pp. 199-200.

4. Marwick Women at War, p. 162.

This chapter examines the impact of the First World War on medical women's careers, and the long- and short-term consequences for women in medicine and for individual women, the war having different implications for different groups of medical women. I begin by considering the situation of medical men during the war, which greatly influenced, without wholly determining, the situation for medical women.

Medical Men and the First World War

When war was declared in August 1914, the arrangements made for the medical care of the military and civilian populations were rudimentary and unco-ordinated, based on the assumption that it would be a short war, with a relatively low casualty rate. Thereafter, the rapidly changing situation, the multiplicity of agencies involved, and the marked reluctance of the War Office to divulge what information it had, made it difficult for contemporaries and for subsequent historians to have a precise picture of what was happening.⁵

At the outbreak of war there were just over 3000 medical officers in the Royal Army Medical Corps (RAMC), of whom more than half were territorials. The BMA took on responsibility for co-ordinating arrangements for the recruitment of doctors. Some doctors began to leave their civilian practices to join the armed forces. Others were absorbed into the military establishment when

5. Abel-Smith Hospitals, pp. 252-283 describes the impact of the war on the hospital and health service at home. W.G. MacPherson History of the Great War, Medical Services, General History Vol I (London: HMSO, 1921) is the official account.

the public and voluntary hospitals where they worked were taken over, wholly or partly, for military use. Commissioned ranks and associated salaries were allocated according to the War Office's interpretation of professional standing. Consultant physicians and surgeons became colonels, general practitioners, district medical officers and housemen, lieutenants. This was only one aspect of the differential experience and treatment of different categories of male doctors. Many of those given senior rank and salaries continued their substantial private civilian practice, while junior colleagues serving full-time with the military at home or overseas risked losing whatever goodwill they had built up.

By December 1914, the number of doctors holding RAMC commissions had risen to over 5,000, about 20 per cent of the doctors in Britain, but many of these were still doing some civilian service.⁶ There were growing numbers of Civilian Medical Practitioners (CMPs), mainly general practitioners or doctors coming out of retirement, helping part-time in small hospitals, clinics and recruitment boards without holding commissions. (After male conscription began in 1916, these were mainly men over 50 and women.) A few male doctors joined voluntary agencies such as the Red Cross. And many male medical students volunteered for the armed services before qualifying.

Early volunteers for full-time RAMC service at home and overseas were mostly young, and some civilian hospitals experienced difficulty in filling resident posts within the first

6. MacPherson, History of Great War I, pp. 44-5; Abel-Smith Hospitals, pp. 256-257 & 270.

few months, especially as such posts usually offered salaries below that given to a newly commissioned RAMC lieutenant. But there was no general, or political, perception of a major shortage of either civilian or military doctors in the early months, or lack of volunteers. In March 1915, the War Office appealed for 2,000 more volunteers to serve at home and oversea. By May 1915, some 5,000 doctors had volunteered for service since August 1914, and RAMC strength had risen to about 6,500.⁷

From the second year of the war, the demand for doctors by the armed services increased. By November 1915, the number of RAMC doctors was over 9,000. The medical course was shortened to four and half years to speed the production of more doctors. Conscription of single men was introduced in January 1916, and for all men in May. Medical students in their first three years of study were not exempt, and men's medical schools were drained of most junior students.

Although the profession had succeeded in retaining some control over the call-up of qualified doctors, it had decreasing discretion in its exercise. By mid-1916, the Government had acknowledged severe shortages of medical staff for military and civilian services. By January 1917, more than half of the active medical profession in Britain had been called up for military service, most of them full-time. Most of those not called up were ineligible on grounds of age, infirmity, sex or because they had

7. MacPherson *History of the Great War I*, pp, 44-45 & 147, BMJ (15 May 1915), 488; BMJ (30 July 1915), 645-647.

already served with the RAMC. They would, in many cases, be CMPs.⁸

The medical services available for the civilian population were thus progressively reduced in favour of the unremitting demands of the military machine (though many RAMC doctors reported that they had had nothing to do). Voluntary hospitals not considered vital to the war effort suffered financially, unaided by exchequer funds, including many of those for women and children. 'The last year of the war strained the medical services of the nation to their limit', with ever-mounting army casualties and the first of the great influenza epidemics.⁹

Casualties among military doctors were minute compared with the total carnage, but not insignificant, given that they were non-combatants (and many nowhere near the front). By November 1915, 200 medical officers were among the 109,743 men officially reported as dead. Over 50 medical graduates from University College alone died while serving with the armed forces between 1914 and 1919.¹⁰ Death rates among the combatant medical students were probably higher. By 1918, there had been a real loss of qualified male medical manpower, and of many of the future recruits. But, like other survivors of the four million men

8. Official figures recorded 12,720 doctors in the armed forces and 11,482 in civilian practice on 1 January 1918. Abel-Smith Hospitals, pp. 263 & 278-9; MacPherson History of Great War I, pp. 145-147.

9. Abel-Smith Hospitals, pp. 280-283.

10. MacPherson History of the Great War, Medical Services, Casualties and Medical Statistics, Vol XII, pp. 4-5; BMJ (28 Nov. 1915), 871, both as quoted in A. Mitchell 'The work of medical women in the First World War'. (Melbourne: Privately printed, 1978.) p.3. W.R. Merrington University College Hospital and its Medical School (London: Heinemann, 1976), p. 118.

directly involved in the armed forces, there were, from 1919, large number of young men anxiously seeking to resume their lives as civilian medical practitioners and as medical students.¹¹

This was the broad context for medical women's wartime careers. An initially slow draining of young doctors was, by the end of 1916, emptying the medical schools, the junior posts in hospitals and the hospitals not directly involved in the war effort. By this time, the scale of recruitment of men, and also women into war work was generating an immense demand for medical inspection and control in addition to any direct involvement with casualties. Medical women were affected by all these developments; but not all aspects of their involvement in the war effort are explicable solely as a response to shortage of medical men.

Women's Medical Education and World War One

In Chapter IV statistical evidence was presented showing that a major long-term effect of the First World War was dramatically to increase the number of women for whom a medical career was possible. For the next forty years there was a "bulge" of women

11. Making allowance for the part-timers whose civilian practices were not disrupted, and Dominion doctors, there were perhaps 9,000 male doctors whose careers had been profoundly interrupted. Some 2,000 male medical students "disappear" from the GMC censuses of students between 1914 and 1918. Detailed local research would be needed to find how many resumed their careers.

from this period making their careers in medicine.¹² Here, I consider the background to this war-time increase in more detail.

The war was just one month old when the LSMW began to call for women to take up the study of medicine as a response to the crisis and the growing shortage of male medical students and doctors.¹³ The intake that October was much publicized as, at 56, the largest ever recorded.¹⁴ In December 1914, the school launched an appeal for £30,000 to build new laboratories to accommodate the extra women students urgently needed.¹⁵ Thus, the drive for more women medical students began before there was a widespread public recognition or experience of doctor shortage, or any official recognition of the value of more women doctors. From one point of view, this drive reflected a recognition of what would happen if the war continued; from another, it was the LSMW's

12. To recap, in the United Kingdom in 1914 there were probably just under 700 women medical students, about 10 per cent of the total. In mid-1916 there were 1379 women medical students registered with the GMC (24 per cent of the total). Of these, 46 per cent were in their first year (31 per cent of all first year medical students). In 1918, there were some 2250 women registered medical students, possibly nearly 40 per cent of all medical students. NB GMC Census Figures, not university figures. Press estimates of the number of medical students (male and female) vary widely during the First World War.

13. Letters from Miss Brooks, Secretary to the LSMW appeared in most of the major national daily papers on 9 and 10 Sept. 1914. Eg Morning Post 9 Sept. 1914; Times 10 Sept. 1914, and others in RFHSM PC Book IV.

14. E.g. Morning Post 5 Nov. 1914 (RFHSM PC Book IV). Not all these students registered for the full medical course, but it did represent an increase of about 100 per cent on the 1913 entry, according to the LSMW Register of Students.

15. The appeal was supported by Times leaders, A.J. Balfour, Asquith, Lord Curzon and other prominent politicians. e.g. Times 5, 8, & 10 Dec. 1914 and 22 & 25 Jan. 1915 Riddell Aldrich Blake, pp. 49-50, & 54-55. Bell Storming the Citadel, pp. 169-170.

joining women's voluntary war effort and attempting to harness the desire of many young middle-class women to display their patriotism and their competence. But it was also an attempt to solve some of the school's problems by seizing opportunities provided by the war and women's enthusiasm.

Since expanding in 1901, the LSMW had seldom been full. How much this was due to the growth of mixed schools in the face of the London grievance and the greater expense of London training, and how much to slowing of the rate of increase of women entering medicine it is impossible to determine.¹⁶ But, by 1914, the school could take more pre-clinical students, and badly needed them for financial stability. The school also needed more students if it was to become a "modern" medical school by implementing the recommendations of the Haldane Commission for full-time pre-clinical teachers. As in most London medical schools, the senior staff of the LSMW and RFH did not share the Haldane Commission's enthusiasm for university-based full-time professorial clinical units as a means of infusing the university ethos into clinical training. But the principle of units run by those still engaged in substantial private practice was accepted, adding further urgency to a long recognized need to increase the beds available

16. See Cock's evidence to Haldane Commission Fifth Report, Appendix p. 128.

for clinical teaching at the RFH.¹⁷

By August 1914, plans for the school's expansion were already drawn up and land for extending the RFH bought. What was needed was a viable number of students with which to launch an appeal for expansion. The war provided the students, and the basis for a public appeal for funds to double the capacity of the school; an appeal which both fostered and benefited from the growing concern over the drain of doctors to the forces. The new building was opened by the Queen in October 1916.¹⁸ The much more expensive plans to double the size of the hospital had to be postponed.¹⁹

In support of the appeal early in 1915, leaders in The Times's reported 'a change in attitude to women doctors as exclusively serving women and children' and the 'dying of prejudice against women doctors'.²⁰ They were, however,

17. Haldane Commission Final Report of the Commissioners (London: HMSO 1913) Cd. 6717. Riddell Aldrich-Blake, pp. 53-54. Bell refers to 'the Commission's recommendation of seven beds per student'. Storming the Citadel, p. 170. But the Commissioners made no such specific recommendation. Haldane Commission op.cit., pp. 131-5.

18. Times 19 Feb. 1915; The Hospital 4 Sept. 1915; Times 8 Nov. 1915; G.M. Benson 'The effect of the war on the medical profession' The Medical Press (2 Feb. 1916; Times 28 March 1916. BMJ ii (30 Sept. 1916), 207; Times 3 Oct. 1916 and many cuttings in RFHSM PC Books IV & V.

19. However, in March 1916, an appeal was launched for £200,000 to establish new ante-natal and obstetrics facilities at the RFH, to aid the task of making good 'current losses by safeguarding infant life'. Daily Telegraph 1 March 1916; The Hospital 4 March 1916 and other cuttings in RFHSM PC Book V. Riddell Aldrich-Blake, pp. 54-55. The funds were used to build the 83-bedded professorial obstetric unit opened in 1921. As the quotation indicates, concern for 'race development' through infant health remained high throughout the war with its 'race destruction'. Lancet (9 Oct. 1915), 631.

20. Times 22 & 25 Jan. 1915.

oversanguine. Many of the early statements from male doctors in support of the appeal stated that more women doctors were being sought to do "women doctors' work". As it became clear that large numbers of women were attending men, the emphasis in the more guarded statements of support shifted to patients' right to free choice of doctor; or it was stressed that when the men returned the women would retire or find,

'fields of congenial work in the treatment of diseases peculiar to women and children and as medical officers of children's clinics in connexion with a proper system of inspection in regard to child life ...'²¹

The LSMW appeal did not meet with support, qualified or otherwise, from all quarters. In the first year of the war, a number of medical women warned prospective women students against the optimistic claims for new opportunities and the disappearance of prejudice. Women were warned that the problem of clinical training was not solved. Claims of a marked increase in posts open to women, and of a fall in applicants to posts, were countered by realistic appraisal of these posts as underpaid and undesirable.²² Press reports of the 'extent to which women were filling posts hitherto held by men' in the first few months give some support to these cautions, in that the number of posts cited

21. Lancet (17 July 1915), 210. For an example of a shift in position compare statements by Professor F.H. Marsh, Professor of Surgery at Cambridge Times 8 Dec. 1914 quoted Bell Storming the Citadel and idem 'The scarcity of doctors' The Cambridge Review (24 Feb. 1915). (RFHSM PC Book IV).

22. These warnings were found in the feminist press, and were generally described as corrections to press reports, rather than direct criticisms of the LSMW. Eg The Englishwoman (Jan 1915), 84-85; Common Cause (12 March, 30 April, 4 June 1915).

was few, and most were in asylums or in the school medical service.²³ But from mid-1915 the number of such reports increased sharply.

Much more forceful criticism of the appeal was sometimes voiced in the medical press, condemning the squandering of funds much needed elsewhere on women who would abandon medicine in favour of domesticity. Furthermore, critics claimed, to link an appeal for a permanent venture to the war effort was, at best, misguided; at worst, some hinted, deceitful. The war would be long over, and any 'temporary and exceptional' demand for their services have ceased, before any extra women qualified. Far better, some were urging by the second half of 1915, to accommodate extra women in the emptying men's schools.²⁴

And, as shown in Chapter IV, this was what eventually happened in London. Between January 1916 and July 1918, seven of the eleven men's schools in London had admitted women to clinical

23. E.g. Girls' Own Paper (March 1915) (RFHSM PC Book IV); Times 25 Jan. 1915.

24. These were usually letters not leaders. Particularly forceful examples include The Medical Press and Circular (28 July 1915); The Hospital (13 Nov. 1915). (RFHSM PC Book V.) From the sources I have used it is hard to gauge how widespread this view was. But it would not be surprising if there was much resentment at the ability of the women's school to capitalize on its opportunity while men's schools were being depleted.

studies, and in two cases to the whole course.²⁵ This was the result of the increase in the number of women students entering the LSMW, needing clinical training which the RFH was too small to provide, and of the drain of male students, particularly after conscription was introduced.²⁶ It did not reflect a new commitment to the principle of co-education in the men's schools.

In December 1915, at the request of the LSMW, a sub-committee of the Academic Council of the University of London was established to consider the adequacy of clinical facilities for women students. This reported in favour of co-education in principle, making some specific recommendations to solve the immediate problems. At a conference chaired by the Vice-Chancellor on 30 January 1917, there was, in the masterly understatement of a report on the same question in 1929, 'considerable divergence of view among the [medical school] representatives attending'. Senate resolved to take no action. Indeed, by the time it received the report the 'question had solved itself, at least for the time being', by the action of individual schools.²⁷

The course of events was similar in the schools outside

25. Press reports rumoured that Charing Cross Hospital Medical School was to admit women during 1915, 'making it clear they were "of a subordinate order and carry no prospect of accession to the full staff"'. The Hospital (24 July 1915) quoted in Abel-Smith Hospitals, p.278. These were premature, women were not admitted until September 1916. The Hospital (24 July 1915) (RFHSM PC Book IV); Times 12 July 1916. In several cases the decision was not formally communicated to the University Senate.

26. The LSMW's entry in October 1915 was 60, rising to over 80 in 1916 and 100 in 1917 and 1918. LSMW Register.

27. University of London Senate Report of the University of London on the Medical Education of Women Undergraduates (1929), reprinted in MWF Newsletter (March 1929), 43. Times 29 Nov. 1916.

London, as described in Chapter IV. The numbers of women entering medicine in Great Britain increased by about 150 per cent between 1914 and 1915, and doubled in 1916. This was the year in which Edinburgh University admitted women to all classes of the University on the same terms as men. Most provisions for separate clinical training for women within the mixed schools were relaxed, without enough male students to justify, or staff to provide, separate teaching for the growing numbers of women.²⁸

As in so many fields, the war brought many women into medicine who would not otherwise have had the opportunity or even the ambition. In many cases these were mature women making major changes in their lives. Doris Odlum had taken an (unofficial) degree at Oxford in 1912, was a lecturer for the Workers' Educational Association, and an active suffragist. The women she met in her work had 'told me how much they wished there were more women doctors ... but I never thought of being a doctor myself' until the war. She entered the LSMW in October 1915.²⁹ Janet Aitken was a professional singer but trained as a masseur to help the wounded when war broke out. This aroused an interest in anatomy and physiology, and 'the newspapers were full of the news that young men doctors were being killed and that women doctors

28. Estimates based on GMC Census. Women entrants continued to increase in 1917 and 1918 outside London. Turner Story of a Great Hospital, pp. 252-255; Anning General Infirmary at Leeds Vol II, pp. 90-91; The Queen (12 Feb. 1916) (RFHSM PC Book IV).

29. Odlum, (1890-1985) DPM 1927, did her clinical studies at St. Mary's, qualifying MB BS in 1924, having interrupted her studies for 18 war work. Autobiographical statement in L.M. Hellstedt Women Physicians of the World (New York: McGraw-Hill, 1978), pp. 49-51; BMJ (9 Nov. 1985), 1356.

would be needed. Aged 28, she "crammed" for matriculation, entering the LSMW in 1917.³⁰

These two women went on to have exceptionally successful professional careers, and to be prominent figures in associations for medical women. But many of their peers disappear after qualifying. A persistent refrain in discussions of the situation of medical women in the post-war years was the 'wholly unsuitable' character of many of the 'great rush of women' into the profession in the war years.³¹ No doubt the turmoil of the war meant many were different from the self-selected few who had entered medicine before 1914 after long consideration and careful planning. But there is another factor in their disappearance. The critics of the LSMW's expansion scheme were partly right. These wartime women entrants completed their studies in the early 1920s, as the men returning from the war were trying to re-establish their careers. In this situation young and inexperienced women were to find few good opportunities to use their skills, and many pressures to give way to the men.

As well as these changes in medical education for women, the war years had a significant impact, at least in the short term, on those already qualified. As for men, the complex and rapidly changing situation and the overlapping of many categories of work means that it is impossible to obtain a precise picture. But

30. Aitken, (1886-1982) MB BS 1922, MD 1924, MRCP 1927. Hellstedt op.cit., pp. 23-24.

31. This was voiced by both men and representatives of medical women. Eg V. Kelynack 'Women in the medical profession: a retrospect for the year 1929', MWF Newsletter (April 1930), 57.

several broad areas of medical women's wartime work can be identified. The first to develop is perhaps the best-known: their role in voluntary hospital units for soldiers.

Hospitals Run by Women for Men

'My good lady, go home and sit still', was the response of an RAMC representative, when the war was a week old, to forty-nine year old Elsie Inglis's offer to do more than teach the ladies of the Voluntary Aid Detachment to roll bandages. The official view of the Red Cross, under War Office control, was also that war was not fit work for medical women. But the patronizing response was a spur to action, becoming a catchphrase among those doing the work it triggered.

The raising of a hospital unit staffed by women, to go to France or Serbia, was immediately proposed by Inglis to the Scottish federation of the National Union of Women's Suffrage Societies. In November the first unit of the Scottish Women's Hospitals (SWH) arrived in Calais. Here, as Dr Alice Hutchison, the medical officer in charge, wrote, 'the Generals were not dying to have us ... But I determined that they should arrive at the stage of being loathe to lose us, before long.' And they duly did.³² In London, Flora Murray and Louisa Garrett Anderson do not appear to have bothered with the British authorities, offering a fully equipped surgical unit for France to the French ambassador in Britain on 12 August, 1914. They raised £2,000 in two weeks and

32. Lawrence Shadow of Swords, pp. 98-105.

the Women's Hospital Corps (WHC) left for Paris on 14 September.³³

Thus began the work of the two best known of the women's voluntary units overseas, which served mainly in France and Serbia, but also in Turkey, Greece, and Russia, and, in the case of the WHC, also in London. The story of these units' heroism and endurance has been told many times.³⁴ I shall only make a few comments on their background, and on their significance for the careers of individuals and for medical women as a whole.

As Inglis's experience with the RAMC illustrates, there was no official place for medical women, as there was for nurses, at the beginning of the war. They were to remain anomalies to the War Office and RAMC bureaucracy throughout the war. The initial involvement of qualified medical women in the war effort was, like

33. F. Murray Women as Army Surgeons: Being the History of the Women's Hospital Corps in Paris, Wimereux and Endell Street (London: Hodder & Stoughton, 1920), pp. 4-7.

34. General narratives include Bell Storming the Citadel, pp. 151-167; Mitchell Women on the Warpath; M. H.F. Ivens 'The part played by British medical women during the war' BMJ (18 Aug. 1917), 202-204. Contemporary autobiographies and biographies and histories of the SWH include F. Balfour Dr Elsie Inglis (London: Hodder & Stoughton, 1918) E. Shaw McLaren A History of the Scottish Women's Hospitals (London: Hodder & Stoughton, 1919); idem Elsie Inglis (London: SPCK, 1919); I.E. Hutton With a Woman's Unit in Serbia, Salonika and Sebastopol (London: Williams & Norgate, 1928); idem Memories of a Doctor in War and Peace. On the WHC see Murray Women as Army Surgeons. The work of some of the other units is described in J. Berry et al The Story of a Red Cross Unit in Serbia, (London: Churchill, 1916); E. Corbett With the Red Cross in Serbia (London: Cheney, 1960); M. St. Clair Stobart The Flaming Sword in Serbia and Elsewhere (London: Hodder & Stoughton, 1919). More recent secondary accounts include Lawrence's excellent biography of Inglis, Shadow of Swords already often cited, and, on Serbia, M. Krippner The Quality of Mercy: Women at War Serbia 1914-1918 (Newton Abbott: David & Charles, 1980). The only analytical account I have found is A. Mitchell's brief 'Medical Women in the First World War'.

that of their lay sisters, entirely a voluntary matter, in the face of much opposition from military authorities. In time, there was less opposition in the field, and many individual senior British officers welcomed the women's help.³⁵ In 1915, the women's units received official approval from the top, when Sir Alfred Keogh, Director-General of Medical Services, approved the establishment of the 550 bed Endell Street Hospital in London, staffed by women from the WHC. But here, as elsewhere, 'the War Office did as little as possible lest they become responsible for women's affairs'.³⁶

The SWH and WHC were two of a number of voluntary agencies in addition to the Red Cross and the Order of St. John which supplied medical and nursing teams abroad for British or allied troops. The precise number is hard to establish. Mitchell identifies seven agencies, and an additional six separate units sometimes given support by these agencies.³⁷ Of these thirteen, only two do not appear to have taken medical women. Several, including Sir James

35. E.g. Bell Storming the Citadel, p. 163; Krippner Quality of Mercy, p. 74.

36. Murray Women as Army Surgeons, pp. 127-129 & 156, . Bell op.cit., pp. 163-165. Though a War Office establishment, the women at Endell Street were denied commissions, and many of the same rights as medical men, though conditions for the women at Endell Street were better than for those women who served directly with the RAMC after 1916 (see below).

37. Mitchell 'Medical Women in the First World War', p.8. Identification of discrete units is difficult because they were known by several different names, and there was frequent exchange of personnel. The thirteen only includes those supplying complete medical teams, and not, for example, the Almeric Paget Military Massage Corps, supplying 2,000 masseuses to the army by 1918, under a woman medical director. See Marwick Women at War p. 42.

Berry's Unit in Serbia (effectively an RFH unit) were mostly women. Three, SWH, WHC and the Women's Imperial Service League, were almost entirely staffed by women, acting as drivers, mechanics, orderlies, technicians, nurses and doctors.³⁸

These overseas medical missions were a major part of the voluntary patriotic work taken up by upper-class women from the start of the war.³⁹ But some, notably the WHC and the SWH were integrally connected with the suffrage movement, (though to different wings). Their founders clearly saw them as a chance to 'kill three birds with one stone: to serve the nation, demonstrate women's fitness for the vote, and advance the claim of medical women to do general work...' in a very public way.⁴⁰

This 'general work' was, of course, work with men as patients. Despite predictions of women's incompetence and their inability to keep order, and of soldiers' refusal to be treated by women out of modesty or lack of confidence, contemporary accounts (admittedly parti pris) aver that the only problems were with the War Office and RAMC bureaucracy. After all, declared Louisa Garrett Anderson, in a speech that hints at the feminism, professionalism and paternalism with which some approached their

38. Mitchell op.cit., pp. 8-9. All three did use some local unskilled male help but the staff they took out were women.

39. Marwick Women at War, pp. 36-42.

40. Lawrence Shadow of Swords, pp. 99-100. Emphasis original. On the SWH's connections with the constitutionalist National Union of Women's Suffrage Societies see *ibid.* pp. 100-102 (and a much quoted letter of Inglis to Mrs Fawcett, 9 Oct. 1914 (Fawcett Library Autograph Letter Collection)). On Murray and Garrett Anderson's associations with the militant WSPU see Murray Women Surgeons, pp. 7, 57, 86.

work:

'Most women doctors have had experience of the treatment of women and children ... if you have found out the way to treat children—what toys they like, what they like for tea, and what frightens them when going for an operation—you have gone a great way to find out how to run a military hospital. (Laughter) My hospital when complete will have 550 beds—550 large babies requiring a great deal of care, a great deal of understanding, and a certain amount of treatment.'⁴¹

Not all women joined these units with all three objects explicitly in mind, though clearly many did. Many had worked in the hospitals run by women in Britain. For them, a women-only unit was a familiar way for women to demonstrate their professionalism.⁴² But not all had this background. The young Isabel Emslie had always worked in hospitals run by men. Her chief tried to persuade her that she was indispensable as, by 1915, she had been placed in charge of both men and women patients in a mental hospital depleted of young male doctors. But she volunteered for the SWH, despite the taunts of her male friends that, "you'll all be quarrelling with each other the whole time, and the show won't last very long; these shows run by women never do", and her own

41. Speech at meeting to promote LSMW appeal Daily Telegraph (18 May 1915) (RFHSM PC Book IV). Perhaps 'maternalism' might be more appropriate than 'paternalism' but it conveys an image of warmth and domesticity at odds with the single-minded professionalism of the leaders of the WHC. (Therein lies the paradox of women doctors.) For scornful comments on the domestic and unprofessional orientation of French women doctors see Murray Women as Army Surgeons, pp. 70-71.

42. Murray, Garrett Anderson, and Winifred Buckley (?-1959), assistant surgeon with the WHC in Paris and Endell St, were all on the staff of the Harrow Road Women's Hospital for Children in 1914. Murray Women as Army Surgeons, p. 258. Others were drawn from the NHW, or had worked in women's hospitals in Scotland.

private doubts on this matter.⁴³

Medical women's involvement in these units varied from five years' continuous service to a few weeks as locum during holidays, with most probably serving about six months. I have identified 89 British medical women who spent some time with one of these units, at least 20 of them more than one year. But this may well be an incomplete list.⁴⁴ The SWH raised £450,000 and ran a total of fourteen different units, many simultaneously, each normally staffed by four doctors on three to six month contracts. At one stage in Serbia there were 50 British women doctors, fourteen in Mrs Stobart's Serbian Relief Fund unit alone.⁴⁵

Of the 89 identified doctors, the majority, 63, had qualified since 1905. But 26 (29 per cent) had been qualified for ten years in 1915 (16 of these before 1900). The majority were probably less than 35 years of age and comparatively inexperienced, and, for many, their service was a brief episode in varied war work. But there were some well over over 40 in 1914, and some, like Louise McIlroy and Frances Ivens, left well-established specialist careers for several years. These two were prominent among a small number who returned with enhanced professional and public

43. Hutton With a Woman's Unit, p. 22-23.

44. Names are from printed sources or Inglis's Reports and letters to Scottish Women's Hospitals Committee, Fawcett Library, checked for nationality in the Medical Register. I have included those such as Aldrich-Blake and Martindale who worked in France in vacations at least one month, but not those mentioned as visiting or as giving occasional help at Endell St. Riddell Aldrich-Blake, p. 51; Martindale Woman Surgeon, p. 163.

45. McLaren History of SWH, pp. 7-8, 366-371 (Almost all SWH doctors were British); Krippner Quality of Mercy, p. 91.

reputations to resume their pre-war work.⁴⁶

For a few, service with the units was a final stage in their careers. At least eight died during or immediately after their service and a number of the older ones retired after their return. Of the younger ones with long service, several continued to work in Serbia or for the voluntary agencies for the rest of their lives.⁴⁷ But most of the younger ones, like their male peers who had served overseas, returned to begin the reassembly of their lives in a highly competitive professional situation.

The voluntary units received great publicity, particularly after 1915, much of it actively sought to raise funds. In the long-term, their greatest significance for medical women as a whole was their dramatic breaking of the taboo on women's attending male patients. Though after the war many medical women would prefer not to attend men (and no doubt vice versa), the argument from propriety had lost most of its force as a means of excluding women. In the short-run, the Units helped the LSMW appeal considerably, and probably encouraged some women to take up medicine. They were also one factor in the belated, (and desperate) recognition by the War Office that medical women might have some value within the RAMC and in the women's services that

46. McIlroy, (?-1968) MB ChB. 1904, DBE, was assistant to the Professor of Obstetrics at the University of Glasgow immediately before the war, becoming professor of obstetrics at the RFHSM in 1921. (Who Was Who Vol VI). Ivens was lecturer in gynaecology at the University of Liverpool (Who Was Who Vol IV).

47. MWF Newsletter (March 1925), 60. On Katherine MacPhail's lifework in Serbia, and Frances Wakefield's in North Africa see Krippner Quality of Mercy, p. 178 & 214.

developed after 1917. Several of the medical women appointed to senior positions had had extensive service with the voluntary units.⁴⁸

Medical Women Join the Official War Effort: 1916-1918

In May 1916, the War Office appealed for the first time for medical women to serve with the RAMC, in Malta, Salonika and Egypt (as a reserve for a contemplated but abandoned Mediterranean campaign), and at home. About 100 women volunteered to go overseas. Women contracted to the RAMC were given no rank, no uniform, none of the taxation and ration rights of male officers. They found themselves with no status in the military hierarchy and, in the Mediterranean, with nothing to do. The newly formed Medical Women's Federation found itself engaged in 'incessant boring agitation' to remove minor grievances, but the establishment was unmoveable on commissions, advised by Crown Law Officers that to give women commissions required legislation.⁴⁹

In 1917, the first of the three women's auxiliary services was begun, bringing together in camps large numbers of young women needing medical treatment, inspection and education, especially

48. McIlroy was one, appointed an RAMC surgical specialist in Constantinople in 1918. Laura Stewart Sandeman (1868-1929) MB Ch.B. 1903, had served a year with the SWH and then as resident medical officer in the Military Hospital at Leith when she was invited to become Medical Controller of the newly formed Queen Mary's Army Auxiliary Corps (QMAAC) in France in 1917. MWF Newsletter (July 1929), 19-23.

49. MWF Symposium 'Women doctors in the British forces, 1914-1918 War' Jnl.MWF 49 (April 1967), 99-100; MWF Symposium 'Medical women's services in the Great War' MWF Newsletter (Jan. 1939), 26-43.

(in the eyes of their superiors) concerning the undesirable consequences of sexual activity.⁵⁰ In all three auxiliaries, a small central staff of medical women, several of whom had extensive public health experience, were appointed to co-ordinate this task.⁵¹ They too were engaged in constant struggle for appropriate recognition of their services.⁵²

The scale of medical women's direct employment by the services was not large, perhaps involving 15 per cent of all active women. But it did set precedents for the future role of medical women in the forces in peace and war, not least creating a legacy of bitterness and suspicion towards the military authorities.

50. First was the QMAAC, under the directorship of a medical woman, Mrs Chalmers Watson, sister of the Director General of National Service (and cousin to Louisa Garrett Anderson), followed by the Women's Royal Naval Service (WRNS) in November 1917 and the Women's Royal Air Force (WRAF) in April 1918. MWF 'Women doctors in the British forces.'

51. The QMAAC eventually had women medical controllers in Britain and France, with about 12 central staff, and more local women medical officers. The WRNS had 2 full-time women medical officers but most of the local work was carried out by male naval practitioners (some of whom 'had not been in charge of a woman patient since their hospital days') or local general practitioners. The WRAF had in total 14 fulltime women medical officers. MWF 'Women doctors in the British Forces', 99-103.

52. The first women medical director of the QMAAC, Isabella Cameron resigned over this, producing slightly better conditions for her two successors, Stewart-Sandemann in France and Jane Turnbull in Britain, and their staff. In the WRAF honorary commissions were granted unofficially. MWF op.cit; Bell Storming the Citadel, pp. 166-167; Marwick Women at War, pp. 86-94 (N.B. Marwick confuses Cameron and Turnbull.)

The women's auxiliaries were only a minor part of British women's official war work. From mid-1915, official reluctance to employ women slackened as men were called up and the need for ammunition grew. From 1916, about 50,000 people at a time, mostly women, were employed in the Ministry of Munitions' factories and thousands more in other factories.⁵³ As in the women's auxiliaries there was an elaborate system of welfare inspection, often deeply resented by the women workers.⁵⁴

Many of the medical inspectors were women, often part-time general practitioners or public health doctors. Their role was mainly to screen new recruits and monitor the toxic effects of TNT, in order to maximize shell production with minimal damage to women's reproductive health, which was still a dominant official concern. In some of their reports, the women doctors recognized the realities of the women's situation, in which the benefits of a decent wage and a better diet might outweigh the dangers of the actual work to pregnant women; although married women's employment was generally regarded as undesirable.⁵⁵

Outside the factories, state concern with the moral and

53. Braybon Women Workers in the First World War, pp. 44-57; Lewis Women in England, esp. pp. 179-181.

54. Braybon op.cit, pp. 141-144; Marwick Women at War, p. 151.

55. E.g. Dr. R. Adamson's report in 1918 arguing that a policy of dismissing pregnant women would lead to induced abortions among women for fear of losing their jobs. R.H.B. Adamson 'Medical work in the munitions factories' in MWF Symposium 'Medical women's services in the Great War', 38-41; Lancet (12 Aug. 1916), 261; and the contributions to official reports on women's health and industrial work written by Janet Campbell, e.g. Report of the War Cabinet Committee on Women in Industry (London: HMSO, 1919) Cmd. 135. For detailed discussion see Braybon Women Workers in the First World War, pp. 112-53; Lewis Women in England, pp. 34-36; A. Ineson and D. Thom 'T.N.T. Poisoning and Women Workers' in The Social History of Occupational Health. Edited by P. Weindling (London: Croom Helm, 1985), pp. 89-107.

physical health of the civilian population was developing in two ways that concerned women doctors. The first was the growing provision of local authority clinics for treatment of venereal diseases, under the provisions of the 1916 Venereal Diseases Act. Though only a few women were appointed to such work during the war, the MWF pressed for the appointment of women to women's clinics from its foundation in 1917.⁵⁶ Second was the process, described in the previous chapter, of formally incorporating the voluntary infant welfare clinics into local authority public health services, a process which accelerated as concern to replenish the population mounted. Increasing numbers of women found themselves being paid for what they had done free for many years—but most of this work was on a part-time basis.

Thus, though several hundred medical women had some state employment during the war, the long-term effect of such work on the structure of medicine, and the career opportunities for medical women, should not be exaggerated. Much of the work was inherently temporary, linked specifically to the war effort. Much was part-time. Only infant welfare work, consolidating pre-war developments, was to provide significant opportunities after 1918.

56. MWF Quarterly (Jan. 1919), 6. Medical women, especially suffragists, had been prominent in the prewar social purity movement pressing for action against male spread of VD, notably L. Martindale Under the Surface (Brighton: Southern Publishing Co. 1908). Though the immediate origins of the 1916 Act were more concerned with the health of soldiery, Scharlieb, a leading social purity campaigner, was a member of the Royal Commission on Venereal Diseases which led to the act. BMJ (29 Nov. 1930), 936.

Medical Women as Substitutes for Men: 1914-1918

As we have seen, by 1917, about half of all British doctors were serving with the armed forces, nearly all of them men. Only a small fraction of the 12,000 doctors in the RAMC could be replaced by women or by elderly men, many of both sexes coming out of retirement to do so. Although there are no central statistics, contemporary reports suggest this increased sharply after 1916. The largest part of medical women's war work was almost certainly as substitutes for individual men in general practice, hospital and public health or resident hospital posts. But this is also the work least well reported in national sources.⁵⁷

A number of the women appointed as assistant MOsH before the war with responsibility for child health acted as MOsH during the war. Several local authorities who had adopted marriage bars before the war exempted medical women during the war for full- and part-time appointments in public health and in hospitals.⁵⁸ Substitution in general practice was primarily a private affair, usually involving neighbouring or retired practitioners. There are many accounts of individual women general practitioners working long hours with vastly increased workloads, often also acting as part-time CMPs.⁵⁹ Some already had, or took on, honorary hospital work, which often swamped the general practice work. In these accounts, several features recur: the sheer volume, and often

57. This is another area where more detailed local study than I have been able to undertake would be valuable.

58. Davies 'Little credit and less cash'.

59. Conditions of service for CMPs were the same for men and women, 20s a day, no rank, no promotion, no uniform and no ration allowance, but private (and NHI) practice could be continued. CMPs could not be moved by the military authorities. This work was also described as 'convenient for women with family duties'. MWF 'Women doctors in the British forces', 99.

tedious nature of the work, the presumption that women would work for nothing, the difference between men and women in the same position due to the military regulations, and the gradual incorporation of women into military work. Two examples illustrate this.

Mabel Ramsay spent the first eight months of the war with a Women's Imperial Service League unit in France and Belgium before returning to her established general practice in Plymouth.

'I was soon involved in much medical work, doing a male colleague's practice, acting as out-patient surgeon and anaesthetist at a Voluntary Hospital, and as a civilian medical practitioner at £1 a day at the three Territorial Hospitals, and in the odd intervals doing my own work ... Later as a [CMP] I was appointed to serve on one of the Medical Boards which assessed war injuries ... At first no woman doctor was permitted to sit on these ... but ultimately the numbers ... were so numerous that sex was forgotten and we had to take our share of attending these wearisome and tiring Boards. Looking back now I wonder how all this work was accomplished for it meant practically a sixteen hour day for three-and-a-half years ...

'... from all women much free service was ... expected. It is interesting now to recall with what a cheerful freewill spirit we all worked without reward or remuneration ...'⁶⁰

Rhoda Adamson was in general practice in Leeds, honorary anaesthetist at the General Infirmary (LGI) and obstetric surgeon at the Maternity Hospital when war was declared. The LGI was partly taken over by the army, and the Second Northern General Hospital was set up, staffed by the male honoraries of the LGI as RAMC officers. She was asked by a senior surgeon to administer his anaesthetics at the military hospital.

'I replied that I would be willing to do so provided that I was given an exactly similar position with my men colleagues. On reference to the Lt. Colonel in command this [commission etc] was turned down ... From 1914 to November, 1918, I spent my time giving anaesthetics ... in the general hospital and

60. MWF Symposium 'Medical women's service in the Great War', 41-42. Ramsay (1878-1954) MB ChB 1906. BMJ (15 May 1954) 1077.

carrying on the work at the Maternity Hospital without a resident and taking my own duties and those of my male colleagues who held commissions at the Second Northern ...⁶¹

From 1916, she added five hours work a night, six days a week, as medical officer to women ordnance workers. When asked again to give anaesthetics at the military hospital, this time with pay, she regretfully refused, because she was, by then, working 'from 8 a.m. to 12 midnight every day except Saturday at 3 p.m. till Sunday at 6 p.m.'. As a result, many serious surgical cases were transferred from the military hospital to the LGI so that she could give the anaesthetics (unpaid).

'While my part in medical women's war work was in no way spectacular or even in many cases other than routine drudgery it... was treated with respect by those with whom I worked. During the whole period of the war I found myself taking over more and more unpaid hospital work to relieve men for work in local military hospitals, though the fact that they held commissions and received pay as officers in the Territorial Army in no way prevented them from working in their private practice for patients from whom they received fees.'⁶²

Apart from this kind of unpaid de facto full-time hospital work, young medical women were, by the beginning of 1915, filling increasing numbers of full-time paid resident posts, mainly in the hospitals not taken over by the military. Although this meant that the majority of these were in special and small hospitals, some were in the teaching hospitals, as the restrictions on women's appointments were relaxed. From 1915, all the house-posts at the RFH were held by women. There was no longer any question of confining them to the women's wards. In December 1916, seven women housestaff were reported at the London Hospital. The

61. *ibid.*, 38.

62. *Ibid.*, 40. The emphasis on unequal treatment is in part due to the context—MWF Symposium—but what is described is a structure which many women found themselves in (though Adamson may have been an unusually skilled anaesthetist).

newly qualified Helena Wright was, with a friend, the first woman resident at Hampstead General Hospital early in 1915, and then the only woman house officer at Great Ormond Street Children's Hospital. She then went as the only woman and only civilian doctor to Bethnal Green Hospital taken over by the military.⁶³

Quite apart from the military regulations, women in hospital posts previously held by men still found themselves subject to restrictions or treated as anomalies, this being especially apparent when they worked alongside men.⁶⁴ But those who qualified close to the beginning of the war and held such posts may have had significant advantages over their predecessors and their immediate successors, in the narrow sense of career advantage. They had unrivalled opportunities for training and clinical experience and may have been able to establish themselves before the majority of men returned and the window closed.⁶⁵

Women holding houseposts previously held by men were not substituting for individual men, since such posts were always temporary. When the war ended there was no question of whether

63. Magazine of L(RFH)SMW 14 (1919), 125; Daily Telegraph 16 Dec. 1916. (RFHSM PC Book VI). Evans Freedom to Choose, pp. 75-80.

64. Dame Hilda Lloyd, MB ChB 1916, first woman president of the Royal College of Obstetricians and Gynaecologists, recalled her valued posts and that she was not allowed to use the male residents' dining room at one hospital, but ate with the very senior matron. Jnl.MWF 40 (July 1958), 180-181.

65. It is not possible to test this systematically, but women who qualified around 1914, and who later achieved great professional success often placed great stress on the quality of their resident training. E.g. Gertrude Herzfeld Mb ChB 1914, who became a leading woman surgeon in Edinburgh received wartime post-qualification surgical training at the Royal Edinburgh Hospital for Sick Children, the first woman to do so, and was appointed to the Honorary staff in 1920. G. Herzfeld' Forty years of surgery: some random recollections and reflections' Jnl.MWF 39 (Oct. 1957), 246.

particular women might keep these posts when contracts expired, only of what their next step might be and of who replaced them. The situation of women who were substituting for individual absent men or "acting" in a permanent position was different. Professional etiquette, social pressure on women, and legal contracts, demanded that 'substituted positions and practices were loyally surrendered at the end of the war'.⁶⁶

In practice this process was neither smooth nor universally welcomed by women, nor did it always happen. In some cases there was no man to return, at least initially. In general practice, the sensitive question of reallocating patients to their proper doctors probably gave rise to much tension between doctors, male and female. Undoubtedly, the practices of some of the women and the men who remained at home were enlarged as a result of their wartime substitution for absent colleagues.⁶⁷ Some women's wartime service in hospitals did lead to permanent appointments to honorary positions. One example was Hazel Chodak Gregory, appointed acting Assistant Physician at the RFH in 1916, who 'virtually ran the medical side from both teaching and clinical aspects together with the late Dr Walter Carr' during the war. In 1920, just after the birth of her son, she was elected Assistant Physician.⁶⁸ But in many cases where women were identifiably

66. MWF 'Medical women's service in the Great War', 27.

67. E.g. Cecilia Williamson, (1884-1914) FRCSI 1910, had made 'small, slow progress' in her Ipswich practice before 1914 but her maternity work in the war 'made her name' and led to honorary appointments at the local hospital. Jnl.MWF 47 (Oct. 1965), 260.

68. Hazel Cuthbert Chodak Gregory, (1886-1952) MB ChB 1910, later turned down the post of Senior Physician at the RFH (the first woman to be offered the post) to head the new children's department. Jnl.MWF 34 (April 1952), 53-54. See Chapter IX.

acting as substitutes they retired or returned to their original posts. None of the women acting MOsH were confirmed in post. It was 1928 before a woman held such a post permanently.⁶⁹

Like their male colleagues, medical women who had been wholly involved in war work, official or voluntary, found this work gradually disappearing after the Armistice. Some, especially the older ones, had established positions to return to with enhanced clinical or administrative skills. Others found new senior opportunities to use these skills on their return to peacetime life.⁷⁰ But many, especially the younger ones, had to start more or less afresh. And, of course, the war had changed personal as well as professional lives, bringing much bereavement and, though the statistical chances of doing so were being reduced, many individuals married during or at the end of the war.⁷¹

I have discussed the four war years in some detail because they have been widely described as bringing major changes to the situation of women in medicine. But the changes in women's position in the profession were less sweeping and exhibit a more complex pattern than has sometimes been thought. The impact of the war on individual medical women in both the short-and long-term, was very varied, as it was for medical men.

69. Bell Storming the Citadel, p. 184.

70. Administrative experience was sometimes put to use in public health after the war. Fairfield returned to be a Senior Medical Officer at the LCC in 1919 after directing the medical services of the WRAF. Who Was Who vol VI. Turnbull left the QMAAC to be one of the five women appointed to the new Ministry of Health's Maternity and Child Welfare section in 1918, replacing Janet Campbell as the head of this section in 1933. Jnl.MWF 41 (Jan. 1959), 46.

71. Personal accounts of the effect of marriage on their immediate postwar medical work are found in Hutton Memories of a Doctor, pp. 205-213; Evans Freedom to Choose, pp. 80-85.

Medical women as a group, or rather a category, emerged from the war with their public prestige immeasurably increased, and with the public taboo on treating men demonstrably broken down. But the basic structure of medical opportunities had not changed. Women were about to emerge from medical schools in vastly increased numbers, enlarging the category but bringing many problems for these individuals in the postwar years, to which I shall now turn.

CHAPTER IX

BACKLASH AND RECOVERY?: 1918-1944

A Glut of Women?

As we have seen, the end of the war saw the civilian medical service in chaos with thousands of doctors being demobilized. Those returning to general practice found their incomes temporarily reduced by loss of patients and the effect of inflation on NHI capitation fees. The public health authorities' plans for reconstruction were soon hit by government economies as unemployment rose. The voluntary hospitals were in acute financial crisis as any exchequer grants for military work were withdrawn. The creation of the Ministry of Health aroused concern about possible moves to extend salaried services, and major hospital reforms were being tentatively floated.¹ At the same time the medical schools were refilling with those whose studies had been interrupted and with new students with ex-service grants.

Not surprisingly, allegations of a glut of doctors were soon heard. Professional spokesmen urged the dissuasion of young men and, above all, young women, from entering a profession where 'the

1. E.g. Abel-Smith Hospitals, esp. pp. 284-302; Honigsbaum Division in British Medicine, pp.45-162; Parry and Parry Rise of the Medical Profession, pp. 196-203.

prospects of gaining a livelihood were meagre.² The majority of such claims emphasized that it was women who were finding (even creating) problems. Many national papers took up the theme as part of a general debate about women's employment.³ Senior medical women and LSMW representatives countered that any apparent overcrowding was temporary, and that many opportunities existed, especially with increasing concern about maternal and child health, for 'the right kind of woman'. Such defences often contained an implicit warning to prospective women students. What was wanted were "professionals" who would give no support to allegations of wastage,

'Women want a fair field and no favour but they have been slow in learning that they must accept the conditions that men have to accept. They are realizing today that they may have to sacrifice domestic ties exactly as men have done in making careers for themselves.'⁴

Concern about overcrowding and the economic constraints being felt by many middle-class families, including medical ones, partly explain the fall in medical school entrants—of both sexes, but especially women—from 1922 until the late 1920s, which was

2. President of GMC quoted Daily Chronicle 22 Sept. 1921 (RFHSM PC Book VI); BMJ (3 Sept 1921), 315; (2 Sept. 1922), 601.

3. The feminist journal Time and Tide (10 Oct. 1924) claimed that The Times and the Evening Standard were particularly active in promoting the idea that there were too many women doctors. Times 4 & 6 Aug. 1921; 22 Sept. 1921; 1 Oct. 1921; Evening Standard, 2 Dec. 1920; 20 Sept. 1921. But the RFHSM PC indicate that they were not unique.

4. Flora Murray in Yorkshire Evening Post 1 Oct. 1920; Miss Brooks, Secretary to LSMW, Daily Chronicle 22 Sept. 1921; Manchester Guardian 21 Feb. 1921; Times 22 Sept. 1921; (RFHSM P C Book VI). The LSMW, like any school, wished to keep its numbers up.

described in Chapter IV.⁵ Even at the LSMW, where exclusion of women was not a factor, entrants fell from 112 in 1919, to 36 in 1923, averaging 50 per year from 1924 to 1929.⁶ But it was not the only factor.

The allegations of glut intensified in the mid-1920s, as the wartime women entrants qualified. The BMJ regularly reprinted an editorial from Public Health giving a dire warning of the poverty of many qualified women. Reports such as one, in 1925, that 78 women had applied for one resident post in a children's hospital in Sunderland were seized on by some as evidence that 'scores if not hundreds of newly-graduated women are seeking in vain for hospital appointments'.⁷ Others argued that such claims revealed 'the chief factor in the case':

'if more appointments of all kinds were open to women the problem of alleged overcrowding would be in a fair way of solving itself. We have only to look below the surface of things to find that sex antagonism has still to be reckoned with...'⁸

As this implies, behind allegations of 'glut' were concerns about the effect of large numbers of women on the profession's status and on the livelihood of members. One anonymous 'Harley Street man' was explicit about one of the grounds for this.

5. Applicants to all courses fell but this was particularly marked in medicine after the initial postwar bulge had passed. UGC Annual Reports, 1922/23-1929/30.

6. UGC Figures.

7. Public Health (1924), 101-102, reprinted in e.g. BMJ (6 Sept. 1924), 433. On women's application to houseposts see Lancet (17 Jan. 1925), 157; (24 Jan. 1925), 207-208; Medical World (Feb. 13, 1925) (RFHSM PC Book VI). Lancet (16 April 1927), 846.

8. Lancet (8 Oct. 1927), 831.

"women are not always to be trusted... there is a widespread suspicion—only a suspicion— among panel doctors that there is a desire in official quarters to swamp the medical profession with women in the hope of establishing a state medical service worked on more or less cheap labour."⁹

The Reaction against Co-Education

Sexual antagonism was also apparent in the reimposition of restrictions on the admission of women to medical schools and teaching hospitals which produced the shift away from co-education in the 1920s described in Chapter IV. None of the provincial and Scottish university medical schools formally closed their doors to women; but many issued discouraging statements and some closed houseposts to women.¹⁰ In London, opposition to the presence of women in the seven men's schools admitting women in the war gathered momentum during the 1920s. Initially, it seemed as if one permanent gain had been made. In 1919, St. Mary's Hospital Medical School agreed to continue to take clinical students from the LSMW, and, in 1920, admitted women directly to pre-clinical studies, with public statements of its commitment to co-education.¹¹ But this proved a unique and short-lived concession.

Ironically, the RFH was one of the first places to react against women's presence. In May 1919, 374 past students of the LSMW petitioned the hospital authorities against proposals to reserve two of the six houseposts for men, a move justified by the

9. Evening Standard 2 Dec. 1920. (RFHSM PC Book VI)

10. Evening News 2 Oct. 1922; Yorkshire Post 23 March 1928. (RFHSM PC Book VI).

11. 'Co-education and St. Mary's Hospital' Time and Tide (10 Oct. 1924), reprinted in Time and Tide Wait for No Man ed. D. Spender (London: Pandora, 1984), p. 248.

hospital's medical committee on the grounds that it, like the LSMW, was committed to the principle of a mixed staff. In the event, formal reservation was not agreed then. But in 1927 the RFH's lay board closed three of the (by then) fifteen houseposts to women, despite the LSMW's protestations, claiming that,

'If the hospital is overrun by women it will suffer in the future. It would become a women's hospital and would then be no good as a teaching hospital...We want to maintain the hospital's reputation for turning out the best type of medical women. The majority of medical women themselves fully endorse the proposals...[for] a certain number of male residents for the good of the hospital.'¹²

In 1919, St. George's Hospital stopped admitting women clinical students, and a subsequent increase in male entrants was attributed to this decision by some.¹³ The following year, the clinical students at University College Hospital Medical School urged the authorities to rescind their 1918 decision to admit women, which had followed University College's admission of women pre-clinical students in 1917. The men's stated objections to women concerned the damage they would cause to the hospital's recruitment and the prospect of submitting to female authority.

'while such Hospitals as Guy's and St. Bartholomew's refuse to admit women students we are convinced that they will continue to be a source of attraction to Public School and Oxford and Cambridge men.

'Again, many second and third year men now in College are looking with alarm to a time when women will be admitted to house appointments. We need hardly point out, gentlemen, the

12. Magazine of L(RFH)SMW 14 (1920) pp. 125-133.

13. Daily Telegraph 30 Oct.1922 (RFHSM PC Book VI). Male entrants to St. George's rose from 2 in 1919/20 to 20 in 1921/22 and 29 in 1922/23, as the immediate postwar increase of male students began clinical studies, and then fell. The direct impact on women's places was minimal as only 7 women had ever been admitted. UGC Figures.

intolerable position of an ex-Service man who has, perhaps, as his House Surgeon over him, a girl of twenty-two...¹⁴

The Medical School Committee compromised, between the men's demand and the pressure of the women students and the College's Provost, by offering twelve places to women clinical students. This arrangement lasted until after the Second World War.

The decision of the London Hospital Medical College to cease admitting women in March 1922 aroused much press comment, partly because of the differing reasons given for the decision. The hospital chairman claimed it was because the best students preferred single-sex schools and, 'we could not risk ruining our school for the problematical benefit to women students who have accommodation elsewhere.'¹⁵ A school representative claimed simultaneously that it was because of the surplus of women doctors and because women doctors wasted their training.¹⁶ But most public attention centred on several staffs' claim that mixed teaching had led to difficulties with certain 'unpleasant' subjects, and that

14. Letter from men students to Medical School Committee, Oct 20th 1920 quoted in Merrington UCH and Its Medical School, pp. 238-239. The Hospital and the College were legally separate institutions, and normally not more than a half of College students did their clinical studies at the Hospital.

15. Times 10 March 1922. The LHMC had admitted more women than any other men's school (120) since 1918, but only 2 in 1921/22.

16. Times 5 March 1921. ('One excuse or the other, Sir, but not both' was the apt comment of Time and Tide 10 March 1922, in Spender Time and Tide, p. 247.)

'in a few months the girls become coarse, immodest and vulgar.'¹⁷

This reassertion of the delicacy argument was greeted with some scepticism in the lay press in 1922, it being generally regarded as a cover for economic interest, and repudiated by the school authorities. But as pressure mounted on women in the four other co-educational schools faced with falling numbers, it was repeatedly reiterated in a way that suggests hostility among some staff and students to women's very presence as well as to its consequences. In 1924, St Mary Hospital Medical School ceased admitting women, and, in 1928, the Westminster, Charing Cross and King's College Hospitals Medical Schools did the same.¹⁸

These decisions were also defended by reference to the alleged surplus of women doctors and their 50 per cent wastage through marriage, to the availability of places for women outside "our" hospitals, and, above all, to the alleged fact that the 'best' were preferring single-sex schools. The traditional London hospital medical schools in the 1920s and 1930s placed great weight on selecting the 'best' students to maintain the standing of the profession. What was wanted was not great examination proficiency but the personal qualities of 'the public school man: "High intelligence, outstanding character, and considerable skill at games".'¹⁹ Prowess at Rugby was not just important for the

17. The issue was extensively debated in the correspondence columns of the Times 3, 5-15 & 21 March 1921. Another charge made by critics was that staff feared loss of income because women would not go into private practice,, and hence not refer patients. Daily News 3 March 1922 (RFHSM PC Book VI).

18. Times 2 & 18 Oct 1924; 12, 20-30 March 1928.

19. Stevens Medical Practice in Modern England, p. 57.

Inter-Hospitals Cup, a major source of school prestige. For many, 'rugger, in this connection, meant "calibre"; it marked moral, mental and physical fitness for medicine.²⁰

It is not merely that women did not play rugby, and took places from rugby players. They discouraged such men from applying, for

'there still remains a very considerable group of young men, as a rule of the more robust physical type, who find it very distasteful to be obliged to listen to lectures on certain subjects in the presence of the opposite sex...My own experience has been, the more virile the young man, the more modest he will be found. The degenerate type physically is the one which finds nothing strange in discussing these intimate matters in the open.'²¹

Thus, contemporary ideas about physical and moral degeneration gave rise to an inverted delicacy argument according to which men needed protection, especially from the unruly, aggressive hoydens in the mixed medical schools. This was the final twist to the argument, drawing on the postwar reaction against women's new confidence and contemporary anti-feminist biologism. Engaging in physical or mental "masculine" activity was held to render women degenerate. Women medical students were repeatedly accused of being aggressive, exploiting the norms of chivalry on the wards and so depriving men of their clinical experience. 'After all, one knows how to treat a male "bounder", but the female prototype

20. 'Senior Mary's man' quoted in Daily News 4 Oct. 1924; Times 20 March 1928; Morning Post 13, Daily Mirror 19 March 1928 and other items for October 1924 and March 1928 in RFHSM PC Book VI.

21. Morning Post 23 March 1928; Nation and Athenaeum (13 March & 14 April 1928) (RFHSM PC Book VI).

opens up a much greater difficulty. She is an intolerable pest.²²

These ideas were not held by all medical men. Their more extreme manifestations were criticized in the lay press and often officially denied by medical school spokesmen emphasizing the allegedly more rational grounds for exclusion of "glut" and wastage through marriage. But the persistent re-iteration of the best students' preference for single-sex schools suggests widespread hostility to women's presence in men's schools, aggravated by, but not entirely due to, falling entries.²³

Medical women, and feminists, particularly the Six Point Group, protested at these restriction of women's choices, and the slights on women's competence and professional commitment. Reflecting contemporary feminist and social concerns, the main argument put forward for women's right to be doctors in the 1920s was their role in raising the health of mothers and children. As their opponents were quick to point out, this was no argument for co-education. One of the difficulties medical women's defenders

22. Yorkshire Post 23 March 1928. See Lewis Women in England, pp. 101-106 on anti-feminist ideas in the 1920s.

23. Whether there was any justification for the belief is hard to establish. The 'very careful enquiry' school authorities claim to have made are not documented, though there are innumerable letters to the medical and lay press saying this was so. Of the three men-only London schools for which UGC figures on entry are available, one, the Middlesex, showed the greatest drop of all from 1920 to the mid 1920s. Comparing intakes of 1920 with 1922 and 1924, both St. Thomas's and St. Bartholomew's show the smallest fall of all the London schools with full courses, and in one case, a gain. This was partly spurious, as neither school appear to have had a markedly increased intake in the immediate postwar years. (Such comparisons are, in any case, possibly misleading, because there may be different proportions of clinical entrants.) On a crude level these figures could have been used by the women's opponents. But they provide no evidence that excluding women led directly to an increase in male entrants in any school.

faced for most of the 1920s lay in demonstrating that women were actually being deprived of clinical training. Entries had fallen so sharply in the face of the backlash that there were places unfilled at the LSMW and RFH and in provincial schools.

By 1928, there were signs of a revival, with more women preclinical students at the women's colleges of Oxford and Cambridge and at King's and University College in London needing clinical training. There were, therefore, particularly vehement protests by women's organizations at the closing of places for women at Charing Cross, Westminster and King's College Hospitals in 1928.²⁴ A second University of London sub-committee on co-education concluded that there were no valid objections to it in principle though recognizing the strength of feeling against women in some schools. It recommended that there be both single-sex and co-educational schools, and that about one hundred additional clinical places for women would be required in the future. But it noted that the University had no effective powers to require men's schools to admit women, without legislation imposing co-education on all constituent schools, including the women's colleges. The same reservations applied to using the University's prospective financial muscle, when from 1929, the Treasury grant would be paid in a central lump sum. Again, the complex institutional and political structure of London University is important for under-

24. 'Memorandum of Joint Committee of Women's Organizations to promote women's opportunities in medical and hospital services' Times 18 Aug. 1928; BMJ (22 Sept. 1928), 544; Lancet (29 Sept. 1928), 662.

standing why co-education was not introduced.²⁵

Thus, the committee's report left unsolved the problem of how extra clinical places for women might be found. Only King's College Hospital reversed its decision and agreed to admit a strictly limited number of women. Some, including the committee's chairman Sir William Beveridge, suggested that small quotas of places for women could be set aside by the largest schools, without undue damage to their prestige. Feminists such as Lady Rhondda suggested enlarging the RFH, the one hospital offering equal opportunity. This idea was opposed by some as 'throwing in the co-educational sponge', and by others as based on a fallacy alleging that the RFH was really the teaching hospital for a single-sex school whose existence was a barrier to the adoption of co-education. Others proposed the use of general hospitals not currently used for teaching, realized eventually with the short-lived clinical school at the West London Hospital from 1937.²⁶

Except for this and the concession at King's College Hospital, no solutions were forthcoming. As male medical students increased in the 1930s the possibility of men's schools admitting women became more unlikely, expansion being impossible because of the financial crisis of the voluntary hospitals. Well-qualified women applicants were being turned down in London and, above all, in Oxford and Cambridge, 'owing to the difficulty of obtaining

25. MWF Newsletter (March 1929), 38-47.

26. Times 19, 24, 28-30 Jan, 2, 4, 6-9, 12-16 Feb. 1929. On the West London Hospital see Lancet (1 Sept. 1934), 494; (17 April 1937), 954; (24 April 1937), 1011.

places in London schools for any but outstanding applicants.²⁷

This widely recognized exclusion of women was part of the background to the establishment of the Goodenough Committee in 1944 to plan for medical education in the National Health Service, and to their adoption of universal co-education and quotas as the only solution that would be tolerated, though not universally welcomed, by the London medical schools. The position of the LSMW had become problematic as pressure for women's entry to men's schools grew in the 1930s. This was recognized by the MWF in its controversial evidence to the Committee. They conceded that if, and only if, universal co-education were introduced with sufficient safeguards for women in men's schools, there would be little justification for the LSMW's continuing as a women's school—the position that the Committee was itself to adopt.²⁸

This overview of the background to the arguments about women's medical education in the inter-war years makes it clear that these were not years of dramatic and sustained breakthrough for prospective medical women. Rather, there was a sustained reaction which caused both a drop in the numbers seeking to have medical careers, and restriction of opportunities for those who did seek to enter medicine. But some did enter, and there were

27. Daily Telegraph 25 March 1937 (RFHSM PC Book VI); 'Report of Co-education Watching Committee' MWF Newsletter (July 1937), 49.

28. See Chapter IV. In its report the Goodenough Committee reproduced many of the MWF's arguments verbatim. MWF 'Memorandum submitted to the Interdepartmental Committee on Medical Schools' MWF Quart. Rev. (April 1943), 56-59. For a personal account of the Goodenough Committee's workings by its woman member see the interview with Janet Vaughan in Women of the Century, ed. L. Caldecott (London: BBC, 198p. 64-67.

also some two and a half thousand women qualified as a result of wartime opportunities and those whose careers had been disrupted by the First World War already in the profession.

Wastage in the Inter-War Years

The claims and counter-claims about overcrowding and wastage of the 1920s were carried on in an almost complete absence of evidence about what was actually happening. There is little doubt that claims of fifty per cent loss through retirement on marriage made in defence of women's exclusion from men's schools were exaggerations. There is equally little doubt that, from 1919 to the late 1920s, young medical women had great difficulty in finding rewarding work, despite the denials emanating from the LSMW. There is ample record of this in contemporary journals and retrospective recollections. There were also strong social pressures and often legal restrictions against married women's employment. It would not be surprising if "wastage" rates were high, compared with men's and with women's in other periods, but there is insufficient data to establish this. A few surveys were carried out, usually in expectation of finding evidence against the allegations of glut. They provide information on women only (but some had poor response rates or were methodologically weak).

In 1926, the LSMW traced its qualifiers from the years 1923 to 1925, and reported that there was no cause for concern about their prospects. Only 15 per cent of respondents (33 of 216) were 'temporarily in want of employment', almost all having had at

least one hospital post.²⁹ In 1928, after the three last schools had closed their doors to women, the MWF followed up these same students and the 410 women qualified from five of the London men's schools in the same years. Seventy-six per cent were in active medical work. Five per cent were not traced, 6 per cent were found to be temporarily unemployed and 10 per cent retired, almost all of them married. But 40 per cent of the 103 who were married were working. These findings were widely disseminated to the press, together with a report that of the 1,000 MWF members living in the British Isles, only 9 per cent were retired.³⁰

The next attempt to assess the activity of medical women in general seems to have been in 1938, again in connection with co-education. The MWF sent a questionnaire to all 6178 women on the Medical Register, but obtained only a 44 per cent response rate. Of the 2369 respondents living in Britain, 13 per cent were retired, some presumably through age, but respondents were probably greatly biased towards the active.³¹ A similar exercise in 1944, produced a 55 per cent response rate. In this wartime survey, 14 per cent of all respondents were not working, 7 per cent of the single and 22 per cent of the married. The Goodenough Committee's check of the BMA's Index in 1944 found 11.5 per cent (669 of 5814 women and less than one per cent of men under 50 were

29. MWF Newsletter (Nov. 1926), 82-83; Manchester Guardian 2 Oct. 1926 (RFHSM PC Book VI).

30. Times 31 May 1928; BMJ (4 June 1928), 24. (MWF membership was probably biased towards older, professionally active and successful women.)

31. MWF Quart.Rev (April 1940), 52; MWF Quart.Rev (Oct. 1945), 11.

retired, both figures likely to be lowered from prewar levels by wartime exigencies).³²

There is, then, little information on the activity rates of women doctors as a whole in Britain between 1918 and 1948. There were, however, some surveys of individual schools. These are too sparse, too varied in their design and the population studied too varied (and usually too small) to give more than the broadest indication of activity at particular times. The highest reported "wastage" I have found refers to the 218 women medical students at Manchester between 1899 and 1923 in 1930. Of these, 178 (82 per cent) qualified. Twenty-six per cent of these were 'engaged in no regular work' at the time of the survey, though many were thought to be 'indirectly using their medical knowledge for the benefit of others'. Forty-four per cent were married, half of these were not working in 1930.³³

In 1936, a full follow-up of the women entrants to St. Mary's Hospital Medical School between 1916 and 1924 was published. Of 255 entrants 230 (90 per cent) had qualified and 17 per cent of these were not working in 1936 (excluding all work that did not directly depend on a medical qualification, occasional locums for husband, and those temporarily out of work). Seven per cent were undertaking 'light professional work (welfare clinics or other part-time work)'. The remainder were in full-time work. Just under half of the respondents (96) were married, 55 of them with

32. Goodenough Report, p. 252.

33. MWF Newsletter (March 1931), 38. All but about 20 of the 178 would have been post-1914 qualifiers.

children. Marriage and motherhood did not preclude working: 65 per cent of those married with children and 73 per cent of those without were working (the former being slightly more likely to be part-time).³⁴

Numbers are small and may not have been typical, referring only to a small group of women probably aged between 35 and 45 in the mid-1930s. But half the admittedly small group of married women with children were in full-time work. The author, herself a married St. Mary's qualifier with children, and deputy editor of the Lancet, noted that several of those not working state their intentions to return when their children are older, and that some have already done this. The bimodal career was not unknown in 1936, but it is impossible to say how common it was.

Before looking in more detail at marriage and medical activity, it is worth noting that there is even less information available on work overseas. During the 1920s, women were frequently told, by opponents and supporters, of the many opportunities overseas. Going abroad does not seem to have been as common a solution to difficulties in finding employment as before 1914. The regular queries by mission societies as to whether women doctors were losing their idealism suggest that missionary commitment was declining. The Women's Medical Service for India, established in 1916, to replace the disliked Dufferin Fund service was

34. M.H. Kettle 'The fate of a population of women medical students' Lancet (13 June 1936), 1370-1374. The high pass rate was attributed to the fact that most students had passed two of the three professional examinations before entering St. Mary's. A 92 per cent response rate was obtained from the 210 alive in 1936.

not popular with British doctors.³⁵ But some did go overseas early in their careers. The survey of recent LSMW qualifiers in 1926 recorded 18 per cent (39) were working as missionaries or in the Indian medical service, 6 were studying abroad. The St. Mary's survey of a longer qualified group reported 12 per cent working abroad and some others having recently returned.³⁶

Marriage and Marriage Bars

The progressive exclusion of women from the men's hospitals was, as I have indicated, often accompanied by claims that fifty per cent left the profession on matrimony and 'these usually the best and most able'.³⁷ The implicit logic of the opponents' case was that marriage was the most rewarding career for women, and, having useful skills, medical women were highly marriageable. So many would marry, and marriage meant abandoning the profession. Defenders of medical women argued either that medical women did not marry as often as was claimed, or that, if they did, they did not abandon the profession on matrimony. Whatever the facts, there was some division among medical women over these two defences, reflecting their differing and sometimes ambivalent views about marriage and medicine.

In the early 1920s, some senior women doctors were not

35. BMJ (6 Sept. 1924) 432; MWF Newsletter (July 1924), 39-40; (March 1927), 28-34; (July 1929), 26-28. Balfour and Young Medical Women in India, pp. 160-187.

36. MWF Newsletter (Nov. 1926), 82-83; Kettle 'Fate of women students', 1371.

37. Times 22 March 1928.

enthusiastic about their women colleagues' marrying. They held that 'women had no right to avail themselves of the hardly-won privilege of a medical education if they did not mean to make the profession which was its object their first interest in life'.³⁸ These women recognized that marriage, and, by implication, motherhood generally would restrict professional commitment, and, often, that it should do so. Yet emphasizing how few married, or opposing marriage too strongly, might generate the charge that women doctors were unnatural women, defeminized by their masculine profession, and render medicine unattractive to some prospective recruits.

Other prominent women argued for a compromise in which the 'very natural event' of marriage and the invaluable experiences of motherhood 'could and should ... be usefully commandeered in the service of science and humanity.' That they might involve reducing professional hours or relinquishing professional duties altogether for a short time was accepted. But women doctors' financial resources would enable them to have efficient paid help 'thus leaving her free to continue some useful professional work, as well as intellectual study, which will fit her more and more to become an inspiring factor in her children's lives'.³⁹ Thus, there was little explicit challenge to the centrality of motherhood in a professional woman's life.

In the context of these ideas, many young entrants to medi-

38. St. John Christine Murrell, p. 117.

39. L. Martindale The Woman Doctor and Her Future (London: Mills & Boon, 1921), p. 129.

cine after 1914, like many of their immediate predecessors, probably began their careers committed to medicine before marriage. How many actually did subsequently marry given these contemporary views is impossible to determine precisely. The generally accepted picture of medical women in the interwar years is that they were less likely to marry than their successors were from the 1950s onwards, and that, if they did, this was often quite late in their careers. The little data available indicate that marrying before or within two or three years of qualification was not common, especially among the 1920s qualifiers, but that at least half did eventually marry. But this evidence needs to be treated with caution, since those not working were more likely to have married. As response to surveys may have been lowest among those not working, marriage rates may have been underestimated.

Some contemporaries made much of the fact that, in 1928, only 16 per cent of the recent London qualifiers had married.⁴⁰ But, as noted earlier, by 1936, almost half of the St. Mary's qualifiers, many of whom were also covered by the 1928 survey, were married.⁴¹ The MPU study of medical women in 1962-63 found

40. Times 18 Aug. 1928; Times 28 Jan. 1929. This survey did not estimate how many had failed to qualify because of marriage. Less than half of the 25 withdrawals from St. Mary's before qualifying were due to marriage. Kettle 'Fate of women students'. 1370. The potentially misleading Census figures also give an impression of low marriage rates among young doctors. In 1931, 76 per cent of "active" women doctors aged 25-34 in England and Wales were single (1156 of 1522).

41. Kettle op.cit. Forty per cent of the handful of women qualifying at Oxford between 1922 and 1930 (11 of 28) had married by 1962, and 13 of the 18 qualifying between 1931 and 1940. A.H. T. Robb-Smith 'The fate of Oxford medical women' Lancet (1 Dec. 1962), 1158.

that 63 per cent of respondents qualifying between 1920 and 1929 had married, but only about 45 per cent of these had done so before or within five years of qualification (29 per cent of all this cohort). Overall marriage rates among those qualifying between 1930 and 1939 were higher, with 72 per cent being ever-married, 55 per cent of them doing so before or within five years of qualification (40 per cent of the cohort).⁴²

At any specific time in the 1920s and 1930s, married women were probably in a minority among active medical women. But as the surveys quoted indicate, by no means all women withdrew from medical practice permanently on marriage or on becoming mothers, even in the competitive 1920s. But decisions about marriage, and continuation of professional careers were not, for many women, a matter of personal preference and circumstance. Many were affected directly or indirectly by marriage bars.

As before 1914, these were not universal in public and voluntary organizations employing women doctors, nor always universally enforced or applied retrospectively.⁴³ But from the

42. Jefferys and Elliott Women in Medicine, p. 29. (Figures are rounded from the original report.) These figures may not be truly representative. Doctors marked as 'retired' in the Medical Directory were not contacted, and the response rate was lower among older doctors. (Ibid. pp. 6-7). In the light of these possible biases it is interesting that the marriage rates found were so high, and higher than those generally found in other, less methodologically sophisticated, retrospective surveys. For example, the MWF survey in 1944 of all registered women found about half respondents aged between 30 and 50 were married, with younger ones slightly more likely to be married. A survey of 1933 qualifiers in 1953 found 54 per cent had married. MWF Quart.Rev. (Oct. 1945), 11; Jnl.MWF 38 (1957), 38.

43. Even the Civil Service made the occasional exception, allowing at least one Home Office medical inspector of factories to keep her post. Kettle 'Fate of women students', 1372.

end of the war they were increasingly introduced or reinstated. By the mid-1920s, formal barriers to married medical women's employment were greater than before 1914. Some bars remained in force until during or after the Second World War. They were most common in public health work, and as this grew after 1918 proportionately more women were affected.⁴⁴ Where there was not an absolute rule requiring resignation on marriage, women were often employed on contracts which specified that their status would be 'subject to determination' should they marry. Some were dismissed on marriage or pregnancy without this being specified in their contracts.⁴⁵ Such bars were, not of course specific to medical women, but after 1918, many authorities removed prewar exemptions for doctors and teachers.⁴⁶

Marriage bars were defended on the grounds that the responsibilities of married life were incompatible with public service. And, especially in the 1920s, frequent reference was made to the priority owed to "breadwinners" in allocating scarce jobs. Women who proved, usually after humiliating enquiry, that their husbands

44. There are fewer incidents of voluntary hospitals' imposing marriage bans reported, but this may be because they less often had to formally state conditions of service for doctors and because marriage generally precluded taking resident posts, one factor in late marriage for doctors of both sexes. There was a widely reported attempt at Birmingham General Hospital to require a pregnant woman doctor to resign in 1929, and to impose a general marriage bar that was, after widespread protest, abandoned. MWF Newsletter (Nov 1929), 31; (July 1930) 63-65; (July 1931), 62-63.

45. E.g. MWF Newsletter (July 1927), 88.

46. See Lewis Women in England, pp. 198-200 on teachers.

were unable to support them might be exempted.⁴⁷ The MWF's public policy was always strongly against marriage bars. It joined the Six Point group in campaigning against the principle that paid work was incompatible with marriage per se and supported individual women through its standing committee on married medical women's work, set up in 1921.⁴⁸

The dominant theme in the campaign against marriage bars was opposition to external state interference with what should be a purely personal decision for individual women. It was argued that married women who wished to work were, ipso facto demonstrating their professional commitment and efficiency, for the expense of hiring competent help ensured that money was not the prime motivation. The loss to the community of expensively trained women, often the best candidates for a post, was particularly stressed in the case of medical women, for whom the experience of marriage might enhance their professional competence. The unfairness of the choice between marriage and use of skills faced by individual women while men's financial and personal circumstances were unexamined was also pointed out.

47. Women so exempted by the LCC were 'required to produce annually to the head of her department satisfactory evidence of the continued incapacity by reason of physical or mental disability of, or desertion by, her husband.' Standing Order 346, LCC, quoted in MWF Newsletter (March 1925), 25.

48. For an overview of the MWF's committee's work between 1921 and 1931 see MWF Newsletter (July 1931), 19-27. The BMA was also officially opposed to the marriage bar on the grounds of external interference with the personal affairs of members of the profession, and the BMJ's policy (not always adhered to) was to refuse advertisements for posts from which married women were excluded. Ibid., 20; Lancet (30 July 1927), 230. . On the general feminist campaign see also Lewis Women in England, pp. 102-103.

The most vigorous public campaign was directed at the LCC. In 1919, reimposing its notorious Standing Order 346 after wartime suspension, the LCC announced that it would end the prewar exemption of medical women. But on this occasion, there being opposition from MWF and others, the decision was not implemented. In 1924, however, this exemption was withdrawn for all future appointments, though the 3 married women among the 34 medical women then employed by the LCC were not dismissed. The LCC remained unmoved by a press campaign and women's deputations until 1936 when the partial exemption of doctors and teachers was restored, ostensibly on the grounds that these were occupations in which marriage might enhance efficiency. The Standing Order was finally completely withdrawn in 1946.⁴⁹

Being in London, and the largest local authority employer of medical women, the LCC attracted particular attention, but it was only one of several authorities whose action gave rise to MWF protest. Though there were a few victories for individual married women and a few policy decisions reversed, in 1931, the MWF committee reported that that they had had little success in a hard battle. Public opinion and the entrenched views of local councillors and lay boards constrained the kind of action that the MWF could undertake without arousing hostility.

The MWF committee also reported much indifference among local medical women and BMA branches. Some medical women and many men opposed their married female colleagues' continuing professional

⁴⁹MWF Newsletter (July 1919), 28; (July 1924), 26; (July 1925), 84-86; (July 1931), 19-22; MWF Quart. Rev. (July 1935), 74-75; (Jan. 1936), 44-45; (Oct. 1945), 48-49.

activity, because of its supposed incompatibility with domestic obligations. But behind some of the indifference or active opposition was the understandable self-interest of individual medical men and single women anxious for employment. Especially in the immediate post-war years, with many young doctors scrambling for work, it is not surprising that appeals to professional or female solidarity over this issue did not generate mass support.⁵⁰

Whatever their personal opinion, for many individual medical women marriage bars in public employment were a fact of life, to be accepted, avoided or negotiated in their professional and personal careers. The majority of those directly affected probably made no public protest. Those who were married and seeking work had to accept their exclusion on formal grounds from many salaried and honorary hospital and public health authority posts, (and their informal exclusion from many more). Some attempted to obtain such posts and failed, many more will probably have never tried.⁵¹ Those who had entered employment subject to a bar would, if the

50. MWF Newsletter (July 1931), 24.

51. Hutton Memories of a Doctor, pp. 212-214 describes the refusal of the LCC to consider her appointment to the Maudsley Hospital despite her sponsorship from the Medical Superintendent, and other similar rebuffs which led her 'to try and succeed in consulting practice' as a psychiatrist'. For seven years she was a part-time unofficial honorary member of the out-patient staff of the Maudsley. Ibid pp. 214 & 218.

question of marriage arose, have had to make a choice.⁵²

Medical women had one significant advantage over teachers. Having to resign from a salaried post on marriage or pregnancy did not necessarily mean abandoning professional activity. Entrepreneurial career and practitioner strategies were theoretically possible in those areas of professional activity without externally set conditions of employment—in general and consulting practice and in many voluntary agencies concerned with maternal and child health.

In the 1920s, it was sometimes claimed that the spread of marriage bars was causing a shift in women doctors' career choice towards general practice away from public health.⁵³ This shift was probably taking place (see below) and marriage bars may have been one, but not the sole, factor. There are many accounts of individuals' career trajectories in which marriage is associated with a move from a salaried post to general practice, and sometimes marriage bars are specifically referred to. Some doctors giving up full-time salaried public health posts on marriage remained active in the voluntary maternal and child health

52. This is, of course, putting the issue too baldly in that some will have acted to ensure the question never arose, and for others there may have been no hesitation about opting for marriage. It was sometimes claimed that the marriage bar prevented the 'best professional women' from marrying, and by implication reproducing, and passing on their talents. Eg Speech of Louise McIlroy reported in Morning Post 21 Dec. 1921 (RFHSM PC Book VI). Such inaction is harder to trace than examples of professionally successful women marrying and leaving public employment.

53. E.g. BMJ (11 Dec. 1926); MWF Newsletter (March 1925), 16.

sector.⁵⁴

Marriage bars were a manifestation of widespread public opposition to the employment of middle-class married women in the interwar years. They were an attempt to separate the world of married women from that of men, and that of single women whose employment outside the home was, by then, largely unquestioned. But they were not universal, even in public health, particularly by the late 1930s. And, as I have indicated, many married medical women, including mothers, did not accept that their civil status was incompatible with professional activity, for much of that professional activity was concerned with the world of married women. But formal restrictions, public opinion, and the constraints that marriage and motherhood did impose, probably meant that this was likely to be general practice or possibly 'light medical work' particularly in voluntary agencies.

54. E.g. Kettle notes as significant in relation to marriage bars the fact that of the 7 of the 10 St.Mary's qualifiers who had formerly held fulltime posts as assistant medical officers of health were married. In some cases the marriage bar was only applied to full-time posts with a local authority, part-time clinic work by married women being acceptable. See also Davies 'Little cash and less credit.'

Unequal Pay in the Inter-War Years

In Chapter VII, I referred to a second consequence of the women's increased entry into bureaucratic employment before 1914, besides marriage bars. Medical women were more likely to be working under formal conditions specifying that women be paid less than men in the same post.⁵⁵ This, too, became more widespread after 1918. In the 1920s, the expansion of public health activities, the large numbers of young medical women, and restrictions on public expenditure encouraged public authorities to attempt to employ women for less than men in some fields. This led to conflict between these employers and affected medical women (and their professional associations) and to tension within the profession.

Conflict over unequal pay was found in all forms of public employment, in municipal and county hospitals, especially the asylum sector, in government service and, above all, in the local health authorities. As with women's work in general, different salary scales for women doing the same work as men was not the only form of financial discrimination. There were more subtle forms, apart from the long-term discrimination arising from unequal promotion opportunities. One grievance concerned differential insurance and superannuation provision, which extended to NHI practitioners, and unequal payment of exceptional bonuses.⁵⁶

55. Unequal pay was not confined to public employment, but as this was the largest sector of salaried employment, with nominally set salary scales and weak professional organization, it was most frequent and most visible here.

56. One example was the unequal cost-of-living bonuses paid at the end of the war by some local authorities to its resident doctors. MWF Newsletter (Jan. 1920), 8; (Sept. 1920), 6.

In the Ministry of Health and the Home Office, medical women were appointed on the same scales as men, though in specifically "women's spheres", and hence not on promotion ladders. But, in 1921, in making its first postwar permanent appointments, the Post Office continued with the differential pay scales first introduced in 1911. Despite many protests this was not lifted until 1935.⁵⁷ The Scottish Board of Control (for lunatic asylums) was another government institution employing one woman deputy commissioner for less than her much less experienced male colleagues.⁵⁸

More significant in number were the policies of local health authorities concerning appointments as full-time assistant medical officers of health and school medical officers. There were nationally approved scales (see below) for such posts. But the only sanction during the 1920s against authorities who did not comply was organizing a boycott of such posts. Conditions of service and security in such posts were also poor, particularly for women.⁵⁹ In some authorities, posts were advertised with different salaries for men and women for the same post. More often, it was indirect through authorities' advertising of posts at salaries below the approved scales.

These 'underpaid' posts sometimes simply undercut the

57. MWF Newsletter (March 1923), 32-34; (July 1924), 12; (July 1930), 56; (July 1935), 44.

58. E.g. MWF Newsletter (July 1930), 56. This question was not put to the test in England in the 1920s as the English Board of Control did not employ any women medical commissioners, until 1931, a fact regretted by the MWF. *ibid.*, 58.

59. Bell mentions (without identifying) the attempt of Surrey County Council to retire all its women medical officers at the age of 55, five years before they became pensionable as an economy measure. This was not enforced after MWF and other protests. Bell Storming the Citadel, p. 183; MWF Newsletter (July 1929), 53-54.

approved minimum rates for a fulltime assistant MOH working directly under a senior medical officer (£600 per annum in 1925). More often, they exploited provisions for probationary appointment, by appointing doctors with more than the minimum experience and without prospect of advancement to such posts.⁶⁰ Some of these posts were advertised as only for women, and many as open to women (unlike most public health posts). Many were specifically for maternal and child health work. Indeed, some authorities justified paying such posts less on the grounds that this was women's work. In the 1920s, a disproportionate number of applicants and acceptors of 'underpaid' posts were believed to be, and probably were, women, creating de facto unequal pay and tension within the profession.⁶¹

Equal pay had been a central tenet of the Association of Registered Medical Women from its foundation in 1879, in the face of accusations that medical women would undercut their colleagues.⁶² Concern over salary discrimination had been a major impetus to the development of the MWF. Nor were the women alone. With the inception of the School Medical Service in 1907 the BMA

60. According to the scale approved by the BMA in 1923 (see below) such posts attracted a salary of £500 per annum in 1925 and were supposedly for one year as part of the three years' post-registration experience considered appropriate for assistant MOsH appointments. MWF Newsletter (July 1926), 79.

61. It is not possible to quantify this precisely, given the difficulty of tracing advertisements and applicants, as not all incidents would have been reported. (Between 1920 and 1927 between twelve and twenty-five such posts a year were reported as being advertised.) But it was widely accepted as being so in the Lancet, BMJ, Public Health and MWF Newsletter, and expressed by both critics and those who were defending women for taking these posts, quoting figures. It seems unlikely to have had no foundation in reality, even if drawing much on prejudice in some cases.

62. 'Epilogue' Chapter V.

adopted a formal policy of equal pay, alive to the implications of "undercutting" by women for the profession as a whole.⁶³ But, before 1918, the BMA had had little role in the economic affairs of medical officers of health, and hence little part in equal pay disputes in this particular field. After the war, this changed and the BMA's central organization gave active support to the MWF's opposition to local authorities' attempts to pay women less than men. The BMJ and Lancet refused to accept advertisements for 'underpaid' posts, listing blacklisted posts with a warning. But there was more to this than feminist commitment within the BMA at a time when some of its members were much exercised over the alleged glut of women.⁶⁴

The BMA's lack of involvement in the pay and conditions of local authority medical officers before 1914 stemmed from prejudice against salaried service in an organization primarily concerned with the interests of general practitioners. Then most general practitioners were opposed to any moves to raise the salaries of public health doctors lest this encourage recruitment and the spread of such services. But, by 1919, NHI had sufficiently improved the incomes of many established general practitioners to produce fear of the opposite: that public health salaries were now so low relative to general practice that the government might be tempted to introduce a whole-time service. The Ministry of Health was, in any case, encroaching on to general practice territory through the expanding maternal and child

63. MWF Newsletter (July 1930), 57.

64. Bell reports the support 'ungrudgingly' given by the BMA gave the MWF over underpaid posts but misses the wider significance. Storming the Citadel, p. 184.

welfare clinics. The result was that the BMA moved to become 'the 'the trade union' spokesmen for the public health corps', offering its assistance to the Society of MOsH in 1919 to raise salaries (but not too much).⁶⁵

Thus the BMA's stance on pay discrimination and 'underpaid' posts was linked to wider concern about the extension of state health services. It saw danger in large numbers of newly qualified doctors of either sex becoming cheap and salaried labour, and called for professional solidarity among medical men, and especially among 'all medical women to help it in resisting such attacks on the solidarity of the profession... It is hardly necessary to add that that the [BMA] can only be successful ... if it receives the loyal support of all medical women.'⁶⁶

There was the rub. Women appeared to be applying for and accepting such posts more than men. The large numbers of women doctors and their exclusion from so many of men's opportunities pressured individual women to take whatever opportunities they could obtain. These factors, women's professional isolation and their marginal status within the British Medical Association may have reduced women's willingness to sacrifice their only job opportunities for abstract professional solidarity. The result was some bitter attacks on medical women from within the profession: taking posts that 'no self-respecting man would take' indicated either that there was a glut of women or that they lacked

65. Honigsbaum Division in British Medicine, p. 84. The BMA approved the salary scales quoted earlier in 1923, having lowered the first proposals made by the Society of MOsH. (Ibid.).

66. From a paragraph regularly reprinted as part of career advice to medical women in the BMJ in the 1920s. Eg BMJ (6 Sept. 1924), 432.

professional loyalty.⁶⁷

The same concern arose within the MWF, the organization most directly concerned with fighting against unequal pay and countering attacks on medical women. The MWF's standing committee on public health scrutinized the press for advertisements of such posts, and protested to the authorities and where possible to applicants, requesting them to withdraw. An MWF leaflet on public health appointments was widely circulated to medical women pointing out: the importance of 'complete loyalty to professional standards' for the position of all women within medicine; the effect of accepting low pay on the profession's status and on individual members in the long-run; the dangers to women of breaches of the equal pay principle; and 'that a woman who has betrayed her professional brethren past, present and to come, cannot expect the support of her colleagues or of professional organisations at any time in her career.'⁶⁸ MWF leaders made speeches deploring the 'humiliating' fact that eleven of thirteen underpaid posts in 1924 were filled by women or the lack of professional cohesion among women such that thirteen women compared to nine men had taken underpaid posts in 1925.⁶⁹

Such policies of the MWF and the BMA did lead some candidates to withdraw, but only about half of active medical women in Britain were members of the MWF. It was generally reported that those accepting under-paid posts were not members, and they were

67. E.g. Public Health (1924), 156-157, 270-271, and for replies to these allegations by women ibid., 183 & 293.

68. MWF Newsletter (July 1927), 40-41.

69. MWF Newsletter (March 1925), 17; (Nov. 1926). p.21.

informed that they would not be accepted as members.⁷⁰ In some cases MWF and BMA intervention led the local authority to raise the salary or improve the conditions for the blacklisted post. One of the major difficulties reported by the MWF was that, at a local level, senior MOsH did not support their junior colleagues.⁷¹

Within the MWF's committee, and in local MWF associations, some sympathy was expressed for the 'young medicals ... least able to refuse posts'. Efforts were made to find means of exercising pressure other than by placing the onus on vulnerable individuals to withdraw. At the suggestion of one local association a note was made of women who had withdrawn applications for underpaid posts, and, where possible work, usually general practice locums, was put their way.⁷² Thus, within the women's professional organization the realities facing young women doctors in the 1920s were recognized, and some attempt made to mitigate the consequences for individuals in the short-term of the boycott. From 1930 the issue was formally resolved in an agreement between the MWF, the BMA, the Society of MOsH, and representatives of the Ministry of Health and local authorities which recommended to all local authorities the principle of 'no differentiation of salary according to sex'. Thereafter, reported cases diminished sharply, though they still occurred occasionally.⁷³

The issue reveals the vulnerability of women in the pro-

70. MWF Newsletter (July 1925), 24.

71. This was a particular complaint in Scotland where the problem was worst. MWF Newsletter (July 1928), 45-47; (Nov. 1928), 33; Public Health (1924), 270 & 293.

72. MWF Newsletter (Nov. 1925), 38.

73. MWF Newsletter (July 1930), 57; (Oct.1934), 71.

fession in the 1920s. As the MWF recognized, suspicion of undercutting would augment the antagonism many medical men felt towards women in the 1920s but women's exclusion from so many avenues made them less able to boycott such posts. In this case, active BMA support was forthcoming because of the concern over salaried services in general.

Women's Medical Careers in the Inter-War Years

The secretary to the MWF for over thirty years, unofficial career adviser to young medical women throughout this time, recalled the 1920s: 'Well qualified medical women could not get houseposts—perhaps half a day a week as clinical assistants (the argument tended to be that men came first)'.⁷⁴ Despite the protestations from spokeswomen of the LSMW that all was well, autobiographical accounts from those who qualified between 1918 and 1926 were very different from their immediate predecessors. Even those who eventually had highly successful professional careers stressed their initial difficulties and the importance of personal contacts in getting a start at this difficult time.⁷⁵

The wartime expansion of the LSMW was not matched by an equivalent increase of resident posts in the voluntary hospitals on which its prewar students had depended for early experience, those run by women and those for children and women. Indeed these latter had probably suffered disproportionately financially in the war. Even so, the LSMW students were fortunate in that there were senior staff willing to sponsor them. The 1926 survey of recent

74. Rew 'Looking back' Jnl.MWF 49 (1967), 35.

75. 'Doris Odlum' in Hellstedt Women Physicians, p. 52.

LSMW qualifiers indicated that more than half of those in Britain had held at least one hospital post.⁷⁶ While there were substantial numbers of women students at St. Mary's and Charing Cross, they were formally declared eligible to the housestaff on equal terms with men and were regularly appointed. Kettle found that 63 per cent of all St. Mary's women had held at least one such post, including 66 per cent of those in general practice in 1936.⁷⁷

Women who were in a small minority in men's schools were in the worst position, without established networks or patrons who would 'push their interests', and strong competition from men.⁷⁸ Some hospitals which had taken women residents in the war reinstated formal bans on women medical staff, but, in general, discrimination against women was becoming less based on formally stated rules of exclusion. An MWF survey of such hospitals in 1925 reported that among those with resident posts, 80 per cent stated that women were eligible. However, as the report noted drily, 'many replies state that women are "eligible" but not at present serving, that is, briefly, men have been appointed.'⁷⁹

By 1931, the shortage of posts was less acute as numbers qualifying had fallen. But there was marked local variation. In Glasgow, a shortage of women to fill available posts was reported. In Edinburgh, women were still rigidly excluded from the Royal

76. Newsletter (Nov. 1926), 82-83.

77. 44 per cent of resident all posts held were at St. Mary's. Kettle 'Fate of women students', 1372. BMJ (6 Sept. 1924), 418.

78. BMJ (24. Jan 1924), 206; MWF Newsletter (July 1923), 41; Evening News (2 Dec. 1923) (RFHSM PC Book VI).

79. MWF Newsletter (March 1925) 20. 423 of 581 hospitals circulated replied (73 per cent).

Infirmery, and post-graduate experience available was 'only suitable for those seeking Public Health appointments', being confined to ante-natal care and venereal diseases apart from six posts at the women's run hospitals. In provincial schools, women were regularly appointed to posts in charge of women and children, but rarely to the senior general posts. Not until 1935 was the first woman resident appointed to Manchester Royal Infirmary.⁸⁰

Thus, in the 1920s, although many did eventually find resident posts, for most, especially for those qualifying outside the LSMW, this was a considerable struggle. It is likely that a higher proportion of women than men had no such experience before entering general practice or public health work, or going overseas.⁸¹ It is probable that proportionately fewer women qualifying in the 1920s, as compared to the 1910s, had the opportunity of the kind of housepost experience that might be the foundation of a consultant career, especially in surgery. In the 1930s, the problem was less acute but women still had small chance of prestigious posts.⁸²

80. MWF Newsletter (July 1931), 47-56; (April 1935), 60. Sometimes exclusion of women from resident posts was defended by reference to the lack of suitable accommodation, for example by the LCC in some hospitals. MWF Newsletter (March 1928), 88. The LCC agreed to the principle of equal opportunity for both hospital and district posts in 1929 when the under the Local Government Act it took over the services of the Metropolitan Asylums Board. MWF Newsletter (July 1931), 48.

81. In its evidence to the Interdepartmental Committee on the Remuneration of Medical Practitioners (Spens Committee) in 1944, the MWF commented on the lack of resident posts among the "bulge" of women general practitioners qualifying in the early 1920s. MWF Quart. Rev. (Oct. 1945), 14.

82. Throughout the 1920s and 1930s, a spell in general practice was still common for men and women who later became consultants, particularly physicians, but it was difficult to build up the necessary hospital connections without "good" resident experience. Stevens Medical Practice in Modern England, p. 55. 'Janet Aitken' in Hellstedt Women Physicians, p.24.

Given the dearth of statistical information on medical work undertaken by men or women in the 1920s and 1930s, it is impossible to make more than extremely tentative educated guesses at the distribution of women across different fields and whether the type of medical work typically done by men and women was different.⁸³ The few surveys of medical women referred to earlier show that about half of the active respondents in Britain were in general practice at any time from 1928 to 1938, possibly a lower proportion than among men.⁸⁴ Interestingly, the ratio of women general practitioners to 'consultants' in these surveys, was lower than that of the "guesstimate" given by Stevens of 6.4: 1 in the late 1930s.⁸⁵ But definitions of 'consultant' varied greatly. Research into the incomes of general practitioners and consultants in the late 1930s done for the Spens Committees in 1945 indicated that women were about 5 per cent of what the survey defined as "true" consultants. They were also 5 per cent of principals in the general practices surveyed; but this was an underestimate because of the probable exclusion of many women in partnership with their husbands.⁸⁶

83. As Stevens points out, 'no authoritative national records were kept, and definitions of practice categories varied. Stevens op.cit., p. 56. What few estimates there were did not often give subtotals for men and women. The problem of accounting for the overlapping part-time appointments in several categories is particularly acute in public health posts.(See below.)

84. This is shown in the survey of MWF members in Times 31 May 1928; for St Mary's qualifiers in Kettle 'Fate of women students', 1371; and among (the few) respondents to the 1938 survey of all women on the register MWF Quart. Rev. (April 1940), 52.

85. Stevens op. cit. p. 56. Among St. Mary's qualifiers there were 2.7 GPs to every 'consultant'(Kettle op.cit, 1371); among MWF members; 2.9:1 among MWF members in 1928 (Times 31 May 1928); 3.4:1 for respondents to the 1938 survey MWF Quart. Rev. (April 1940), 52.

86. Ministry of Health Report of the Interdepartmental Committee on Remuneration of General Practitioners Appendix II

In contrast, there is strong qualitative and some problematic quantitative evidence that women were markedly over-represented after the First World War, as before, in preventive medical work with women and children, which, following the establishment of the Ministry of Health and the Maternal and Child Welfare Act of 1918, was increasingly provided by the state.⁸⁷

Maternal and Child Health in the Inter-War Years

Political, professional and public concern about the reproductive health of the nation intensified after the end of the war. Continuing concern about infant welfare was linked to a movement to make motherhood safer in the face of persistently high rates of maternal mortality. Historians have shown that, as before the war, women were prominent activists in these movements. Women's groups holding a range of views campaigned for better services and did much of the day-to-day voluntary work. In the professional sector, the medical staff of the Ministry of Health's maternity and child welfare section produced a constant stream of reports and recommendations. These five staff were, from the start, all women, led by Dr, later Dame, Janet Campbell.⁸⁸

(Spens Report) (London: HMSO, 1946). Cmd. 6810, pp. 18 & 26; idem Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists Appendix III (London: HMSO, Cmd. 7420), p.30.

87. 17 per cent of MWF members in 1928 and 21 per cent of the 1938 survey respondents were in 'public health' (type of post and hours unspecified) Times 31 May 1928; MWF Quart. Rev. April 1940, 52. (Women were 10 per cent of active doctors enumerated in the 1931 Census, and about 10 per cent of registered doctors).

88. Especially Lewis Politics of Motherhood; Stacey and Davies 'Division of Labour'; Davies 'Little credit and less cash'; 'Whose Baby? The politics of medical reconstruction and the problem of maternity and child welfare in the 1920s'. Unpublished paper CD/11, 1981. The medical staff of the maternal and child welfare section of the Ministry of Health were all women until 1948. Ministry of Health Annual Reports.

These other studies have described the many facets of the movement and the differing perceptions of the problems and their solutions by different groups of women and men. I shall only consider its impact on the careers of women doctors. As before the war, this movement gave women many opportunities for work, but such opportunities were often to prove limiting. Not all aspects of the movement enlarged medical women's career opportunities in the long-run. I shall begin by considering changes in obstetrics.

I have already alluded to the frequent references to maternal and child welfare in the defences of women doctors in the 1920s, particularly at the LSMW. These often laid great stress on the RFH's professorial obstetrics unit as being at the forefront of the movement to make childbirth safer by producing skilled women doctors.⁸⁹ Thus, such defences were linked to the movement for the medicalization of childbirth. This medicalization was manifested in pressure to improve medical obstetrics training, increased local authority antenatal clinics and an increase in the proportion of births taking place in hospitals from about 15 per cent in 1927 to 54 per cent by 1946. Such developments led to conflicts between doctors and midwives, between promoters of state and of private medical services, and within the medical profession between GPs and hospital obstetricians.⁹⁰

The move to medicalize childbirth promoted, and in turn was actively promoted by, the development of obstetrics and gynaecology as a single distinctive hospital based medical specialty.

89. E.g. Time and Tide (13 April 1928), quoted in Spender Time and Tide, pp. 254-255.

90. Honigsbaum Division of British Medicine, p. 159. See also Lewis Politics of Motherhood, pp. 117-157; Stevens Medical Practice in Modern England, pp. 43-45.

Despite RCS and RCP opposition, the British College of Obstetricians and Gynaecologists (BCOG) was founded in 1929 to prevent further divorce of obstetrics and gynaecology (and to separate gynaecology even more distinctly from general surgery), to be a common voice for the specialty and to provide, through examination, a single portal of entry to the specialty. The BCOG quickly became the dominant professional voice in obstetrics policy.⁹¹ These developments were to create new obstacles for women in the specialty.

Earlier, I argued that to claim that early medical women did not specialize in diseases peculiar to women was potentially misleading, given the contemporary organization of medical work.⁹² Women's limited opportunities for hospital surgical experience meant that few could become specialist gynaecologists as that specialty developed. But if women did develop specialist surgical skills before 1914, they were generally de facto gynaecological surgeons. Women's only appointments to the senior honorary staff of general voluntary hospitals before 1914 were as gynaecologists. This continued to be almost entirely so in the inter-war years.

The founders of the BCOG were exclusively male. One records that 'women gynaecologists hesitated to join an organization founded by men'. He does not make explicit the reasons for the women's hesitation. But his description of the shooting parties and dinners in the course of which the college was planned and of

91. W. F. Shaw Twenty-Five Years: The Story of the Royal College of Obstetricians and Gynaecologists 1929-1954 (London: Churchill, 1954); Stevens Medical Practice in Modern England, pp. 43-45.

92. This claim is made in Harrison 'Women's health and the women's movement', p. 53.

the doubts of some fellows about 'the revolutionary step' of electing a woman president in 1949 gives us some clues to the atmosphere.⁹³ But its masculine exclusiveness should not be exaggerated, being much less than in the RCP or RCS (admittedly not a difficult feat). It did, after all, elect women fellows from the start, co-opting one to its council, and a woman president. There were women in this field deemed eligible for such status by men.⁹⁴

In the context of concern over maternal mortality, the BCOG achieved rapid success in establishing their examination as a requirement for consultant appointments. This had long-term consequences for women contemplating careers in this specialty, and, indeed, other hospital specialties. To strengthen the status and staffing of their specialty within hospitals, the COG specified an unprecedented compulsory period (initially one year) of specialist resident training in BCOG approved hospitals as a prerequisite for their examination. This precedent was soon followed by the RCS, and other post-graduate examining bodies, but the BCOG's formal requirements were stricter and longer than others for many years.⁹⁵

Thus, the BCOG's single entry portal represented a significant shift in the form of specialist qualifications by incorporating a

93. Shaw Twenty-Five Years, esp. pp. 19-27, 46 & 159. (Quotation also given in Harrison op.cit. p. 55).

94. Harrison (op.cit.) notes that in 1931, 5 per cent (4 of 89) of BCOG Fellows were women and, in 1945, 11 per cent (27 of 242). As he says, women were hardly prominent in the BCOG, but 11 per cent is not insignificant given how few women there were in any elite positions. In 1931, there were still no women fellows of the RCP and in 1945, 2 (of about 2,000)! Clarke History of the RCP, vol III, pp. 976-977.

95. Crompton and Sanderson 'Credentials and careers', 30.

strong 'organisational' requirement, a shift that was to occur in all fields of hospital medicine.⁹⁶ This change in the formal organization of a field of medical work originated as much from inter-professional rivalries in the political arguments about obstetrics care as from technical requirements. It affected women in two ways in the long-run. First, women may have been less able than men to obtain the appropriate resident posts, given that small hospitals were not favoured. Secondly, the requirement of a prolonged period of full-time resident experience would, in the future, pose a particular barrier to married women pursuing specialist careers in obstetrics and gynaecology.

These developments within hospital medicine were only one aspect of the maternal and infant welfare movement, and, in the 1930s, their main impact on medical women lay in the future. More immediate, and directly affecting more medical women, was the rapid increase in local authority (LA) provision of ante-natal and infant welfare clinics following the 1918 Maternal and Child Welfare Act of 1918. Voluntary sector provision also continued to play an important part in the movement.⁹⁷

From 1918, the number of posts available as medical officers

96. The Diploma in Obstetrics & Gynaecology began in 1931, being superseded as a specialists' examination by Membership (MCOG) in 1936. (The Diploma reverted to being an examination in obstetrics proficiency for intending general practitioners, renamed the D.Obst). Shaw Twenty-Five Years, pp. 82-89.

97. In 1918 there were 120 LA and voluntary ante-natal clinics in England and Wales, rising to 995 LA clinics in 1931, 1307 in 1937, and 1687 in 1943 (252 voluntary clinics. The number and growth of infant welfare clinics was much larger. Lewis Politics of Motherhood, p. 152 & 100-109; G. F. McLeary The Development of British Maternity and Child Welfare Services (London: National Association of Maternity and Child Welfare Centres and for the Prevention of Infant Mortality, 1945); idem The Maternity and Child Welfare Movement (London: P.S. King, 1935.)

to such clinics, LA or voluntary increased sharply. The antagonism of general practitioners to state services meant that clinic medicine was still primarily inspection and prevention.⁹⁸ As before the war, such work was regarded by many as 'not proper medical work' and as work eminently suitable for medical women. Reports of the work of such clinics almost invariably stated that the medical officers in charge were very often, even usually, women.⁹⁹

But as before 1914, how many women were so engaged in such work and the kinds of career paths associated with such work is impossible to determine from central sources. Depending on, among other things, the size of the borough, medical officers to LA clinics might be full-time maternity and child-welfare officers, or full-time assistant MOsH engaged in such work either exclusively or in combination with other public health responsibilities. Some assistant MOsH were part-time, combining work in this capacity with private practice. Other clinics (LA and voluntary) were staffed by general practitioners or by those for whom part-time sessional clinics were their only professional work.

Davies has analysed the careers of doctors actively engaged in promoting maternal and child health nationally in the inter-war years, and shown marked differences between men and women. Male activists were mainly in senior and secure positions, not

98. Lewis op.cit. pp. 103-105, & 151-153; Stacey and Davies 'Division of Labour', pp. 26-32; Honigsbaum Division in British Medicine, pp. 34-5.

99. McCleary Maternity and Child Welfare Movement, p. 211; BMA Medico-Sociological Committee The Value of Maternity and Child Welfare Work in Relation to the Reduction of Infant Mortality (London: BMA 1921), p. 4. Report of Proceedings of National Conference on Maternity and Infant Welfare (5-7 July, 1922), p.113.

necessarily in public health, remote from direct contact with children. If they were doing clinic work it was as young men on their way to becoming MOsH. Women activists, in contrast, had mainly been working for many years as assistant LA medical officers or held a series of part-time clinic posts in voluntary or public clinics, perhaps having left full-time employment on marriage. Her findings are revealing about the sexual division of labour within public health work and within medicine as a whole.¹⁰⁰

The grants provided under the Maternal and Child Welfare Act led many local authorities to create full-time posts to administer and often staff the new clinics.¹⁰¹ As this coincided with the end of wartime work for many women doctors and the beginning of the increased output of women from medical schools, many young women were reported as seeking such posts. With no formal requirement of higher qualifications, they offered the security of an immediate salary with no capital to find and, in theory, the prospects of advancement within the public health service.

But many of these posts were the underpaid posts discussed earlier with poor conditions of service, no prospects, and subject to marriage bars. By 1923 there was a strong reaction against the presumption that such posts were suitable for inexperienced women. Besides warnings about underpaid posts, prospective entrants were warned that competition for promotion was extremely keen, and often the minimum salary would be a maximum. Without good relevant

100. Davies 'Little credit and less cash'.

101. BMA Value of Maternity and Child Welfare Work, p. 4; Honigsbaum Division in British Medicine, p. 85.

post-graduate experience and higher qualifications, most of the openings in public health work were, women were warned, 'blind alleys'. These warnings came from both established women in public health concerned that the value of their work was being undermined and from disillusioned recent recruits (as well as from opponents of medical women). Women were encouraged to try general practice as likely to be ultimately more rewarding, personally, professionally and financially.¹⁰²

These warnings were well-founded in that women entering maternity and child welfare LA posts tended to remain in such posts for many years, or had to leave on marriage. We cannot assume that all women perceived these limitations as problems. But the dilemma discussed in Chapter VII remained. Some women saw maternal and child health work as a discrete area of medical work where women's talents were especially appropriate. They emphasized the importance of prior experience of midwifery and general practice to gain clinical skills and experience in personal relationships with mothers and children. In short, maternal and child health workers should be mature women.¹⁰³

Other medical women saw their work for women and children as just one stage of a career in general public health work, for which the Diploma in Public Health (DPH) was the crucial qualification. For these women, their continued exclusion from other sectors of public health work, especially tuberculosis work, and the refusal to appoint women to positions of authority

102. MWF Newsletter (July 1924), 20-23; (Nov 1924), 22. The same complaints were also made about school health work. MWF Newsletter (Nov 1923), 23.

103. MWF Quart.Rev. (April 1941), 63-67. MWF Newsletter (Oct. 1935), 42-48. Davies 'Little credit and less cash'.

over men were constant grievances.¹⁰⁴ These complaints intensified in the late 1930s, as general practitioners' hostility to these individually based state preventive services grew in the face of the growing likelihood of new state intervention in primary care. Powerful voices within the BMA were questioning the role of such clinics. Women in clinic work were placed on the defensive, as GPs threatened to encroach on their work while their other options within public health were few. This may be one reason why, by the late 1930s, some MOsH were reporting difficulty in recruiting women assistant medical officers of health, which might be one factor in the lifting of marriage bars in some areas.¹⁰⁵

The maternal and child welfare movement, like the infant welfare movement before the First World War, did provide women with opportunities for work at a time when these were badly needed. Such openings for women, however, rarely constituted entry points to an upward career trajectory in public health, being, objectively, 'sidetracks' within the medical officer of health career structure. Opportunities for promotion within the field were few. Yet it would be wrong to assume that all women saw their posts in this way or took them as last resorts. Some undoubtedly

104. MWF Quart.Rev (Jan. 1938) 39-40; (Jan 1939), 63-4; (July 1939) 69-70; (April 1941) 45-52.

105. Stacey and Davies 'Division of Labour', 27; Davies 'Whose baby'; idem 'The GP and infant welfare in the inter war years' Bulletin of the Society for Social History of Medicine, 30-31 (June & Dec. 1982), 9-12. This encroachment of general practitioners was quite separate from the role of general practitioners as sessional medical officers in LA clinics. It was a bid to change the conception, location and control of preventive work with mothers and children. On recruitment difficulty see e.g. MWF Newsletter (July 1939), 74.

did, especially in the immediate post-war years. But, as before the war, medical women's enthusiasm for the promotion of maternal and child health through avenues open to them, led many to work enthusiastically for 'little credit and less cash'.¹⁰⁶

The same was true for the part-time opportunities in maternal and child welfare work. These were even less part of an organized career path. Some of this work was done as an adjunct to general practice. But some, particularly in the voluntary sector were married women who, in Kettle's terms, were undertaking 'light professional duties only'.¹⁰⁷ Undertaking such work might be a response to restricted opportunities for married women, and of enthusiasm for the work. This is illustrated by one further facet of the inter-war maternal and child welfare movement.

From the 1920s, many groups began campaigning for increased provision of birth control for married women, to promote the health of the nation or, among women's groups, to promote the health of individual women.¹⁰⁸ Before the First World War, most women doctors seem to have shared the public opposition to birth control of most of their male colleagues and most feminists, who feared it would be a charter for male sexual licence.¹⁰⁹ As attitudes began to change in the early 1920s, and the public debate gathered momentum, medical women appeared to be as divided

106. Davies 'Little credit and less cash'.

107. Kettle 'Fate of women students', 1371.

108. Lewis Politics of Motherhood, pp. 196-214. A. Leathard The Fight for Family Planning (London: MacMillan, 1980).

109. Notable exceptions in the first generation were Alice Vickery-Drysdale and Kate Mitchell West whose association with the Malthusian League was mentioned in Chapter VI. Ledbetter History of the Malthusian League, pp. 35 & 121.

over the issue as their male colleagues. There were some notable medical women opponents, but others were prominent among the activists, establishing and staffing voluntary clinics such as the Walworth Women's Welfare Centre and the North Kensington Clinic.¹¹⁰

Although the medical staff of voluntary clinics and in the few LA clinics that developed after 1930, were not exclusively women, many were. Here again, we have work on the margins of medical work that is consistently described by its supporters as especially appropriate for women to actually do, though many of the leading medical spokesmen were men.¹¹¹ For a few medical women such as Helena Wright, birth control was to become the basis of a full-time "specialist" career, combining voluntary clinic work, private practice, tireless public campaigning, and training of doctors in contraceptive techniques. But it was a career without an institutional base within established medical institutions.¹¹² More often, voluntary clinic work was an adjunct to general practice or domestic commitments on the part of enthusiasts for this controversial work. In those local authorities who provided advice, it was, organizationally, a subordinate part of maternal and child welfare work, with all the

110. Such women opponents included Scharlieb and, in public until exposed by Marie Stopes, McIlroy. Lewis Politics of Motherhood, p. 203. Leathard Fight for Family Planning, 22. In 1922, the MWF felt unable to make any public pronouncement of its views, because of the sensitivity of the issue, but in 1927 drew attention to the lack of instruction in medical schools. MWF Newsletter (July 1922), 15; Lewis op.cit., p. 206.

111. Report of Conference on the Giving of Information on Birth Control by Public Health Authorities. (London: 4 April, 1930).

112. Evans, Freedom to Choose, esp. pp. 124-158.

consequences that that entailed. As this marginal field of preventive medicine became routinized, it became another area where women were to find opportunities for work, but few outlets for career advancement.

This survey of the movement for maternal and child health in the inter-war years has indicated that, as before the war, many medical women saw this as a field where they had a contribution to make. But the kinds of professional opportunities that developed differed between segments, drawing on and consolidating the embryonic pre-war pattern of gender divisions in this field.

For the predominantly male hospital-based practitioners of obstetrics and gynaecology the campaign to save mothers provided a powerful boost to the cohesion and visibility of their specialty, leading to stronger control over recruitment, and more organized career paths through compulsory hospital training. In contrast, in the preventive field, the marginal status of the work, the hostility of general practitioners to a movement associated with either strong lay involvement or state services, and the gender of many of those doing the medical work, did not provide conditions conducive to such development. Instead there emerged a fragmented pattern of low visibility 'practitioner' opportunities, reinforcing the construction of this work as "women's work". This was the pattern prevailing as moves to establish a national health service gathered momentum.

General Practice for Women in the Inter-War Years

The growth in "specialist" welfare services for mothers and infants, whether clinic or hospital based, was important for the developing gender division of labour, but involved only a small minority of medical women at any time. Most women still spent most of their professional lives in general practice. In 1933, the BMA estimated that women were 13 per cent of all general practitioners.¹¹³ For many women qualifying in the immediate postwar years, entry to general practice was, as in other fields, intensely competitive, with few assistantships open to women or women's practices for sale. Putting up a plate was still the only option for many. Mabel Rew recalled,

'the ponderings on possible places—studying the location of new housing estates etc., etc. —then turning the pages of the Medical Directory¹¹⁴ to see how many general practitioners were already there...

As the numbers of women qualifying increased in the mid-1920s, so did concern at the growing number of assistantships being offered to women at extremely low salaries, even for board only, and sometimes with some additional expectations. Great exception was taken by the MWF in 1929 to an advertisement for 'a Lady Assistant willing to assist in household duties.'¹¹⁵

There is little data on the time women spent as assistants, with or without view to partnership, and how this compared with the experience of men. An MWF survey in 1944 reported the average age of assistants to be 37.8 years, and that 22 per cent of

113. MWF Newsletter (Oct. 1934), 44.

114. MWF 49 (1967), 35.

115. Newsletter (July 1929), 72; (July 1928), 85.

general practitioners respondents were assistants without view to partnership; but this may reflect wartime conditions.¹¹⁶

Despite the difficulties in entering practice in the mid-1920s, this field was widely commended as a one in which women had a good chance of success, subject to hard work and a sensible choice of area, and as compatible with marriage. As the numbers of young women qualifying fell relative to the number of women in practice, so the problem of entry lessened. The MWF 1944 survey reported that 55 per cent of women principals had purchased existing practices for cash or out of practice income and only 35 per cent had put up a plate.¹¹⁷

The First World War had brought many women doctors into regular contact with male patients and men's practices for the first time, under temporary arrangements. After the war, some women continued to express reservations about sharing practices with men (other than husbands), fearing that this might be taken by the public as stemming from women's lack of confidence. Many women opted, from principle or pragmatism, for women partners, judging from the regular reports of new and successful women-only partnerships in the inter-war period.¹¹⁸

116. MWF Quart.Rev. (Oct. 1945), 12. The report noted that half the respondents were married, and that many assistants were part-time for surgery hours only. Response rate was less than 50 per cent so figures may well not be representative.

117. Quart. Rev. (Oct. 1945), 14. The commentary implied this was a marked change.

118. MWF Newsletter (July 1925), 64. Kettle 'Fate of women students', 1372; Jnl MWF (April 1954), 63-64.

Others welcomed the increasing frequency with which medical men were applying for 'the services of women either as locum tenentes, assistants or partners' as evidence of women's increased acceptability and integration within the profession. By the mid-1930s, partnerships of women with unrelated men were no longer considered unusual.¹¹⁹ But if respondents to the MWF survey in 1944 were representative, women were somewhat less likely to be in partnerships than all general practitioners.¹²⁰

Some women did continue to refuse male patients after the end of the war. But, by the 1930s, this was widely believed to be a rapidly declining minority, confined to older doctors, and it was increasingly regarded as professionally inappropriate.¹²¹ Reference was increasingly made to the desirability of women general practitioners in the future being 'the family medical adviser'. However, there was general agreement that women general practitioners attracted mainly women (and children) as patients. Some medical women drew attention to the likely consequence of this: women doctors' patients were likely to make greater demands

119. MWF Newsletter (March 1930), 57.

120. 34 per cent of the women principals in the MWF survey in 1944 were in partnership compared to an estimated 45 per cent of all general practice principals in 1938. MWF Quart. Rev. (Oct. 1945), 14; Spens Committee Report on General Practitioners, p. 19.

121. MWF Newsletter (Oct. 1934), 45; BMJ (28 Dec. 1940), 918. For women in panel practice in London in 1921, there was, briefly, some disincentive for women to do this, as fees reduced by 7 per cent (later 3.5 per cent) were deemed payable to those with lists restricted to one sex. But this was removed following BMA and MWF protest. Lancet (14 May 1921), 1036; (1 Oct. 1921), 725.

on their services for the same remuneration and, given their position under NHI, possibly for less remuneration.¹²²

In this connection, two further differences in which women's position in general practice differed from men's at this time are of interest. According to the Spens Committee's survey, the average earnings of women principals in general practice were less than half those of male principals in the late 1930s.¹²³ This was almost certainly due to smaller list sizes, often the result of married women practitioners limiting their patients. But greater workload per patient might have had some effect. Secondly, the proportion of women general practitioners 'on the panel' also seems to have been less than that of men in the 1920s and 1930s. Their predominantly female and child patients may have been one reason for this.¹²⁴ It is possible, then, that though many women general practitioners benefited from the increased security and stability of income that NHI brought to this field of medicine after the First World War, they may have benefited less than men.

122. Eg MWF Newsletter (Oct. 1934), 44-50. The context for this was the evidence of married women's greater sickness absence and discussions of the extension of NHI to dependents.

123. Spens Committee op.cit. Appendix II, pp. 19-27. There was no difference in the age distribution of men and women.

124. In 1922, the Ministry of Health reported only 215 women panel practitioners at a time when three-quarters of all general practitioners were estimated to be on the panel. Lancet (5 May 1923, 984; Honigsbaum Division in British Medicine, pp. 111-112). In 1926, about 400 women panel practitioners were reported—equivalent to about 19 per cent of estimated active women doctors Evening Standard 4 Oct. 1926 (RFHSM PC Book VI). In 1933, the BMA estimated there were 37 per cent of all women general practitioners were on the panel (996 of 2658) and that women were 6 per cent of total NHI practitioners. MWF Newsletter (Oct. 1934), p. 44. However, 90 per cent of respondents to the MWF survey in 1944, reported some panel income (less than half their total income for 85 per cent). MWF Quart.Rev. (Oct. 1945) p.15.

Hospital and Specialist Practice for Women in the Inter-War Period

The inter-war years saw increasing division between consultants and general practitioners under the impact of NHI and increasing specialization within medicine. Though many general practitioners, male and female, especially in provincial towns, continued to hold appointments at voluntary hospitals in the 1920s and 1930s, the pattern of such appointments was changing. The role of the hospital was changing from a shelter for the sick poor to a centre of specialist medical work. Many medical specialties were slowly becoming institutionalized segments of the profession rather than special interests.¹²⁵ The result was an extremely confused and confusing picture of specialist medical practice and shifting career paths. And it is only possible to give a broad indication of the fields which women did and did not take up and of the impact of these changes on the hospitals run by women.

These, like most voluntary hospitals, were badly in need of funds at the end of the First World War. They were also faced with the question whether hospitals run by women to train women were still viable or desirable, given the acceptance of women into the men's schools and the increasing emphasis among younger women doctors on professional integration. Some urged that women's efforts should be directed towards increasing the number of hospitals with mixed staff. For others, the closure of the men's schools to women confirmed the continued need for these special

125. These changes are discussed in detail in Stevens Medical Practice in Modern England, pp. 38-64; Honigsbaum Division in British Medicine, pp. 110-149. Kettle reports that one-third of St. Mary's women in general practice held hospital appointments, a figure comparable to Stevens's estimate for all general practitioners. 'Fate of women students.', 1371; Stevens op. cit. p. 56.

opportunities for women for the time being. They were not defended in public as in principle desirable for medical women's status.¹²⁶

No new general hospitals run by women were established after 1916, apart from the small number of beds opened at the Bermondsey Medical Mission in 1921.¹²⁷ But two new special hospitals were opened, reflecting contemporary medical interests. Appeals for funds for the Elsie Inglis Memorial Maternity Hospital in Edinburgh stressed that furthering the campaign for safer motherhood was a fitting tribute to this woman doctor and the 50-bed unit opened in 1925.¹²⁸ Growing interest in radiotherapy led to the establishment in 1929 of the Marie Curie Hospital, Hampstead, specifically for radium treatment of uterine cancer. This venture had its origins in the MWF's cancer research committee set up in 1924. The radium purchased by this committee was initially rotated between the RFH, the SLH, the EGA and the New Sussex Hospitals, an arrangement whose disadvantages became apparent. The Marie Curie was therefore established to centralize the work, with the women gynaecologists from the four hospitals providing the honorary staff.¹²⁹

If women's hospitals were to continue as training hospitals, as well as provide an adequate service to patients, they had to

126. Eg Times 6 Feb. 1929; MWF Newsletter (July 1930), 19.

127. Originally 12 beds, this was expanded to 20 in 1928. MWF Newsletter (April 1936), 68-69.

128. MWF Newsletter (July 1925), 59; Campbell 'Three Scottish Women's Hospitals. A second maternity hospital staffed by women which greatly expanded in the 1920s, from 40 to 90 beds under the same impetus was the Salvation Army's Mother's Hospital, Hackney. MWF Newsletter (March 1924), 53; MWF Quart.Rev. (Oct. 1945), 37.

129. MWF Newsletter (March 1930), 19-23.

keep pace with changing expectations of clinical experience and technical facilities for specialist training. The general hospitals in particular had to change if they were to justify their claim to this status. The result was, as for all voluntary hospitals, a constant appeal for funds throughout the 1920s and 1930s. Some of the general hospitals did achieve considerable growth, the two largest, the SLH and the EGA, having 140 and 106 beds respectively by the mid-1930s.¹³⁰

One of the special hospitals, the Women's Hospital for Children, closed in 1923 unable to afford the necessary development to remain viable.¹³¹ Others were more successful. By 1930, the Lady Chichester Hospital had expanded to fifty beds, and, under the 1930 Mental Treatment Act, was working in liason with the Royal Sussex County Hospital, caring for male and female patients. For the Manchester Babies' Hospital, a major expansion in 1935 was associated with a change of name (to the Duchess of York's Hospital) and of policy, appointing men to the staff.¹³²

In 1920, there were 95 medical appointments (resident and honorary) at hospitals run by women. In 1930, the total had risen to 181, and to 217 by 1938.¹³³ But despite this considerable

130. MWF Newsletter (July 1933), 23-24; (July 1930), 21; Glasgow Private Hospital was re-opened in 1925 as the Redlands Hospital for Women, with 45 beds, increasing to 74 by 1948. the New Sussex Hospital had 53 beds by 1930, and 72 by 1948. Jnl. MWF (April 1967), 109-110.

131. MWF Newsletter (Nov. 1923), 42. The death of Flora Murray, one of the key initiators was a crucial factor here, for the small hospitals were likely to be dependent on individuals.

132. Jnl. MWF 37 (1955), 83; 45 (1966), 27.

133. Medical Directory entries for hospitals identified here and in Chapter VII (including The Mothers and the Duchess of York's Hospital). The number of women holding posts was less than the totals given because of the pattern of multiple honorary appointments.

expansion, it is clear that these hospitals could provide opportunities for only a small proportion of the growing numbers of qualified medical women. They were also, even after expansion, not large hospitals. This limited the specialist experience they could provide in comparison with many mixed hospitals, and was to have a major bearing on their fate under the National Health Service.¹³⁴ They still provided the nucleus of a women's network of sponsorship, patronage and consultant referral, but they were doing so under increasing difficulty.

What place did women have in this increasingly specialized pattern of medical practice, either as consultants, or as general practitioners with special interests? All the evidence I have found indicates that few were established in general medicine and even fewer in general surgery. Where women did have special interests, they were mainly concerned with the care of women, children or the mad, or in the expanding service specialties.¹³⁵ This pattern was a product of both women's special interests and the structure of opportunities open to them.

I have already shown that after the temporary impact of the First World War, women were still largely excluded from the major hospitals, and especially from the kind of posts that might lead to specialist careers in general medicine or surgery. Almost all

134. On the problems of developing general surgery as distinct from gynaecological surgery at the Bruntsfield, see Jnl.MWF 39 (1957), 247.

135. MWF Newsletter (March 1925), 18-28; MWF Newsletter (July 1931), 47-56. This is based on my search of the MWF Journal and BMJ for obituaries of women, and appointments listed in the MWF Newsletter and Quarterly Review in the 1920s and 1930s. As before the war, it is not possible to compare women's distribution with men's, only to indicate the fields that women did enter.

of the small number of women I have identified with such careers in the 1920s and 1930s, were connected with the hospitals run by women. A further consequence of this is that few could develop skills in those specialties which were 'developing within the major hospitals as sophisticated disciplines' within medicine and surgery, such as orthopaedics.¹³⁶

Though obstetrics and gynaecology was developing as a distinct specialty with its own college, the form this development took probably led to the channelling of women's interest in this field into public health clinics. The care of children was another field where many women saw themselves as having a special role; a role which was exercised mainly in public health work or, in the case of general practitioners, by holding honorary appointments at provincial hospitals. Paediatrics was slow to develop as a consultant specialty separate from general adult medicine. In the context of concern over infant health there were moves to promote this development, but it was not a high status field. Though the vast majority of the first consultant paediatricians, and all the early members of the British Paediatric Association were men, this was a field in which a few women achieved considerable professional success.¹³⁷

136. Stevens Medical Practice in Modern England, p. 41.

137. Hazel Chodak Gregory's decision to take charge of the new children's department at the RFH in 1926, rather than the more prestigious post of senior physician (the first woman to be offered the post) was influenced by her commitment to child health and 'the fact that no one of her colleagues was ready to assume this responsibility'. Twelve years later, Beryl Corner became Bristol's first consultant for children's diseases, at the extra-ordinarily early age of 26. Jnl.MWF 34 (1952), 54; 'Beryl Corner' in Hellstedt Women Physicians, pp. 400-401. The first 4 women were elected to the British Paediatric Association in 1945. See H.C. Cameron The British Paediatric Association 1928-52 (London: Metcalf & Cooper, 1945).

In Chapter VII, it was noted that there were a small group of second-generation women with a special interest in mental illness, and that some of the limited opportunities for hospital appointments for women were in asylum work. After the war, this also appears to be a field in which some women developed a special interest, reflected in the establishment of an MWF sub-committee on psychological medicine in 1927. No doubt this was partly because it was a low status field in which there were a growing number of opportunities. But it was also a field in which some felt that medical women had a special contribution to make, given the apparently large numbers of women suffering mental illness. And the established women in the field could act as sponsors.¹³⁸

Another facet of the developing specialization within medicine in the inter-war years was the increasing demand for support services, such as anaesthetics, pathology and radiology, stimulated by scientific and technical innovations within and outside medicine. In the 1920s and 1930s, none of these fields were fully established medical specialties but there was much organizational activity among practitioners to establish boundaries and improve status. Women were not prominent in the organizational activity but they did enter, and were encouraged to enter, the spaces that were being created for such work. Initially, there were relatively few barriers to entry, and such specialist qualifications as were established were not dependent on long periods of hospital training.

As Stevens has pointed out, this kind of work had low status within medicine, because of the uncertainty whether such work was

138. MWF Newsletter (July 1927), 43, 48-49; (Jan 1932), 55. Hellstedt Women Physicians, pp. 52-53.

within the province of the medically trained clinician, or consisted of routine technical tasks to be delegated to others. Anaesthetics and pathology were retained by doctors, but moved from the province of junior surgeons to that of part-time general practitioners, or indeed of specialists—specialists, however, clearly regarded as subordinate to the clinicians they supported. It seems to me likely that the social relations implicit in this relationship were one factor why women were able to find posts here.¹³⁹

In 1920, there was a growing collection of diagnostic and therapeutic activities using radiation and electrical equipment, performed by doctors and by non-medically qualified personnel, ranging from electrical engineers supplying diagnostic X-Ray services, to physiotherapists using electro-therapeutics. And, in the 1920s, it was an overcrowded field. Larkin has shown how, through a process of 'occupational imperialism', medicine retained a core of tasks as the specialties of radiology and radiotherapy and delegated others to paramedicals. In this process, social factors, including gender, were as important as technical ones, with radiography and physiotherapy being defined as female tasks, subordinate to (usually) male doctors.¹⁴⁰

Again, medical women were not visible in this organizational struggle, but there were several prominent in the field. Radiology and related fields of physical medicine were commended as a field

139. Stevens Medical Practice in Modern England p. 49. In anaesthetics the only specialist qualification was a general diploma intended for general practitioners. In pathology there was little specific training laid down in the inter-war years.

140. Larkin Occupational Monopoly, pp. 60-91.

for women doctors in the 1920s, though it was recognized as a competitive one.¹⁴¹ The lack of institutional structure meant that there were few barriers to entry, particularly before the war. At the RFH, radiology was a woman's province at the start. Florence Stoney began a department there and one at the EGA in 1902. During the war, she was head of the X-ray department at a large military hospital where she trained a number of women.¹⁴² Though boundaries were being drawn between medical and non-medical work, individuals could occasionally cross them. I have identified fifteen women who took up medicine and then radiology or electro-therapeutics, as a development of their careers as masseuses or the like.¹⁴³ Finally, there were the women radiotherapists associated with the work of the Marie Curie Hospital, specifically concerned with the treatment of women's diseases.¹⁴⁴

I have only been able to undertake a brief examination of the place of women in the increasingly specialized world of what was becoming hospital-centred medicine. The inter-war period saw a marked increase in the complexity of the division of labour within medicine as well as between medicine and other occupational groups. Many features of the pattern of specialty organization

141. Martindale The Woman Doctor, p. 87; MWF Newsletter (ov. 1925), 21-26. 8 per cent of those taking the Diploma in Medical Radiology and Electrology (DMRE) from Cambridge between 1920 and 1925 were women.

142. Florence Ada Stoney (1871-1933) LKQCPI MB BS 1898. MWF Newsletter (Jan. 1933), 64-66.

143. Justina Wilson (?-1949) LSA 1916 had taken up massage when her husband retired, entered medical school in 1910, took the DMRE in 1920 and began the physiotherapy departments at the RFH and later St. Mary's, Paddington. Jnl. MWF (Jan. 1950), 54.

144. The work was directed by Elizabeth Hurdon, MD, with small team of women doctors and technicians. MWF Quart.Rev (Oct. 1941), 59-62; Jnl.MWF 39 (1957), 86.

that prevail today were crystallizing in this period. There was increased emphasis on higher qualifications, and the beginning of more institutionalized career lines within fields other than surgery. But the form these took differed markedly between different fields.

It would be overemphatic to speak of gender-typing of specialties. Women were too few, and most of the specialties too inchoate for this to be an appropriate term. But the social structuring of particular fields made women's entry more or less likely, and they found spaces in some of those fields that were developing outside the entrenched dominant specialties of medicine and surgery, especially in those which had weak control over recruitment.

Conclusion

The 1920s saw a sustained reaction within many sectors of the profession to the large numbers of women qualifying that coincided with intensification of opposition to married middle-class women's employment. Women entrants to medical school fell, and most newly qualified women had to take what opportunities they could find, and resolve the dilemmas posed by the competing demands of medicine and marriage. The divergence between the professional careers of single and married women doctors probably increased. In the 1930s this pressure lessened. But women still faced many formal barriers and, as important, barriers created by the informal organization of the profession.

The formal organization of medical practice was changing rapidly with growing state intervention and increased fragmentation of medical practice into distinct specialties, with asso-

ciated posts and career paths. This process limited women's opportunities in some directions, but where boundaries were fluid and entry controls weak, women were sometimes able to enter and develop special interests. One aspect of this was the gradual division of the area which women had seen as their special field, the care of women and children, into three organizationally separate fields: general practice, hospital medicine and public health. In this last field we can see the development of a distinctive gender pattern of work, with women concentrated in non-career posts. Many women still saw themselves as having a special role in the care of women and children, and recognized that, in general practice, much of their work would be in this field. But the idea of the special, limited mandate was rejected. There was also, in the 1930s, increased pressure for the extension of women's opportunities for co-education, and posts in hitherto male hospitals. The goal of professional equality was increasingly seen as one to be achieved through assimilation.

Epilogue: Women Doctors in the Second World War

The Second World War brought great disruption to the personal and professional lives of medical women in Britain. Women doctors served with the Armed Forces and women's auxiliaries, particularly with the army. Some concessions to their professional status were made, such as the granting of 'relative rank' through commissions in the women's forces, and equal pay with male colleagues. But often, as in the First World War, medical women found themselves treated primarily as women rather than as doctors.¹⁴⁵ Most

145. *Jnl. MWF* 49 (1967), 105; *MWF Quart.Rev.* (July 1939), 47-51 & 67-68; (July 1940), 55-57; (Jan 1941), 31-35; (July 1942), 34-37. At the peak of the war, 600 women doctors were

smaller proportion of male doctors were called up to serve with the Armed Forces (and far fewer killed). As Chapter IV showed, the number of women medical students increased from about 2,000 in 1938-39 to about 2,900 in 1946, from 16 per cent of all medical students to 22 per cent.¹⁴⁹ Although considerable, this did not bring such a disproportionate "glut" of young inexperienced women into the profession at the end of the war.

The end of the war was, however, to have a profound impact on the careers and career opportunities of medical women. There was pressure on all women to withdraw from work in a strongly pro-natalist social climate. At the same time, belying public concern about the birthrate, marriage and motherhood were becoming ever more popular.¹⁵⁰ Large numbers of doctors were being released from the armed forces and the EMS to resume their careers. And the implementation of the National Health Service, and the Goodenough Report was imminent.

149. UGC Statistics.

150. D. Riley War in the Nurseries (London: Virago, 1983), pp. 150-188.

CHAPTER X

WOMEN DOCTORS AND THE NATIONAL HEALTH SERVICE: 1948-1977

Introduction

In this final chapter, I consider the opportunities for medical women and the constraints on their careers in the first thirty years of the National Health Service in England and Wales.¹ These years have seen many changes in the opportunities available for medical careers, in the circumstances of medical women, and in the social context in which they have made their careers. I begin by analyzing the impact of the health service and its subsequent development on women's career opportunities up to the mid-1970s, and I consider how the problems of medical women were perceived in health policy. Finally I review some of the evidence concerning those who have made their medical careers in this period, looking in particular at those who trained in the 1950s and 1960s.²

From the start of the NHS, it was specified (or tacitly assumed) that, once in the profession, women should be trained and employed on exactly the same terms as men. In this sense, formal

1. The health services in Scotland have been organized separately, and as their development has differed in several important respects, the discussion in this chapter concerns England and Wales only unless otherwise stated.

2. I do not attempt to consider in detail those younger women, entering medical school as the post-Todd expansion got under way. They have not had time to have long medical careers and about whom there is little information. Their experience may be different from their immediate predecessors.

equality has prevailed within the NHS.³ But, conversely, many of the difficulties that women doctors have faced since 1948 have arisen from the fact that these terms were set largely with men in mind. These terms were not new, but represented a consolidation of pre-war patterns. At the same time, medical women's circumstances were changing, which perhaps makes it harder for many to comply with these men's terms. Not until the 1960s was there substantial interest in whether medical women's (and the community's) interests might be served by special provision for women. But the basic terms were left unchanged. Only recently, largely after the period covered here, has questioning of the terms themselves and their significance for women been evident, although there is, as yet, little sign of change.

Medical Careers and the National Health Service

Since 1948, the NHS has been a near monopoly employer (or contractor) of doctors in Britain, but the relationship between "employer" and employee" has been an extraordinarily complex one. The NHS did not bring an end to professional control over the organization of medical work, but strengthened it in many respects. While the NHS brought about a major transformation in the organization of medical services in Britain, its structure was firmly based 'on the professional patterns of the past'.⁴ It changed the career possibilities for many while institutionalizing a traditional career structure at the heart of the new service,

3. I do not mean they were treated equally in practice, only that such matters as unequal pay and formally specified barriers to qualified women's entry to particular fields and posts have been relatively unimportant under the NHS.

4. Stevens Modern Medical Practice, p. 124.

and in so doing, generated problems that are still unsolved.⁵

At a general level, these 'professional patterns of the past' consisted of the three major services that I have considered in previous chapters: general practice, the voluntary hospital sector, and the local authorities, with responsibilities for both preventive work and the public hospitals (with small numbers of doctors working outside these three main sectors, for example, in the Armed Forces). With the NHS, this pattern was enshrined in the 'tripartite' structure of medical services that persisted until the 1974 re-organization.

A National Hospital Service

The major impact of the National Health Service on doctors' careers was through its transformation of the hospital service. On 5 July 1948, 1145 voluntary hospitals and 1545 municipal hospitals were taken over by the NHS.⁶ These included the hospitals run by women for women, which became part of larger administrative groups, as there was no special provision for such hospitals under the 1946 National Health Service Act. There is no space here to describe their gradual closure or absorption into mixed staff units. By 1967, only five remained as separate units staffed by women, including three general hospitals, the Bruntsfield Hospital, the Elizabeth Garrett Anderson Hospital (EGA), and the

5. These problems and the development of the medical career structure under the NHS is discussed in inter alia Stevens op.cit.; M. Elston 'Medical autonomy: challenge and response'. In Conflict in the National Health Service (London: Croom Helm, 1977), pp. 26-51; and more recently in House of Commons Fourth Report from the Social Services Committee: Session 1980-81: Medical Education Vol I. (London: HMSO, 1981), House of Commons Paper 31-1, pp. xxvii-lxiii.

6. Ham Policy-Making in the NHS, p. 16.

South London Hospital (SLH). By 1986, no hospitals staffed by women were full general hospitals.

Their disappearance may reflect decision-makers' rejection of a case for hospitals run by women for women, but it stemmed mainly from their vulnerability as small urban hospitals (or TB hospitals) to the centralization of hospital services that has taken place within the NHS, especially since the 1960s. Some disappeared without reaction in the 1960s, which perhaps reflected women's ambivalence about their role for training and treating women in an era of little active feminism. Others have been the focus of major campaigns.⁷ In the 1970s and 1980s, the women's movement—with its critique of male-dominated medicine—has been one stimulus for campaigns against proposals to close the EGA and the SLH, campaigns which ultimately ended in failure.⁸

Given this gradual attrition, and a climate of opinion against single-sex institutions for much of the period, the significance of the women's hospitals for women's medical training was

7. The first of these was in 1957, when the Scottish South-Eastern Regional Hospital Boards decided, against the wishes of Southern Hospital Group's Board of Management, to merge a vacant consultant post at the Bruntsfield and Elsie Inglis Hospitals with one at two other small Edinburgh Hospitals. The possibility of a male appointment to the women's hospitals raised a storm of protest, petitions, questions in Parliament and a judgement in the Scottish Court of Session that the Secretary of State for Scotland should overrule the Regional Board and insist on the post being advertised for women only in the first instance. A woman was eventually appointed. *BMJ* Supplement (9 Feb. 1957), 62; (16 March 1957), 116-117; (23 March 1957), 130; (6 July 1957), 4-5; (20 July 1957), 52; (23 Nov. 1957), 1247.

8. The SLH closed in 1986. The EGA still exists as a separate unit providing out-patient services, and some gynaecological beds. On the proposals to close the EGA in the mid-1970s see J. Anderson 'The possible closure of the Elizabeth Garrett Anderson Hospital: a case study in the politics of community health decision-making'. Unpublished M.Sc dissertation, University of London, 1976.

greatly diminished under the NHS. Even more than before the war, they were too few and too small to provide opportunities for more than a fraction of the women qualifying. Nor, on their own, could they provide the kind of specialist post-graduate experience training that was becoming regarded as appropriate for consultant careers. But in 1977 it was still the case that one-fifth of the women consultant general surgeons in England and Wales were at the EGA—two out of ten.⁹

The coming of the National Health Service did more than nationalize the country's hospitals. It introduced a standard career structure throughout the hospital system, a structure that was, from 1948, to be at the heart of medical training and careers. This was the so-called 'Spens ladder' modelled on the structure that had existed before the war in (and only in) the major voluntary teaching hospitals. A small number of consultants (now salaried but with part-time private practice permitted) were to be the only doctors with full clinical responsibility, each one heading a 'firm' of doctors in training grades of limited tenure, who provided much of the direct patient care.¹⁰ The adoption of this structure has had several important implications.

Firstly, it was (and is) clearly a "career" structure. No general criteria for consultant status were laid down, but from 1948 it was to be entirely contingent on specified hospital appointments. There was no place for the 'self-styled specialist',

9. Guardian 28 Feb. 1978.

10. Named after Sir Will Spens, chairman of the Report that recommended this structure. Ministry of Health Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists (London: HMSO, 1948) Cmd. 748. The training grades instituted were house officer, senior house officer, registrar and senior registrar (only in the larger hospitals).

and the consultant of the future was likely to have spent all his or her career within the hospital system.¹¹ A timetable and a route for reaching such positions were prescribed, in the expectation of an orderly sequence of continuous full-time employment in hospitals (including substantial periods of resident and night duty), in successive grades, for at least eight years after registration. This often involved several geographical moves, and extensive study for post-graduate qualifications. These became the expectations against which individuals assessed their progress, and were assessed. And they were expectations which women with competing family demands had more difficulty in meeting than men. Disorderly career patterns became more disadvantageous, and the scope for flexibility in the early years reduced. Movement between hospital medicine and general practice was increasingly expected to be one-way— an irreversible "fall" from the ladder.¹²

Secondly, there has been persistent tension between training and service demands. For most of the NHS's history, there has been a tendency for the junior grades to expand faster than the opportunities available at the top.¹³ This was particularly

11. Stevens Modern Medical Practice, p. 98.

12. The term derives from Lord Moran's (in?)famous evidence to the Pilkington Commission on Doctors' and Dentists' Remuneration in 1957. Pilkington Report Vol II, Qns. 1020-22.

13. Social Services Select Committee Medical Education, p. liv. The reasons behind this are many. Before 1948, the increase in the service component of juniors' work was apparent as technical tasks in medicine grew and were delegated downwards. Under the NHS this increased, and financial constraints and established consultants' opposition hindered the relative expansion of the consultant grade for most of the post-1948 period. In the 1960s the expansion of hospitals spread the 'firm' system still more widely, and the service load was increasingly passed down to overseas trained "pairs of hands". Elston 'Medical Autonomy'; Stevens Modern Medical Practice, pp. 139-152.

marked from the early 1960s, when, following the 1962 Hospital Plans, a major expansion of the NHS hospital system began. Between 1956 and 1974 the number of NHS consultants in England and Wales grew by 70 per cent, from about 6,500 to 11,500. But the numbers of hospital doctors in the junior grades increased by 140 per cent, from about 8,000 to almost 20,000. Between 1974 and 1980 consultants increased by 14 per cent and junior doctors by 28 per cent.¹⁴ Although junior grades continued to be loosely described as "training posts", implying an active programme of education and the eventual prospect of consultancy, in many cases this was a misnomer. Many incumbents of such posts were "pairs of hands" only, providing medical services with small prospects of advancement. This was particularly likely for those in non-teaching hospitals; for although the NHS brought this teaching hospital staffing structure to provincial hospitals it did not eliminate the difference in status and prospects for advancement between the two types of hospital. Higher specialist training opportunities were increasingly concentrated in the former.

Attempts to reduce the imbalance between the number of juniors in training and the number of consultant opportunities took four main forms between 1948 and 1978: increasing the consultant grades without accompanying increase in juniors (often proposed but rarely achieved); restricting entry to training grades, notably senior registrar posts; redesignation of lower grades (or some posts within the grades) as service rather than training posts; and the use of service posts that were not part of the training ladder, either through unestablished posts such as

14. Ministry of Health and DESS Hospital Staffing Statistics for England & Wales.

clinical assistantships or the so-called 'sub-consultant' grades.¹⁵

The latter grades originated from the desire, in 1948, to maintain hospital services while safeguarding the high standards envisaged for the consultant grade. The thousands of self-styled specialists were assessed by leading consultants for their eligibility for consultant posts, or for appointment to a second specialist grade—Senior Hospital Medical Officer (SHMO), instituted to accommodate those of lesser calibre, or those who did not seek full clinical responsibility. Thus the 'personal grading system' of the major teaching hospitals was extended to the entire hospital system.¹⁶ How many women were reviewed and how they fared compared to men is impossible to determine from national sources.¹⁷ The MWF received complaints that women were not being appointed as consultants in the early days, either from prejudice or ignorance, and expressed concern about the disappearance of the GP-consultant.¹⁸ And, by 1963, when national figures tabulated by

15. Social Services Select Committee Medical Education, pp. xxvii-xlix.

16. Stevens Modern Medical Practice, p. 100. A tenured grade of Junior Hospital Medical Officer was also added to the Spens Structure for those less experienced than SHMOs not pursuing specialist training.

17. Even where information is available at a national level it was not tabulated by sex until the 1960s. If women were more likely than men to be in small hospitals, in part-time posts, or in specialties such as anaesthetics where the SHMO grade was considered appropriate, then it is possible that they were more likely to be graded as SHMOs at the beginning of the NHS than men. Pre-war women consultants apparently had lower incomes than men. The survey for the Spens Committee found that 70 per cent of the small number of women consultants (excluding any GP-consultants) earned less than £1,000 per year, compared to only 24 per cent of men. Spens Report on Consultants, pp. 28-30. On the SHMO grade and anaesthetics see Ministry of Health RHB Circular (50) 96.

18. Jnl. MWF (April 1952), 19-20; (July 1946), 12-13; (July 1948), 14.

sex became available, women were 18 per cent of the 1721 SHMOs in England and Wales but only 6 per cent of the 7512 consultants.¹⁹

In 1948, the SHMO grade had been envisaged as temporary, but appointments to the grade increased in the 1950s—one factor in the growing disquiet at the imbalance in the career structure. In 1961, the Platt Committee, established to examine this, supported the principle of consultant-led teams on which hospital staffing was based. Because the SHMO grade was irrevocably tainted by its origins as a grade for failed consultants, the Committee recommended its replacement by a new sub-consultant grade of Medical Assistant. This was instituted in 1964.²⁰ The proposed sub-consultant grades were intended to preserve the character of consultant posts by providing a tenured alternative for those who, for whatever reason, were not qualified for this restrictively defined status, or did not aspire to it. Critics of the sub-consultant grade argued that their existence prevented adequate expansion of consultant opportunities; that they relegated incumbents to second-class status and lower pay; and that they were used for the relegation of those of second-class status, particularly women and overseas doctors. From the early 1970s, following another attempt to rebalance the career structure by expanding the number of consultant posts, appointments to the Medical Assistant grade, subsequently renamed Associate

19. Ministry of Health Hospital Medical Staffing Statistics, 1963.

20. Ministry of Health Report of the Joint Working Party on the Medical Staffing Structure in the Hospital Service (London: HMSO, 1961). Platt Report. Platt also recommended the establishment of the 3 year vocational training scheme for GPs, and the establishment of the Hospital Practitioner grade, hospital appointments for principals in general practice.

Specialist, were only made on a personal basis. The arguments about such a grade still continue.²¹

The NHS hospital career structure also became increasingly differentiated horizontally as specialties and sub-specialties continued to proliferate after 1948. As before 1948 there was no single pattern of development. Subdivision took place on the basis of technique, body system or organ, and patient group. The extent to which specialties sought to establish their own organization and examinations varied. The high status surgical sub-specialties continued to rely on their influence within the RCS. Others, usually less prestigious ones, like pathology and psychiatry set up their own colleges and examinations.

Between 1948 and the late 1970s, consultant appointments in all fields came to depend on acquiring post-graduate qualifications, and associated experience in approved posts. The organization of post-graduate training became more formalized. This did not necessarily diminish the importance of sponsorship from established members of the profession or of social and personal characteristics in determining who might progress upwards or into particular posts, among those meeting the requirements of technical proficiency set by the profession. However, this is an area that has been scarcely explored in studies of the British medical profession.²²

21. Social Services Select Committee Medical Education, pp. liii-lvii. (In July 1986, plans for a new sub-consultant grade were announced. Times 10 July 1986.)

22. In his classic study of Canadian doctors Hall points out these factors are not substitutes for technical proficiency, but operate after this has been demonstrated. 'Stages of a medical career', p. 332. Appointments to 'firms', especially at junior levels have been traditionally regarded as consultant prerogatives but there have been no studies examining this in detail. For a claim that the development of training schemes whereby doctors

Different specialties continued, however, to vary greatly in the organization of their training and work routine, in the period of approved service and the degree of mobility required, and in the extent to which provision for part-time training was made. Specialties differed in the financial rewards they offered, either through the opportunities for private practice or through the distinction awards allocated to supplement some consultants' salaries. They also varied greatly in their competitiveness, in the balance between the number of qualified juniors seeking specialist posts and the number of vacancies.²³ Thus a state of overall imbalance in the hospital career structure co-existed with some specialties' having insufficient recruits, either because of their unpopularity with young doctors or because of consultant posts' having expanded more rapidly than the training ladder, or both. In particular, the expansion of the hospital service in the 1960s and changes in medicine have generated demand for technical support services; and government policy in the past decade has been to expand the so-called "Cinderella" services for the elderly, mentally ill and mentally handicapped. During the 1970s, anaesthetics, geriatrics, psychiatry, radiology and pathology, and the new field of community medicine appeared regularly in the lists of "shortage" specialties.²⁴

rotate between different consultants has not diminished its importance because of their location in teaching hospitals see MWF Careers Symposium, p. 34.

23. This long-recognized feature of the hospital system was given new prominence in the 1970s. In an effort to encourage doctors to adjust their expectations in line with opportunities, the DHSS began publishing regular tables showing shortage specialties (too few qualified applicants for consultant vacancies) and those with a surplus of applicants. These tables appear regularly in Health Trends.

General Practice and the National Health Service

The immediate effect of the NHS on most general practitioners was much less dramatic than on their hospital-based colleagues. The GPs had retained their independence as self-employed contractors, relieved of the need to purchase the 'goodwill' of practices and with a clientele freed of the obligation to pay directly. Entry into general practice required no special training other than the six months hospital experience in medicine and in surgery, compulsory for full registration from 1953. Becoming a principal depended on finding a suitable vacancy, not always easy in the competitive conditions of the 1950s. For those who could not, entry was still through salaried assistant posts, perhaps with the prospect of partnership. The same option was available, to a limited extent, for those who did wish to undertake the full obligations of NHS general practice, twenty-four hour care of patients, still done on a single-handed basis by many.

For women the new arrangements had several implications. The (albeit weak) attempts to control the geographical distribution of GPs meant that women applying to establish a new practice would now be in competition with male colleagues. Disquiet was often expressed within the MWF about the partnership arrangements proposed for women. And the NHS Medical Practices Committee responsible for approving partnership contracts scrutinized those involving husband and wife particularly closely, being concerned that both parties would be doing a full share of the work.²⁵

24. Evidence on doctors' attitudes to shortage specialties in the late 1970s is reported in Institute of Manpower Studies The Determinants of Doctors' Career Decisions Report for DHSS (Brighton: IMS, 1979)

25. Jnl. MWF 39 (July 1957), 212; 44 (Oct 1962), 164.

One recurrent question for the MWF in the early years, which arose because of the abolition of the sale of goodwill, was whether Executive Councils should make special efforts to replace a retiring woman with another woman. Such practices were often advertised as formerly 'woman's practices'. In the early 1950s, the MWF urged retiring women to plan ahead, to avoid a situation where Executive Councils had a choice of many experienced men and few inexperienced women.²⁶ But by 1957, the trend among new women principals in general practice was reported as away from single-handed practice (like their male colleagues) and away from 'all women partnerships', a trend welcomed by Annis Gillie, prominent MWF member, and a major architect of general practice reforms in the 1960s. Like many leading medical women of this time, she welcomed this trend as a sign that 'women doctors are now so woven into the texture of general medical services that we just take them for granted'.²⁷

The major change for general practitioners brought by the NHS was the intensification of the division between general practice and hospital medicine. GPs' exclusion from posts at all but the smallest of hospitals, except as clinical assistants, was one factor that contributed to declining morale in the 1950s, culminating in crisis in the mid-1960s. This was resolved by the adoption of a new 'Charter' for family doctors in 1966, substantially improving financial incentives for group practice. This helped a gradual recuperation in the morale and recruitment

26. Jnl. MWF (Jan. 1950), 30; (Jan 1951), 28-29.

27. Jnl. MWF 42 (April 1960), 74-75 & 78. Of 95 new women principals in 1957 64 went into mixed partnerships, 10 into partnership only with women and 21 into single-handed practice.

in general practice in the 1970s. At the same time, the College of General Practitioners was successfully promoting a new image of general practice as a vocation, and new entrants increasingly undertook a vocational training programme. The provisions for part-time and salaried partners were improved and these, and trainees, largely came to replace assistants. Thus general practice under the first 30 years of the NHS was slowly transformed from a 'cottage industry' in which 40 per cent of principals were single-handed to one in which group practice was the norm and for which, formal training was becoming established.²⁸

Although general practice has remained the most common long-term career destination of British medical graduates, its size relative to the hospital sector has changed. In 1949 there were about 18,000 general practitioners in England and Wales, and nearly 12,000 hospital doctors, of whom about 4,000 were consultants. In 1964, there were about 22,000 general practitioners and 18,500 hospital doctors, of whom just under 7,000 were consultants, and in 1979, 24,000 general practitioners co-existed with 34,000 hospital doctors of whom 12,500 were consultants.²⁹

28. On the development of general practice under the NHS see Stevens Modern Medical Practice, esp. pp. 100-105 & 286-319; Honigsbaum Division in British Medicine, pp. 301-319. On vocational training see P. Day Women Doctors: Choices and Constraints in Policies for Medical Manpower Project Paper 28 (London: King's Fund, 1982), pp. 52-54. On the changes in general practice since the 1960s see M. Jefferys and H. Sachs Rethinking General Practice (London: Tavistock, 1983).

29. Ministry of Health Annual Reports; DHSS Statistics and Research Division. Numbers of general practitioners include trainees and assistants.

The Changing Form of Public Health

From 1948, the NHS did not have a complete monopoly over the employment of doctors, but those who remained outside it became increasingly marginal to health service provision and health policy. There were those who remained outside the tripartite structure altogether, working wholly in private practice, occupational health, the pharmaceutical industry or the other small spheres of medical activity on the periphery of the main services.³⁰ More importantly for medical women, the local authority health services remained outside the NHS, but denuded of most of their clinical responsibilities and clinical staff, with the incorporation of their hospitals into the new health service.

The hierarchical career structure from medical officer to MOH remained, but the role of those on it was left uncertain. Medical Officers of Health found 'their empires diminished' and their control over the remainder under pressure from other occupational groups, including general practitioners seeking to extend the scope of their role as 'family doctors'.³¹ Against a background of low morale, uncertain status and recruitment difficulties, and looming local government re-organization, the idea of the community physician as a planner and administrator of health

30. In 1965 and 1974, 9 per cent of all men and women doctors on the CMRC index were recorded as active but in 'other' categories of work besides the NHS hospitals, the general medical services (general practice) and the local authority/community health services. MWF Report of Careers Symposium: Women in Medicine 1979-What is Our Future? 9 March 1979. (London: MWF, 1979), 83-84. This group also includes those working in university posts, many of whom have close connections with the NHS as teachers of medical students and honorary clinicians.

31. J. Lewis 'The roots of community medicine', Bulletin of the Society for the Social History of Medicine 38 (1986), 56.

services for the community developed during the 1960s.³²

After 1948 the preventive services for mothers and children were almost the only clinical responsibilities remaining within the local authority services. And the anomalies and uncertainties concerning this work that were apparent before 1939, became increasingly evident. Was this work a central part of public health as this was becoming redefined? Was it specialist work with children in its own right, with a distinctive contribution to make, whose image was unfortunately 'bedevilled by the woman who wants to do a few clinics ... but who hasn't a clue about the wider issues at stake'? Or was it 'undoubtedly dull work' to be shared by as many doctors as possible, or only suitable for those who wished for 'pin money', being an 'excellent way of making money but nothing else'? Did clinics where no treatment could be given have any rationale now that women and children could have free, comprehensive health care from general practitioners? Were they not an unnecessary duplication of services, wasting the time of busy women who had to take themselves and their children from clinic to GP and back again?³³

These questions were asked by those (women) involved in this work, concerned about the lack of consideration given to this field in planning the post-1948 health services and its limitations as an avenue for rewarding careers. They were also asked increasingly by paediatricians and general practitioners calling for the integration of preventive and treatment services for children, and by those concerned with reformulating "public health" as a wholly non-clinical field. The demise of the clinic

³². Lewis op.cit.; DHSS Report of the Working Party on Medical Administrators (London: HMSO, 1972) (Hunter Report).

³³. Jnl. MWF (Oct. 1954), 52-53; Jnl.MWF (Jan 1947), 39-40; Jnl.MWF 44 (1962), 40; Jnl.MWF (Oct. 1950), 36.

doctor was increasingly predicted from the late 1950s.³⁴ In the absence of any agreed substitute, however, clinics did not disappear; but continued, as an increasingly marginal field of medical activity, staffed in the variety of ways that prevailed before 1948. Many large authorities initially expressed a preference for full-time staff, and cut back on part-time workers in the 1950s. But lack of recruits to public health careers meant that this did not happen everywhere and that possession of the DPH could not be insisted on as a pre-requisite.³⁵ Clinic work was, in many areas, work that could be undertaken without formal qualifications, and on a part-time, usually sessional, basis.

Re-organization of the health services in 1974 incorporated the local authority services into the NHS and, in doing so, formalized the growing division between their clinical and administrative functions. The non-clinical specialty of community medicine, with consultant level specialists who had responsibilities for managing the health services and a hospital-type training ladder, was established throughout the health service. The child health and school medical services were left in limbo, awaiting the creation of a new integrated child health service whose form is still not clearly determined.³⁶ Before 1974, as I

34. Stacey and Davies 'Division of Labour', pp. 32-44, analyze the different images of child health work proposed in this period; Lewis op. cit.

35. Jnl.MWF (July 1951), 30-32; (April 1958), 120-123. There was some administrative re-organization in 1948, generally creating larger areas by transferring services from District to County Councils. On the dismissal of 27 women part-timers in Birmingham in 1957 see BMJ Supplement (18 May 1957), 278.

36. In 1974, no plans were made for the community health services pending the recommendations of the committee chaired by Professor Court DHSS Report of the Committee on Child Health Services (London: HMSO, 1976)—whose recommendations have not

suggested earlier, women clinical medical officers in child health were often not on advancing trajectories up the public health career ladder. After 1974, such doctors were unambiguously left without 'status or career structure', providing services under the direction of members of a separate specialty.³⁷

Thus, changes in the organization of hospital provision and general practice medical services in the first thirty years of the NHS did not foster the continued existence of separate women's hospitals and general practices. Within public health, the field where women had long had a prominent place appeared increasingly to be the field of anomalous and dead-end work, while simultaneously being accessible to most medical practitioners.

Under the NHS, the career structure for medical practitioners became increasingly formalized into two main, and one minor, parallel "career" ladders of very different length and complexity, and competitiveness. But some of the posts within each ladder were simultaneously "service" and "training" posts, and associated with

been adopted. Under the 1974 re-organization, provision was made for consultant community medicine posts at Area level for specialists in maternity and child health, but these posts disappeared with the Area tier of administration in 1982.

37. BMA Central Committee for Community Medicine Career Structure and Training for Community Health Doctors: Report of the Community Health Doctors Sub-Committee (London: BMA, 1982) p. 2. (This summarizes the different reports on child health services and associated careers produced since the late 1960s.) Both this report and A. Ward 'Women doctors in the community health services', Community Medicine 3 (1981), 307-313, underplay the extent to which Community Health Doctors were probably in "dead end" jobs before 1974. Clinic-based family planning work has similarly occupied an ambiguous place in the restructured health services. After the 1967 Family Planning Act much of the work of the Family Planning Association became a local authority responsibility and in 1974 the NHS Family Planning Service was instituted as a free, clinic-based service but GPs have increasingly claimed this work, following the introduction of special payments. Leathard Fight for Family Planning, pp. 157-176.

each ladder were posts that were off the main ladder. Figure 10.1 illustrates this structure as it had developed by 1974.³⁸

Developments within the different branches of medicine contributed to and were shaped by changing concern about the supply of doctors, concern governed by the perception of surplus in the 1950s followed by shortage in the 1960s (and reversion to surplus in the late 1970s). In Chapter IV, I showed how this change affected the opportunities for women to enter medicine. It also meant a fluctuation in the employment opportunities for doctors and changing perceptions of the patterns of British women doctors' participation in medicine. Throughout the history of the NHS, there have been attempts to adjust both the overall quantity of doctors and the imbalances— attempts which have, for the most part, failed, because of the diverging interests and differing power of those concerned with policy-making and its implementation.³⁹

Women have had, at best, a small voice in this policy-making because of their scant representation within the leadership of the profession's main associations or in senior positions locally.⁴⁰

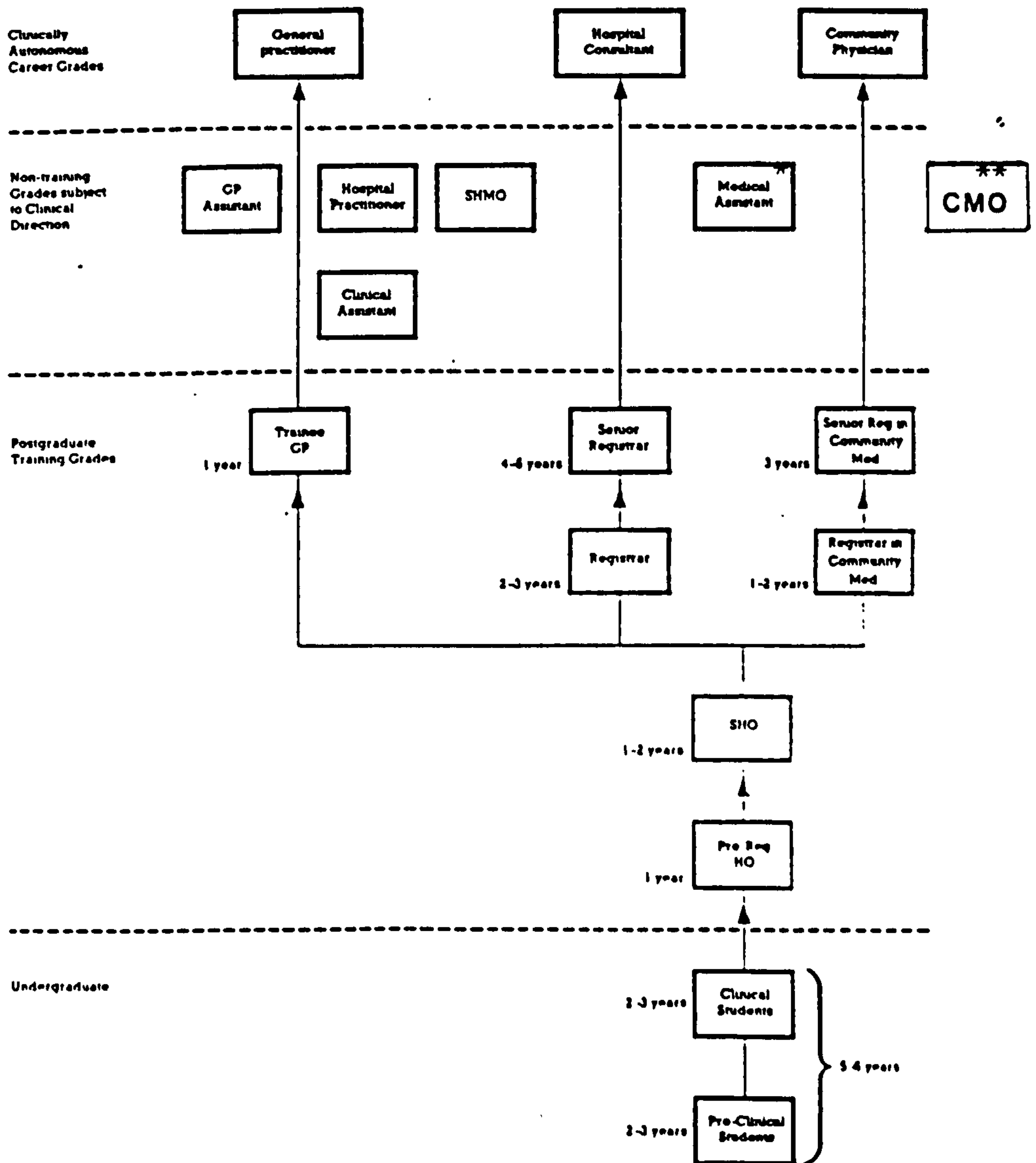
38. It will be noted that the Community Health Services were omitted completely in the original source. Those fields of work outside the NHS are also omitted.

39. Eckstein Pressure Group Politics; Stevens Modern Medical Practice; Elston 'Medical autonomy: challenge and response'; Social Services Select Committee Medical Education, Vol I, pp. xxvii-lxiii; Ham Policy-Making in the National Health Service, pp. 78-98 & 177-191.

40. Bewley and Bewley 'Hospital doctors' career structure and misuse of womanpower'; Jnl. MWF 55 (1973), 39-47. This also means they had little voice in the internal decisions of these professional bodies that affected women's careers in specifying training requirements by Royal Colleges. Absence of women does not necessarily mean that their interests are not heeded (any more than their presence guarantees their voices are heard), but it seems reasonable to assume it makes it less likely. Nor are women's interests uniform, or uniformly perceived.

FIGURE 10.1:

Medical Career Structure within the NHS



Office of Health Economics, Compendium of Health Statistics, 1984

* Renamed Associate Specialist 1980-.

** Clinical Medical Officer/Senior Clinical Medical Officer

They were not, however, always completely absent. Individual women doctors served on some of the major committees.⁴¹ The MWF gave evidence to the major inquiries, and was represented on some of the BMA and NHS committees and worked in many ways to promote medical women's opportunities. Such efforts took different forms as the circumstances and attitudes of women themselves changed, and as concern about women's place in medicine within the profession as a whole altered, not solely because of changes in the numbers of women entering the profession.⁴²

Changing Perceptions of the Problems of Medical Women and of the Problem of Medical Women: 1948-1977

The overwhelming concern of the organized medical profession in the immediate post-war years was, not surprisingly, with the coming National Health Service. In the protracted and intense arguments, women's position and the recommendations of the Goode-nough Report for co-education were only a very minor theme. The MWF was represented on the committee set up under the auspices of the BMA to negotiate with the Minister of Health. Its representatives were concerned about the implications of some specific proposals for women, but, in general, concurred with the main proposals, or shared the concerns of the BMA's negotiators.⁴³

41. For example, the role of Dr. Janet Vaughan in the Goode-nough Committee between 1942 and 1974 was mentioned in Chapter IV. Dame Josephine Barnes, a gynaecologist, served on the Todd Commission. There was no woman on either the Willink or the Platt Committees.

42. Only about 10 per cent of registered women doctors in the UK have been members of the MWF for most of the period covered in this chapter so their views are not necessarily representative, but it was the only national organization of women doctors.

43. E.g. MWF Newsletter (April 1943), 49-52; (Oct 1943), 29;

As these negotiations were proceeding, the war that had brought many "retired" married women with children, including women doctors, into paid work was ending. And so were most of the practical measures to aid married women's employment, although most marriage bars in public employment remained permanently withdrawn. Demobilized men were returning to medical schools and seeking to resume their careers in an uncertain and confused employment situation. The already limited supply of domestic workers on which married medical women's professional careers largely depended was further diminished by the increase in marriage and motherhood among all women, and by changing social attitudes to such work and to mothers' employment outside the home in general. Popular psychology influenced by Bowlby and the values of the new welfare state promoted full-time motherhood as a fulfilling and desirable role for women.⁴⁴

Medical women themselves were not immune from these developments. Those who studied during the war were more likely to marry, and did so earlier in their careers than their predecessors.⁴⁵ This was the beginning of a trend among medical women to higher marriage rates and to marriage at an earlier stage in their professional careers, a trend which was to continue for

(April 1946), 22-24. On the negotiations (with no mention of women's views see Stevens Modern Medical Practice, pp. 65-106; J.E. Pater The Making of the National Health Service (London: King's Fund, 1981).

44. Jefferys 'Marriage, motherhood and medicine', 198; Riley War in the Nursery, pp. 150-190.

45. The MPU survey in 1962-63 found that 34 per cent of those qualifying between 1940 and 1944, and 38 per cent of those qualifying between 1945 and 1949 married within three years after qualification compared with only 25 per cent of those qualifying in the 1930s. Jefferys and Elliott Women in Medicine, 29.

the next thirty years, and which led to a marked increase in the proportion of medical women who were mothers.⁴⁶ There has been no detailed investigation of the influence on medical women of contemporary theories about the ill-effects of mothers' employment on child health and development. But some of this generation have recalled the pervasiveness of such ideas in their training.⁴⁷

Thus, in the immediate postwar years, increasing numbers of young medical women were faced with decreasing opportunities for, and increased barriers to, practice, in a climate that was not conducive to combining motherhood with extensive professional commitment, at least while children were small. In this context, part-time work for married medical women began to be regularly discussed within the MWF's journal for the first time in the late 1940s and early 1950s, though not as a major issue.⁴⁸ The difficulties faced by single and married women in getting suitable employment were raised periodically; but the predominant concerns of the MWF for much of the 1950s were with socio-medical problems rather than with members' careers. Some at least held the view that, after 1948, with broadly equal conditions of service established, and the entry of women into the London men's schools achieved, 'the position of medical women was apparently satisfactory and the Federation could, so it seemed, be relatively content'. Professional success was seen by some established women

46. Ibid; B. Beaumont 'Training and careers of women doctors in the Thames Regions', BMJ (21 Jn. 1978), 191; Ward et al Careers of Medical Women. Medical women have remained less likely to marry and later marriers than all women, but those that have married have had more children than all wives of Social Class I men.

47. E.g. S. Tyrell Lancet (5 Aug. 1978), 309, quoted in Ward et al. op.cit., pp. 14-15; BMJ (5 June 1954), 1322.

48. E.g. MWF Jnl. (April 1947), 32; (July 1951), 31-35.

to depend largely on individual women's determination.⁴⁹

For most of the 1950s medical women received scarcely any mention in the main medical press, and in debates about medical staffing. By 1953 the profession was pre-occupied with surplus, unemployment, and the overcrowded lower ranks of the hospital ladder as consultant expansion slowed after 1950.⁵⁰ In such a situation, women's opportunities were not a priority. The Willink Committee made some very approximate estimates of women's activity rates and assumed that these, and current levels of women in medical schools (taken to be 20 per cent), would remain stable for the future.⁵¹ Women were a taken-for-granted small minority whose activity was marginal to the main concerns of the profession.

From the end of the 1950s, however, there was growing concern with the career opportunities, or, at least, with the activity, of medical women. Behind this development were two factors. The first was the growing desire of married women doctors for improved opportunities. On the one hand the climate of opinion was becoming more favourable to married women working, although the expense of domestic help and the tax structure remained disincentives for wives of professional men to work.⁵² On the other hand, in the eyes of some, 'more and more medicine [was] becoming closed to those who are not prepared or able to give a full working week'. Such part-time opportunities as existed were mainly casual or temporary ones, except for those who

49. Jnl. MWF 49 (1967), 89; BMJ (15 May 1954), 1143.

50. Eckstein Pressure Group Politics.

51. Willink Report, pp. 3-6.

52. Jefferys 'Marriage, motherhood and medicine', 200-201.

had achieved consultant status. The complaint was increasingly voiced by MWF members and in the medical journals that medical women, especially married women, still had to prove themselves very much better than a man to get any post. As more of them were married than ever before, more were facing such prejudice.⁵³

The second factor, from 1960, was the re-assessment of the assumptions of the Willink Committee and the growing concern about the shortage of doctors in Britain. The demand for doctors was apparently outstripping the supply from medical schools. This supply was, according to some, effectively even less than it appeared because the Willink Committee had underestimated the proportion of women entrants.⁵⁴ Moreover, the shortage was, many argued, being exacerbated, by two, apparently increasing, sources of loss of qualified British doctors, which in the early 1960s became "social problems" requiring solution. The first was the alleged increase in emigration.⁵⁵ The second was the apparently growing "wastage" of women from practice.

Thus, in the early 1960s there was apparently medical work to be done, and medical women seeking to do it. The claims of an acute shortage of doctors led many individual women and the MWF to

53. Jnl.MWF 40 (1958), 124; 43 (1961), 123.

54. One of the most influential papers calling for a revision of the Willink estimates noted that the ratio of male to female entrants to medical schools had not been 4:1 as Willink had suggested in the mid 1950s, but 3.12:1 in 1954-5 and 3.53:1 in 1957-8. F. Lafitte and J.R. Squire 'Second Thoughts on the Willink Report', Lancet (3 Sept. 1960), 538. Lafitte and Squire's own prediction of a 3.6:1 ratio of male to female for the 1960s was also a considerable underestimate. In 1960/61 it was 3.1:1 and only in one year (1965/66) did it drop below 3.4:1.

55. On the evidence and arguments about emigration see B. Abel-Smith and K. Gales British Doctors at Home and Abroad (London: Bell, 1964).

point to the difficulties married medical women had in finding openings compatible with their domestic commitments. They suggested that here was an untapped resource of medical labour, which could be drawn on if suitable working arrangements were adopted.⁵⁶ In this context, the investigation of medical women's activity rates became 'a minor industry' in the 1960s.⁵⁷ Several surveys of the women graduates from individual schools, published between 1962 and 1964, showed that among more recent graduates the proportion in active practice was lower than among those who had been qualified for some time.⁵⁸ In 1966, the publication of the findings of two national surveys of medical women, carried out in 1962-63 and in 1964, showed that, in total, about 80 per cent of all women respondents were actively engaged in medical work, and that among inactive and part-time doctors there was a pool of under-utilized women anxious for more work. But they also showed more recent qualifiers as less likely to be active than those qualified in the 1930s and 1940s, associated with their greater propensity to marriage and the youth of their children.⁵⁹

Some took this evidence of declining activity rates and

56. E.g. *BMJ* Supplement (23 Dec. 1961), 266 ; *BMJ* (13 Jan. 1962), 113; (2 June 1962), 1522; (7 July 1962), 56; (26 Oct. 1962), 1066.

57. Ward et al. Careers of Medical Women, p. 13.

58. Robb-Smith 'Fate of Oxford Medical Women'; J. Kahan and N. MacFaul 'Middlesex women graduates 1947-1961: A survey of their careers', Middlesex Hospital Journal, 62 (1962), 192-194; J.E. Lunn 'A survey of Sheffield medical women graduating over the years 1930-1952', Medical Care, 2 (1964), 197-202; A.G.W. Whitfield 'Women medical graduates of the University of Birmingham 1948-1958', Postgraduate Medical Journal, 40, 176.

59. Jefferys and Elliott Women in Medicine; J.E. Lawrie, M.L. Newhouse, P.M. Elliott 'Working capacity of women doctors', *BMJ* (12 Feb. 1966), 409-412. The latter surveyed all women on BMA lists of doctors in every region of the United Kingdom.

increasing family commitments of younger women as grounds for reducing women's opportunities. Calls for the expansion of medical schools were, in some cases, accompanied by proposals to further restrict women's entry, or to select only those who were likely to persist in practice.⁶⁰ This was the context in which the quota system described in Chapter IV was operating in the early 1960s. However, the Todd Commission rejected the case for 'arbitrary upper limits' on women entrants, adopting an individualistic and meritocratic stance on medical school selection.⁶¹ As Chapter IV showed, the Commission's recommendations led to an increase in women's entry to medical education. But they did not bring an end to arguments about the desirability of this.

For others, the national surveys indicated that the 'overall wastage among women doctors is not as alarming as is sometimes suggested'.⁶² For them, the urgent problem was to improve, not reduce, opportunities for existing and future medical women, for the benefit of individual women and, given the urgency of the shortage of doctors, for the benefit of the community. The MWF pressed for a more flexible approach to medical staffing, and for women medical students to be advised more systematically to equip themselves with further training and qualifications before

60. E.g. *BMJ* (10 March 1962), 714; (5 March 1966), 610; (16 April 1966), 984.

61. 'In our view the main criterion for admission to a university medical course should be the ability of the applicant to profit from the course and be a good doctor.' Todd Report, p. 123. The Todd Report based its recommendations for the future intake of medical students on the assumption that the intake of women to medical schools and their activity would at about the same levels as in the mid-1960s. *Ibid.* 144.

62. Lawrie et al. 'Working capacity of women doctors', 412.

embarking on matrimony and motherhood. But the main emphasis was on the encouragement of those currently qualified to use their skills more fully. The MWF established a counselling service for such women. A few ad hoc refresher or retraining schemes were begun, but such developments were on a very small scale.⁶³

The DHSS promoted the development of special provisions for married medical women from 1969. Circular HM(69)6 requested regional boards to take active steps to encourage inactive women to enter all grades of hospital work including the senior training grades, and advised on new provisions for doing so.⁶⁴ As with many centrally issued policy proposals, implementation of this scheme varied with local enthusiasm and commitment, and gaining approval and financing of these largely super-numerary posts proved a protracted and inflexible process. The training posts that were approved in the early years were concentrated in the "shortage" specialties.⁶⁵ Of the 313 posts of Senior Registrar and Registrar created under HM(69)6 between October 1971 and April

63. The best-known of these was based in Oxford. R. Rue 'Employment of married women doctors in hospitals in the Oxford Region', Jnl. MWF 49 (1967), 210-212. (Reprinted from the Lancet). The first initiative from the Ministry of Health to refer to the needs to encourage women doctors to return to work was Memorandum ECN 544 (ECL 27/66) which promoted refresher courses for any doctor wishing to enter general practice after a break. On this, and other central initiatives see Day Women Doctors, pp. 62-88.

64. National Health Service Circular HM(69)6 'Re-employment of Women Doctors'. In 1972 the Women Doctors Retainer Scheme was introduced for keeping women unable to have more than a minimum commitment to medicine in touch with professional developments. National Health Service Circular HM(72)42 'Women Doctors Retainer Scheme'.

65. B. Beaumont 'Special provisions for women doctors to train and practise in medicine after graduation: a report of a survey', Medical Education 13 (1979), 284-291; Day Women Doctors, 61-71; MWF 'Evidence to the Royal Commission on the National Health Service' (1976).

1975, over half were in anaesthetics and psychiatry, none in surgery and three in obstetrics and gynaecology.⁶⁶

Two factors encouraged this concentration, and perhaps constrained women's choices. Concern over hospital staffing in the early 1970s was turning from overall shortage to the maldistribution of recruits between specialties. Thus it was argued by some that to encourage special opportunities for women to train part-time in fields that were already oversupplied was a waste of resources and not in the interest of individual women seeking consultant opportunities.⁶⁷ At the same time, the concentration reflected the reluctance of some of the "demanding" specialties, notably all branches of surgery and obstetrics and gynaecology, to modify their training arrangements substantially (reluctance on the grounds that standards would fall); and the relative alacrity with which some of the fields with shortages did so.⁶⁸

Thus, over the first thirty years of the NHS, the "problem" of women doctors in health policy became the problem of married women doctors, and their competing family obligations. For some these obligations were grounds for limiting women's presence in medicine either in general or from certain fields. For others, the problem was how, given these competing obligations, more women

66. DHSS Statistics and Research Division. Central records were not kept on approval of posts in other grades.

67. E.g. DHSS Women in Medicine Report of a Conference 4-5 July 1975. (London: DHSS, 1975); BMJ (10 Jan. 1976), 78-81.

68. BMJ (10 Jan. 1976), 56; Elston 'Women in the Medical Profession', 127-131; Beaumont 'Special provisions'. The first post-graduate examination bodies to approve part-time training were the Faculty of Anaesthetists and the Royal College of Psychiatrists. The RCOG and the RCS have been among the last. Day Women Doctors, pp. 70-71.

might be enabled to make fuller use of their qualifications. Both of these views were initially articulated in the context of the increasing rigidity of the career structure and acute concern over doctor shortage. Perhaps one reason why there were no major policy initiatives was that this shortage was being diminished by the rapid increase in overseas-trained doctors taking posts in the NHS.⁶⁹ As the number of women qualifying rose in the early 1970s, of whom an increasing proportion were married, more attention was paid to the question of part-time training for "careers" as well as for part-time opportunities for returners.⁷⁰ But such provisions were still envisaged as exceptional, not as an established part of the career structure in all fields of medicine. As concern over shortage gave way to concern over imbalance, the question of the fields in which such provision might be made became prominent in arguments about the alleged conflict between 'the philosophy of women's liberation ... and the emphasis on efficacy and efficiency and value for money in the provision of health care services'.⁷¹

By the end of the 1970s, perception of the "problem" of women doctors was changing again, with the sharp rise in the numbers qualifying, renewed concern about surplus and diminished prospects for all doctors.⁷² And medical women were pressing for more

69. Smith Overseas Doctors in the National Health Service.

70. Beaumont's 1976 survey found 34 per cent of women doctors born between 1945 and 1949 were married on qualification compared to 29 per cent of those born between 1940 and 1944, and fewer in preceding cohorts. 'Training and careers of women doctors in the Thames regions', 191.

71. Update (Oct. 1973), 903; British Journal of Medical Education 7 (1973), 143.

72. These issues are reviewed in Social Services Select

radical solutions to their and the profession's career problems.⁷³
But such developments mainly concern the most recent qualifiers,
not those with whom I am concerned.

Committee Medical Education, and revealed in the published minutes of evidence to the committee.

73. E.g. MWF evidence to the Social Services Committee Medical Education: Minutes of Evidence 18 March 1981 (London: HMSO, 1981). House of Commons Paper 31-xvii, pp. 680-730. A number of feminist groups of women doctors developed from 1979 outside the MWF, the most active of these being Women in Medicine, set up in 1981, and with about 200 members early in 1986. Women in Medicine Newsletter (May 1986), 3.

Medical Careers Under the NHS

Having outlined the context in which women made their medical careers in the first thirty years of the NHS, I turn to an all-too-brief account of some features of those careers. I shall concentrate on two features arising from the previous discussion. I consider the activity patterns of medical women in relation to continued allegations of wastage, the pressure for part-time work and the changing career structure. Then I consider the fields where women have worked in medicine since 1948. I draw on both cross-sectional data from official statistics and surveys of those who qualified before the major expansion of from the late 1960s, especially of those who qualified in the early 1950s and 1960s.⁷⁴

The Activity of Women Doctors in the Postwar Years

Many of the claims made about the high "wastage" of women from medicine since the Second World War were as exaggerated or misleading as those made before the war, despite the greater amount of information available. In such claims, data referring to aggregates were sometimes confused with data referring to individuals; participation rates at particular points in time were sometimes taken to indicate patterns of participation over a lifetime.⁷⁵ The different sources of information on medical women's activity in these postwar years all show that the vast majority of medical women since the war were active at any

74. These were the groups covered in the Medical Careers survey in 1976 and the much larger 1977 survey, of women registering between 1949 and 1951 and in 1965, reported in A. Ward et al. Careers of Medical Women.

75. E.g. Evidence of medical school dean to House of Commons Select Committee on Sex Discrimination Bill quoted in R. Davies Women and Work (London: Arrow, 1975), 132; BMJ i (29 Jan 1977) 317.

one
 time.⁷⁶ But, where comparable information is available, they also indicated that on average women were less likely to be active at any single time, and worked less over time, than comparable men.⁷⁷

Profiles of the activity of cohorts of women over time and cross-sectional comparisons of different age groups of medical women since the war have shown the characteristic 'bimodal' pattern of women's activity, with a low point of activity occurring in the first decade after qualification. Within each cohort single women's activity rates were higher than those of married women, with or without children, and comparable to those of men (where these were known). If active, married women, especially married women with children under school age, have been more likely than single women to be working part-time. However, over the thirty years there have been changes in women's activity patterns, reflecting the greater frequency of marriage and motherhood, its tendency to occur earlier, and the changes in attitudes and oppor-

76. Sources include CMRC data since 1965 and the major surveys of all medical women already mentioned: Jefferys and Elliott Women in Medicine in 1962 and Beaumont 'Training and careers of women doctors in the Thames regions'; surveys of qualifiers from particular schools, notably the follow-up of 1,0557 RFHSM women qualifiers from the years 1945 to 1964 in 1966. C.A. Flynn and F. Gardner 'The careers of women graduates from the Royal Free Hospital School of Medicine, London', British Jnl. of Medical Education 3 (1969), 28-42 and the cohort studies Ward et al Careers of Medical Women, and the Medical Careers survey.

77. Men's contribution other than their emigration rates, was given little scrutiny, generally being assumed to be virtually 100 per cent. One difference given little attention to date in considering men's and women's contribution to medical practice over their lifetime is that male doctors' death rates have been higher than women's. See A. Maynard and A. Walker Doctor Manpower 1975-2000: Alternative forecasts and their resource implications Royal Commission on the National Health Service Research Paper No. 4 (London: HMSO, 1978), p. 16. Of the original Medical Careers study population 9 men but no women were known to be dead by 1976.

tunities, described in the first part of this chapter.

Comparisons of cross-sectional data and of successive cohorts of medical women indicate that the cohorts of doctors qualifying in the early years of the NHS had lower activity profiles over time than both their predecessors and their immediate successors. And, when these groups were surveyed in the 1960s, they were at the low point in their bimodal curve. The survey of RFHSM qualifiers in 1966 showed that those who qualified between 1945 and 1949, and between 1950 and 1954 showed higher rates of not working in the first decade of qualification compared to later qualifiers.⁷⁸ Both the Sheffield and the Medical Careers survey show that those who qualified in the mid-1960s were more likely to be in active practice at the same stage since qualification compared with those who qualified in the first half of the 1950s, and that the low point in their activity occurred earlier and was followed by a steeper rise in the return to work.⁷⁹

Beaumont's 1977 survey and CMRC data show a marked decline in the proportion of medical women not working in every age and qualification group between the 1960s and mid-1970s. Tables 10.1 and 10.2 show CMRC data on men's and women's activity rates by age-group for 1965 and 1974.⁸⁰ There was a rise in the total proportion of women doctors active from about 80 per cent to about 90 per cent, a similar proportion to that found for both cohorts

78. Flynn and Gardner 'Careers of women graduates from the RFHSM', 33.

79. Ward Careers of Medical Women, p. 72; Elston 'Half Our Future Doctors', p. 118.

80. See also Beaumont 'Training and careers of women doctors in the Thames regions', 192. Both this survey and the CMRC Index included overseas-trained doctors with full registration.

in the Sheffield survey in 1977 and for the Medical Careers female respondents. At the time of the survey, 99.5 per cent of the men and 91 per cent of the women were in active medical work, and of these, 98 per cent of men but only 57 per cent of women were working full-time, the proportion being the same in both cohorts.

As might be expected from the previous discussion, this overall increase in activity took place largely through an increase in the proportion of women doctors working part-time and a decline in the proportion not working. The Sheffield survey found a decrease in the proportion of women working full-time at any stage of their careers between the early and late cohort. This reflected the lower proportion of single women in the later group, 12 per cent compared to 17 per cent, and the earlier marriage of those who had married. One-third of the 1965 qualifiers compared to 16 per cent of the early cohort were married by the end of the year after qualification.⁸¹

Medical women, then, have exhibited similar changes in employment activity to women in Britain as a whole since 1948, in showing this shift to part-time working of women in their 30s and 40s.⁸² These overall patterns may conceal a wide variety of individual activity patterns over time, but they suggest an increase in the proportion of women pursuing discontinuous and part-time careers, as marriage rates have risen.⁸³ Medical

81. Ward, op.cit. 68.

82. J. Martin and C. Roberts Women and Employment: A Lifetime Perspective: The report of the 1980 DE/OPCS Women and Employment Survey (London: HMSO, 1984), pp. 11-2; A. Hunt A Survey of Women's Employment (London: HMSO, 1968) and Myrdal and Klein Women's Two Roles. There are however major differences in the actual patterns displayed by medical women and all women because of the former's lower and later marriage rates, and greater attachment to the labour market at all ages.

83. On the distinction between aggregate and individual

Careers' respondents were asked to provide a detailed work history and details of any break of more than two months from medicine since qualifying. In total, 78 per cent of the women but only 18 per cent of men had had a break of at least two months from medical work since qualifying. The most common reason for women's breaks were pregnancy and care of children, moves following husbands' careers and illness associated with pregnancy. For 76 per cent of women and 46 per cent of men with such breaks, they were for more than a year's duration. Thus, among this admittedly small group of women, continuous working was rare, and continuous full-time working even rarer. Only 12 of the women (12 per cent) had spent the whole period since qualification (either 12 or 22 years) in full-time medical work, and of these 6 were unmarried. On the other hand, only twenty-two of the women had a true 'bimodal' career, that is a period of continuous medical activity followed by a single break of at least two months and then resumption of continuous activity. The rest had a more complex mixture of periods of medical activity and breaks, including for some, prolonged periods of what one interviewee described as 'have stethoscope, will travel', doing local general practitioner locums at irregular intervals.

What this brief review of women's patterns of activity suggests is that during these first thirty years of the NHS the proportion of all medical women whose work histories did not correspond to the male norm probably increased, at a time when changes in the medical career structure were making such

activity patterns see S. Dex Women's Work Histories: an analysis of the Women and Employment Survey Department of Employment Research Paper No. 46. (London; DES, 1984).

TABLE 10.1:Activity Rates for doctors, by age group. 1965

(All fully and provisionally registered doctors in Great Britain: CMRC)

	Women		Men	
	Total Number Female Doctors	Percentage Active	Total Number Male Doctors	Percentage Active
All Ages	14987	65.8	58055	88.3
Under 30	2323	84.5	7099	99.1
30 - 34	1952	71.4	7759	97.9
35 - 39	2181	72.1	7256	98.3
40 - 44	2044	74.1	7148	98.1
45 - 49	1471	73.8	6299	98.0
50 - 54	1143	73.9	5910	97.1
55 - 59	712	75.8	4484	94.6
60 - 64	940	52.4	4236	84.3
65 - 69	1320	26.3	3444	53.6
70 and over	901	12.1	4420	21.0

TABLE 10.2:Activity Rates for Doctors by Age Group; 1974.

(All fully and provisionally registered doctors in Great Britain: CMRC)

	Women		Men	
	Total Number Female Doctors	Percentage Active	Total Number Male Doctors	Percentage Active
All Ages	19180	79.4	65755	88.2
Under 30	3497	98.1	9655	99.9
30 - 34	2576	91.5	8177	99.7
35 - 39	2153	90.2	7438	99.3
40 - 44	1887	90.5	6516	99.0
45 - 49	2187	90.7	6735	98.9
50 - 54	1928	89.4	6611	98.5
55 - 59	1237	85.7	5842	97.7
60 - 64	884	71.9	4946	91.7
65 - 69	626	31.6	3550	49.4
70 and over	2205	8.3	6285	18.6

Information for Tables 1.1 and 1.2 was supplied by the
Medical Women's Federation.

departures more significant in relation to the career structure. What the causes of this were is impossible to discuss here. But it is possible to consider the question of what fields of medicine these increasingly discontinuous careers have taken place in.

Women's Medical Work in the National Health Service

In the first section of this chapter I described the different career opportunities available to medical women within the three main fields of medicine, indicating that the three main fields provided very different kinds of career ladders for women (and men), and that, by implication, those with discontinuous careers or who were seeking part-time work would be more likely to be found in some fields than in others, and in some posts than others. That this was the pattern is indicated by both official statistics on health service employment available since 1963 and from surveys of medical women's work since 1948. Women were not evenly distributed in the various fields of medicine and the pre-war pattern of their being more likely to be in some fields than others continued, and was perhaps reinforced, as their numbers rose after the war.

Tables 10.3 and 10.4 give an estimate of the overall distribution of doctors in the mid-1960s and mid-1970s derived from the CMRC Index.⁸⁴ The fall in the number and proportion of inactive women doctors is clearly shown in Table 10.3, as is the much more rapid increase in hospital doctors than in general practice. The table shows that women were markedly under-represented in general practice and slightly underrepresented in hospital medicine

84. The CMRC index includes some doctors inactive through illness and retirement as well as some whose occupation is unknown in the 'inactive' category. Parkhouse Medical Manpower, pp. 51-54.

compared to their presence in the profession as a whole. The proportion of women among active doctors however was very similar to their presence in hospital medicine, being 16 per cent in 1965 and 21 per cent in 1975. Women were over-represented among those in the 'inactive' category and in the small number of doctors whose main employment was in the local authority field.

Table 10.3 gives the distribution of men and women doctors between the different categories of work, showing that women as a whole were much more likely than men to be in the local authority health services, and less likely to be in general practice. Comparing active doctors alone these differences are more marked. In 1965, 18 per cent of women, and 3 per cent of all men were in the local authority services, and in 1974, the corresponding figures were 12 and 3 per cent. In 1965, 26 per cent of active women and 41 per cent of active men were in general practice, and in 1974, 24 per cent of women and 39 per cent of men. Broadly similar distributions of active medical women's current posts were found in, respectively, the survey of RFHSM graduates in 1966 and in Beaumont's survey in 1976.⁸⁵ At any one time during the 1960s and 1970s it seems that between 40 and 50 per cent of all women doctors held hospital posts and about one-quarter were in general practice, and about one-fifth or more were in public health, a field in which only a minute proportion of men were found.

85. The distributions found are not precisely the same as the CMRC data because of the differences in the populations studied Flynn and Gardner 'Careers of women graduates from RFHSM', 34; Beaumont 'Training and careers of women doctors in the Thames' regions', 192. This last survey found a higher proportion of women doctors in the community health service (23 per cent), and Flynn and Gardner's data referred to numbers of posts not individuals.

TABLE 10.3:

All Fully and Provisionally Registered Doctors in Great Britain by Occupation showing Percentage who are Women: 1965 and 1974.

Occupation (1)	1965			1974		
	Total number of Doctors	Number of women Doctors	% of women	Total number of Doctors	Number of women Doctors	% of women
All fully and provisionally Registered Doctors	73042	14987	20.5	84935	19180	22.6
Hospital	27080	4179	15.4	35153	7016	20.0
General Medical Service	23726	2549	9.4	26044	3687	14.2
NHS/Local Authority	3261	1787	54.8	4202	2753	65.5
Other Medical Employment	7074	1347	19.0	7803	1765	22.6
Inactive	11901	5125	43.1	11733	3959	33.7

Source: CHRC main tables

Notes:

1. Where a doctor has more than one occupation, that recorded is determined by the following priority list:

- a. Doctors in the NHS Hospital Service (on annual returns)
- b. Doctors in the NHS General Medical Service (on annual returns)
- c. Doctors holding paragraph 94 hospital appointments.
- d. Doctors employed by Local Authorities/Community Health Services
- e. Other medical employment
- f. Doctors in the NHS Hospital Service (not on annual returns)
- g. Doctors in the NHS General Medical Service (not on annual returns)

This information was made available by the Medical Women's Federation.

TABLE 10.4:

Comparison of male and female doctors distribution
in medical work, 1965 and 1974^a

(Fully and provisionally registered doctors in Great Britain,
 CMRC Index)

	1965		1974	
	Percentage in each occupation		Percentage in each occupation	
	Male	Female	Male	Female
Hospital	39	28	43	37
GMS	36	17	34	19
CHS/LA	3	12	2	14
Other	10	9	9	9
Inactive	12	34	12	21
	----	----	----	----
	100	100	100	100
	----	----	----	----
(N)	(58055)	(14987)	(65755)	(19180)

Source G. Ford 'Career Choices' in Medical Women's Federation
 Careers Symposium: Women in Medicine 1979 - What is our Future?

(MHF: London, 1979) p. 83-84.

^a Raw data, and allocation of multiple occupations as in Table 10.3.

These figures include doctors at all stages of their careers, and some of the differences will reflect the different age distribution of men and women doctors. Both the Sheffield study and the Medical Careers study found that among their respondents who had been in practice at least twelve years the proportion in general practice was higher, about one-third of all those active in the mid-1970s, and just over one-third in all forms of specialist or hospital medicine, with about a quarter of active women doctors in the community health services, at the time of the survey. Among the Medical Careers survey's male respondents, 38 per cent were in hospital practice, and 46 per cent in general practice, and 1 per cent in community medicine.⁸⁶

As the notes to Table 10.3 imply, these figures are based on the allocation of each doctor to a single occupation. A doctor who is a general practitioner and a part-time clinical assistant or a clinical medical officer with a local authority only appears as a general practitioner. These tables, and the other figures quoted, do not indicate the characteristic feature of some medical women's work that I referred to in previous chapters, pattern of holding several part-time posts in parallel such that none appears to take priority. Among Medical Careers' respondents this was true for 14 per cent of active women at the time of the survey, and for no men, in itself an indication of the 'disorderly' careers followed by women.⁸⁷

It seems likely that the careers of many medical women in this period did not follow the upward ascent implied by the presc-

⁸⁶. Medical Careers' figures refer to doctors in the United Kingdom only.

⁸⁷. Jefferys and Elliott Women in Medicine, p. 10, reported that 2813 women working part-time held a total of 3657 posts. In the figures for Medical Careers the post in which respondents spent most time was taken as the main post.

riptive career ladders as set out in Figure 10.1. The Medical Careers' survey found that 49 per cent of all the women surveyed had had what has been described as a "circular" career, up to the time of the survey.⁸⁸ The sequence of posts they had held had no upward progression, and the women were in posts that did not carry full clinical responsibility at the time of the survey. All these women had married within two years of qualification, one of many indications that the timing of marriage, as well as the event itself, was an important influence on professional career development. Only 6 per cent of men had such a "circular" career. This pattern seems to have been particularly true for those who qualified in the 1950s, with those who qualified in the 1960s being more likely to have achieved career posts because of their greater continuity of employment.⁸⁹

Hospital Medicine

After 1953 all British-trained doctors seeking full registration had to start their careers in hospital, in compulsory pre-registration houseposts.⁹⁰ Men and women were therefore to be found on the bottom rung of the ladder in approximately the proportions in which they qualified from medical school. But

88. P.A. Pollalis, R. Flynn and E.G. Knox 'Foundations of Medical Manpower Planning in the United Kingdom'. In Patterns for Uncertainty: Planning for the Greater Medical Profession, eds. G. McLachlan, B. Stocking and R.F. Shegog (Oxford: National Provincial Hospitals Trust, 1979), p. 44.

89. Ward et al. Careers of Medical Women indicates this was largely achieved through women entering general practice and becoming principals.

90. Appointments to these were often occasions for sponsorship, and in the Medical Careers study, women were slightly less likely than men to have done both their posts within their teaching hospital (17 per cent compared to 28 per cent).

subsequently through the 1960s and early 1970s, there was a tendency for the proportion of women on the ladder to diminish in successive grades, particularly the proportion of married women, for until 1970 almost all training posts had to be held on a full-time basis. In contrast, the proportion of women in the sub-consultant grades off the training ladder remained consistently higher than in hospital medicine as a whole. Women were 30 per cent of Medical Assistants from the time the grade was begun, and over 40 per cent after 1975. Beaumont found these posts to be mainly held by married women with children on a part-time basis.⁹¹

Women did not become more evenly distributed in the different specialties within hospital medicine as their numbers increased after 1948. The pattern was the one which is already familiar. Women remained conspicuously absent from all surgical specialties. The various surveys of medical women's activity from the 1960s found that women were most frequently working in anaesthetics, psychiatry, paediatrics, general medicine and medical specialties and obstetrics and gynaecology. But married women have been more likely to be working in the first two of these than in the others, and these were generally entered later in careers than the other fields.⁹² The proportion of consultants in obstetrics and gynaecology remained constant at 12 per cent between 1963 and 1978, a period in which the proportion of all consultants who were women rose from 6 per cent to 10 per cent. This increase in the

91. DHSS Hospital Staffing Statistics for England and Wales; Beaumont 'Training and careers of women doctors in the Thames regions', 192.

92. Beaumont op.cit; Ward op.cit.

proportion of women consultants was mainly through the expansion of the "shortage" specialties in which they were well-represented.⁹³

General Practice

General practice continued to be the most common career destination for all women qualifying in this period who have achieved career posts, a field that could be entered without qualifications or training, and, increasingly on a salaried partnership basis. And the number of women general practitioners in England and Wales increased by 55 per cent between 1963 and 1976, during which time the number of male general practitioners actually fell as a result of the demoralization described earlier and the greater attraction of hospital work.⁹⁴ The Sheffield survey found that single women qualifying in 1965 were less likely to make their careers in general practice than those from the earliest cohort.⁹⁵ But the proportion of married women entering the field rose, as the organization of general practice changed to facilitate less continual commitment for those with domestic obligations.

93. Elston 'Half Our Future Doctors', p. 126.

94. DHSS Health and Personal Social Services Statistics for England and Wales.

95. Ward et al. Careers of Medical Women, p. 94.

Public Health, Community Health and Community Medicine

Taking this field as a whole, this was the one field of medicine where women were conspicuous by their presence in the first thirty years of the NHS. The tradition of women's work in this field that was well-established before the war continued. At least during the 1960s and 1970s, the majority of doctors employed in this sector, on a full-time and part-time basis have been women. About one-fifth of all active women doctors appear to have had their main employment in this field, and a considerably larger number did some sessional work in addition to other appointments.

But, as I indicated in the first section of the chapter, the divisions between the women's work in this field and the administrative work that existed before the war did not disappear. Women remained significantly under-represented in the senior administrative grades. In 1972, women were 56 per cent of all full-time staff in the service in Great Britain, and 50 per cent of all the doctors doing some work in the field. They were over 70 per cent of all the full-time clinical medical officers, but 30 per cent of deputy MOHs and 8 per cent of MOHs. The formal division brought about by re-organization meant that in 1977 there were about 7,500 clinical medical officers, 67 per cent of them women, and 917 community medicine staff (all grades) of whom 24 per cent were women, ranging from 1 out of 13 Regional Medical Officers to 31 per cent of the consultant grade specialists in community medicine.⁹⁶

Who has worked in public/community health since 1948? The evidence suggests that it has been, above all, a niche for the returning married woman with children, who left medicine because

96. DHSS Statistics and Research Division.

of marriage without gaining any postgraduate qualifications, and who re-entered medicine via a small number of clinic sessions. The Sheffield survey found that it was a field entered on later in women's careers than other fields and that the reasons given for selecting this field were more likely to concern the compatibility of the working arrangements than for other fields.⁹⁷

Conclusion

Behind the distribution of women doctors in the first thirty years of the National Health Service lie the innumerable and continual adjustments that individual medical women have made in response to the 'facts of life' in both their professional and personal lives.⁹⁸ For many, these 'facts' of life will almost certainly have included both direct discrimination and more subtle prejudice as well as the competing obligations of marriage and motherhood. I have not attempted to analyze these in this final chapter. Rather, I have tried to indicate how the structures that the health service inherited created a context in which, though there were more women in medicine than ever before, they did not become more visible within the profession, or to medical sociologists. For many of these women who have made their careers under the National Health Service the comment of one woman covers the experience of many.

'I haven't had a "career" in medicine. I've only worked.'

97. Ward 'Women doctors in the community health services'; Beaumont 'Training and careers of women doctors in the Thames regions', p. 192 and Flynn and Gardner 'Careers of women graduates from the RFHSM', p.34 both show that public health is a much more frequent choice for married than single women doctors.

98. Hughes 'Making of a physician', 24.

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