

# Introduction: Disapproval, Curiosity, Amusement, Obstinate Hostility? Women and Surgery, 1860–1918

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In the second half of the nineteenth century, significant changes in surgical practice coincided with the entrance of women into the medical profession. The links between the two, however, have never been explored. From the very early days of women's attempts to become doctors, it was the possibility of them performing surgery which most haunted critics and friends alike, as well as potential patients. In April 1859 the *British Medical Journal* presented a disturbing vision for its readers. Imagine a female surgeon:

the Semiramis of surgery, a Fergusson in woman's outward guise, amputating a thigh, or removing a diseased jaw or elbow-joint, aided by assistants of like sex and mind, and surrounded by a host of fair damsels, who regard the proceedings of the operator with that appreciation of the cool head and the ready hand which medical students so well know how to feel! Imagine some fair and amiable damsel, a female Rokitansky, poring with inquisitive eye over a collection of ulcerated Peyer's patches or a piece of softened cerebral substance, or assiduously endeavouring to ascertain, by the aid of the microscope, the presence or absence of fatty degeneration in a piece of heart-tissue, or to determine the nature of a tumour which her associate Semiramis has just removed! Call to mind all things that are done in the ordinary course of hospital duties, or even of general practice in town or country; and imagine, good reader, if you can, a British lady performing them.

Women who would practise medicine and surgery must do so wholly; there is no shirking the obligation. If they attempt to do less, they will fail in the duty they undertake; and the male sex will have an unfair advantage over the female, in being able to command a higher exercise of professional skill and knowledge.<sup>1</sup>

Although represented as unthinkable when considered in the same breath as British ladies, the female surgeon was to become a more real addition to the medical profession in the next half-century than the author of this article could have ever envisaged. Without the requisite attainments, women would be unable to prove their medical and surgical capabilities;

<sup>1</sup> 'Room for the Ladies!', *British Medical Journal (BMJ)* 1.119 (9 April 1859), 292–4; 293.

with them, they would succeed in carrying out all the professional duties expected, regardless of their status as ‘British ladies’. This was something the scoffing writer recognised, even if he did not believe in women ever attaining such qualities.

The professional expectations placed upon women medical practitioners were exacerbated by the lack of opportunities to advance clinical skills. This was especially evident in surgery, where women were doubly hampered by social proprieties, as well as professional prejudice against lancet-wielding females. Attain the requisite ‘qualities’, however, they did. By September 1914, Louisa Garrett Anderson could provide a view of an operating theatre staffed by women which would have startled the author of ‘Room for the Ladies!’ in its similarity to his nightmarish vision:

We have a lot of surgery: sometimes I am in the theatre from 2 to 9 or 10 at night, and have eight or more operations. The cases come to us very septic and the wounds are terrible. Today we are having an amputation of thigh, two head cases perhaps trephine and five smaller ones. We have fitted up a satisfactory small operating theatre in the ‘Ladies Lavatory’ which has tiled floor and walls, good water supply and lighting. I bought a simple operating table in Paris and we have arranged gas rings and fish kettles for sterilisation.<sup>2</sup>

A woman surgeon, surrounded by others of her sex, carrying out complex procedures on men and without male assistance would have been enough of a surprise. The location of the theatre, in an unmentionable all-female space, made aseptic with domestic and culinary accoutrements would surely have been the final straw. More familiar, however, would have been the reaction, as detailed by Garrett Anderson’s colleague, Flora Murray, to the female surgeon’s desire to do something to help as the Great War began. ‘The feeling of the Army Medical Department towards women doctors could be gauged by the atmosphere in the various offices with which business had to be done’, sighed Murray: ‘In one there was disapproval; in another curiosity and amusement; in a third obstinate hostility.’<sup>3</sup> While concessions had been made towards the female surgeon by 1918, reactions all too similar to those encountered nearly sixty years before were still to be seen and heard.

*British Women Surgeons* explores the crucial period between 1860 and 1918. These years witnessed a number of key developments in the history of medicine and surgery, alongside women’s official entry into the

<sup>2</sup> Louisa Garrett Anderson to Elizabeth Garrett Anderson, Hôpital Auxiliaire, Hôtel Claridge, Paris, 27 September 1914, 7LGA/2/1/09, The Women’s Library, London School of Economics.

<sup>3</sup> Flora Murray, *Women as Army Surgeons* (London: Hodder and Stoughton, n.d. [1920]), p. 126.

medical profession and increased campaigning for social and political rights. In *Making a Medical Living* (1994), Anne Digby has identified this period as vital to the development of the medical marketplace.<sup>4</sup> The second half of the nineteenth and early twentieth century saw the growth in the medical and social importance of the hospital and work on the history of surgery locates, at this juncture, both changing (lay and medical) perceptions of the surgeon and alterations in surgical practice. These adjustments were stimulated by, amongst others, anaesthetics and asepsis, the development of surgical instruments, changes in anatomical and physiological understanding, and the advent of the X-ray. It is my intention in this book to assess the position of the woman surgeon at this exciting moment in history. I will argue that she is a pivotal figure who intersects with such social, medical and surgical developments and whose place in the history of medicine has been long neglected. With the exception of research into women's participation in the medical and surgical mobilisation of the Great War, the qualified female surgeon has not been the focus of historical analysis.<sup>5</sup> While women's entry into the medical profession in the mid-nineteenth century has proved a popular area of research, what resulted from this experiment has barely been considered.<sup>6</sup> Therefore, I will not re-examine the much-told narrative of women's battle to join the professional ranks. Rather, I want to explore

<sup>4</sup> Anne Digby, *Making a Medical Living* (Oxford: Oxford University Press, 1994).

<sup>5</sup> The recent work of Jennian Geddes has transformed this field. See, for example, 'Deeds and Words in the Suffrage Military Hospital in Endell Street', *Medical History* (MH), 51.1 (January 2007), 79–98; 'The Women's Hospital Corps: forgotten surgeons of the First World War', *Journal of Medical Biography*, 14.2 (May 2006), 109–17.

Women's role in surgery before 1800 has also been investigated. See, for example, Celeste Chamberland, 'Partners and Practitioners: Women and the Management of Surgical Households in London, 1570–1640', *Social History of Medicine* (SHM), 24.3 (December 2011), 554–69 and A.L. Wyman, 'The Surgeoness: The Female Practitioner of Surgery 1400–1800', *MH*, 28.1 (January 1984), 22–41.

<sup>6</sup> With the notable exception of two still unpublished theses: Mary Ann C. Elston, 'Women Doctors in the British Health Services: A Sociological Study of their Careers and Opportunities', PhD thesis, University of Leeds, 1986, and Elaine Thomson, 'Women in Medicine in Late Nineteenth and Early Twentieth-Century Edinburgh: A Case Study', PhD thesis, University of Edinburgh, 1998. For the Scottish context, see also Wendy Alexander, *First Ladies of Medicine* (Glasgow: University of Glasgow Wellcome Unit for the History of Medicine, 1987) and M. Anne Crowther and Marguerite Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007). More recently, for the Irish context, Laura Kelly, *Irish Women in Medicine, c.1880s–1920s* (Manchester: Manchester University Press, 2013). For examinations of individual medical women in America, see Carla Bittel, *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth-Century America* (Chapel Hill, NC: University of North Carolina Press, 2009), Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850–1995* (Cambridge, MA and London: Harvard University Press, 1999), and, more specifically focused on surgery, Regina Morantz-Sanchez, *Conduct Unbecoming a Woman* (New York: Oxford University Press, 1999).

what happened once that initial fight was won. Given the assumption that it would be impossible for women to perform surgery for mental, physical and moral reasons, their reaction to this discipline needs to be measured. Why was surgery considered particularly inappropriate, or appropriate, for women? What surgical procedures did women carry out and where did they operate? Did they attempt controversial surgery and what was their attitude to the increasing fears about malignant disease, frequently encountered in gynaecological cases at the turn of the twentieth century? What role did women surgeons play in the Great War at the front, but also at home, where unprecedented opportunities came their way? What was the experience of those who were operated upon by female surgeons and who were they? These questions will allow an exploration, through printed sources, private letters and case notes, of the ways in which the woman surgeon participated in the developments, controversies and changing public perception of surgery and the surgeon between 1860 and 1918.

For medical and lay alike, surgery in this period exemplified both the progressive nature of science and technology and the corresponding fear that surgeons had too much power over their patients. No longer had the operator to utilise brute strength to hack off limbs as quickly as possible before the patient bled to death; with anaesthesia and asepsis, time and care could be taken to ensure a successful procedure was performed while the patient was insensible. Areas of the body could be treated surgically in ways they could never have been before without a prone patient and an aseptic operating theatre and surgeon. In 1890, Sir Thomas Spencer Wells looked back upon half-a-century of surgical progress and concluded with a reassuring glimpse into the next century:

And for our younger Fellows and Members – for the surgeons of the future – may we not be confident that with the energetic spirit of inquiry now awakened, with an enlightened determination to apply all the resources of modern scientific discovery to the perfecting of our art with a conscientious aim at making it as truly conservative as is compatible with usefulness and progress and with honourable feeling and highly cultivated judgment, directing hands delicately and expressly trained, we may augur for the surgeons of the coming time an influence supremely beneficent for mankind, and promise to its devotees the dignity and distinction justly earned by their life-giving and health-preserving work.<sup>7</sup>

For Spencer Wells, surgeons were conscientious and restrained, preserving health rather than wilfully encouraging illness for personal profit. The professional body was refined, diligent and possessed a delicacy of

<sup>7</sup> Sir T. Spencer Wells, 'The Bradshaw Lecture on Modern Abdominal Surgery', Part II, *BMJ*, 2.1565 (21 December 1890), 1465–8; 1468.

touch. Fundamental to Spencer Wells' assessment was his careful mention of the need to make surgery 'truly conservative' in order to advance the profession. This was a deliberate attempt to deflect attention away from the sort of surgery – knife-wielding, radical, heroic – which characterised earlier periods, and towards procedures which conserved and protected. Spencer Wells' account of surgical progress, with its fastidious and benevolent tone, aimed to counter past horrors with a record of innovation, development and perfection, coupled with the 'honourable feeling and highly cultivated judgment' of the thoughtful surgeon. This spirited defence sought to challenge those who doubted the wisdom of risky procedures.

For some, however, very little had changed. Surgery was still unnecessary butchery. It was harder to shake off the trade associations than Spencer Wells believed: surgeons were still viewed as aspiring, not actual gentlemen. The development of antiseptic and aseptic procedures may have made surgery less painful both for patient and operator, but theoretical advance was not always followed by practical adoption.<sup>8</sup> Spencer Wells' field – abdominal surgery – was visceral, bloody and brutal, and, by implication, so was the abdominal surgeon. Accusations of wilful carelessness dogged the surgical profession in the late nineteenth and early twentieth centuries. What surgeons viewed as perfecting their craft through experimentation could be seen by others as reckless concern for reputation rather than for the patient's needs.<sup>9</sup> Surgical independence – both from other surgeons and from the team who assisted an operation – meant that the surgeon stood aloof, distant from any regulation. The *British Journal of Surgery (BJS)* was established in 1913, and a year later it led with a telling editorial about surgical practices in early twentieth-century Britain. Currently, 'workers' were 'isolated from one another', which slowed progress and ensured irregular outcomes. '[W]hereas', the 'Introductory' continued, 'if they could act together, not only would individual surgeons gain in breadth of view and soundness of conclusion, but there would certainly result a general advance in knowledge which only comes with co-operative effort.' The journal had been set up to counter the 'individualistic, competitive and secretive' bent of surgery, by

<sup>8</sup> On the varying degrees of procedural adoption, see Michael Worboys, *Spreading Germs* (Cambridge: Cambridge University Press, 2000).

<sup>9</sup> Sally Wilde's work has been the most recent and illuminating exploration of risk and experimentation in surgery. See *The History of Surgery*, at [www.thehistoryofsurgery.com](http://www.thehistoryofsurgery.com); 'Truth, Trust, and Confidence in Surgery, 1890–1910: Patient Autonomy, Communication, and Consent', *BHM*, 83.2 (Summer 2009), 302–30; and with Geoffrey Hurst, 'Learning from Mistakes: Early Twentieth-Century Surgical Practice', *Journal of the History of Medicine and Allied Sciences (JHMAS)*, 64.1 (January 2009), 38–77.

providing a ‘common meeting place [. . .] to which all contribute’, and ‘the gatherings of an association which all [could] attend’.<sup>10</sup> Although ‘the business’ of surgery took place behind closed doors, the *BJS* reassured its readers that surgical ‘science’ was ‘altruistic, public, and above all, co-operative’. That it took until the second decade of the twentieth century to establish a general surgical publication implies professional unity had not yet been achieved. Co-operation in surgical enterprise was necessary, not already apparent.

Indeed, the history of surgery in general has suffered from critical neglect, akin to the closed world of the operating theatre described above. What had once resembled a public performance had largely retreated into a private, sterile space by the start of the twentieth century.<sup>11</sup> More than thirty years ago, Christopher Lawrence expressed surprise at the scant attention paid to surgery in the history of medicine.<sup>12</sup> Recently, Thomas Schlich has reiterated the call for more analysis of surgical knowledge and practice, which has ‘attracted little serious historical interest’.<sup>13</sup> Both mention women’s history as an exception to the silence, but Lawrence remarks that work in this area renders surgery marginal to the primary focus on gender. Indeed, women’s history has a curious attitude to surgical procedure. Too often, in this discipline, women are the victims of brutal male operators who seek to mutilate the weak and defenceless.<sup>14</sup> Ludmilla Jordanova has gone so far as to claim that ‘[c]learly, surgery is a male act’.<sup>15</sup> Lawrence relates this attitude to the thrustingly ‘masculine’ language surrounding surgical procedures; actions characterised by ‘power, penetration and pleasure; of nature being unveiled, revealed, known and conquered’.<sup>16</sup> Consequently, research on women’s place in

<sup>10</sup> ‘Introductory: The Need of Co-operation in Surgical Enterprise’, *British Journal of Surgery*, 2.5 (1914), 1–3; 1.

For more on professionalization in general from the late nineteenth century onwards, see Harold Perkin, *The Rise of Professional Society*, second edition (London and New York: Routledge, 2002) and Anne Witz, *Professions and Patriarchy* (London and New York: Routledge, 1992).

<sup>11</sup> Thomas Schlich, ‘Surgery, Science and Modernity: Operating Rooms and Laboratories as Spaces of Control’, *History of Science*, 45.3 (September 2007), 231–56.

<sup>12</sup> Christopher Lawrence, ‘Democratic, divine and heroic: the history and historiography of surgery’, in Lawrence, ed., *Medical Theory, Surgical Practice* (London and New York: Routledge, 1992), pp. 1–47; p. 10.

<sup>13</sup> Thomas Schlich, *The Origins of Organ Transplantation* (Rochester, NY: University of Rochester Press, 2010), p. 8.

<sup>14</sup> For the classic example of female patient as victim, see Mary Poovey, ‘“Scenes of an Indelicate Character”: The Medical “Treatment” of Victorian Women’, *Representations*, 14 (Spring 1986), 137–78. For a response to Poovey, see Morantz-Sanchez, *Conduct Unbecoming*.

<sup>15</sup> Ludmilla Jordanova, *Sexual Visions* (Madison, WI: University of Wisconsin Press, 1989), p. 153.

<sup>16</sup> Lawrence, ‘Democratic, divine and heroic’, p. 31.

the history of surgery has always placed them ‘under the knife’, as patients rather than surgeons.<sup>17</sup> The history of surgery itself might have benefited from research into women’s position within it, but women have correspondingly suffered by being reduced to passive objects, operated upon rather than operating.

Certainly, the linguistic frisson embedded in the surgical act affected discourse surrounding the rights and wrongs of the woman surgeon from the outset. As a 1908 article by Theodore Dahle in the *Sunday Chronicle* put it, with scarcely disguised excitement: ‘Women like men must school themselves to see glittering, keen-edged knives parting live human flesh.’<sup>18</sup> The sharp and sparkling instruments dazzle in this image; the sense that the operation is illicit, but enthralling, is compounded by the sharp cuts made and the living, breathing nature of the body which is being ‘parted’. Dahle rightly considered the performance of surgery as something which would affect any operator, regardless of sex. To carry out a surgical procedure requires nerve, courage, strength and the confidence to take responsibility for the action performed. It is important not to forget, however, that surgery needs enthusiasm for carving through flesh and bone. As the ongoing debate about women’s suitability for diplomas of the Royal College of Surgeons revealed only too evidently, when medical women had been assimilated into other parts of the profession, they were far from accepted in the operating theatre as late as the 1890s. While some members were in favour of women’s entry simply because they would never attain the masculine strength to compete on level terms with men, the views of others were exemplified by a Dr Barnes, who noted that:

surgery, of all other things, was the highest grade of the profession, demanding, as it did, the highest talent, skill and mental and physical powers, and those, he thought, did not belong to women. [ . . . ] Surgery belonged to men and strength, and where strength was there the great amount of gentleness lay. It was simply a horrible thing for him to see women operate. They might be gentle in their minds, but they certainly had not the power which was necessary to perform serious surgical operations. He thought it was a degrading thing to admit women to the study of medicine in any branch, and it applied most strongly to surgery.<sup>19</sup>

<sup>17</sup> Ann Dally, *Women Under the Knife* (London: Hutchinson Radius, 1991).

<sup>18</sup> Theodore Dahle, ‘A Great Medical School for Women and its Work’, *Sunday Chronicle* (undated, but from internal evidence, 1908), in *London School of Medicine for Women and Royal Free Hospital Press Cuttings, Volume IV: January 1904–August 1915*, H72/SM/Y/02/004, London Metropolitan Archives (hereafter LMA).

<sup>19</sup> ‘Royal College of Surgeons of England. Annual Meeting’, *BMJ*, 2.1819 (9 November 1895), 1176–1178; 1178. Barnes can be one of two men of this name who were Fellows at the time, both of whom were general surgeons: John Wickham Barnes (1830–1899); or Robert Barnes (1817–1907). See *Plarr’s Lives of the Fellows* at [livesonline.rcseng.ac.uk](http://livesonline.rcseng.ac.uk).

Such paradoxical, and clearly deliberate, grounding of gentleness in strength showed both the desperate attempt of some members of the RCS to exclude the weaker sex on physical and moral grounds, and also the Victorian surgeon's insecurity about his own place within the profession and within society. Specialty, Barnes concluded, was far beyond the capability of the average female; confine women, by all means to operating upon their own in 'the inferior grades of obstetrics and gynaecology', but do not allow them even then to perform complex procedures, for which they are unfit.

'Fitness' to operate was a constant refrain when surgeons of both sexes were discussed. Of course, this meant fitness in the sense of aptitude, but also the ability to maintain composure and health throughout any surgical procedure. I have chosen to date this book from 1860 because this was when Elizabeth Garrett Anderson first decided to make medicine her profession.<sup>20</sup> It was also the first time a woman with such an ambition in Britain experienced an operation, not as a patient, but as a future practitioner. In a letter to her friend Emily Davies, Garrett Anderson described the experience, witnessed while ostensibly nursing at Middlesex Hospital. Given the assumption that women would not be able to stand the strain of surgery as onlookers, let alone operators, Garrett Anderson's reaction was intriguing:

It was a stiffish one, and I did not feel at all bad, the excitement was very great but happily it took the form of quickening all my vitality, instead of depressing it. I was excessively tired after it was all over, but this effect will soon cease I should think. I stood with all the pupils in the theatre, and they gave me the best place for seeing and then took no more notice of me, which was exactly the right style.<sup>21</sup>

Neither displaying weakness nor feeling faint, Garrett Anderson actually tired herself out with the physical thrill of the situation. Indeed, four days later, she noted that '[i]t is rather provoking that people will think so much of the difficulties, in spite of my assurances that far from their being appalling I am enjoying the work more than I have ever done any other study or pursuit'.<sup>22</sup> It is also noticeable that the male medical students chivalrously allowed Garrett Anderson the best viewpoint during the operation. We can only conjecture why this happened, but when she enquired about pursuing her chosen career, Garrett Anderson was

<sup>20</sup> I will refer to women doctors by their best-known names throughout, to avoid confusion.

<sup>21</sup> Elizabeth Garrett Anderson to Emily Davies, Bayswater, Wednesday 5 September 1860, HA436/1/1/1: Letters from Elizabeth Garrett Anderson to Emily Davies: June–December 1860, Ipswich Record Office, Suffolk.

<sup>22</sup> Elizabeth Garrett Anderson to Emily Davies, 9 September 1860, 9/10/015, ALC/2905, The Women's Library.



repeatedly put off by those who suggested that any business involving cutting open bodies, dead or alive, would be ‘too much for any woman to stand with enough composure of mind to study’.<sup>23</sup> That her only exhaustion was from excitement meant that Garrett Anderson held up mentally and physically to the challenge.

Surgery required both a strong stomach and a steady hand. As satirical periodical *Punch* put it in one of its many skits on women doctors, entitled ‘Chloe, M.D.’, in July 1876: ‘the Surgeon, who needs, that his work may be done, / Lion’s heart, Eagle’s eye, Lady’s hand – must have Manhood and Genius in one’. Underneath its mockery, *Punch* revealed the complexity of the surgeon’s task, as well as the multifaceted nature of surgery itself. In spite of the link implied between feminine touch and surgical procedures, ‘Chloe, M.D.’ denied women the facility to cope with the demands of the operating theatre: ‘She that once at blood’s flowing had swooned, / With the deftness of feminine fingers might tenderly bandage a wound’.<sup>24</sup> Here, ‘feminine fingers’ could swiftly perform the simplest of remedies, but, overcome with fear at a more severe injury, lacked the steadiness, pluck and nerve needed by a surgeon. Swooning at the sight of a cadaver was (and still is) a regular part of medical education. Although it was not a part which the profession desired to acknowledge, it was an attribute which was expected of, and indeed foisted onto, disruptive, ineffective women when faced with the unpleasant results of a dissection or an operation. It was precisely this presumed inability to cope with the unruly body, however, that medical women used again and again to their advantage. When she later came to contribute a chapter for women medical students to an 1878 textbook, Garrett Anderson countered any suggestion that alleged female delicacy would lead to collapse in the face of dissection or surgery. This was contrasted, in the same publication, with hints for male counterparts at potential distress. Charles Bell Keetley’s *The Student’s Guide to the Medical Profession*, although occasionally reading like a boys’ adventure story, opened its discussion of dissection with the information that it will be ‘repulsive at first’ and recommended ‘[k]eeping your knives sharp’.<sup>25</sup> Garrett Anderson’s advice firmly denied any feeling as strong as repulsion and suggested, in a professional manner, that the experience was more intriguing than troubling: ‘I know of nothing in the medical education especially distasteful to female students. Everyone expects to dislike dissecting, but as a matter of fact no

<sup>23</sup> Elizabeth Garrett Anderson to Emily Davies, Aldeburgh, January 1861, HA436/1/1/2, Ipswich Record Office.

<sup>24</sup> ‘Chloe, M.D., On Mr Cowper-Temple’s Bill’, *Punch*, Saturday 15 July 1876, 24.

<sup>25</sup> Charles Bell Keetley, *The Student’s Guide to the Medical Profession* (London: Macmillan, 1878), p. 25.

one does – it is found to be extremely interesting’. As an extension of this argument, ‘[i]t is very natural’, remarked Garrett Anderson, that surgery should ‘attract [ladies] more than medicine’, because, in common with their male contemporaries, it was ‘much more interesting’.<sup>26</sup> According to Garrett Anderson, confident behaviour was only to be expected of the female medical student, who was ‘naturally’ led towards the physical and intellectual challenges posed by surgery.

This ability to remain calm and upright was insisted upon repeatedly by women doctors in spheres as diverse as periodical articles and Select Committees. The interview format beloved of New Journalists in the 1890s allowed curious outsiders glimpses into the world of the female medical student. And, of course, the first thing most wanted to know was how women coped with the more squeamish aspects of their education. An article entitled ‘How the Medicine Woman is Trained’, published in the *Sketch* in June 1898, showed a fascination with whether or not girls have ‘nerve, pluck, and endurance sufficient to carry them through the long course of work’. The secretary of the London School of Medicine for Women (LSMW), Miss Douie, retorted: ‘I have never seen a girl faint in the operating theatre, though male students often do in their early days. I do not know of any girl who has given up the work after beginning it.’ Amusingly enough, the male journalist, although stressing that he did not ‘shrink from [exploring] the dissecting-room’, was forced to conclude that ‘it was not a pretty sight from the layman’s point of view, although the room is pretty, very light, and very airy’.<sup>27</sup> The stylistic repetition, focusing attention on the spaciousness of the room, actually has the effect of stressing the claustrophobia felt by this ‘layman’, as he was forced to look away from the unattractive sights.

Male queasiness was evident in a completely different form when reading Garrett Anderson’s evidence to the 1891 House of Lords Select Committee on Metropolitan Hospitals.<sup>28</sup> Their Lordships displayed a distinctly unworldly attitude when quizzing their witness, becoming perplexed at her achievements. Lord Zouche asked Garrett Anderson whether she ‘performs operations’; Garrett Anderson replied: ‘Yes, we perform ovariectomy, and similar operations’. Earl Cathcart then enquired, a little incredulously, ‘Do you think that women have strength enough of wrist to do those things?’, to which his witness replied simply:

<sup>26</sup> ‘A Special Chapter for Ladies Who Propose to Study Medicine’, in *ibid.*, pp. 42–8; p. 47.

<sup>27</sup> S.L.B., ‘How the Medicine Woman is Trained’, *Sketch*, 15 June 1898, in *Royal Free Hospital Press Cuttings, Volume 3: May 1878–January 1904*, H72/SM/Y/02/003, LMA.

<sup>28</sup> Evidence of Mrs Elizabeth Garrett Anderson, M.D., 5 March 1891, *Select Committee of House of Lords on Metropolitan Hospitals* (1890–1891), 16452–531.

‘Yes’. Having carried out countless surgical procedures herself, Garrett Anderson must have found the disbelief at female physical prowess amusing. Indeed, there is a real sense in Garrett Anderson’s evidence that she enjoyed teasing her naïve interlocutors, but, as the last question makes clear, she also desired to stress female commitment to their education and, later, to their career. Indeed, Garrett Anderson had ‘heard of men fainting occasionally’, but did ‘not know that I have ever heard of any of our women fainting’ at what the Earl of Arran claimed were ‘the terrible sights and scenes in the operating theatre’. Women, assured Garrett Anderson, had far more than strong wrists; constitutionally they were thoroughly sound, unlike some of their more precious male colleagues. But she was careful not to alienate her audience and added, craftily, ‘but I daresay it takes both of them a little time to get used to it’. This balanced response, of course, although not removing the previous comment, tempered it, without losing her implication.

Time and again, excitement, rather than the potential ‘terrors’ posed by surgery, dominated nineteenth- and early twentieth-century accounts by and about the woman surgeon. Mary Scharlieb, who became one of the foremost early women surgeons, looked back with fondness in her 1924 *Reminiscences* upon the rough and ready surgical procedures in India, where she began her career: her sister as anaesthetist, her maid as assistant surgeon and her ‘Mahomedan ayah’ in charge of the carbolic spray for antiseptics.<sup>29</sup> Similarly, Isabel Hutton, whose *Memories* (1960) explored her studies at the University of Edinburgh in the early 1900s, offered one of the most detailed and fascinating accounts of women’s medical education. Hutton’s ‘hankering’ after the surgical wards distracted her from medicine; but it was also the difference between the patients which convinced her of the attraction of surgery.<sup>30</sup> In spite of contemporary assumptions about institutional oppression, surgical patients were not at all coerced into their operations; neither were they hopeless and despairing: the victims of a butcher’s knife.<sup>31</sup> For Hutton, the ‘excitement, stimulation and drama of the surgical side’ was matched by ‘the cheerful, hopeful patients; there was always some gaiety and a joy shared by all when an anxious case came through its ordeal and joined

<sup>29</sup> Mary Scharlieb, *Reminiscences* (London: Williams and Norgate, 1924), pp. 111–12.

<sup>30</sup> Isabel Hutton, *Memories of a Doctor in War and Peace* (London: Heinemann, 1960), p. 203.

<sup>31</sup> See, for example, the work of medical man Edward Berdoe, who, as ‘Aesculapius Scalpel’, wrote damning indictments of surgical heartlessness in the fictional *St Bernard’s* (London: Swan Sonnenschein & Co., 1887), and *Dying Scientifically* (London: Swan Sonnenschein & Co., 1888).

the ranks of the gay and gossipy convalescents'.<sup>32</sup> By contrast, on the medical side: 'the whole tempo was very slow'. Although Hutton put surgery to the back of her mind as she progressed through her degree, the 'hankering' only left her when she joined the Scottish Women's Hospitals to serve in Serbia during the Great War, as we shall see in chapter 4. Then, despite 'little experience', she performed, like other women, and, of course, men, in her situation, specialist operations for which she had never been trained. Although Hutton had finally followed her desires, she also could not resist noting that her wartime experience was 'possibly [the most worthwhile] of my life. It was a time of strain and of anxiety, but it was a period of achievement and happiness for us all.'<sup>33</sup> Hutton and her fellow wartime female surgeons threw upon the excitement of the unknown, and had a thrilling taste of what might have been.

As the previous examples imply, once women began to practise surgery, those reporting on the development sought to mesh two previously unthinkable categories together. By masculinising female operators or feminising surgery polar opposites began to merge into something more palatable. Intrigue about the budding female surgical practitioner sent journalists to investigate these hybrid creatures. In *Photographing Medicine*, Daniel M. Fox and Christopher Lawrence have remarked that published images of medical students taught in laboratories were not as popular in Britain as in America.<sup>34</sup> British women medical students, however, were perpetually photographed in laboratory situations, and described again and again in dissecting rooms.<sup>35</sup> The *Sketch* reporter was joined by a number of other brave souls who ventured into the LSMW in the 1890s and early 1900s. Whereas the former choked on the atmosphere, a *Daily Mail* correspondent simply could not come to terms with what he witnessed in 1898. He was put in his place before he had even been taken on a tour of the building by the formidable Miss Douie. 'Never suggest', he warned, 'that constant contact with suffering and the attendant horrors of the surgical table tend to harden a woman or deaden her susceptibilities.' Taken – noticeably – to the 'door' of the dissecting room, a merry scene was witnessed across the threshold:

<sup>32</sup> *Ibid.*, p. 50.      <sup>33</sup> *Ibid.*, p. 203.

<sup>34</sup> Daniel M. Fox and Christopher Lawrence, *Photographing Medicine* (New York and London: Greenwood Press, 1988), p. 46.

<sup>35</sup> For an opposite view, which focuses on female practitioners being represented in comfortable spaces such as the common room at the LSMW in order to 'cosmeticise or render more palatable the essentially shocking impact of knowing women had worked on anatomy in the dissecting room', see Carol Dyhouse, 'Driving Ambitions: Women in Pursuit of a Medical Education, 1890–1939', *Women's History Review*, 7.3 (1998), 321–43; 323.

I could see in a long well-lighted room three tables, at each of which attractive girls were seated, their heads bent upon their work of dissection, and their hands busy. At the centre table two gladsome students, delving with nimble hands, passed at intervals to lean forward upon their work, and exchange the merry quiplet. So happy were they that they might have been snipping out patterns for summer frocks or dissecting merely a tender duckling at the supper table.<sup>36</sup>

As ‘the sweet girls carved on in silence’, the reporter’s attention was only briefly drawn to the ‘indescribable things on the table’, which he imagined would ‘probably have smiled’ at the profound interest taken by the ‘bright-eyed girls’ in their ‘muscular organisation’. In order to cope with what he saw on his tour around the school, the reporter was compelled to feminise the actions of the would-be practitioners. By likening their cutting action to that of a dress pattern or the dissection of a small, weak animal, it became both acceptably feminine and harmless. Neither were the students scarred by their studies; they remained jolly, content and dedicated to their work.

Female reporters were equally confused about how to represent a woman surgeon. Prize-winning former student of the LSMW, Adela Knight, the first Australian woman to qualify in medicine, caught the eye of a *Lady’s Pictorial* representative at the New Hospital for Women in 1898. ‘Very sweet and gentle’ was the verdict of the paper, which admired her ‘soothing such of the patients who were tired and fretful’.<sup>37</sup> Such a portrait, more suitable to a nursemaid than a talented house surgeon, belied the skill which had earned Knight her academic distinction. However, the admiration did not stop at Knight’s sweet nature. Attention turned swiftly to her attire: ‘this lady did not show that contempt for awkward appearance with which some lady medical students, even those present on the occasion may be charged’. While her ‘tasteful and well-fitting’ ensemble removed Knight from any accusations of masculinity or blue-stockings, it also proved that the woman surgeon could carry out her work while dressing in a becomingly feminine manner. Nothing was shocking or odd about Adela Knight. Indeed, ‘[s]he gives the impression of being the right woman in the right place’. When Knight died unexpectedly less than a year later, at the age of 25, obituaries lauded her qualities and lamented the ending of a career which had promised so much.<sup>38</sup>

<sup>36</sup> ‘Lady Doctors’, *Daily Mail*, 3 June 1898, in *RFH Press Cuttings, Volume III*.

<sup>37</sup> ‘Opening of the New Hospital for Women’, *Lady’s Pictorial*, 26 July 1890, in *Newspaper Cuttings: New Hospital for Women, 1871–1968*, H13/EGA/144, LMA.

<sup>38</sup> See, for example, ‘Miss Adela McCulloch Knight, M.B. Lond.’, *Queen*, 30 May 1891 and ‘The Late Miss Knight’, *Lady’s Pictorial*, 23 May 1891, 44, in *RFH Press Cuttings, Volume III*.

Adela Knight was neither anomalous nor ill-suited to her role. Instead, her ‘right[ness]’ meant that she fitted her position perfectly.

Knight’s death reminded the press of the untimely demise of a previous distinguished student of the LSMW six years before: Helen Prideaux. In an unfortunate coincidence, Knight had been the recent recipient of the prize named in Prideaux’s honour. This funding had allowed Knight to travel to Vienna, where she contracted her fatal illness.<sup>39</sup> Prideaux’s death, at the age of 27, had been hastened by diphtheria, caught while working as a house surgeon at Paddington Children’s Hospital. As Elston has remarked, she was the first woman to obtain a post in open competition in a London voluntary hospital.<sup>40</sup> Surprisingly, the reaction of the medical press to her death brought this young woman squarely into the profession for which she had given her life. Prideaux’s *BMJ* obituary labelled her ‘one of the most brilliant and widely known’ of LSMW graduates. At Paddington, she obtained ‘long desired’ ‘intimate clinical study’, but her happiness lasted only for a month. The obituary detailed at great length her decline, along with the ‘terrible sufferings’ she experienced after a tracheotomy and a laryngotomy, as she fought for breath. Although she was ‘acutely conscious’ of her likely fate, ‘she felt no alarm’: ‘but, with a self-control, courage, and determination which were wonderful, she assisted in carrying out all the treatment, no matter how painful’. ‘No complaint of her great sufferings escaped her’; ‘entire self-sacrificing power’ was hers to the last. The loss of this ‘above all womanly’ person, whose ‘unusual moral and physical courage’ and ‘fine intellect’ was devastating for her friends, for the medical profession, but also for society itself.<sup>41</sup> While this eulogy was certainly written by a fellow medical woman, the press coverage of Helen Prideaux’s death was fascinating. Indeed, she was later utilised as an example of professional dedication, regardless of sex.

For Sir William Gull, who led the meeting held to establish a fund in her memory, Prideaux ‘had vindicated the right of woman to take the highest position in a difficult and intellectual profession’. By ‘leading the honours list’ and obtaining the University of London’s Gold Medal in Anatomy, she had ‘swept away’ prejudice ‘from the path of all who might follow her’. As a former opponent of women’s entry into the medical profession, Gull’s change of heart was remarkable. Now that women had established their rights to a medical education, he could no longer object.

<sup>39</sup> Mrs Fenwick Miller, ‘The Ladies’ Column’, *Illustrated London News*, 2719 (30 May 1891), 715.

<sup>40</sup> Elston, ‘Women Doctors in the British Health Services’, pp. 157–8.

<sup>41</sup> ‘Obituary: Frances Helen Prideaux’, *BMJ*, 2.1301 (5 December 1885), 1089.

‘The spirit of medicine’ was, after all, Gull proclaimed, ‘one of intellectual freedom’; to rise above prejudice and objection was the highest possible objective in establishing an award. Women’s work, such as that performed by Helen Prideaux, reflected well upon the whole profession, not simply the female part of it.<sup>42</sup> Similarly, the initial announcement of her death had caused the *BMJ* to reflect on the wider consequences of medical and surgical work for all practitioners. In an article entitled ‘The Perils of Medicine’, the death of one ‘of the most distinguished and most promising of the lady-graduates of medicine’ was described as ‘so painful’. ‘Cut down at the commencement of her career’, Prideaux had shared in the lot befalling those who took ‘fatal risks’ in the practise of their craft. Alongside the death from scarlet fever of an equally qualified male contemporary, St Thomas’ house surgeon, Robert Lawson, the year had ended sadly with the ‘cut[ting] off’ of two young hopefuls. The periodical did not choose to separate the events; instead the focus turned to every victim of professional duty. Lawson and Prideaux were but two examples of those who had been struck down by their very dedication to patient and profession. Both were designated, alongside fallen comrades, as ‘soldier[s] of medicine’.<sup>43</sup> Rather than isolating Helen Prideaux as an example of a woman unable to cope with her circumstances, the profession rallied around its own, simultaneously lamenting and championing the sacrifice.

Whereas we have seen the move towards a qualified acceptance of the woman surgeon both by press and profession alike in the last two decades of the nineteenth century, some felt that a change in surgery itself had made this possible. When it looked back upon anaesthesia’s golden jubilee in 1896, the *Hospital* remarked that the past fifty years had seen a dramatic change in the ways in which surgery was performed, but also in the composition of operating theatre personnel. In the past, before anaesthesia, surgical procedures were carried out solely to conserve life or limb and were few in number. Now, patients could elect to undergo surgery, with the knowledge that they could be cured by the operation. Genuine ‘surgical usefulness’ had, therefore, been a result of recent developments. So far, so familiar. However, the periodical then turned towards another consideration; one which it felt is ‘of hardly inferior weight to’ the benefits afforded to the patient. Indeed, in an extension of the argument put forward by Thomas Spencer Wells,

<sup>42</sup> ‘Sir William Gull on the Admission of Women to the Medical Profession’, *BMJ*, 1.1313 (27 February 1886), 414–15; 414.

<sup>43</sup> ‘The Perils of Medicine’, *BMJ*, 2.1301 (5 December 1885), 1076.

with anaesthetics in use, a class of men have espoused the surgical art, and continue to adopt it in ever-increasing numbers, who, under the older conditions of surgical practice, would not have been willing – would not, indeed, have been able – to practise surgery at all. The pre-anaesthetic surgeon was often spoken of as a ‘butcher’; and the term was in those days hardly one of disparagement. If the surgeon was a cultured man, with the skill of the competent butcher thrown in, so much the better both for himself and the patient. But the days of ‘swift’ operations are over, never, we may hope, to return. Now, thanks entirely to anaesthetics, the surgeon is not a ‘butcher’, but an ‘artist’; a skilled user of the finest tools – of tools which can be manipulated without any distracting thought, and employed with the calm deliberateness needed to secure the highest possible result which the scientific conservation of life and structure and function can possibly attain.<sup>44</sup>

In other words, surgery had become more acceptable, more palatable: sensitive, one might add. Surgical art was now skilful, requiring gentleness and artistry. The instruments of the trade had been honed into superlative aids. No longer brutal tools to butcher flesh, they were not wielded, but utilised delicately as an extension of knowledgeable, refined fingers. By the turn of the nineteenth century, those who would not have been considered suitable to carry out surgical procedures had been drawn into the profession, attracted by its increasingly sophisticated outlook.

Although this is, of course, an idealised depiction of impossibly painless, bloodless surgery, by 1900, the sense that an operation was no longer traumatic, for surgeon or for patient alike, was a very real one. If, as *Punch’s* ‘Chloe, M.D.’ had argued in the 1870s, surgeons needed a ‘Lady’s Hand’, then women were seen as perfect operators. Far from having an unsuitable physique for surgery, female hands, smaller and more dexterous, were ideal for the fiddly, complex procedures being developed thanks to an unconscious patient. In his free time, famed surgeon Frederick Treves liked to observe Mary Scharlieb operate because ‘her movements, her sureness, her delicacy, were invaluable to watch’.<sup>45</sup> Louisa Garrett Anderson too wrote of Scharlieb’s ‘slender hands seeming to go everywhere with marvellous speed’.<sup>46</sup> Nimble, swift and, most importantly, sure of her direction, it was the sheer choreography of Scharlieb’s surgical prowess which entranced. Anaesthesia encouraged skilfulness – a very different sort from that of the days of ‘butchery’. Some,

<sup>44</sup> ‘The Jubilee of Anaesthesia’, quoted verbatim from the *Hospital*, in *Times*, 35023 (Friday 16 October 1896), 7.

<sup>45</sup> P.H., ‘Women in Medicine’, *Lady’s Pictorial*, 20 August 1910, in *RFH Press Cuttings, Volume IV*.

<sup>46</sup> Louisa Garrett Anderson, *Elizabeth Garrett Anderson 1836–1917* (London: Faber and Faber, 1939), p. 242.



according to Elizabeth Garrett Anderson, even preferred the female hand to conduct an operation. In an undated speech, from the late 1890s or early 1900s, Garrett Anderson remarked, ironically, that ‘the demand for medical aid from women is much more pronounced on the surgical than on the medical side. It is precisely what I think was not expected in the early days’. Surgery now took ‘the place of honour’ at women’s hospitals. ‘Even husbands, the most critical of judges’, Garrett Anderson continued, ‘say not rarely how glad they are to trust their wives into women’s hands.’ Once, indeed, a patient’s husband said to a member of the NHW’s staff that “‘for medical treatment they had a very good man where they lived but that when it came to a cutting business he preferred a woman’”.<sup>47</sup> For one, unidentified female doctor, however, women had become ‘magnificent surgeons’ in order to abolish surgical procedures, save in case of accidents.<sup>48</sup> By perfecting operative techniques and by practising methods which ‘tend to prevention’, women surgeons were dedicated to becoming the best in order to put an end precisely to unnecessary surgical interference. Thanks to ancillary, but fundamental, changes in the ways in which surgeons operated, a feminised, sanitised surgery had resulted by the first decades of the twentieth century.

This ‘new’ surgery was one in which women could and did participate. Indeed, despite predictions to the contrary, women’s initial achievements in the medical profession were primarily surgical. By the end of the period covered by this book, Christine Murrell was able to claim that surgical success was greater than medical in financial terms because of the high fees women could command: ultimately £1,000 to £2,000 a year for her services.<sup>49</sup> In the early years, beyond the greater press coverage given to Garrett Anderson’s solo attempts to gain her education piecemeal or the heavily publicised battles at the University of Edinburgh, where Sophia Jex-Blake and others were fighting the authorities, solid success was being achieved more quietly. The Birmingham and Midland Hospital for Women (BMHW) was the first institution in the country to appoint a female house surgeon in 1872. Even though the relevant examining bodies in Britain had yet to open their courses to women and the other

<sup>47</sup> Elizabeth Garrett Anderson, ‘Notes from an Address’, Miscellaneous Documents, HA436/6/2, Ipswich Record Office. Dated to the late 1890s or early 1900s from internal evidence of a ‘forty or fifty year’ period since women began to demand entry to the medical profession.

<sup>48</sup> P.H., ‘Women in Medicine’.

<sup>49</sup> Christine M. Murrell, ‘The Medical Profession Including Dentistry’, in Edith J. Morley, ed., *Women Workers in Seven Professions* (London: George Routledge & Sons, 1914), pp. 137–67; p. 158.

two candidates were registered men, Louisa Atkins' Zurich qualification was accepted by the board of the hospital.<sup>50</sup> A year later, Joseph Chamberlain could report that this bold, original and pioneering experiment was an enormous success. 'A fair field and no favour should be given to a competent lady candidate', he remarked, adding that 'the accession of that lady to the number of practitioners of surgery would be welcomed'. Atkins' 'zeal and ability' had been recognised by colleagues and patients alike; the former, indeed, had regarded her as 'he could not say confrère, but as a consoeur'.<sup>51</sup> She was the same as them, but different, yet this did not affect the way in which she was treated. Her appointment was not a one-off experiment by the BMHW either. During the 1870s alone, signalling their commitment to supporting women's progress in vital junior posts, the institution employed two further women house surgeons: Edith Pechey and Annie Reay Barker.<sup>52</sup>

Female medical students looked with pride upon those whom they placed in the vanguard of their profession. The 'Topical Song' at the 1895 LSMW Christmas entertainment singled out surgical achievements to be celebrated:

One step we have made which alone brings renown,  
Five London BS's are gems in our crown;  
We have passed cent. per cent., and whatever may be,  
Our successors in this can't do better than we.  
And we do not stop short of the highest degree,  
For we've got an MS who was trained at the Free!<sup>53</sup>

For these students, each step forward, each examination success should be celebrated, no matter how small; every increment was a move towards acceptance. What is also noticeable here was camaraderie. If the wider world chose to dismiss achievements, then they were recognised and promoted within the small community of current and ex-students. Despite

<sup>50</sup> See entry for 16 July 1872, Minute Book of the Medical Committee, June 1871 to March 1892, HC/WH/1/5/1 and 'Special Meeting', 23 July 1872, Board of Governors Meetings Minutes: 29 May 1872–29 March 1892, HC/WH/1/1, Birmingham City Archives, Library of Birmingham. On the hospital itself, see Judith Lockhart, 'Women, Health and Hospitals in Birmingham: The Birmingham and Midland Hospital for Women', PhD thesis, University of Warwick, 2008.

<sup>51</sup> Joseph Chamberlain speaking at the Annual Meeting, reported in *The Third Annual Report of the Birmingham and Midland Hospital for Women* (Birmingham, 1874), pp. 5–8; p. 5.

<sup>52</sup> See Minute Book of the Medical Committee, 31 July 1875 for Pechey's appointment; 13 June 1876 for Barker's, HC/WH/1/5/1, Birmingham City Archives.

<sup>53</sup> 'Topical Song. Sung at the Christmas Entertainment, 1895', *London (Royal Free Hospital) School of Medicine for Women Magazine*, 3 (January 1896), 117. Future references to this periodical will be shortened to *L(RFH)SMWM*. The 'MS' is Louisa Aldrich-Blake.

ongoing antagonism towards medical women, the song reserved, surprisingly, a cheer for the RCS:

There is still one advance we should much like to see  
 In a body inclined too conservatively;  
 So deficient in morals they thought that we were,  
 They feared we might rise to their President's chair.  
 Though physicians were snuffy, the surgeons were kind –  
 Operations compel a more radical mind:  
 But if FRCS and MRCP  
 Are denied us, we'll flourish the London MD.<sup>54</sup>

While it was not until 1908 that the vote to allow women to join the RCS was finally won, and the first Fellow, Eleanor Davies-Colley, was admitted in 1911, pressure had been mounting in the 1890s.<sup>55</sup> The *Daily Graphic* reported in November 1895 that 'women must see very little to discourage them' in having lost the vote only by a 'very small majority'.<sup>56</sup> Indeed, the RCS' Council as a body had been largely in favour of the admission of women to its examination; it was the Royal College of Physicians who denied, in the necessary conjoint assessment, overall victory. It is hardly a wonder that the students saw a cause to laud the 'kind' RCS in their 'Topical Song'.

Surgical recognition was important because it was the final hurdle in women's professional acceptance. Membership of the Royal Colleges was the ultimate public attainment, but it is vital to acknowledge that, behind the scenes, in operating theatres of varying sizes across the country, numerous women were carrying out surgery, however slight those procedures might have been. As Christopher Lawrence remarks, 'surgical practise of the simplest sort must have been one of the commonest encounters in the history of medicine'.<sup>57</sup> So, even if those designated 'surgeons' were fewer in number than other practitioners, as was the case too with male colleagues, it does not follow that most medical women did not encounter any surgery at all after completing their degrees. While acknowledging the prevalence of minor surgical procedures in the lives of patients and practitioners alike, *British Women Surgeons* will focus primarily upon institutional contexts, because this was where most surgery

<sup>54</sup> Ibid.

<sup>55</sup> For Davies-Colley's achievement in November 1911, see 'Hospital and School News' and 'Examination Results', *L(RFH)SMWM*, 8.51 (March 1912), 36; 43; 44.

<sup>56</sup> 'Royal College of Surgeons. The Council and the Admission of Women', *Daily Graphic*, 16 November 1895, in *RFH Press Cuttings, Volume 3*. The vote was narrowly lost by 48 votes in favour of women's admission to 58 against. See 'The Royal College of Surgeons', *BMJ* (9 November 1895).

<sup>57</sup> Lawrence, 'Democratic, Divine, and Heroic', p. 10.

took place between 1860 and 1918.<sup>58</sup> I have also chosen to focus primarily upon metropolitan institutions, as many medical women practised in London, alert to the surgical opportunities to be gained by remaining in the capital.<sup>59</sup> However, this does not mean that women did not practise elsewhere, as the country-wide backgrounds of those who served during the Great War will illustrate in the final two chapters of this book. Additionally, there has been a corresponding dearth of studies on hospitals in which women worked. While some supported women's surgical ambitions, others did not. It is vital to remember, however, that even if many hospital boards were antagonistic to women surgeons across the period covered by this book, those who wanted to specialise in surgery found ways of so doing. There was little point lamenting a sorry lot when initiative, and, very importantly, sound financial backing, meant that jobs could be created for women surgeons. If the British mind, as Christine Murrell put in in 1914, was naturally slow to admit women to positions of responsibility, then 'heavily handicapped' women had retaliated by 'taking matters into their own hands' and establishing their own institutions.<sup>60</sup> From Elizabeth Garrett Anderson's St Mary's Dispensary, opened in 1866, to Maud Chadburn and Eleanor Davies-Colley's South London Hospital for Women and Children, which was completed half a century later, this book explores the work actually carried out by women surgeons, rather than the more usual focus on the missed opportunities. Without denying that those who chose surgery as a career were few, for whatever reason, the woman surgeon was a reality through this period. Women encountered more obstacles than their male colleagues, of course, but the ways in which they operated between 1860 and 1918 present a more fascinating, varied picture than one which removes surgical agency from them altogether.

Indeed, the majority of surgery in institutional contexts performed by women was of a serious kind and it is upon this field that *British Women Surgeons* will concentrate. Far from working towards the abolition of surgical practice, women contributed actively to the operative itch which characterised the end of the Victorian period and the first two decades of the twentieth century. As More's analysis of American gynaecological cases suggested, 'women initially were more willing to

<sup>58</sup> Joel D. Howell, *Technology in the Hospital* (Baltimore, MD: Johns Hopkins University Press, 1995).

<sup>59</sup> Digby notes that '[h]onorary hospital appointments were of even greater importance to the career of a surgeon than to a physician' *Making a Medical Living*, p. 33; for the concentration of medical women in London, see *ibid.*, p. 167.

<sup>60</sup> Murrell, 'The Medical Profession', p. 154.

operate than men'.<sup>61</sup> Every surgeon, regardless of sex, discovered that confidence was gained through operating, even if every patient suffering from the same condition presented different problems. In *Seven Lamps of Medicine* (1888), Scharlieb claimed succinctly that surgical 'knowledge is power, and the feeling of power contributes greatly to the calmness and dexterity from which it is performed'.<sup>62</sup> This book charts the growth of women's surgical experience from the faltering first days of male assistance to the positions of responsibility attained during the Great War on the home and the battle fronts. In so doing, it will provide the 'much-needed case studies of specific institutions', which Elston called for in 2001.<sup>63</sup> Women may have worked primarily in female-run institutions, but they did not designate them 'special' hospitals and were insistent on their general status.<sup>64</sup> The treatment of particular groups – namely, women and children, until the Great War – must not be equated with narrow and limited expertise.<sup>65</sup> Indeed, smaller, women-run hospitals such as the New Hospital for Women (NHW) and the South London Hospital for Women (SLHW) treated a far wider range of conditions than the RFH, where women were in charge of the Gynaecological Department from 1902, precisely because of their claim to generalism. The smallest institutions where theatre facilities were not as developed, such as the initially six-bed Edinburgh Hospital for Women and Children, saw an increase in surgical procedures in the early twentieth century. Only minor surgery had been performed in the first decade and a half of the hospital's existence, but, coinciding with Elsie Inglis' appointment as junior surgeon and gynaecologist, 'operations [became] more important than has been the case in recent years'. The patients seen that year suffered from complaints which were 'more of an acute character'.<sup>66</sup>

<sup>61</sup> More, *Restoring*, p. 53.

<sup>62</sup> Mary Scharlieb, *Seven Lamps of Medicine* (Oxford: Horace Hart, 1888). See also Owen H. Wangensteen and Sarah D. Wangensteen, *The Rise of Surgery* (Folkestone: Dawson, 1978) about the acquisition of surgical technique through experience (p. 236).

<sup>63</sup> Mary Ann Elston, "'Run by Women, (mainly) for Women": Medical Women's Hospitals in Britain, 1866–1948', in Anne Hardy and Lawrence Conrad, eds., *Women and Modern Medicine* (Amsterdam: Rodopi, 2001), pp. 73–107; p. 74.

<sup>64</sup> This was, of course, in opposition to the way in which special hospitals were emerging at the time. See George Weisz, *Divide and Conquer* (New York: Oxford University Press, 2006).

<sup>65</sup> For example, Geddes remarks that women's surgical practise was 'almost exclusively gynaecological' before 1914. See 'Deeds and Words', 85, and 'The Doctors' Dilemma: Medical Women and the British Suffrage Movement', *Women's History Review*, 18.2 (April 2009), 203–18; 205.

<sup>66</sup> 'Medical Officer's Report', *Twenty-Seventh Annual Report of the Edinburgh Hospital and Dispensary for Women and Children, 1905–1906* (Edinburgh, 1905), p. 5, LHB8/7/26, Bruntsfield Hospital and Elsie Inglis Memorial Maternity Hospital Archives, Lothian Health Services Archive, Edinburgh University Library, Edinburgh.

It was medical women's realisation that their patients both wanted and needed surgery, in combination with their own desire to provide such services, that saw many female-run institutions becoming increasingly surgical centres by 1918.

*British Women Surgeons* begins with an exploration of the ways in which the New Hospital for Women, established initially as a dispensary, rapidly became an institution which promoted the surgical skills of medical women. Behind the propaganda, however, things were not progressing as smoothly as the management of the NHW would have liked. Internal schisms over the ways in which Garrett Anderson operated threatened the hospital with controversy. In many ways, the New played out all the early concerns which the profession and the public had about the ability of women surgeons to carry out complex procedures, exacerbated because of insufficient specialist training. It was also a victim of its own publicity. Annual reports and newspaper columns praised the low death rates resulting from women surgeons unafraid to take a risk, but inside the hospital procedures were not going to plan. Too frequently, the male honorary consultants were performing operations, while the much-lauded female staff watched or assisted at best. With Garrett Anderson's retirement in 1892, the New's confidence was bolstered by the elevation of Mary Scharlieb to Senior Surgeon. Much more assured than her predecessor, Scharlieb instigated a new era in the hospital's surgical procedures. Ever mindful of what she owed to her team, Scharlieb placed the individual surgeon squarely within the wider network of personnel, both within and outside the operating theatre. The way in which the NHW operated in the late nineteenth century changed for the better.

In 1902, Mary Scharlieb departed for the Royal Free Hospital, in another landmark for the woman surgeon, to run the Gynaecological Department, where she was assisted by Ethel Vaughan-Sawyer. The next chapter follows her to consider the patient base at the RFH. Whom did Scharlieb and Vaughan-Sawyer treat? What surgical solutions did they offer and how did the patients react to their surgeon, the procedures they underwent and their experience of hospital life? The relationship between the working-class female patient and her practitioner has been strangely neglected, with, as Thomson laments, a focus on motherhood dominating historical analysis.<sup>67</sup> In order to redress this balance, my second chapter will examine the rich vein of RFH gynaecological case notes between

See also Thomson, 'Women in Medicine', p. 143 for the list of procedures; and, for Inglis, Margot Lawrence, *Shadow of Swords* (London: Michael Joseph, 1971).

<sup>67</sup> Thomson, 'Women in Medicine', p. 167.

1903 and 1913 to explore the nearly 1,500 woman patients who experienced surgical treatment under Scharlieb and Vaughan-Sawyer during these years. Increasingly, as the third chapter will show, women surgeons were carrying out procedures for one of the most feared diseases of the late nineteenth and early twentieth centuries: cancer. Previous analyses of women practitioners have suggested that they were abandoning surgery in the 1910s to make way for other, less invasive procedures such as radium treatment.<sup>68</sup> However, in hospitals such as the NHW, the RFH and the SLHW, surgery was still the primary recourse when cancer was discovered; radiotherapy was employed only for lost causes. The first two decades of the twentieth century were an exciting time for the surgical treatment of malignant disease, when operations, such as Wertheim's for cancer of the cervix, were devised and developed in an attempt to combat this most feared killer of women in the prime of life. For female surgeons in these three metropolitan hospitals, unafraid to try new procedures, surgery was the best way to save their patients' lives. Working-class women were often blamed in the medical and lay press for their slow response to the troubling symptoms of cancer. Case notes from the RFH will be utilised to consider how such women reacted to their condition and to the resulting treatment. With such a breadth of coverage in the records of the RFH, from 1903 to 1919, the historian can follow through on those who underwent surgery for the 'cure' period of five years and more.

By the beginning of the twentieth century, women surgeons were unafraid to attempt the most complex of operations for malignant disease. Yet they would face entirely new challenges from 1914, which would try their new-found confidence. The final two chapters examine the ways in which the Great War provided exciting professional opportunities both near to the battlefield and on the home front. When offers of assistance were brushed aside in no uncertain terms by the War Office, the response was unsurprising, given over half a century of similar reactions. Firstly, the advice was ignored. And, secondly, women simply established their own hospitals in various European countries, as they had done in Britain. In so doing, they gained not only their first real experience of operating on the opposite sex, but increased professional confidence in their surgical abilities. In a conflict where injuries did not resemble anything seen before, even by the most seasoned military surgeon, women took up the challenge and learned, along with their male colleagues, how to operate

<sup>68</sup> See, for example, Ornella Moscucci, 'The "Ineffable Freemasonry of Sex": Feminist Surgeons and the Establishment of Radiotherapy in Early Twentieth-Century Britain', *BHM*, 81.1 (Spring 2007), 139–63.

in the theatre of war. At home, with male members of the profession, at all levels from student to consultant, leaving their posts to serve abroad, women remained to plug the gaps. An enormous growth in the number of female students of medicine was coupled with the opening of medical schools and of many general hospital appointments, both previously shut to women applicants. While some took advantage of the situation and plunged into new worlds, others remained devoted to single-sex education and, as the wartime inauguration of the SLHW revealed, female-run institutions. As *locum tenens* for the length of the conflict only, as they were repeatedly reminded, women took up places fully aware that the measures were temporary. In the long run, what mattered, both at home and abroad, was that newly-promised opportunities were grasped tightly because too soon they would end and the status quo would be re-established.

During the Great War, in May 1916, the *Daily Sketch* offered its readers an assessment of a once *rara avis*:

The public, as a whole, knew nothing of her, although it imagined a great deal. It imagined, for instance, that it never could bring itself to trust a woman doctor; that she would inevitably lose her nerve at the critical moment; and that she must in any case be a curious, unsexed, morbid creature to be willing to study anything so repellent and terrible as medicine. There are still individuals who think and talk thus, but the public generally knows better than this. To-day the medical woman may be found practising in quiet little south coast watering places. She is treating the wounded in great hospitals close to the firing-line in France. She is caring for the women and children of the hill-tribes in frontier towns in India. She is waiting with calm patience and unceasing labour to be taken prisoner by the enemy rather than leave her wounded patients in Serbia. She is seeing patients every morning in her house in Harley St. She is resident medical officer in hospitals all over the country, tending the sick among the civil population and the soldiers in the wards needed for the army. She is running a big practice in a provincial town and driving her car herself because the chauffeur had joined the army. She is at remote stations of the Empire upholding the honour, the goodwill, the power and the stability of the British rule.<sup>69</sup>

In 1860, there were no medical women. Half a century later, there were nearly a thousand living women on the Medical Register.<sup>70</sup> By the start of the academic year of 1918–1919, there were 665 new entrants alone to medical schools across Britain and Ireland, nearly a third of the total

<sup>69</sup> 'Women and the Medical Profession', *Daily Sketch*, 13 May 1916, in Letters from Elizabeth Garrett Anderson and Louisa Garrett Anderson to Miss Brooks and Miss Sage, 1910–1943, HA436/1/4/6, Ipswich Record Office.

<sup>70</sup> Louie M. Brooks refutes that the numbers are 'small': 930 in only 34 years, 'Women as Doctors', *Pall Mall Gazette*, 20 January 1912, in *RFH Press Cuttings, Volume IV*.



number.<sup>71</sup> As the *Daily Sketch* piece made clear, there were still those who could not countenance a woman competently examining the bodies of others without breaking down. What is most telling about this article, though, is the sheer range of possibilities for surgical practice especially to be found by the second decade of the twentieth century, across the country and abroad. It is those potential avenues which *British Women Surgeons* will explore further, following practitioners through the closed doors of operating theatres to see what precisely went on inside. Those who chose surgery were undoubtedly few, as was the case with male colleagues, but every single medical student, of either sex, had some knowledge of surgical procedures. Indeed, whether carrying out minor procedures in general practice, assisting as house surgeons in hospitals across Britain, or operating on wounded soldiers all over Europe, women's surgical skills had never been more needed nor praised. Ultimately, this book is a history of the 'quiet perseverance' with which women surgeons operated.<sup>72</sup> So quietly, indeed, that their contribution to women's professional achievements, as well as their willingness to take risks, has been forgotten. That persistence can be rightly reconsidered through the wealth of archival resources available. *British Women Surgeons* will move away from previous assessments, which focus on what medical women did not achieve in this period. Instead, I will chart, unashamedly, the growth of female surgical confidence, and do so precisely through documenting the operations they performed.

<sup>71</sup> 'Annotations: The Supply of Medical Students', *Lancet*, 192.4952 (27 July 1918), 113.

<sup>72</sup> 'Women Doctors. How They Have Won Through By Quiet Perseverance', *Pall Mall Gazette*, 20 June 1913, in *RFH Press Cuttings, Volume IV*.