The Medical Women's Federation (MWF): 1879-1948

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Abstract

Founded in 1917, the Medical Women's Federation (MWF) is the largest and most influential body of women doctors in the United Kingdom. Despite an extensive archive held at the Wellcome Library in London, no comprehensive study of the organisation's formative work currently exists. This thesis sheds new light on the history of the MWF from the year of its original formation as the Association of Registered Medical Women (ARMW) in 1879 to the founding of the National Health Service (NHS) in 1948. Chapter One analyses the issues faced by the ARMW during its first three decades. Far from being insignificant, the Association played a crucial role in combating the professional isolation of medical women. Chapter Two scrutinises the ARMW's response to the First World War, and considers the roles played by women doctors both on the home front and overseas. Chapter Three assesses the MWF's activities during the interwar years through three key themes – resistance, recovery, and reform. The Federation's efforts to expand the opportunities available to female practitioners are considered alongside an examination of the role played by individual members in transforming perceptions of women's health. The final chapter of this thesis investigates how the MWF supported its membership during the Second World War, providing novel insights into the variety of work undertaken by medical women. Though the conflict offered a unique opportunity for the Federation to reassert its dominance, the organisation ultimately failed to learn from its past mistakes. The Afterword offers a brief examination of the extent to which women doctors were involved in the formation of the NHS. By drawing on a rich archive of sources, this thesis reveals wide-ranging new perspectives on the personal and professional experiences of British medical women during this seventy-year period, making a significant contribution to the history of women in medicine.

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This thesis is dedicated to the memory of George and Carol Halsey

I could not have asked for more loving grandparents

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List of abbreviations

ARMW	Association of Registered Medical Women
ARP	Air Raid Precautions
ATS	Auxiliary Territorial Service
BMA	British Medical Association
BMHW	Birmingham and Midland Hospital for Women
BMJ	British Medical Journal
DDMS	Deputy Director of Medical Services
DPH	Diploma in Public Health
EMS	Emergency Medical Service
GMC	General Medical Council
GPO	General Post Office
KQCPI	Kings and Queens College of Physicians in Ireland
LCC	London County Council
LSMW	London School of Medicine for Women
MOH	Medical Officer for Health
MWIA	Medical Women's International Association
MWF	Medical Women's Federation
NHS	National Health Service
NHW	New Hospital for Women
RAF	Royal Air Force
RAMC	Royal Army Medical Corps
RFH	Royal Free Hospital
SMOA	School Medical Officers' Association

SWH	Scottish Women's Hospitals
VAD	Voluntary Aid Detachment
WAAC	Women's Army Auxiliary Corps
WAAF	Women's Auxiliary Air Force
WHC	Women's Hospital Corps
WISL	Women's Imperial Service League
WRNS	Women's Royal Naval Service
WSA	Worshipful Society of Apothecaries

Introduction

When Elizabeth Blackwell, the first woman to have her name placed on the British Medical Register, reflected upon the crippling sense of isolation she had felt as the lone female practitioner within a male-dominated field in 1864, she remarked that: 'There was a blank wall of social and professional antagonism facing the woman physician that formed a situation of singular and painful loneliness, leaving her without support, respect, or professional council.[1] The following year, Blackwell was joined on the Medical Register by Elizabeth Garrett Anderson, who would have to wait a further 13 years before her next female colleague was officially recognised by the General Medical Council (GMC).[2] The difficulties which women such as Blackwell and Garrett Anderson faced in entering the medical profession during the latter half of the nineteenth century have received significant historical attention.[3] In contrast, there remain a number of gaps in knowledge regarding the ways in which medical women overcame the lack of 'support, respect, and professional council' with which they had to contend once qualified. The first generation of women doctors found themselves in an extremely precarious position; whilst they had earned their place within the walls of the profession, they were barred from entering almost all of its established

[1] Elizabeth Blackwell, *Address on the Medical Education of Women* (New York: Baptist & Taylor, 1864), p.5.

[2] Eliza Walker Dunbar was the third woman to have her name placed on the Medical Register in 1877, after being licensed by the Kings and Queens College of Physicians in Ireland (KQCPI).

[3] See for example: Louisa Garrett Anderson, *Elizabeth Garrett Anderson, 1836-1917* (London: Faber and Faber, 1939); Jo Manton, *Elizabeth Garrett Anderson* (London: Butler and Tanner, 1965); E. Moberley Bell, *Storming the Citadel* (London: Constable & Co, 1982); Mary Ann Elston, 'Women Doctors in the British Health Services: a sociological Study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986; Catriona Blake, *The Charge of the Parasols: Women's Entry into the Medical Profession* (London: The Women's Press, 1990); Kaarin Leigh Michaelson, 'Becoming "Medical Women": British Female Physicians and the Politics of Professionalism, 1860-1933', unpublished doctoral thesis, University of California, Berkeley, 2003; Claire Brock, *British Women Surgeons and their Patients, 1860-1918* (Cambridge: Cambridge University Press, 2017); Olivia Campbell, *Women in White Coats: How the First Women Doctors Changed the World of Medicine* (New York: Park Row Books, 2021). For the Scottish context, see: Sophia Jex-Blake, *Medical Women: A Thesis and a History* (Edinburgh: Oliphant & Co., 1886); Shirley Roberts, *Sophia Jex-Blake: A Woman Pioneer in Nineteenth Century Medical Reforms* (London: Routledge, 1993); Elaine Thomson, 'Women in Medicine in Late Nineteenth and Early Twentieth-Century Edinburgh: A Case Study', unpublished doctoral thesis, University of Edinburgh, 1998; William Knox, *The Lives of Scottish Women: Women and Scottish Society 1800-1980*, (Edinburgh: Edinburgh University Press, 2006); M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007). For the Irish context, see: Laura Kelly, *Irish Women in Medicine, C.1880's-1920's: Origins, Education and Careers* (Manchester: Manchester University Press, 2012).

structures.[4] Medical women were not only excluded from studying at British universities and denied clinical training in a number of the country's hospitals, they were also prevented from joining the profession's representative organisation.[5] The British Medical Association (BMA) refused to accept women doctors as members until 1894, meaning that they were unable to benefit from the same intellectual exchanges and camaraderie enjoyed by their male colleagues.[6] In order to overcome the isolation which threatened their future within the profession, medical women were forced to adapt by creating their own opportunities and networks. In 1879, the Association of Registered Medical Women (ARMW) was founded to represent the rights and interests of female practitioners, and in 1917, local branches of the Association joined to form the Medical Women's Federation (MWF).[7]

This thesis argues that the MWF played a pivotal role in the professional lives of women doctors during its first seven decades. By charting the evolution of the organisation from its inception as the ARMW in 1879, to the formation of the National Health Service (NHS) in 1948, it examines how the Federation supported its membership during this defining period in medical history, and considers the extent to which the organisation fulfilled its founding aims.[8] Writing on the 80th anniversary of the MWF in 1997, Lesley A. Hall remarks that: 'Ever since it was placed here in 1988, the archive of the Medical Women's Federation has proved one of the most popular collections held by […] the Wellcome Institute'.[9] In spite of the interest that continues to be elicited by the collection, no comprehensive study of the organisation's early work currently exists. Furthermore, the work of the ARMW between 1879 and 1916 continues to be relegated to a mere

[4] The term 'first generation' loosely refers to women doctors who qualified to practice medicine before 1900. The second generation are those who qualified between 1900 and 1930, and the third are those who qualified between 1930 and 1950.

[5] Elston, 'Women Doctors in the British Health Services', p.159.

[6] Tara Lamont, 'The Amazons Within: Women in the BMA 100 years Ago', *BMJ*, 2 (19th December 1992), 1529-32 (p.1531)

[7] ARMW Minute Book, Wellcome Library, London, SA/MWF/P/1/1.

[8] See, for example: Anne Digby, *Making a Medical Living* (Oxford: Oxford University Press, 1994); Irvine Loudon, John Horder, and Charles Webster (eds), *General Practice under the National Health Service, 1948-1997* (London: Clarendon Press, 1998); Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999); Lawrence Conrad and Anne Hardy (eds), *Women and Modern Medicine* (Amsterdam: Rodopi, 2001); Tania MacIntosh, *A Social History of Maternity and Childbirth* (Oxford: Routledge, 2012); Claire Brock, *British Women Surgeons and their Patients, 1860-1918* (Cambridge: Cambridge University Press, 2017); Deborah Brunton, *Medicine in Modern Britain: 1780-1950* (Oxford: Routledge, 2019).

[9] Lesley A. Hall, 'Eighty years of the Medical Women's Federation: The MWF Archive in the Contemporary Medical Archives Centre, Wellcome Institute for the History of Medicine', *Medical Woman*, 2 (Summer 1997), 6-9 (p.6).

footnote in the MWF's history. The primary aim of this thesis is therefore to address the gaps in knowledge that currently exist within the field. A study of the lives and careers of medical women cannot be considered complete without a detailed analysis of the role played by their professional organisation. The ARMW is worthy of examination in its own right; far from being an 'ineffective lobbying force', the Association played an important role in women doctors' careers during the late nineteenth and early twentieth centuries.[10] Similarly, the MWF made significant efforts to advance the position of women in medicine from 1917 onwards through its campaigns for gender equality. In order to contextualise the discussion of the ARMW in Chapter One, the Introduction outlines the paternalistic arguments which sought to prevent women from entering the medical profession. It then briefly charts how women overcame these barriers during the late 1860s and early 1870s, before examining the historiography and methodology that informs this thesis. By shedding new light on the complex history of the MWF, this thesis makes both an original and significant contribution to the history of women in medicine.

Victorian conceptions of the female body

In order to better understand the difficulties faced by women wanting to pursue a professional career during the late nineteenth century, one must first consider the ways in which the female body was pathologized. Following the discovery of spontaneous ovulation in 1843, perceptions of menstruation changed dramatically.[11] Rather than being viewed as a purifying physiological process, a woman's monthly bleeding was exposed as the by-product of a savage internal battle:

> The congestion of the ovary, ripening of the ovule, effusion of the serum of blood into the Graafian follicle; its rupture; the escape of the reproductive cell; its seizure by the fimbriae of the Fallopian tube; its journey along the oviduct and descent into the uterus; the hyperannia of the latter, the turgesence of its mucous membrane, the rupture of its blood vessels, and local haemorrhage; this

[10] Kaarin Leigh Michaelson, 'Becoming "Medical Women": British Female Physicians and the Politics of Professionalism, 1860-1933', unpublished doctoral thesis, University of California, Berkeley, 2003, p.123.

[11] Catherine Gallagher, *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century* (London: University of California Press, 1986), p.26.

> entire succession of processes seemed to cause greater perturbation of the economy, because occurring at intervals.[12]

The debilitating nature of menstruation is highlighted through the use of violent phraseology such as 'seizure', 'rupture', and 'haemorrhage'. Because so much vital energy was needed to safely complete this arduous process, it was believed that any unnecessary mental or physical strain during this time could have dire consequences. Henry Maudsley, a prominent nineteenth-century alienist, expresses this view in *Sex in Mind and Education* (1884).[13] He argues that the female student 'does not easily regain the vital energy that was recklessly spent on learning', and concludes that 'if a woman attempts to achieve the educational standards of men […] she will lack the energy necessary for childbearing and rearing'.[14] By selfishly choosing to pursue a higher education, women risked their ability to procreate in the future. Maudsley goes on to assert that it would be foolish for women to attempt to compete with men on an intellectual level, as: '[they] are marked out by Nature for very different offices in life […] and the healthy performance of her special functions renders it improbable she will succeed'.[15] The propagation of such myths thus served as a form of social control, as women continued to be bound to the domestic sphere on account of their reproductive functions.

Unsurprisingly, prevailing arguments against women entering the medical marketplace during the late nineteenth century centred on their inherent inability to meet the physical and intellectual demands of the job.[16] As medical practitioners, women would routinely find themselves responsible for the care of their own sex in labour, when in fact they might be menstruating or even pregnant themselves. It was widely accepted that women experienced mental and physical exhaustion during menstruation, making it impossible for them to make complex life and death decisions in the interests of their patients. Dramatized scenarios which featured lone women

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[12] Mary Putnam Jacobi, *The Question of Rest for Women during Menstruation* (New York: G.P. Putnam's Sons, 1877), p.13.

[13] Henry Maudsley, *Sex in Mind and Education* (New York: C.W. Hardeen, 1884).

[14] Ibid., p.19.

[15] Ibid., p.7.

[16] See, for example: Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago, 1987); Ornella Moscucci, *The Science of Woman* (Cambridge: Cambridge University Press, 1990); Patricia Vertinsky, *The Eternally Wounded Woman: Women, Doctors, and Exercise in the late Nineteenth Century* (Manchester: Manchester University Press, 1990); Claire Brock, 'The *Lancet* and the Campaign Against Women Doctors, 1860-1880', in *Creating Science in Nineteenth-Century Britain*, ed. by Amanda Mordavsky Caleb (Newcastle: Cambridge Scholars' Publishing, 2007), pp.130-145; Hilary Marland, *Health and Girlhood in Britain: 1874-1920* (London: Palgrave, 2013); Claire Brock, 'The Fitness of the Female Medical Student, 1895-1910', in *Picturing Women's Health*, ed. by Francesca Scott, Kate Scarth and Ji Won Chung (London: Pickering and Chatto, 2014), pp.139-157.

doctors battling against the elements to attend a challenging obstetric case were routinely published in the medical press:

> The idea of a medical women being called out of bed, perhaps at a catamenial period, on cold winter's night, to walk or drive several miles along a dreary country road, in snow or rain, to attend any midwifery case, is repugnant to a properly constituted mind; but if we consider that the case may be one of placenta praevia, or severe post-partum haemorrhage, or ruptured uterus, it becomes positively shocking.[17]

Whilst such perilous situations were deemed to be 'positively shocking', thoughts of women partaking in gruesome dissections, and intimately examining the anatomy of the male body, were especially 'repugnant'. Across the world, questions of propriety dominated discussions of the 'lady doctor': 'picture a modest woman placing herself in the position of having […] to dissect the body of a dead man. Fancy the degradation the sex must be exposed to in passing through so abominable a scene'.[18] It was believed that in becoming doctors, women would irrevocably unsex themselves; if their bodies and minds survived the pressures of higher education unscathed, then the gruesome nature of medical practice would, undoubtedly, deliver the *coup de grâce*.

These fears are foregrounded in a sketch entitled 'The Feminine "Faculty"' which appeared in *Punch* in May 1873 (Figure 0.1).[19] On arriving home, a male doctor is informed by his startled housemaid that he has a visitor waiting for him in his surgery. Due to the unnatural appearance of the stranger, the housemaid is left confused as to their sex: "'He – She – would come in, Sir, - and I think" (*shuddering*) "It's a man in a woman's clothes Sir!!!"'.[20] In a humorous reference to her loss of femininity, the bespectacled Dr Mandragora Nightshade (whose namesake is a toxic, bulbous plant) is depicted looking intently at a skull in the adjacent room.[21] As a result of pursuing a male profession, Dr Mandragora Nightshade has willingly unsexed herself; rather than being associated with beauty and fertility, she is instead defined by death. As Maudsley argues in *Body and Mind* (1870):

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[17] 'London: Saturday, April 28, 1877', *Lancet,* 1 (28th April 1877), 617-618.

[18] Anon., *Parliamentary Debates: Legislative Council and Legislative Assembly, Session 1875-1876* (Melbourne: John Ferres, 1876), p.1318.

[19] 'The Feminine "Faculty"', *Punch,* 24th May 1873, p.218.

[20] Ibid.

[21] Skulls are a common memento mori motif; in the *Punch* sketch, Dr Mandragora Nightshade is reminded of her lack of femininity and the inevitability of death.

> While woman preserves her sex, she will be necessarily feebler than man, and, having her special body and mental characters, will have […] her own sphere of activity; where she has become thoroughly masculine in nature, or hermaphrodite in mind […] then she may take his ground, and do his work, but she will have lost her feminine attractions, and probably also her chief feminine functions.[22]

As increasing numbers of women sought meaningful work, such myths which sought to pathologize the female body were challenged, and social constructions of femininity began to evolve.[23] Rather than being hindered by their own reproductive systems, women were viewed as the natural medical advisors of their own sex because of their shared knowledge and understanding of the 'special suffering' peculiar to the female body.[24] In response to those that argued that women simply could not cope with the gruesome nature of hospital work, advocates for female physicians countered that in their roles as nurses, the fairer sex had been exposed to the 'foulest sights and most painful scenes' for centuries, and yet their 'delicacy' and 'womanliness' continued to be upheld and revered.[25] Similarly, as women began to enter universities across Europe, gaining degrees in various disciplines, it became clear that the female sex were both intellectually and physically capable of undertaking the same work as their male counterparts. Following the appearance of Blackwell's name on the Medical Register in 1858, it was not long before other women resolved to follow in her footsteps and pursue a career in medicine.

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[22] Henry Maudsley, *Body and Mind: An Inquiry into Their Connection and Mutual Influence, Specially in Reference to Mental Disorders* (London: Macmillan and Co, 1870), pp.32-3.

[23] As Chapter 3 examines, female practitioners were crucial in dispelling the myths which pathologized menstruation and the menopause during the interwar years.

[24] Sophia Jex Blake, *Medical Women, a Thesis and a History* (Edinburgh: Oliphant & Co., 1886), p.136.

[25] Ibid., p.36.

Figure 0.1 'The Feminine "Faculty"', *Punch*, 24th May 1873 (*Punch*). The ominous figure of the unsexed woman doctor is equated with death.

Women's entry into the medical profession

In spite of the paternalistic arguments which sought to deny women's entry to the profession, the 1860s and 1870s played host to a barrage of sustained attacks on the medical citadel.[26] Writing in 1861, an anonymous contributor to the *Lancet* remarked on the outbreak of war within the British medical profession: 'The apple of discord is to be cast into our hospitals […] The advanced guard of the Amazonian Army which has so often threatened our ranks, on paper, has already carried the outposts and entered the camp'.[27] Having been permitted to take classes in 'Materia Medica' and chemistry at the Middlesex Hospital, Elizabeth Garrett (later Garrett Anderson) had succeeded in

[26] This section has previously been published as part of a journal article: Sophie Almond, 'The Forgotten Life of Annie Reay Barker, M.D', *Social History of Medicine,* 34 (August 2021), 828-850.

[27] 'A Lady Amongst the Students', *Lancet*, 2 (6th July 1861), 16.

her quest to 'penetrate' the male stronghold.[28] Due to the widespread opposition to women doctors that existed within the profession, Garrett Anderson decided upon a measured, and most importantly non-confrontational, approach to gaining supporters for the woman doctor movement. Rather than aggressively canvassing institutions, she chose to procure private instruction from individuals, using her connections and feminine charm to steadily win their respect.[29] Following years of careful negotiations and numerous setbacks, Garrett Anderson sat the licensing examinations of the Worshipful Society of Apothecaries (WSA) in September 1865, and having passed, she became the second woman to have her name placed on the British Medical Register.[30] Like Blackwell, Garrett Anderson was acutely aware of her professional isolation: 'I was in the fortress as it were, but alone and likely to be for a good time'.[31] After begrudgingly submitting to her persistent legal challenges, the WSA firmly closed its doors to any further women hoping to acquire the LSA qualification.[32] Although she had secured her medical license, Garrett Anderson's strategical manoeuvring was not yet complete; her next task was to secure the formality of a medical degree. Her only option was to apply to a university in Europe; the Universitié de Paris had recently accepted Mary Putnam Jacobi as the first woman to study medicine in 1868, therefore it offered a high chance of a favourable outcome.[33] Garrett Anderson's 'indomitable perseverance and pluck' paid off, and in June 1870 she was finally awarded the title of M.D.[34] By respectfully requesting, rather than doggedly demanding, access to medical training, Garrett Anderson won the esteem of the medical profession, paving the way for future progress to be made.

Given its significance within the movement, news of Garrett Anderson's success in Paris quickly reached Sophia Jex-Blake, who was in the midst of her own battle in Edinburgh. Garrett Anderson's breakthrough in Paris was undoubtedly 'worth a great deal' to their collective cause; however, in Jex-Blake's opinion, the question of women studying and qualifying in the United Kingdom needed to be agitated - the time for direct action was now.[35] Jex-Blake was painfully aware

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[28] Ibid.

[29] Jo Manton, *Elizabeth Garrett Anderson* (London: Butler and Tanner, 1965), pp.147-50.

[30] Ibid., p.163.

[31] Ibid.

[32] Margaret Todd, *The Life of Sophia Jex-Blake* (London: Macmillan, 1918), p.232.

[33] Carla Bittel, *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth Century America* (North Carolina: UNC Press, 2012), p.64. The Universitié de Paris was a centre of excellence for anatomy and medicine, and was considered to be far superior to London. See: Andrew Cunningham, *The Anatomist Anatomis'd : An Experimental Discipline in Enlightenment Europe* (London: Taylor & Francis, 2010).

[34] 'Miss Garrett', *BMJ*, 1 (18th June 1870), 636.

[35] Todd, *The Life of Sophia Jex-Blake*, p.232.

of the fact that if she went abroad for her medical degree, she had little chance of being included on the Medical Register, as there was no way of procuring a professional license. Without one, she would be left 'hold[ing] a position exactly analogous to that of the most ignorant quack or herbalist who might open a penny stall for the sale of worthless nostrums'.[36] In order to achieve the official recognition she required, Jex-Blake needed to open the doors of a British university to women. Deciding to confront the issue head-on, Jex-Blake formally applied to the University of Edinburgh to attend medical lectures in March 1869.[37] The Medical Faculty and University Senatus agreed, in principle, to Jex-Blake attending classes, but the university's court rejected her petition, concluding that they were not prepared to 'make a temporary arrangement in the interests of one lady'.[38] Refusing to be defeated at the first hurdle, Jex-Blake rallied like-minded women desirous of studying medicine to join her in Edinburgh.[39] Having secured arrangements for separate classes, Jex-Blake finally achieved her objective, matriculating in the winter session of 1869 alongside nine other women.[40] Jex-Blake's celebrations, and her tactical advantage, were, however, short-lived. The movement in Edinburgh was marred by a number of heavily publicised controversies, including the Surgeon's Hall riots of November 1870, and the libel lawsuit which followed.[41] Similarly, following her exam failure three years later, Jex-Blake publicly questioned the professionalism of her examiners in the *Times*: an action which was condemned by both sides of the medical woman debate.[42] In June

[36] Sophia Jex-Blake, *Medical Women,* p.70.

[37] Todd, *The Life of Sophia Jex-Blake,* p.235.

[38] Ibid, p.246.

[39] Sophia Jex-Blake, 'Medical Education For Women', *Times*, 28th July 1869, p.10.

[40] Todd, *The Life of Sophia Jex-Blake*, p.264. In her account of her time at Edinburgh, Jex-Blake recalls matriculating alongside Edith Pechey, Helen Grant, Matilda Chaplin Ayrton, and Isobel Thorne in the winter session of 1869. She was later joined by Mary Anderson and Emily Bovell, and the group became known as the 'septem contra Edinam' or 'Edinburgh Seven'. However, as Crowther and Dupree (2007) note, this designation is inherently problematic. Contrary to popular belief, ten, not five, women signed the matriculation register for the winter session of 1869, with more joining later. Influenced by Jex-Blake's exclusionary attitude towards those who existed outside of her inner circle, the names of Elizabette Ken, Mary Cudell, Emily Rosaline Masson, Mary Spalding Roberts, and Elizabeth Mary Clark have been widely forgotten.

[41] Ibid, p.240. Arriving at Surgeon's Hall to take their anatomy exam, the group of female medical students were met with a hostile crowd of their peers and onlookers who shouted abuse, threw rubbish, and attempted to bar their entrance. Jex-Blake later publicly identified the ringleader of the group, and was subsequently sued for defamation.

[42] Isobel Thorne wrote to Jex-Blake in 1873 to tell her of the 'irreparable damage' her behaviour had done to the cause. Jex-Blake's examination failure, and her accusations of unprofessionalism, were discussed by professors from the University in the *Times*.

1873, the inner court of the University of Edinburgh declared that the 1869 decision to admit women was illegal, by a majority of seven to five.[43] Thus, the Scottish campaign came to an abrupt end.

Whilst many of the Edinburgh students followed Garrett Anderson's strategy of finishing their degrees abroad, Jex-Blake refused to abandon her belief that the battle for the medical education of women needed to be fought, and ultimately won, on British soil. Rather than following the straightforward path to her M.D. in Europe, she instead turned her attentions to founding a medical school, solely for female students, in London.[44] Unsurprisingly Jex-Blake and Garrett Anderson disagreed on how the school should be managed; the danger was that if the school, and its diploma, were not officially recognised, then its female students 'would at once be marked as a special class of practitioner, subordinate and inferior to the ordinary doctor'.[45] In a similar vein, Garrett Anderson believed that women should be patient and work towards being educated alongside men, rather than rushing into a female-only medical school.[46] Co-education had a number of benefits, but most importantly, it did not single women doctors out as being *requiring* of special arrangements. If co-education could be established, medical women would be regarded as a permanent feature within the profession, rather than an experiment.[47] Jex-Blake had hoped for mixed classes before 1871 when she started in Edinburgh, but following her experience of ungentlemanly behaviour, she later concluded that 'boys of a low social class, of small mental calibre, and no moral training, are utterly unfit to be admitted to a mixed class'.[48] Jex-Blake agreed, in theory, that co-education would be beneficial for female medical students; however, she was not prepared to wait decades for it to be achieved naturally without any intervention.[49]

In spite of her initial concerns, Garrett Anderson agreed, under duress, to join the venture alongside Blackwell and Jex-Blake, and in October 1874, 14 women began their studies at the London School of Medicine for Women (LSMW).[50] Although the modest opening of the LSMW had been a success, the school had yet to be officially recognised by any of the professional

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[43] William Knox, *The Lives of Scottish Women: Women and Scottish Society 1800-1980* (Edinburgh: Edinburgh University Press, 2006), pp.79-83.

[44] Todd, *The Life of Sophia Jex-Blake*, p.415.

[45] Manton, *Elizabeth Garrett Anderson*, p.240.

[46] Ibid., p.241.

[47] Charles R. Drysdale, 'Notes on Female Education in Ordinary Medical Schools', *Medical Press and Circular*, 66 (25th June 1873), 548-550 (p.550).

[48] Jex-Blake, *Medical Women*, pp.156-7.

[49] Ibid., p.156.

[50] Ibid., p.179.

examination bodies, and no hospital training had been secured for its students.[51] Both of these issues prevented those studying at the LSMW from qualifying to practice medicine, which led to a number of students leaving to seek their education elsewhere.[52] Faced with the prospect of having to close just two years after it had first opened, the LSMW was, in many ways, saved by the Medical Act of 1876. Brought before parliament by Russell Gurney, an outspoken supporter of the medical woman movement, the revised Medical Act enabled licensing bodies to recognise 'any qualification for registration granted by such body to all persons without distinction of sex'.[53] In spite of the new law, universities and licensing bodies in Britain remained reluctant to admit women to their examinations. In October 1876, the Executive Committee of the LSMW wrote to the Kings and Queens College of Physicians in Ireland (KQCPI) to request that they consider officially recognising the school as a place of education for female students.[54] In response, a representative of the KQCPI made an unannounced visit to the LSMW three months later, in order to examine 'every apartment in the institution'.[55] Having witnessed two students at work in the dissecting room, the inspector commended the school on the quality of its cadavers, commenting on the lack of 'offensive odour in the room'.[56] The report concluded that 'the means of educating the ladies are sufficient, and quite as good as some of the private schools throughout the United Kingdom'.[57] In February 1877, the LSMW was given full recognition by the KQCPI.[58]

The KQCPI was uniquely liberal in regards to the woman doctor question; in the same month as the visit to the LSMW, the college licensed its first female candidate under the new Medical Act.[59] The reasons for this liberality are complex; licensing women had clear financial benefits, however, Dublin had an established history of supporting women in higher education. As Laura Kelly notes, the Royal College of Science for Ireland admitted women as early as 1867.[60] By opening

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[51] Ibid., pp.182-183.

[52] Knox, *The Lives of Scottish Women,* p.86.

[53] John Macqueen, *The Law Reports* (London: William Clowes and Sons, 1876), p.289.

[54] Letter from the Executive Committee of the LSMW to the KQCPI, 19th October 1876, Royal College of Physicians of Ireland Heritage Centre, Dublin, RCPI/2/3/5/5.

[55] 'Report on The London School of Medicine for Women, 30 Henrietta Street, Brunswick Square, W.C', Royal College of Physicians of Ireland Heritage Centre, Dublin, RCPI/2/3/5/5.

[56] Ibid.

[57] Ibid.

[58] Ibid.

[59] Laura Kelly, *Irish Women in Medicine, C.1880's-1920's: Origins, Education and Careers* (Manchester: Manchester University Press, 2012), p.9.

[60] Ibid., p.36. The Royal College of Science in Ireland was previously known as the Museum of Irish Industry.

its doors to women, the KQCPI crucially gave those who had already gained their M.Ds abroad the opportunity to become fully registered; between 1877 and 1887, the college licensed 47 women.[61] Comparatively, only three women graduated from the LSMW during the same period, which reflects the fact that students who completed their studies at the school represented a 'second wave' of medical women.[62] Student numbers at the LSMW dramatically increased from 1890 onwards, with 87 women graduating from the school in the final decade of the nineteenth century.[63] Having campaigned tirelessly towards the opening of medical schools and licensing bodies to women, Jex-Blake was acutely aware that, unlike many of her colleagues, she was yet to be fully qualified. Faced with the possibility that younger women, who had not dedicated years of their life to the movement, might register before her, she finally submitted to completing her degree abroad. In January 1877, Jex-Blake graduated from the University of Bern with her M.D, and four months later, she passed the KQCPI examinations, becoming the fifth woman to be licensed by the college.[64] The following year, the University of London finally agreed to admit women to all of its degrees, including medicine, declaring that 'it was only fair and reasonable that women should be admitted to examinations on the same terms as men'.[65]

Whilst the LSMW had overcome the issue of professional recognition and affiliation, the fact still remained that the school was unable to provide its students with the requisite hospital experience. After months of perseverance, the Royal Free Hospital (RFH) finally agreed to accept students from the LSMW, on the proviso that they would receive a guaranteed fee of no less than £400 per annum, as well as an additional fee of 300 guineas to cover the costs of any subscriptions lost as a result of the female students being admitted.[66] In October 1877, three years after it had been founded, the LSMW opened for the winter session with an impressive intake of 34 students.[67] In a thinly veiled reference to the difficulties she had experienced with Jex-Blake, Garrett Anderson's inaugural address emphasises the importance of professional solidarity:

> You should bear in mind that from this day forth, you are not mere isolated units in society, you are not merely women who desire to help the best interests of all women, but that you are members of a noble profession, and that you have the

[61] Ibid., p.11.

[62] Ibid.

[63] Ibid.

[64] Todd, *The Life of Sophia Jex-Blake*, p.440.

[65] Manton, *Elizabeth Garrett Anderson*, p.255.

[66] Ibid., p.252.

[67] Ibid., p.254.

> responsibility which is linked with comradeship towards every other medical person, man or woman. Let us strive to enter the common life, let us free ourselves from petty jealousies, let us […] promote the highest aims and interests of the profession, to purge it of its flaws and to add to its honour.[68]

Victory had, at last, been won; however, Garrett Anderson was painfully aware that female practitioners would face an ongoing battle for acceptance. Though women were qualifying in increasing numbers, they remained an isolated minority, lacking the 'respect, support, and professional council' necessary to elevate their precarious positions and to improve their knowledge and expertise. As Chapter One examines, the ARMW played a central role in securing both recognition and respect for medical women within the 'noble profession'.

Historiography

The work of the ARMW and the MWF is by no means absent from the historical record, but no comprehensive history of the organisation, which acknowledges the transition from Association to Federation, currently exists.[69] Rather than being two unrelated entities, the ARMW and the MWF are intimately linked, and a history of one organisation cannot be told without including the history of the other. Building upon existing research, this thesis charts the evolution of the organisation alongside the changing role of female practitioners between 1879 and 1948. Garrett Anderson and Jex-Blake's hard-won victories over the medical establishment dominate accounts of the first generation of medical women; E. Moberly Bell, Jo Manton, and Catriona Blake all outline the careers of these two pioneering women, but fail to look beyond their successes, or to consider the

[68] Elizabeth Garrett Anderson, *Inaugural Address* (London: H.K Lewis, 1877), pp.20-21. Emphasis my own.

[69] For limited overviews of the MWF, see: Mary Ann Elston, 'Women Doctors in the British Health Services: a Sociological Study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986; Peter Mohr, 'Women-run hospitals in Britain: A historical survey focusing on Dr Catherine Chisholm (1878-1952) and The Manchester Babies' Hospital (Duchess of York Hospital)', unpublished doctoral thesis, University of Manchester, 1995; Lesley A. Hall, 'Eighty years of the Medical Women's Federation: The MWF Archive in the Contemporary Medical Archives Centre, Wellcome Institute for the History of Medicine', *Medical Woman*, 2 (Summer 1997), 6-9; Kaarin Leigh Michaelson, 'Becoming "Medical Women": British Female Physicians and the Politics of Professionalism, 1860-1933', unpublished doctoral thesis, University of California, Berkeley, 2003; David Doughan and Peter Gordon (eds), *Dictionary of British Women's Organisations, 1825-1960* (London: Routledge, 2014).

varying experiences of their wider circle of colleagues.[70] Shedding new light on the early history of the MWF allows for a more complete understanding of the figure of the woman doctor, including the difficulties she faced within the profession, and her changing position in wider society. The influence and status of medical women evolved greatly over time, but so too did their professional organisation. Until now, research which has examined the work undertaken by the MWF has done so in isolation, overlooking the complexities concealed behind the Federation's public façade. Through its chronological structure, this thesis provides an 'insiders' history of the Federation, charting the successes, failures, and change experienced by the organisation during a defining period in medical history.

Historical understandings of the changing role of the woman doctor, and the issues which she inevitably encountered within the male-dominated field, were transformed following the doctoral research conducted by Mary Ann Elston in 1986.[71] Through a comprehensive sociological study, Elston charts the careers of female practitioners beyond the nineteenth century, outlining the trajectory of their medical education and professional opportunities between 1860 and 1970.[72] Elston calculates the numbers of women that qualified to practice medicine during this period, arguing that the influence and impact of this 'invisible minority' has long been underestimated.[73] By examining the professional barriers which medical women faced on account of their sex, Elston traces how career strategies evolved over successive generations.[74] Material from the MWF archive is at the forefront of Elston's research; however, the precise role played by the Federation in the

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[70] E. Moberley Bell, *Storming the Citadel: The Rise of the Woman Doctor* (London: Constable & Co, 1953); Jo Manton, *Elizabeth Garrett Anderson* (London: Butler and Tanner, 1965); Catriona Blake, *The Charge of the Parasols: Women's Entry into the Medical Profession* (London: Women's Press, 1990). For Blackwell, see: Jennifer Brosnan, 'The contribution of Elizabeth Blackwell to Sex Education, 1849-1910', unpublished doctoral thesis, University of Leicester, 2017.

[71] Mary Ann Elston, 'Women Doctors in the British Health Services: a sociological study of their careers and opportunities', unpublished doctoral thesis, University of Leeds, 1986.

[72] For more on the history of medical education, see: Vivian Nutton and Roy Porter (eds), *The History of Medical Education in Britain* (Amsterdam: Rodopi, 1995); Thomas Neville Bonner, *Becoming a Physician Medical Education in Britain, France, Germany, and the United States, 1750-1945* (Baltimore: Johns Hopkins University Press, 2000); Roger French and Andrew Andrew Weir (eds), *British Medicine in an Age of Reform* (London: Taylor & Francis, 2005); Carol Dyhouse, *Students: A Gendered History* (London: Taylor & Francis, 2006); Christopher Lawrence, *Medicine in the Making of Modern Britain, 1700-1920* (London: Taylor & Francis, 2006); M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007); Michael Whitfield, *Academic General Practice in the UK Medical Schools, 1948-2000: A Short History* (Edinburgh: Edinburgh University Press, 2011).

[73] Elston, 'Women Doctors in the British Health Services', p.1.

[74] Ibid., p.5.

careers of medical women remains, for the most part, on the periphery of her discussion.[75] More recently, Claire Brock has offered new perspectives on the experiences of British women surgeons and their patients between 1860 and 1918.[76] Brock's investigation marks a significant contribution to the history of women in medicine, charting how female practitioners became surgeons, what sort of surgery they performed, and how they were viewed by both their male and female colleagues.[77] Brock's case studies of the New Hospital for Women (NHW) and the Royal Free Hospital (RFH) illuminate the experiences of medical women at varying stages of their careers against a backdrop of rapidly changing social and political circumstances.[78] Whilst many of the women doctors who feature in *British Women Surgeons* were active members of the ARMW and the MWF, the organisation similarly does not fall within the scope of Brock's enquiry. This thesis builds upon the solid foundation laid by Elston and Brock, extending the history of women in medicine to include a critical examination of their professional organisation. Through a close analysis of minute books, the MWF's own publications, and personal correspondence, it scrutinises the Federation's early ambitions, considering the extent to which the organisation evolved to meet the changing needs of its membership.

In addition to the history of medicine and gender, this thesis engages with a number of key themes, including: politics; class; professionalism; war; and women's health. Understandings of how professional women engaged with political matters during the early twentieth century have been informed by the work of Alison Oram, Elizabeth Crawford, Julia Bush, and Jennian F. Geddes, among others.[79] Oram examines how female teachers responded to feminist politics between 1900 and 1939, arguing that as an occupational group, they rapidly developed a strong

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[75] Ibid., p.158.

[76] Claire Brock, *British Women Surgeons and their Patients, 1860–1918* (Cambridge: Cambridge University Press, 2017).

[77] Ibid.

[78] For more on the RFH, see: Lynne A. Amidon, *An Illustrated History of the Royal Free Hospital* (London: The Special Trustees for the Royal Free Hospital, 1996); Lynsey T. Cullen, 'Patient Records of the Royal Free Hospital, 1902–1912', unpublished doctoral thesis, Oxford Brookes University, 2011.

[79] Alison Oram, *Women Teachers and Feminist Politics, 1900-39* (Manchester: Manchester University Press, 1996); Elizabeth Crawford, *The Women's Suffrage Movement: A Reference Guide, 1866-1928* (London: Routledge, 1999); Julia Bush, *Women Against the Vote Female Anti-Suffragism in Britain* (Oxford: Oxford University Press, 2007); Jennian F. Geddes, 'Deeds and Words in the Suffrage Military Hospital in Endell Street', *Medical History*, 51 (January 2007), 79-98; Jennian F. Geddes, 'Culpable Complicity: the Medical Profession and the Forcible Feeding of Suffragettes, 1909-14', *Women's History Review*, 17 (2008), 79-94; Jennian F. Geddes, 'The Doctors' Dilemma: Medical Women and the British Suffrage Movement', *Women's History Review*, 18 (2009), 203-218.

political consciousness which they sustained throughout the period.[80] Female teachers held varying and conflicting ideas of what professionalism constituted, and their engagement with political matters created a great deal of antagonism within the mixed-sex National Union of Teacher's.[81] As Geddes' research explores, such findings can similarly be applied to women doctors and their professional organisation.[82] Medical women supported the suffrage movement both privately and publicly; however, politics and the ideals of professionalism were often uncomfortable bedfellows.[83] Whilst Geddes examines the activities of the London branch of the ARMW, she does not place the Association's response within the wider context of the organisation's early history. Drawing upon new material found in the MWF archive, this thesis provides a more wide-ranging account of the organisation's engagement with political matters. Furthermore, it traverses the Federation's journey of uncertainty and self-censorship by considering the ways in which the organisation's actions were influenced by the burden of legacy left behind by the first generation of medical women.

Research into the work undertaken by female practitioners during the First World War is an area of women's history that has evolved exponentially over the past two decades, with gaps in knowledge being addressed by Leah Leneman, Jennian Geddes, Ian Whitehead, Claire Brock, and Wendy Moore, among others.[84] The heroic activities of all-female medical units such as the Women's Hospital Corps (WHC) and the Scottish Women's Hospitals (SWH) dominate discussions of this period, with Brock offering the only comprehensive study of medical women's surgical experiences both on the home front and overseas.[85] This thesis sheds new light on the

[80] Oram, *Women Teachers and Feminist Politics, 1900-39*, p.8.

[81] Ibid., p.117.

[82] Jennian F. Geddes, 'The Doctors' Dilemma', 203.

[83] Ibid.

[84] Leah Leneman, 'Medical Women at War, 1914-1918', *Medical History*, 38 (April 1994); Jennian Geddes, 'Deeds *and* Words in the Suffrage Military Hospital in Endell Street', *Medical History*, 51 (January 2007), 79-98; Ian Whitehead, *Doctors in the Great War* (Barnsley: Pen & Sword, 2013); Claire Brock, *British Women Surgeons and their Patents, 1860-1918* (Cambridge: Cambridge University Press, 2017); Wendy Moore, *Endell Street: The Trailblazing Women who Ran World War One's Most Remarkable Military Hospital* (London: Atlantic Books, 2020).

[85] Brock, *British Women Surgeons*, pp.181-285. For discussions of the WHC, see: Flora Murray, *Women as Army Surgeons*, (London: Hodder & Stoughton, 1920); Leah Leneman, 'Medical Women at War, 1914-1918', *Medical History*, 38 (April 1994), 160-177; Jennian F. Geddes, 'The Doctors' Dilemma: Medical Women and the British Suffrage Movement', *Women's History Review*, 18 (2009), 203-218; Jennian F. Geddes, 'Deeds *and* Words in the Suffrage Military Hospital in Endell Street', *Medical History*, 51 (January 2007), 79-98; Jennian F. Geddes, 'The Women's Hospital Corps: Forgotten Surgeons of the First World War', *Journal of Medical Biography*, 14 (2006), 109-117; Wendy Moore, *Endell Street: The*

work undertaken by medical women during the First World War through the case studies of Muriel Lloyd, the Women's Imperial Service League (WISL), and Malta.[86] By examining original material, it offers new perspectives on the ways in which the ARMW responded to the conflict, and how women doctors utilised their increased professional freedoms to prove themselves as capable practitioners. The First World War was a crucial turning point in the history of the ARMW, yet the Association's activities pre-1917 have been routinely overlooked, and a number of misconceptions relating to the motivations behind the formation of the MWF continue to proliferate. For example, Peter Mohr, Kaarin Leigh Michealson, and Helen Jones incorrectly assert that the Federation was formed in direct response to the mistreatment of medical women working under the War Office, when in fact plans for uniting the regional Associations had been discussed years before this.[87] This thesis corrects such inaccuracies by analysing the ARMW's evolution into the MWF. In doing so, it fills an important gap in knowledge, examining the organisation's flawed ambitions to regenerate and proliferate within the medical profession.

In spite of there being many historical accounts of first generation medical women, the experiences of their colleagues beyond 1918 have received comparatively less attention. This is because the interwar years are often viewed as a fallow period for women doctors; after the War, medical schools closed their doors to female students, and the careers and opportunities available to medical women suffered as a result of ingrained prejudices.[88] Brock examines the experiences of women surgeons during the interwar years, shedding new light on the surgical careers of Louise McIlroy, Louisa Martindale, and Maud Forrester-Brown.[89] Brock argues that the interwar years

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Trailblazing Women who Ran World War One's Most Remarkable Military Hospital (London: Atlantic Books, 2020). For the SWH, see: Lady Frances Balfour, *Dr. Elsie Inglis* (New York: G H. Duran, 1919); Eva McLaren, *A History of the Scottish Women's Hospitals* (London: Hodder and Stoughton, 1919); Eileen Crofton, *Angels of Mercy: A Women's Hospital on the Western Front 1914-1918* (Edinburgh: Birlinn, 2013); Marlène Cornelis, "'My dears, if you are successful over this work, you will have carried women's profession forward a hundred years:" The Case of the Scottish Women's Hospital for Foreign Service', unpublished master's thesis, University of Glasgow, 2018; Natasha Stoyce, 'Theatres of War: The Experiences of the Serbian Unit of the Scottish Women's Hospitals during the Great War', unpublished doctoral thesis, University of Leicester, 2021.

[86] For more on the experiences of Dr Isabella Stenhouse in Malta, see: Katrina Kirkwood, *The Mystery of Isabella and the String of Beads* (Norwich: Loke Press, 2016).

[87] Peter Mohr, 'Women-run Hospitals in Britain', p.115; Kaarin Leigh Michaelson, 'Becoming "Medical Women"', p.39.

[88] For more, see Elston (1986).

[89] Claire Brock, 'Women in Surgery After the Great War', in *The Palgrave Handbook of Women and Science since 1660*, ed. by Claire G. Jones, Alison E. Martin, and Alexis Wolf (Basingstoke: Palgrave Macmillan, 2022), 593-610.

marked an important period in history for women surgeons, who strengthened their position as specialists by learning from the mistakes of the past and pushing forwards towards the future.[90] All three women were active members of the MWF; however the Federation itself is not relevant to the focus of Brock's investigation. This thesis builds upon Brock's investigation by examining the interwar activities of the Federation and its members through the lens of three key themes: resistance, recovery, and reform. The various professional barriers which medical women faced during the 1920s and 30s, and the effectiveness of the Federation's response to these issues, has similarly received limited attention.[91] In *The Evolution of British General Practice*, Anne Digby assesses the training, careers, and income of medical women during the interwar years.[92] Digby outlines the difficulties faced by female practitioners wanting to set up their own private practices, but only briefly mentions the role of the MWF Loan fund in assisting medical women starting out in general practice.[93] By investigating the MWF's response to issues such an unequal pay and marriage bars, and by undertaking a quantitative analysis of the Federation's minute books, this thesis reveals the extent of the organisation's efforts to assist the recovery of women doctors' careers in the immediate post-war years.

Other studies which examine the work undertaken by medical women during the interwar years have primarily focused on the theme of women's health. Research which analyses the role played by female practitioners in transforming social and medical understandings of menstruation, the menopause, and birth control has grown considerably in recent years, with notable contributions being made by Julie-Marie Strange, Barbara Brooks, Lesley A. Hall, and Caroline Rusterholz.[94] Strange examines the role played by the MWF in challenging medical narratives of

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[90] Ibid.

[91] Elston (1986) offers a brief discussion of the Federation's response to the reintroduction of marriage bars.

[92] Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999).

[93] Ibid., p.160.

[94] For women doctors and menstruation, see: Julie-Marie Strange, 'Menstrual Fictions: Languages of Medicine and Menstruation, c. 1850–1930', *Women's History Review*, 3 (2000), 607-628; Julie-Marie Strange, 'The Assault on Ignorance: Teaching Menstrual Etiquette in England, c.1920s to 1960s', *Social History of Medicine*, 14 (2001), 247-265; Julie-Marie Strange, 'In Full Possession of Her Powers: Researching and Rethinking Menopause in early Twentieth-century England and Scotland', *Social History of Medicine*, 25 (2012), 685-700; Barbara Brookes, '"The Glands of Destiny": Hygiene, Hormones, and English Women Doctors in the First half of the 20th century', *Canadian Bulletin of Medical History*, 23 (2006), 49-67. For women doctors and birth control, see: Lesley A. Hall, 'A Suitable Job for a Woman: Women Doctors and Birth Control to the Inception of the NHS', in *Women and Modern Medicine*, ed. by Anne Hardy and Lawrence Conrad (Amsterdam: Rodopi, 2001), pp.127-148; Caroline Rusterholz, *Women's Medicine: Sex, Family Planning and British Female Doctors in Transnational Perspective, 1920–70* (Manchester: Manchester University Press, 2021).

menstruation and the menopause, arguing that the organisation played an important role in changing perspectives of reproductive health by publishing qualitative research that foregrounded the experiences of healthy women.[95] Whilst Strange investigates the MWF's public influence in menstrual education, and assesses the Federation's influential menopause survey, she does not delve behind the organisation's public façade to consider the tensions that existed between senior members of the Federation, and between regional Associations.[96] Similarly, Lesley A. Hall analyses how medical women interacted with the issue of birth control during the 1920s and 30s, outlining the opinions expressed by senior members of the MWF.[97] Though Hall touches upon the work of the Federation's Birth Control Committee, the intricacies of how this controversial subject was debated behind closed doors, and the distinct views held by regional Associations, falls outside the scope of her enquiry.[98] This thesis examines the challenging dynamics at play within the MWF, offering new insights into the organisation's public and private engagement with issues relating to women's health.

There also exists a conspicuous gap in knowledge regarding the roles undertaken by British medical women between 1939 and 1945. Elston chooses to only provide an outline of this period in an epilogue to her penultimate thesis chapter, arguing that the Second World War had a 'relatively insignificant' effect on the careers of women doctors.[99] In *Women Doctors in War*, Judith Bellafaire and Mercedes Herrera Graf trace the roles played by American medical women in conflicts between 1861 and 2001.[100] They analyse the experiences of 75 women doctors employed by the United States Army in the Second World War, concluding that their work did little to influence the Medical Department's opinion of female practitioners.[101] Though their research highlights the wartime efforts of medical women in the United States, Bellafaire and Graf do not

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For women doctors and eugenics debates, see: Greta Jones, 'Women and Eugenics in Britain: The case of Mary Scharlieb, Elizabeth Sloan Chesser, and Stella Browne', *Annals of Science*, 52 (1995), 481-502; Lesley A. Hall, 'A Suitable Job for a Woman: Women Doctors and Birth Control to the Inception of the NHS', in *Women and Modern Medicine*, ed. by Anne Hardy and Lawrence Conrad (Amsterdam: Rodopi, 2001), pp.127-148; Claire Debenham, *Marie Stopes' Sexual Revolution and the Birth Control Movement* (London: Palgrave Macmillan, 2018).

[95] Strange, 'Menstrual Fictions', p.623; Strange, 'In Full Possession of Her Powers', p.687.

[96] Strange, 'Menstrual Fictions'; Strange, 'In Full Possession of Her Powers'.

[97] Lesley A. Hall, 'A Suitable Job for a Woman', p.137.

[98] Ibid.

[99] Elston, 'Women Doctors in the British Health Services', p.359.

[100] Judith Bellafaire and Mercedes Herrera Graf, *Women Doctors in War* (College Station: Texas A&M University Press, 2009).

[101] Ibid., p.95.

make any comparisons with the work undertaken by British women doctors. The plethora of research that explores women's work during World War Two has, thus far, overlooked the sheer variety of roles which medical women inhabited on the home front.[102] Furthermore, the overseas experiences of British women doctors have received limited historical attention. One exception is Bernice Archer, who offers a brief examination of the experiences of British medical women interned by the Japanese in the Far East.[103] Drawing on a rich collection of sources, including oral testimonies and articles published in the MWF *Journal,* this thesis makes a significant contribution to the history of medicine by shedding new light on the personal and professional sacrifices made by women doctors during the Second World War. Through an analysis of the Federation's correspondence with the War Office, and the verbatim minutes of the War Services Committee, it offers novel insights into how the organisation attempted to re-establish its authority within the profession. Furthermore, it considers how the MWF prioritised the emotional wellbeing of its members during a period of widespread risk, uncertainty, and change.

Finally, historians have, until now, failed to consider how medical women engaged with the formation of the NHS post-1945. Elston dedicates a chapter to the careers of women doctors in the NHS between 1948 and 1977, but does not consider how female practitioners initially reacted to the proposed plans.[104] Similarly, in *The National Health Service, a Political History*, Charles Webster outlines the objections of the BMA to the new state medical service, but does not scrutinise the stance taken by the MWF or individual medical women.[105] The Afterword of this thesis offers a brief exploration of how the organisation ultimately failed to advocate for the rights and interests of its members against a backdrop of unprecedented medical, political, and social reform.

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[102] For example, see: E. Burton, *What of the Women? A Study of Women in Wartime* (London: Frederick Muller, 1941); Harold L. Smith, *Britain in the Second World War A Social History* (Manchester: Manchester University Press, 1996); Mark Donnelley, *Britain in the Second World War* (London: Routledge, 1999); Carol Harris, *Women at War 1939–1945: The Home Front* (Stroud: Sutton Publishing, 2000); Gail Braybon and Penny Summerfield, Out of the *Cage: Women's Experiences in two World Wars* (London: Routledge, 2013); Penny Summerfield, *Women Workers in the Second World War* (London: Taylor & Francis, 2013).

[103] Bernice Archer, 'The Women of Stanley: Internment in Hong Kong 1942–45', *Women's History Review*, 5 (1996); Bernice Archer, *The Internment of Western Civilians under the Japanese, 1941-1945, A Patchwork of Internment* (London: Routledge, 2004).

[104] Elston, 'Women Doctors in the British Health Services', p.361.

[105] Charles Webster, *The National Health Service, a Political History* (Oxford: Oxford University Press, 2002).

Methodology

As previously outlined, the period of investigation for this thesis is from the founding of the ARMW in 1879, to the formation of the NHS in 1948. The decision to limit the scope of this project to these dates was made due to the sheer volume of source material which exists relating to the MWF. The formation of the NHS was a pivotal moment in the history of the medical profession in this country, and thus presented an ideal stopping point. Due to the geographical location and focus of the MWF, this thesis primarily focuses on medical women who qualified and worked in the United Kingdom. The chapters are arranged chronologically, rather than thematically, in order to assess the ongoing evolution of the MWF as an organisation, and to give a detailed picture of the issues which the Federation faced at different points in history. This thesis predominantly makes use of the archives of the MWF, which are held at the Wellcome Library, London.[106] This extensive collection spans from 1879 to 2001, and consists of hand-written minute books, printed newsletters and journals, and other miscellaneous ephemera.[107] Copies of a large proportion of the documents held within the MWF archive are also kept at the offices of the Federation in Tavistock Square. There is a small amount of material relating to the MWF, and its local Associations, in archives outside of London. For example, the Manchester Central Library houses a Federation scrapbook which includes material from 1914 to 1970.[108] Similarly, material relating to the Liverpool and Yorkshire Associations can be found at the Liverpool Medical Institute and the Borthwick Institute of Archives.[109] Details of the careers of medical women featured in this thesis were taken from multiple sources, such as the U.K and Ireland Medical Directory, British Medical Register, and obituaries published in the *BMJ*, MWF *Newsletter* (1919-1934), MWF *Quarterly Review* (1934-1946), and MWF *Journal* (1947-1973).

Through a close reading of private papers, alongside other official records such as minute books, this thesis employs a collective biographical perspective.[110] Barbara Caine argues that collective biography is best conceived as a 'continuum extending from individual studies which are grouped together to make a collective whole, to those works in which the primary subject is a

[106] Archives of the Medical Women's Federation, SA/MWF, Wellcome Library, London.

[107] Ibid.

[108] Medical Women's Federation Scrapbook, GB124.Q217, Manchester Central Library.

[109] Papers of the Medical Women's Federation (Liverpool Branch), GB 1174 MWF, Liverpool Medical Institute; Yorkshire Association of Medical Women Archive, YAMW, Borthwick Institute for Archives, University of York.

[110] For more on collective biography, see: K. Cowman, 'Collective Biography', in *Research Methods for History*, ed. by L. Faire and S. Gunn (Edinburgh: Edinburgh University Press, 2011), pp.83-100.

group of people, and which focus on the interactions and shared experiences of its members'.[111] This thesis analyses a number of individual case studies in order to ground its examination of the MWF within a wider historical and social context. In doing so, it relies heavily on the use of anecdotal evidence. Women's lives are notoriously difficult to trace, and the fragments scattered throughout this thesis allow for a more meaningful picture to be formed.[112]

In Chapter One, the short-lived careers of Eliza Frikart and Annie Reay Barker are used to examine the internal dynamics of the Association, as well as the pressures faced by the first women who qualified to practice medicine. In Chapter Two, Muriel Lloyd's correspondence provides insights into the experiences of medical women on the home front, as well as their interactions with colleagues serving overseas. Similarly, in Chapter Three, the relationship between Minnie Madgshon and the MWF sheds new light on the shared experiences of medical women facing professional inequalities during the interwar years. Whilst the primary focus of this study is the early history of the Federation itself, collective biography allows for an enhanced understanding of the complex connections and interactions that exist within established networks and groups. As Lawrence Stone has noted, collective biography naturally lends itself to prosopography – the investigation of the common background characteristics of a group of actors in history by means of a collective study of their lives.[113] This thesis draws upon elements of prosopography, investigating the background, education, careers, activities and ideals of individual medical women in order to probe deeper into the internal dynamics of the MWF and the shared connections and interests of its members. Whilst this thesis does not constitute a rigorous database of British women doctors, biographical details are present throughout, allowing for correlations to be made. By examining the individual alongside the collective, it offers a richer understanding of the role played by the Federation in the professional lives of medical women during this period.

As outlined above, this thesis relies heavily on the official written records of the Federation. As with any historical sources, it was crucial that the MWF's minute books were read with an acknowledgment of the context in which they were written, and that the viewpoints of their creators were considered. Such records provide only a partial, censored account of what was discussed at meetings. Where feasible, record linkage work has been undertaken to examine their

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[111] Barbara Caine, *Biography and History* (Basingstoke: Palgrave Macmillan, 2010), p. 58.

[112] For example, see: Ann D Gordon, Mari Jo Buhle, and Nancy Schrom Dye, 'The Problem of Women's History', in *Liberating Women's History: Theoretical and Critical Essays*, ed. by Berenice A. Carroll (Champaign: University of Illinois Press, 1976), pp.75-92.

[113] Lawrence Stone, 'Prosopography', *Daedalus*, 100 (1971), 46-79 (p.46).

representative contexts, with sources such as private correspondence, personal diaries, articles published in the medical and lay press, and public health records being employed. In the case of the first generation of medical women who qualified in the late nineteenth century, this posed a unique challenge. Many of the founding members of the Federation eschewed all forms of publicity, and surviving correspondence is sparse.[114] In order to overcome this issue, this thesis utilises a number of other sources, such as the UK and Ireland Medical Directory, British Medical Register, and sanatorium case books. There are a number of items relevant to this thesis which have not survived the passing of time, including the minutes of ARMW meetings held between 1906 and 1915, and the records of the London Association of the MWF from 1917 onwards. In these cases, annual reports published by the Association, and the surviving minute books of the Federation, have been used to trace the organisation's activities during these periods. This thesis similarly engages in quantitative analysis of these sources by scrutinising membership numbers and the financial basis of the MWF's activities.

Both the ARMW and MWF were made up of numerous local Associations; for clarity, all references to the ARMW in Chapter One and Chapter Two refer to the central London Association. Furthermore, by 1939, there were 20 local Associations of the MWF.[115] This thesis does not undertake any substantial case studies of regional Associations due to the voluminous nature of the central MWF archive. As mentioned above, the records of the Liverpool Association (1909-1976) and the Yorkshire Association (1912-2003) have survived. It was not feasible to analyse these in any great depth; however, the minute books of both Associations were consulted in relation to some of the overarching themes discussed in this thesis. Unless otherwise indicated in the text, all references to the Federation refer to the organisation as a whole, presided over by the Executive Council (1916-1948), Executive Officers (1921-1925), and Executive Committee (1925-1948).

Chapter Outline

Chapter One charts the organisational activities of the ARMW between 1879 and 1913. Having been previously overlooked in historical accounts of women doctors in favour of its successor, the

[114] The autograph letter collection of Elizabeth Garrett Anderson is held at the Women's Library. Additional material is held at Suffolk Record Office.

[115] MWF Annual Report 1939, SA/MWF/B.1/21.

MWF, this chapter argues that the Association offers novel insights into the personal and professional lives of early women doctors. It analyses the importance of the ARMW as a professional organisation at a time when women were 'painfully' isolated within the male-dominated profession. Far from being a purely social endeavour, the Association sought to mirror itself on the British Medical Association (BMA), offering its members the opportunity to broaden their scientific knowledge by discussing complex cases. The tensions which existed within this group of pioneering medical women are then considered. Many women doctors struggled to meet the professional expectations set out for them by Garrett Anderson, the group's self-appointed leader. By shedding new light on the previously untold experiences of Eliza Frikart and Annie Reay Barker, this chapter scrutinises the complex pressures faced by women who were tasked with proving the capability and worth of their sex as practitioners. As increasing numbers of women entered the profession, debates relating to equal pay for equal work came to the fore. This chapter argues that the Association prioritised gaining the respect of the BMA over understanding the difficulties facing recent graduates. Tasked with tackling its first divisive issue on behalf of its membership, the ARMW misguidedly adopted a hard-line approach, ostracising women doctors who were forced by their personal circumstances to accept underpaid posts. Similarly, though the vast majority of medical women supported the enfranchisement of the female sex, the Association's public response to the suffrage movement was found to be lacking. Whilst affirming that the ARMW undoubtedly had its limitations, this chapter argues that the organisation played an important role in the professional lives of medical women during the late nineteenth and early twentieth centuries.

In Chapter Two, the ARMW's response to the outbreak of the First World War is considered. By examining the letters sent to the Association in late 1914, it charts the vital work carried out by medical women on the home front. Far from being surplus to requirements, women doctors proved to be essential in keeping the 'machine at home' going throughout the conflict. By examining the experiences of recent graduates such as Muriel Lloyd, this chapter rediscovers the complex challenges experienced by women doctors who were forced to remain on the home front whilst their friends and colleagues left to serve overseas. Having been told by the government that their services were not required on the frontline, many medical women chose to defy official orders, founding their own medical units and travelling across Europe. This chapter investigates the largely overlooked work of the Women's Imperial Service League (WISL) in Belgium and France, arguing that the professional courage and dedication displayed by the unit's medical staff proved beyond all doubt that women could withstand the extreme conditions of war. The valuable scientific work carried out by medical women in Malta is then discussed alongside an examination

of the unfavourable working conditions which medical women were expected to endure whilst working under the War Office. In February 1917, the ARMW was dissolved, making way for the MWF. Whilst the mistreatment of medical women working in the services undoubtedly influenced the formation of the new Federation, this chapter argues that it was not the primary impetus; contrary to popular belief, discussions surrounding the need for a new representative organisation took place before the War. Chapter Two concludes by evaluating the effectiveness of the MWF's campaign to secure rank, commission, and uniform for medical women, arguing that the new Federation made a number of errors in judgement during its first 18 months.

In Chapter Three, the work of the MWF during the interwar years is explored through three key themes: resistance, recovery, and reform. Following the end of the First World War, the issue of equal pay for equal work resurfaced once more as male doctors returned from the front, and unemployment rates continued to rise across the country. Having learnt from their previous mistakes, the MWF adopted a new strategy of resistance, choosing to support, rather than ostracise, its most vulnerable members. Working in collaboration with the BMA and individual women doctors, the Federation embarked on a relentless campaign for equality within the profession during this period. This chapter investigates the MWF's response to the marriage bars which similarly sought to exclude women from public health work, and considers the reasons why the Federation ultimately failed to resist the restrictions imposed by local authorities. Whilst the MWF focused a large majority of its time and attention to resisting the injustices faced by medical women, they also dedicated resources to facilitating the profession's recovery by broadening the opportunities available to members. This chapter assesses the impact of the Federation's loan fund on the careers of medical women in general practice, and considers the importance of the personal and professional support offered by the organisation to women doctors at all career stages. As scientific understandings of hormones improved during the 1920s and 30s, perceptions of menstruation and the menopause evolved. This chapter scrutinises the MWF's engagement with women's health research, and considers the role taken by individual female practitioners in advancing medical reform. By foregrounding the subjective experiences of women themselves, myths which pathologized the female sex were undermined. The Federation's response to the controversial subject of birth control is also explored. Whilst the MWF found themselves unable to publish an official position on the matter, local Association's privately expressed varying views on the use of modern contraceptive at meetings of the Executive Council. Chapter Three argues that these opinions were heavily influenced by the public health issues facing women and their families in local communities. Far from being supported by their professional organisation, medical

women were left to educate themselves on the complexities of birth control on behalf of their patients.

The final chapter of this thesis examines the work undertaken by the MWF during the Second World War. Having failed to secure full commissions for medical women in the army during the First World War, the Federation were anxious to ensure that the services of female practitioners were not overlooked for a second time. This chapter analyses the MWF's strategy for confronting the War Office during peacetime, arguing that the organisation were determined to pre-empt the government's dismissive tactics. In spite of their best efforts, the Federation were unable to successfully negotiate with those in power, finding themselves in a state of ignorance at the outbreak of war in September 1939. Excluded from all official communications, senior members of the MWF became increasingly desperate in their attempts to gather information, jeopardising the reputation of the organisation in the process. Though the Federation were locked in a fierce battle of wills with the War Office for the majority of the War, the organisation made significant efforts to support the needs of its membership. Local Association meetings and the *Quarterly Review* played a crucial role throughout the War, providing members with a platform to share their feelings during a time of extraordinary change and uncertainty.

By shedding new light on the work undertaken by female practitioners on the home front and overseas, Chapter Four makes an important contribution to the history of women in medicine. As had been the case two decades previously, medical women took on additional responsibilities as part of the war effort, working long hours with limited domestic help to ease the increased burden on civilian medical services. Indiscriminate bombing of the home front exposed women doctors to the brutal realities of war on an unprecedented scale; however, once these periods of intense activity had passed, medical women returned to the drudgery of routine medical practice. In comparison to the First World War, there were limited opportunities for women doctors to practice frontline medicine between 1939 and 1945. Those who did serve overseas with the RAMC and civilian relief organisations often found themselves with nothing to do, as military priorities were constantly changing. Many of the British medical women practising in the Far East were captured by the Japanese as prisoners. This chapter maintains that women doctors played a vital role in maintaining the health and morale of western civilians imprisoned in internment camps. Whilst the Second World War was not defined by the same heroic actions as the First World War, the contributions made by medical women both on the home front and overseas proved once again that female practitioners were eminently capable of assimilating themselves within the masculine military establishment. The Afterword of this thesis offers a brief

examination of the extent to which medical women, and their professional organisation, were involved in the formation of the NHS during the immediate post-war years.

Through an analysis of the MWF's early history, this thesis navigates the changing position of women in medicine during the late nineteenth and early twentieth centuries. It demonstrates that medical women continued to face social, institutional, and professional barriers throughout the course of their careers, never fully achieving true equality within the male-dominated field. It also reveals the Federation's failure to successfully confront and overcome these challenges, and examines how the organisation battled to remain relevant during this defining period in medical history. By offering novel insights into the internal dynamics of the MWF, and the professional and personal lives of its members, this thesis addresses many of the significant gaps in knowledge which exist within the history of medicine.

Chapter One

Advocates and Activists: The Association of Registered Medical Women (ARMW), 1879-1913

As the Introduction examined, the struggles of early medical women active during the late nineteenth century have received increasing historical attention over the last 50 years. Despite this, the professional body which many chose to pledge their allegiance to has yet to be fully explored, having been relegated to a mere footnote in history.[1] Founded in response to the British Medical Association's (BMA) refusal to admit medical women as members, the ARMW positioned itself in the vanguard of social and political change by championing issues which affected women doctors and their patients. Crucially, the ARMW provided medical women with the opportunity to share knowledge and expertise, facilitating the establishment of professional and social networks.[2] At a time when women doctors were precariously isolated within the medical profession, this served to combat their isolation, ensuring that their voices were heard, and that their interests were represented.[3]

This chapter argues that the ARMW is worthy of examination in its own right, as it played a fundamental role in the professional lives of first and second generation medical women. As the introduction to this thesis discussed, a history of the MWF is not complete without considering the activities of the Association which preceded it. This chapter lays the foundation, providing essential context with which to interrogate the professional interactions of early women doctors. By examining the short-lived careers of Eliza Frikart and Annie Reay Barker, two founding

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[1] For a brief overview of the ARMW in relation to the work of the MWF, see: Peter Mohr, 'Women-run Hospitals in Britain : A historical Survey focusing on Dr Catherine Chisholm (1878-1952) and The Manchester Babies' Hospital (Duchess of York Hospital)', unpublished doctoral thesis, University of Manchester, 1995; Kaarin Leigh Michaelson, 'Becoming "Medical Women": British Female Physicians and the Politics of Professionalism, 1860-1933' , unpublished doctoral thesis, University of California, Berkeley, 2003.

[2] For more on women and professional networks during the nineteenth century, see: Ellen S. More. 'The Blackwell Medical Society and the Professionalization of Women Physicians', *Bulletin of the History of Medicine,* 61 (December 1987), 603-28; Suzanne Le-May Sheffield, *Revealing New Worlds: Three Victorian Women Naturalists* (London: Routledge, 2001); Elizabeth Crawford, *Enterprising Women: The Garretts and their Circle* (London: Francis Boutle, 2002); Joanne Shattock, 'Professional Networking, Masculine and Feminine', *Victorian Periodicals Review*, 44 (2011), 128-140; Linda H. Peterson (ed), *The Cambridge Companion to Victorian Women's Writing* (Cambridge: Cambridge University Press, 2015); Jo Devereux, *The Making of Women Artists in Victorian England* (Jefferson: McFarland and Co., 2016).

[3] For more on gender and precarious professionals, see: Heidi Eggington and Zoë Thomas (eds), *Precarious Professionals* (London: University of London Press, 2021).

members of the ARMW, it challenges the assumption that the successes of prominent figures such as Garrett Anderson are representative of all early women doctors' experiences. Far from being a united community, this group of pioneers were often at odds with one another, with many proving to be unable or unwilling to live up to the professional expectations that were thrust upon them by the group's self-appointed leader. Secondly, this chapter scrutinises the limitations of the ARMW's social and political activism at the turn of the twentieth century; as the number of women on the Medical Register steadily rose, issues of equality in the workplace, and in society as a whole, came to the fore. Though the Association aggressively advocated for equal pay for women doctors, ostracising any members who refused to conform, its response to the issue of women's suffrage was comparatively conservative. This chapter concludes by considering the extent to which the ARMW achieved its founding aims during its first three decades.

Professional recognition

Whilst medical women had succeeded in placing their names on the British Medical Register by the late 1870s, the problem of professional recognition still remained. The BMA, founded in 1832, was the primary organisation which doctors joined once they were fully qualified.[4] Its object was the 'diffusion and increase of Medical Knowledge', and the 'Maintenance of the Honour and Respectability of the profession'.[5] In spite of the Association's aim to promote 'harmony and good feeling' within the 'liberal' profession, the question of the admission of women had long been a contentious issue.[6] Eight years after qualifying in 1865, Garrett Anderson applied for membership of her local branch of the BMA.[7] Being welcomed as members of the Association was an important hurdle for women doctors to overcome. Not only would it signify their final acceptance as a permanent feature within the field of medicine, but it would also attest to their ongoing commitment to upholding the profession's ideals. Reflecting on the early years of her mother's career, Louisa Garrett Anderson illustrates the significance of medical women gaining access to the BMA:

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[4] Peter Bartrip, *Themselves Writ Large: The British Medical Association, 1832-1966* (London: BMJ Publishing Group, 1996), p.5.

[5] Ibid.

[6] Ibid.

[7] Jo Manton, *Elizabeth Garrett Anderson* (London: Butler and Tanner, 1965), p.235.

> Membership of the British Medical Association would be of value to [medical women]. To be excluded [from the BMA] would be a stigma. At branch meetings doctors met on friendly terms; professional difficulties and experiences might be discussed; the papers on medical subjects were useful. In a sense, the Association was a trade union. It protected the rights and safeguarded the interests of medical practitioners, and it guided members in the observance of professional conduct. The ethics of the profession and its courtesies had to be learnt by young doctors and their best school was the Association.[8]

The Paddington branch of the BMA unanimously accepted Garrett Anderson's nomination, and she was duly elected as a member in February 1873.[9] Far from being kept secret, Garrett Anderson's election was printed in the *BMJ*, however, the majority of members remained unaware of the fact of her membership until 1875, when she read a paper on obstetrics at the annual meeting of the BMA in Edinburgh.[10]

Sir Robert Christison, whose antagonism towards medical women had been worsened by his interactions with Jex-Blake at the University of Edinburgh, utilised his position as president of the BMA to make his views on women doctors known.[11] A vote was called on the question of whether women should be permitted to be members of the Association. The results were both encouraging and frustrating in equal measure; 3072 members voted against the motion, whilst 1051 voted in favour.[12] Whilst Garrett Anderson's election to the Paddington branch of the BMA was begrudgingly declared to be legal, and therefore unable to be overturned, Frances Hoggan, the only other female member, was disenfranchised on account of her name not being on the Medical Register at the time of her admission.[13] At the annual meeting of the Association in 1878, Garrett Anderson gave a rousing speech on the importance of solidarity within the medical profession, arguing that the exclusion of women as members of the BMA went against the founding principles of the organisation: 'If the Association exists to promote medical science it ought to promote it generally and not partially […] women as well as men now being in the medical profession their interests should be cared for'.[14] Speaking a year after the Kings and Queens College of Physicians

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[8] Louisa Garrett Anderson, *Elizabeth Garrett Anderson* (London: Faber and Faber, 1939), p.251.

[9] Frederick J. Brown, 'Female Medical Education', *BMJ*, 1 (14th June 1873), 690-91 (p.691).

[10] Garrett Anderson, *Elizabeth Garrett Anderson*, p.257.

[11] Ibid.

[12] Ibid., p.256.

[13] Ibid.

[14] Ibid., p.261.

of Ireland (KQCPI) had opened its licensing examinations to women, Garrett Anderson was sure of the fact that the number of women on the Medical Register would continue to steadily increase year on year. It was futile of the BMA to continue to exclude women doctors; the tide of public opinion had started to turn. Many members present at the meeting agreed with Garrett Anderson's observations; however, when another vote was called on the motion of admitting female members, the result ultimately remained unchanged.[15]

Garrett Anderson thus found herself facing a similar dilemma to that which she had experienced with the Worshipful Society of Apothecaries (WSA) in 1865; she was the only medical woman on the 'inside', and the doors had been firmly shut behind her. As had been the case more than a decade before, an alternative strategy had to be employed; the issue of the professional recognition of medical women needed to be urgently addressed. The founding basis of Garrett Anderson's solution is briefly referred to in a letter from her sister-in-law, Mary Marshall, who was in the midst of completing her medical degree at the Universitié de Paris, to her Father, the Reverend Anderson:

> Elizth [sic] wishes me very much to remain [in London] over the 14th in order to be present at a large soirée which she gives to the medical women and to which she has invited many interesting people – my remaining for it depends on whether I can arrange to have an important meeting of our new 'Société des Femmes' put off from the 11th to the 18th.[16]

Marshall's letter suggests that Garrett Anderson was in the habit of playing host to her fellow medical women on a regular basis, going to the additional effort of inviting 'many interesting people' – possibly to speak on medical-related matters. Given that she was the first woman to qualify to practice medicine in Britain, Garrett Anderson may well have felt a sense of duty to those who came after her, creating informal professional networks to help those following in her footsteps. Whilst the exact nature of this gathering is unclear, it is reasonable to suggest that it was similarly an informal 'Société des Femmes', organised by Garrett Anderson as a temporary substitute for the BMA meetings which everyone except herself were excluded from attending. As she had asserted at the annual BMA meeting in Bath, the 'strength and vitality' of the movement

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[15] Tara Lamont, 'The Amazons Within': Women in the BMA 100 years Ago', *BMJ*, 2 (19th December 1992), 1529-32 (p.1531). Garrett Anderson remained the only female member of the BMA until 1892. She was later elected president of the East Anglian branch of the BMA in 1897.

[16] Letter from Mary Marshall to the Reverend Anderson, 2nd January 1879, Suffolk Record Office, Ipswich, HA436/1/4/8/2.

was unassailable – why then, should women doctors not take action, and form their own medical association?

The Association of Registered Medical Women (ARMW)

Four months after Garrett Anderson's soirée, a preliminary meeting of the 'Registered Medical Women of the United Kingdom' was held in London on the 6th May 1879.[17] The names of those who were present at this meeting are not recorded; however, it seems likely that at the very least, Garrett Anderson, who had previously organised these gatherings, and Eliza Walker Dunbar, who was tasked with writing the minutes, were in attendance. It was resolved that:

1. All Registered Medical Women be invited to attend a Meeting for reading of papers and discussion on Medical subjects to be held at the School of Medicine for Women 30 Henrietta St [sic] on the first Tuesday of May 1880 at 2.35 pm.
2. That a dinner be held on the evening of the day of the Medical Meeting or otherwise as may be arranged by the Hon Sec.
3. That the Hon Sec be required to send notices of Meeting and Dinner early in January to all Registered Medical Women and invite papers on Medical Subjects.
4. That Dr. E.W. Dunbar be appointed Hon Sec for 1880.[18]

Similarly to the BMA, one of the primary founding principles of the ARMW was to further medical knowledge through the 'reading of papers and discussion on medical subjects'.[19] Whilst the Association sought to encourage fellowship between women doctors, who were precariously isolated within the profession, it is important to note that the meeting and the dinner were considered to be two separate entities. Like the BMA, the ARMW wanted to be viewed as a legitimate scientific organisation, rather than a female social club. On the 4th May 1880, the first

[17] Association of Registered Medical Women Minute Book, Wellcome Library, London, SA/MWF/P/1/1. Further references will be given by date only.

[18] Ibid. Further abbreviations appear in the original.

[19] Following the establishment of regional branches of the ARMW in the early twentieth century, the founding branch of the Association became known as the London Association of Registered Medical Women. For the purposes of this chapter, the term 'ARMW' will be used to refer to this branch unless otherwise indicated in the text.

official meeting of the ARMW was held, as planned, in the library of the LSMW.[20] Those present were: Elizabeth Blackwell; Elizabeth Garrett Anderson; Sophia Jex-Blake; Louisa Atkins; Annie Reay Barker; Annie Clark; Mary Marshall; Matilda Chaplin-Ayrton; Eliza Frikart; and Eliza Walker Dunbar (Appendix 1).[21]

In a further display of tension between early medical women, Frances Hoggan, who had been the first woman to receive a medical degree from a European university in 1870, refused to be affiliated with the Association on the grounds that it did not permit those who were not yet registered to join as members.[22] Given that the Association was founded by medical women, for medical women, this exclusionary criteria is informative. The motivation behind this founding principle would have likely been due to the importance placed on mirroring the organisational values of the BMA. Above all else, women doctors wanted the ARMW to be taken seriously as a professional body. If those who were not yet qualified were permitted to be members, the formality of the meetings would be undermined, and the public image of the organisation would be compromised. Whilst each of the 10 women present at the meeting had gone through their own personal struggle to qualify, evidently the consensus was that those who had yet to place their name on the Medical Register had to earn their right to receive professional support from their colleagues. In future years students from the LSMW were often present at meetings, suggesting that whilst they could not officially become members of the Association, they were welcome to partake in the sharing of medical knowledge on an informal basis.

In recognition of her seniority, Blackwell was elected to preside over the meeting, becoming the ARMW's first president (Table 1.1). Future presidents were similarly chosen in order of their qualifying rank, which evidences the fact that medical women were expected to have an acute awareness of their place within the established hierarchy. If a member was absent from the annual meeting when it was their turn to be president, the next in line was elected instead.[23] Dunbar read a paper on 'Four cases of obstruction of the intestines', and it was resolved:

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[20] Meetings were held at the LSMW for a further six years, before the venue changed to the Medical Institute at the New Hospital for Women (NHW). Other venues for the annual meeting included hotels, and members' own homes.

[21] Michaelson (2003) incorrectly asserts that there were nine founding members of the Association, rather than 10, based on the fact that Matilda Chaplin-Ayrton did not attend the dinner following the medical meeting.

[22] Minutes of the Annual Meeting, 4th May 1880. Frances Hoggan (1843-1927) refused to be affiliated with the Association throughout her career. Hoggan gained her M.D from the University of Zurich three months before Garrett Anderson in 1870, but remained unable to secure her medical license until 1877.

[23] This happened in 1882, when Edith Pechey was elected ahead of Eliza Walker Dunbar.

1. That members should be invited in future by the Hon Sec [sic] to propose questions for discussion as well as papers on medical subjects.
2. By 8 to 2 (10 present) that the limiting [of] invitations to annual meeting and dinner to registered medical women of the United Kingdom should for the present continue to stand.
3. Mrs Marshall M.D be elected Hon Sec for 1880.
4. That dinner in 1881 be provided at a charge of 8/- per head with 2/- extra for wine.
5. By 9 to 1 that a second dinner to guests should not be given in 1881.[24]

Given the fact that women had been qualified to practice medicine in Britain for a relatively short amount of time, it is perhaps understandable that the majority of members were not in favour of opening the Association to either unqualified women, or to women doctors practising medicine in other countries. For the time being, the newly formed ARMW needed to focus its attentions on pressing issues affecting those who were registered in the United Kingdom.[25] Following the medical meeting, the women reconvened for an elaborate dinner at the 'Trafalgar Greenwiche [sic]'.[26] After an evening of excess, which included 14 different menu items, it was unanimously resolved that: 'In future the annual dinner should not take place on the evening of the day of the medical meeting but on some other evening to be fixed by the Hon Sec [sic]'.[27]

[24] Minutes of the Annual Meeting, 4th May 1880. Further abbreviations appear in the original.

[25] Three foreign members of the Association are listed in the 1883 meeting minutes; however, it is likely that these were British women doctors who were practising overseas.

[26] Minutes of the Annual Meeting, 4th May 1880.

[27] The menu consisted of: salmon souchet (poached with stock and roots); fried savouries; crab omelettes; black pudding; Italian style red mullet; Indian style salmon cutlets; whitebait; lamb chops with cucumber; veal sweetbreads with spinach; roast ducklings; maraschino jelly; French patisserie; wine jelly; and iced pudding.

Date	President	Date	President
1879	-	1898	Julia Cock
1880	Elizabeth Blackwell	1899	Julia Cock
1881	Elizabeth Garrett Anderson	1900	Mary Scharlieb
1882	Edith Pechey	1901	Mary Scharlieb
1883	Louisa Atkins	1902	Florence Nightingale Boyd
1884	Elizabeth Dunbar	1903	Florence Nightingale Boyd
1885	Annie Reay Barker	1904	Helen Webb
1886	Louisa Atkins	1905	Helen Webb
1887	Edith Pechey	1906	Louisa Aldrich-Blake
1888	Annie Reay Barker	1907	Louisa Aldrich-Blake
1889	Annie E. Clark	1908	May Thorne
1890	Mary Marshall	1909	May Thorne
1891	Mary Marshall*	1910	May Thorne
1892	Mary Marshall	1911	Constance Long
1893	Mary Emily Dowson	1912	Frances Ivens
1894	Florence Nightingale Boyd	1913	Jane Walker
1895	Julia Cock	1914	Jane Walker
1896	Elizabeth Garrett Anderson	1915	Jane Walker
1897	Elizabeth Garrett Anderson	1916	Jane Walker

Table 1.1 Presidents of the Association of Registered Medical Women (ARMW), 1879-1916.[28]

In 1881, the Association's resolve to ensure that medical women were successfully integrated within the profession was tested when the International Medical Congress, which was due to be held in London that year, refused to permit women doctors to take part, in spite of their qualifications and experience. One of the first resolutions of the newly formed ARMW was to draft a letter to the congress' Executive Committee in protest at their decision. Echoing the sentiments expressed by Garrett Anderson at the BMA meeting in 1878, it was argued that: 'As there are now the names of 25 women on the English medical register, all of whom are practicing medicine […] the interest of medical science will be best served by excluding no one on the ground of sex'.[29] It was agreed that the letter should be 'printed on a sheet of paper in parallel columns of

[28] Presidents were not always explicitly stated in the ARMW minute book, however, it was customary for newly elected presidents to sign the previous year's meeting minutes and accounts. The only discrepancy with this practice appears in 1891. Whilst Helen Webb (1854-1926) signed the minutes for 1890, Jane Walker (1859-1938) was recorded as being in the chair at the meeting. Mary Marshall was elected president in 1890 and 1892, and it was previously unheard of for a president's leadership to be interrupted. Given the fact that Webb, Walker, and Marshall were all present at the annual meeting in 1891, it seems most likely that Marshall continued her presidency, delegating the responsibility of signing the previous year's minutes to Webb. Post 1907, meeting minutes ceased to be recorded in the same minute book. In this case, presidents were confirmed through the yearly reports or by letters sent to the *Times* from the Association.

[29] Minutes of the Annual Meeting, 3rd May 1881.

English, French, and German' and that 'as many signatures of duly qualified medical women should be obtained as possible'.[30] In spite of the Association's best efforts, the committee refused to change their stance. Faced with their exclusion from the international gathering, the ARMW employed a strategy of soft diplomacy, organising their own garden party for the congress delegates at the LSMW. Each member was assigned to pay for a different aspect of the gathering, with a total recorded expenditure of '£80.5.6'.[31] Over 600 visitors attended, suggesting that international opinion on women doctors was far from negative. The garden was decorated with international flags, a band played, and the guests 'appeared much to enjoy themselves', making the day a resounding success.[32]

The following year, a memorandum was sent to every member of the ARMW regarding changes to the organisation of the annual meetings. It was proposed that 'each year three or four questions should be chosen for the collective consideration of the members of the Association', in order to better facilitate the exchange of knowledge between women doctors.[33] Examples of sample questions included 'what is the normal range of puerperal temperatures?', 'what percentage of iodine or carbolic acid is strong enough to arrest the development of the lowest forms of life?', and 'in cases of rotary lateral spinal curvature, what are the indications of treatment by gymnastics?'.[34] It is interesting to note that these questions did not exclusively deal with issues relating to pregnancy and childbirth; members of the ARMW were eager to expand their medical knowledge beyond the expected professional remit of women doctors. Whilst it was hoped that every registered medical woman would join the Association and engage with the annual, and later monthly meetings, attendance remained static in comparison to the steadily increasing number of women on the Medical Register (Figure 1.1). Between 1880 and 1889, 15 was the highest number of members present at an annual meeting of the ARMW, representing only 25 per cent of the medical women on the register that year.[35] Total membership numbers did show a gradual increase between 1896 and 1913, suggesting that the second generation of medical women were perhaps more eager to join the Association and take an active role than their predecessors (Figure 1.2).

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[30] Ibid.

[31] Ibid. This was a significant amount, representing approximately £10,000 today. Reflecting her status within the group, Garrett Anderson spent the most money on music for the gathering.

[32] Minutes of the Annual Meeting, 2nd May 1882.

[33] 'Association of Registered Medical Women' pamphlet, May 1882, SA/MWF/P/1/1.

[34] Ibid.

[35] Attendance of the annual meetings increased after 1889. In 1896, when Garrett Anderson was elected president for the second time, 33 members were present at the meeting.

Even so, these numbers were still small in comparison to the total number of women on the Medical Register. Some women doctors may not have wanted to be affiliated with the ARMW, being of the opinion that the Association was a poor substitute for membership of the BMA. In 1893, a proposal was put forward by Dunbar to 'dissolve the Association of Registered Medical Women, in view of their admission to the British Medical Association'.[36] As Dunbar was absent from the meeting, and 'no one had anything to say in its favour', the motion 'fell to the ground without further discussion'.[37]

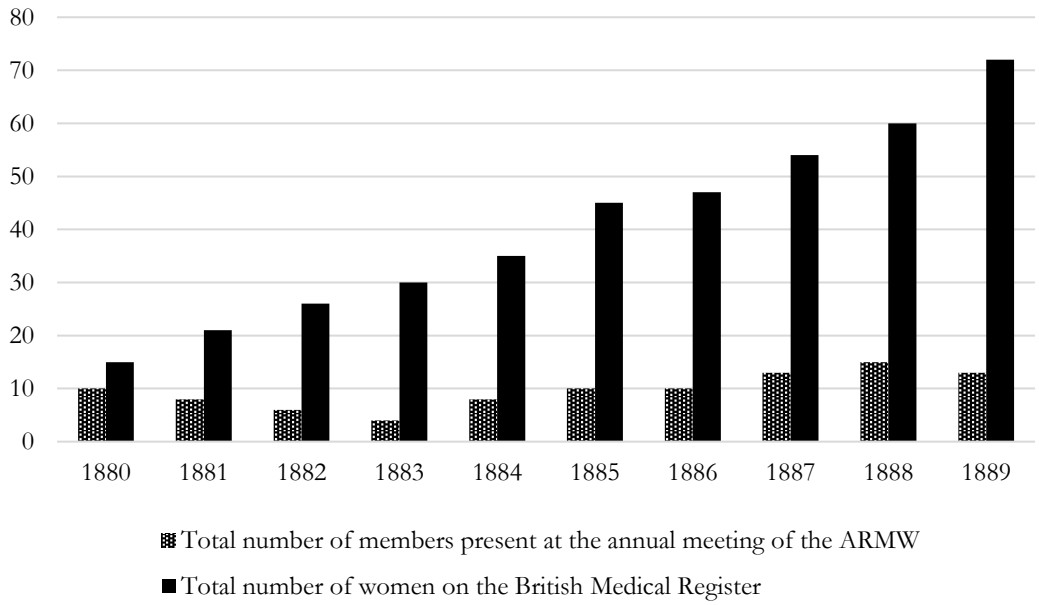

Figure 1.1 Total number of members present at the annual meeting of the ARMW compared with the number of women on the British Medical Register, 1880-1889.[38]

[36] Minutes of the Annual Meeting, 6th June 1893.

[37] Ibid.

[38] Total numbers of members present at meetings calculated from annual meeting minutes (SA/MWF/P.1/1). Numbers of women on the British Medical Register calculated from lists published in the *Englishwoman's Review*.

Figure 1.2 Total number of ARMW members, 1896-1913.[39]

Whilst Ellen More asserts that female medical societies functioned as 'an effective instrument of professional integration and legitimation', and were 'agents of [both] feminism and professionalization [sic]', it is also evident that they functioned as a form of professional control.[40] Medical women who became fully registered during the year were 'asked', rather than 'invited', by the Secretary to join the Association before the next annual meeting, suggesting that there was an implicit expectation that every newly qualified medical woman should join the ARMW.[41] Such passive aggressive tactics would later become a hallmark of the MWF's modus operandi, leading to the organisation alienating many of its members. The Executive Committee of the Association would have been anxious to attract as many members as possible in order to ensure their compliance with the ethics of the profession; as Edinburgh had shown, the actions of one medical woman had the propensity to affect the movement as a whole. In her brief discussion of the ARMW, Kaarin Michaelson argues that: 'The convivial atmosphere at branch meetings encouraged socializing, thereby helping to foster an ethos of *sympathetic "sisterhood"* among medical women'.[42]

[39] Total number of members calculated from annual meeting minutes (SA/MWF/P.1/1) and annual reports (SA/MWF/C.74).

[40] Ellen S. More. 'The Blackwell Medical Society and the Professionalization of Women Physicians', *Bulletin of the History of Medicine,* 61 (December 1987), 603-28 (p.603).

[41] Minutes of the Annual Meeting, 12th June 1883.

[42] Kaarin Leigh Michaelson, 'Becoming "Medical Women", p.123. Emphasis my own.

Such an analysis, founded upon gender stereotypes, overlooks the intricate dynamics at play within this group of professional women. Beneath the façade of 'sympathetic sisterhood', women doctors were often at odds with one another, resistant to accepting the established hierarchy and the culture of conformity thrust upon them by Garrett Anderson. In 1883, Jex-Blake sent a letter to the ARMW, proposing changes to the constitution.[43] Evidently her suggestions were not satisfactorily responded to, as the following year, she wrote again to withdraw her membership from the Association.[44] Jex-Blake's resignation suggests that she remained unable to reconcile herself with Garrett Anderson's influence within the Association.

Similarly, a professional disagreement between Atkins and Garrett Anderson led to Atkins resigning from the ARMW 'with much regret' in 1889.[45] Whilst working at the New Hospital for Women (NHW), Atkins raised concerns regarding the surgical competency of Garrett Anderson.[46] When these concerns were not adequately addressed by the hospital's Management Committee, Atkins saw no other option but to leave the hospital. Atkins had hosted the annual meeting of the ARMW at her home in West London in 1886 and 1887, and it was 'proposed and carried unanimously that next year's meeting be held, subject to Mrs Atkins [sic] convenience, at the Rectory Cottage Hanwell, on the second Tuesday in June 1888'.[47] Following Atkins' resignation from the NWH in April 1888, the location of the annual meeting was, rather tellingly, changed to the 'Inns of Court Hotel, Holborn'.[48] Atkins no longer felt comfortable hosting Garrett Anderson, or the Association over which she held such influence, in her home. The resignations of two founding members of the Association further demonstrates the discord that existed among early medical women. For many, Garrett Anderson's elevated position within the profession was problematic; as the first woman to qualify in Britain, she was, in effect, irreproachable. As Mary Ann Elston notes, such disagreements between the early medical pioneers reveal a tension between the ideals of professional community and individualistic conceptions of the role of women doctors.[49] Whilst the ARMW provided medical women with a forum to discuss their collective

[43] Minutes of the Annual Meeting, 12th June 1883. Whilst the official constitution of the ARMW is referred to as early as 1882, the first surviving copy dates from 1892.

[44] Minutes of the Annual Meeting, 12th June 1884.

[45] Minutes of the Annual Meeting, 11th June 1889.

[46] Claire Brock, *British Women Surgeons* (Cambridge: Cambridge University Press, 2017), p.37.

[47] Minutes of the Annual Meeting, 14th June 1887.

[48] Minutes of the Annual Meeting, 12th June 1888.

[49] Mary Ann Elston, 'Women Doctors in the British in the British Health Services: a Sociological Study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986, p.156.

professional positions, as the rest of this chapter evidences, it also served to widen the rifts that had been exposed in the battle for qualification.

Professional expectations

Having proven, in qualifying, that women were as educationally able as men, the founding members of the ARMW were tasked with establishing themselves as competent, dignified, and resilient medical practitioners. Failure to embody these ideals would undermine the legitimacy of women's place within the medical marketplace, and tarnish the hard-won reputation of the movement. An immense pressure was therefore placed on the first generation of women doctors to uphold the values of their newly-formed professional identity – the eyes of their male colleagues, and society in general, were upon them. As Garrett Anderson notes in the *Medical Student's Guide* (1878): 'Women can less easily afford to be second-rate; their professional work will be more closely scrutinised; mistakes will ruin them more quickly than they will men'.[50] If women doctors failed in their mission to prove themselves worthy, the doors to universities and senior hospital appointments would remain closed to the female sex in the decades to come.

One of the main aims of the ARMW was therefore to ensure the compliance of the movement's earliest advocates, in order to safeguard long-term success. Whilst Jex-Blake's and Atkins' resignations foreground the antagonism which existed at the heart of this group of pioneering women, the fates of two lesser known founding members of the Association demonstrate that not every woman doctor was willing, or able, to fulfil the exacting expectations of their role. Until now, histories of women in medicine have primarily focused on the successes that defined the movement, with many failing to delve deeper into the forgotten stories which undermine the prevailing narrative of idyllic sisterhood.[51] Thus, much can be learnt from the 'failed' careers of Eliza Frikart and Annie Reay Barker, as they provide a unique perspective on the varying levels of difficulty and success experienced by women attempting to establish themselves professionally during this period.

[50] Elizabeth Garrett Anderson, 'A Special Chapter for Ladies who Propose to Study Medicine', in *The Medical Student's Guide to the Medical Profession*, ed. by Charles Bell Keetley (London: Macmillan and Co., 1878), pp.42-48 (p.43).

[51] One notable exception in relation to the second generation of medical women is: Claire Brock, 'The Disappearance of Sophia Frances Hickman, M.D', *History Workshop Journal*, 80 (2015), 161-82.

In December 1893, Frikart became the only member ever to be expelled from the ARMW on account of her unprofessional conduct, having refused to internalise Garrett Anderson's pillars of professionalism – 'judgement and moderation'.[52] Frikart had graduated from the University of Zurich in 1877, receiving her licenses in medicine and midwifery from the KQCPI two years later.[53] Perhaps concerned about the limited opportunities available to women doctors, Frikart left her position as house physician at the NHW in 1880 to practice medicine in Europe, where attitudes towards women doctors were far more liberal.[54] Having spent 10 years in Switzerland, she sailed to Australia to exploit its untapped female medical market in 1893.[55] Frikart wasted no time in advertising her arrival, spreading word of her unique selling point in newspapers across the country:

> *Dr Eliza M'Donogh, M.D, LKQP., LM* etc, who is the only duly qualified and registered lady specialist in Australia, may be consulted at her institute, Mitchell Street […] She cures with absolute certainty all Private, Chronic, Skin, Blood, and Nervous Diseases, Fits, Liver, Heart, Lung, Kidney troubles, Irregularities, etc. The doctor's phenomenal skill has been endorsed by Press and public. Write nature of trouble, and save future suffering. Confidence absolute. *Avoid* quacks. Call on, or address the only legally qualified lady doctor advertising in Australasia.[56]

Freed from the oppressive atmosphere of British medical society, Frikart exercised carte blanche in reinventing the professional identity of the woman doctor, publicising her services wherever she went. The use of euphemistic language such as 'Private' and 'Irregularities' suggest that Frikart was also expanding into abortive practices. This was later confirmed in 1895, when her name became embroiled in an abortion case tried at the Supreme Court in New Zealand, alongside the notorious abortionist 'Dr Bridgewater'.[57]

Whilst effective, such shameless self-promotion was highly unprofessional, going against the moral and ethical code to which all doctors were expected to adhere. Under the Medical Act

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[52] Minutes of the General Meeting, 19th December 1893; Garrett Anderson, *Inaugural Address,* p.21.

[53] C. A. Biggs (ed), *The Englishwoman's Review of Social and Industrial Questions, Volume XI, January to December 1880* (London: Englishwoman's Review, 1880), p.22.

[54] Ibid.

[55] C. A. Biggs (ed), *The Englishwoman's Review*, p.88.

[56] 'Dr Eliza M'Donogh', *Melbourne Herald*, 28th October 1892, p.3. Italicisation reflects capitalisation in the original.

[57] 'Supreme Court', *Wellington Evening Post,* 5th December 1895, p.4.

of 1858, both the General Medical Council (GMC) and the Medical Register had been implemented to improve the standards of the profession, which was plagued with dubiously qualified 'quacks' who 'cried up their goods in the market […] puffed their wares in newspapers […] [and] mass-marketed cure-alls and catholicons'.[58] Though the Act sought to bolster the public's perception of doctors by differentiating between those who were properly qualified, and those who were not, the medical marketplace remained a 'Paradise of Quacks' well into the late nineteenth century.[59] The dangers of unprofessional advertising were a grave concern for all qualified doctors; not only did they damage the reputation of the profession as a whole, but they also put patients' lives at risk. Individuals would make increasingly unsubstantiated claims about the superiority of their medical practice in order to attract new business over their competitors, touting cure-all tonics and treatments. As the *Lancet* remarks: 'When trumpeting is in vogue, the loudest trumpeter has the best chance of being heard […] an advertisement affords no test of a man's ability, or his truthfulness, or of his honour'.[60] In spite of Frikart's advice to 'Avoid quacks', her declaration that she is able to cure, with 'absolute certainty' and 'phenomenal skill', such a wide range of ailments ironically bears all the hallmarks of quackery. Later advertisements include mention of an exclusive 'nerve food, nerve tonic and nerve alternative' guaranteed to 'rapidly and pleasantly restore vigour, health, and happiness', suggesting that Frikart's advertisements became increasingly disreputable as her medical alliance expanded.[61]

Unsurprisingly, given that their license featured so prominently in her advertisements, the KQCPI soon became aware of Frikart's scandalous conduct in Australia. In a letter sent on the 8th December 1892, the college demanded an immediate explanation from Frikart for the 'gross violation' of the declaration that she had taken in 1879, in which she had solemnly sworn 'not to endeavour to obtain practice, or to attract public notice, by any unworthy means'.[62] The college registrar warned that licentiates had been removed from the roll book for similar conduct, a punishment which would prevent her from legally practicing medicine within the United Kingdom.[63] In spite of the severe professional consequences, Frikart ignored the KQCPI's warning and continued to advertise prolifically, expanding her market to New Zealand in 1893.[64]

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[58] Roy Porter, *Quacks: Fakers and Charlatans in Medicine* (London: Tempus, 2003), p.17.

[59] William Dale, *The State of the Medical Profession of Great Britain and Ireland* (Dublin: Pannin and Co, 1875), pp.24-25.

[60] 'Objectionable Advertising', *Lancet,* 2 (28th December 1861), 618-19 (p.619).

[61] 'Dr Frikart M.D', *Timaru Herald*, 1st August 1894, p.4.

[62] Letter from G.P.L Nugent to Eliza Frikart, 8th December 1892, College Minute Book, RCPI/2/1/1/22.

[63] Ibid.

[64] 'Dr Frikart, M.D', *Bruce Herald*, 4th August 1893, p.4.

Between May 1893 and August 1894, a staggering 907 of Frikart's advertisements appeared in New Zealand newspapers, averaging nearly two per day.[65] Whilst Garrett Anderson carefully crafted her reputation and public image in private over the course of her career, Frikart was unashamedly brazen in her approach.[66] One notice published in the *Timaru Herald* in January 1894 contains a number of glowing testimonials from the press, and interestingly one from a male patient - Thomas Francis Dowling.[67] Dowling 'solemnly and sincerely' declares that his kidney and bladder problems of four years standing have been cured by Frikart's 'remarkable skill and ability', professing that without her intervention, 'I am sure I would be in my grave now'.[68]

This declaration is noted to have been signed in the presence of a legal professional, which implies that Frikart was ready and able to defend herself against any accusations of falsity. The fact that Frikart was openly advertising her medical services to men would have been shocking to her colleagues in London on a number of counts. The first generation of women doctors strategically emphasised their expertise in treating women and children as it provided them with an 'acceptable' area of medicine in which to operate, securing professional opportunities which their male colleagues often disregarded as being inferior. By ignoring this unwritten rule, Frikart threatened the integrity of the woman doctor's sphere of influence, and her begrudgingly-accepted position within the profession. Similarly, until the First World War, medical women had a relatively low exposure to male patients. The Royal Free Hospital (RFH) was the only place where female medical students were involved in treating the opposite sex, on the children's ward and in the hospital's casualty department.[69] If women doctors did decide to treat male patients in their private medical practices, this was done discreetly, as it undermined the public image of medical women as the natural attendants of their own sex. The fact that Dowling's ailments specifically related to his urinary system would have made Frikart's treatment particularly risqué. Her decision to include his testimonial would have undoubtedly been a tactical one; treating male patients added yet another string to her professional bow, expanding public interest and her commercial opportunities. Clearly, there was no limit to the lengths Frikart was willing to go to in order to make a name for herself in the southern hemisphere.

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[65] National Library of New Zealand, 'Dr Frikart'. <https://natlib.govt.nz/> [accessed 25th June 2019].

[66] Claire Brock, 'Elizabeth Garrett Anderson and the Professionalism of Medical Publicity', *International Journal of Cultural Studies*, 11 (September 2008), 321-42 (p.325).

[67] 'Dr Frikart', *Timaru Herald,* 22nd January 1894, p.4.

[68] Ibid.

[69] Some hospitals had their own rules regarding the maximum age that male children could be treated by female doctors. See Brock (2017).

At the height of her promotional campaign, Frikart was interviewed for the notoriously opinionated *Fair Play*, an illustrated journal marketed exclusively to 'sensible men and women'.[70] In a two-page spread which includes a photograph, Frikart offers her opinion on a number of contentious subjects, including the social acceptability of women smoking (whilst smoking a 'scented cigarette' herself), and women's suffrage (Figure 1.3). When asked whether she has much time to devote to socialising, Frikart replies: 'I have neither the time nor inclination. Society […] is only fit for fools and idlers and nothing bores me so much as your vapid society woman or man, with their insane small talk and scandal mongering'.[71] On the subject of jealousy from male colleagues, Frikart responds 'with a smile': 'the green-eyed monster is not confined to the amorous swain […] *I live my live as I deem fit*, and in doing my humble best to assuage pain and help my fellow creatures, I am content'.[72] Frikart's unguarded comments suggest that she was aware of the professional outrage that was brewing back home in Britain, and had no intention of modifying her behaviour. Her strategic inclusion of the language of healing in her answer is used to bolster her public image: portraying herself to the world as a 'humble' doctor, rather than a dishonourable quack. Similarly, the decision to use a formal academic photograph to accompany the relaxed interview demonstrates the calculated nature of Frikart's self-promotion. Whilst the 'green-eyed monster' chastised her advertising, she was content with living her life according to her own rules. In the midst of her success, Frikart had forgotten the sacrifice she had made when she qualified as a member of the medical profession – she was no longer an individual with any freedom over how she conducted herself in public.

[70] 'Straight Talk', *Fair Play*, 4th November 1893, p.1. *Fair Play* published 27 issues from November 1893 to November 1894.

[71] 'Fair Play interviews a Lady Physician, her opinions – social and professional', *Fair Play*, 30th December 1893, p.8.

[72] Ibid. Emphasis my own.


Fair Play INTERVIEWS.

A Lady Physician.

THE FIRST IN NEW ZEALAND.

HER OPINIONS—SOCIAL & PROFESSIONAL.

Figure 1.3 Eliza Frikart's photograph published in *Fair Play* magazine (Papers Past).

Just one year after receiving her warning letter from the KQCPI, the *New Zealand Medical Journal* sent a number of Frikart's advertisements to Dublin in protest at her dishonourable exploits. In response, the college initiated an inspection committee to investigate the accusations of professional impropriety.[73] Having found sufficient evidence to support the charge of 'conduct infamous in a professional respect', Frikart's name was officially removed from the college roll on the 1st December 1893.[74] Such was the magnitude of Frikart's misconduct, the KQCPI made an official petition to the GMC to consider the evidence collected against her. Five months later, Frikart was struck off the Medical Register, ending her medical career once and for all.[75] Following the KQCPI's decision, news of Frikart's disreputable conduct reached the ARMW, with an

[73] Letter from G.P.L Nugent to Eliza McDonogh, 2nd February 1894, RCPI/2/1/1/22.

[74] Ibid.

[75] 'The General Medical Council of Medical Education and Registration', *Lancet*, 2 (21st July 1894), 159. Following the 1895 abortion case, Frikart returned to England and was subsequently tried for 'falsely using the title of doctor of medicine' at the Cardiff Police Court. Given that she had been a doctor, she was found not-guilty, much to the dismay of the medical profession. Frikart continued on a downward spiral, and was tried for cheque fraud at the Old Bailey in 1903. Once again, she was found not-guilty.

extraordinary meeting being held to discuss the matter.[76] Having procured copies of the offending advertisements, they were read aloud and found to be 'of a most objectionable nature'.[77] In spite of the fact that Frikart had not attended a meeting in over a decade, and likely had not continued to pay her membership fees, it was agreed by all members present that 'such a grave breach of professional etiquette could not be passed over in silence'.[78] Whilst Frikart may not have technically been a current member of the Association, the fact that she was a medical woman meant that her behaviour was, by default, a matter of great concern for her colleagues.

Not wanting to be left out of the official process, the ARMW conducted an internal review of the evidence, coming to the unanimous conclusion that Frikart should be expelled from the Association with immediate effect.[79] Frikart's refusal to embody the ideals of the profession which she belonged to demonstrates that, for some early women doctors, the culture of conformity which was thrust upon them on qualification was intolerable. Medical women were expected to be irreproachable, and to graciously accept, for the time being, the limits on their professional opportunities. Claire Brock notes that: 'potential women doctors, when trying to access the bastion of male privilege, had an even finer line to tread between self-exposure and an acceptable public and professional character'.[80] By going abroad, Frikart believed that she could construct a new professional identity, and escape the restrictions which held her colleagues at the ARMW back. It is interesting to note that Frikart's professional misconduct has, until now, failed to be discussed outside of New Zealand, perhaps because her story fails to fit the narrative of virtuous women doctors, such as Garrett Anderson, who were active in the late nineteenth century. Frikart's prolific advertising campaign reveals the uncomfortable truth that women doctors were just as attracted by financial gain as their male colleagues – femininity did not, necessarily, go hand in hand with altruism. By choosing to revolt, albeit unsuccessfully, against the professional constraints imposed on female practitioners by the medical profession, Frikart provided an unsettling example of how calculated a woman doctor could be in her pursuit of success.

[76] Minutes of the General Meeting, 19th December 1893.

[77] Ibid.

[78] Ibid.

[79] Ibid.

[80] Brock, 'Elizabeth Garrett Anderson and the Professionalism of Medical Publicity', p.326.

Annie Reay Barker

Whilst Frikart was unwilling to uphold Garrett Anderson's exacting expectations, the youngest founding member of the ARMW found herself unable to withstand the pressure placed on women doctors to succeed, above all else, during their fierce fight for recognition. On the 23rd March 1896, Annie Reay Barker, M.D was brought to the Holloway Sanatorium in Virginia Water with a diagnosis of 'Chronic Mania'.[81] Barker had excelled in her studies at both the University of Edinburgh and the Universitié de Paris, and was the eighth woman to have her name entered on the British Medical Register.[82] She made history as the first female doctor to be appointed to a senior hospital position at the Birmingham and Midland Hospital for Women (BMHW) in 1878, and in recognition of her achievements, and respected status within the profession, was chosen to give the inaugural address at the LSMW in 1881.[83] Once a successful physician with a promising career ahead of her, Barker found herself in the unfamiliar role of sanatorium patient, stripped of the authority and purpose that had defined her for two decades. Barker's quiet departure from public life seemingly went unnoticed by her former colleagues, and her death nearly 50 years later similarly went unremarked in the medical press.

As this chapter has examined, histories of first generation medical women have, for the most part, failed to delve deeper into the 'failures' which undermine the prevailing narratives of heroic sisterhood and triumph over professional adversity.[84] In Barker's case, her mental illness led to her professional successes being almost entirely erased from the historical record. Forgotten stories such as Barker's deserve to be told. They provide a unique perspective on the varying levels of difficulty experienced by women attempting to establish themselves within the medical

[81] Holloway Sanatorium Patient Admission Register, Patient number 1591, Surrey History Centre, Surrey, 3237/5/1. This section has previously been published as an article: Sophie Almond, 'The Forgotten Life of Annie Reay Barker, M.D', *Social History of Medicine,* 34 (August 2021), 828-850.

[82] Roll of Licentiates in Medicine and Midwifery 1866-1948, RCPI/5/2/1/3.

[83] C. A. Biggs (ed), *The Englishwoman's Review of Social and Industrial Questions, Volume XI, January to December 1881* (London: Englishwoman's Review, 1881), pp.466-67.

[84] For example, see: Sophia Jex-Blake, *Medical Women: A Thesis and a History* (Edinburgh: Oliphant & Co., 1886); E. Moberley Bell, *Storming the Citadel* (London: Constable & Co, 1982); Catriona Blake, *The Charge of the Parasols: Women's Entry into the Medical Profession* (London: The Women's Press, 1990). Brock (2015) provides insights into the suicide of Sophia Frances Hickman, a prize-winning graduate of the LSMW who went missing from her post at the RFH in in August 1903. Similarly, Gerada (2018) gives a brief overview of Jeannie Macleod, a highly commended graduate of the University of Aberdeen who took her own life whilst at work in April 1902.

profession during this period, and provide further insights into the inner workings of this pioneering group of women.

Having decided to pursue a career in medicine, Barker studied alongside Jex-Blake at the University of Edinburgh between 1870 and 1872, completing her studies at the Universitié de Paris in 1874.[85] Before graduating, she joined the BMHW in July 1876 as a House Surgeon and House Physician.[86] The BMHW had a proven track-record of supporting the careers of women doctors; in July 1872, Atkins was controversially employed by the hospital as the country's first female House Surgeon.[87] In contrast, the RFH, which exclusively provided training to female medical students from the LSMW, did not appoint a newly qualified woman doctor to a House Post until 1901.[88] Three years later, Edith Pechey, one of Jex-Blake's most admired Edinburgh comrades, succeeded Atkins at the BMHW.[89] Her appointment was similarly controversial; yet to fully complete her medical degree, she was, for all intents and purposes, both unqualified and unlicensed.[90] Like Pechey, Barker had yet to complete her degree or attain a medical license; however, her academic record and personal references were similarly accepted in their place. Barker's appointment, and subsequent hiatus to sit her final examinations in Paris, were noted in the hospital's *Annual Report*:

> Miss A R Barker ['s] […] manner of fulfilling the duties of her post are highly approved and appreciated by the Acting Staff. Miss Barker was for some time absent in Paris, on leave, for the purpose of submitting herself to the necessary

[85] The reason why Barker was excluded from Jex-Blake's history of her time in Edinburgh is likely due to the fact that Barker followed Garrett Anderson's advice, completing her degree in Paris rather than staying to petition universities in the U.K. Barker was explicitly named as one of the plaintiffs in the action brought against the University of Edinburgh by Jex-Blake in June 1873. In spite of Barker's public support, Jex-Blake viewed her departure to Europe as a betrayal, spurning her in retaliation. For more on Barker and the Edinburgh medical scene, see: M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007); Sophie Almond, 'The Forgotten Life of Annie Reay Barker, M.D', *Social History of Medicine,* 34 (August 2021), 828-850.

[86] Board of Governors Meeting Minutes, 6th July 1876, Birmingham City Archives, Library of Birmingham, HC WH/1/1/1.

[87] Minute Book of the Medical Committee, 16th July 1872, HC/WH/5/1, BCA.

[88] 'Hospital and School News', *London (Royal Free Hospital) School of Medicine for Women Magazine*, 19 (May 1901), p.800. The LSMW became affiliated with the Royal Free Hospital in 1877.

[89] Minute Book of the Medical Committee, 31st July 1875.

[90] Board of Governors Meeting Minutes, 31st July 1875.

> examinations for the degree of Doctor of Medicine […] She has now returned, and the Committee are happy to state she has been successful in her object.[91]

The following year, Barker was licensed by the KQCPI, becoming the eighth woman to have her name placed on the Medical Register.[92] Whilst Barker's name has been most frequently associated with accounts of the BMHW's progressive attitude towards women doctors, the historical significance of her time spent working at the hospital has repeatedly been overlooked.

Being in full possession of her degree and medical license, Barker desired to find a position with greater responsibility. In April 1878, she handed in her notice, and was thanked by the Board of Governors for her service to the hospital.[93] Fortuitously, shortly after Barker resigned, two posts in the newly opened outpatient department at the BMHW were advertised - one for a Physician, and one for an Assistant Surgeon.[94] Whilst the Medical Act of 1858 gave licensing bodies the authority to admit all candidates, regardless of sex, for examination, the Royal College of Surgeons (RCS) refused to admit medical women as Fellows until 1911.[95] The role of physician in the outpatient department, was, therefore, open to all qualified practitioners; however, no woman was qualified to apply for the surgical post. Undeterred by this fact, Barker submitted her application along with two male candidates.[96] Judith Lockhart incorrectly asserts that the two positions advertised were for a 'Lady Physician' and 'Assistant Surgeon', therefore inferring that Barker was not in direct competition with Chubborn and Edginton.[97] The Board of Governors minute book clearly records the order of proceedings for the vote, which demonstrates, without any doubt, that Barker was on an equal footing with the male candidates:

> Each voter is to be at liberty to give two votes, but only one vote to one candidate. A voter may, if he please, vote for one candidate only. The candidate having the greatest number of votes to be declared elected […] the result of the first ballot was as follows: Dr Annie Barker 31, Dr Chubborn 4, Dr Edginton 18. Dr Annie Barker was accordingly declared elected. In the second ballot Dr

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[91] ARMW Annual Report, 1876, HC/WH/1/10/1.

[92] Roll of Licentiates in Medicine and Midwifery 1866-1948, RCPI/5/2/1/3.

[93] Board of Governors Meeting Minutes, 2nd April 1878.

[94] 'Birmingham and Midland Hospital for Women', *Birmingham Daily Post,* 7th June 1878, p.1.

[95] Claire Brock, *British Women Surgeons,* p.19.

[96] Minute Book of the Medical Committee, 11th July 1878.

[97] Judith Lockhart, 'Women, Health and Hospitals in Birmingham: The Birmingham and Midland Hospital for Women, 1871-1948', unpublished doctoral thesis, University of Warwick, 2008, p.75.

> Chubborn received 5 votes, & Dr Edginton 28. Dr Edginton was declared elected.[98]

Barker's decisive victory reflects the high regard in which her colleagues at the BMHW evidently held her; having been democratically elected to the hospital's permanent staff, her character and professional expertise were shown to have taken precedence over her gender.

In recognition of her position as a respected medical woman, Barker was afforded the honour of giving the inaugural address at the LSMW in October 1881. She used the opportunity publicly to praise the BMHW for its progressive attitude towards employing women doctors, and, rather tellingly, urged the students to remain dignified in the face of adversity:

> Miss Barker […] gave a concise sketch of the history of the movement for the medical education of women, and then congratulated the students on the way in which they had worked to maintain its dignity and reputation […] Miss Barker bore personal testimony to the progress which had been made in Birmingham, and expressed her pleasure in speaking of the fairness, practical good sense, and kind feeling with which medical women had been received there. The prejudices against women doctors must, Miss Barker told the students, be overcome, not by showing ill will in return, but by honest, true work, and by showing that, though they have entered a profession, they have lost none of the refinement and dignity of true gentlewomen.[99]

Barker's address was noted to have attracted 'a crowded meeting', and was 'received by all with much enthusiasm'.[100] Having secured herself the medical education which she had fought so hard for, Barker had overcome the 'prejudices' faced in becoming a woman doctor with her dignity and reputation firmly intact. Speaking during the time that, tragically, would later prove to be the climax of her professional life, Barker envisioned a future full of promise for herself, in the supportive environment of the BMHW, and for the students that had yet to embark on their own careers. What she did not yet know was that her career as an accomplished medical woman would shortly come to an abrupt end, and that she would fall victim to mental illness.

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[98] Board of Governors Meeting Minutes, no date recorded, p.190.

[99] C. A. Biggs (ed), *The Englishwoman's Review of Social and Industrial Questions, Volume XI, January to December 1881* (London: Englishwoman's Review, 1881), pp.466-67.

[100] Ibid.

Towards the end of 1882, Barker's ill health began to affect her hospital work. Between August 1878 and August 1882, she had attended 38 out of 46 Medical Board meetings at the BMHW, sitting in the chair for eight of them.[101] In September 1882, Barker was uncharacteristically absent from the monthly meeting, which marked the beginning of her decline: 'A letter was received from Dr Annie Barker announcing that owing to ill health she was for the present absent from her duties on the outpatient staff'.[102] Two months later, Barker was still unable to perform her work at the hospital; however, she noted a small improvement.[103] Barker's optimism for recovery was sadly short-lived; after five months' leave, she was forced to write to the Medical Board expressing her regret that she could no longer continue in her position due to her ill-health. Her resignation was accepted, and she was thanked by the Board of Governors for her services to the hospital.[104] After Barker resigned from her post in Birmingham, she returned home to Aldershot. However, she continued intermittently to practice medicine privately in London. In 1885 and 1887, Barker's address was listed in the *Englishwoman's Review* as '37 Gloucester Place', which was the same address used by Atkins between 1885 and 1889.[105] Given Barker's traceable activity in 1885, 1887, and 1888, it is likely that she experienced highs and lows in her health, which allowed her to continue working, albeit transiently, during this time.

In 1889, Barker was uncharacteristically absent from the annual meeting of the ARMW, having been an active member for over a decade. Unlike Frikart, Barker regularly attended meetings, and was elected president in 1885 and 1888 (Figure 1.4). Barker's resignation was not noted, as was usually the practice, in the Association's minute book, which suggests that she did not write to her colleagues to inform them of her early retirement from the profession. Barker's name continued to be listed on the LSMW's Board of Governors until 1899, which further supports the view that she simply did not tell anyone that she was no longer practising medicine, and no one thought to ask.[106] The reason why Barker avoided attracting any attention would have been due to the true nature of her illness. Mental instability attracted shame and embarrassment. Its causes were not fully understood, therefore those who suffered from diseases of the brain and disorders of the mind were treated as social outcasts, with their morality often being placed under

[101] Minute Book of the Medical Committee, August 1878–August 1882.

[102] Board of Governors Meeting Minutes, 3rd October 1882.

[103] Ibid., 7th November 1882.

[104] Ibid., 6th February 1883.

[105] C. A. Biggs (ed), *The Englishwoman's Review of Social and Industrial Questions, Volume XVI, January to December 1885* (London: Englishwoman's Review, 1881), p.69.

[106] London School of Medicine for Women Annual Reports, LMA, H72/SM/A/O1/01/002.

question.[107] As a woman, and a pioneering doctor, Barker's illness would have been especially humiliating; she had devoted her professional life to proving wrong those who thought that women were incapable of dealing with the stresses of medical practice. Public knowledge of this incapacity would have tarnished Barker's reputation and diminished the legacy of her career and undermined the medical women's cause. As Brock notes, women doctors in this period were self-defined by a 'robustness' of both body and mind.[108] This was a self-conscious characterisation motivated by the fact that public opinion – and large numbers of their male colleagues – continued to dispute women's 'mental, physical and moral capacity to act as members of the medical profession'.[109] Sharing the full extent of her illness with her colleagues would have been an impossible task. It would have meant admitting weakness – something that had been stigmatised in the fight for women's admission to the medical profession.

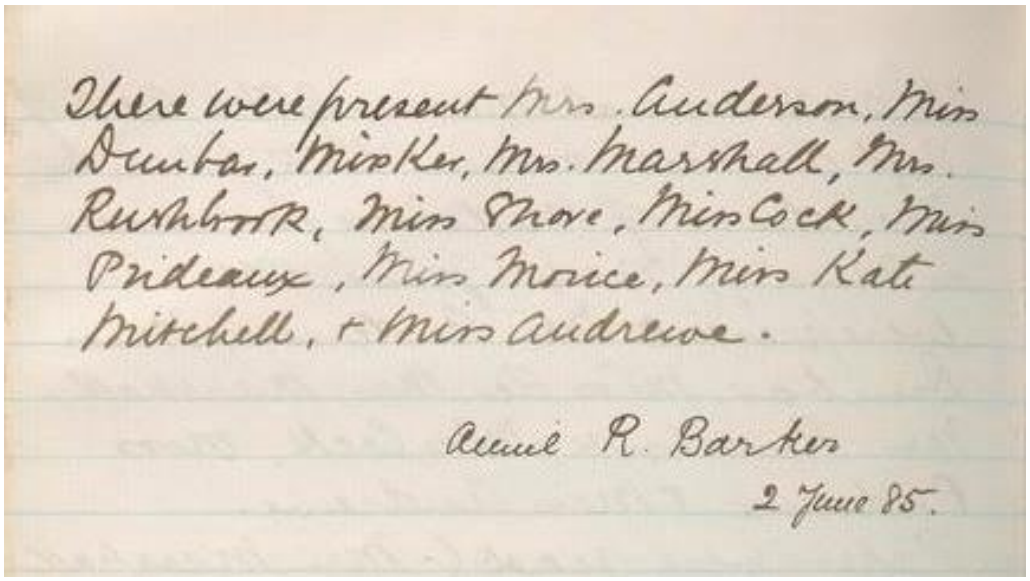

Figure 1.4 Annie Reay Barker's signature in the ARMW minute book, 1885 (Wellcome Library).

[107] For more on social perceptions of insanity, see: Andrew Scull, *Madness in Civilisation: A Cultural History of Insanity* (London: Thames and Hudson, 2015).

[108] Claire Brock, 'The Disappearance of Sophia Frances Hickman, M.D', *History Workshop Journal*, 80 (Autumn 2015), 161-82 (p.161).

[109] Ibid.

No longer occupied with the work that she had loved, Barker's health deteriorated rapidly. On 23rd March 1896, she was taken to the Holloway Sanatorium at Virginia Water by her brother, Frederick.[110] The occupation which had defined her life for more than a decade – 'Doctor of Medicine' – was recorded on admission alongside the diagnosis which would remain with her for the next fifty years: 'Chronic Mania'.[111] The underlying organic cause of Barker's mania, as defined by the medical officer who admitted her, is unknown. No family history of mental illness is recorded in Barker's case notes, however research has revealed that her younger sister, Emma, similarly died in a mental institution in 1938, aged 81.[112] No cause was listed for Barker's mental illness in the Sanatorium's admission register, suggesting that it was unlikely to have been organic in nature. In a cruel twist of fate, Barker's name and qualifications continued to be listed on the Medical Register until 1903.[113] Similarly, her details were reprinted in the Medical Directory until 1905, nine years after becoming a patient in Holloway, with the final entry noting that her address was 'uncommunicated'.[114] Barker's arrival in Virginia Water marked the end of her life of responsibility and purpose as a practising physician. This being said, the 50 years that she spent as a patient are no less important. Surviving case books offer fascinating insights into how Barker's former profession continued to influence her reality within the walls of the sanatorium. Her unwavering refusal to show any sign of weakness, decades after she first became a patient, further supports the view that the pressures faced by these early women doctors had devastating and long-lasting effects on Barker.

Unfortunately, the case book which contains Barker's admission notes, a photograph, and a further 11 years of medical records dating from 1896 to 1907, has not survived.[115] In their absence, what can be deduced is that either her illness had worsened to the extent that she could no longer be cared for by her family at home, or her family's circumstances had changed. Interestingly, it is noted in the admission register that Barker's 'Age on first Attack' was 30, which

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[110] Holloway Sanatorium Patient Admission Register, Patient number 1591, SHC 3237/5/1.

[111] Ibid.

[112] 'Emma Florence Coburn', UK Newspaper Index, <www.ancestry.com> [accessed 6 November 2019]. The extent of Emma's illness and the exact date of her admission to Brooke House Mental Hospital are unknown. After marrying in 1898, she disappears from the address shared with her husband in the 1901 census in 1911, suggesting that her admission is likely to have occurred during this decade.

[113] 'Annie Barker', UK Medical Registers 1859-1959, <www.ancestry.com> [accessed 16th November 2018].

[114] 'Annie Barker', UK & Ireland Medical Directories 1845-1942, <www.ancestry.com> [accessed 9th November 2018].

[115] Supplementary Patient Case Book, February 1887-May 1926, SHC 3473/3/1/1/18. The first case book entry in July 1907 refers to a continuation from 'Book IX 135-178'.

would coincide with the beginning of her decline whilst working at the BMHW in the early 1880s. The first surviving entry which refers to Barker dates from 11th July 1907, 11 years after her admission to Holloway:

> Patient continues in a state of chronic mania asserting that she has sovereign right here, always asking for a cab to drive to Buckingham Palace or Aldershot. Jealous of any authority other than her own, forbidding the doctors to go near patients etc etc – She is occasionally noisy at night – She refuses any physical examination.[116]

Barker's memories of her past evidently remained at the forefront of her mind throughout her time spent at Virginia Water. Her delusions of grandeur, viewed as being indicative or her 'Chronic Mania', were inextricably intertwined with her lived experiences as a medical practitioner. Barker's refusal to accept the authority of her doctors, and her refusal to be examined or show any sign of physical weakness suggests that she could not accept, or understand, the passive role of patient in which she now found herself. Barker's attempts to go home to Aldershot, a place of familiarity intimately connected with her past, similarly conveys that in her distorted version of reality, everything remained as it had been; she was a doctor, and her work was not yet done.

Barker's staunch resistance to medical authority did not abate; despite having not practised medicine in a hospital setting for more than a decade, she continued to be drawn to the 'tools' of her trade, with stethoscopes and keys serving as tangible reminders of the responsibility she once held:

> 5th January 1909 – Patient […] will have nothing to do with the A.M.O, stating that she is the only Dr here.
>
> 2nd April 1909 – Continues mildly excited, asking that keys stethoscope etc may be given to her, as she has sovereign right here.
>
> 10th January 1910 – Thinks she is the only Doctor in the place, which belongs to her. Appears in good physical health.
>
> 19th July 1915 – Demented, has grandiose delusions – says that she is the Queen of England and frequently calls for imaginary policemen to arrest the nurses and M.O […] has no useful occupation.

[116] Ibid.

> 9th February 1920 – Still calls herself a Queen, also that she is the only doctor here, tried to snatch away my stethoscope saying it was hers.[117]

Much to the dismay of the Sanatorium's Medical Officers, Barker continued to refuse all physical examinations, which meant that the staff had to presume, from outward appearances alone, that she was free from illness and disease: 'She *appears* in good physical health, except for an occasional cold for which she *always* refuses treatment'.[118]

In 1921, a quarter of a century after entering the Sanatorium, Barker was forced to show weakness and accept help from those who were caring for her. At 70 years old, she fell and broke her leg, leaving her with no option but to recognise that she was not, in fact, 'the only doctor in this place'. In an uncharacteristic, yet touching, mark of deference, the medical officer used Barker's professional title in their account of her accident: 'Dr Barker slipped in the gallery today and fell on her left side, fracturing the neck of her left femur. She objected much to being nursed but in the end allowed herself to be undressed and X-rayed'.[119] The reason why the attending physician chose to use Barker's title in this particular moment is open to interpretation; perhaps they were taken aback by her unwavering resolve, moved by the extent to which she would try to cling onto her independence, in spite of excruciating pain. In the following entry, written in the same hand two months later, Barker is once again referred to as the 'patient', the glimmer of humanity which had been present having passed. In her own mind, Barker had returned to her role as indomitable woman doctor after a brief hiatus, and no longer required the input of any physician other than herself: 'Patient is now able to stand on her leg and walk a little. She seems to get a considerable amount of pain but will not allow examination […] She is looking thinner and paler than before the accident'.[120] A year after her fall, Barker was noted to have made a satisfactory physical recovery but her 'exulted delusions' remained unchanged.[121]

Perhaps unsurprisingly, given her unwavering resolve, Barker's last surviving entry in the patient case book, written three decades after her admission to Virginia Water, echoes her first. Barker's past life as a doctor remains firmly present in the foreground of her confused reality, a testament to the devotion that she had to her profession: 'Asks almost every day for her "medical

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[117] Ibid.

[118] Ibid., 20th October 1920. Emphasis my own.

[119] Ibid., 27th June 1921.

[120] Ibid., 22nd August 1921.

[121] Ibid., 29th August 1922.

and surgical things" and always wants my stethoscope when she sees it'.[122] On 2nd June 1945, aged 93, Barker passed away having spent the majority of her life as a patient in Holloway Sanatorium.[123] Her estate, worth in excess of £50,000, remained unclaimed until 1949, when a distant relative was eventually found.[124] In spite of remaining on the periphery of her professional circle throughout her career, as one of its youngest members, Barker went on to outlive all of her former colleagues. Although she had ceased treating patients by the late 1880s, in her own mind at least, she continued to 'practice' medicine well into her old age. Given that the details of Barker's former life no longer existed in living memory, she received no obituary in the medical or lay press.

By shedding new light on Frikart and Barker's stories, much can be learnt about the numerous pressures faced by early medical women. Having qualified, women doctors were tasked with conforming to an impossibly stringent set of professional ideals. They were expected to prove the legitimacy of women's place within the profession by succeeding in all of their endeavours, whilst remaining resolutely dignified in the face of continued opposition. They were expected to be feminine, whilst also being mentally and physically robust; public knowledge of any mental or physical weakness would have fuelled the arguments of those who questioned the female sex's ability to withstand the rigour of professional work. Any mistake, or temporary lapse in judgement, would irrevocably damage the reputation of the movement, and jeopardise the opportunities of future medical women. As Virginia Drachman notes, 'the struggle to become a physician was simply their first battle in the more enduring struggle to *be one*'.[125] For Frikart and Barker, this great responsibility was clearly insurmountable. Whilst 10 medical women founded the ARMW in 1879, by 1890 only Garrett Anderson, Blackwell, and Dunbar remained active members.[126] As for the other founding members, three had resigned, two had left the country to practice abroad, one had suffered a mental breakdown, and one had died (Appendix One). The victories won by these pioneering women at the end of the nineteenth century had come at a remarkably high price; however, the difficulties faced by Frikart and Barker were far from resolved. Issues of equality continued to affect the careers of medical women, whose numbers were steadily rising year on

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[122] Ibid., 1st April 1926. Barker's records from 1926-1945 are unavailable.

[123] In spite of extensive research, Barker's final resting place has not been found. It is likely that her funeral was organised by the Parish, and she was buried in an unmarked grave.

[124] Annie Reay Barker', English Newspaper Index Cards, 1790-1976, <www.ancestry.com> [accessed 16 November 2018].

[125] Virginia Drachman. 'Female Solidarity and Professional Success: The Dilemma of Women Doctors in Nineteenth-Century America', *Journal of Social History*, 15 (1981-2), 607-19 (p.607). Emphasis my own.

[126] Annual Meeting Minutes, 3rd June 1890.

year. By 1901, 456 women were on the Medical Register, and over 1000 female medical students were commencing their first year of studies in London, Edinburgh, and Glasgow.[127] Faced with limited progress in a rapidly changing social and political landscape, the ARMW was forced to review its tactics at the turn of the century in order to retain influence and control within the profession. As had been the case with Frikart and Barker, this ultimately led to the reputation and public image of the Association being prioritised over the interests of its most vulnerable members.

Equal pay for equal work

As the number of women on the Medical Register grew exponentially at the turn of the century, issues surrounding equal pay and professional opportunities were at the forefront of the ARMW's work. Appointments outside of hospitals run by women were extremely limited before 1914; Elston notes that in 1907, 60 per cent of house posts held by medical women qualified for less than four years were either in hospitals run by women, or voluntary hospitals for women and children.[128] Many hospitals and government bodies remained unconvinced that employing women doctors was worth the additional inconvenience; in Manchester, the governors of the city's infirmary refused to appoint a medical woman to a resident post until 1935, arguing that there was not a sufficient number of woman doctors to warrant the expenditure associated with providing separate accommodation.[129] When positions outside of hospitals for women and children did arise, the pay offered to women was often significantly less than that offered to men for the same work. By accepting such posts, medical women not only contributed towards their own exploitation, but they also served to undersell the labour of their male colleagues. The issue of equal pay was, therefore, one which affected the medical profession as a whole. Having first accepted women as members 15 years previously, the BMA worked alongside the ARMW and the LSMW to combat incidences of salary discrimination, closely monitoring advertisements placed in the *BMJ* and the *Lancet*. Any found to be offering a lower salary to medical women were printed with a clear warning notice, and the offending institution was subsequently blacklisted. Such collaboration between the different institutions reflects the fact that the presence of women doctors had been, for the most part, accepted within the medical profession once and for all.

[127] Elston, 'Women Doctors in the British Health Services', p.59; Ibid., p.83

[128] Ibid., p.225.

[129] Ibid., p.331.

At the BMA's annual meeting in 1907, it was officially resolved that: 'no distinction [should be] made on the ground of sex as regards to the amount of emoluments to be paid to lady practitioners'.[130] Bolstered by the support of the BMA, the ARMW urged its membership to refuse jobs which had evident pay discrepancies. In a letter published in the *Times* from 1908, the ARMW asserts that:

> As women are equally bound as men by the ethical laws of the profession, women practitioners should, *under no circumstances*, accept a lower salary that which has been agreed upon by the profession as a minimum [...] as medical women have had exactly the same training and education as medical men, it is difficult to see on what grounds a different scale of remuneration would be justifiable.[131]

By refusing to accept posts with discriminatory salaries, the ARMW hoped that employers would realise that they could no longer take advantage of women doctors as cheap labour. Medical women had been successfully established within the profession for over three decades; it was no longer justifiable for them to be viewed as a distinct, second-class group. As the BMA argues: 'there is no good reason whatsoever for regarding them [women doctors] in any way as a separate body of practitioners'.[132] In 1908, the ARMW resolved to found a Vigilance Committee with the BMA, in order to further monitor advertisements placed in the medical press. Louisa Garrett Anderson and May Thorne were selected to represent the Association, and in 1909 18 posts were blacklisted by the committee.[133]

Like their predecessors, the second generation of medical women were expected to remain in solidarity with one other, and to conform to the expectations of their professional body. In order to deter medical women from undermining the cause, the ARMW adopted a hard-line policy for policing pay discrimination. Intelligence was shared between the LSMW, ARMW, and the BMA, and any member known to have accepted less than the agreed upon minimum for full-time work was personally contacted by the Executive Committee of the Association.[134] It is possible that the ARMW adopted such an extreme approach because of the fact that they had been, for the first time, invited by the BMA to work alongside them on such an important issue. Anxious to

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130 'Medical Women and Public Employers', *BMJ*, 1 (11th January 1908), 106-7 (p.106).

131 'Salaries of Medical Women', *Times*, 10th January 1911, p.11. Emphasis my own.

132 'Medical Women and Public Employers', p. 106.

133 'Scottish Association of Registered Medical Women', *Lancet*, 2 (20th November 1909), 1550-51 (p.1550).

134 In 1912 it was agreed that £250 per annum as a minimum was sufficient remuneration for a full-time post.

prove themselves to the Association they aspired to emulate, the Executive Committee showed no appreciation of the difficulties faced by female medical graduates entering a competitive and over-subscribed profession. In January 1908, May Thorne, president of the ARMW, wrote to the LSMW requesting the names and contact details of two medical women who had recently accepted positions as Assistant Medical Officers for Health in Huddersfield.[135] In a probing letter to Eleanor Sproull, Thorne asks:

> Do you mind letting me know whether there is anything specially advantageous in the posts of medical officers for health at Huddersfield, one of which I understand you hold at a salary of £100-110 per annum? […] I wondered why these posts of medical officers for health were advertised for women doctors only unless it was felt that women would be willing to take lower salaries than men.[136]

In response to this probing examination, Sproull rather tellingly enquires whether Thorne's request for information is of a personal or an official nature, suggesting that she was unwilling to surrender any personal details unless they were kept private, and out of the press.[137]

In her reply, Thorne ignores Sproull's query, instead choosing to emphasise the Association's firm belief that 'medical women's work should be of the best [quality] and they should not take salaries that undersell the work of men'.[138] In an attempt to defend herself, Sproull explains that her low salary is offset by the experience that she is gaining in the field of infant mortality, and the temporary nature of the position.[139] In her opinion, if a woman doctor did not accept the salary it would be lowered even further, and the position would be advertised to nurses or unqualified inspectors, depriving medical women of a valuable opportunity.[140] Rather than vetoing the post, Thorne should consider it as a career stepping stone for medical women.[141] Unconvinced by Sproull's argument, Thorne instructed the Vigilance Committee to blacklist

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[135] Letter from Acting Secretary of the LSMW to May Thorne, 6th January 1908, SA/MWF/C.82.

[136] Letter from May Thorne to Eleanor Sproull, 16th January 1908.

[137] Letter from Eleanor Sproull to May Thorne, 18th January 1908. For more on Sproull's early career and her correspondence with her fellow Edinburgh Medical College graduates, see: Barbara Brookes, 'A Corresponding Community: Dr Agnes Bennett and her Friends from the Edinburgh Medical College for Women of the 1890s', *Medical History*, 2 (April 2008), 237-256.

[138] Letter from May Thorne to Eleanor Sproull, 21st January 1908.

[139] Letter from Eleanor Sproull to May Thorne, 24th January 1908.

[140] Ibid.

[141] Ibid.

Huddersfield, preventing the town from advertising in the *BMJ* and the *Lancet*. Unsurprisingly, Thorne's decision elicited an impassioned response from the town's chairman for health, who took the opportunity to lambast the ungrateful nature of women doctors:

> We had opened this new door for medical women – an entirely new opening – and I must ask you earnestly to consider whether it is right or fair to 'black list' a town that has done this for your branch of the profession. You cannot of course be aware of the effort I have made personally to obtain this opening for you, against prejudice and opposition of every kind. *I thought I had succeeded and now you fling this back in my face*.[142]

Such a vitriolic attack demonstrates how disruptive and unpopular the joint campaign between the BMA and the ARMW truly was, both for the medical women who were looking to further their careers, and for the town officials who wanted to fill their vacant positions.

In 1912, the Association similarly intimidated Bristol City Council into amending the salary offered for the position of Lady Medical Inspector of Midwives.[143] In a letter from the medical secretary of the BMA to Frances Ivens, the coercive role of the ARMW is made explicitly clear: 'If I hear of any women practitioners who are intending to apply for the appointment I will at once inform you, and *I trust that you will bring all the pressure to bear upon them that you can*'.[144] Unaware of the warning attached to the position, two medical women applied for the position in Bristol, but both 'expressed her inability to accept any appointment considered improper by the Associations to which she belonged' when invited to interview.[145] Evidently, the ARMW's threatening tactics were successful. The BMA congratulated the women on their courage in front of the board, remarking that: 'they were already entangled in the spider's web, and might well have been gobbled up altogether'.[146] Whilst women doctors who supported the cause were publicly praised, those who chose to prioritise self-interest over professional solidarity were isolated by the ARMW, and later by the MWF: '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'.[147]

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[142] Letter from Benjamin Broadbent to May Thorne, 29th May 1908. Emphasis my own.

[143] Letter from Acting Medical Secretary of the BMA to Frances Ivens, 26th March 1912.

[144] Ibid.

[145] 'Underpayment of Women Medical Officers', *BMJ,* 1 (27th April 1912), 972.

[146] Ibid.

[147] MWF *Newsletter* (July 1927), 40-41.

This uncompromising approach was put into practice in March 1912, when a letter was received from a member regarding her unequal salary as an Assistant Medical Officer at the Post Office.[148] Having reviewed the facts of the case, the committee concluded that 'as Miss Cooke had at a former date accepted her post under definite conditions as regards to salary, no further action could at present be taken on her behalf'.[149] Interestingly, this item is crossed through in the minute book and marked in capitals as 'Not Official', suggesting that the Executive Committee were anxious to keep their curt response off the record.[150]

At the turn of the century, women doctors occupied a uniquely precarious position within the profession; their opportunities remained limited, and due to the glut of female medical graduates many could not afford to turn down salaries deemed to be inadequate. Whilst the ARMW professed to represent the interests of all medical women, the treatment of those who chose to defy the orders of the Vigilance Committee proved that this was not strictly the case. Having faced more than a decade of isolation, the ARMW were far more concerned with gaining the respect of the BMA, rather than acknowledging the difficulties facing its members.

Women doctors and the suffrage movement

Given the history of the movement, and the fact that medical women continued to face inequalities within the profession during the early twentieth century, it is unsurprising that many second generation women doctors chose to publicly support women's fight for political representation. In her introductory address at the LSMW in 1904, Mary Murdoch urged the students sat before her to 'join a suffrage society, and to realise that when men and women cooperate in the work of a nation that nation really succeeds'.[151] Medical women's support for the suffrage movement was by no means novel; as early as the late 1860s Garrett Anderson was engaged with the cause, albeit discreetly. The fight for women's right to higher education and a professional career was far from won, and as such, other political matters required careful negotiation. In a letter to her sister, the leading suffragist Millicent Garrett Fawcett, in June 1867, Elizabeth Garrett Anderson expresses her concern over publicly giving her name to the cause as she writes: 'I think it wiser as a medical

[148] ARMW Minute Book, 4th March 1912.

[149] Ibid.

[150] Ibid.

[151] 'London (Royal Free Hospital) School of Medicine for Women', *Lancet*, 1 (18th April 1903), 1073-74 (p.1074). The LSMW did not have its own suffrage society until 1914.

woman to keep somewhat in the background as regards to other movements'.[152] Similarly, Jex-Blake, who was no stranger to controversy, showed uncharacteristic caution when she 'wonder[ed] whether it would be wise to publicly associate herself with another feminist cause'.[153] Politics and the ideals of professionalism were evidently uncomfortable bedfellows for medical women. As the suffrage movement continued to gain momentum at the turn of the century, many women doctors found themselves facing a dilemma between upholding the dignity and expectations of their profession, and being true to their own personal and political beliefs.[154]

Jennian Geddes has argued that whilst few medical women were willing to participate in militant suffrage activities, public demonstrations and marches offered a more acceptable means of showing public support for the cause.[155] On the 13th June 1908, over 10,000 women took part in the second march of the National Union of Women's Suffrage Societies (NUWSS).[156] The medical section, which contained over 140 women doctors, was headed by Garrett Anderson. All of the women proudly marched in their academic dress, with the *Times* making special note of the 'brave show they made'.[157] The lead banner carried by the medical women was said to be 'one of the most beautiful', comprising rich white silk, with the word 'Medicine' in gold letters across the top (Figure 1.5).[158] Stirred into action by the large number of women doctors participating in suffrage demonstrations, the ARMW sent a questionnaire to every woman on the Medical Register in November 1908, to ask their opinion on whether women should be given the

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[152] Blake, *The Charge of the Parasols*, p.69.

[153] Shirley Roberts, *Sophia Jex-Blake: A Woman Pioneer in Nineteenth Century Medical Reforms* (London: Routledge, 1993), p.109.

[154] For more on social class and women's responses to the suffrage movement, see: Julia Bush, *Women Against the Vote Female Anti-Suffragism in Britain* (Oxford: Oxford University Press, 2007).

[155] Jennian Geddes, 'Deeds *and* Words in the Suffrage Military Hospital in Endell Street', *Medical History*, 51 (2007), 79-98 (p.82). Among the medical woman involved in militant suffrage action was Louisa Garrett Anderson (1873-1943). She was arrested in March 1912 for smashing a window in Knightsbridge as part of a WSPU protest. Louisa Martindale (1872-1966), future president of the MWF, chose to engage with the suffrage movement through her controversial book *Under the Surface*, which was published in 1909. For more on women doctors engagement with the suffrage movement, see: Jennian F. Geddes, 'The Doctors' Dilemma: Medical Women and the British Suffrage Movement', *Women's History Review*, 18 (2009), 203-218.

[156] 'The Woman Suffrage Procession', *Times*, 13th June 1908, p.9.

[157] Ibid.

[158] Ibid.

franchise.[159] A total of 553 medical women responded to the question 'Are you in favour of women's suffrage?', with a staggering 538 answering 'yes', and only 15 answering 'no'.[160]

Figure 1.5 The lead banner of the medical section, NUWSS march, 13 June 1908 (LSE Women's Library).

The Executive Committee of the ARMW sent the conclusive results of their questionnaire to the Prime Minister, Herbert Asquith, emphasising the unique position of medical women to comment on a matter which affected not only themselves, but also their patients:

> We venture to submit that these striking figures show that the practice of our profession, which gives an intimate knowledge of the conditions of all classes, leads to the conviction that the enfranchisement of women is essential to their well-being […] we therefore ask for an opportunity to […] present the subject to you from a somewhat different point of view.[161]

The Association felt strongly that many of the social and medical ills that faced the female sex could be remedied by giving select women the right to vote, and earnestly sought the opportunity to share their distinct perspective with members of Parliament face to face. The Prime Minister's

[159] 'Women's Suffrage: Medical Women and the Premier', *Times*, 14th December 1908, p.6.

[160] Ibid.

[161] Ibid.

reply, was not, however, the response for which the ARMW were hoping. In spite of the 'influentially signed' nature of the deputation request, the 'pressure of public business' prevented the Prime Minister from receiving the medical women in person.[162] Undeterred, the Executive Committee responded with a comprehensive statement outlining the reasons why, in particular, women doctors suffered from profound 'political helplessness'.[163] While medical women were self-supporting and paid taxes, they did not have political representation. As a result, they were 'denied a voice in the regulation of [working] conditions', which went against the 'foundation of English liberty'.[164] Similarly, the majority of medical women were not only graduates from a university, but were also self-supporting, which meant that they possessed 'a double qualification for the exercise of the franchise, the property qualification and the University graduates qualification'.[165]

As members of the medical profession, women doctors were also routinely exposed to 'many classes of women […] the underpaid, the unemployed, the criminal, the degenerate, the intemperate […] and the prostitute', and as such were well placed to assert the benefits that the vote would have for them.[166] Rather ironically, whilst medical women were 'debarred from exercising the elementary right of citizenship' because of their sex, as doctors, they had 'the legal power to sign certificates of insanity which deprive[d] men of their right to vote'.[167] Medical women were united in their opinion that the enfranchisement of the female sex would have widespread social, moral, and medical benefits, however the Prime Minister was not convinced. He failed to reply to the Executive Committee's letter, which served to chasten the Association's interest and involvement in the subject. Having ensured that their exchange with the Prime Minister was published in the national newspapers, the ARMW remained silent on the issue of women's suffrage for a further two years.[168] In November 1910, the Association sent a further letter, this time signed by 404 medical women, to the Premier expressing their opinion that the final stages of the conciliation committees bill on women's suffrage should be allowed to pass.[169] They urged that 'the dignity of the House of Commons would be diminished' if the 'justice of the claim made by women

[162] Ibid.

[163] Ibid.

[164] Ibid.

[165] Ibid.

[166] Ibid.

[167] Ibid.

[168] The Association also published the exchange as a pamphlet, 'Medical Women on Women's Suffrage', which can be found at the Women's Library.

[169] 'Medical Women and the Suffrage', *BMJ*, 2 (28th November 1908), 1641.

for the Parliamentary vote' continued to be ignored, and reiterated their view that, as taxpayers, medical women were especially entitled to have a political voice.[170] Once again, Asquith failed to reply to the Association's letter, which led to the Executive Committee's unanimous decision that 'no further action in the matter should be taken'.[171]

Whilst it has previously been thought that the Association was true to its word, and had no further involvement in such political matters, archival research has uncovered a draft copy of an additional letter intended to be sent to the Prime Minister in 1912.[172] The letter reiterates the arguments made by the Association in 1908 and 1910, and further outlines the hypocrisy of female doctors not being permitted the right to vote by adding that 'medical women are entrusted with the same duties and responsibilities [as men] both legal and social […] and are employed by the State in Prisons, Schools, Public Health and the Post Office'.[173] The Association's reluctance to unreservedly ally itself with the suffrage cause can, in part, be explained by a postscript added to the letter by Frances Berry. Tellingly, she proposed that the following be added to the final paragraph: 'We trust that […] Parliament will not allow its judgement to be warped by the recent *ill-judged and unjustifiable tactics* of a small section of Woman's Suffrage supporters'.[174] The Association feared that the 'ill-judged' and 'unjustifiable' militant activities of the Women's Social and Political Union (WSPU) would 'warp' the judgement of those in power and make them blind to the rational arguments of non-radicals like themselves.[175] Clearly, the Association did not want to jeopardise its professional reputation by involving itself too deeply in the controversy that surrounded the suffrage movement. For example, in spite of its relevance to the medical

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[170] Ibid.

[171] Executive Committee Minute Book, 20th February 1911, SA/MWF/P.1/2.

[172] Geddes (2009) makes no mention of the draft letter in her study of medical women's response to the suffrage movement. This document is not dated, however given its reference to 'extending the Franchise to Men of all classes' while still leaving women 'wholly unrepresented', it is probable that this letter is referring to Asquith's 'Manhood Suffrage Bill' which was originally proposed in November 1911. The announcement of the Bill, which excluded women, led to mass window-smashing and heightened suffrage militancy in early 1912. For example, see: Sophia Wingerden, *The Women's Suffrage Movement in Britain, 1866-1928* (London: Palgrave, 1999).

[173] Draft letter to the Premier, SA/MWF/C.74.

[174] Ibid., emphasis my own.

[175] Elizabeth Garrett Anderson was a member of the WSPU between 1908 and 1911. After the heightened violence which followed the failure of the conciliation bill of 1912, she publicly detracted her support for their militant methods. For more on Garrett Anderson and Suffrage, see: Elizabeth Crawford, *The Women's Suffrage Movement: A Reference Guide, 1866-1928* (London: Routledge, 1999).

profession, and its ethical implications, the ARMW refused to offer an official position on the force feeding of suffragettes in prison.[176]

In November 1911, the Association received a letter from the London Society for Women's Suffrage (LSWS) explicitly asking for 'the support of the Association in a forthcoming demonstration and procession at Richmond'.[177] The letter was duly considered by the committee at the monthly meeting, but rather unsurprisingly, the request was rejected. The secretary was subsequently requested to send a reply to the effect that such an invitation was 'outside the scope of the association's activities'.[178] Having tried, and failed, to engage with the suffrage cause, the ARMW was no longer willing to be publicly associated with such a controversial political matter. Compared to other representative bodies of professional women, the Association's response to the suffrage movement was extremely conservative, especially in comparison to their involvement in the equal pay dispute.[179] It is, however, worth considering that during this time the ARMW were preoccupied with the National Insurance Bill, which was set to drastically alter the provision of medical care in the United Kingdom.[180] The Association had a number of members serving on the BMA's Medical-Political Committee, therefore it is perhaps understandable that this took precedence over participation in suffrage demonstrations.[181] Similarly, it is worth noting that the Executive Committee did not sanction a single medical woman for their actions as militant suffragettes during the early twentieth century.[182] This suggests that for the first time, the Association made an explicit distinction between the conduct of women doctors in a professional setting, and their conduct as private citizens, choosing to turn a blind eye to the criminal activities of a number of its members.

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[176] Whilst the ARMW itself did not take an official stance on the forcible feeding of suffragettes, individual members, such as Louisa Garrett Anderson, did. Only three medical women (including Garrett Anderson) offered an individual opinion on the matter in the *BMJ*, whilst hundreds of others signed petitions.

[177] Executive Committee Minutes, 28th November 1911.

[178] Ibid.

[179] For example, the National Association of Women Pharmacists, which was founded in 1905 by Margaret Buchanan and Isabella Clarke, was actively involved in the suffrage movement.

[180] For more on the National Insurance Act (1911), see: Martin Gorksy and Sally Sheard (eds), *Financing Medicine: The British Experience since 1750* (Abingdon: Routledge, 2006).

[181] ARMW Annual Report, 1911-1912, SA/MWF/C.74.

[182] Alice Ker (1853-1943), who was a senior member of the ARMW, was arrested alongside Louisa Garrett Anderson for smashing windows in Knightsbridge in March 1912. As a result of her actions, she was asked to resign from her position as honorary physician to the Birkenhead Rescue Home.

Conclusion

The ARMW played an integral role in supporting medical women who qualified during the latter part of the nineteenth century, having been founded at a crucial point in time. The examinations of both the KQCPI and the University of London were open to women, and by 1882, six graduates had been exclusively educated at the LSMW.[183] Had the Association not been founded when it was, medical women would have been forced to wait a further 12 years for official representation within the BMA. Undoubtedly many would have been wary of facing such strong opposition alone, and it is possible that the number of women entering the profession would have plateaued had it not been for the Association's intervention. Thus, the importance of the ARMW activities during this period cannot be overlooked.

In its first decade, the Association provided recognition for women doctors facing an uphill battle for acceptance within the male-dominated profession. Formal meetings allowed for the free exchange of medical knowledge, and served to focus the movement's efforts to gain equal opportunities for all female practitioners. Meetings of the Association also exacerbated deep-rooted tensions between the early pioneers. As the self-appointed matriarch of the group, Garrett Anderson expected all women doctors to conform to the profession's exacting standards, and to accept, without question, her authority within the movement. Unsurprisingly, Jex-Blake and Atkins found themselves unable to tolerate Garrett Anderson's status within both the organisation and the profession as a whole; both chose to cut all ties with the Association that was supposed to represent their interests. Similarly, Frikart and Barker failed to live up to the professional ideals that were thrust upon them, suggesting that the ARMW was, in many ways, deliberately ignoring the pressures facing its members in favour of focusing on the public image of the movement.

This blinkered attitude continued into the twentieth century, as the Association took an uncompromising stance on issues such as equal pay. Tasked with working alongside the BMA for the first time, the ARMW proved its commitment to the cause by publicly ostracising those who undermined its authority. Once again, the Association failed to recognise, or sympathise, with the issues affecting some of its members, instead choosing to prioritise the opinion of the Association it sought to emulate. Similarly, the ARMW made a conservative effort to engage with the suffrage movement, petitioning the Prime Minister on a number of occasions to take into consideration the views of medical women. Having received no positive response, the Association had no further

[183] 'Registered Medical Women', *Englishwoman's Review*, 1882, p.39.

involvement in the movement, refusing to represent the overwhelming opinion of its members on the public stage. Whilst the ARMW evidently struggled to navigate shifting political and social priorities, Elston's assessment that the organisation was a minimal substitute for the professional communities enjoyed by men is superficial.[184]

As this chapter demonstrates, the Association was involved in a complex process of negotiation and renegotiation, with tensions between short-term tactics and long-term strategies straining relationships with members, especially those who had just joined the profession. It proved extremely difficult for the ARMW to navigate these highs and lows, thus historians have, until now, overlooked the importance of engaging with these challenging dynamics. In spite of the fact that the ARMW achieved relatively little progress in its first three decades, the Association remained committed to its founding principle of supporting the professional and personal lives of women doctors. Opportunities for participation were made available at both the local and national level; in 1913, the Association's membership stood at over 200, with regional branches being formed across the country in Scotland, Manchester, Liverpool, Leeds, and Sheffield.[185] Far from becoming obsolete after the admission of women to the BMA in 1893, the ARMW continued to push for change within the medical profession, ensuring women doctors had a voice in the midst of growing political unrest.

[184] ARMW Annual Report, 1912-1913.

[185] Regional branches of the ARMW elected their own officers and discussed their own local business.

Chapter Two

'Can you recommend a good lady doctor?': Medical Women and the First World War, 1914-1918

In September 1914, Richard Hingston, a general practitioner from Cornwall, found himself in need of urgent help. Increasing numbers of doctors were joining the army, and the patient list at his countryside practice was becoming unmanageable. Both Hingston and his practice partner were over 50 years of age, and they could no longer cope with the extra demand brought on by the War. Having advertised the position of doctor's assistant in the medical journals to no avail, Hingston realised that a new course of action was required. With no hope of attracting any medical men of fighting age, the services of a 'lady doctor' had to be secured. He promptly wrote to the secretary of the ARMW:

> Dear Madam, can you recommend a good lady doctor? [...] All the registered medical women can't go to the War + [sic] I thought you might know of one that wants to keep the machine at home going […] The lady ought to be able to cycle.[1]

Hingston's letter accurately reflects the vexing situation on the home front shortly after war was declared. As the conflict progressed and more doctors were called up to serve with the Royal Army Medical Corps (RAMC), vacancies inevitably became more difficult to fill. Medical women therefore found themselves in the novel position of being in high demand; positions which had previously been out of reach to them became available as professional barriers disappeared. Like Hingston, many doctors found themselves relying on their female colleagues to keep their private practices open and their hospitals fully staffed. The majority of women doctors were content in keeping 'the machine at home going'; however, some felt that it was their patriotic duty to treat wounded men overseas. In spite of facing an uphill battle for recognition and acceptance in the masculine theatre of war, all-female medical units such as the Women's Hospital Corps (WHC) and the Scottish Women's Hospitals (SWH) successfully operated across Europe for the duration of the conflict. Both at home and abroad, medical women responded enthusiastically to the temporary conditions which afforded them professional freedom, and the opportunity to prove themselves as skilled practitioners on the world stage.

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[1] Letter from Richard Hingston to Kate Haslam, 14th September 1914, SA/MWF/C.158. The following letters are similarly held in this collection. The abbreviation '+' is used in letters throughout this chapter.

As the representative body of women doctors, the ARMW similarly found itself in urgent demand at the outbreak of war. Whilst the Association had struggled to position itself as an authoritative presence within the medical profession in its first three decades, this chapter argues that the First World War was a crucial turning point, as it served to validate the organisation's influence and usefulness. The roles undertaken by women doctors between 1914 and 1918 are well documented; however, a holistic view of the ARMW and MWF's work during this period has yet to be achieved.[2] Mary Ann Elston and Ian Whitehead do not mention the ARMW in their discussions of medical women in the First World War, instead choosing to focus on the role of the MWF from 1917 onwards.[3] This chapter examines the ways in which members of the Association contributed to the war effort on both the home front and the frontline, and considers how the ARMW provided support for its members during this period of international conflict. The formation of the MWF in February 1917 was a defining moment in the organisation's history, yet the motivations behind this wartime regeneration have yet to be critically analysed. Contrary to popular belief, the unequal treatment of medical women working under the War Office was not the primary driving force behind the Federation.[4] In fact, there was a significant delay between issues being raised by members and the MWF taking decisive action on their behalf. Administrative difficulties blinkered the Federation to the wider issues affecting its membership, and whilst the MWF did go on to campaign for commissions, rank, and uniform for women doctors, in doing so it alienated members whose experiences diverged from the official agenda. This chapter concludes

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[2] See, for example: Lady Frances Balfour, *Dr. Elsie Inglis* (New York: G H. Duran, 1919); Eva McLaren, *A History of the Scottish Women's Hospitals* (London: Hodder and Stoughton, 1919); Flora Murray, *Women as Army Surgeons* (London: Hodder & Stoughton, 1920); Leah Leneman, 'Medical Women at War, 1914-1918', *Medical History*, 38 (April 1994), 160-177; Lucy Noakes, *Women in the British Army, War and the Gentle Sex, 1907-1948* (Oxon: Routledge, 2006); Jennian F. Geddes, 'Deeds *and* Words in the Suffrage Military Hospital in Endell Street', *Medical History*, 51 (January 2007), 79-98; Eileen Crofton, *Angels of Mercy: A Women's Hospital on the Western Front 1914-1918* (Edinburgh: Birlinn, 2013); Ian Whitehead, *Doctors in the Great War* (Barnsley: Pen & Sword, 2013); Claire Brock, *British Women Surgeons and their Patients, 1860-1918* (Cambridge: Cambridge University Press, 2017); Marlène Cornelis, '"My dears, if you are successful over this work, you will have carried women's profession forward a hundred years:" The Case of the Scottish Women's Hospital for Foreign Service', unpublished master's thesis, University of Glasgow, 2018; Wendy Moore, *Endell Street: The Trailblazing Women who Ran World War One's Most Remarkable Military Hospital* (London: Atlantic Books, 2020); Natasha Stoyce, 'Theatres of War: The Experiences of the Serbian Unit of the Scottish Women's Hospitals during the Great War', unpublished doctoral thesis, University of Leicester, 2021.

[3] Mary Ann Elston, 'Women Doctors and in the British Health Services: A Sociological study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986, pp.263-295; Ian Whitehead, *Doctors in the Great War* (Barnsley: Pen & Sword, 2013), pp.107-125.

[4] Managing Committee Minutes, 21st March 1912, SA.MWF/P.1/2.

by assessing the impact that the First World War had upon the wider position of women in medicine.

Outbreak of war

On the 14th August 1914, just 10 days after Britain declared war on Germany, the ARMW sent an urgent circular to every qualified medical woman requesting details of the assistance they were able to give during the current state of national emergency.[5] In spite of membership numbers only totalling 155 at the end of the 1913-14 committee year, the Association intended to become a bureau of information that represented every woman on the Medical Register.[6] The ARMW's circular made it clear what the role of women doctors was likely going to be during the War: 'medical women will […] be needed for civilian work rather than work directly connected with the army […] there will be vacancies at home which medical women may usefully fill'.[7] In August 1914, approximately 3000 medical officers held commissions with the RAMC.[8] By December, this had risen to 5000 – almost 20 per cent of all medical men.[9] Whilst there were no major shortages of doctors during the first months of the War, as Hingston's letter shows, changes were beginning to be felt at a local level, and the number of men leaving for the army was guaranteed to rise. Thus it was of paramount importance that data should be collected on the availability of female practitioners across the United Kingdom, in order to effectively organise help where it was needed most. The surviving reports offer fascinating insights into medical women's initial reactions to the War. Across the country, women doctors were preparing to serve their local communities in any way they could, and were eager to show the Association that they were doing their bit for the war effort.[10]

[5] Association of Registered Medical Women circular, 14th August 1914, SA/MWF/C.157.

[6] List of Members of the Association of Registered Medical Women 1913-1914, SA/MWF/C.74.

[7] Association of Registered Medical Women circular, 14th August 1914.

[8] Mary Ann Elston, 'Women Doctors in the British in the British Health Services: a Sociological Study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986, p.265.

[9] Ibid., p.266. By January 1918, 50 per cent of male doctors were recorded as serving in the armed forces.

[10] Hand-written and typed lists which detail the names and addresses of women doctors willing to help with the war effort suggest that approximately 80 medical women responded to the circular, representing 51 per cent of members. Approximately 24 of these letters have survived.

Many medical women were ready to respond to the ARMW's call to arms, having organised their own arrangements with husbands and colleagues as soon as it had become clear that war was imminent. In Dartmouth, Violet Alabaster was making preparations to take over her husband's private practice after he volunteered his services to the RAMC; whilst in Ramsgate, Grace Dundas was appointed by the town council to cover her husband's role as medical officer for health.[11] Several local authorities temporarily rescinded their marriage bars at the beginning of the War, allowing married medical women to apply for senior appointments in hospitals and public health services.[12] In Buckinghamshire, Zilla Scruley occupied the roles of both acting school medical officer and medical officer for health for the county, whilst in Scarborough, Helen Gingsby worked in the local town asylum for a colleague who had gone to the front.[13] Similarly in Leeds, Clara Stewart had taken over her husband's full time role as clinical pathologist to the general infirmary, as he had been forced to move to the resident staff of the hospital 'as they were so short of qualified men'.[14] Answering the Association's call for information, Stewart wrote: 'One woman here is helping with anaesthetics in place of a man who is in the RAMC, but I have not heard of any special opportunity for medical women to help in this district'.[15] As would be expected, hospitals across the country were affected differently depending on the number of medical men that had been called up for service with the army.

It is interesting to note that whilst medical women continued to be paid less than men in a number of hospital positions and government roles, many were eager to volunteer their services pro bono for the families and dependents of serving men in their communities. In Croydon, Ella Flint found herself stretched just weeks after the outbreak of war:

> I have already promised gratuitous attendance to dependents of those serving with the army […] In addition to this I am engaged already to attend some midwifery on behalf of + solely in the interest of a doctor of this neighbourhood

[11] Letter from Violet Alabaster to K. Haslam, 20th August 1914; Letter from Grace Dundas to K. Haslam, 14th August 1914.

[12] Elston, 'Women Doctors in the British Health Services', p.289. As Chapter Three investigates, marriage bars came back into force in many public posts during the interwar years. In London, medical women working for the county council could only be exempted if they provided annual proof that their husbands were unable to financially support them.

[13] Letter from Zilla Scruley to K. Haslam, 5th September 1914; Letter from Helen Gingsby to K. Haslam, 5th September 1914.

[14] Letter from Clara Stewart to K. Haslam, 25th August 1914.

[15] Ibid. The anaesthetist Stewart refers to here is Rhoda Adamson (1886-1971).

> who has gone off to the War. I think I shall not have much time to undertake any other work but will of course do anything gratuitously that I can in this town.[16]

Similar stories of gratuitous work came from women doctors across the country. In York, Louise Fraser planned to provide maternity services to the wives of army reservists, whilst in Brighton, Helen Scatcliff had agreed to treat the families of her husband's men whilst he served as a Territorial Army officer.[17] Likewise in Manchester, Margaret Hutton had arranged to work as matron at the local emergency hospital for the Red Cross, whilst in Paignton, Muriel Morris had formed a voluntary hospital with 22 beds with the capacity to expand to 50.[18] As these letters demonstrate, medical women undertook a wide variety of roles throughout the conflict, allowing them to expand their clinical experience and to pursue their ambitions of working as independent practitioners. Many women doctors found themselves in the privileged position of being able to provide some of their services free of charge; however, others simply could not afford to. Maud Ferié self-consciously writes: 'Unfortunately [I can] only take a paid post. I am a little over thirty years of age. I have excellent testimonials, and I think I may truthfully say I am a fairly capable medical woman'.[19] Ferié, who was a New Zealand national, eventually found work as a Clinical Assistant at Great Ormond Street Hospital.[20]

The balance of evidence indicates that the majority of women doctors planned to meet the medical needs of their local communities. However, for a small number of individuals, this was not enough, as they believed their skills could be used to help those directly affected by the War. In South Hampstead, Mary Acworth hoped to get closer to the action: 'I am willing to give any medical service I can + I do not desire payment. I should be glad to know what help is required + if I could assist with the wounded'.[21] In Malvern, Mabel Williams believed her conflict experience could be put to good use in a hospital run by women: 'I had charge of the Base Hospital on the Corfu coast during the Atlantic war, and I have the ordinary officer medal for active service […] I

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[16] Letter from Ella Flint to K. Haslam, 26th August 1914. Original emphasis.

[17] Letter from Louise Fraser to K. Haslam, 19th August 1914; Letter from Helen Scatcliff to K. Haslam, 31st August 1914.

[18] Letter from Mary Hutton to K. Haslam, 16th August 1914; Information on Muriel Morris taken from hand-written list.

[19] Letter from Maud Ferié to K. Haslam, 5th September 1914.

[20] 'Maud Ferié', UK and Ireland Medical Directory, <www.ancestry.com> [accessed 18th December 2019].

[21] Letter from Mary Acworth to K. Haslam, 16th August 1914.

could go to any hospital where help was most needed'.[22] Eager to contribute to the rehabilitation of wounded soldiers, Florence 'Barrie' Lambert had already offered her scheme of massage therapy to the War Office and Red Cross: 'I think I had better stick to that as it will entail a great deal of work'.[23] Lambert's massage corps became so successful that she was later awarded the honorary rank of major by the RAMC in 1915, and was asked to supervise all of the massage and electrical departments attached to convalescent camps throughout England and Northern Ireland.[24] Medical women practising abroad similarly expressed their interest to help with the war effort. In Northern India, Mary Iles felt compelled to contribute: 'Now people are saying the War will last several years […] if you should be short of women doctors I would like to help'.[25] Likewise in Haringey, Eleanor Hill found her practice overseas disrupted by the War: 'I should have been returning to my hospital in Baghdad this autumn but will probably be prevented from doing so […] I am anxious to find some temporary work'.[26] As we shall see in Chapter Four, medical women practising overseas during the Second World War were similarly conflicted between prioritising their own personal safety and fulfilling their sense of duty to the patients who depended upon them.

As had been hoped, those in need of a woman doctor contacted the ARMW for assistance. In Hereford, a 'lady locum' was needed for a small district practice, though their ability to become a female companion, rather than a professional colleague, was deemed to be most important: 'Nice open place and not much work and comfortable home – want someone who would be company for wife'.[27] In spite of the demand for medical women increasing dramatically, in many cases, respect for their professional work remained low. It is possible that this would have become more apparent as the War progressed; a significant majority of the male general practitioners left behind on the home front were ineligible for military service due to their advanced age, making it more likely that they would have held such antiquated views.[28] This would inevitably have had some impact on the experiences of women doctors during wartime. Hospitals were similarly forced to expand the roles of their female house surgeons in order to keep up with demand. In Scarborough, a House Surgeon was required for the general infirmary. Interestingly, no gender for the post was specified, as was usually the case: 'the work is not excessive; it is varied;

[22] Letter from Mabel Williams to K. Haslam, 18th August 1914.

[23] Letter from Barrie Lambert to K. Haslam, 15th August 1914.

[24] 'Dame Barrie Lambert', *BMJ*, 2 (21st December 1957), 1494.

[25] Letter from M. Iles to K. Haslam, 20th September 1914. Iles later went on to serve with the RAMC in Malta.

[26] Letter from Elanor Hill to K. Haslam, undated.

[27] Letter from The Medical Agency to K. Haslam, 31st August 1914.

[28] For more on relations between male and female colleagues in hospital practice during the War, see Brock (2017).

patients of both sexes, medical + surgical are looked after by the House Surgeon'.[29] Some calls for help received by the ARMW were more conventional than others. In Kensington, philanthropist Catherine Shaw hoped to engage the services of a medical woman in order to fulfil her ambitious plan of accommodating 16 wounded Indian soldiers: 'My scheme is for a resident lady physician + 3 nurses. I want a lady doctor who knows Hindustani + India + is sympathetic + likes its peoples + she must be a skilful surgeon'.[30] It is unknown whether Shaw's excessive requirements were ever filled, but what is clear is that the services of women doctors were in high demand at the outbreak of war. Howard Marsh, Professor of Surgery at the University of Cambridge, summarised the unprecedented situation in the final months of 1914 in the following terms: 'I believe another epoch for women is at hand'.[31] Women doctors reacted to the outbreak of war with action and purpose; however, in the months and years that followed, many were left feeling overwhelmed at their increased responsibility, and the feelings of professional isolation that followed.[32] Having succeeded in rallying medical women across the country to share their contributions towards the war effort, the ARMW were faced with one of their most challenging tasks to date – namely providing personal and professional support to its members during a time of unprecedented uncertainty and upheaval.

Medical women on the home front

Whilst the work carried out by medical women who served in voluntary hospital units overseas has been written about extensively, comparatively less attention has been given to the quotidian experiences of women doctors who remained on British soil to treat the civilian population. The notable exception is Claire Brock, who offers a detailed account of the surgical experiences of medical women operating on the home front and overseas between 1914 and 1918.[33] Few contemporaneous accounts of civilian medicine were ever recorded, perhaps because this work

[29] Letter from M. Walker to K Haslam, 1st September 1914.

[30] Letter from Catherine Shaw to K. Haslam, 22nd October 1914. Emphasis in original.

[31] 'The Need for Medical Women', *The Common Cause,* 11th December 1914, p.591.

[32] For more on professional isolation both during and after the First World War, see: Carol Dyhouse, 'Driving Ambitions: Women in Pursuit of a Medical Education, 1890-1939', *Women's History Review*, 7 (1998), 321-343, and Carol Dyhouse, 'Women Students and the London Medical Schools 1914-39: The Anatomy of a Masculine Culture', *Gender and History*, 10 (1998), 110-132.

[33] Claire Brock, *British Women Surgeons and their Patents, 1860-1918* (Cambridge: Cambridge University Press, 2017).

was not deemed to be noteworthy in comparison to frontline medicine, or because these medical women were simply too busy to make a record of their experiences.[34] As Chapter Four demonstrates, this similarly remained the case during the Second World War, as medical women eschewed all forms of public memorial. Because of this, the thoughts, feelings, and experiences of the hundreds of medical women who helped to keep the 'machine at home going' during both world wars have proved difficult to trace.[35] In 2019, the archive of two doctors, Muriel Lloyd and her husband, Maitland Radford, was made available to the public at the Wellcome Library, London.[36] Lloyd graduated from the LSMW in 1913, and worked in a number of junior hospital positions during the war years.[37] After being awarded a Diploma in Public Health (DPH) in 1917, she went on to have a distinguished career in maternity and child welfare, working in deprived communities across London until her retirement in 1961.[38] This untapped resource, which includes letters written between the two during the First World War, offers novel insights into the personal and professional difficulties faced by women doctors during this period of international conflict. Though remaining on the home front was considered by the government to be the only viable option for medical women, recent graduates like Lloyd were left feeling immense frustration at their options being limited on account of their sex. Compared to the heroics of treating soldiers injured in battle, routine hospital work was viewed as monotonous, with limited opportunities for excitement of any kind.

In August 1914, Lloyd was working 30 hours a week as an Assistant Anaesthetist at the RFH.[39] As was routinely the case for junior positions such as this, the role was both temporary and unpaid, but board and lodging were provided.[40] In a letter to Radford written three days after war had been declared, Lloyd expressed her irritation at being confined to the home front:

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[34] The Liddle Collection, housed at the Brotherton Library, Leeds, contains a small number of recollections from medical women who practised on the home front and overseas during the First World War, including Ruth Verney (1894-1986).

[35] In comparison, there are many letters, diaries, and published recollections of medical women who served with voluntary hospitals overseas. The wartime letters of Louisa Garrett Anderson are held at the Women's Library, London. Correspondence and diaries relating to the Scottish Women's Hospitals are similarly held at the Women's Library, London, and at the Mitchell Library, Glasgow.

[36] 'Radford, Drs Maitland and Muriel', PPRAD, Wellcome Library, London.

[37] 'Particulars in relation to Dr Muriel Radford's applications', undated typed list, PP/RAD/A/1.

[38] 'Muriel A Radford', *BMJ,* 1 (30th April 1983), 1450-1451. Lloyd died in 1983, aged 84.

[39] 'Royal Free Hospital', undated handwritten work schedule, PP/RAD/A/1.

[40] Elston, 'Women Doctors in the British Health Services', p.291.

> *We all envy you* […] according to the War Office women doctors + students are encumbrances in active service […] we are going to help in the wards or wherever we shall be needed in the hospital. We can also join the Red Cross Society and if needed bring the wounded into the hospitals. So here I am, still being assistant anaesthetist, waiting, + watching. I have given 12 [anaesthetics] + so far no fatalities […] Everybody talks war + thinks war. Our hospital is third on the reserve list, so I daresay we will be busy presently.[41]

As an 'encumbrance', Lloyd was forced to wait in anticipation for the chance to prove herself useful. Whilst she lists the areas in which she can keep herself busy, it is clear that Lloyd felt static, 'watching + waiting' as everything changed around her. Her ongoing tally of successful anaesthetics served as the only marker of her professional progress. One week later, Lloyd's exasperation at her own inaction had reached boiling point: 'One is getting more and more restless wondering when one's own chance will come […] I LONG to be a MAN. And to wear uniform'.[42] Not only could medical men like Radford use their skills to treat the wounded overseas, but they also had the privilege and honour of wearing military uniform whilst doing it. For Lloyd, this was a double-blow. Medical women enjoyed greater professional freedoms than ever before on the home front, but many remained unsatisfied with their positions, and longed for the opportunity to join the action overseas.

In September 1914, news of Louisa Garrett Anderson and Flora Murray's intentions to take a hospital unit to France quickly spread within the tight-knit community of London medical women of which Lloyd was a member. Unsurprisingly, the opportunity to serve with the WHC was highly sought after; not only did it offer women doctors the promise of a thrilling adventure into the unknown, but it also offered them the chance to be part of something bigger. In spite of her enthusiasm to escape the mundanity of the home front, Lloyd was not chosen to join Garrett Anderson and Murray in France. In a letter to Radford, Lloyd failed to hide her bitter disappointment at not being 'one of the lucky ones':

> Such a fight has been going on – Duty v. Love of new Experiences and Excitement. The French government are very keen to have a hospital run by women […] Miss Garrett Anderson is setting it up + at first they thought they'd need 12 doctors. I was asked to be one of them – today they had a committee +

[41] Letter from Muriel Lloyd to Maitland Radford, 7th August 1914, Wellcome Library, London, PP/RAD/C/2/1. Emphasis my own. Further letters are taken from this collection unless stated otherwise.

[42] Letter from Lloyd to Radford, 13th August 1914. Emphasis in original.

> only six will go. If necessary they'll send back for more. But I do feel that at present women are needed at home, there are hardly enough of us to fill our own posts […] Mac [Lloyd's friend] was asked to go too, she was much more firm in her refusal than I was + I shall hope to go later on.[43]

In an attempt to mitigate her feelings, Lloyd rewrites the narrative, stating that she refused the WHC's offer on account of her sense of 'duty' to the civilian population. It seems more likely that Lloyd was not chosen because the Corps already had an able anaesthetist in Murray, and because she had not practised surgery since graduating from medical school. Though Lloyd was undoubtedly jealous of her colleagues who went to France, her letters show that she continued to take a keen interest in the work being carried out by medical women overseas.

As increasing numbers of medical men left their posts on the home front to serve overseas, women doctors were given greater opportunities to expand their clinical experience. Whilst many medical women relished the chance to prove themselves as competent practitioners in positions which had previously been closed to them, some were left feeling unprepared for the roles which they were expected to fulfil.[44] For Lloyd, having to work independently with limited senior support was a particularly stressful experience:

> Casualty work at present consists of everything […] At times it seethes […] You just sort of swim your way through the patients + hope you are treating them right + at times I long to run away from the hotness of it all. Anaesthetics have now reached 62 […] they are going alright except for one man who stopped breathing for about a minute – too much $CHCl_3$! [Chloroform]. But he soon recovered.[45]

The responsibility of administering anaesthetics was one which continued to weigh heavily on Lloyd's mind throughout her time at the RFH: 'I'm terrified of not being able to cope when things go wrong'.[46] Whilst the professional ambitions of young medical women thrived under wartime

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[43] Letter from Lloyd to Radford, 2nd September 1914.

[44] For more on women doctor's experiences on the home front, see Brock (2017).

[45] Letter from Lloyd to Radford, 30th August 1914.

[46] Letter from Lloyd to Radford, 4th September 1914. For more on the history of emotions during wartime, see: Michael Roper, *The Secret Battle, Emotional Survival in the Great War* (Manchester: Manchester University Press, 2010); Christine E. Hallett, *Containing Trauma Nursing Work in the First World War* (Manchester: Manchester University Press, 2011); Christine E. Hallett, '"Emotional Nursing": Involvement, Engagement, and Detachment in the Writings of First World War Nurses and VADs', in *First World War Nursing: New Perspectives*, ed. by Alison S. Fell, and Christine E. Hallett (Oxon: Routledge, 2013), pp.182-213; Lucy Noakes, *Dying for the Nation: Death, Grief and Bereavement in Second*

conditions, anxieties surrounding their relative competency and experience continued to simmer just below the surface. It is interesting to note Lloyd's use of 'when' rather than 'if'; in spite of new surgical innovations in the early twentieth century, chloroform remained a dangerous and unpredictable anaesthetic.[47]

Medical women were similarly tested when it came to treating male patients on the wards. As had been the case in Scarborough, the RFH had no choice but to broaden the scope of women's hospital work on account of the ongoing shortages.[48] For the first time, women doctors were exposed to treating adult male patients outside of the casualty department.[49] Having internalised the Victorian ideals of what was deemed to be appropriate for a female practitioner, Lloyd was initially reluctant to partake of the new working conditions: 'they [the hospital] asked me to take the House Physician's place … but you know my convictions with regard to men patients, so of course I said no'.[50] In spite of the progress made since women first qualified to practise medicine in the late nineteenth century, practitioners such as Lloyd continued to primarily treat the diseases of women and children, as this was deemed to be most agreeable for both doctor and patient.[51] On account of the War, such restrictions, whether imposed by institutions or by women doctors themselves, were no longer tenable. Two months later, Lloyd's reservations had disappeared; faced with the end of her temporary six-month contract, she had no choice but to be pragmatic and to accept the challenge posed by the new position: 'You will be amused when I tell you that on my new post I shall have a ward of twenty men patients […] no men applied, so they appointed two women House Physician's and two women House Surgeon's [sic]'.[52] Despite her initial scepticism, Lloyd found treating male patients 'surprisingly enjoyable'.[53] Even so, it is perhaps telling that, after spending two years treating children at the North Eastern Fever Hospital between May 1915 and

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World War Britain (Manchester: Manchester University Press, 2020); Lucy Noakes, Claire Langhamer and Claudia Siebrecht (eds), *Total War, An Emotional History* (Oxford: Oxford University Press, 2020); Linda Maynard, *Brothers in the Great War Siblings, Masculinity and Emotions* (Manchester: Manchester University Press, 2021).

[47] Stephanie J. Snow, 'Surgery and Anaesthesia: Revolutions in Practice', in *The Palgrave Handbook of the History of Surgery*, ed. by Thomas Schlich (London: Palgrave, 2018), pp.195-214 (p.208).

[48] A similar situation also occurred at Hampstead General Hospital. See Brock (2017).

[49] Brock, *British Women Surgeons*, p.249.

[50] Letter from Lloyd to Radford, 17th August 1914.

[51] For example, see: Mary Ann Elston, 'Run by Women, (mainly) for Women: Medical Women's Hospitals in Britain, 1866-1948', *Women and Modern Medicine*, ed. by Anne Hardy and Lawrence Conrad (Amsterdam: Rodopi, 2001), pp.73-108.

[52] Letter from Lloyd to Radford, 26th October 1914. Emphasis in original.

[53] Letter from Lloyd to Radford, 2nd November 1914.

September 1917, Lloyd ended the War as a medical officer to the antenatal clinics at the King Edward Memorial Hospital in Ealing.[54] Lloyd's time treating male patients at the RFH was an enlightening experiment, but it did little to change the course of her career.

As Lloyd's letters demonstrate, hospital work on the home front was full of unique challenges for medical women, especially for those who had only recently graduated. Young medical women were especially eager for the chance to prove themselves capable in the theatre of war, and had to navigate a complex range of emotions when colleagues, friends, and fiancés were offered the opportunity to treat the wounded in Europe, and they had to stay behind. Similarly, women doctors like Lloyd were given greater responsibility and freedom as more men left for the front, but this often led to crises of confidence, as there was an expectation to carry out duties which they felt unprepared for. Lloyd's letters suggest that the 'horror and ugliness of War' had the propensity to make medical women feel isolated and despondent: 'I often feel very sad and lonely […] One longs to have thoughts other than one's own for companions'.[55] Whilst such sources are scarce, Lloyd's unique testimony provides insights into the typical experiences of women doctors on the home front, and the difficulties which they faced.

After lobbying medical women to share their contributions towards the war effort, the ARMW refocused its efforts on offering professional and personal support to medical women during a time of great uncertainty. Throughout the War, scientific discussions continued to take place at the monthly meetings, with topics being chosen by members. These discussions offered the opportunity for medical women to share knowledge with one another, whilst also providing support for those who felt the need to enhance their clinical skills. Similarly, in March 1915, the dinner which usually accompanied the annual meeting was cancelled on account of the food shortages being experienced across the country.[56] It was replaced with an afternoon 'at home' with the Association's president, Jane Walker, which allowed medical women from different career stages to socialise with one another in an informal environment. Furthermore, the ARMW made a concerted effort to keep its membership informed of the work being carried out by medical women overseas. This helped to keep members connected with one another, in spite of the distance which stood between them.

In the 1914-15 committee year, talks on medical women and the War were given at a number of the monthly meetings by Louisa Aldrich-Blake, Hilda Clarke, Florence Lambert,

[54] 'Particulars in relation to Dr Muriel Radford's applications', undated typed list.

[55] Letter from Lloyd to Radford, 26th October 1914.

[56] ARMW Managing Committee Minutes, 26th January 1915.

Florence Stoney, Elsie Inglis, and Mabel Ramsay.[57] Collections for gifts and monetary donations were also organised by the Association for the hospital at Royaumont run by Frances Ivens.[58] Following the successful opening of Endell Street Military Hospital in early 1915, members of the ARMW's Executive Committee formed an additional sub-committee to discuss the possibilities of opening their own open-air hospital in London, staffed exclusively by medical women.[59] Walker and Aldrich-Blake, who was honorary treasurer, joined forces with representatives from the NHW, RFH, and LSMW. The subcommittee forwarded their plan to the War Office, and were told by Sir Alfred Keogh, Director General of Army Medical Services, that their offer would be gratefully received if the need were to arise.[60] Far from being ineffective during the first half of the conflict, the ARMW continued to play an important role in the professional lives of medical women, especially those who remained on the home front. For members like Lloyd, the professional network offered by the Association was indispensable; not only did it help to diminish feelings of loneliness, but it also provided medical women with the support necessary to make the most of the new opportunities open to them.

Medical women overseas

At the outbreak of war, the government initially dismissed the services of medical women wanting to assist the war machine overseas, being of the firm opinion that they would be encumbrances on active service. Undeterred by the difficulties faced in going overseas without the support of the War Office, women doctors founded and funded their own hospital units, operating throughout Europe for the duration of the War. The two most prominent organisations were the WHC and SWH; collectively, they engaged the services of over 100 medical women.[61] Garrett Anderson, Murray, and Inglis, the women doctors who headed these units, were all members of the ARMW.[62] Given the extent of their activities across Western and Southern Europe, the WHC and the SWH

[57] ARMW Annual Report, 1914-1915, SA/MWF/C.74.

[58] Managing Committee Minutes, 24th November 1914.

[59] ARMW Annual Report, 1914-1915.

[60] Ibid.

[61] Cornelis (2018) defines the SWH cohort as 92 medical women. Geddes (2006) notes that 15 medical women worked with the WHC at Endell Street Military Hospital.

[62] List of Members of the Association of Registered Medical Women 1913-1914.

have received considerable historical attention.[63] The Women's Imperial Service League (WISL), another hospital unit staffed exclusively by medical women, has been largely overlooked.[64] In comparison to the WHC and the SWH, the WISL spent only five months in Antwerp and Cherbourg, treating hundreds, rather than thousands, of patients.[65] Despite this, the unit still made a valuable contribution to the war effort, proving, without question, that women doctors were able to uphold the highest standards of professionalism, even in the most challenging of circumstances.[66] Mabel St Clair Stobart, an ardent suffragist and aid-worker with no formal medical training, organised the WISL to go to Antwerp under the Belgian Red Cross in September 1914 (Figure 2.1).[67] Significantly, all six members of the medical staff – Florence Stoney, Mabel Ramsay, Joan Watts, Emily Morris, Helen Hanson, and Rose Turner – were members of the ARMW.[68] The women chosen were a mixture of well-established and newly-qualified doctors; Stoney, Hanson, and Turner had been qualified for 19, 16, and 13 years respectively, whilst Watts, Ramsay, and Morris had all been qualified for five years or fewer.[69]

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[63] For the WHC, see: Flora Murray, *Women as Army Surgeons*, (London: Hodder & Stoughton, 1920); Jennian F. Geddes, 'Deeds *and* Words in the Suffrage Military Hospital in Endell Street', *Medical History*, 51 (January 2007), 79-98; Wendy Moore, *Endell Street: The Trailblazing Women who Ran World War One's Most Remarkable Military Hospital* (London: Atlantic Books, 2020). For the SWH, see: Eva McLaren, *A History of the Scottish Women's Hospitals* (London: Hodder and Stoughton, 1919); Eileen Crofton, *Angels of Mercy: A Women's Hospital on the Western Front 1914-1918* (Edinburgh: Birlinn, 2013); Natasha Stoyce, 'Theatres of War: The Experiences of the Serbian Unit of the Scottish Women's Hospitals during the Great War', unpublished doctoral thesis, University of Leicester, 2021.

[64] Brock (2017) and Thomas (2019) offer brief accounts of the WISL in relation to the work of Florence Stoney.

[65] Mabel L. Ramsay and Florence A. Stoney, 'Anglo-French Hospital, No. 2, Chateau Tourlaville, Cherbourg', *BMJ*, 1 (5th June 1915), 966-68 (p.966).

[66] It is worth noting that historic accounts of units such as the WHC, SWH, and WISL authored by medical women themselves are hagiographic in nature, having been written with the explicit intention of furthering the case of women doctors. Such accounts self-consciously expunge the negative and unflattering moments which would have inevitably occurred. For more on issues relating to representativeness and 'truth', see: Jessica Meyer (ed), *British Popular Culture and the First World War* (Leiden: Brill, 2008).

[67] Mabel St Clair Stobart, *The Flaming Sword in Serbia and Elsewhere* (London: Hodder and Stoughton, 1916), p.10.

[68] List of Members of the Association of Registered Medical Women 1913-1914.

[69] 'Florence Stoney'; 'Mabel Ramsey'; 'Joan Watts'; Emily Morris'; 'Helen Hanson'; 'Rose Turner', UK and Ireland Medical Directory <www.ancestry.com> [accessed November 5th 2019].

Figure 2.1 The medical and nursing staff of the WISL hospital at Antwerp, 1914. Stobart is sat in the centre of the image, with Stoney on her right, and Ramsay on her left (Imperial War Museum).

After two days of travel, the unit reached Antwerp on the 22nd September 1914.[70] Under the leadership of Stoney, the disused concert hall they had been allocated was made ready for patients. Ramsay recalls that:

> Within two hours we had all set to work and cleaned up the hospital and the beds we had brought were set up and we were ready to receive patients. The operating theatre was made ready and two days layer the X-ray room was in working order […] All the members of the unit were duly inoculated against typhoid within 24 hours of arrival. There were many alterations required to make this concert hall suitable, i.e. basins, baths, proper lavatory accommodation, stoves for warming, etc. All was expeditiously put in, almost as quickly as the rubbing of Aladdin's lamp.[71]

Though these tasks were menial, the medical women seized the opportunity to make a clean and efficient hospital out of their disorderly surroundings. The unit's 150 beds were soon filled, and

[70] Mabel L. Ramsay, 'Women's Imperial Service Hospital at Antwerp', <http://scarletfinders.co.uk> [accessed 20th October 2019].

[71] Ibid.

the staff of the WISL worked 'all day and all night' to keep up with the patients who arrived from the front.[72] Working conditions for the women doctors were far removed from what they were used to at home; operations could only be conducted during daylight on account of the enforced blackout across the city, and after a German bomb struck the local pumping station, water had to be collected by hand from a nearby well.[73]

As the Germans advanced through Belgium, the WISL found themselves facing increasing dangers. One week after the unit arrived in Antwerp, bombings of the city intensified.[74] Morris and Turner felt obliged to return to England, whilst the remaining medical staff waited for orders to evacuate the city.[75] On the 8th October 1914, the aerial bombardment of Antwerp began, and the hospital found itself under direct fire.[76] Patients who could be safely moved were carried down to the cellar by the female staff. According to Stobart, the medical women:

> Took no notice of the shells, which whizzed over our heads, without ceasing, at the rate of four a minute, and dropped with the bang of a thousand thunderclaps, burning, shattering, destroying everything around us.[77]

The hospital took a number of close hits, but the remaining medical women remained calm under immense pressure, working tirelessly to ensure that their patients were safe. Ramsay recalls that 'about 9 am a shell fell just in front of the hospital close to the cellars, but no one was hurt. A tea-cloth lying on the ground to dry disappeared and was seen no more'.[78] Unwilling to dwell on the immense danger which they found themselves in, the unit organised an evacuation of the medical staff, commandeering several London motor buses.[79] Stoney describes the surreal experience of leaving the burning city sat on an ammunition case: 'the city was blazing in over twenty places, the oil reservoirs [were] in a pillar of fire 100 feet high, but nothing else seemed to matter once we got

[72] Ibid.

[73] Ibid.

[74] Ibid.

[75] Ibid.

[76] Ibid.

[77] Stobart, *Flaming Sword*, p.10.

[78] Ramsay, 'Women's Imperial Service Hospital'. Emphasis my own.

[79] Ibid.

away from the whiz of the shells'.[80] Staggeringly, no members of the WISL were injured during the offensive and the evacuation which followed.

Having survived the 18-hour bombardment of the city, the unit returned to England, and news of their heroism quickly spread. As Stobart notes, 'The principle that women could successfully conduct a war hospital in all its various departments had now been amply proved'.[81] In November 1914, Stobart was invited by the French Red Cross to establish another hospital in Cherbourg, this time in a disused chateau (Figure 2.2).[82] Stoney, Ramsay, and Watts resumed their positions on the medical staff, and were joined by three other medical women – Mildred Staley, Kathleen Gibson, and Ina Clarke.[83] In December 1914, Mary Keene, a fellow member of the ARMW, spent two weeks at the hospital in order to cover some of the women doctors' Christmas leave.[84] She later reported her experiences back to the Association:

> The Chateau was not well-suited to use as a Hospital, however there were some good large rooms which provided the wards […] I undertook injections and dressings changes. The patients we received came straight from having a field dressing which had not been changed for three or four days! […] I was horrified by the state of the wounds. Pus literally poured out from huge pockets almost by the pint […] Miss Aldrich-Blake visited the hospital just after Christmas, and we were all so jubilant when an amputation through the thigh which she performed healed perfectly.[85]

The realities of front-line medicine proved to be shocking to Keene. Though the work included life-saving surgery, medical women spent the majority of their time on the time-consuming task of trying to stop the spread of infection in patients with festering wounds.

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[80] Florence A. Stoney, 'The Women's Imperial Service League Hospital', *Archives of the Roentgen Bay*, 19 (April 1915), 388-93 (p.388).

[81] Stobart, *Flaming Sword*, p.13.

[82] Stoney, 'The Women's Imperial Service League Hospital', p.388.

[83] Mabel L. Ramsay and Florence A. Stoney, 'Anglo-French Hospital, No. 2, Chateau Tourlaville, Cherbourg', *BMJ*, 1 (5th June 1915), 966-68 (p.966). Staley (1866-1947) qualified in 1891, whilst Clarke (1885-1953) qualified in 1909. Gibson (?-?) was not fully qualified, and was only in possession of the M.B.

[84] Mary Keene, 'Account of Visit to Mrs Sinclair Stobart's unit, Cherbourg, 1914', SA/MWF/C.169.

[85] Ibid.

Figure 2.2 Anglo-French Hospital No. 2, Chateau Tourlaville, Cherbourg (Wikimedia).

Between November 1914 and February 1915, the unit treated 206 patients at the chateau.[86] Stoney recalls that the consulting surgeon for the whole of Cherbourg begrudgingly came to visit the hospital, thinking that it was a waste of time to see somewhere staffed entirely by women doctors.[87] On seeing the brilliant work of the medical staff, he was forced to concede that: 'The Cherbourg hospital is very well organized, the patients are very well cared for and the surgeons are of equal value to the best surgeons'.[88] The WISL had proved that medical women were just as skilled as their male counterparts in surgery, and were also capable of organising their own hospital, much to the surprise of the consulting surgeon. By February 1915, the flow of patients to Cherbourg was beginning to slow. Moved by the plight of the Serbian typhoid epidemic, Stobart and half of the hospital staff returned home in preparation for their new venture, whilst Stoney and the remaining medical women continued to treat the few patients left at the chateau.[89] The following month, the hospital could no longer justify its running costs, so the unit's resources were split between the French Red Cross and the SWH hospital at Royaumont.[90] Having spent a total of five months overseas in Antwerp and Cherbourg, Stoney and Ramsay returned to England,

[86] Ibid.

[87] Stoney, 'The Women' Imperial Service League Hospital', p.393.

[88] Ibid.

[89] Ibid.

[90] Ibid.

where they spent the remaining years of the War.[91] In April 1915, both women were invited to share their experiences at the ARMW's monthly meeting.[92] By giving Stoney and Ramsay the opportunity to share their experiences with their colleagues, the ARMW helped to ease their transition back to normality, ensuring that they remained connected with both their colleagues and their professional organisation.

Malta

As the First World War entered its third year, medical women were employed under the War Office in a number of capacities, both at home and abroad. Having finally accepted that there was a dearth of military doctors throughout Europe in May 1916, the government appealed for the 'mobilisation of the whole of the medical services of this country' in order to mitigate the crisis.[93] This call to arms was initially limited to the conscription of medical men of fighting age, but Sir Alfred Keogh, Director General of Army Medical Services, knew that this alone would not solve the problems being faced by the RAMC. Increasing numbers of officers were being killed in action, which meant that medical men stationed further afield had to be redistributed to where they were needed most, namely casualty clearing stations located near the front.[94] This led to the already dwindling resources of the RAMC being stretched to their limit; fewer numbers of medical men could be spared to treat the wounded in base hospitals near the coast, a fundamental link in the casualty evacuation chain.[95] Having initially rejected the assistance offered by medical women, Keogh was forced to accept that they could offer a temporary solution to the army's problems. As Treasurer of the ARMW and Dean of the LSMW, Aldrich-Blake was well-placed to send a circular on behalf of Keogh to all women on the Medical Register, asking them whether they would be willing to serve with the RAMC in Southern Europe. This letter was sent to nearly 800 women doctors; however, no copies have survived. What can be deduced is that Aldrich-Blake's circular received a positive response from medical women across the country; between August 1916 and

[91] Stoney was appointed head Radiographer at the Fulham Military Hospital, whilst Ramsay worked as an Anaesthetist, Surgeon, and Civilian Medical Practitioner in Plymouth.

[92] ARMW Annual Report, 1914-1915.

[93] 'Medical Mobilization', *The Times,* 13th June 1916, p.3.

[94] Ibid.

[95] For more on the function of base hospitals during WW1, see: Ian Whitehead, *Doctors in the Great War* (Barnsley: Pen & Sword, 2013).

July 1917, 82 medical women served in Malta, with approximately 25 per cent being members of the ARMW, and later the MWF.[96]

In spite of the fact that this group represents the second largest deployment of women doctors overseas during the First World War, little has been written about the work carried out by medical women serving in Malta.[97] Kirkwood offers a biographical account of the experience of her great-grandmother, Isabella Stenhouse, who served in Malta between August 1916 and spring 1918.[98] Unusually, Stenhouse was joined in Malta for a short time by members of her family. Just one week after she had proudly signed her contract with the RAMC, one of her three sisters tragically died, having fallen, or possibly jumped, out of the top-storey window of their tenement flat in Edinburgh.[99] Unable to bear the thought of losing another child, Stenhouse's mother made the journey to Malta, accompanied by her eldest daughter.[100] For many women doctors, their work in Malta either came after service with one of the voluntary hospital units, or was followed by more noteworthy appointments elsewhere. For example, Dorothy Hare was amongst the first group of medical women to embark for Malta, serving at St. George's Hospital between July 1916 and February 1918.[101] On her return to England, she was appointed General Medical Director of the Women's Royal Naval Service (WRNS). An undated first-hand account of Hare's wartime service is held in the MWF archive, but no mention is made of her time spent in Malta.[102] Similarly, in the MWF's feature on the First World War, published in the January 1939 *Newsletter*, no recollections from members who had served in Malta were included, even though at least eight of the medical women were still alive when the piece was published.[103]

As a Mediterranean island, Malta was well-situated to house military hospitals, as it was close enough to Gallipoli, Salonika, and Macedonia to receive patients without being at risk of

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[96] The names of medical women who served in Malta have been cross-referenced with the ARMW membership list published in 1913 (SA/MWF/C.74), and the first MWF membership list published in 1919 (SA/MWF/B.3/1).

[97] Colonel Walter Bonnici's website <www.maltaramc.com> offers a complete list of the medical women who served in Malta during the First World War, which includes biographical information and limited service histories. Elston (1986) and Whitehead (2013) offer no account of the work carried out by medical women in Malta during this period.

[98] Katrina Kirkwood, *The Mystery of Isabella and the String of Beads* (Norwich: Loke Press, 2016).

[99] Ibid., p.238.

[100] Ibid.

[101] 'Dorothy Christian Hare' <https://www.maltaramc.com> [accessed 8th January 2020].

[102] Letter from Dorothy Hare to the Secretary of the MWF, undated, SA/MWF/C.168.

[103] 'Medical Women's Service in the Great War, 1914-1919', MWF *Newsletter* (January 1939), 26-42. Names of medical women who served in Malta were cross-referenced with the obituary list of MWF members published on the Wellcome Library website <www.wellcomelibrary.org> [accessed 19th January 2020].

aerial bombardment.[104] German submarine attacks on hospital ships were common, making travel to and from the island perilous. One medical officer shared details of his 'thrilling' journeys in the *BMJ* under the pseudonym 'Aggrieved':

> On the voyage out we were attacked by submarine […] later the ship in which I sailed was sunk. I went from Malta to Sicily […] that ship was sunk, and the third ship in which I travelled from Sicily to England was also sunk'.[105]

Working conditions for doctors serving in Malta were similarly challenging; one doctor described the island as an interminable 'hotbed of enteric [typhoid] and dysentery', whilst Alice Hutchison, who briefly worked in Malta with the SWH in 1915, described the patients she encountered as 'gaunt and unkempt […] ragged, dirty, hungry-looking […] and doggedly dejected'.[106] On the 2nd August 1916, the first group of medical women left England for the Mediterranean.[107] Amongst them were five members of the ARMW: Dorothy Hare; Janet Horwood; Elizabeth Lepper; Mary Martin; and May Thorne.[108] Horwood and Thorne were the most senior of the group, having both been qualified for 20 years, whilst Martin was the most junior, having only graduated from the University of Edinburgh with a Bachelor's degree in Medicine and Surgery in 1915.[109] Of the 82 women who served in Malta, 56 per cent had been qualified for five years or fewer, and only 34 per cent had been qualified for more than a decade.[110] Unburdened by private practices and families of their own, newly-qualified medical women were eager to expand their clinical experience by serving with the RAMC in Europe.

The work carried out by medical women in Malta was varied, with many being encouraged to pursue their own interests and specialisms. May Thorne, who had previously been president of the ARMW between 1908 and 1910, worked among the nurses and families of military personnel

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[104] 'Military Hospitals in Malta during the Great War', <https://www.maltaramc.com> [accessed 8th January 2020].

[105] 'Service in Malta', *BMJ*, 1 (17th May 1919), 630.

[106] Ibid; 'Military Hospitals in Malta during the Great War', <https://www.maltaramc.com> [accessed 8th January 2020].

[107] Ibid.

[108] Further transports to Malta in 1916 took place on the 12th, 16th, 24th, 26th, and 28th of August, the 1st, 10th, and 25th of September, and on the 20th October, 18th November, and 9th December. Two further transports took place during 1917.

[109] 'Janet Horwood', 'May Thorne' and 'Mary Martin', UK and Ireland Medical Directory, <www.ancestry.com> [accessed 8th January 2020].

[110] Names of the women who served in Malta were cross-referenced with entries in the UK and Ireland Medical Directory.

on the island. In a letter sent to the MWF in 1921, Helen Greene commends the 'admirable' dedication shown by Thorne in Malta: '[she] worked for the good of her patients, her fellow-doctors, and women in general. And she never faltered.[111] Similarly, Mary Martin, who had previously worked at a private asylum in Ireland, set up her own mental hospital in Malta whilst serving with the RAMC.[112] Isobel Addey Tate, who had served with the WISL in Serbia in 1915, was put in charge of the Bacteriology Department at Valetta Military Hospital.[113] Tate had previously been praised for her work in a military hospital in Chichester, where she had single-handedly plated over 2000 samples for the resident bacteriologist.[114] In January 1917, Tate tragically succumbed to typhoid fever, likely contracted in the course of her work.[115] Her funeral was attended by 38 of her fellow medical women, and she was recorded in the *BMJ* as a casualty of war.[116] Elizabeth Moffett, who was a member of the Birmingham and District branch of the ARMW, worked alongside a visiting Ophthalmic Surgeon at Valetta Military Hospital during the spring of 1917.[117] Moffett examined eye changes in 80 cases of trench nephritis [kidney infection], and the results were published in the *BMJ*.[118] Prudence Gaffikin, who had trained at Queen's College, Belfast, carried out cardiac research alongside Sir Archibald Garrod at Maneol Hospital.[119] The results were published in the *Lancet,* though Gaffikin received no formal recognition for her work.[120] Elizabeth Lepper similarly conducted research on blackwater fever [complication of a malaria infection], malaria, and dysentery whilst serving at St. David's Hospital.[121] Her results were published in *BMJ Military Health*, and she later presented her work at a meeting of the MWF in November 1919.[122]

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111 Helen Greene, 'Medical Women Serving with the RAMC in Malta and Egypt', 8th April 1921, SA/MWF/C.169. Following her service in Malta, Greene (1865-?) later served in Egypt until May 1919.

112 Ibid.

113 'Isobel Addey Tate', <www.maltaramc.com> [accessed 8th January 2020].

114 Ibid.

115 'Isobel Addey Tate Obituary', *Daily Malta Chronicle*, 1st February 1917, p.6.

116 Ibid.

117 'Elizabeth Moffett', <www.maltaramc.com> [accessed 8th January 2020].

118 J. Kirk, 'Eye changes in Trench Nephritis', *BMJ,* 1 (5th January 1918), 7-8.

119 'Prudence Gaffikin', <www.maltaramc.com> [accessed 8th January 2020].

120 A. Garrod, 'A Variety of War Heart', *Lancet*, 2 (30th June 1917), 985-986.

121 Elizabeth Lepper, 'Notes on Sixteen Cases of Blackwater Fever Occurring in Malta', *BMJ Military Health*, 30 (1st April 1918), 378-394.

122 'Reports on Meetings', *BMJ*, 1 (15th November 1919), 634.

The medical women who served in Malta were able to conduct valuable scientific research, and enjoyed many of the same professional freedoms as their male colleagues. This being said, their official status under the War Office was far from equal. Women doctors who worked for the RAMC were not given temporary commissions, and were denied uniform and rank (Figure 2.3). Irrespective of their previous experience and level of skill, they automatically ranked lower than the most recently commissioned male officer on account of their sex.[123] Furthermore, without uniform, medical women were denied the professional respect of those working under them, and the respect of the general public when they were off duty. When travelling, female medical officers were only entitled to third-class tickets, whilst their male counterparts and female Voluntary Aid Detachments (VADs) were permitted to travel in first.[124] Women doctors working in the army were also financially disadvantaged; they were routinely denied ration, billeting, and travel allowances, and were assessed for income tax at the higher rate of civilians, rather than as temporary members of the Armed Forces.[125]

Medical women had eagerly grasped the opportunity to serve under the War Office, however it was not long before these issues made their working lives intolerable. The unequal treatment of women doctors serving in Malta and Egypt is incorrectly cited as being the primary impetus behind the ARMW's transformation into the MWF in February 1917.[126] Yet, as this chapter investigates, this was not the case. The MWF took years, not months, to come to fruition, and once formed, the organisation initially chose to ignore the disadvantages experienced by medical women employed by the War Office. Whilst women doctors had succeeded in proving their professional worth overseas, on the home front, the MWF struggled to establish itself as their new representative organisation, and in doing so failed to meet the needs of its growing membership.

[123] Ian Whitehead, *Doctors in the Great War*, p.112.

[124] Ibid.

[125] Ibid., p.113.

[126] Elston (1986), Leneman (1994), Jensen (2008), and Whitehead (2013) incorrectly state that the First World War was the primary driving force behind the formation of the MWF. One exception is Digby (1999), who offers a brief, but accurate, account of the MWF's beginnings.

Figure 2.3 The medical and nursing staff of St. Ignatius Hospital, Malta, 1917. Isabella Stenhouse (centre third row) and another woman doctor (second from right, third row) are wearing civilian mufti, having been denied the uniform of the RAMC (reproduced by kind permission of Katrina Kirkwood, Stenhouse's Granddaughter).

Medical Women's Federation

Though the origins of the MWF are believed to be firmly aligned with the employment of medical women under the War Office, minutes of the ARMW's Management Committee clearly show that the question of affiliation was in fact first raised in May 1912. Alongside discussions of the National Insurance Act, it was recorded that: 'Dr Long brought forward a proposal that affiliation with the other women's Associations […] might be effected. The President [Frances Ivens] thought such a step would lead to increased knowledge among medical women'.[127] Ivens agreed that the matter would be raised at the next annual dinner; however, there is no further evidence of the subject being discussed. In February 1914, Ethel Williams, president of the North Eastern ARMW, wrote

[127] Managing Committee Minutes, 21st March 1912.

to the Association's senior management to express her dismay that no further action in the matter had been taken:

> What is the London Association doing about affiliation? Are they going to sit on their scheme until the next annual meeting, or are they going to allow us to do something? […] We don't want to become rebellious, but I think what will happen shortly […] is that we will make our own scheme taking in all the associations we can get, and the members of the federated associations who belong to the London association will resign.[128]

As had been the case with other issues of importance, the ARMW were clearly reluctant to take any immediate action with regards to Federation. For Williams, this was unacceptable. She had pressing cases which urgently required the input of the entire profession. If the Association would not agree to move things forward, she was prepared to take matters into her own hands.

In spite of Williams' threat of rebellion, the ARMW ignored the issue for a further 11 months. In March 1915, it was unanimously decided that discussions should once again be adjourned, on account of the fact that 'nothing further had transpired in the matter'.[129] In October of the same year, delegates from each of the regional associations were appointed in order to discuss the possibility of amalgamating local branches of the ARMW.[130] Affiliation would, it was hoped, create a more centralised organisation that was better placed to represent issues which affected medical women across the country. Following years of inaction, Walker addressed members on the necessity of forming a new Association in January 1916:

> *Why should an Association be formed now at all? Why is the Registered Medical Women's Association not sufficient?* […] The Registered Medical Women's Association does not represent the whole of medical women. Out of a possible 883 members in the United Kingdom, there are only 230 who belong to the existing Association. It is really important to get this scheme formulated and at work before the War is over so that in debatable matters where women's interests are seriously at stake, there may be a large representative body prepared to express its opinion.[131]

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[128] Letter from Ethel Williams to Louisa Aldrich-Blake, 16th February 1914, SA/MWF/C.80.

[129] Ibid.

[130] Managing Committee Minutes, 19th October 1915.

[131] 'Association of Registered Medical Women' typed speech, 11th January 1916, SA/MWF/C.81. Emphasis my own.

It is clear from Walker's speech that the First World War was one of the primary driving forces behind the formation of the MWF; however, it is evident that the scheme had been discussed both before the outbreak of war, and before significant numbers of medical women had begun officially working under the War Office. As Walker notes, ARMW membership numbers represented a small percentage of the total number of women on the Medical Register; it seems likely that that the Association wished to utilise the spirit of wartime comradeship in order to attract new members.

In an undated pamphlet sent to all existing ARMW members, Walker outlines the newly focused aims of the MWF:

> The work of medical women is […] becoming daily more needed and more appreciated, and in view of the call on the whole profession it is felt that every means should be taken to organise such work, *in the interests of medical women, of medical men, and of the nation as a whole* […] It is earnestly hoped that every medical woman will join the Association because it will be looked upon as a responsible professional body, able to voice the opinion of medical women on matters of public policy […] The stronger the organisation, the more useful it will be.[132]

It was hoped that the new Federation would have far-reaching benefits for the medical profession and the nation as a whole. As had been the case with the ARMW, the MWF aspired to emulate the impact and influence of the BMA by establishing itself as a strong voice for women within the profession, and crucially by effecting meaningful change for its members. Walker's patriotic call to arms evidently paid off in the short-term; on the cusp of the MWF being founded between 1916 and 1917, the organisation experienced its largest increase in membership, rising from 230 members to 355.[133] As Figure 2.4 shows, membership numbers continued to rise during the MWF's first decade, as more medical women realised the advantages of joining the Federation.[134]

[132] 'Medical Women's Association' Draft Pamphlet, SA/MWF/C.74. Emphasis my own.

[133] Annual Report, 1917-1918, SA/MWF/B.1/1.

[134] One-hundred-and-twenty-five members joined between 1916 and 1917, representing the largest increase in the organisation's history. The second largest was between 1919 and 1920, when 120 members joined. This could be related to the large number of female medical students who were due to graduate after the end of the War.

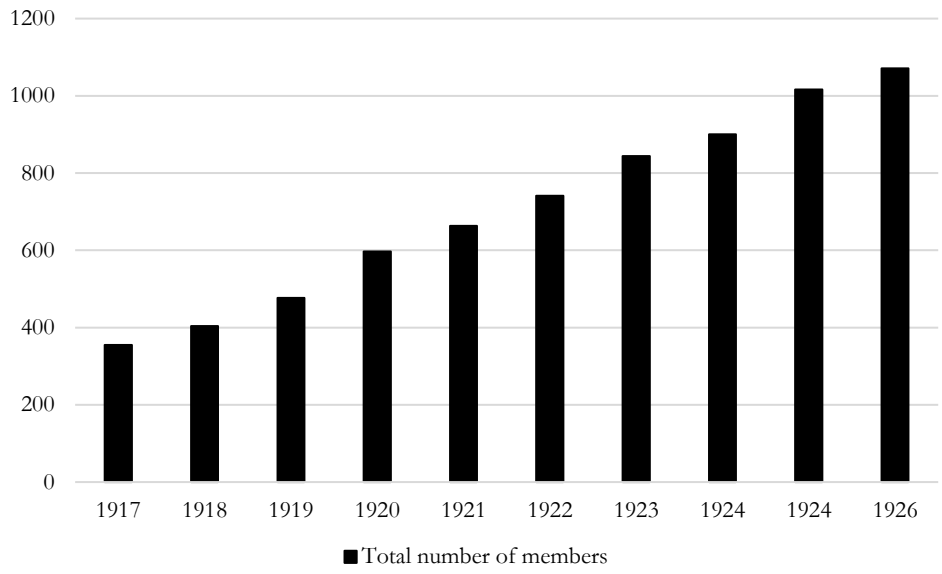

Figure 2.4 Total number of MWF members, 1917-1926.[135]

Contrary to popular belief, the transition from the old Association to the new Federation was far from seamless, and the MWF was blighted with a number of financial and administrative difficulties in its first 18 months. Whilst these issues are relatively insignificant when looked at individually, when combined they paint a bigger picture that explains how the MWF became out of touch with its membership, particularly those who were working with the RAMC in Malta. After its founding in February 1917, the MWF faced significant financial difficulties, as the initial costs of setting up the organisation proved to be higher than anticipated. The Federation's income from its increased number of membership fees totalled £346; however, a third of this had to be paid to the lawyer who negotiated the official registration of the organisation with the Board of Trade.[136] Similarly, the cost of renting new rooms for the Federation's office came to £80 per year, with an additional £60 having to be spent on furniture and decoration.[137] Writing to the MWF's expanded membership also proved to be costly, with £100 being spent on stamps, typing, and printing in the first six months alone.[138] This meant that the Federation had to operate on an

[135] Membership numbers have been calculated from figures published in the MWF's annual reports (SA/MWF/B.1/1 – SA/MWF/B.1/10).

[136] MWF Council Minutes, 29th September 1917, SA/MWF/A/1/1.

[137] Ibid.

[138] Ibid.

extremely limited budget in the coming year, making any planned activities impossible. Further problems were encountered in the run up to the MWF's first annual meeting in March 1917. In response to the ARMW being disbanded and reformed, the Irish Association of Registered Medical Women chose to officially disband, citing irreconcilable differences.[139] Similarly, a new branch was founded in Glasgow which covered the West of Scotland, which meant that the two other Scottish Associations were forced to change their names to reflect this new addition.[140] To make matters worse, the increased workload of the Federation almost led to the part-time secretary, M. Vince, handing in her resignation. After attempts to mollify failed, Vince issued her ultimatum in a letter to the Executive Council - either her hours of work had to be changed so that she could take on other morning work, or she had to be officially employed on a full-time contract for an annual salary of £150.[141]

The Executive Council were anxious to retain Vince, but the Federation's annual income barely covered its current expenditure. In a letter to Aldrich-Blake, Walker expressed her frustration at the double-bind in which she found herself caught: 'we must have a whole-time secretary […] we shall not get through the work […] unless we have someone at work always. We shall only get more members by showing that we can get through the work'.[142] If the MWF was not able to keep up with its administrative duties, no one would take the organisation seriously, and membership numbers would inevitably fall. Similarly, if the council chose to raise subscription fees, newly-qualified medical women would be deterred from joining. Having herself guaranteed the sum of £30 over three years, Walker secured financial donations from Louisa Garrett Anderson, Mary Scharlieb, Ethel Williams, Helen Boyle, and Frances Huxley, and Vince was able to begin her full-time position two months later.[143] Though this particular issue was eventually resolved, the MWF continued to face organisational teething problems throughout 1917. Delays in defining geographical boundaries for the local Associations meant that the Federation were unable to fulfil the legal requirements set by the Board of Trade, and there continued to be disagreements over the remuneration of the Executive Council's travel

[139] MWF Council Minutes, 23rd March 1917.

[140] Ibid.

[141] Letter from M. Vince to Frances Huxley, 6th March 1918, SA/MWF/C.94.

[142] Letter from Jane Walker to Louisa Aldrich-Blake, 5th April 1918.

[143] Letter from Louisa Garrett Anderson to Jane Walker, 15th April 1918; Letter from Mary Scharlieb to Jane Walker, 24th April 1918; Letter from Ethel Williams to Jane Walker, 27th April 1918. The issue of M. Vince's salary was raised once again in November 1918, with Ellen Orr putting forward the motion that it was 'wholly inadequate'. It was decided that Vince should be given the power to find suitable help to reduce her workload.

expenses.[144] These difficulties led to the Federation being unable to give its full attention to the issues being raised by medical women both at home and abroad. At the same time that the Federation was struggling to establish itself, medical women serving under the War Office in Malta and Egypt were becoming increasingly exasperated at their unequal working conditions. In spite of Walker's statement that the MWF would authoritatively represent the opinion of all medical women, letters and meeting minutes reveal that there was a significant delay between members voicing their concerns over these issues, and the organisation taking definitive action on their behalf.

Commissions, rank, and uniform

More than a year after medical women had first been employed to work in the army, reports of their unequal treatment under the War Office began to reach the newly-formed MWF. In September 1917, Ina Clarke, who had served with the WISL in Cherbourg, alerted Walker to the difficulties being experienced by Amy Nash, who was working in a military hospital in Lancashire: 'Her grievances are mostly due to an unutterable horror of a superior officer but she is suffering also from lack of proper standing + uniform […] [She] is going to resign at once.[145] Eleven days later, another letter was received from a medical woman working in a South London military hospital. Like Nash, Winifred Ross found herself being undermined by her colleagues due to her lack of commission and uniform:

> In July 1917, a notice was sent out by the War Office saying they could not authorise any uniform for women doctors, but we might, if we wished, wear an armlet with the R.A.M.C badges […] the armlets confer no special privileges, and convey no special meaning […] they are certainly not understood by patients, nurses, hospital orderlies etc […] I know that the younger women, just out of college, are made to feel at once that they are in an inferior position to the newly graduated man who has obtained a commission […] I think that in the army atmosphere there is no doubt that a commission would be of immense value in definitely fixing our status.[146]

[144] MWF Council Minutes, 29th September 1917.

[145] Letter from Ina Clarke to Jane Walker, 14th September 1917, SA/MWF/C.159.

[146] Letter from Winifred Ross to M. Vince, 25th September 1914.

It is interesting to note that both of these letters relate to work being carried out under the War Office on the home front. Working in an 'army atmosphere' without commission, rank, and uniform was universally impossible for medical women, whether in Britain or in Europe. Without the means to define their status, women doctors were automatically positioned at the bottom of the military hierarchy.

In response to these concerning letters, the MWF sought the advice of Mona Chalmers Watson, Chief Medical Controller of the Women's Army Auxiliary Corps (WAAC).[147] Chalmers Watson stated that much progress had been made in establishing the position of medical women working under the War Office. Women doctors who worked in connection with the WAAC were to be formed into a section of the RAMC, uniform was to be worn, and a ration allowance was to be paid to those undertaking full-time service.[148] Chalmers Watson herself boasted an impressive annual salary of £400, and medical women working under her command would receive 24 shillings a day.[149] Having misguidedly presumed that the working conditions of medical women in the WAAC were representative of the entire army, the MWF took the decision to take no further action on the matter. The Federation's secretary sent the following response to all members who had written to express their concerns:

> Dear Madam […] At the Council meeting of the Federation held on the 29th, Dr Chalmers Watson gave an account of the progress made in establishing the position of medical women working under the War Office […] In view of this *satisfactory arrangement* the Council of the Federation has decided not to take any step with regard to the pay or position of medical women working under the War Office.[150]

The organisation's refusal to support its members was not well received. As had been the case in the late nineteenth century, factionalism within the organisation remained an ever-present issue; members felt disillusioned by the Executive Council's seeming indifference when it came to such an important issue. After being made aware of the content of the MWF's letter to aggrieved members, Helen Trevithick wrote to the Secretary to resign from her membership in January 1918: 'Had I seen this letter earlier I should not have joined the Federation […] I disagree in toto with

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[147] For more on Chalmers Watson and the WAAC, see: Lucy Noakes, *Women in the British Army: War and the Gentle Sex, 1907-1948* (London: Routledge, 2006).

[148] Managing Committee Minutes, 29th September 1917.

[149] Ibid.

[150] Letter from M. Vince to Ina Clarke, 9th October 1917. Emphasis my own.

the opinion of the Council […] [the] pay and position of women working under the War Office is most unsatisfactory'.[151] Trevithick had made a subscription to the MWF's initial running costs, and felt completely let down by the organisation which had been founded in order to better represent the interests of members such as herself.

Trevithick had suffered considerably in her role as Medical Officer at a military hospital in Plymouth, and used the opportunity of her resignation to speak candidly about her own experience: 'From the time I joined [the hospital] in Nov. 1916 [sic], until I went on leave in Sep. 1917 [sic], I was on duty every day, including Sundays, with the exception of 48 hours leave in February'.[152] Following an increase in the number of patients at the hospital she was in charge of, Trevithick was replaced by a male RAMC officer without any explanation and relegated to the position of his 'assistant': 'I had to be de-graded because I was a woman'.[153] Similarly, because of her lack of uniform, Trevithick found herself attracting unwanted attention when out in public: 'Another outcome of the denial of uniform to women Medical Officers is the unpleasant comments that are invited, [we] are invidiously contrasted with the V.A.Ds and other badged and uniformed war workers, and are labelled as "slackers"'.[154] Whilst Nurses, V.A.Ds, and other female volunteers received considerable praise for their invaluable contributions towards the war-effort, the work carried out by medical women was not as publicly visible.[155] In civilian mufti, medical women could easily be mistaken as middle-class 'slackers' who believed that such work was beneath them.[156] Unsatisfied with sending just one letter to the Federation, Trevithick also wrote directly to Walker to express her anger at the MWF's decision to ignore the disadvantages faced by its members: 'By deciding not to take any step with regard to the pay or position of medical women working under the War Office", [the Council] has let women down so completely that it will be very difficult to raise them up'.[157] In Trevithick's opinion, the Federation were completely oblivious to the working conditions of any medical woman outside of the profession's flagship hospital – Endell Street: 'It seems you have no representative on the Council engaged in a Military

[151] Letter from Henrietta Kate Trevithick to M. Vince, 18th January 1918.

[152] Ibid. Further abbreviations appear in the original.

[153] Ibid.

[154] Ibid.

[155] For more on the public image of women war workers, see: Gail Braybon, *Women Workers in the First World War* (Abingdon: Routledge, 1981).

[156] For more on the experiences of middle-class women during the First World War, see: Vera Brittain, *Testament of Youth: An Autobiographical study of the Years 1900-1925* (London: Victor Gollancz, 1933).

[157] Letter from Henrietta Kate Trevithick to Jane Walker, 20th January 1918.

Hospital in England. Endell Street Hospital is unique, and cannot be cited as an example of how the system works'.[158] As had been the case with unequal pay, the organisation's senior leadership remained out of touch with the everyday lived experiences of women doctors. Distracted by administrative work relating to the newly formed Federation, they initially chose to overlook the challenges being faced by individual members working with the army.

In order to emphasise the fundamental difference between the treatment of men and the treatment of women by the War Office, Trevithick offers a stark comparison of the privileges enjoyed by her brother-in-law, and those denied to her on account of her sex:

> My Brother-in-law gave up his practice and his home and volunteered for a years' service; I also gave up my home, and volunteered for the duration of the War […] He was at once given a commission as Lieutenant, an allowance for uniform, and a ration allowance, in addition to his daily pay. I was given no commission, no allowance for uniform, and no allowance for rations […] At the end of our first years' service my brother-in-law became "Captain". I remained as I was.[159]

In March 1918, Walker wrote to John Goodwin, Lieutenant General of the RAMC, to express her concern over the letters of complaint she was receiving from members of the MWF: 'We fear there will be a general stampede of them if something is not done to ease the situation'.[160] In response, the government permitted medical women working overseas to wear uniform similar to that of the WAAC, with the RAMC badge.[161] This small victory was, however, rather insignificant to medical women like Trevithick, as uniform without commission or rank made no difference to the disadvantages that they faced. Another two months passed before the issue of women working under the War Office was discussed again at an MWF meeting in May 1918. Realising that the initial advice given by Chalmers Watson was not representative of all medical women, Anne Mercer Watson, who was working in a military hospital in Aberdeen, was invited to make a statement to the council.[162] She reported that all of the various difficulties experienced by medical women would be removed if they were given temporary honorary commissions.[163]

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[158] Ibid.

[159] Ibid.

[160] Letter from Jane Walker to General Goodwin, 11th March 1918.

[161] The WAAC later became known as the Queen Mary's Army Auxiliary Corps (QMAAC) in April 1918.

[162] MWF Council Minutes, 25th May 1918.

[163] Ibid.

At the MWF's annual meeting, held on the same day, it was 'unanimously decided to press the Government by all means in our power for temporary rank for such women. We recognise clearly that uniform without rank is of very little value'.[164] This decision came eight months after the first letter on the subject had been received, a delay which is particularly significant in light of the MWF's founding principles. Having agreed to take a stand on behalf of medical women working under the War Office, Walker publicly voiced the concerns of her members in the *Times*: 'They are suffering not only financially, but in their professional position. Above all, they have found that in working without rank […] they have not the authority necessary to carry out their duties.[165] In the same month, the MWF wrote to the NUWSS asking for guidance on how to successfully canvass members of Parliament.[166] Though the Federation were desperate to publicly project confidence, behind closed doors, it is clear that the organisation was struggling to find its feet. Following the advice given, the Federation sent a number of letters to those who were likely to sympathise with their position: 'The Council would be most grateful for any support which you could give them both inside or outside of the House'.[167] In November 1918, when Parliament was once again in session, Walker published further statements in the *Globe* on the matter of 'Lady Army Doctors', in order to ensure that the important question of temporary commissions for women 'might not be forgotten'.[168] Unwilling to remain complacent in spite of the publicity gained on the matter, the MWF wrote directly to the Secretary of State for War to ask him to reconsider his position, using candid statements from medical women to strengthen their argument: 'Wherever we go we are looked at by the Officers as if we were dirt; the young pretty medical girl is pretty dirt and I am just dirt!'.[169] The repetition of the word 'dirt' highlights the intense frustration and anger felt by medical women; although they were making a host of personal and professional sacrifices as part of the war effort, they were treated as second-class practitioners, receiving no reward or recognition for their work from the government.

Various deputations were also organised by the MWF in conjunction with the BMA; in 1918, the organisations were successful in persuading the government to grant medical women relief under the service rate of income tax, and this was also backdated to 1915.[170] Though the

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[164] Managing Committee Minutes, 6th June 1918.

[165] Jane Walker, 'Medical Women in the Army', *Times*, 4th July 1918, p.13.

[166] Letter from the NUWSS to the Secretary of the MWF, 23rd July 1918, SA/MWF/C.165.

[167] Letter from the Secretary of the MWF to Edward Hemmerde, M.P, 25th July 1918.

[168] Jane Walker, 'Lady Army Doctors', *Globe*, 2nd November 1918, p.3.

[169] Draft letter from the MWF to the Secretary of State for War, undated, SA/MWF/C.164.

[170] Whitehead, *Doctors in the Great War*, p.113.

MWF worked tirelessly to improve the position of women working under the War Office in the final years of the War, in doing so they were forced to dismiss any other concerns raised by members which were deemed to be of less importance. Convincing the army to recognise the status of medical women was a complex and time-consuming task, involving a great deal of bureaucracy; any other distractions would waste valuable time, which would be better spent negotiating. In August 1918, Catherine Fraser wrote to the Federation to voice her concern over the disadvantages faced by medical women working under the Ministry of Munitions.[171] Like those working under the War Office, medical officers in the Ministry of Munitions received no uniform or travel allowances, or special tax assessments.[172] Fraser strongly believed that munition workers should not be excluded from the Federation's efforts, because 'after all, union is strength'.[173] In response to Fraser's letter, the Secretary of the MWF replied that whilst Walker sympathised with her situation, 'the argument [for army doctors] would be very much weakened if we attempted to bring under it a demand for uniform for women who are working under civilians'.[174] Although there was a 'strong case for agitation', given their present focus, the MWF felt that it was 'much better to keep the case separate'.[175] No further action on the matter was taken.

Similarly, the MWF's determined campaign for commissions caused considerable trouble for Letitia Fairfield, who served as 'Woman Medical Director' for the Royal Air Force (RAF) during the War. Fairfield was one of the few medical women permitted to wear military uniform, and was given the rank of Lieutenant-Colonel.[176] Because of her privileged position, Fairfield would often pass on non-secret information to the MWF's secretary to keep her abreast of the working conditions for medical women serving in the Air Force.[177] In return, Vince would pass on the details of women doctors who were suitable recruits for medical posts.[178] Although Fairfield had firmly told Walker that it was useless to push for commissions in the Air Force, as it was legally impossible for them to be granted, the MWF refused to let the matter drop. In a leaflet sent to members of Parliament and the War Office, the Federation erroneously stated that honorary commissions had been granted to Nursing Sisters in the RAF, and argued that they should,

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171 Letter from Catherine Fraser to the Secretary of the MWF, 28th May 1918, SA/MF/C.165.

172 Ibid; Letter from the Secretary of the MWF to Catherine Fraser, 8th August 1918.

173 Ibid.

174 Letter from the Secretary of the MWF to Catherine Fraser, 8th August 1918.

175 Ibid.

176 Lieutenant Colonel Letitia Fairfield travel permit, 25th March 1919, SA/MWF/C.172.

177 Letitia Fairfield, handwritten statement to the MWF, 2nd January 1967.

178 Ibid.

therefore, be granted to medical women.[179] This mistake caused great confusion, and Fairfield was blamed for the misunderstanding by her senior colleagues.[180] The MWF's campaign not only led to members such as Fraser being ignored, but it also led to the positions of senior medical women such as Fairfield being undermined. The Federation were, therefore, working for the interests of a select group of women doctors, and not the entire profession as they had stated in their founding principles.

Even after the War had ended, the MWF continued to campaign for commissions for medical women in the army. In March 1919, the MWF organised a joint deputation with the BMA to present their arguments to Lord Peel, the Parliamentary Undersecretary to the Secretary of State for War.[181] The Federation selected senior members to attend, but an unfortunate situation ensued when Garrett Anderson misread her invitation. Being under the false impression that the MWF's request also extended to Murray, Garrett Anderson confirmed that they would both attend, but that given their position, they would first have to get the permission of the Deputy Director of Medical Services (DDMS).[182] The Federation was forced to inform Garrett Anderson that she was in fact mistaken, and that only one space on the panel remained.[183] As a result of the snub, Garrett Anderson informed the MWF that neither herself, nor Murray, were available to attend.[184] When asked if the reason was because the DDMS had refused them permission, Murray rather tellingly replied to the Federation that they had not asked for it, but it likely would have been given to them if they had.[185] Following the misunderstanding, Walker, Thorne, Helen Boyle, and Christine Murrell were selected to represent the Federation.[186] After a month of careful consideration on the position occupied by women doctors employed with the army, Winston Churchill wrote to the MWF with his response to their demands.[187] The deputation contended that there were no duties in the army that could not be undertaken by medical women, but Churchill disagreed:

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[179] 'Medical Women in the Army, the Case for granting them Temporary Commissions', undated pamphlet, SA/MWF/C.164.

[180] Fairfield, handwritten statement.

[181] MWF Council Minutes, 7th April 1919.

[182] Letter from Louisa Garrett Anderson to M. Vince, 11th March 1919, SA/MWF/C.163.

[183] Letter from M. Vince to Louisa Garrett Anderson, 17th March 1919.

[184] Letter from Louisa Garrett Anderson to M. Vince, 21st March 1919.

[185] Letter from Flora Murray to M. Vince, 26th March 1919.

[186] 'Commissions for Medical Women in the Army', undated typed list, SA/MWF/C.163.

[187] Letter from Winston Churchill to the MWF, 2nd May 1919, SA/MWF/C.253.

> The provision of suitable accommodation would be impossible. They [medical women] would be out of place in the continual and intimate contact into which a Medical Officer is brought with the soldier […] Women could not carry out venereal inspections or lecture Troops on the prevention of venereal disease […] Not only would soldiers object to examination by women, but there would at once be a public outcry at such a breach of convention […] These arguments prove beyond refutation that Medical Women cannot perform all tasks which are at present undertaken by Medical Officers.[188]

Whilst women doctors had been treating female venereal disease patients for decades prior to the opening of community clinics across the country in 1917, it was still deemed to be unacceptable for them to be exposed to male patients suffering from the same complaints.[189] Venereal disease was undeniably rife throughout the armed forces; however, it is telling that Churchill chose to use this fact as the primary rationale for denying women commissions in the army. Such an issue was by no means insurmountable, suggesting that in light of the achievements made by women doctors during the War, the government were forced to draw upon popular tropes in order to justify the continued exclusion of female practitioners from the medical services of the crown.

To add to the injustice of this decision, Churchill used the opportunity of his letter to express his 'deep appreciation […] for the valuable services rendered by medical women during a lengthened period of great *stress and anxiety*'.[190] The 'willingness' and 'untiring devotion to duty' shown by medical women could not be repaid through the granting of commissions, but had, according to Churchill, 'earned the gratitude of all ranks'.[191] It is interesting to note Churchill's use of language in describing the role of medical women during the War, which minimises the life and

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[188] Ibid.

[189] There is no evidence to suggest that women doctors treated male patients for venereal disease either on the home front or overseas during the War, but it is not outside the realms of possibility. Community clinics offering confidential treatment for men, women, and children opened across the country in 1917. For more on the prevalence of venereal disease during the First World War, see: Edward H. Beardsley, "'Allied against Sin": American and British Responses to Venereal Disease in World War 1', *Medical History*, 20 (1976), 189-202; Bridget A. Towers, 'Health Education Policy 1916-1926: Venereal Disease and the Prophylaxis Dilemma', *Medical History*, 24 (1980), 70-87; Lesley A. Hall, *Hidden Anxieties: Male Sexuality, 1900-1950* (Cambridge: Polity Press, 1991); Mark Harrison, 'The British Army and the problem of Venereal Disease in France and Egypt during the First World War', *Medical History*, 39 (1995), 133-158; Bruce Cherry, *They Didn't Want to Die Virgins: Sex and Morale in the British Army on the Western Front, 1914-1918* (Warwick: Helion and Co., 2016).

[190] Ibid.

[191] Ibid.

death situations experienced by units such as the WISL to mild 'stress and anxiety'. Similarly, the 'devotion' of medical women is feminised, categorising them as diligent helpmates rather than committed professionals. Refusing to accept Churchill's argument, the MWF sent a further letter outlining the reasons why women doctors should receive equal treatment in the army: 'The War Office asked medical women to do work previously done by medical men who held commissions. This they have done, and we claim that they should be given what they deserve for this work'.[192] After receiving the same response, Walker was forced to admit defeat: 'Your Council […] deeply regret that the Federation has failed to get justice done to the hundreds of medical women who served in the army, but they hope that members may rightly feel that […] every effort on their behalf.[193] Whilst the Federation had failed to win equality for its members, Walker's campaign succeeded in drawing attention to the remarkable work carried out by medical women both at home and abroad. Writing on the eve of the Second World War, Isabel Emslie Hutton shared what she had learnt from her time spent with the SWH: 'I found that [medical women] could endure hunger, discomfort, fatigue, bad feeling and danger to an unlimited extent, and that it was not a matter of brawn […] it was all a matter of grit and heart'.[194] Though Hutton and her colleagues were denied the respect and recognition that they deserved, their unwavering dedication, courage, and resilience definitively proved the capabilities of medical women to operate in the masculine theatre of war.

Conclusion

The First World War was a pivotal turning point for medical women, as the conflict provided them with the opportunity to expand their professional horizons in uniquely unrestricted conditions. The ARMW immediately responded to the national crisis, encouraging its members to share their contributions towards the war effort. The letters received by the Association in August 1914 highlight the broad range of roles undertaken by female practitioners throughout the War, and foreground the determination of medical women to serve their communities, and their country, in any way possible. Women doctors skilfully filled the positions left vacant by medical men; however, it is clear that their sense of patriotic duty was often taken advantage of by their superiors. Medical

[192] Letter from MWF to Winston Churchill, 26th May 1919, printed in the MWF Annual Report, 1919-1920, SA/MWF/B.1/2.

[193] Ibid.

[194] 'Commissions for Medical Women in the Army', undated pamphlet, SA/MWF/C.163.

women worked dangerously long hours in both paid and voluntary positions, with their private practices often suffering as a result of their temporary hospital work. Rhoda Adamson, who served as an anaesthetist in Leeds between 1914 and 1918, remembered the sheer exhaustion of her wartime work in the MWF's *Newsletter*: 'I was working from 8 a.m. to 12 midnight every day except Sunday […] I found myself taking over more and more unpaid hospital work to relieve men for work in local military hospitals'.[195] Similarly, Ramsay, who had served with the WISL in Antwerp and Cherbourg, remembered the 'cheerful free will and spirit' that had led to her working pro bono: 'we all worked without reward or remuneration […] I managed with £1 a week for my extras and when a pair of shoes became an urgent necessity I had to defer payment. *We were all in the same boat.*[196]

The majority of women doctors covering temporary posts in both hospitals and private practices were expected to surrender their positions when doctors returned home from the front, and many of the opportunities made available to female practitioners disappeared as the medical profession returned to its status quo.[197] As was the case with Lloyd, many medical women chose to return to the areas of medicine most commonly occupied by female practitioners, such as maternity and child welfare. The ARMW continued to provide professional support to medical women during wartime by running meetings as usual, and by keeping members informed of news from colleagues who were serving overseas. Whilst women doctors found themselves facing new challenges and responsibilities, the Association kept them connected to their professional network, ensuring that they were able to withstand the upheaval and uncertainty of the international conflict. Both at home and abroad, medical women demonstrated their ability to meet the demands of war with unwavering tenacity. The work conducted by the WISL, and the medical women who served in Malta, proved the capability of women doctors to operate in the theatre of war, and forced both the public, and the War Office, to acknowledge their accomplishments. Though the contributions of medical women were widely commended, the government refused to reward female practitioners working in the army with recognised rank, commissions, and uniform.

Women doctors spent the latter half of the War battling against the professional and financial disadvantages placed upon them on account of their sex. Having initially ignored the

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[195] 'Medical Women's Service in the Great War, 1914-1919', *MWF Newsletter* (January 1939), 26-42 (pp.38-39).

[196] Ibid., p.42. Emphasis my own.

[197] Elston (1986) notes that Cecelia Williamson (1884-1964) gained honorary appointments in Ipswich as a result of her work during the War. Similarly, Hazel Cuthbert Gregory (1886-1952) was elected Assistant Physician at the RFH on account of her work as Acting Assistant Physician in the final years of the War.

indignities being suffered by medical women working in military hospitals at home and overseas, the MWF eventually took up the fight for equality on behalf of all medical women in 1918. The fight for commissions represented a crucial turning point for the Federation; the second generation of women doctors were presented with a unique opportunity to fulfil the burden of legacy left behind by their forebears, and to meaningfully advance the position of women in medicine on the world stage. In light of this, the Executive Council tirelessly campaigned for commissions both publicly and privately, canvassing influential politicians in a desperate attempt to secure victory for the organisation's members.[198] In spite of gaining wide publicity on the issue, the MWF struggled to juggle its competing priorities, and the organisations' efforts ultimately proved to be futile. The case for equality was undoubtedly advanced to some extent by the MWF's actions, but the Government remained unconvinced that medical women could ever be successfully incorporated into the army, and commissions were not granted until after the Second World War.[199]

The MWF made a number of critical errors in its first 18 months; whilst the organisation was focused on regeneration, it tried to achieve too much too quickly, undermining its ambition to be capacity building. Similarly, as had been the case in the early years of the ARMW, the MWF continued to pursue objectives in spite of the negative impact on members, meaning that professional infighting and factionalism remained an ever-present issue. Such behaviour was both self-destructive and self-defeating for an organisation that was striving to establish its presence within the profession. The First World War did much to improve the public's perception of women doctors; however, as the next chapter examines, their status and position within the medical profession remained largely unchanged after the Armistice was signed.

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[198] For example, see: 'Doctors and the Army', *Times*, 29th May 1918, p.3; Jane Walker, 'Medical Women in the Army', *Times,* 4th July 1918, p13; Letter from Bishop of London to MWF, 12th July 1918, SA/MWF/C.160; Letter from Edward Hemmerde M.P to MWF, 30th July 1918; Letter from H.W. Carr-Gomm, M.P to MWF, 30th July 1918; 'The Status of Medical Women in the Army, *Medical Press*, 2 (9th October 1918), 266. Walker's letter to the *Times* was also sent by the MWF to 30 regional newspapers.

[199] Whitehead, *Doctors in the Great War*, p.117.

Chapter Three

'Unite with your colleagues, for the good of the profession, and the world at large': Resistance, Recovery, and Reform, 1919-1938

In December 1921, four years after the MWF had been founded, Mary Sturge, incumbent president of the organisation, published an article entitled 'The Medical Women's Federation – Its Work and Aims' in the quarterly *Newsletter*.[1] Amidst the country's, and the medical profession's, continued recovery from the First World War, Sturge felt it necessary to analyse the value of the Federation's work to date, and to reaffirm its importance as a professional organisation. In order to prove that the organisation's founding principle – 'unity is strength' – was still an ideal that women doctors should collectively pursue, Sturge posed three questions: 'Has the Federation accomplished anything practical for medical women?'; 'Has its existence been a benefit or a hindrance to our fellow practitioners who are men'; and finally 'Has it accomplished anything to the benefit of the general public'.[2] These questions suggest that in the shadow of failing to gain commissions for its members working in the army in 1919, the MWF found itself facing an identity crisis. As Richard Overy notes, the interwar period in Britain was defined by some as 'The Morbid Age', characterised by feelings of anxiety, doubt, and fear, as the country was forced to come to terms with its exposed vulnerabilities.[3] Following the difficulties faced by medical women during the War, Sturge was determined that its members would not lose faith in the Federation: 'The Federation's effectiveness could easily be doubled and trebled if all seventeen hundred qualified women became members […] Unite with your colleagues, for the good of the profession, and the world at large'.[4] By coming together once more to support a common cause, medical women would ensure the longevity of the MWF's work, allowing it to expand its usefulness to the profession, and 'the world at large'.

This chapter argues that the years between the World Wars were a defining period for the MWF, as the Federation experienced three key phases - resistance, recovery, and reform. Firstly, it analyses how the Federation staunchly resisted the return of pre-war inequalities within public health work, including disparate pay for male and female doctors. The MWF had, in conjunction

[1] Mary Sturge, 'The Medical Women's Federation – Its Work and Aims', MWF *Newsletter* (December 1921), 17-25.

[2] Ibid., p.18.

[3] Richard Overy, *The Morbid Age: Britain and the Crisis of Civilisation, 1919-1939* (London: Penguin, 2009), p.1.

[4] Sturge, 'The Medical Women's Federation – Its Work and Aims', p.25.

with the BMA, advocated for 'equal pay for equal work' since the turn of the century; however, the return of male doctors from the front, along with the expansion of public health services, led to arguments surrounding the relative worth of women's work being reignited once more. This chapter argues that the organisation's response to the issue of equal pay during the 1920s and 30s was far more effective than it had previously been, as the Federation chose to work with, rather than against, its members. Through an analysis of the MWF's response to the reintroduction of marriage bars, it scrutinises the Federation's resistance against the arguments which stated that women doctors could not be both responsible practitioners as well as diligent wives and mothers. The MWF utilised national newspapers to share their view that the roles were not mutually exclusive, and that married medical women were best placed to serve the medical needs of wives and mothers. Though committed to their campaign, the MWF ultimately struggled to convince public health boards to change their restrictive policies. The MWF played a central role in the recovery of medical women's position within the profession during the interwar years, providing financial support to its members to expand their opportunities – especially in general practice. Low interest loans with affordable repayment plans were offered to those wishing to leave hospital work to start their own consulting surgeries, and a benevolent fund was made available to those who found themselves unable to work through illness. As we will see, these funds, which have previously been overlooked in studies of the MWF, were crucial in supporting the careers of medical women: a novel perspective which historians have not only misconstrued but missed.

Finally, this chapter investigates the Federation's efforts to reform aspects of women's health during the 1920s and 30s. As increasing numbers of women left the home to enter education and the workplace, medical myths which pathologized menstruation and the menopause were undermined. Julie-Marie Strange has briefly outlined the MWF's work in relation to the construction of new languages of menstruation, arguing that whilst medical women recast normative menstrual experiences, they remained tied to a culture of discretion.[5] Similarly, Barbara Brookes has charted the role of British women doctors in educating women and girls about their changing bodies, arguing that as hormonal knowledge increased, new gendered assumptions about health emerged.[6] This chapter argues that the organisation's role in creating 'new languages of menstruation' has, in many ways, been overstated.[7] Individual members of the MWF, such as Alice

[5] Julie-Marie Strange, 'The Assault on Ignorance: Teaching Menstrual Etiquette in England, c.1920s to 1960s', *Social History of Medicine*, 14 (2001), 247-265.

[6] Barbara Brookes, '"The Glands of Destiny": Hygiene, Hormones, and English Women Doctors in the First half of the 20th century', *Canadian Bulletin of Medical History*, 23 (2006), 49-67.

[7] Strange (2001) argues that the MWF's publications 'signalled the creation of a new menstrual language'.

Sanderson Clow, dedicated their careers to dispelling the menstrual myths proliferated by Victorian medical men, rewriting languages of menstruation long before the Federation published its first advice pamphlets.[8] Similarly, whilst the MWF were eager to empower women to take back control of their reproductive health, they were unwilling to publicly engage in the controversial subject of birth control. Many female practitioners struggled to reconcile themselves with the use of modern contraceptive methods, which offered women freedom from the bonds of motherhood. Lesley A. Hall has written extensively on the medical profession's response to birth control, outlining the public opinions of high-profile members of the Federation.[9] Caroline Rusterholz has also considered the influence of British medical women in transnational debates, charting the formation of the International Planned Parenthood Federation.[10] Whilst the public views expressed by the London Association have received attention from both Hall and Rusterholz, the private views of the MWF's nine other local Associations, recorded in the council minute book, have, thus far, been overlooked.[11] This chapter demonstrates that they are worthy of investigation in their own right, as they offer unique regional perspectives on the issue of birth control. Furthermore, they provide greater insights into the reasons behind the organisation's refusal to engage in public debates on the subject. This chapter concludes by considering the extent to which the Federation fulfilled Sturge's aims of benefitting medical women, medical men, and the general public during the interwar period.

Resistance: Equal pay during the interwar years

Chapter One examined the equal pay disputes that occurred at the turn of the century, as medical women attempted to integrate themselves within the male-dominated profession and prove their worth as competent practitioners. Faced with the opportunity to work alongside the BMA for the first time, the ARMW adopted a hard-line approach to dealing with members who accepted

[8] Sanderson Clow's papers are held in the MWF archive, Wellcome Library, London, SA/MWF/M.1/1-10.

[9] Lesley A. Hall, 'A Suitable Job for a Woman: Women Doctors and Birth Control to the Inception of the NHS', in *Women and Modern Medicine*, ed. by Anne Hardy and Lawrence Conrad (Amsterdam: Rodopi, 2001), pp.127-148; Lesley A. Hall, *Sex Gender and Social Changes in Britain since 1880* (Basingstoke: Palgrave Macmillan, 2012); Lesley A. Hall, *Outspoken Women: An Anthology of Women's Writing on Sex, 1870–1969* (London: Routledge, 2014).

[10] Caroline Rusterholz, 'English Women Doctors, Contraception and Family Planning in Transnational Perspective (1930s-70s), *Medical History*, 63 (2019), 153-172; Caroline Rusterholz, *Women's Medicine: Sex, Family Planning and British Female Doctors in Transnational Perspective, 1920–70* (Manchester: Manchester University Press, 2021).

[11] Hall, 'A Suitable Job for a Woman', p.133; Rusterholz, *Women's Medicine*, p.53.

underpaid posts, exiling them from the Association as punishment for their lack of professional loyalty. Following the return of 'male medicals' from the front, the issue of equal pay for equal work resurfaced once more, and was at the forefront of the MWF's work during the interwar years. Mary Ann Elston notes that conflict over unequal pay was found in all forms of public employment, especially public health work, as the expansion of state-run medical services, along with the financial restrictions imposed by the government, led to local authorities attempting to cut costs.[12] In 1921, 11.3 per cent of the country's workforce was unemployed.[13] In response to the economic crisis, the government reduced the National Health Insurance capitation fee, meaning that general practitioners got paid two shillings less for each panel patient they treated.[14] The influx of female graduates who had begun their studies during the War led to junior positions being in high demand; whilst senior woman doctors publicly denied that the medical marketplace was overcrowded, behind closed doors, they accepted that large numbers of women were struggling to obtain their first posts. By way of example, in January 1924, Louisa Aldrich-Blake reported to the Federation's Executive Officers that 591 students had graduated from the LSMW in 1923, and spoke of the 'difficulties of such a large number obtaining posts'.[15] Throughout the 1920s and 30s, the MWF fought tirelessly to put an end to the pay inequalities experienced by women doctors; reports of underpaid public health posts from across the country featured in almost every meeting of the Federation's Executive Committee during this period. Indeed, in October 1926, the details of seven new cases were read in one meeting, prompting further discussions on what more the MWF could do to mitigate the crisis.[16]

The BMA continued in its pre-war stance of resisting pay discrimination, but placed the onus on medical women to uphold professional solidarity by resisting underpaid posts. Fears that the labour of the entire medical profession would be cheapened by a small number of selfish women doctors remained a principal concern for many – 'It is hardly necessary to add that the

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[12] Mary Ann Elston, 'Women Doctors in the British in the British Health Services: a Sociological Study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986, p.322.

[13] S.N. Broadberry, 'Unemployment in Interwar Britain, a Disequilibrium', *Oxford Economic Papers,* 3 (1983), 463-85 (p.463).

[14] Anne Digby and Nick Bosanquet, 'Doctors and Patients in an Era of National Health Insurance and Private Practice, 1913-1938', *Economic History Review*, 41 (1988), 74-94 (p.76).

[15] Minutes of the Executive Officers, 14th January 1924, SA/MWF/A.2/1. Further minutes from 1921 to 1925 come from this collection.

[16] Minutes of the Executive Committee, 6th October 1926, SA/MWF/A.2/2. Further minutes from December 1925 to June 1930 come from this collection.

[BMA] can only be successful […] if it receives the loyal support of *all* medical women'.[17] Similar views were shared in various articles published in *Public Health*; general practice no longer guaranteed a secure living for female practitioners, and the disloyalty of a select few was bringing the entire profession into disrepute.[18] This view did not go unchallenged; one anonymous female medical officer defended the young and inexperienced graduates who were accepting posts with inadequate pay: 'It seems unfair to blame [them] entirely. It is not only women who accept these posts'.[19] Lady Florence Barrett, a long-standing member of both the ARMW and the MWF, similarly wrote to *Public Health* to challenge the view that women doctors should be held solely responsible for the lowering of professional standards: 'Medical women have been working loyally to prevent the acceptance of under-paid posts. Such an editorial as yours will only encourage public bodies to offer lower salaries to women, and thereby damage the profession as a whole'.[20] In spite of Barrett's assertion that medical women were in complete solidarity with their colleagues, the lists of applicants for underpaid public health posts told a different story; in April 1924, *Public Health* reported that 11 out of 13 candidates were women doctors.[21] Such figures were humiliating for the MWF, who continued to defend the steadfast loyalty of its members in both medical journals and the national press.

The Federation's official policy for resisting unequal pay was outlined by Frances Ivens in December 1924.[22] Local authorities had to be dealt with robustly in collaboration with the BMA if there was to be any hope of securing equality for medical women across all areas of public health work.[23] In contrast to the ARMW's pre-war policy, Ivens makes no mention of alienating women doctors who accepted underpaid posts, which suggests that the Executive Council had an acute awareness of the economic conditions affecting its members. In 1927, the MWF warned medical women in the *Newsletter* that any betrayals of professional loyalty would lead to their membership being revoked; however, there is no evidence of this being put into practice.[24] What is clear from the minutes of the Executive Council is that whilst medical women were expected to stand in solidarity with one another, individual circumstances were respected, and no unwanted

[17] 'Women in Medicine', *BMJ*, 2 (6th September 1924), 432.

[18] 'Women in Medicine', *Public Health*, 37 (April 1924), 156-7 (p.157).

[19] Anon., 'Women in Public Health Appointments', *Public Health*, 37 (September 1924), 324.

[20] Lady Florence Barrett, 'Women in Medicine', *Public Health*, 37 (August 1924), 183.

[21] 'Women in Medicine', *Public Health*, p.156.

[22] Minutes of the Executive Officers, 11th December 1924.

[23] Ibid.

[24] MWF *Newsletter* (July 1927), p.39.

interventions were actioned by the Federation. Though the MWF wrote to women doctors who had accepted underpaid posts to strongly urge them to withdraw, few were willing, or indeed financially able, to take the advice offered to them. In October 1922, Lydia Henry, a former SWH surgeon, wrote to the MWF to advise them that she was 'adjusting her difficulties privately' in regards to her insufficient salary, 'but thanked the Federation for its offer of help'.[25] Similarly in January 1925, Dorothy Gollies applied for membership of the Federation, having accepted an underpaid post at Kent County Council six months previously.[26] It was agreed that she should be permitted to join the MWF, but a lively discussion followed on 'what might be accepted as conduct which would render a medical woman ineligible for membership'.[27] It is evident that the MWF were sympathetic to the difficulties faced by graduates entering a crowded medical marketplace; where possible, the names of those who chose to withdraw their applications were recommended for locum positions, with the Executive Council making use of their professional networks to share information on suitable applicants.[28] Thus, the neglected evidence in the MWF archive reveals the tensions between policy and pragmatism, and it is this that previous studies have not appreciated.

By working with, rather than against, its members, the MWF formed lasting relationships in the fight for equality within the workplace. Members on the 'inside' of institutions that employed women doctors would pass pertinent information to the Federation in order to aid their campaign, and vice versa. A striking example of one such mutually-beneficial arrangement is that which existed between the Executive Council of the MWF and Minnie Madgshon, an Assistant Medical Officer employed by the General Post Office (GPO).[29] Over the course of two decades, Madgshon worked in close partnership with the Federation, informing them of every new development in relation to medical women's salaries in an effort to effect meaningful change within the civil service. Whilst the MWF were ultimately unsuccessful in their attempts to persuade the GPO to change its policy, the continued efforts made on behalf of Madgshon and her colleagues highlights the true extent of the Federation's commitment to achieving gender equality for its members. Madgshon first made contact with the ARMW in February 1912, informing them of the unequal

[25] Minutes of the Executive Officers, 5th October 1922.

[26] Ibid., 10th July 1925.

[27] Ibid.

[28] *Medical Women's Federation Quarterly Review*, November 1935, 38, SA/MWF/B.2/8.

[29] 'Minnie Madgshon', UK, Postal Service Appointment Books, 1737-1969, <www.ancestry.com> [accessed 2nd April 2020]; Madgshon (1867-1951) joined the GPO as an Assistant Medical Officer in 1896. Edith Shove (1848-1929) was the first medical woman to be employed by the GPO as an Assistant Medical Officer in 1883.

salary she was receiving at the Post Office; whilst men and women both started out on £180 per annum, men were granted an annual increase of £20 to a maximum of £400, whilst women only received an annual increase of £15 to a maximum of £300.[30] In a letter to May Thorne in December of the same year, Madgshon professed that whilst she was willing to resign her post in accordance with the Association's position on equal pay, she was worried that it might lead to a step backwards for the cause: 'The salary attached to my post is now the 3rd highest on the medical staff at the Office […] I think that I can fight better from within than without, don't you agree?'.[31] Madgshon resolved to continue in her post, and to use her inside knowledge to keep the ARMW informed of the working conditions of medical women in the GPO.

Madgshon wrote to the Association again with an update in March 1915, but due to the War, the issue was shelved by the Association until they were in a position to give it their full attention.[32] In October 1919, seven years after first writing to the Association, Madgshon was hopeful that with the help of the newly-formed Federation, the matter of equal pay for equal work might be 'satisfactorily settled from within' once and for all.[33] Madgshon's aversion to the issue being made public in the national press suggests that whilst she remained committed to the pursuit of gender equality within the GPO, she wished to avoid a situation where her own hard-won position was jeopardised. The MWF promptly wrote to the Secretary of the BMA to ask whether they had any information on salaries at the GPO that might support Madgshon's case.[34] When the BMA responded in the negative, the MWF advised Madgshon that whilst they were unable to offer any practical assistance without clear evidence, she should inform the Treasury that 'the principle of equal pay for equal work, without distinction of sex, is accepted by the whole [medical] profession'.[35] In September 1921, Madgshon, who had been promoted to the position of Chief Woman Medical Officer at the Post Office, once again used her privileged position to inform the MWF of a new development.[36] Having been refused publication by both the *BMJ* and the *Lancet* on the grounds of insufficient pay, the GPO was, rather sneakily, privately advertising for the position of a female Assistant Medical Officer at a paltry salary of £250 per annum, with an annual

[30] Letter from Minnie Madgshon to May Thorne, 3rd February 1912, SA/MWF/C.85.

[31] Letter from Minnie Madgshon to May Thorne, 13th December 1912.

[32] Letter from Minnie Madgshon to Kate Haslam, 30th March 1915.

[33] Letter from M. Vince to Alfred Cox, 1st October 1919, SA/MWF/D/1.

[34] Ibid.

[35] Letter from M. Vince to Minnie Madgshon, 8th October 1919.

[36] Minutes of the Executive Officers, 28th September 1921.

increase of £15 to a maximum of £400.[37] The MWF contacted every medical woman who had been approached for the post, and promptly sent a letter to the Post Master General, Frederick Kellaway, expressing the view that such flagrant inequality would have a detrimental impact on the position of women in medicine.[38] The Executive Officer's request for a deputation was denied, as Kellaway found himself 'unable to entertain the false claims put forward by the Federation'.[39]

Unwilling to accept this provocative rebuttal, Lady Florence Barrett, who was incumbent president of the Federation, published an open letter to the GPO in both medical journals and the national press in February 1923.[40] Barrett re-emphasised the fact that medical women received the same training and qualifications as men, and argued that women medical officers in the GPO carried out their duties without 'extra favours or special consideration'.[41] Barrett's defence of medical women did not go unanswered. The following month, an anonymous male medical officer working at the GPO published a scathing response in the *Lancet*: 'It is an axiom that women cheapen labour […] the Post Master General naturally pays the women the value of the service they give and not the value of service given by men'.[42] In an act of professional solidarity, both Barrett and Madgshon published responses to the misleading 'blend of "inside information", distortion, and inaccuracy' submitted by 'Clericus'.[43] Whilst Barrett reiterated the points she had previously made, Madgshon defended the work of her medical staff under the pseudonym 'Medica': 'Even women sometimes fall down stairs […] or have pulmonary and other haemorrhages, and whatever fractures or other mischances occur amongst the 14,000 women under the charge of the women medical officers are dealt with by them.[44] Speaking as someone who had an intimate knowledge of the hardships endured by medical women in the Post Office, Madgshon forcefully rebuts Clericus' claims that female practitioners could not possibly attend to accidents and other complicated work. One month later, Clericus published another letter in the

[37] In July 1922, a female Assistant Medical Officer post in Grimsby was advertised in the *BMJ* for £350 per annum. In contrast, a male Assistant Medical Officer post in Oldham was advertised for £600 per annum. In 1925, the minimum salary agreed upon between the MWF and the BMA for a full-time Assistant Medical Officer post was £600.

[38] Letter from the MWF to the GPO, 4th November 1921, SA/MWF/D.1.

[39] Letter from the GPO to the MWF, 8th November 1921.

[40] MWF Council minutes, 14th October 1922; The letter was published in the *Times, Daily Telegraph, Scotsman, Dundee Advertiser, Bristol Evening News,* and the *Manchester Guardian.*

[41] 'Medical Women's Federation – Medical Women in the Post Office', *Lancet*, 201 (24th February 1923), 403.

[42] 'Clericus', 'Women in the Post Office Medical Department', *Lancet*, 1 (10th March 1923), 511.

[43] 'Medica' [Minnie Madgshon], 'Women in the Post Office Medical Department', *Lancet*, 1 (17th March 1923), 567.

[44] Ibid.

Lancet, attacking the supposed loyalty of medical women like 'Medica': 'Is this a woman's way of showing traditional loyalty to her department and her colleagues?'.[45] Having already succinctly expressed their views on the subject, and wanting to avoid any further debates in the medical press, Barrett and Madgshon agreed that no further response was required.

In January 1925, having once again been refused publication by the *BMJ* and the *Lancet*, the GPO wrote directly to Louisa Aldrich-Blake, Dean of the LSMW, to advertise an Assistant Medical Officer post.[46] Not realising Aldrich-Blake's close association with the MWF, the GPO requested that she recommend the post to her recent graduates. The salary offered to women was almost identical to that which had been privately advertised four years previously; in contrast, the base salary offered to men for the same work had risen by £100 per annum, with the upper threshold now standing at £600.[47] In light of the blatant salary discrimination, Aldrich-Blake refused to endorse the position, and wrote to the Deans of the other London medical schools, who were all men, to advise them to take the same decisive action.[48] In both 1929 and 1931 further advertisements for posts at the Post Office appeared in the *Times* with the same inadequate salary.[49] After nearly 30 years working for the GPO, Madgshon retired between 1925 and 1930, and as the Federation felt that they had exhausted every available option over the past two decades, no further action in the matter was taken.[50] Though the MWF ultimately failed to win equality for Madgshon and her colleagues, their mutual partnership did much to benefit the cause, providing the Federation with information to which they would not otherwise have been privy. The Federation's commitment to a firm, yet supportive, strategy for achieving gender parity was not completely in vain; in 1930, three decades after the ARMW had first founded their Vigilance Committee, a formal agreement was made between the BMA, MWF and the Ministry of Health that there should be 'no differentiation of salary according to sex' in public health posts.[51] Whilst the MWF's collaborative approach to tackling the issue of equal pay led to progress being made within the profession, a number of barriers continued to thwart the careers of medical women

[45] 'Clericus', 'Women in the Post Office Medical Department', *Lancet,* 1 (21st April 1923), 821.

[46] MWF Council Minutes, 22nd January 1925.

[47] Ibid.

[48] Ibid.

[49] 'Public Appointments', *Times*, 11th July 1929, p.3; 'Public Appointments', *Times,* 13th April 1931, p.3.

[50] Minutes of the Executive Committee, 20th July 1929.

[51] MWF *Newsletter* (July 1930), 57. Though cases of inadequate remuneration continued to occur occasionally, the number of reports reduced dramatically after the agreement was made.

throughout the interwar period. Resisting the marriage bars which were reintroduced by local authorities after the Armistice was signed proved to be another long-fought battle for the MWF.

Medical women and marriage bars

Just as unequal pay had been used to discriminate against female practitioners in public health appointments, so too were the marriage bars that sought to exclude women doctors from the medical profession. A small number of local authorities had pre-war policies which stipulated that women had to give up their positions on marriage, unless it could be proven that their husbands were not able to financially support them.[52] These restrictions were generally relaxed to allow medical women to fill vacant posts as part of the war effort.[53] As male doctors returned from the front, and unemployment figures continued to rise during the interwar years, marriage bars were reinstated by local authorities across the country.[54] The 1919 Sex Disqualification (Removal) Act stated that: 'A person shall not be disqualified by sex or marriage […] from being appointed to or holding any civil or judicial office or post, or from entering or assuming or carrying on any civil professional vocation'.[55] Whilst the Act sought to give women equal rights and opportunities in the workplace, it exempted the civil service, meaning that local authorities had the power to impose marriage bars across all departments.[56] The London County Council (LCC), which had lost almost 11 per cent of its male workforce to fatalities in the War, was one of the first governing bodies to reinstate its exclusion of married women workers in 1919.[57] One of the primary arguments against employing married women was that they were less efficient workers than their single counterparts on account of their distracting domestic duties.[58] Similarly, from a social perspective it was believed that families would suffer unnecessarily if wives and mothers were absent for prolonged periods

[52] Medical women working for the LCC were required to provide annual proof of their husband's dependence.

[53] Elston, 'Women Doctors in the British Health Services', p.289.

[54] S.N. Broadberry, 'Unemployment in Interwar Britain, a Disequilibrium', p.463.

[55] UK Government, 'Sex Disqualification (Removal) Act 1919', <http://www.legislation.gov.uk> [accessed 14th April 2020].

[56] Helen Glew, 'Regulating Marriage: Gender, the Public Service, the Second World War, and Reconstruction in Britain and Canada', in *Gender and the Second World War: The Lessons of War*, ed. by Corinna Peniston-Bird and Emma Vickers (London: Palgrave, 2017), pp.88-101 (p.89).

[57] Jay Winter and Jean-Louis Robert (eds), *Capital Cities at War: Paris, London, Berlin 1914-1919, Volume 1* (Cambridge: Cambridge University Press, 1997), p.81.

[58] 'Standing Committee on Married Medical Women' typed minutes, undated, SA/MWF/D.1/3.

of time.[59] As had been the case with the issue of equal pay for equal work, the MWF were hopeful that a forceful response would persuade local authorities to withdraw their restrictive policies. In November 1919, the MWF sent a deputation to the LCC to protest their decision to dismiss married medical women.[60] Though the MWF were initially successful in their endeavour, the decision was ultimately overturned in 1924, and marriage bars for women doctors and teachers remained in place at the LCC until 1935.[61]

In response to the growing number of local authorities implementing marriage bars, the MWF formed a dedicated standing committee to deal with the matter in 1921.[62] The first case brought to the attention of the committee was that of Gladys Miall Smith, a married medical officer of health working at St. Pancras Borough Council, who was given a month's notice by her employer in October 1921.[63] Miall Smith was one of the first medical woman to be publicly dismissed on account of her marital status, and, as such, several women's organisations were anxious to take legal action on her behalf: 'The general opinion is that taking the case to the courts will serve some useful purpose. I may feel I must do it […] it might prevent other councils taking similar action'.[64] The MWF were strongly of the opinion that dismissals on the ground of marriage alone were not only contrary to the 'spirit' of the Sex Disqualification (Removal) Act, but also involved unjust interference in the private lives of medical women.[65] Whilst the committee were committed to resisting the decision of the St. Pancras Borough Council, some members were left feeling aggrieved at the Federation's decision to support Miall Smith's case: 'Dr Gilchrist pointed out that a great deal of support for the dismissal of married medical women is coming from the unmarried medical woman who are finding it hard to get jobs […] for themselves'.[66] As had been the case with those who accepted posts with unequal pay, the MWF sympathised with graduates struggling to find positions in a time of great economic uncertainty. Even so, the Federation remained firm in their position that the rights and liberties of women doctors had to be protected: 'It is very important for all of us who see clearly the general principle to influence the thought of these young

[59] Ibid.

[60] 'Married Medical Women and the London County Council', MWF *Newsletter* (September 1920), 6-7.

[61] Glew, 'Regulating Marriage', p.89.

[62] Minutes of the Standing Committee on Married Medical Women, 17th November 1921, SA/MWF/D.4/1/1.

[63] Letter from Gladys Miall Smith to MWF, 2nd November 1921, SA/MWF/D.4/1/1.

[64] Ibid.

[65] Minutes of the Standing Committee on Married Medical Women, 17th November 1921.

[66] Ibid.

unmarried medical women'.[67] After seeking legal advice, it was decided that Miall Smith's case was unlikely to succeed in the courts.[68] Unwilling to let the issue drop, the MWF unanimously agreed that a press campaign should be the next course of action, as it was vitally important that public opinion was educated on the injustice of marriage bars.[69]

At the same time as Miall Smith was being dismissed by St. Pancras Borough Council, three married medical women were being forced to resign from their positions as medical officers of health at the Glasgow Corporation.[70] In response, the MWF wrote an open letter in the *Times* to protest against the exclusion of married women doctors from public health appointments in December 1921.[71] The council argued that denying medical women the right to undertake the work that they were 'exceptionally fitted for' would have a disastrous effect on local communities: 'It should be borne in mind that a woman wishing to continue practising her profession after marriage generally denotes a keen devotion to her work'.[72] It is interesting to note that arguments both for and against the employment of married medical women relied upon ingrained gender stereotypes. Women doctors were still believed to be 'exceptionally fitted' to treating the ailments of children and their own sex, and it was similarly maintained that 'the nature of a married woman is often more peaceful and content', meaning that their work was likely to be less affected by disorder and inefficiency.[73] It was also argued that if medical women were being dismissed on account of their husbands' financial stability, logic would dictate that medical men whose rich wives supported them, and those who had their own private means, should be excluded too.[74] Whilst the Federation were satisfied that their timely response would do much to change public opinion, others were not so convinced. Reporting on the letter published in the *Times*, the *Glasgow News* was particularly damning: 'In their belated protest against Glasgow Corporation and St. Pancras Borough Council for refusing to employ medical women who are married and whose husbands are in employment, the MWF had nothing particularly new to say'.[75]

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[67] Ibid.

[68] Letter from Medical Secretary to Louise McIlroy, 17th November 1921.

[69] Letter from Louise McIlroy to Medical Secretary, 24th November 1921.

[70] Letter from Carol F. Norrie to Marion Gilchrist, 15th November 1921.

[71] 'Married Medical Women', *Times*, 6th December 1921, p.6.

[72] Ibid.

[73] Lady Barrett, 'Married Medical Women', MWF *Newsletter* (November 1921), 8-11 (p.9).

[74] Ibid.

[75] 'Married Medical Women', *Glasgow News*, 7th December 1921, p.2.

Despite their belated public response to marriage bars, the MWF remained committed to resisting the discrimination of medical women in the workplace. In February 1922, the Federation joined representatives from 45 other women's organisations to discuss the question of marriage bars in professional employment.[76] Delegates unanimously agreed that the policies adopted by local authorities lowered the standard of women's work and undermined their position and value within society, as well as threatening national productivity.[77] Outrage at local authorities' interference in the private lives of medical women featured heavily in both the national press and medical journals throughout the 1920s. In a letter to the *Times*, an anonymous correspondent ridiculed St. Pancras Borough Council by highlighting the absurdity of their decision to punish highly capable practitioners for choosing to marry a financially secure man: 'If this practice is to be generally followed it means that a woman of brains who qualifies for the medical profession must, however gifted, expect to give up her life's work on marriage unless she can secure a dependent husband'.[78] Similar sentiments were expressed by Marion Mackenzie, a medical woman from Leeds, in an uninhibited letter published in the *BMJ* in May 1922:

> Surely it is a waste for women to spend so much on qualifying and then […] to stay at home and do another woman out of a job, which she is probably much better at than oneself, and which personally I loathe with a deadly hatred […] this inquisition about our affairs is intolerable. Next you will be asking us if we are in love, as if so we are ineligible, as love, it is well known, distracts one from work […] Ye gods! No wonder the independent girl of today is so chary of marriage.[79]

According to Mackenzie, whilst the majority of men were able to support their wives, many chose not to, refusing to provide them with an adequate housekeeping allowance.[80] Crucially, work provided independence for married women from all social classes. It is likely that a number of medical women reading Mackenzie's letter would have been in sympathy with her confession that

[76] Minutes of the Standing Committee on Married Medical Women, 2nd February 1922.

[77] Ibid.

[78] A.N, 'Married Medical Women', *Times*, 29th December 1921, p.3.

[79] Marion E. Mackenzie, 'Married Medical Women Whose Husbands are able to Support Them', *BMJ*, 2 (20th May 1922), 820.

[80] Ibid.

she loathed child-rearing; women doctors in the 1920s and 30s were generally expected to resign from salaried positions in hospitals and local authorities upon their confinement.[81]

The injustice of young medical women being forced to give up their profession before they had a chance to reap any of the rewards of their personal and financial sacrifices greatly angered the MWF. Such a step was retrograde given the advances that many married first generation medical women had made within the profession. In a letter published in the *BMJ* in November 1924, May Dickinson Berry, honorary secretary of the Federation, strongly condemned the widespread movement to exclude married women from professional work: 'Does the public desire all professional women to be celibate? […] It has been well said "what women really want is equal opportunities and to be left well alone"'.[82] Though the MWF continued to campaign relentlessly for equal opportunities for married medical women, local government bodies refused to change their policies. In August 1925, Elizabeth Kirker, a medical officer working for Southwark Borough Council, was asked to resign from her post 12 months after her marriage, in spite of the fact that she had sought permission from her employer prior to the wedding.[83] Similarly, in 1929, Hilda Shufflebotham, an Anaesthetist at Birmingham General Hospital, was asked to resign from her position after requesting three months' leave to have her first child.[84] After initially rescinding their decision, the Board of Management voted in favour of barring all married medical women from any future employment at the hospital.[85] In 1927, the Married Women (Employment) Bill, which sought to put an end to marriage bars once and for all, was put forward by Sir Robert Newman.[86] Nancy Astor, who had previously supported the MWF on issues of gender equality, employed her characteristic wit to rebuke her own political party's opposition to the Bill in a House of Commons Debate: 'I know women who could have twins every year and still be more efficient than Members of Parliament […] we have to fight a

[81] Elston, 'Women Doctors in the British Health Services', p.320. Elston notes that some medical women were able to continue their professional activities after having children by working in private practice or by volunteering in areas of maternal and child welfare. There were also some notable exceptions; the RFH continued to employ Ethel Vaughan Sawyer after her marriage and the birth of her first child in 1907 and 1908. See Brock (2017).

[82] F. May Dickinson Berry, 'Married Women in Professions', *BMJ*, 2 (29th November 1924), 1925.

[83] 'Married Women's right to Work', *The Vote*, 14th August 1925, p.261.

[84] Minutes of the Standing Committee on Married Medical Women, 23rd September 1929. Hilda Shufflebotham (1891-1982) later became the first female president of the Royal College of Obstetricians and Gynaecologists in 1949.

[85] Ibid.

[86] Alison Oram, *Women Teachers and Feminist Politics, 1900-39* (Manchester: Manchester University Press, 1996), p.168.

long-standing enemy, and that enemy is that a man should judge where a woman should be'.[87] In spite of widespread support, the Bill failed to pass a second reading.[88]

The MWF continued in their resistance against marriage bars throughout the 1930s, in spite of the limited progress that had been achieved. In 1931, the Federation were successful in reversing the decision of the Birmingham Public Health Department to dismiss all of the married medical woman in their employment.[89] After receiving a deputation from the MWF, which included a patient from one of the maternity and child welfare clinics, members of the board were persuaded that married women doctors were essential to the running of the city's public health services.[90] Following this victory, marriage bars received infrequent attention from the Executive Committee, suggesting that the MWF became increasingly unwilling to engage in public campaigns as the years progressed. In 1934, the Federation were approached by the Open Door Council to participate in a further protest against the LCC, but the Executive Council refused, stating that they were unable to involve themselves in any matter which was not purely medical in nature.[91] Having pushed for an end to marriage bars for over a decade, publishing letters in national newspapers and deputising Members of Parliament, the MWF resolved to let others continue the fight on their behalf. The Federation remained in close contact with members on the subject; in 1933, the Executive Council supplied a medical student with ephemera from the married medical women's standing committee to aid her preparation for a debate on marriage bars.[92] After successfully arguing the case that marriage did not impede the work of medical women, the student wrote to thank the MWF for their support: 'My opponent was an unmarried woman doctor, she was a nervous and hesitating speaker […] I think good seed has been sown and I am very grateful for the help you supplied'.[93] Whilst a number of medical women were forced to leave the medical profession on account of their marital status, some were able to continue working in voluntary capacities or in private practice, where formal restrictions were generally not imposed. Private practice offered women doctors the freedom to earn a good living without the restrictive bureaucracy of working for a hospital or city council. The MWF loan fund was integral to the

[87] Helen Jones, *Women in British Public Life, 1914-50: Gender, Power, and Social Policy* (London: Routledge, 2000), p.53.

[88] Ibid.

[89] 'Standing Committee on Married Medical Women', typed minutes, 1931, SA/MWF/D.4/3.

[90] Ibid.

[91] Letter from the Open Door Council to the MWF, 2nd May 1934.

[91] Letter from the MWF to the Open Door Council, 10th May 1934.

[92] Letter from A. E. Parsons to Violet Kelynack, 20th March 1933.

[93] Ibid.

recovery of medical women's careers following the First World War, providing members with the financial means to work as independent practitioners.

Recovery: The MWF loan fund

Women doctors faced several institutional barriers within the medical profession during the interwar years which hampered their professional progress. For recent graduates, hospital and public health posts were not only difficult to come by, but the salaries advertised were often woefully insufficient.[94] Similarly, marriage bars led to many medical women having to give up their profession before they had a chance to hold a senior position or to specialise.[95] One area of medicine which did offer exciting career prospects was general practice, as it provided women doctors with the opportunity to develop their skills as practitioners whilst also avoiding the restrictive policies which sought to exclude them from the profession. At the end of the nineteenth century, women doctors struggled to establish hospital careers on account of the widespread prejudice that existed against them.[96] Unwilling to waste their hard-won qualifications, many first generation medical women founded their own private practices in order to secure their futures within the profession.[97] Similarly, the congested state of the medical marketplace in the immediate post-war period encouraged women doctors to adapt by developing their own distinct career paths and patient constituencies.[98] Reflecting back on three decades spent in general practice in 1926, Ethel Williams, a longstanding member of the Federation, writes: 'I have never regretted the decision I made to devote my professional life to general practice. It has brought much hard work, an enormous amount of interesting scientific work, and many very pleasant friendships'.[99] Unlike hospital work and public health appointments, general practice gave medical women complete control over both their personal lives and professional careers, making it a popular choice for recent graduates. In a survey conducted in 1928, 40.6 per cent of MWF members were recorded

[94] Elston, 'Women Doctors in the British Health Services', p.222.

[95] Ibid., p.320.

[96] See Elston (1986).

[97] Elston, 'Women Doctors in the British Health Services', p.320. For example, Eliza Walker Dunbar founded a successful private practice in Bristol after resigning from her post at the Bristol Royal Hospital for Sick Children in 1873.

[98] Ibid.

[99] Ethel Williams, 'Thirty Odd Years in General Practice', MWF *Newsletter* (November 1926), 52-57.

as being in general practice, and in 1933, the BMA estimated that 13 per cent of all general practitioners were women.[100]

Whilst many medical women were willing to withstand the long working hours and complex social problems, general practice was a field that was extremely difficult to break into. Elston notes that low-paid assistantship positions were highly competitive in the interwar period, and established women's practices were rarely advertised.[101] This meant that for many medical women, 'putting up a plate' remained the only viable option to enter the field.[102] Establishing a private practice presented a daunting task for women doctors at all career stages:

> We need advice on the best way to begin, whether in rooms or with a house; on the minimum amount of money necessary, on the kind of apparatus to collect […] how far is it right for women to ignore the professional etiquette about setting up a plate near other doctors? [It] is all a matter of anxiety to a beginner.[103]

In order to secure appropriate premises and to buy the necessary equipment, a significant financial outlay was required, with no substantial returns on the investment being achieved for at least the first five years.[104] Extensive research on suitable locations was also required, as practices would only succeed if they were in a promising area: 'The ponderings on possible places – studying the locations of new housing estates etc. – then turning the pages of the Medical Directory to see how many general practitioners were already there'. [105] Outside of the large industrial cities where female practitioners were commonplace, the figure of the woman doctor was often met with disdain and suspicion. As had been the case in the late 1890s, medical women in the interwar period continued to be viewed by many as unwelcome outsiders in a male dominated field. This was particularly apparent in general practice, as competition within local communities heightened pre-existing anxieties over job security. In Conan Doyle's short story 'The Doctors of Hoyland' (1894), Dr James Ripley is horrified to discover that his new competitor, Verrinder Smith M.D, is in fact a woman: 'He had never seen a woman doctor before, and his whole conservative soul rose up in

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[100] MWF *Newsletter* (October 1934), 44; 'Women Medical Students', *Times*, 31st May 1928, p.10.

[101] Elston, 'Women Doctors in the British Health Services', p.345. The MWF set-up a vacant posts bureau in 1922 to help make it easier for members to find practices for sale.

[102] Ibid. 'Putting up a plate' involved securing a metal sign with a doctors' name and qualifications to the front door of their private practice, announcing their presence in the area to prospective patients and rival doctors.

[103] Letter from Kathleen Tillyard, MWF *Newsletter* (November 1923), 34.

[104] M.H. Kettle, 'The Fate of a Population of Women Medical Students', *Lancet*, 1 (13th June 1936), 1370-1374 (p.1373).

[105] Mabel Rew, 'General Practice', *MWF Journal* (January 1967), 35.

revolt at the idea […] he felt as if a blasphemy had been committed'.[106] Following a road accident, Smith skilfully sets Ripley's compound fracture, leading him to acquiesce to his brother, an assistant surgeon, that: 'She knows her work as well as you or I […] we may have been a little narrow in our views'.[107] In spite of the initial difficulties involved in founding a successful medical establishment, general practice offered medical women the security of a rewarding and varied career.

Given the long-term benefits of starting a new career as a general practitioner, members of the MWF's Executive Council were eager to encourage members to pursue a career in the field, but feared that the financial implications would prove to be an insurmountable barrier to recent graduates.[108] The Federation were committed to facilitating the post-war recovery of women doctor's careers, and to expanding the opportunities available to its members. In June 1923, the MWF loan fund was founded by Lady Barrett to offer financial assistance to those wanting to start a career in general practice.[109] In its first two years, the fund benefited from a number of large donations from established women doctors, including £500 from one member who wished to remain anonymous, and the remaining balance of the Mary Murdoch Memorial Loan Fund, which totalled £740.[110] Additionally, in May 1926, Christine Murrell founded the John Rains Memorial Fund in memory of her grandfather, pledging a further £1000 to help members to become general practitioners.[111] As had been the case in the late nineteenth and early twentieth centuries, senior women doctors continued to have an invested interest in the professional progress of their younger counterparts. Between January 1924 and October 1935, the two funds played a principal role in the careers of medical women, loaning nearly £11000 to MWF members in order to fund 48 private practices across the country.[112] More than half of the applicants had been qualified for three years or fewer, supporting the view that general practice was a popular field for recent graduates who had struggled to secure hospital posts.[113] One applicant, Ethel Stacy, had been qualified for 30 years when she applied for a £400 loan to expand her practice in Bedford in April 1932, suggesting

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[106] Arthur Conan Doyle, 'The Doctors of Hoyland', *Idler*, April 1894, 226-238 (p.230).

[107] Ibid., p.236. Ripley later proposes to Smith, who initially views the proposal as a scheme to unite their private practices. She refuses, stating that she intends to dedicate her life to science.

[108] Minutes of the Executive Officers, 20th June 1923. Barrett gifted £50 to form the nucleus of the loan fund.

[109] Ibid.

[110] Ibid., 28th February 1924. The Mary Murdoch Memorial Loan Fund had been founded in 1916.

[111] Ibid., 31st May 1926. For more on Murrell's career, see St John (1935).

[112] Loan applications, renewals, and repayments were detailed in the Executive Committee Minutes.

[113] Elston, p.345.

that experienced medical women wanting a career change similarly benefited from the MWF loan fund.[114] As would be expected, the majority of practices were located in large cities such as Birmingham, Manchester, Liverpool, and Glasgow, with nearly 50 per cent being established in London (Figure 3.1).

Figure 3.1 Locations of private practices in the United Kingdom financed by the MWF loan fund.[115]

Applying for a low-interest loan from the MWF was a rigorous process; confidential investigations were conducted to assess the suitability of both the medical woman and their proposed practice location.[116] Letters of guarantee were also required, as well as an insurance premium to cover the amount of the loan, which the applicant was expected to pay.[117] Enquiries

[114] Ethel Stacy (1877-1938) was much-loved by both her colleagues, and her patients, alike. She was described in her obituary as having an optimism that 'could scarcely fail to communicate itself even to the most severely ill'.

[115] Locations of private practices taken from Executive Committee Minutes (SA/MWF/A.2).

[116] Minutes of the Executive Committee, 31st May 1926.

[117] Ibid., 10th July 1925.

were carried out by members of the Executive Council, who had access to a wide range of contacts through their professional networks: 'An application for £100 from Dr Grace Shirlaw was considered […] it was understood that the prospects were good. It was agreed to make confidential enquiries regarding the practice and Dr Shirlaw's suitability from Dr Catherine Chisholm'.[118] If these checks proved to be satisfactory, the woman doctor in question was invited to a face-to-face interview, after which a final decision was then made.[119] In a small number of cases, this process was overridden if the applicant was personally known to a member of the MWF council.[120] This suggests that like the patronages which often existed within male medical fraternities, having a professional relationship with a senior medical woman could be financially advantageous. In spite of the benefits of going into practice with another medical woman, only four of the 48 loans granted were joint applications. Professional partnerships reduced the initial financial burden of starting out in general practice and increased the number of patients who could be taken on. Similarly, having another medical opinion close at hand proved to be indispensable in treating complex cases, an opinion which Ethel Williams strongly shared: 'There is a very great advantage of two or more women going into partnership […] My friend's mind is the box on which I strike my intellectual matches'.[121] In December 1926, Marjorie Hayward and Rosalind Bradley applied for £100 to buy a practice in Hampstead, North London.[122] Nine years later, the two medical women were still in partnership together at the same address, demonstrating that the MWF loan fund played an instrumental role in establishing long-lasting professional relationships.[123]

It is interesting to note that the highest number of applications to the loan fund were made in 1933, just as the country was experiencing a severe economic downturn; unemployment levels had reached a peak of three million, or 20 per cent of the working population.[124] This coincided with a significant increase in the average age of loan applicants in the early 1930s, suggesting that a number of experienced medical women were being forced to reconsider their careers as a result of the worsening financial crisis (Figure 3.2). For example, in 1932, loan applicants had been qualified for an average of 10.8 years. In contrast, the majority of loans

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[118] Ibid., 31st May 1926.

[119] Ibid.

[120] Minutes of the Executive Committee, 29th January 1926.

[121] Ethel Williams, 'Thirty Odd Years in General Practice', 54.

[122] Minutes of the Executive Committee, 3rd December 1926.

[123] 'Marjorie Hayward', UK and Ireland Medical Directory (1935), <www.ancestry.com> [accessed 29th April 2020].

[124] Keith Laybourn, *Modern Britain Since 1906: A Reader* (London: I.B Tauris and Co., 1999), p.105. Eleven applications to the loan fund were made in 1933.

awarded in the mid to late 1920s were to inexperienced women doctors qualified for less than three years, who were hoping to begin their careers in general practice. Several medical women who took out loans with the MWF experienced financial difficulties, with many defaulting on their repayments or insurance premiums. In June 1927, Dorothy Peake was loaned £100 to start a practice in Bethnal Green.[125] Eight years later, she still owed the Federation £15, which she hoped could be repaid in three instalments.[126] In a study conducted by the BMA in 1938, it was reported that medical women working in general practice earned significantly less than their male counterparts; 42 per cent of the 331 women doctors surveyed reported taking home less than £800 per year.[127] This was still a significant amount of money, being four times the average annual salary of medical officer positions in hospitals and public health authorities.[128] Unlike other financial lenders, the Federation were invested both on a financial and personal level in the practices which they funded, offering professional advice where necessary to help ensure the success of individual ventures. For example, in April 1928, Vera Crawford applied for a £150 loan to fund a practice in Kenya.[129] Her loan was approved, but it was strongly recommended by the Executive Committee that she should obtain a postgraduate qualification in order to build upon her existing skills and knowledge before going abroad.[130]

[125] Minutes of the Executive Committee, 10th June 1927.

[126] Ibid., 18th October 1935.

[127] Anne Digby, *The Evolution of British General Practice,* p.170. In comparison, male doctors between the ages of 40 and 64 routinely earned more than £2000 per annum.

[128] Medical officer posts were advertised in the *BMJ* for between £100 and £450 per annum in 1938. The average salary was approximately £200.

[129] Minutes of the Executive Committee, 26th April 1928.

[130] Ibid.

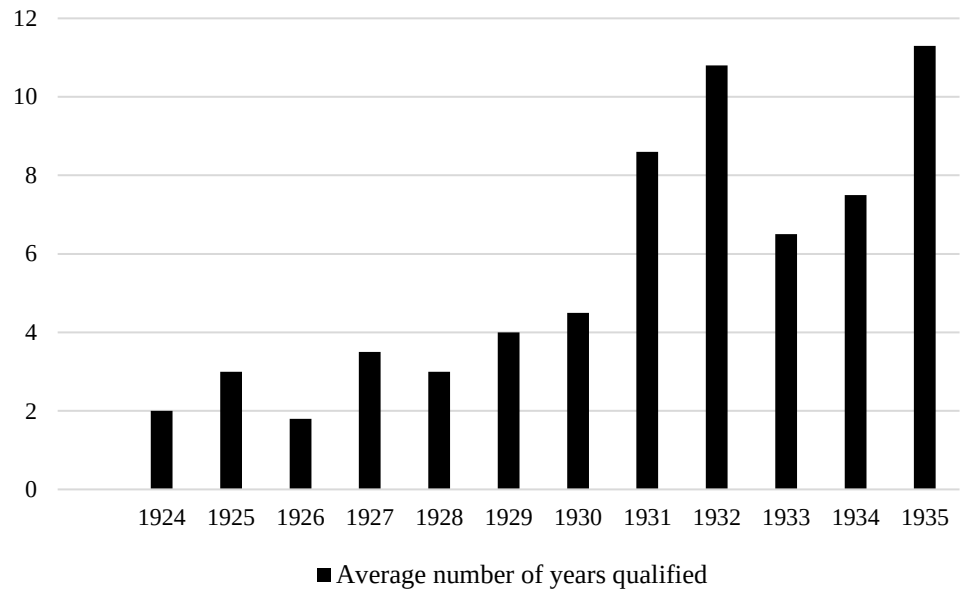

Figure 3.2 Average number of years qualified at year of loan application, 1924-1935.[131]

Whilst the MWF loan funds were strictly for the purpose of helping women doctors to establish themselves in general practice, a number of applications were accepted for other professional endeavours. In April 1928, the MWF agreed a loan of £100 to Thiza Redman for the purpose of purchasing a car to collect and distribute samples for her bacteriological work in Liverpool.[132] Similarly, Lydia Grey was awarded £100 in December 1933 to pay for her membership exam of the Royal College of Physicians.[133] The MWF also supported its members experiencing personal and professional hardship by offering assistance through the benevolent fund. Between October 1923 and October 1935, 17 applications were accepted.[134] In February 1927, Jane Walker put forward the case of Isobel Johnson, a married woman doctor with 20 years of experience who was unable to find any work.[135] After some discussion, the council agreed to pay Johnson's rent for a period of six weeks.[136] Likewise, in February 1931, £10 was gifted to Kathleen Hanby to pay for her private sanatorium treatment following a nervous breakdown.[137]

[131] Names of successful applicants to the MWF loan fund were cross-referenced with their entries in the UK Medical Directory.

[132] Ibid., 26th April 1928.

[133] Ibid., 1st December 1933.

[134] Benevolent fund applications were similarly recorded in the minutes of the Executive Committee.

[135] Minutes of the Executive Committee, 4th February 1927.

[136] 'Isobel Johnson', UK and Ireland Medical Directory <www.ancestry.co.uk> [accessed 29th April 2020].

[137] Ibid., 13th February 1931.

She later made a full recovery, remaining in general practice in Manchester until 1942.[138] The small acts of kindness distributed by the Federation's benevolent fund made a significant difference in the professional and personal lives of medical women. Furthermore, the MWF loan fund provided women doctors with the financial means to establish long-standing relationships in local communities. The true importance of the bond between a general practitioner and their patient is made clear in the case of Christine Murrell and Elizabeth Bagshot.[139] In October 1930, the MWF loan fund received a £500 legacy from Bagshot – 'as a token of my heartfelt love and admiration of Christine Murrell both as my doctor, and I am proud to add, as my friend'.[140] Through its loans, the Federation played a vital role in the recovery of women doctors' careers in the United Kingdom in the years following the First World War. Without them, many medical women would not have been able to establish careers in general practice. By expanding the opportunities available to female practitioners, the Federation helped to foster close relationships between doctors and their patients, which served to improve the care provided to women and children in local communities. This proved to be particularly important during the interwar years, as increasing attention began to be given to redefining understandings of women's health.

Reform: Menstruation and the Menopause

Having resisted the gender inequalities that existed within the profession, and supported the recovery of women doctors' careers, the MWF turned its attention to medical reform. The Introduction to this thesis analysed the ways in which Victorian medical men sought to exclude women from professional life by pathologizing their reproductive functions. Menstruation was believed to be a debilitating illness, made all the more dangerous by strenuous work and undue mental exhaustion.[141] The menopause was similarly viewed as a perilous epoch, marking the end of a woman's useful contribution to society.[142] Such myths survived into the twentieth century; however, as women of all ages continued to prove their efficiency in the workplace, and scientific

[138] 'Kathleen Hanby', UK and Ireland Medical Register <www.ancestry.co.uk> [accessed 29th April 2020].

[139] Murrell (1874-1933) established a private practice with Elizabeth Honor Bone (1896-1950) in Bayswater in 1903. Murrell's grandfather, John Rains, financed the practice. They remained in practice together until Murrell's death in October 1933.

[140] Minutes of the Executive Committee, 4th October 1930.

[141] See: Henry Maudsley, *Sex in Mind and Education* (New York: C.W. Hardeen, 1884).

[142] See: Edward Tilt, *The Change of Life in Health and Disease* (Philadelphia: P. Blakiston, 1882).

understandings of hormones improved, new narratives of female ability emerged.[143] Harrison argues that improvements to women's health were central to the success of the feminist movement throughout the nineteenth and twentieth centuries, and that a number of individual female practitioners accelerated these medical advances through their professional work.[144] Women doctors were, therefore, influential advocates of the capable modern woman, being at the forefront of women's health research during this period. In 1913, Catherine Chisholm studied the menstrual experiences of 500 girls in Manchester to ascertain whether menstrual discomfort affected their school attendance.[145] She found that 58.6 per cent experienced no pain during the menstrual period, concluding that hard mental or physical work did not cause any adverse effects.[146]

Seven years later, Sanderson Clow, who was medical inspector to the Ladies College, Cheltenham, published the results of her pre-war survey into 1200 schoolgirls' experiences of menstruation.[147] Sanderson Clow found that 73 per cent were free from discomfort during their monthly period, and 40 per cent reported to continue their usual exercise whilst menstruating.[148] Surprisingly, only 23 per cent of girls had baths during menstruation, suggesting that outdated myths surrounding the dangers of water were still present amongst the educated classes.[149] Sanderson Clow found that mothers needed to be educated on the benefits of taking exercise during the monthly period, as girls were often prevented from walking, cycling, and riding when they were at home.[150] Not every medical woman agreed with Sanderson Clow's conclusions; Mary Andrews, a woman doctor from Sheffield, argued that over-activity at school could have a dangerous effect in later life.[151] She gave the example of an athletic country girl who refused to take breaks from strenuous exercise whilst at school.[152] After beginning her medical degree at university, the girl found herself incapacitated for days on end each month, and was unable to walk more than half a mile.[153] In Andrews' opinion, this was due to her over-exhaustion as a child.

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143 For more on menstrual myths, see Strange (2000, 2001).

144 Brian Harrison, 'Women's Health and the Women's Movement in Britain: 1840–1940', in C. Webster (ed.) *Biology, Medicine and Society 1840–1940* (Cambridge: Cambridge University Press, 1981), pp.15-71 (p.50).

145 'North of England Obstetrical and Gynaecological Society', *Lancet*, 1 (8th March 1913), 690.

146 Ibid.

147 Alice Sanderson Clow, 'Menstruation during School Life', *BMJ*, 2 (2nd October 1920), 511-513.

148 Ibid., p.511.

149 Ibid.

150 Ibid.

151 Mary Andrews, 'Menstruation during School Life', *BMJ*, 2 (9th October 1920), 568.

152 Ibid.

153 Ibid.

Echoing the sentiments expressed by the Victorian physician Edward Clarke in *Sex in Education* (1875), Andrews concluded that 'menstruation is a temporary drain on a girl's vital energy, and it calls for special care'.[154] Sanderson Clow declined to publish a response to Andrews' vindication of 'molly-coddling' during the menstrual period.[155]

The following year, Sanderson Clow opened the discussion on menstruation at a meeting of the School Medical Officers' Association (SMOA), arguing that the benefit of vigorous exercise for schoolgirls was 'beyond all doubt'.[156] Letitia Fairfield shared similar sentiments, stating that in her experience as women's medical inspector to the RAF, menstrual disabilities were more prominent in sedentary workers.[157] She did, however, caution against women playing football or riding motorcycles, as these masculine pursuits caused 'considerable strain on the pelvic region'.[158] Whilst women were encouraged to exercise, they were expected to participate in 'safe' activities which did not threaten their future childbearing abilities. Shortly after the meeting, the SMOA published an educational pamphlet to be distributed to schools across the country – *Advice to Girls Concerning the Monthly Period*.[159] The school medical officers emphasised that the monthly period was 'not a malady but a natural function' and promoted the importance of maintaining a high standard of personal hygiene.[160] At the British Congress of Obstetrics and Gynaecology meeting in April 1923, it was noted that a number of male specialists continued to share the view that 'nobody expects the menstrual process to be free from pain entirely'.[161] Once again, Sanderson Clow persuasively argued that 'if pain [during menstruation] was not *expected*, it frequently would not appear', prompting the *Lancet* to pose the question 'how unwell is the woman who is "unwell"?'.[162] In recognition of her expertise in the field, Sanderson Clow was invited to give the opening paper of the obstetrics section at the BMA's annual conference in July 1924.[163] Having interviewed a further 220 women studying at teacher training college, she concluded that exercise

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[154] Ibid.

[155] Ibid.

[156] 'Games for Girls', *BMJ,* 2 (12th November 1921), 804-809 (p.804).

[157] Ibid., p.805.

[158] Ibid.

[159] *Advice to Girls Concerning the Monthly Period*, School Medical Officers' Association, date unknown, SA/MWF/M.1/6.

[160] Ibid.

[161] '"Unwell"', *Lancet*, 2 (16th June 1921), 1219.

[162] Ibid.

[163] Alice Sanderson Clow, 'Discussion on Dysmenorrhea in Young Women: Its Incidence, Prevention, and Treatment', *BMJ,* 2 (27th September 1924), 558-566.

drastically reduced the occurrence of dysmenorrhea, or painful menstruation.[164] If workplaces provided female staff with sympathetic nurses, comfortable beds, hot water bottles, and hot drinks, they would find increasing numbers of women experienced severe discomfort.[165] She recommended that all employers of female labour should refuse any leave of absence for menstrual disability, as 'the extra hardship endured by the few would be well compensated for by the benefit conferred on the many'.[166] In order to bring about a radical reform in the public's perception of menstruation, and to improve women's status within the workplace, any special dispensations for female employees had to be removed.

While Sanderson Clow was engaged in researching the menstrual experiences of schoolgirls during the early 1920s, the MWF were occupied in fighting the marriage bars and pay discrimination that sought to exclude women doctors from the medical profession. In April 1924, Ethel Williams proposed that a subcommittee on menstruation should be formed by the Federation in order to investigate its effects on school attendance.[167] It was decided that the issue should be referred back to the local Associations for comment and discussed at the next council meeting.[168] Seven months later, Williams reported that general practitioners in the North Eastern district had been exempting large numbers of girls from school during their monthly periods, in spite of the fact that the majority experienced little disruption to their everyday activities.[169] Williams and Chisholm agreed to gather statistics and write a report on the subject.[170] In spite of her expertise in the area, Sanderson Clow was not invited to contribute. After significant delays, Williams and Chisholm eventually presented their findings to the council in May 1925, and the results of their report were later published as a two-page pamphlet for mothers and schoolmistresses – *Advice Regarding Menstruation*.[171] Repeating the findings published by Sanderson Clow five years previously, the pamphlet stressed that menstruation was a natural function, and that work and play should be carried on as normal during a girl's monthly period.[172] Restorative exercises such as 'floor polishing', 'bean picking', and 'floor patting' were advised to counteract

[164] Ibid., p.564.

[165] Ibid.

[166] Ibid.

[167] Minutes of the Executive Council, 1st November 1924.

[168] Ibid.

[169] Ibid.

[170] Ibid.

[171] *Advice Regarding Menstruation,* MWF pamphlet, 1925, SA/MWF/B/4/5.

[172] Ibid.

any pain that might be experienced.[173] Though the Federation's pamphlet proved to be immensely popular, with over 10,000 copies being printed in the first year, it was almost an exact replica of the one which had previously been published by Sanderson Clow and the SMOA.[174] The president of the SMOA wrote to the Executive Council to express her disappointment at the apparent plagiarism, and an apology for 'any apparent discourtesy' was sent by the Federation in response.[175]

Unbeknown to the Executive Council, the London Association had similarly taken the initiative to publish a memorandum on menstruation in early 1925 – *The Health of Adolescent Girls*.[176] Like the SMOA's pamphlet, it emphasised the importance of schoolgirls remaining active during menstruation, and taking regular baths.[177] As president of the local Association, Christine Murrell had commenced a large-scale survey of schoolgirls' experiences of menstruation in collaboration with the Ling Association of trained gymnastics instructresses and the Head Mistresses' Association in early 1925.[178] Questionnaires were sent to over 100 schools across the country, and by 1930, almost 6099 individual responses had been received.[179] It was found that 55 per cent of schoolgirls between the ages of 14 and 18 experienced no pain during their monthly period, which was considered to be remarkable given that 'popular tradition pictures their lives as so profoundly affected by this physiological change'.[180] As professional women, members of the London Association were motivated to produce evidence that supported the view that menstruation rarely caused pain or disruption to everyday life. Such data further validated their position within the profession, and the position of women in education and the workplace more generally. When members of the Executive Council were made aware of the London Association's actions, which had been carried out without their prior knowledge or consent, heated discussions over the legality of local Associations publishing their own material took place over the following 12 months.[181] Whilst Lady Barrett argued that 'such scientific work redounded to the credit of the Federation as a whole', only the Liverpool Association expressed their support of branches having local autonomy.[182] After much disagreement, the resolution that no local Association was permitted to

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[173] Ibid.

[174] Minutes of the Executive Council, 18th June 1926.

[175] Ibid.

[176] *The Health of Adolescent Girls*, London Association pamphlet, 1925, SA/MWF/B/4/5.

[177] Ibid.

[178] Minutes of the Executive Council, 7th May 1925.

[179] 'Menstruation in Schoolgirls', *Lancet*, 2 (5th July 1930), 57-62.

[180] Ibid., p.58.

[181] Minutes of the Executive Council, 19th June 1926.

[182] Ibid., 13th May 1927.

publish any material without the prior consent of the Executive Council was passed by 17 votes to 10.[183] Following the professional disagreements between the London Association and the Executive Council, no further discussions of menstruation took place for the next two years.[184] Given the close attention which had already been given to the subject throughout the early 1920s, it seems likely that the Federation would have been eager to focus its attention on other matters which required urgent attention, such as co-education in medical schools.[185]

After publishing *Advice Regarding Menstruation* in 1925, the MWF refocused its efforts on another area of women's health that had similarly received little scientific attention – the menopause. In October 1926, Sanderson Clow put forward a motion to form a subcommittee to investigate women's experiences of the menopause.[186] As had been the case with her research into menstruation, Sanderson Clow believed that a statistical report would serve to correct the prevailing misconceptions about the 'change of life'.[187] Discussions of the menopause were conspicuously absent from the *BMJ* and the *Lancet* throughout the early twentieth century. In 1919, Guthrie Rankin published an article on the 'Climacteric of Life' in the *BMJ,* sharing his findings from both male and female patients over the age of 50.[188] He concluded that women in particular should be convinced that a 'new and more subdued plan of life must be courageously adopted' in order to avoid a premature death.[189] In medical textbooks, the menopause was similarly pathologized, being routinely linked to obesity, hysteria, hypothyroidism, chronic pharyngitis, anaemia, heart disease and skin disorders.[190] At the first meeting of the Menopause Committee, two separate questionnaires were drafted for members of the general public and medical women.[191] Whilst Form A permitted lay women to share their experiences of the menopause in their own words, Form B provided women doctors with tick boxes of symptoms.[192] In order to obtain a representative sample, it was integral that women from all social classes were interviewed. Whilst

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[183] Ibid.

[184] In 1929, Sanderson Clow proposed that a new subcommittee on dysmenorrhea should be formed.

[185] For more on the debates surrounding co-education in medical schools, see: Claire Brock: 'Women in Surgery After the Great War', in *The Palgrave Handbook of Women and Science since 1660*, ed. by Claire G. Jones, Alison E. Martin, and Alexis Wolf (Basingstoke: Palgrave Macmillan, 2022), pp.593-610.

[186] Minutes of the Executive Council, 21st October 1926.

[187] Ibid.

[188] Guthrie Rankin, 'The Climacteric of Life', *BMJ*, 1 (18th January 1919), 63-67.

[189] Ibid, p.67.

[190] Frederick Price, *A Textbook of the Practice of Medicine* (Oxford: Oxford University Press, 1923).

[191] Minutes of the Executive Committee, 31st October 1926.

[192] 'Medical Women's Federation Questionnaire Form A', SA/MWF/B/4/6.

members approached their own patients, forms were also sent to employers of women and public assistance institutions.[193] Due to the personal nature of the questionnaire, women were hesitant to participate; in 1927, only 179 responses had been received from the 11,700 questionnaires that had been printed.[194] Unlike the onset of menstruation, the menopause was viewed as an embarrassing time that marked the end of 'useful' womanhood.[195] In many cases, it was impossible to know from outward appearances alone which women should be approached to participate in the survey, as the age of onset varied so considerably.[196] Such conversations were especially sensitive in the workplace, as the menopause was commonly associated with profound mental and physical illness.[197]

After significant delays, the findings from the MWF's survey of 1000 women, aged between 21 and 91, were published in January 1933.[198] The report showed that almost 90 per cent of women carried on their usual activities during the menopause, and 36.4 per cent of respondents were free, or relatively free, from symptoms such as flushing, headaches, and nervous instability.[199] In an advice pamphlet published by the Federation, the menopause was recast as a minor inconvenience rather than a debilitating malady.[200] As had been the case with menstruation, the MWF were eager to emphasise women's ability during the 'change of life'. Women were reassured that their role in society had not diminished, as 'those over 50 have a very important part to play and can be very attractive people'.[201] Most importantly, those approaching the menopause remained eminently capable of professional work, in spite of their body's 'altered rhythm'.[202] Following the publication of the MWF's survey, further studies into women's experiences of the menopause were conducted, and advice books written by women, for women, became increasingly

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193 Minutes of the Executive Committee, 12th May 1927.

194 Ibid.

195 Metaphors of degeneration and decay were often used in medical textbooks to describe the menopause. See: Julie-Marie Strange, 'In Full Possession of Her Powers: Researching and Rethinking Menopause in early Twentieth-century England and Scotland', *Social History of Medicine*, 25 (2012), 685-700.

196 'An Investigation of Menopause in One Thousand Women`, *Lancet*, 221 (14th January 1933), 106-108 (p.107).

197 Wendy Mitchinson, *Body Failure: Medical Views of Women, 1900-1950* (Toronto: University of Toronto Press, 2013), p.262.

198 'An Investigation of Menopause in One Thousand Women', *Lancet*, 1 (14th January 1933), 106-108.

199 Ibid, p.108.

200 'The Change of Life, MWF pamphlet, date unknown, SA/MWF/B/4/6.

201 Ibid.

202 Ibid.

popular.[203] Given the average age of the medical women that sat on the Executive Council of the Federation, it is perhaps unsurprising that they were united when it came to conducting research based on their own recent experiences. Local Associations were distracted by professional jealousies when it came to publishing menstrual advice pamphlets; however, they were committed to publishing an authoritative statement on the menopause. Compared to the survey published by the London Association in 1930, the Federation did not achieve a large sample size, leading to questions regarding the representativeness of their data.[204] The research conducted by female practitioners during the interwar years helped to create new paradigms of reproductive health which empowered women to embrace their natural physiological functions. Though the MWF were eager to engage with new hormonal understandings of menstruation and the menopause, other scientific advances relating to women's health proved to be far more controversial. As the use of modern birth control methods became increasingly popular during the interwar period, medical women were forced to confront the issue both privately and publicly, and to consider the competing moral, ethical, and health implications for their patients.

Birth control

As this chapter has illustrated, female practitioners were in the vanguard of women's health research throughout the 1920s and 30s. At the same time as new narratives of menstrual ability were beginning to emerge, debates surrounding birth control began to erupt in the medical and lay press.[205] In many ways, the interwar years played host to a social and sexual revolution, as the work of Marie Stopes brought knowledge of modern contraceptive methods to the masses.[206] Both male

[203] Marie Stopes published *Change of Life in Men and Women* in 1936.

[204] Before publication, the Executive Council excluded 100 responses from Jewish women living in East London, as they indicated a 'persistent variation' from the other data gathered.

[205] The treatment of venereal disease remained a matter of high priority during the interwar years. For more, see: Roger Davidson, 'Venereal Disease, Sexual Morality, and Public Health in Interwar Scotland', *Journal of the History of Sexuality*, 5 (1994), 267-294; Roger Davidson and Lesley Hall (eds), *Sex, Sin and Suffering: Venereal Disease and European Society since 1870* (London: Routledge, 2001); Samantha Caslin, 'Transience, Class and Gender in Interwar Sexual Health Policy: The Case of the Liverpool VD Scheme', *Social History of Medicine*, 32 (2019), 544-564; Anne Hanley, "Sex Prejudice" and Professional Identity: Women Doctors and Their Patients in Britain's Interwar VD Service', *Journal of Social History*, 54 (2020), 569-598.

[206] Clare Debenham, *Marie Stopes' Sexual Revolution and the Birth Control Movement* (London: Palgrave Macmillan, 2018), p.3. For a contrasting view of the effects of Stopes' publications on sexual practices, see: Kate Fisher, *Birth Control, Sex, and Marriage in Britain, 1918-1960* (Oxford: Oxford University Press, 2006). For the eugenics debates which

and female doctors were divided on the use of contraceptives, and as the self-appointed guardians of women's health, the MWF found it impossible to offer a public stance on the subject. One of the primary arguments in favour of birth control was that it gave working-class women the opportunity to free themselves from the suffering inherent in multiple pregnancies.[207] In 1915, the Women's Cooperative Guild published *Maternity, Letters from Working Mothers* to highlight the need for a state maternity scheme.[208] The Guild wrote to over 600 members to ask them about their experiences of maternity, and the responses laid bare the acute mental and physical hardships experienced by women across the country.[209] One respondent remarked that she was a 'ruined woman' after enduring seven pregnancies in as many years.[210] Suffering from the effects of a prolapsed uterus, she was unable to carry out her household duties without wearing a body belt.[211] Another woman, who was a mother to 10 children, recalled how she 'did nothing but cry' when she was told by her doctor that her factory work had caused the stillbirth of her second baby.[212] Shortly afterwards, her husband became unemployed, and her next child was also stillborn.[213]

Similarly, one woman reported to have been in a continual state of pregnancy for 15 years, having suffered four live births and 10 miscarriages.[214] She was unable to walk further than the top of her street without leaking urine.[215] Conversely, others feared that contraceptives would endanger

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underscore discussions of birth control, see: R. Soloway, *Birth Control and the Population Question in England, 1870–1930* (Chapel Hill: University of North Carolina Press, 1982); J. Grier, 'The "Perfect" Contraceptive: Eugenics and Birth Control Research in Britain and America in the interwar years', *Journal of Contemporary History*, 30 (1995), 637-64; Greta Jones, 'Women and Eugenics in Britain: The case of Mary Scharlieb, Elizabeth Sloan Chesser, and Stella Browne', *Annals of Science*, 52 (1995), 481-502; R.A. Peel (ed.), *Marie Stopes, Eugenics and the English Birth Control Movement* (London: Galton Institute, 1996); J. Grier, 'Eugenics and Birth Control: Contraceptive Provision in North Wales, 1918–1939', *Social History of Medicine*, 11 (1998), 443-48; Alison Bashford and Phillipa Levine (eds), *The Oxford Handbook of the History of Eugenics* (Oxford: Oxford University Press, 2010); Jane Carey, 'The Racial Imperatives of Sex: Birth Control and Eugenics in Britain, the United States and Australia in the interwar years', *Women's History Review*, 21 (2012), 733-52; Claire Debenham, *Marie Stopes' Sexual Revolution and the Birth Control Movement* (London: Palgrave Macmillan, 2018).

[207] For more on the physical suffering caused by multiple pregnancies, see Brock (2017).

[208] Women's Cooperative Guild, *Maternity, Letters from Working Mothers* (London: G. Bell and Sons, 1915).

[209] Ibid, p.194.

[210] Ibid., p.29.

[211] Ibid.

[212] Ibid., p.76.

[213] Ibid.

[214] Ibid., p.61.

[215] Ibid.

women by increasing the sexual demands of their husbands.[216] One mother of seven children disclosed that within a few days of giving birth she was 'tortured' by her husband, who had 'not a bit of control' over his passions.[217] Another remarked that 'until men are taught […] the right use of the organs of reproduction, and until [they] realise that the wife's body belongs to herself', the suffering of women would not be alleviated.[218] Out of the 200 letters published by the Guild, only one woman reported to have used 'preventatives' in order to space her pregnancies.[219] Having suffered during the pregnancies of her four children, she was at peace with her decision to take control of her health: 'I sometimes think that the Great Almighty has heard the poor women in travail, and shows her a way of rest. I had a fight with my conscience […] but I have no qualms now'.[220] In her opinion, if 'simple' women like herself could be educated on the means of preventing conception, much harm and misery would be avoided.[221] Debates surrounding the use of contraceptives were similarly influenced by the rapidly rising maternal mortality rates being reported across the world; in 1920, the United States had the highest rate of any Western country – approximately 70 per 1000 births.[222] In comparison, the United Kingdom had an estimated rate of 40 per 1000 births, which was still worryingly high.[223] In an effort to tackle the prevalence of postpartum sepsis and haemorrhage, childbirth became increasingly medicalised. In the United Kingdom, specialist clinics and maternity homes were founded to improve the antenatal and postpartum care given to women in the community.[224] On a global scale, the Medical Women's International Association (MWIA) similarly sought to improve maternal mortality rates through the sharing of knowledge and expertise between female practitioners.[225] Given the dangers that childbirth continued to pose in the twentieth century, it is unsurprising that many women were eager to educate themselves on modern methods of birth control.[226]

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[216] Ibid., p.49.

[217] Ibid.

[218] Ibid., p.28.

[219] Ibid., p.94.

[220] Ibid., p.95.

[221] Ibid.

[222] Robert Morse Woodbury, 'The Trend of Maternal Mortality Rates in the United States Death Registration Area, 1900-1921', *American Journal of Public Health*, 1 (1924), 738-743 (p.741).

[223] Ibid., p.742.

[224] Tania McIntosh, *A Social History of Maternity and Childbirth* (Oxford: Routledge, 2012), p.47.

[225] 'Medical Women's International Association 1924 Meeting, July 15th–19th', meeting programme, SA/MWF/C.136. For more on the MWIA and the MWF, see Ward (2010).

[226] For more examples of women seeking contraceptive advice, see: Hall (1978).

Roused by the increasing attention being given by the general public to the use of contraceptives, the London Association met to consider the matter in June 1921.[227] The discussion was opened by Elizabeth Wilks, a medical woman who had dedicated her career to the treatment of sick and mentally deficient children.[228] Perhaps unsurprisingly, given her life's work, Wilks' arguments were informed by the principles of eugenics. She strongly advocated state birth control 'as the only practical method of preventing the renewal of the race principally from the worst stocks'.[229] The First World War served to heighten existing anxieties surrounding the quality and productivity of future generations.[230] In 1921, a survey of 2.1 million children conducted by the Board of Education showed that 48 per cent were suffering from some sort of mental or physical defect.[231] Wilks argued that whilst the intelligent classes widely practised individual birth control, undesirable members of society had neither 'the prudence nor the initiative' to take any measures to limit their offspring.[232] Mary Scharlieb expressed her concern over the medical and moral implications of artificial birth control methods.[233] In her opinion, preventing any natural process caused irrevocable nerve damage, and the use of contraceptives would remove the fear of any consequences from the husband.[234] Lady Florence Barrett echoed similar sentiments, arguing that in the case of working class women, frequent pregnancies were often less injurious to their health than the effects of excessive sexual demands.[235] She concluded that 'it was important for medical women to think out their own views' on the subject, and proposed to lay the matter before the other local Associations.[236]

Following the publication of the London Association's meeting report in the *BMJ*, an animated discussion of birth control took place in the journal's correspondence section. Charles Killick Millard, Medical Officer of Health for Leicester, opposed the views expressed by Scharlieb, stating that in his own experience, he had found no evidence to suggest that the use of

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227 'Reports of Societies – Birth Control', *BMJ*, 1 (2nd July 1921), 11-12 (p.11).

228 Wilks (1861-1956) had previously held posts at the Home for Mentally Deficient Children in Stamford Hill, the Women's Hospital for Children in Harrow, and the Evelina Hospital in Southwark.

229 'Reports of Societies – Birth Control', p.11.

230 Richard Overy, *The Morbid Age*, p.96.

231 Ibid.

232 'Reports of Societies – Birth Control, p.11.

233 Ibid.

234 Ibid., p.12.

235 Ibid.

236 Ibid.

contraceptives led to sterility and nervous disease.[237] He had conducted a study of 65 doctors, and found that 56 per cent had expressed approval of birth control in some form.[238] Barbara Crawford, a medical woman from Chester, expressed similar views, arguing that many of her patients had successfully practised birth control for years with 'nothing but benefit'.[239] She argued that working class women suffered from nervous disorders due to overwhelming exhaustion, rather than the prevention of natural functions, and that the adequate spacing of pregnancies was one way of alleviating such problems.[240] Gibbon Fitzgibbon, a gynaecologist from Dublin, agreed with both Killick Millard and Crawford, arguing that nothing destroyed love in the home more swiftly than 'the worry and anxiety of making ends meet owing to too large a family'.[241] Conversely, Alfred Seller, a doctor from Lancashire, expressed the opinion that birth control was both 'illegitimate and immoral', and that any man who had sexual intercourse for the purpose of pleasure, rather than reproduction, was 'prostituting his own body and that of his wife'.[242] Elsie Inglis echoed similar sentiments, asserting that the widespread use of contraceptives by the middle and upper classes would lead to the home becoming 'a centre of selfishness'.[243] In her opinion, the practice of birth control endangered womanhood, 'the fortress of our national character and strength'.[244] Whilst many working class women suffered from the effects of multiple pregnancies, Inglis argued that every practitioner had knowledge of the 'hearty strong mother of sixteen children'.[245] Following the large amount of letters received on the subject, the *BMJ* restricted any further coverage to official reports and notices.[246]

Four months after the London Association had first met to discuss the issue of birth control, the MWF council met to discuss the opinions of the local Associations. Interestingly, the majority were largely in favour of birth control; only the South Western branch reported to be in complete agreement with the views expressed in London.[247] A recurring theme in all of the responses was the fact that medical women felt that further scientific research needed to be

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[237] C. Killick Millard, 'Birth Control', *BMJ* 1 (23rd July 1921), 131.

[238] Ibid.

[239] Barbara Crawford, 'Birth Control, *BMJ* 1 (23rd July 1921), 131.

[240] Ibid.

[241] Gibbon Fitzgibbon, 'Birth Control', *BMJ* 1 (27th August 1921), 338.

[242] Alfred Seller, 'Birth Control', *BMJ* 1 (13th August 1921), 262.

[243] Elsie Inglis, 'Birth Control', *BMJ* 1 (27th August 1921), 339.

[244] Ibid.

[245] Ibid.

[246] The subject remained absent from the pages of the *BMJ* until 1927.

[247] Minutes of the Executive Council, 11th November 1921.

conducted into the different types of contraceptives.[248] The Hull branch of the Yorkshire Association offered a remarkably candid response to the question of birth control: 'Dr Marie Stopes' books are much read in this district […] *it would be useless for medical women to oppose her propaganda on Birth Control* […] most of the Hull members agree with her on most points'.[249] Members of the Hull Branch included Ethel Townend, Ada Jackson, and Bertha Hind, who oversaw the treatment of over 5000 women and 16000 children in the city's maternity clinics in 1921.[250] The reason why the medical women of Hull largely agreed with Stopes on matters of birth control can be better understood by considering the economic difficulties faced by their patients. As a port city, Hull's unemployment rate was considerably higher than the national average during the interwar years, as the distribution, building, and fishing industries suffered disproportionately from the country's severe economic downturn.[251] The Annual Reports published by the medical officer of health (MOH) offer further insights into the city's public health concerns. In 1921, Hull's infant mortality rate was recorded as 106 per 1000 births, significantly higher than the national average.[252] In children under the age of 12 months, premature birth, diarrhoea, and pneumonia were the leading causes of death.[253] In the same year, 7362 of the city's dwellings were reported as being unfit for human habitation.[254] The financial hardship and deprivation experienced by families in Hull offers one explanation for the city's declining birth rate, which dropped dramatically from 29.1 per 1000 in 1920, to 21.8 per thousand in 1925.[255] Women in Hull educated themselves on both traditional and modern methods of contraception, and it seems likely that, given the high levels of poverty within the city, these decisions would have been supported by their doctors.[256] As members of the Hull branch noted, it would be 'useless' for medical women to oppose the idea of birth control when it was already so popular with their patients; as practitioners primarily concerned with the health of women and children, they could either move with the times or be left behind.

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[248] Ibid.

[249] Minutes of the Executive Council, 11th November 1921. Emphasis my own.

[250] J. Wright Mason, *Annual Report of the Medical Officer of Health,* Kingston upon Hull, 1921, p.24.

[251] T.K Gribbin, 'The Population and Employment of Kingston upon Hull and the Humberside area, 1921-1948', *Bulletin of Economic Research*, 2 (1950), 129-154 (p.135).

[252] Mason, *Annual Report*, p.33.

[253] Ibid.

[254] Ibid, p.54.

[255] J. Wright Mason, *Annual Report of the Medical Officer of Health,* Kingston upon Hull, 1925, p.13.

[256] Traditional methods included abstinence and withdrawal, whilst modern methods included condoms, spermicides, and cervical caps. See Rusterholz (2021).

Members of the Manchester branch were similarly influenced by the extreme poverty of their patients when it came to birth control; Catherine Chisholm and Marguerite Douglas Drummond reported that the majority of the city's women doctors were in favour of contraception on ethical grounds.[257] Due to the radical industrialisation and rapid growth of the city during the early nineteenth century, Manchester had a long history of poor working conditions, dangerous overcrowding, and widespread deprivation.[258] The long-lasting effects of these factors on the health of the city's inhabitants is evident in the MOH report for 1921; the infant mortality rate was reported to be 104.6 per 1000 births, increasing to 177 per 1000 births for illegitimate babies.[259] Poor sanitation and cramped living conditions similarly affected the health of the adult population, and 300,000 people, or 40 per cent of Manchester's total population, were in receipt of either indoor or outdoor poor law relief from the city council.[260] This shocking statistic demonstrates the acute deprivation experienced by the city's inhabitants, adding further context to the views on birth control expressed by Manchester's medical women.[261] Whilst members supported the concept of preventing pregnancies for ethical reasons, Chisholm and Douglas Drummond made it clear that the local branch were not in favour of Stopes' unscientific publications.[262] They argued that the public's attention should be drawn to the fact that she was not a qualified medical woman, and that her advice was therefore not based on any relevant expertise.[263] Similar views were expressed by representatives from the North Eastern and Liverpool branches. Ethel Williams, Lille Johnson, Frances Ivens, and Margaret Joyle collectively condemned the propaganda published by Stopes, but reported that members were largely in favour of individual birth control.[264] They agreed

[257] Minutes of the Executive Council, 11th November 1921.

[258] See: Friedrich Engels, *The Condition of the Working Class in England in 1844*, trans. by Florence Kelley Wischnewetzky (London: Sonnenschein & Co, 1885).

[259] R. Veitch Clark, *Annual Report of the Medical Officer of Health,* Manchester, 1921, p.30.

[260] Ibid., p.44.

[261] In 1926, Olive Gimson, a member of the Manchester Association, was appointed as consultant physician to the Manchester, Salford and District Mother's Clinic. In 1931, she went on to work at the Withington Hospital's birth control clinic. See: Mo Moulton, *Mutual Admiration Society* (London: Corsair, 2019).

[262] Minutes of the Executive Council, 11th November 1921.

[263] Ibid. For more on the women doctors' opinions of Stopes, see: Lesley A. Hall, 'A Suitable Job for a Woman: Women Doctors and Birth Control to the Inception of the NHS', in *Women and Modern Medicine*, ed. by Anne Hardy and Lawrence Conrad (Amsterdam: Rodopi, 2001), pp.127-148.

[264] Ibid.

that further advice on the subject should be published by the Federation in order to better inform the opinions of women doctors.[265]

In contrast, the South Western branch of the MWF, represented by Mabel Ramsay and Bertha Mules, thoroughly disapproved of the propaganda published by Stopes, and were strongly against the use of contraceptives.[266] One possible explanation for this position is the worryingly low birth rates recorded in cities such as Bristol and Plymouth, which fell within the geographical boundaries of the local Association. In Bristol, the birth rate was reported to be 19.9 per thousand population in 1921, which the MOH attributed to the 'deliberate' use of birth control methods by otherwise fertile women.[267] Likewise in Plymouth, where Ramsay practised for the duration of her career, the city recorded its lowest birth rate on record in 1925 – 18.1 per thousand population.[268] It is clear from the cities' MOH reports that poverty was not the primary impetus behind women choosing to prevent pregnancy. Bristol had an infant mortality rate of 67 per 1000 births in 1921, well below the national average, suggesting that the health of women and their babies was generally good.[269] Following the First World War, Bristol's city council focused its efforts on clearing slums and building new housing estates; in 1921, no houses were found to be unfit for human habitation.[270] These extensive improvement works helped alleviate the city's unemployment problem, whilst also drastically improving living conditions for the poor.[271] Similarly, in 1923, Plymouth had an infant mortality rate of 50 per 1000 births, the lowest rate ever recorded by the MOH.[272] One possible explanation for the declining birth rate of Bristol and Plymouth is that women were marrying later in life, and were having fewer children as a result.[273] In his report for 1925, Austin Nankivell, Plymouth's MOH, argued that the birth rate of 'feeble-minded' women was greatly in excess of 'normal persons', because the lower classes did not have the means of protecting themselves against multiple pregnancies.[274] Members of the Birmingham Association shared similar views, reporting to be in favour of birth control if it could be made widely effective

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[265] Ibid.

[266] Ibid.

[267] D. S Davies, *Annual Report of the Medical Officer of Health*, Bristol, 1922, p.2.

[268] A.T. Nankivell, *Annual Report of the Medical Officer of Health*, Plymouth, 1925, p.16.

[269] Davies, *Annual Report*, p.5.

[270] Ibid, p.57.

[271] Ibid.

[272] Nakivell, *Annual Report*, p.96.

[273] Ibid., p.3.

[274] Ibid., p.74. Interestingly, Nankivell was arrested for six counts of gross indecency with other male persons in 1933. He was sentenced to six years in prison and was struck off the Medical Register by the GMC.

for 'low grade and moral defectives'.[275] Birmingham had high levels of deprivation across the city; in 1921, over 23,000 houses were found to be unfit for human habitation.[276] Similarly, 3.4 per cent of all births in the city were illegitimate, with unmarried mothers being described as 'resenting all help and eluding supervision'.[277]

Having received the reports from the local Associations it was agreed that a special committee should be formed to investigate the 'ultimate effects of Birth Control on imperial health and national welfare'.[278] Members of the committee included: Barrett; Ivens; Martindale; Wilks; Sturge; Rhoda Adamson; Helen Boyle; Lucy Naish; Phoebe Bigland; Marion Gilchrist; Margaret East; and Laura Sandeman.[279] These women represented five of the Federation's nine local Associations, suggesting that the council were eager for different regional perspectives to be represented on the committee. In May 1922, members met to outline the three categories of women who they believed would benefit from instruction on contraceptive methods.[280] Class A were women who were required to prevent pregnancy on medical grounds, due to previous intrapartum and postpartum problems, long-term health conditions, or a family inheritance of insanity.[281] Class B were working class women who were deemed to be unusually fertile, and had to carry out continuous heavy work in order to support their families.[282] It is interesting to note that the committee recommended that knowledge of modern contraceptives should be withheld from working class women in the first instance, and that abstinence and sexual intercourse during the safe period should instead be advised.[283] Class C were defined as members of the general public who were motivated for reasons other than ill-health and poverty to prevent pregnancies.[284] All classes of women were viewed by the committee as being in desperate need of accurate birth control advice; in particular, classes B and C required careful counselling on the subject.[285] Given the diversity of opinions expressed by the local Associations, the MWF council concluded that

[275] Minutes of the Executive Council, 11th November 1921.

[276] John Robertson, *Annual Report of the Medical Officer of Health*, Birmingham, 1921, p.58.

[277] Ibid., p.8.

[278] Minutes of the Executive Council, 11th November 1921.

[279] Ibid., 6th May 1922.

[280] Minutes of the Executive Council, 6th May 1922.

[281] Ibid.

[282] Ibid.

[283] Ibid.

[284] Ibid.

[285] Ibid.

they were unable to make any public pronouncement on the subject at present.[286] It was, however, unanimously agreed that the Federation should refuse to advertise any of Stopes' books in the *Quarterly Review*.[287]

In October 1922, the Birth Control Committee met again to discuss the conclusions of their investigations.[288] It was agreed that when consulted by an otherwise 'eugenically sound' woman on the subject of preventing pregnancy, it was the duty of doctors to advise against their use unless pregnancy was undesirable for another medical reason.[289] If a patient claimed that their decision to use contraceptives was a 'personal matter', sexual intercourse during the safe period or condoms should be advocated as the least harmful means of preventing pregnancy.[290] The committee also expressed the view that the government should expand measures to prevent the 'propagation of the mentally deficient and insane, and the criminal classes'.[291] It is perhaps telling that the Birth Control Committee voted against the Manchester Association's suggestion that a questionnaire should be sent to all medical women asking their views on the subject. Members argued that such an exercise would be prohibitively expensive, and that any findings would be based on 'individual opinion rather than expert observation'.[292] The following year, three pamphlets were written by members of the Birth Control Committee – *Conception Control* by Adamson, *The Eugenic Aspect of Birth Control* by Wilks, and *General Questions on Sex and Marriage* by Barrett.[293] Representatives from the local Associations disagreed on whether the pamphlets should be published under the name of the MWF, given their controversial subject matter. In spite of the views expressed privately by members on the eugenic aspects of birth control, it was felt that it would be 'inadvisable' for the Federation to publish Wilks' inflammatory pamphlet, which called for the mass sterilisation and segregation of 'idiots and imbeciles'.[294] After some discussion it was agreed that it could be published in the *Newsletter* as 'the writer's own expression of her opinion', as long as it was clearly stated that the MWF took no responsibility.[295] Similarly, it was agreed that

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[286] Ibid.

[287] Minutes of the Executive Committee, 19th March 1936.

[288] Minutes of the Executive Council, 13th October 1922.

[289] Ibid.

[290] Ibid.

[291] Ibid.

[292] Ibid.

[293] Ibid., 19th October 1923.

[294] Elizabeth Wilks, 'The Eugenic Aspect of Birth Control', 1923, p.8, SA/MWF/B/4/4.

[295] Minutes of the Executive Council, 19th October 1923.

Adamson's pamphlet also had to be published under her own name, as it might give the impression that the Federation approved of the different contraceptive methods which she discussed.[296]

In 1924, the Birth Control Committee was dissolved, and the MWF remained silent on the matter for a further seven years.[297] Having been failed by their professional organisation, many medical women were forced to take matters into their own hands, writing directly to Stopes for explicit advice on contraceptive methods in order to better inform their patients.[298] For example, Bigland, who had been a member of the Birth Control Committee, went on to found the Mother's Welfare Centre in Liverpool in 1926.[299] Similarly, Helena Wright, a member of the London Association, dedicated her career to making birth control both acceptable and accessible, working at the Mother's Clinic in North Kensington for three decades.[300] Reflecting on her career in 1973, Wright recalled her feelings during the 1920s: 'It seemed to me […] that birth control was the single subject that women doctors had to get hold of'.[301] The opinions of the Executive Council, which largely consisted of medical women over the age of 40, delayed discussions regarding the teaching of contraceptives in medical schools by over a decade. In spite of doctors expressing the view that they felt ill-equipped to advise their patients on the subject, birth control was not considered to be worthy of inclusion on university curriculums; like obstetrics, it was considered to be low status.[302] In 1931, it was finally resolved by the Federation's council that 'instruction in birth control methods with the medical reasons for and against [should] be included in the ordinary gynaecological curriculum'.[303] Given the range of opinions expressed by members across the country both for and against birth control, it would have been impossible for the MWF to offer an official position without alienating a significant proportion of its membership. Other issues, such as fighting unequal pay and marriage bars, along with expanding professional opportunities for women doctors, demanded the Federation's full attention. As had been the case with women's suffrage at the turn of the century, it was left to individual members to campaign for meaningful reform on behalf of medical women and their patients.

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296 Ibid.

297 MWF *Newsletter* (November 1924), 27.

298 Rusterholz, *Women's Medicine*, p.56.

299 Bigland (1886-1930) died unexpectedly four years after opening the clinic, leaving behind her husband and two children.

300 Rusterholz*, Women's Medicine,* p.v.

301 Ibid., p.1.

302 Ibid., p.18.

303 Minutes of the Executive Council, 19th October 1923.

Conclusion

The interwar years marked a defining period in the MWF's history, as the organisation was called upon once more to represent the interests of medical women on both the national and international stage. Having taken over from the indomitable Jane Walker, who had served as president for seven years, Mary Sturge was determined that the Federation would continue to make its mark within the profession. Writing in 1921, she expressed the hope that the MWF would prove its usefulness by accomplishing practical things for medical women to benefit their careers.[304] Equal pay for equal work was a central tenet of the Federation throughout the interwar years, as women doctors continued to be discriminated against in public health posts. Unwilling to accept that, on account of the war, medical women should step aside for men and accept lower salaries, the MWF attempted to raise public awareness of the issue. Long-standing relationships such as the one formed with Minnie Madgshon proved to be mutually beneficial, and crucially served to restore confidence in the Federation. Rather than ostracising members who were obliged to accept underpaid posts, the MWF learnt from its past mistakes, and instead chose to offer support in securing locum positions. By refusing to accept defeat despite years of setbacks, the Federation validated the professional worth of medical women across the country. Furthermore, by uplifting the profession as a whole, the MWF's campaign also benefited medical men, fulfilling the second aim expressed by Sturge in her presidential address.[305] The Federation similarly committed to safeguarding the professional status of its members in the fight against marriage bars. Small victories were won, but the MWF once again failed to achieve widespread reform. There are many possible reasons as to why the Federation was not more successful in its endeavours. As had been the case in previous decades, the MWF struggled to win the full support of the BMA, and it is arguable that the organisation did not do enough to gain momentum on the subject in the medical and lay press due to its inherent self-consciousness.

In addition to resisting gender inequalities within the profession, the MWF made significant efforts to expand the career opportunities available to women doctors during a time of great financial uncertainty. The Federation's loan fund enabled medical women to take control of the professional prospects by providing low interest loans to start their own private practices.

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[304] Mary Sturge, 'The Medical Women's Federation – Its Work and Aims', MWF *Newsletter* (July 1921), 17-25.

[305] Ibid., p.18.

'Putting up a plate' was a daunting prospect for medical women at all career stages; however, the rigorous application process employed by the Executive Council helped to ensure that women doctors were successful in their endeavours. By offering financial assistance through the benevolent fund, the Federation also demonstrated that they cared about the personal difficulties being experienced by its members.

Perhaps the most divisive task which the MWF faced during the interwar years was reforming aspects of women's health. Proving that women and girls suffered no pain during menstruation was crucial, as it substantiated the figure of the accomplished modern woman. This was achieved through research which foregrounded women's own subjective experiences. The pioneering work carried out by Sanderson Clow into schoolgirls' experiences of menstruation was, in many ways, undervalued by the Executive Council, who were adamant that the Federation should publish its own statement on the subject. Once again, tensions between senior members continued to limit the effectiveness and influence of the organisation's work, leading to a lack of cohesion on important subjects that affected both women doctors and their patients. However, local Associations of the MWF did unite to conduct the menopause survey, emphasising the message that women remained important members of society beyond their childbearing years.

Though members of the Federation were personally invested in supporting the view that women were physically capable of fulfilling roles outside of the home, the issue of birth control was one which divided the profession. Modern contraceptives were an unknown entity, yet medical women were expected to form their own opinions on the subject and act in the best interests of their patients. This caused much anxiety amongst members of the MWF – 'Birth control has such infinite and uncertain reactions that no one can see the end or say whether it is good or bad. Will it make for a healthier population or a more difficult and nervous one?'.[306] It is perhaps unsurprising that the Federation felt ill-equipped to offer authoritative advice on such a complex issue. As had been the case with other aspects of women's health research, individual medical women advanced the movement on behalf of their colleagues and patients, whilst their professional organisation looked on. Reflecting on the difficulties facing medical women in 1929, Ethel Bentham writes: 'This is a time of very swift transitions, public opinion is fluid and uncertain, old prejudices crop up continually in unexpected places, and the new wine is everywhere bursting its old bottles'.[307] As women's roles in society evolved, 'old prejudices' were undermined, and medical knowledge advanced exponentially as a result. The MWF did its best to support women

[306] Ethel Bentham, 'The New Position of Women', MWF *Newsletter* (November 1929), 19-22 (p.20).

[307] Ibid., p.22.

doctors through this period of uncertainty, urging them to 'unite for the good of the profession, and the world at large'.[308] However, further transitions were on the horizon. As political tensions began to rise in the mid-1930s, the prospect of a second international conflict became an unavoidable reality, and medical women once again found their professional worth being challenged by the masculine military establishment.

[308] Sturge, 'The Medical Women's Federation – Its Work and Aims', p.25.

Chapter Four

'When that hour strikes danger, we sally forth, crowned with tin hat, to grope around our practices': Medical Women at War, 1939-1945

In an unconventional article published in the *Quarterly Review* in December 1940, Madeleine Baker, a general practitioner and poet from Bath, offers a personal reflection on her wartime experiences of both darkness and death:

> During these December hours of short visibility, we hurry to and fro on our lawful occasions obsessed by the thought that all too soon the black-out must engulf us and our patients. Or when that hour strikes danger, we sally forth, crowned with tin hat, to grope around our practices, or like "the eyeless worm that boring turns the soil", turning the rubble of civilisation, we seek out Horror. Truly Chaos for us has acquired a particular meaning […] And Death? How quickly death to us has become "civilian slaughterings" in empty spaces where once in city streets Wisdom cried out "and no man regarded it".[1]

Breaking the mould of scientific articles that were routinely published in the *Quarterly Review*, Baker's poetic 'gleanings' offer fascinating insights into the complex mixture of emotions felt by women doctors during the War.[2] Unlike the First World War, the Second World War brought the brutal realities of enemy action to the home front on an unprecedented scale. Baker alludes to Proverbs 1:24 to highlight the devastating consequences of society ignoring Wisdom's cries – entire communities were destroyed in a matter of hours by the night-time air raids which swept across the country between September 1940 and May 1941.[3] Blinded by the darkness of the black-

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[1] Madeleine Barker, 'December Gleanings in Black-Out Hours', *MWF Quarterly Review* (January 1941), 35-37. Parts of this chapter have been published as an article: Sophie Almond, 'When that hour strikes danger, we sally forth': Women Doctors at War, 1939-1945', *Women's History Review* (December 2021, ahead of print) <https://doi.org/10.1080/09612025.2021.2002514>.

[2] Ibid., p.169. For more poetic reflections, see: Catherine Reilly (ed.), *Chaos of the Night, Women's Poetry and Verse of the Second World War* (London: Virago, 2007).

[3] For more on the Blitz, see: Juliet Gardiner, *The Blitz, The British Under Attack* (London: Harper Press, 2010); Juliet Gardiner, 'The Blitz Experience in British Society, 1940-1941', in *Bombing, States and Peoples in Western Europe 1940–1945*, ed. by Andrew Knapp and Richard Overy (London: Bloomsbury, 2011), pp.171-184; Peter Adey, David J. Cox, and Barry Godfrey (eds), *Crime, Regulation and Control During the Blitz* (London: Bloomsbury, 2016); Marc Wiggam, *The Blackout in Britain and Germany, 1939-1945* (London: Palgrave Macmillan, 2018).

out, and filled with an uneasy sense of anticipation and excitement, Baker 'grope[s]' around her practice as she prepares to carry out her duties. As medical professionals, women doctors were expected to 'sally forth' into the 'Chaos' in order to serve their patients, with little regard for their own personal safety. Armed only with their 'tin hat' and medical bag, the task of 'seeking out Horror' would have likely been both terrifying and exhilarating in equal measure. Having become hardened to the horrors of war, death has acquired a new meaning for Baker; it is no longer associated with an individual tragedy, rather, it has transformed into something routine and impersonal – 'civilian slaughterings'. Working under extraordinary conditions, women doctors displayed remarkable bravery and resilience, proving to their critics in the War Office and wider society that they were eminently capable of responding to the challenges posed by war.

Whilst the heroic exploits of female practitioners during the First World War have been written about in extensive detail, the experiences of third generation doctors like Baker who practiced between 1939 and 1945 have, thus far, evaded critical attention.[4] Similarly, the work carried out by the MWF during this time of extraordinary social and professional upheaval has continued to be overlooked by historians. Mary Ann Elston chooses to disregard the period entirely, arguing that it had a limited impact on the careers of medical women.[5] This chapter demonstrates that the Second World War was far from insignificant; rather, it represents a crucial turning point in the history of women in medicine. Having spent the last 60 years campaigning for the rights and interests of its membership, the Federation faced its most important challenge to date – namely, securing long-term equality for women doctors within a rapidly evolving medical landscape. Firstly, this chapter examines how the MWF attempted to secure army commissions for medical women prior to the outbreak of war in September 1939. Determined that women doctors would not suffer the same indignities as in the First World War, the Federation wrote to the War Office in December 1937 in an attempt to resolve the matter once and for all.[6] As had been the case two decades previously, the government initially refused to accept the services of

[4] See: Flora Murray, *Women as Army Surgeons* (London: Hodder & Stoughton, 1920); Mary Ann Elston, 'Women Doctors in the British Health Services: a Sociological Study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986; Leah Leneman, 'Medical Women at War, 1914-1918', *Medical History*, 38 (April 1994); Claire Brock, *British Women Surgeons and their Patients, 1860-1918* (Cambridge: Cambridge University Press, 2017); Wendy Moore, *Endell Street: The Trailblazing Women who Ran World War One's Most Remarkable Military Hospital* (London: Atlantic Books, 2020). Existing studies of the history of women in medicine rarely go beyond the interwar years. Elston is the only exception.

[5] Elston, 'Women Doctors in the British Health Services', p.359.

[6] Letter from the MWF to the Secretary of State for War, 6th December 1937, SA/MWF/C.176.

medical women, and later only employed them in junior administrative positions.[7] It then investigates how the MWF adapted to support the needs of its membership during wartime. As blackout restrictions and petrol shortages made long-distance travel increasingly difficult, local Association meetings and the *Quarterly Review* became vital tools in keeping members connected with their professional colleagues.[8] On the home front, women doctors took on additional responsibilities to support the medical needs of their local communities, experiencing first-hand the devastating consequences of indiscriminate bombing. Unlike in the First World War, medical women serving overseas had limited opportunities to engage in frontline medicine; however, those already practising in the Far East were forced to endure brutal conditions as prisoners. This chapter concludes by assessing the effect that the Second World War had on the professional position of the MWF.

Pre-war negotiations

As military hostilities continued to escalate across the world in 1937, it became increasingly clear that a second international conflict was on the horizon.[9] Having ultimately failed to secure future army commissions for medical women in May 1919, the MWF were adamant that the third generation of medical women would not be subjected to the same inequalities as their predecessors.[10] Rather than waiting years for the War Office to address the matter, the Federation instead decided to pre-empt their dismissive tactics by confronting the issue directly. The council wrote to the Secretary of State for War, Leslie Hore-Belisha, in December 1937:

> The present generation of medical women are anxious to play their part in active service at home or abroad. The events of the last war showed that owing to a lack of preparation, medical women worked under grave handicaps and suffered considerable personal disabilities […] we believe that the present is a suitable time to discuss the questions of a) the status and conditions under which medical

[7] By December 1939, only three medical women had been appointed to positions in the army.

[8] In 1939, there were 20 local Associations of the MWF.

[9] 'Premier and Peace', *Daily Mail,* 22nd December 1937, p.8. In March 1936, German military forces directly contravened the Treaty of Versailles by reoccupying the Rhineland. In July 1937, the Second Sino-Japanese War began after Japan invaded China.

[10] Letter from MWF to Winston Churchill, 26th May 1919, reprinted in the MWF Annual Report, 1919-1920, SA/MWF/B.1/2.

> women would be employed in time of war, and b) the possibility of training medical women in preparation for duties […] The Medical Women's Federation is advancing its point of view as a body of responsible citizens concerned primarily with the welfare of the country, rather than with any sectional or personal interest'.[11]

Wanting to avoid accusations of self-interest in the midst of an impending national crisis, the Executive Committee attempted to mitigate its criticism of the Government by framing themselves as 'responsible' citizens. The letter's defensive tone suggests that the Federation were anxious to be viewed as concerned medical professionals, rather than as a group of meddling women. Whilst the MWF would have undoubtedly been anxious about the 'welfare' of the country in general, the organisation's primary aim was to ensure that medical women were finally given the respect and recognition that they deserved. The Federation had spent the interwar years battling against the ingrained prejudices of public health authorities, and could not allow the War Office to undermine the tentative progress that had been made within the profession. By employing passive aggressive tactics and resolving the matter *before* the outbreak of war, it was hoped that the services of women doctors would be utilised to the best national advantage.

The MWF requested that Hore-Belisha receive a small deputation of medical women to discuss the matter 'on a proper footing', but he declined, stating that it would be 'premature' to accept such a meeting.[12] Hore-Belisha was under the impression that the BMA were dealing with the issue 'in a general way', when in fact the Federation had been informed that it was 'outside the scope of the BMA's terms of reference'.[13] Whilst the BMA had begrudgingly accepted Letitia Fairfield as a member of the Central Emergency Committee, they were unwilling to waste time discussing what they perceived to be a trifling issue.[14] Undeterred, the Federation sent a further memorandum to Hore-Belisha in March 1938 to emphasise their grave concerns: 'Medical women will find it extremely difficult to co-operate […] if they have no knowledge of what their status will be. A formula of equality breaks down at once if male doctors are given commissions and women are not.[15] In reply, Hore-Belisha stated that 'enquiries were being made', leaving the MWF to continue with their preparations for war whilst they waited for a response.[16] One of the

[11] Letter from Violet Kelynack to Leslie Hore-Belisha, 6th December 1937, SA/MWF/C.176.

[12] MWF Council Minutes, 30th April 1938, SA/MWF/A.1/4.

[13] Ibid.

[14] Ibid. Fairfield was later appointed Senior Woman Medical Officer to the Armed Forces in 1940.

[15] 'Medical Women and National Defence', *Quarterly Review* (April 1939), 47-57 (p.57).

[16] MWF Council Minutes, 30th April 1938.

council's primary concerns was that the third generation of women doctors, who had not lived through the previous conflict, had a limited understanding of the difficulties which their colleagues had faced.[17] Members such as Jane Walker, who had presided over the organisation between 1913 and 1920, feared that younger medical women would undermine the Federation's efforts and disregard the sacrifices made by their predecessors by accepting positions in the army on undesirable terms.[18] In order to avoid conflict between the generations, it was agreed that a symposium on the subject should be organised, with the experiences of older members who had previously served in the army being published in the medical press.[19] Following an animated discussion with Fairfield, who had not been consulted on the matter, the call for participants was, rather tellingly, retracted: 'it would probably be inadvisable for any public recital of past grievances to be made at this stage, as it might prejudice Mr. Hore-Belisha unfavourably'.[20] As had been the case in previous decades, the MWF were eager to protect their public image, therefore it was essential that the organisation avoided any unseemly publicity.

In July 1938, the Federation finally received the long-awaited reply from Hore-Belisha.[21] Having considered the country's resources, he was of the opinion that there was a sufficient amount of medical men to meet the needs of the army, and that women doctors would inevitably be absorbed by the additional requirements of the civilian population.[22] Echoing the non-committal attitude of his predecessors, Hore-Belisha concluded his letter by adding that: '*If* a woman doctor is employed on military work, it is considered that she would be given a grading which would rank with officers in the Army'.[23] This vague statement did little to clarify the situation, as it inferred that medical women would, once again, be treated as separate entities, being employed *with*, rather than *in*, the RAMC. Whilst the MWF felt strongly that this reply was wholly unsatisfactory, it was decided that sending an immediate rebuttal was inappropriate, due to the worsening political crisis overseas.[24] Instead, the Federation focused its efforts on securing

[17] Ibid.

[18] Ibid.

[19] Letter to members, 10th May 1938, SA/MWF/C.176. Walker also served as Honorary Treasurer of the MWF between 1926 and 1932, and Honorary Secretary between 1932 and 1938.

[20] Report of Committee on Medical Women and National Defence, September 1938.

[21] Letter from Leslie Hore-Belisha to Violet Kelynack, 25th July 1938, SA/MWF/C.179.

[22] Ibid.

[23] Ibid. Emphasis my own.

[24] MWF Council Minutes, 29th October 1938.

representation for medical women on the BMA's Local Emergency Committees.[25] These committees were tasked with organising the distribution of medical practitioners in major towns and cities, yet in many areas, women doctors were being routinely overlooked as members. In an effort to rectify the oversight before the outbreak of war, the MWF raised the matter informally with their long-standing ally, George Anderson, the BMA's secretary: 'In the last war a very large number of medical women took over men's practices when they were away […] It is essential to have medical women on the professional committees which are regulating these replacements'.[26] Though Anderson assured the Federation that he would do everything in his power to resolve the matter, local committees continued to refuse the input of medical women. In Harrogate, the Local Emergency Committee claimed that 'there is presently no need for the help of a lady doctor', but told medical women that '*in the event of an emergency arising*, a lady will be co-opted at once'.[27] The use of the antiquated term 'lady doctor' highlights the irreverent attitude of the Harrogate branch. Given that the committees had been formed for the specific purpose of preparing the country's medical services for the imminent war, it is clear that disdain for medical women continued to fester within parts of the BMA.[28]

Whilst the council waited for an opportune time to resume their correspondence with Hore-Belisha, the Federation received a devastating blow. The sudden death of Jane Walker in November 1938 marked the end of an era for the organisation. After joining the ARMW in 1887, Walker had spent 35 years on the MWF's Executive Committee, and was one of the only surviving members of the first generation of medical women who had qualified before the turn of the century.[29] In one of the many obituaries published in the *Quarterly Review*, Chisholm commemorates Walker's 'far sightedness, statesmanship, shrewdness, determination, and broadmindedness', describing her as 'the midwife who presided over the birth of the lusty infant

[25] In 1937, the BMA formed Local Emergency Committees across the country in order to compile a register of medical practitioners that were available for military service. Whilst hundreds of medical women put forward their names before the outbreak of war, many waited months or years to hear back from the War Office.

[26] Letter from Violet Kelynack to BMA, 26th November 1938, SA/MWF/C.176.

[27] Letter from C. Trist Gasking to Marion Keyes, 4th April 1939. Emphasis my own.

[28] Medical women such as Elizabeth Garrett Anderson and Catherine Chisholm were elected Chairs of local branches of the BMA; however, the Association did not have its first female president until 1979.

[29] Minutes of the ARMW, 14th June 1887. Walker served as Honorary Treasurer of the MWF between 1926 and 1932, and Honorary Secretary between 1932 and 1938. In April 1938, Walker was awarded the Federation's first lifetime membership at the annual meeting in recognition of her services to medical women. Other surviving members of the first generation of medical women included Annie Reay Barker (1851-1945) who qualified in 1877, and Ethel Williams (1863-1947) who qualified in 1891.

which has now reached maturity'.[30] Having ensured the safe delivery of the new Federation, Walker had diligently nurtured it through the challenges of infancy and adolescence, leaving behind an organisation that would continue to thrive. Determined to honour her legacy, the council agreed that the issue of medical women's employment in the army needed to be agitated once again.[31]

In March 1939, the MWF sent a further letter to Hore-Belisha, who had yet to publicly confirm his statement that women doctors would be given relative rank:

> This delay […] is causing the gravest embarrassment to members of the Federation. They do not know what commitments to undertake or how to cooperate in schemes for War Service […] for reasons we have already laid before you we are exceedingly anxious to have this matter settled before a time of crisis recurs. We are being strenuously pressed by branches across the country for an early reply.[32]

Having first raised the matter 15 months previously, the Federation would have felt gravely embarrassed that they had failed to secure any assurances for its members. Once again, Hore-Belisha refused to meet with representatives of the MWF to discuss the matter in person, instead stating dismissively that 'enquiries were being made'.[33] Fairfield, who was privy to the confidential discussions of the Central Emergency Committee, was not surprised by Hore-Belisha's evasive attitude: 'The policy of the War Office is quite clear, they are going to say nothing unless or until war breaks out + [sic] then they hope to get us on their own terms!'.[34] In spite of the Federation's best efforts, two years of correspondence with the War Office had yielded no results; as the country prepared itself for war, the role, if any, that medical women would play in the defence of the realm remained unclear.

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[30] Catherine Chisholm, 'Jane Harriet Walker', MWF *Quarterly Review* (January 1939), 19-20 (p.20).

[31] MWF Council Minutes, 27th April 1939.

[32] Letter from Violet Kelynack to Leslie Hore-Belisha, 13th March 1939.

[33] Letter from Leslie Hore-Belisha to Violet Kelynack, 16th March 1939.

[34] Letter from Letitia Fairfield to Violet Kelynack, 10th April 1939.

Medical women and war services

Having failed to establish its authority with the War Office during peacetime, the MWF found itself in a state of ignorance at the outbreak of war in September 1939. As the government's primary ally, the BMA had been given the responsibility of coordinating the medical profession's response to the conflict.[35] The Federation were excluded from all official communications, and were forced to rely on inside sources such as Fairfield in order to keep abreast of the developing situation. As this chapter reveals, this state of dependence led to deep rifts developing within the MWF; finding themselves at a constant disadvantage, senior members disagreed on the best strategy to adopt, and ultimately failed to win the respect of those in power. Whilst the first and second generation of women doctors had been able to plan their practical responses to the First World War in advance, the third generation were left in a state of uncertainty and confusion as they awaited instructions from the War Office and the BMA:

> We are getting complaints that members, although registered with the BMA months ago, cannot find out in any way what they are expected to do. Some of them feel that they are being neglected merely because they are women! I expect it takes time to get this vast machine in motion?[36]

Faced with no other option than to address the matter publicly, the MWF commissioned a short piece in the *Lancet* to air the grievances of women doctors: 'As things stand, there is no guarantee that women doctors employed in the services will have any more definite status than they did in the last war'.[37] Without clear terms of employment, medical women could not weigh up the relative pros and cons of continuing with their private practices and hospital work. Bridget Gurney, a general practitioner from Eastbourne, felt torn between serving her patients and contributing towards the War effort: 'I wonder if you could help me in my present dilemma […] is it my duty to volunteer for work in the Army?!'.[38] The Federation advised Gurney that her private practice offered much better financial and professional prospects than service with the army, and reassured her that by continuing in her present work, she was not letting her country down.[39]

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[35] MWF Council Minutes, 30th April 1938.

[36] Letter from Mabel Rew to Letitia Fairfield, 3rd September 1939.

[37] 'Medical Women in the Services', *Lancet*, 2 (16th September 1939), 660.

[38] Letter from Bridget Gurney to Violet Kelynack, 21st November 1939.

[39] Letter from Violet Kelynack to Bridget Gurney, 22nd November 1939.

Three days after the *Lancet* article was published, word reached the MWF that the War Office was preparing to make a public announcement: 'They have agreed to let us have practically everything except commissions, i.e. equal pay and emoluments, uniform, promotion'.[40] Unlike in the First World War, medical women would have recognised status, being permitted to wear the rank badges of an officer.[41] Yet, they were, rather tellingly, denied the privilege of wearing the full RAMC badge, which included the Corps' motto – '*In Arduis Fidelis'* – 'Faithful in Adversity'.[42] The badge symbolised the selfless devotion and courage of its wearers who would go to any lengths to save their patients on the battlefield.[43] As women doctors were not permitted to partake in active duty, they were, for all intents and purposes, deemed unworthy and thus refused the honour. Though the government had been forced to concede that the services of female practitioners would be required, this petty snub supports the view that they did not view medical women as being capable of upholding the legacy and traditions of the RAMC. By December 1939, only four women doctors had been appointed to junior positions in the army.[44] Similarly, no medical women had been appointed to the army's medical boards, meaning that all female recruits were being examined by men.[45] To add further insult to injury, the medical forms used for women were exactly the same as those used for men, meaning that there was no space to record any details relating to menstruation.[46] When Fairfield attempted to raise the MWF's concerns at the Central Emergency Committee, she was pointedly told by her fellow members to 'mind my own business'.[47] Faced with such blatant disregard for the services of medical women, the MWF resolved to escalate their plan of attack:

> It was agreed […] that the time had arrived when the position might be tackled politically as well as medically. There was overwhelming evidence of the urgent need for the appointment of a medical woman controller in each of the services

[40] Letter from Mabel Rew to Violet Kelynack, 19th September 1939.

[41] Letter from the War Office to George Anderson, 21st September 1939.

[42] Ibid. This decision was later overturned in October 1939.

[43] John Broom, *Faithful in Adversity: The Royal Army Medical Corps in the Second World War* (Barnsley: Pen & Sword, 2019), p.9.

[44] Minutes of the Executive Committee, 16th December 1939, SA/MWF/A.2/4.

[45] Ibid.

[46] Ibid.

[47] Letter from Letitia Fairfield to Elizabeth Bolton, 22nd January 1940.

> with an adequate staff of medical women serving under her. External pressure was needed to bring this fact before the services.[48]

Having been abandoned by the BMA, the Federation had no hope of securing senior positions for women doctors without the support of influential political allies. By placing trusted, and most importantly, tactful, medical women in each of the armed services, the MWF were confident that the War Office could be persuaded to grant commissions to female practitioners.

In order to focus the Federation's strategic response, a dedicated War Services Committee was formed in February 1940.[49] By collecting intelligence from local Associations and individual members, it was hoped that the MWF would be able to respond quickly to the actions of the War Office and the BMA.[50] The records of the War Services Committee, which operated between February 1940 and September 1943, represent one of the largest collections in the MWF's archive.[51] Hundreds of letters and memorandums were sent between senior members of the Federation, conveying the enormity of the task which the organisation faced.[52] In order to stay informed of the latest developments, the committee relied upon numerous lines of communication, and when pertinent information came to light, it had to be quickly disseminated to all relevant parties. Unusually, the minutes of the committee's first meeting exist in both verbatim and edited form, offering novel insights into the exchanges which took place between members behind closed doors.[53] Having decided upon a political strategy, the relative merits of approaching various high-profile individuals were discussed:

> Mrs [Elizabeth] Bolton says Trefusis Forbes [Director of Women's Auxiliary Air Force] wants women doctors but does not want anything to do with them herself.
>
> [Letitia] Fairfield thinks she has not been a good friend to us.

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[48] MWF Council Minutes, 26th January 1940.

[49] Minutes of the War Services Committee, 3rd February 1940.

[50] Ibid.

[51] Committee on Medical Women and War Services, SA/MWF/C.179 – SA/MWF/C.184; Minutes of the War Services Committee, SA/MWF/A.4/9.

[52] The reason why these records have survived whilst others have not is likely due to the fact that the MWF relocated its offices to Kent for the duration of the War. In contrast, the records of the London Association were destroyed after the MWF's London offices suffered bomb damage.

[53] The unedited minutes can be found in the collection SA/MWF/C.179, whilst the official record of the meeting can be found in the committee's minute book, SA/MWF/A.4/9.

> [Janet] Aitken says she would be prepared to approach her unofficially, and ask whether she would like to have a woman director (medical).
>
> [Janet] Campbell says do not see her in her office. Say we are not wanting to interfere but to offer help if we can. A few people privately may be able to change official opinion.
>
> [Letitia] Fairfield says it is dangerous as more harm can be done too.[54]

Members were keen to recruit as many politicians and senior military personnel as possible to support their cause; however, Fairfield was wary of breaking military protocol: 'Everything should go to the Director of Army Medical Services. Never write to anyone in a junior position, it is most improper'.[55] Her concerns were valid; if the MWF's clandestine efforts to undermine the War Office became widely known, it could seriously damage the organisation's reputation.

As the War progressed, further disunity began to emerge amongst members of the committee. Given Fairfield's privileged position as the only medical woman on the Central Emergency Committee, it is perhaps unsurprising that many of her colleagues were envious of her professional standing. In addition to official business, personal gossip was also exchanged within the letters sent between members: 'Dr Fairfield works terribly hard in the interests of medical women, but, in strict confidence, Dr Anderson told Dame Janet that the service members of the central committee did not like her as she got their backs up!'.[56] In an attempt to emulate Fairfield's status within the MWF, some members chose to break rank by taking matters into their own hands. Impatient at the lack of progress being made with the BMA, Gladys Sandes invited a senior member of the Association to dinner in order to 'get at him' over the examination of recruits.[57] She mistakenly believed that medical women were being paid less than men for the same work, when in fact the examination of male recruits was on a different standing all together.[58] Sandes was informed of her misunderstanding just hours before the dinner, and an embarrassing quarrel was narrowly avoided: 'She goes stepping in without consulting anybody. I think she is under the impression that we don't press hard enough'.[59] Ursula Shelley committed a similar faux pas after

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[54] Minutes of the War Services Committee, 3rd February 1940.

[55] Ibid.

[56] Letter from Mabel Rew to Clara Stewart, 12th July 1940.

[57] Ibid.

[58] Ibid.

[59] Ibid.

being invited to attend a private meeting of the War Office.[60] Rather than alluding to what was discussed in general terms, Shelley distributed a confidential report amongst members of the Federation which included the names of all those in attendance: 'I am certain that if Colonel Dunkerton [Assistant Director of Medical Services] or Colonel McSheehy [Deputy Director of Medical Services] saw it they would never employ Dr Shelley again and would refuse to recognise the MWF'.[61] Whilst disaster had, once again, been narrowly avoided, tensions between Fairfield and the other members of the committee continued to rise. Such behaviour not only threatened to undermine the small progress that had been achieved regarding appointments, but it also risked the MWF being portrayed as a disreputable and untrustworthy organisation.

In spite of the best efforts of the committee, the MWF continued to be overlooked as the professional organisation of medical women by those in power. The Federation were refused the privilege of being told directly when new appointments of women doctors had been made, and instead had to wait months for them to appear in the *London Gazette*.[62] Specific details of these appointments were similarly withheld from the Federation, meaning that the organisation had to rely on the co-operation of medical women to keep them informed. This strategy was not always successful; in January 1940, Genevieve Rewcastle was the first woman to be appointed as medical superintendent of the Women's Royal Naval Service (WRNS), but as she was not a member of either the BMA or MWF, nothing was known about the terms of her employment (Figure 4.1).[63] It was reported in the *Daily Mail* that Rewcastle had been granted the relative rank of surgeon commander, but after further investigation by Fairfield, it was discovered that she had no actual status, and was being paid just £400 a year.[64] Members of the committee 'pounced' on Rewcastle, explaining the serious repercussions that her irregular position could have on the employment of other medical women.[65] Whilst the MWF were successful in securing Rewcastle the relative rank and pay of surgeon lieutenant, it seems that she did not forget the organisation's unsolicited interference.[66] In April 1941, the MWF wrote to the Director General of the Royal Navy Medical

[60] Letter from Letitia Fairfield to Janet Campbell, 23rd August 1940.

[61] Ibid.

[62] Letter from Director General of Army Medical Services to the MWF, 5th December 1939.

[63] Letter from Letitia Fairfield to Elizabeth Bolton, 22nd January 1940.

[64] 'The Navy's First Woman Doctor', *Daily Mail*, 18th July 1940, p.3; Letter from Mabel Rew to Dr Morland, 20th July 1940.

[65] Letter from Mabel Rew to Dr Morland, 20th July 1940.

[66] Ibid.

Service to request that he employ more medical women in the WRNS.[67] In response, he stated that all medical requirements were 'fully and satisfactorily catered for', quoting the results of a recent survey which revealed that only 2.1 per cent of female recruits expressed a desire to be examined by a woman doctor.[68] It soon transpired that the unfortunate survey, which was published in the national press, had in fact been orchestrated by Rewcastle herself: 'The one medical woman in the service undertook this enquiry – and I have a shrewd suspicion she was satisfied with the result she obtained'.[69] This public embarrassment was a major setback for the MWF; faced with such a conclusive statistic, the Federation could no longer argue that it was necessary to employ women doctors in the armed services on grounds of propriety alone. Five months later, the Royal Navy Medical Service appointed four consultant gynaecologists, all of whom were men.[70] The MWF protested the decision in the strongest terms, and the Admiralty eventually agreed to accept the expertise of Louise McIlroy.[71]

[67] Minutes of the War Services Committee, 20th June 1941.

[68] Ibid.

[69] Letter from Mabel Rew to Doris Odlum, 28th July 1941.

[70] Minutes of the War Services Committee, 20th June 1941.

[71] Ibid., 15th August 1941.

Figure 4.1 Genevieve Rewcastle arriving for her first day of work at the WRNS headquarters (National Maritime Museum).

Tensions between senior members of the MWF were further raised following the government's decision to grant full military status to the women's services in April 1941.[72] As official members of the armed forces, female officers serving in the Auxiliary Territorial Service (ATS) and the Women's Auxiliary Air Force (WAAF) were granted full commissions, rather than relative rank.[73] Four months later, commissions in the women's services were also extended to medical women serving in the RAMC.[74] Members of the War Services Committee were strongly against accepting the commissions, writing to the army Council to condemn their decision:

> The proposal to segregate medical women in the Women's Forces, so that they would serve with and not in the RAMC […] is unacceptable to medical women. Women doctors volunteer with the Army as <u>doctors</u> and not as women, and

[72] House of Commons, *Hansard's Parliamentary Debates: The Official Report* [online], 10th April 1941 (vol 370, col 1699-700) <https://hansard.parliament.uk/> [accessed 7th January 2021].

[73] Ibid. Medical women serving in the WRNS were commissioned into the Royal Navy Volunteer Reserve (RNVS).

[74] Minutes of the War Services Committee, 15th August 1941.

> they consider that any arrangement which places them in a separate category from their colleagues infringes this fundamental principle.[75]

Not for the first time, Fairfield disagreed with her colleagues. It was legally impossible for women to be granted full commissions in the land forces; officers in the RAMC were soldiers as well as doctors, and, as such, were expected to be able to lead a regiment into battle if an emergency situation arose.[76] In her opinion, commissions in the women's services were entirely satisfactory as long as equal pay, pensions, and status were guaranteed.[77] Fairfield believed that public opinion of medical women would suffer greatly if the new terms were not approved by the Federation: 'you are probably right in saying they [medical women] do not want it; they may not, but they will not refuse it. Such an attitude would injure the MWF'.[78] Choosing to ignore Fairfield's warning, the committee unanimously agreed that they would accept nothing less than complete equality within the medical services of the crown: 'we will do wrong to the future if we do not stick to our principle'.[79] In March 1942, Fairfield retired from her post as senior medical officer of the armed forces, and ceased all correspondence with her colleagues on the War Services Committee.[80] It is perhaps telling that whilst Fairfield's successor, Albertine Walker, was congratulated on her promotion by the MWF, no such letter was sent to Fairfield in appreciation of her services.[81]

Remaining unmoved by the MWF's repeated protestations, the army authorities continued to offer medical women serving in the RAMC the choice between retaining their relative rank, or being granted full commissions in the women's services.[82] In response, the Federation sent a memorandum to every woman doctor qualified for less than two years to outline the organisation's position.[83] The MWF argued that whilst relative rank in the RAMC was still unsatisfactory, it was more advantageous than the commissions being offered in the women's services as it 'left the door open' for a more equitable arrangement to be made at a later date.[84] In a further letter published in the *Lancet*, Clara Stewart, the Federation's president, expressly advised medical women to refuse

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[75] Draft memorandum to Army Council, September 1941.

[76] Minutes of the War Services Committee, 10th September 1941.

[77] Ibid.

[78] Ibid.

[79] Ibid.

[80] Minutes of the War Services Committee, 4th March 1942.

[81] Ibid.

[82] Draft letter to medical women qualified for less than two years, 1942, SA/MWF/C.184.

[83] Ibid.

[84] Ibid.

the new commissions, stating that she was 'profoundly disturbed' by the army's violation of professional equality.[85] Private correspondence between Stewart and Mabel Rew reveals the acute pressure felt by members of the committee to succeed: 'The whole thing makes me sick at present, it really is next to impossible to make it intelligible'; 'I am anxious to prove that we are as clear headed as any committee of men'.[86] Blinded by an obstinate determination to prove themselves as capable negotiators, senior members of the Federation failed to acknowledge the wider views of the profession, or, indeed, its own membership. The BMA refused to offer any assistance on the matter, and it was reported that 80 per cent of female medical officers accepted commissions in the women's services.[87] In June 1942, the War Office announced that all new recruits to the RAMC were to be given commissions in the women's services.[88] The matter was considered closed, and the committee were forced to accept defeat: 'There is no option. The commissions must be accepted […] so there we are! What now?'.[89] Though the MWF set out with a clear strategy for confronting the War Office in 1937, members of the committee ultimately failed to work in unity with one another once war had been declared. Cut off from all official communications, the MWF grew increasingly desperate in its attempts to stay abreast of the latest developments, irrevocably damaging professional relationships in the process. Having failed in its endeavour to achieve complete equality of status for medical women in the army, the War Services Committee was dissolved in September 1943.[90]

The Federation in wartime

Though the MWF spent the majority of the conflict in a fierce battle of wills with the government, the organisation remained committed to providing personal and professional support to its membership. Wanting to avoid any unnecessary disruption to the day-to-day running of the Federation, the council carefully planned its response to the outbreak of War. It was agreed that the council and Executive Committee should continue to meet at least twice a year, but that the

[85] Clara Stewart, 'Medical Women with the Forces', *Lancet*, 2 (4th July 1942), 22.

[86] Letter from Clara Stewart to Mabel Rew, 9th April 1942; Letter from Mabel Rew to Clara Stewart, 10th April 1942.

[87] Committee on medical women and war services, 29th January 1942.

[88] Letter from Mabel Rew to Janet Campbell, 15th June 1942.

[89] Ibid.

[90] Minutes of the MWF Council, 4th September 1943.

number of representatives from local Associations should be reduced by half.[91] Due to widespread petrol shortages, meetings had to be accessible by a main railway line, with attendees being given an allowance for bed and breakfast in order to avoid having to travel home during the blackout.[92] Similarly, in October 1939, the MWF's office was moved to Mabel Rew's house in Hayes, Kent, where it remained for the duration of the conflict.[93] As the majority of medical women would be isolated from their colleagues, it was of vital importance that the Federation's 20 local Associations continued to meet regularly. Concerned that attendance at meetings might suffer as a result of the War, the council suggested that gatherings should be held on weekday afternoons or Sunday mornings to accommodate members' disrupted work schedules.[94] Local Associations responded enthusiastically, organising a variety of social and clinical activities to raise the spirits of medical women during wartime. Members in Aberdeen were treated to medical film screenings on topics such as 'the treatment of trichomonas [sexually transmitted infection]' and 'the abdominal viscera', whilst in Sheffield, demonstrations of blood grouping and transfusion were given on a clinical ward round.[95] In Birmingham, the annual dinner was replaced with a trip to watch a comedy play at the theatre, whilst in Yorkshire, members attended Sunday morning tea-parties.[96] Air raids regularly interrupted meetings; however, medical women remained unflappable. Proceedings were momentarily halted in Liverpool when the air-raid siren sounded during an afternoon gathering in August 1940, but after members were comfortably installed in the president's basement shelter and refreshments were replenished, discussions continued as normal.[97] For the duration of the conflict it was reported that local Association meetings were well attended, highlighting the importance that women doctors placed on preserving a sense of community and purpose during uncertain times.

The council also stated its intention to continue publishing the *Quarterly Review* at the beginning of the War.[98] Having evolved from the MWF *Newsletter* in 1934, the *Quarterly Review* was sent to every member of the organisation as part of their subscription fee, making its circulation

[91] MWF Council Minutes, 14th October 1939.

[92] Ibid.

[93] Ibid. The MWF's London office was bombed during the War, leading to the records of the London Association being destroyed.

[94] 'The Federation in Wartime', MWF *Quarterly Review* (January 1940), 45-46 (p.46).

[95] 'The Medical Women's Federation News and Notes', MWF *Quarterly Review* (April 1940), 64-69 (p.64); Ibid., p.68.

[96] Ibid., p.65; Ibid., p.69.

[97] 'The Medical Women's Federation News and Notes', MWF *Quarterly Review* (October 1940), 36-39 (p.37).

[98] Minutes of the Executive Committee, 14th October 1939.

close to 8000 copies per year.[99] For many medical women, the journal functioned as a professional lifeline, keeping them informed of the latest clinical developments and Federation news. As a sign of their ongoing commitment to the *Quarterly Review*, the council appointed Florence Cowlin, a woman doctor from Surrey, as honorary editor in May 1940.[100] Under Cowlin's stewardship, the journal adopted a more domestic tone for the duration of the conflict; a 'personalia' section was added to share new appointments in the armed services, and local Associations were encouraged to supply detailed reports of their monthly meetings.[101] The advertisements featured in the *Quarterly Review* similarly adapted to meet the changing needs of medical women. In a stark reminder of the dangers faced by women doctors in the line of duty, life, sickness, and accident insurance was regularly advertised, with members being offered preferential rates from select companies if they took out policies through the MWF.[102] The pharmaceutical company May & Baker also carefully selected the products which it featured on the front cover of the *Quarterly Review*.[103] Reflecting the sense of normality that was felt by medical women during the first eight months of the War, the obstetric anaesthetic Vinesthene was advertised in the April 1940 issue.[104] In contrast, during the height of the London Blitz in January 1941, the barbiturate Soneryl was marketed as an effective treatment for patients suffering from the terrors of air-raids.[105] The MWF relied on advertising income to cover the majority of the *Quarterly Review's* costs, but as the War progressed, the price of materials and printing rose exponentially.[106] In 1938, the net cost of producing four issues was £51; however, by 1943, this had risen to a staggering £336.[107] In April 1942, the paper shortage crisis reached its peak, and the MWF spent £105 publishing its most expensive single issue to date (Figure 4.2).[108] Unwilling to compromise on either the quality or the quantity of the *Quarterly Review*,

[99] MWF Annual Report, 1935, p.17, SA/MWF/B.1/20.

[100] Ibid., 4th May 1940.

[101] 'The Federation in Wartime', p.46

[102] 'Federation News and Notes', MWF *Quarterly Review* (April 1940), p.69.

[103] For more on May & Baker pharmaceuticals, see: John. E Lesch, *The First Miracle Drugs, How the Sulfa Drugs Transformed Medicine* (Oxford: Oxford University Press, 2007).

[104] MWF *Quarterly Review* (April 1940), front page. The period between September 1939 and May 1940 was commonly referred to as the 'Phoney War' due to the lack of military action.

[105] MWF *Quarterly Review* (January 1941), front page.

[106] In July 1941, it was reported that the cost of paper had increased by £10 per issue, and the cost of printing had risen by 10 per cent.

[107] MWF Council Minutes, 29th October 1938; Ibid., 28th March 1944.

[108] Ibid., 9th July 1942. It was reported that only 50 per cent of the net cost of this issue was covered by advertising income.

the council agreed to exclude the annual list of members, and reduced the number of pages in line with the government's paper control order.[109]

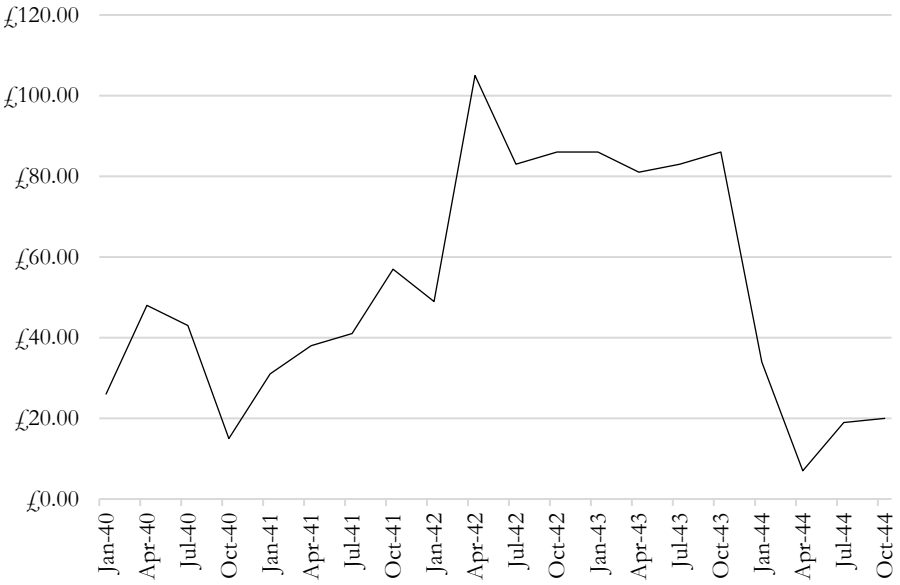

Figure 4.2 Total cost of publishing issues of the *Quarterly Review* between January 1940 and October 1944.[110]

In spite of the numerous difficulties which the MWF faced in producing the *Quarterly Review*, only one of the 24 issues published during the War was delayed in being sent out to members.[111] Furthermore, articles of special interest written by medical women continued to be prioritised by Cowlin even though space was at a premium. In recognition of the unprecedented circumstances in which women doctors found themselves, contributors were given the freedom to express themselves as individuals as well as practitioners. Articles such as Baker's 'December Gleanings' were crucial in strengthening the sense of community that existed within the MWF, as they served to reassure medical women that they were not alone in their experiences.[112] In April 1941, Sybil Eastwood, senior physician at the South London Hospital for Women, published an

[109] Ibid.

[110] Publishing costs of the *Quarterly Review* were routinely reported in the MWF Council Minutes (SA/MWF/A.1).

[111] The January 1940 issue was delayed in order to include the most recent correspondence with the War Office.

[112] Madeleine Barker, 'December Gleanings in Black-Out Hours', MWF *Quarterly Review* (January 1941), 35-37.

article in the *Quarterly Review* on the treatment of air raid casualties.[113] She concluded her scientific analysis with a candid reflection on the realities of wartime hospital practice:

> This account of a hospital's work in war is an account in medical language. It deals with 'cases', with 'causalities'. It conceals in these words an odious reality of pain and misery coming suddenly upon a number of concrete individuals […] the medical work cannot be regarded separately from the human contact with people who have just had their world literally blown up around them. They become intensely important to one in a most personal and direct manner […] I suppose it is psychologically rather like the relationship between a lifeboat crew and the shipwrecked people they have dragged from the sea.[114]

Since the late-nineteenth century, medical women had been expected to embody the professional ideals of resilience and fortitude in order to prove themselves as capable practitioners. As examined in Chapter One, weakness, whether mental or physical, was viewed as a barrier to women entering the field and being respected by their male colleagues.[115] By acknowledging the 'odious' reality of the pain and misery that she had witnessed, Eastwood gives voice to the emotional toll that the War had on 'concrete' individuals such as herself. Like lifeboat crew, doctors were tasked with dragging their patients away from the clutches of death, but in this moment of shared human contact, an irrevocable, 'intensely important' connection is formed. Cowlin's decision to publish the article in full reveals the extent of the MWF's commitment to supporting its membership. Rather than striving to match the scientific rigour of the *BMJ* and the *Lancet*, the Federation instead chose to prioritise the wellbeing of women doctors by normalising an acceptance of emotional vulnerability.[116]

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[113] Sybil Eastwood, 'Air Raid Casualties in EMS Hospitals', MWF *Quarterly Review* (April 1941), 17-26.

[114] Ibid., p.25.

[115] See: Sophie Almond, 'The Forgotten Life of Annie Reay Barker, M.D', *Social History of Medicine,* 34 (August 2021), 828-850.

[116] After the War, an editorial board was appointed to oversee the rebranding of the publication, and in 1947, the *Quarterly Review* evolved into the MWF *Journal*. For more on doctors and emotions, see: Fay Bound Alberti, *Medicine, Emotion and Disease, 1700-1950* (London: Palgrave Macmillan, 2006); Michael Brown, 'Surgery and Emotion: The Era Before Anaesthesia', in *Handbook of the History of Surgery*, ed. by Thomas Schlich (London: Palgrave Macmillan, 2017), pp. 327-348. For contemporary discussions of medicine and emotion, especially in the field of surgery, see: Agnes Arnold-Forster, 'A Small Cemetery: Death and Dying in the Contemporary British Operating Theatre', *Medical Humanities*, 10 (July 2019), 278-287; Agnes Arnold-Forster, 'Resilience in Surgery'*, British Journal of Surgery*, 107 (March

As well as ensuring that medical women remained connected with their professional colleagues, the MWF continued to support its membership by providing assistance in cases of unfair treatment and dismissal. Although some progress had been gained by the Federation in relation to public health appointments, issues of equality continued to affect women doctors in hospital practice. In January 1940, Ellen Douglas Morton, a woman doctor from Glasgow, was dismissed from her position as honorary surgeon at the Royal Samaritan Hospital on account of her recent marriage.[117] Norton's husband was also a senior member of the medical staff, and it was argued that their close relationship would impact the smooth running of the hospital.[118] In conjunction with the Scottish Western Association, the MWF wrote a number of letters to protest Norton's dismissal; however, the board of governors ultimately refused to rescind their decision.[119] Similarly, in August 1940, the Federation were asked to intervene in the case of Edith Busse, a Jewish refugee who had fled Germany in 1933.[120] After gaining the Scottish triple qualification in 1936, Busse had immediately joined the MWF as a member.[121] At the outbreak of War, Busse was categorised as a 'friendly alien' by the Home Office on account of her citizenship, which severely affected her successful private practice in Wembley.[122] Busse was exempt from internment on the Isle of Wight, but was banned from using her car and was also subject to a strict curfew, making her medical work all but impossible.[123] The Federation resolved to send a letter to the Aliens Department at New Scotland Yard to support Busse's appeal, and referred the case to Eleanor Rathbone, a Member of Parliament who was known for her tireless advocacy of persecuted refugees.[124] It is unclear whether Busse's appeal was successful or not, though she remained on the

2020), 332-333; Agnes Arnold-Forster *, Cold, Hard Steel: The Surgical Stereotype Past and Present* (Manchester: Manchester University Press, 2022).

[117] Minutes of the Executive Committee, 26th January 1940.

[118] Ibid.

[119] Ibid., 4th May 1940.

[120] Ibid., 10th August 1940.

[121] Ibid. Founded in 1884, the Scottish triple qualification was a popular route into medicine for refugee students and doctors during the mid-twentieth century. For more, see: HM Dingwell, 'The Triple Qualification Examination of the Scottish Medical and Surgical Colleges, 1884–1993', *Journal of the Royal College of Physicians of Edinburgh*, 40 (2010), 269-276.

[122] 'Edith Busse', World War Two Alien Internees, 1939-1945, <www.ancestry.co.uk> [accessed 22nd January 2021].

[123] Minutes of the Executive Committee, 10th August 1940. Another refugee medical woman, Elsie d'Amain, was interned on the Isle of Wight between June 1940 and March 1941. Following her release, the MWF provided d'Amain with financial assistance through the benevolent fund.

[124] Ibid. Busse's husband was naturalised by the Home Office in March 1946. For more on Rathbone, see: Susan Penderson, *Eleanor Rathbone and the Politics of Conscience* (New Haven: Yale University Press, 2004).

British Medical Register until 1955.[125] Whilst the council had stubbornly refused to acknowledge the overwhelming consensus of women doctors employed in the army, the MWF responded perceptively to the wider issues being faced by its members. By encouraging local Associations to meet regularly throughout the War, and by continuing to publish the *Quarterly Review*, the Federation demonstrated its ongoing commitment to supporting the personal and professional lives of medical women.

Medical women on the home front

As had been the case in the First World War, medical women played an integral, yet widely understated, role on the home front during the Second World War.[126] In spite of the importance that was placed on documenting everyday life on the home front both during and after the conflict, the experiences of medical women are largely absent from the historical record.[127] Whilst female recruits, housewives, shop assistants, factory workers, teachers, and nurses engaged with Mass-Observation and oral history projects, preserving diaries, letters, and personal testimony, the majority of women doctors appear to have eschewed both public and private acts of memorialisation.[128] This may have been because female practitioners were exceptionally busy; as medical professionals in the midst of a national crisis, many would not have had the time or the inclination to record their experiences.[129] It is also possible that unlike their nursing colleagues, women doctors did not view their contributions as being noteworthy or extraordinary in the

[125] 'Edith Busse', UK and Ireland Medical Register, 1955 <ww.ancestry.co.uk> [accessed 22nd January 2021].

[126] Whilst the work of American medical women on the home front has been briefly considered by Bellafaire and Graf (2009), no attention has been given to the work undertaken by British women doctors during the Second World War. For more on women's work during the Second World War, see: E. Burton, *What of the Women? A Study of Women in Wartime* (London: Frederick Muller, 1941); Harold L. Smith, *Britain in the Second World War A Social History* (Manchester: Manchester University Press, 1996); Mark Donnelley, *Britain in the Second World War* (London: Routledge, 1999); Carol Harris, *Women at War 1939–1945: The Home Front* (Stroud: Sutton Publishing, 2000); Gail Braybon and Penny Summerfield, Out of the *Cage: Women's Experiences in two World Wars* (London: Routledge, 2013); Penny Summerfield, *Women Workers in the Second World War* (London: Taylor & Francis, 2013).

[127] For more on British cultural memory and the Second World War, see: Lucy Noakes and Juliette Pattinson (eds), *British Cultural Memory and the Second World War* (London: Bloomsbury, 2014).

[128] Dorothy Sheridan (ed.), *Wartime Women: A Mass-Observation Anthology, 1937-1945* (London: Phoenix Press, 2000), p.5.

[129] For example, whilst Muriel Radford (née Lloyd) wrote extensively about her experiences as a newly qualified medical woman during the First World War, she wrote comparatively little during the Second World War.

immediate post-war years, holding concerns about the professionalism of publicising their experiences.[130] Excluding the records collated by the MWF, all of the personal accounts that survive in public archives were written by women doctors who were newly-qualified during the War, suggesting that the conflict represented a defining moment in their careers.[131] Though medical women were reluctant to share their experiences publicly, many engaged with the Federation's own efforts to create a 'permanent historical record' of members' wartime employment.[132] In collaboration with the Imperial War Museum, the Federation sent a questionnaire to every member in 1950, with over 400 responses being received.[133] Women doctors engaged in general practice, public health, and hospital medicine were encouraged to share their remarks, offering fresh insights into the variety of work undertaken on the home front.[134] Similarly, in the 1990s and 2000s, renewed efforts were made to document everyday life during the Second World War before the memories of the last surviving generation were lost forever.[135] In March 1996, the Liverpool Medical Society held a meeting on 'Women in Medicine during World War Two'.[136] Twelve of the 14 'eye-witness accounts' shared by women doctors who graduated between 1935 and 1948 were published by the society the following year, providing a unique regional perspective of wartime medical practice.[137]

In spite of the demanding nature of civilian medicine, female practitioners ably adapted to meet the demands of wartime conditions. One-hundred-and-forty questionnaire responses were

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[130] For more on women doctors and the professionalism of publicity, see: Claire Brock, 'Elizabeth Garrett Anderson and the Professionalism of Medical Publicity', *International Journal of Cultural Studies*, 11 (2008): 321–342. Men who remained on the home front in civilian roles similarly did not view the Second World War as a watershed moment in their careers. See: Linsey Robb and Juliette Pattinson (eds), *Men, Masculinities and Male Culture in the Second World War* (London: Palgrave, 2018).

[131] The Wellcome Library hold the wartime recollections of Thelma Phelps, who was a student at the LSMW during the War (MS.8585). Phelps qualified in 1944, and went on to specialise in community medicine. Similarly, the Wellcome Library also hold the recollections of Molly Newhouse, who qualified in 1937 (MS.8766). Newhouse worked with the RAMC during the War, and later established a career in general practice and occupational health.

[132] Letter from Mary Mitchell to members of the Cambridge and District Association, 9th September 1950, SA/MWF/C.197.

[133] The responses were later analysed by the Federation's honorary secretary, Beryl Harding, and published as a series in the MWF *Journal* in 1955.

[134] Only the questionnaire responses received from general practitioners have survived in full (SA/MWF/C.198).

[135] The BBC 'WW2 People's War' project collected testimonies between June 2003 and January 2006.

[136] Liverpool Medical Society, *Women in medicine during World War Two, Twelve Eye Witness Accounts* (Liverpool: Liverpool Medical Society, 1996), p.1.

[137] Ibid.

received by the Federation from members who were engaged in general practice during the conflict.[138] General practice remained the most popular career choice for medical women; in a survey of 2749 women doctors conducted by the MWF in 1939, 38 per cent reported to be working in the specialism.[139] Owing to the impending threat of aerial bombing, the government set in motion a mass civilian evacuation plan at the outbreak of War.[140] Over the course of three days, approximately 1.5 million people were relocated from major cities to reception areas across the country in September 1939.[141] Because the majority of evacuees were women and children, many women doctors based in large towns and cities found that their patient lists had almost completely disappeared overnight, leaving them in acute financial difficulty: 'It is an impossible position. They cannot leave the remnant of their practice, and yet they are not earning enough to meet current expenses.'[142] Conversely, women doctors based in rural locations found that their patient lists had swelled to unmanageable proportions, with many evacuees arriving in poor health and with limited knowledge of personal hygiene practices.[143] Whilst these changes often proved to be temporary, being directly affected by the different waves of evacuation, women doctors were expected to overcome the challenges created by the War without complaint.[144]

The Federation sought to alleviate the difficulties being experienced by its members, but faced opposition at every turn: 'We wrote to one big town in a reception area enquiring as to the possibilities of medical women being received to help […] but were told that a number of retired medical men were gladly undertaking the extra work!'.[145] In October 1939, Dorothea Fox, a general practitioner from Wimbledon, wrote to the MWF to suggest that they conduct a survey on transfers of population so that the scale of the problem could be properly understood.[146] She argued that the results would highlight the areas where help was needed most, and that medical

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[138] A. Beryl Harding, 'Work done by British medical women in general practice', MWF *Journal* (January 1955), 20-24 (p.20).

[139] MWF Council Minutes, 26th January 1940.

[140] Juliet Gardiner, *Wartime Britain 1939-1945* (London: Headline Book Publishing, 2004), p.21.

[141] Ibid.

[142] Undated telephone message, SA/MWF/C.177.

[143] A. Beryl Harding, 'Work done by British Medical Women in General Practice', 20.

[144] At the outbreak of war, male doctors of all ages, as well as medical students, were exempt from conscription. The majority worked as part of the Emergency Medical Service (EMS), whilst those who were willing were recommended for military service by their local BMA Medical War Committee. In June 1940, medicine was removed from the list of reserved occupations, with newly qualified male doctors being offered commissions in the RAMC.

[145] Letter from the Violet Kelynack to Dorothea Fox, 5th September 1939, SA/MWF/C.179.

[146] Letter from Dorothea Fox to Violet Kelynack, 4th September 1939.

women whose practices had diminished could be relocated in order to manage the increased workload.[147] Local Associations were tasked with collecting information on evacuees, but many refused, stating that it was impossible to collect accurate data, and that such a scheme would lead to local practitioners being undercut by outsiders.[148] This would not only attract 'derogatory criticism of the ethics of medical women', but would also directly undermine the work of the BMA's Local Emergency Committees.[149] It was eventually agreed that Fox's proposal was professionally unethical, and the survey was abandoned.[150]

General practitioners were already established as trusted figures within local communities, meaning that they were well-placed to undertake work with the Air-Raid Precaution (ARP) service. In addition to their routine surgeries and home visits, women doctors volunteered as local fire-watchers, manned mobile clinics and first aid posts, and provided medical assistance to public shelters.[151] Marguerite Stewart, a medical woman from Clapham, recalls that a third of her private practice disappeared as a result of evacuation.[152] In addition to her daytime work, she was tasked by her local authority to visit communal air-raid shelters in order to check for illness and to maintain morale.[153] Writing just five years after the end of the War, Stewart notes that the relentless nature of wartime general practice was made easier by the 'Keep Calm and Carry On' Blitz spirit embodied by her patients:

> All medical work in London was war work – whether it be 'standing-by' at an incident, marvelling at how much dust the human throat could tolerate as rescue squads dug steadily on; or it might be driving by gun-flash to a nursing home to the old lady who always had a heart attack when the guns began to bark […] How much the gay courage, laughter and steadiness of the people of the neighbourhood helped the morale of the doctor they will never know […] it was a pleasure to be among them.[154]

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147 Ibid.

148 Letter from the Ipswich, Colchester, and District branch of the MWF to Violet Kelynack, 6th November 1939.

149 Ibid.

150 Hand-written notes on survey of population, 16th December 1939.

151 Ibid.

152 Marguerite Stewart, handwritten notes, SA/MWF/C.198.

153 Ibid.

154 Ibid.

Anna Seager, a general practitioner from Heswall, Merseyside, found that her patient list increased dramatically at the outbreak of war.[155] Scores of people moved out of Liverpool in anticipation of bombing raids, and were later joined by those made homeless by the sustained aerial attacks on the city which peaked in May 1941.[156] After her husband volunteered to serve in the RAMC in 1939, Seager took over the running of his busy practice, with a record of 27 home visits and two surgeries in one day.[157] She was also on-call overnight, and an extension of her front door bell fitted under her bed provided a 'grim awakening' when assistance was required by local midwives.[158] Like many overworked general practitioners, Seager loathed having to organise the 'books' after a long day's work.[159] Having noticed that her bills were always late, one private patient offered to take charge of Seager's finances, a small but significant act of kindness that 'changed my life'.[160] Unlike Stewart, Seager's reminiscences are influenced by the benefit of hindsight and experience, having been written almost 50 years after the end of the conflict. In spite of the passing of time, she recalls the details of her work with clarity, offering a candid reflection on her wartime exhaustion.

The responses received by the MWF similarly highlight the difficulties which medical women faced in juggling the competing demands of their personal and professional lives. Gail Braybon and Penny Summerfield argue that the government were extremely reluctant to introduce any policies that would change the conventional role of women at home during the Second World War.[161] Though thousands of married women participated in war work, state-organised childcare was, for the most part, woefully inadequate.[162] Furthermore, privately organised childcare arrangements became increasingly unreliable as more women entered the workplace, and people's personal circumstances changed overnight.[163] Good organisation and grim determination were the only tools which women had to overcome the 'double burden' of their paid employment and

[155] Liverpool Medical Society, *Women in Medicine during World War Two*, p.12.

[156] Richard Whittington-Egan, *The Great Liverpool Blitz* (Oldcastle: The Gallery Press, 1987), p.3.

[157] Liverpool Medical Society, *Women in Medicine during World War Two*, p.13.

[158] Ibid.

[159] Ibid.

[160] Ibid. Patients that were not eligible for medical benefits under the National Insurance Act (1911) continued to pay general practitioners directly for treatment until the founding of the NHS.

[161] Gail Braybon and Penny Summerfield, *Out of the Cage: Women's Experiences in Two World Wars* (London: Routledge, 1987), p.235.

[162] Ibid.

[163] Ibid., p.241.

domestic work.[164] One general practitioner worked in her private practice from 6am to 9pm every day, as well as being on-call as an anaesthetist to the local burns squad.[165] She had six children under 14 years of age at home, including evacuees, and had no choice but to manage with 'intermittent and ever-changing' daily help.[166] Similarly, another medical woman from Cambridge writes that 'a lack of any domestic help of any sort' remained her overriding impression of the War.[167] On top of her general practice work, she served as county medical officer for infant welfare, volunteered for the local Red Cross, and worked night shifts as a fire-watcher.[168] Every evening she cooked for five, as well as caring for her 80 year-old mother.[169] Overwork and stress had gendered impacts on the emotional and physical wellbeing of women doctors, as they were expected to expand their professional responsibilities as part of the war effort, whilst also navigating domestic difficulties, such as food shortages and lack of childcare, within the home.

Unlike in the First World War, the Second World War exposed medical women on the home front to the dangers of enemy action on a previously unseen scale. In addition to her routine practice work, one medical woman from Dover volunteered at anti-aircraft sites.[170] Her most alarming memory was having to reverse a mobile canteen along the cliff edge whilst under machine gun fire from a German plane.[171] Though some women doctors experienced brief moments of excitement and danger, the majority reported that wartime general practice was, for the most part, gruelling and mundane.[172] One medical woman from Yorkshire recalls that she spent five and a half years driving down country lanes during the blackout with only the car's side lights to guide her – 'that was my only war experience'.[173] Another humorously inverts the gendered message of the First World War recruitment poster – 'Daddy, what did you do in the Great War?' – as she writes: 'When I am old and my great niece asks me "what did you do in the war Auntie?" I shall say, "I treated scabies dear."'.[174] Driven by an unwavering commitment to their profession, women

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[164] Ibid., p.235.

[165] A. Beryl Harding, 'Work done by British medical women in general practice', p.20.

[166] Ibid.

[167] Ibid.

[168] Ibid.

[169] Ibid.

[170] Ibid., p.21.

[171] Ibid.

[172] Ibid., p.24.

[173] Ibid.

[174] Ibid. Scabies, an infectious skin condition caused by mites, spread uncontrollably in communal air-raid shelters during the War.

doctors undertook a vast number of responsibilities during the Second World War. Though the majority of general practitioners made personal and professional sacrifices in the service of their patients, their contributions to the War effort went largely unrecognised and were not commemorated in the decades which followed. This could be because the role of the woman doctor was viewed as routine and unremarkable in comparison to roles which were time-limited and extraordinary, such as munitions workers. One of the few exceptions is Hannah Billig, a woman doctor from London's East End who was awarded the George Medal for her heroic actions in March 1941.[175] Billig continued to provide medical assistance to people injured in an air-raid whilst suffering from a broken ankle, later becoming known as the 'Angel of Cable Street'.[176]

In spite of the marriage bars that had been enforced by local authorities in the 1920s and 30s, public health remained the second most popular career choice for medical women. In 1940, the results of the Federation's career survey showed that 21.2 per cent of medical women worked in the specialism.[177] One-hundred-and-seven responses to the Federation's Imperial War Museum survey were received from women doctors employed in the public health service.[178] Like general practitioners, public health doctors were subjected to long hours and monotonous work for the duration of the War. Community health clinics were overwhelmed with new patients, as reception areas were 'swollen to unimaginable proportions' by the mass transfer of population.[179] To make matters worse, public buildings were routinely commandeered as part of the War effort, meaning that medical women were often forced to hold their clinics in uncomfortable and unsuitable premises.[180] In addition to their full-time work, public health doctors similarly took on additional responsibilities and commitments as part of the war effort.[181] One woman doctor from Belfast worked as a school medical officer during the day, but spent her evenings teaching first-aid courses and responding to air-raids in her local area.[182] She recalls that: 'the worst raid was in Easter 1941 when whole streets of houses were destroyed […] in many cases nothing could be done'.[183] Another member from Newcastle reports that as medical officer for health, she was given the

[175] MWF *Quarterly Review* (April 1941), 69.

[176] Ibid.

[177] MWF Council Minutes, 26th January 1940.

[178] A. Beryl Harding, 'Medical women attached whole or part time to the public health service', MWF *Journal* (July 1955), 177-181 (p.177).

[179] Ibid.

[180] Ibid.

[181] Ibid., p.178.

[182] Ibid.

[183] Ibid.

unenviable task of inspecting every evacuee leaving the city.[184] Her record was 840 children in one day, each being auscultated [listening to chest sounds through a stethoscope] and having their throat examined.[185] When a 500lb bomb fell nearby it provided welcome relief from the relentless schedule – the children were handed back to their mothers, and she was able to smoke a quiet cigarette.[186]

The difficulties of having to manage without any domestic help were also keenly felt by public health doctors. One woman doctor confesses that when she travelled to clinics on the train, she would often leave her baby in the guard's van so that she could enjoy an uninterrupted packed lunch.[187] Another admits that she took up gardening in an attempt to bolster her food rations, but ended up despising the task as it just added to the stress of her existing workload: 'in the summer when the day's work was done I could often be seen tending my garden by moonlight. From being a lover of nature I grew to hate the sight of vegetation'.[188] Under wartime conditions, time spent in nature was no longer synonymous with leisure, rather, it became another area of female responsibility, pushing women closer towards burnout. Like general practitioners, public health doctors worked tirelessly in the service of their patients, rarely giving any consideration to their own personal wellbeing. Whilst a small number of female practitioners were given the opportunity to fulfil roles previously closed to them, such concessions proved to be temporary; as Elston asserts, the Second World War did little to aid the overall career progression of women in medicine.[189]

Medical women working in hospital medicine similarly expanded the scope of their practice in response to the increased demands on civilian medical services. The MWF received 107 responses from women doctors engaged in hospital work during the War.[190] Five of the seven hospitals across the country staffed exclusively by women were requisitioned by the emergency

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[184] Ibid., p.179.

[185] Ibid. Such examinations were, out of necessity, cursory, and were often viewed as undermining the skill of the practitioners which conducted them. For more on women doctors and public health work, see Elston (1986).

[186] Ibid.

[187] Ibid., p.180.

[188] Ibid.

[189] Elston, 'Women Doctors in the British Health Services', p.359. For example, one woman doctor was asked to act as medical officer to a home guard battalion in Wiltshire, which involved her being briefed on the city's classified defence scheme. Similarly, a medical woman from County Durham was asked to work as a colliery doctor and police surgeon for two years during the War on account of illness.

[190] Beryl Harding, 'The Emergency Medical Service', MWF *Journal* (October 1955), 250-254 (p.250).

medical service (EMS) at the beginning of the conflict.[191] They were reorganised to accept air-raid casualties of both sexes, with rules regarding the treatment of male patients being temporarily relaxed.[192] The Elizabeth Garrett Anderson Hospital became a casualty clearing station, and it was reported that the isolation of male and female beds became 'somewhat unimportant' during emergency situations.[193] Medical staff at the South London Hospital for Women similarly found it impossible to segregate patients in the aftermath of air-raids, and adopted a principle of keeping families together when their homes had been destroyed.[194]

At the height of the Blitz, medical women working in hospitals were forced to confront the devastating consequences of indiscriminate bombing on a daily basis. Anne McCandless, a medical woman from Southport who graduated in 1939, recalls the moment when she experienced V1 rockets, or 'doodlebugs', for the first time.[195] Looking at what they thought was a shot-down German plane out of the mess hall window, McCandless and her colleagues cheered, but they soon realised their mistake when 300 casualties arrived at the hospital an hour later: 'I was appalled by the widespread destruction […] we were living through a nightmare'.[196] McCandless worked 70 to 80 hours per week for six years, and was so exhausted by the end of the War that she resigned from her post to take 3 months complete rest.[197] Medical students were also exposed to the brutal realities of war; in her second year of clinical study in Liverpool, Jean Parry was asked to identify bombing victims.[198] Reflecting gendered attitudes to the violence of war, Parry's male colleagues had to undress and label the piles of bodies that filled the local school, whilst she was given the sensitive task of interviewing relatives.[199] She notes that this was the only distinction between the sexes that she experienced during the conflict.[200]

Several women doctors displayed outstanding bravery and courage when their hospitals suffered direct hits. In their discussion of female volunteers in the home guard, Penny Summerfield

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[191] Ibid., p.252. The Elsie Inglis Memorial Maternity Hospital in Edinburgh, and the Duchess of York Hospital in Manchester, were not commandeered by the EMS on account of their specialist status.

[192] Ibid.

[193] Ibid., p.253.

[194] Ibid.

[195] Liverpool Medical Society, *Women in Medicine during WW2*, p.15.

[196] Ibid.

[197] Ibid., p.16.

[198] Ibid.

[199] Ibid.

[200] Ibid.

and Corinna Peniston-Bird contend that air attacks on the home front made the gendering of conflict particularly hard to maintain during the Second World War.[201] A number of women doctors were called upon to embody the stereotypically male role of rescuer in the service of their patients. Laura Bateman, medical officer at the Brook Hospital in London, was awarded the George Medal in 1941 for her fearless actions in saving two of the hospital's maids.[202] Suspended from her ankles by a hospital porter, Bateman burrowed through the unstable wreckage to administer both casualties with an anaesthetic, showing little regard for her own safety.[203] Similarly, Alison McNairn, assistant medical officer at City General Hospital, Plymouth, was commended for her selfless bravery during an air-raid in March 1941.[204] McNairn was in charge of the children's ward when it suffered a direct hit, and she was buried to her neck in debris.[205] After she was released, McNairn refused treatment for her own injuries until all of the surviving patients had been attended to, and surgical operations had resumed.[206] After the major bombing raids of 1940 and 1941 had passed, the majority of hospital doctors returned to the monotony of routine practice. One woman doctor from Scotland remembers the exhaustion that she felt as the only consultant obstetrician for a city of over 40,000 people.[207] Similarly, Frances Martin, a medical woman from Liverpool, recalls that one of her lasting wartime memories was having to manage a mass outbreak of paratyphoid that had been spread by the consumption of cream cakes made at a local bakery [208]

For the majority of women doctors, medical work on the home front was unexceptional. Though many were given additional responsibilities, opportunities were far less varied than in the First World War, as comparatively fewer male doctors were called up to serve with the RAMC.[209] What is clear from these personal reflections is that the Second World War did much to disrupt the personal and professional lives of medical women. In spite of their existing commitments,

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[201] Penny Summerfield and Corinna Peniston-Bird, 'Women in the Firing Line: The Home Guard and the Defence of Gender Boundaries in Britain in the Second World War', *Women's History Review*, 9 (2000), 231-255.

[202] 'General Memoranda', MWF *Quarterly Review*, (July 1941), 69.

[203] Ibid.

[204] Ibid.

[205] Ibid.

[206] Six nurses, 19 babies, and one mother were killed in the blast. In 2006, McNairn's George Medal, and her two RAMC service medals, were sold at auction for £5,200. A cassette tape of McNairn's wartime reminiscences was also included in this lot, but it has not resurfaced in any public archive.

[207] Beryl Harding, 'The Emergency Medical Service', p.251.

[208] Ibid., p.17.

[209] Elston, 'Women Doctors in the British Health Services', p.360.

women doctors prioritised the needs of their local communities, selflessly volunteering their services as part of the war effort. Furthermore, married medical women also carried the burden of their domestic duties, caring for their own children, evacuees, elderly relatives, and, in some cases, their injured husbands without complaint.[210] The sacrifices made by women doctors during this period were not, for the most part, rewarded or recognised, and had a negligible impact on their ongoing professional development. As Elston notes, in the immediate post-war years, female practitioners at the beginning of their careers faced decreased opportunities, as many of the practical measures that supported the employment of married women disappeared.[211]

Medical women overseas

As Chapter Two examined, hundreds of medical women served across Europe during the First World War. In contrast, opportunities for women doctors to practise frontline medicine were extremely limited during the Second World War. This is largely due to the fact that the army operated a far more efficient medical service, and because all-female medical units such as the WHC and SWH were not re-established.[212] Following the humiliating military losses that had taken place between 1914 and 1918, army officials became more medically conscious, developing new techniques to preserve scarce human and material resources.[213] Close cooperation was formed between the medical and combatant branches of the armed forces, meaning that the shortages which had necessitated the mass mobilisation of medical women in May 1916 were not repeated.[214] Female practitioners sent overseas with the women's services primarily ministered to the minor ailments of administrative staff, whilst those fortunate enough to be attached to mobile RAMC units were rarely positioned near the frontline.[215] Though the WHC and SWH had proven to be

[210] One medical woman from Liverpool took on the responsibility of rehabilitating her husband after he suffered a brain injury during active service.

[211] Elston, 'Women Doctors in the British Health Services', p.382. The number of domestic workers were widely diminished by the increase in marriage and motherhood among all women in the post-war years. Similarly, the end of the War and the formation of the NHS combined to create an uncertain employment situation.

[212] Mark Harrison, *Medicine and Victory: British Military Medicine in the Second World War* (Oxford: Oxford University Press, 2004), p.2.

[213] Ibid.

[214] Ibid.

[215] Harrison notes that frontline medical units were more widely dispersed during the Second World War, as large concentrations of troops were at increased risk of aerial bombing.

unmitigated successes, the Second World War was defined by vastly different social and political circumstances. Not only had the woman's movement provided the organisational structure to make such an ambitious enterprise possible, but the propinquity of battlefields had meant that frontline casualties were easily accessible in 1914.[216] In contrast, widespread bombing of the home front, combined with the Nazis' rapid occupation of Europe, made travel increasingly difficult during the Second World War.[217]

In spite of this, members of the third generation of medical women were eager to follow in the footsteps of their predecessors. Marion Coleman, a woman doctor from Hull, wrote to the MWF in June 1940 to express her desire to serve overseas: 'Is there any chance of a medical woman's unit being formed for active service? I am healthy, + strong + no dependents, have little surgical experience, but lots of medical + anaesthetics'.[218] Florence Davies, who had qualified in 1939, similarly felt equipped to withstand the demands of the battlefield: 'I have been through two civil wars + a week of air raids in China […] I should be more at home amongst the rough and tumble of a front line aid post as I am used to bullets'.[219] Many medical women like Davies were desperate to immerse themselves in the 'rough and tumble' of the frontline; however, those that were sent overseas soon realised that the reality of military medicine was far from glamorous. The majority of complex injuries were treated by specialist surgical units in the field, and the rapidly changing nature of modern warfare meant that short periods of intense activity were often followed by months of acute boredom.[220]

Noel Fenton, a newly-qualified medical woman from Liverpool, was conscripted to serve with the women's services in July 1943.[221] Fenton was initially given the mundane task of overseeing routine sick parades, but following the D-Day landings, she was ordered to go to France with a RAMC unit.[222] After landing in Normandy, the unit set up a small tented hospital for allied

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[216] The SWH were officially affiliated with the National Union of Women's Suffrage Societies (NUWSS), which had over 500 local branches across the country. Approximately 92 medical women served overseas with the SWH between 1914 and 1919.

[217] On the home front, civilians were advised to avoid unnecessary travel as petrol was rationed and train services were dramatically reduced. Overseas, British passenger ships were routinely targeted by German submarines. Four medical women were lost at sea due to enemy action during the Second World War.

[218] Letter from Marion Coleman to Mabel Rew, 9th June 1940, SA/MWF/C.181.

[219] Letter from Florence Davies to Mabel Rew, 11th June 1940, SA/MWF/C.180.

[220] Harrison, *Medicine and Victory*, p.113.

[221] Liverpool Medical Society, *Women in Medicine during World War Two,* p.21.

[222] Ibid.

troops on the Bayeux-Saint-Lô road.[223] Casualties were evacuated down the line at dusk, and Fenton recalls working through the night to manage the steady stream of patients.[224] Whilst units stationed further inland treated head, chest, and abdominal wounds, Fenton and her colleagues treated less serious cases such as leg and arm injuries.[225] After the heavy fighting in the region had ceased, Fenton was redeployed to the Far East, but on arrival in India she found that there was little medical work for her to do.[226] In an effort to keep herself busy, Fenton enrolled herself on an anaesthetics course, assisting in routine operations until she was eventually demobilised in January 1947.[227] Though the latter half of her military service was relatively uneventful, Fenton's wartime experience did help her to secure a position as a supernumerary anaesthetics registrar on her return to England.[228]

Ivy Oates, a medical woman from Sheffield, also served with the RAMC in North Africa and India between December 1943 and April 1947.[229] Rather than dealing with gunshot wounds or bomb blast injuries, Oates recalls that the majority of her patients were soldiers riddled with malaria and tuberculosis.[230] Having escaped from Singapore through the Burmese mangroves, they arrived in India destined to die: 'all you could say was they died in a clean bed amongst their own people instead of rotting in the jungle, eaten by wild animals'.[231] Rather tellingly, given the unvarying nature of her medical work, one of Oates' lasting wartime memories was the voracious appetite of the local insect population.[232] Having safely stored an entire chocolate cake in a kitchen cupboard, she later returned to find it reduced to a pile of crumbs, with a trial of ants coming out of her front door.[233] Unlike Fenton, Oates' military service did little to benefit her post-war career. In joining the army she had given up her ambition to specialise in paediatrics, instead becoming a general practitioner.[234] When asked in 2005 if she ever regretted her decision, Oates replied in the

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[223] Ibid., p.22.

[224] Ibid.

[225] Ibid.

[226] Ibid.

[227] Ibid.

[228] Ibid.

[229] Ivy Oates, 'A Woman Doctor', part one to part five, <http://www.bbc.co.uk/history/ww2peopleswar/> [accessed 16th February 2021].

[230] Ibid., part three.

[231] Ibid.

[232] Ibid.

[233] Ibid.

[234] Ibid.

negative: 'I would probably have been a consultant and made much more money, and perhaps would have achieved more. But I don't know if I would have been a better person'.[235] Working in general practice exposed Oates to patients from all walks of life, allowing her to make a difference in her own community. Though she had little opportunity to expand her clinical skills whilst overseas, treating Japanese prisoners proved to be an edifying experience.[236]

For Isobel Allardyce, the final months of the War proved to be the busiest period in her overseas service. Having qualified in 1937, she was selected to serve with a mobile hospital unit jointly organised by the Red Cross and St. John's Ambulance Brigade in September 1944.[237] Rather than being for the benefit of allied troops, the hospital's 40 beds were solely for the relief of civilian casualties across Europe.[238] The unit was staffed by three doctors, one matron, one senior sister, eight registered nurses, 12 members of voluntary aid detachments, one cook, and two ambulance drivers.[239] Allardyce and her colleagues were initially sent to a dilapidated château in Normandy which had been converted into a small hospital by a French medical student.[240] The medical staff spent six weeks treating a variety of routine ailments, but it soon became clear that there was not enough work to keep everyone busy.[241] The same issue was encountered in Belgium and Holland, and it was not until the unit advanced to the German town of Kevelaer that they found themselves inundated with patients.[242] For the first time in six months the hospital's beds were full, as thousands of displaced people arrived by convoy each night.[243] Allardyce recalls watching 'crowds of ex-prisoners from the concentration camps in their blue and white striped suits wandering aimlessly along, with small bunches of lilac clutched in their hands'.[244] After the War was over, the unit remained in Germany, providing medical assistance to the town of Celle.[245] Positioned just 13 miles from Bergen-Belsen, the town was overrun with refugees, and within hours the unit's 52

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235 Ibid.

236 Ibid.

237 Liverpool Medical Society*, Women in Medicine during World War Two*, p.13.

238 Ibid. Allardyce notes that the unit was 'the first of its kind', but this is not strictly true. A small number of privately-funded units staffed by medical women were sent to Europe during the First World War with the primary objective of treating civilian casualties. See Leneman (1994).

239 Ibid., p.14.

240 Ibid.

241 Ibid.

242 Ibid.

243 Ibid.

244 Ibid.

245 Ibid., p.15.

beds had been filled.[246] In an effort to manage the chaos, the medical staff took charge of a large hospital, setting-up wards for ex-prisoners, children, and expectant mothers.[247] By June 1946, the majority of patients had been repatriated, and Allardyce returned to England.[248] Like Oates, Allardyce's pre-war ambition had been to specialise in paediatrics, but following her overseas service she too settled upon a career in general practice.[249] Having spent three years practising medicine across Europe in challenging conditions, it is possible that Allardyce felt unwilling to make any further personal sacrifices in pursuit of a hospital career.

Though the medical work carried out by woman doctors such as Fenton, Oates, and Allardyce was far more routine than the heroic exploits of their predecessors, their contributions were no less important. By demonstrating their ability to adapt at short notice, and by diligently carrying out their orders without complaint, they once again proved that medical women were eminently capable of operating within the masculine theatre of war. During the First World War, women doctors serving overseas had acted, for the most part, entirely independently from their male colleagues. They organised and planned their own medical response across Europe, carrying out surgical procedures with minimal monitoring or supervision from outside bodies. In contrast, the Second World War called for greater co-operation between the sexes, as medical women served alongside their male colleagues for the first time.

Medical women as prisoners

Whilst a number of women doctors actively sought opportunities to partake in the 'rough and tumble' of the battlefield, those who were already practising medicine overseas found themselves at the mercy of the Axis Powers in September 1939.[250] The rapid occupation of large swathes of Southeast Asia by Japanese forces led to the internment of approximately 130,000 allied civilian men, women and children during the Second World War.[251] The exact number of British medical

[246] Ibid.

[247] Ibid.

[248] Ibid.

[249] Ibid.

[250] The Second Sino-Japanese War had begun in July 1937, making the situation in the Far East extremely volatile.

[251] Bernice Archer, *The Internment of Western Civilians under the Japanese, 1941-1945, A Patchwork of Internment* (London: Routledge, 2004), p.5. For more on Japan during WW2, see: G. B. Endacott, *Hong Kong Eclipse* (Oxford: Oxford

women who were captured as prisoners is unclear; in 1938, 542 women doctors were listed in the 'overseas' section of the Medical Register, and in April 1939, the MWF reported to have 147 overseas members.[252] The experiences of western internees have received considerable historical attention; however, the work undertaken by British women doctors in internment camps has yet to be explored in any great detail.[253] This is primarily because only a very small number chose to share their experiences in the years following the war, likely because of the sheer scale of the horrors they were forced to endure; by 1955, only four medical women had answered the MWF's call for information, something which the Federation found 'deeply regrettable'.[254] Unique insights into the perilous position of women doctors practising in the Far East can be found in the pages of the *Quarterly Review*.[255] In January 1939, the Federation anticipated the wartime needs of its members practising outside of the United Kingdom by forming a dedicated overseas Association.[256] The founding aim of the Association was to facilitate the discussion and sharing of medical knowledge; however, it carried out a much more important role when war was declared by the Japanese in December 1941.[257] Margaret Balfour, who had been appointed as the

University Press, 1978); Haruko Taya Cook and Theodore F. Cook, *Japan at War: An Oral History* (New York: The New Press, 1992); Joseph Kennedy, *British Civilians and the Japanese War in Malaya and Singapore* (London: Macmillan, 1987); Louis G. Perez, *Japan at War: An Encyclopaedia* (Santa Barbara: ABC Clio, 2012).

[252] MWF Council Minutes, 30th April 1938; Ibid., 28th April 1939.

[253] For more on women interned in the Far East, see: Lynn Z. Bloom, 'Till Death us Do Part: Men's and Women's Interpretations of Wartime Internment', *Women's Studies International Forum*, 10 (1987), 75-83; Margaret Brooks, 'Passive in War? Women Internees in the Far East 1942-45', in *Images of Women in Peace and War*, ed. by Sharon Macdonald, Pat Holden, and Shirley Ardener (London: Macmillan, 1987), pp. 166-178; Sheila Allen, *Diary of a Girl in Changi 1941-45* (Kenthurst: Kangaroo Press, 1994); Peggy Abkhazi, *'Enemy Subject': Life in a Japanese Internment Camp 1943-45* (Stroud: Alan Hutton Publishing, 1995); Bernice Archer, 'The Women of Stanley: Internment in Hong Kong 1942-45', *Women's History Review*, 5 (1996), 373-399; Bernice Archer, *The Internment of Western Civilians under the Japanese, 1941-1945, A Patchwork of Internment* (London: Routledge, 2004).

[254] 'Work of British medical women in internment camps', SA/MWF/C.197. The Imperial War Museum recorded the personal reminiscences of a number of British women interned by the Japanese in the late 1970s and 80s, including several nurses, but no medical women participated.

[255] The 'Medical Women's Overseas Association News' section of the *Quarterly Review* included information regarding the whereabouts of British medical women as well as updates on clinical developments.

[256] Minutes of the Overseas Association Committee, 10th May 1939, SA/MWF/P.2.

[257] Japanese forces rapidly advanced across Southeast Asia; by March 1942, colonial communities in China, Hong Kong, Malaya, and the Dutch East Indies (modern day Indonesia) had been shattered.

Association's secretary, spent much of her time gathering information on the uncertain fates of British medical women overseas.[258] Snippets of news were then published by the MWF:

> Dr Agnes Mary Dunn (née Ramsbotham) with her week-old baby just succeeded in getting away from Singapore at the last moment.
>
> We hear from her sister that Dr Elizabeth Gibson chose to remain in Kuching after the invasion of Sarawak. Her husband has been reported missing, believed killed; but of Mrs Gibson there is no further news.[259]

The grave nature of the announcements highlight the impossible situation in which women doctors practising overseas found themselves. Medical women like Agnes Dunn were fortunate to escape in time; the majority of British citizens found themselves trapped by the advancing Japanese forces.[260] Both unwilling and unable to leave the countries to which they had dedicated their careers, women doctors were captured along with their compatriots, spending anywhere between 3 and 4 years in squalid internment camps.[261]

In spite of the extraordinary circumstances that they found themselves in, medical women interned by the Japanese displayed remarkable resilience, prioritising the welfare of their patients above their own feelings of despondency. Frances McAll, a medical woman from Edinburgh, was interned in China along with her husband and young daughter in March 1943.[262] Conditions inside Yangchow camp were dire; food was in constant short supply, there was no running water, and the toilet facilities for hundreds of prisoners consisted of a row of buckets.[263] Knowing that their medical expertise would be crucial in preventing outbreaks of disease, McAll educated her fellow internees on matters of infant welfare, whilst her husband took on the role of public health officer.[264] When a 16-year-old boy developed appendicitis, McAll was tasked with giving the anaesthetic in conditions wildly different to those she had experienced at medical school: 'we were

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[258] Minutes of the Overseas Association Committee, 2nd July 1942.

[259] MWF *Quarterly Review*, April 1943, 80.

[260] Eileen Smyly (1894-1987) managed to escape China in December 1941. Due to a lack of space on the boat, she was forced to leave her colleague, Mary Gell (1894-1978), behind. For more on the difficulties of civilian evacuation from the Far East, see Archer (2004).

[261] Medical women in China and Hong Kong were interned in late 1941, whilst those practising in Malaya were not captured until February 1942.

[262] Frances and Kenneth McAll, *The Moon Looks Down* (London: Darley Anderson, 1987), p.37.

[263] Ibid.

[264] Ibid.

not equipped to undertake emergency surgery […] between us we possessed one pair of surgical gloves, two pairs of artery forceps, one scalpel and a very small bottle of chloroform'.[265] Miraculously, given the absence of any antiseptics or antibiotics, the boy went on to make a full recovery.[266]

McAll and her family were later moved to a condemned factory in Shanghai which held 1200 internees, including 200 women and 40 children under 18 years of age.[267] As the only woman doctor, McAll was given the responsibility of overseeing the welfare of the camp's children, a gendered decision which reflects the fact that female practitioners continued to be viewed as the most appropriate medical attendants of their own sex.[268] The Japanese had banned the use of all electrical equipment apart from the hospital's steriliser, so when a baby was born in freezing conditions in January 1945, McAll was forced to warm him over an illicit hotplate.[269] As a result of acute boredom, hunger, and apprehension, the camp's doctors faced increasing resistance from their fellow internees as the War dragged on.[270] McAll recalls that the innocuous suggestion of eating potato skins for their extra vitamin B content caused a minor riot, as people were unwilling to give up their last shred of freedom.[271] Similarly, McAll was accused on three separate occasions of hoarding luxuries such as sanitary towels, laxatives, and milk powder because of her privileged position as a doctor.[272] In September 1945 the camp was liberated, and following her return to England McAll setup in general practice.[273] Though she had suffered during her interment, at one point almost dying from anaphylaxis, McAll did not permit herself to become dispirited.[274] By remaining positive in the face of overwhelming adversity she fulfilled an integral role in the camp, ensuring that those under her care did not lose hope.

As well as overseeing the general health and welfare of women and children, medical women also carried out extensive scientific research during their time spent as prisoners. After

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[265] Ibid., p.39.

[266] Ibid.

[267] Frances McAll, typed report, 27th October 1952, SA/MWF/C.195.

[268] Ibid.

[269] Ibid.

[270] Ibid.

[271] Ibid.

[272] Ibid.

[273] Frances and Kenneth McAll, *The Moon Looks Down*, p.89.

[274] McAll was picking castor beans when she got a splinter stuck under her thumb. Within minutes she had gone into anaphylactic shock due to the ricin, and had to be injected with adrenalin.

qualifying in 1923, Annie Sydenham left England to work as an anaesthetist and obstetrician with the London Missionary Society in Hong Kong.[275] In December 1941, Sydenham was interned in Stanley camp along with 2500 other western civilians.[276] Among them were 40 doctors, three of whom were female, and 100 trained nurses.[277] Given her extensive medical experience, Sydenham was appointed as welfare officer to the camp's 400 children.[278] The role involved conducting periodical examinations in order to monitor their physical condition, with the neediest being assigned extra food rations.[279] Internees survived on a semi-starvation diet, largely consisting of rice, thin fish soup, boiled lettuce, root vegetables, and a small amount of bread.[280] Sydenham's survey of 92 boys and 96 girls aged between five and 17 years reveals that adolescent boys were the most affected by malnourishment, being on average 31 lbs lighter than the normal weight for their age group.[281] While all of the children in Stanley were underweight, the majority remained healthy and happy under Sydenham's watchful supervision: 'one hopes and believes that the children have not suffered any permanent damage to their health […] and they should not have suffered psychologically either, for their lives were on the whole free from care' (Figure 4.3).[282] In addition to her nutritional surveys, Sydenham also investigated the effects of internment on menstruation.[283] In a study of 436 women and girls aged between 15 and 45, she found that 53.7 per cent suffered from prolonged amenorrhea.[284] Reporting her findings in the *BMJ* in 1946, Sydenham argued that the emotional shock of war, coupled with the inevitable effects of

[275] Annie Sydenham, typed report, 9th April 1950, SA/MWF/C.195.

[276] Ibid. Unusually, Sydenham's internment was reported in the *Daily Herald* under the title 'Little Annie is Prisoner'. Though Sydenham was 48 years old in 1942, 'Little Annie' was her nickname from the Westminster Congregational Church. For more on Stanley internment camp, see: Archer (1996, 2004), and Emerson (2008).

[277] Bernice Archer, *The Internment of Western Civilians under the Japanese*, p.128. The identities and nationalities of the other two female doctors are unknown.

[278] Annie Sydenham, typed report, 9th April 1950. There were approximately 300 children in Stanley aged between 6 and 16 years, and 100 children under five years of age. Approximately 50 babies were born during interment.

[279] Ibid.

[280] Ibid.

[281] Ibid. Girls aged between five and seven years were least affected, averaging only 2 lbs under their desired weight.

[282] Ibid. Only two deaths of children were reported during interment – one from coeliac disease, and one from drowning.

[283] Ibid.

[284] Annie Sydenham, 'Amenorrhoea during Internment', *BMJ*, 2 (3rd August 1946), 159.

malnourishment, caused women's menstrual cycles to become severely disrupted.[285] Interestingly, the lack of adequate nutrition did not affect the health of babies born in the camp; six girls and seven boys were born in 1944, with birth weights ranging from 5 lbs 12 ozs to 9 lbs.[286] The importance of Sydenham's work cannot be underestimated; the scientific surveys she conducted not only benefited the patients under her care during internment, but they also contributed to the advancement of medical knowledge following her release. After being freed from Stanley in August 1945, Sydenham spent 12 months recuperating in England before returning to her missionary work in Hong Kong.[287] In spite of her personal and professional sacrifices, Sydenham's work in Hong Kong went unrecognised by the British government.

Figure 4.3 Children at Stanley Internment Camp, Hong Kong, September 1945 (Imperial War Museum).

[285] Ibid. Sydenham's assertion that malnutrition played a role in the amenorrhea she recorded in the camp was contested by another doctor in the *BMJ*. He argued that an excess of adrenaline was likely the primary cause. See N. Sher, 'Amenorrhea during internment', *BMJ*, 2 (7th September 1946), 345.

[286] Ibid.

[287] 'Annie Sydenham', Outward Passenger Lists 1890-1960, 14th September 1946, <www.ancestry.co.uk> [accessed 10th March 2021].

Cicely Williams, a medical woman who had dedicated her career to the colonial medical service, similarly carried out nutritional research during her interment in Malaya.[288] Following the Japanese occupation of Singapore in February 1942, Williams was interned in Changi camp along with five other medical women and 70 nurses (Figure 4.4).[289] The former prison was built to hold 600 people, but was used to accommodate 3000 internees.[290] Memoirs written by other female internees following their release from Changi offer rare insights into how the medical women were viewed by their fellow campmates. Margaret Hopkins was described as being 'extremely irritating […] slightly aloof and therefore arrogant seeming […] but also courageous, clear-headed and responsible', while Helen Worth was reported to be 'very determined (her enemies said pig-headed)'.[291] In her position as camp nutritionist and female commandment, Williams was held in high esteem, receiving the accolade of being 'the most brilliant and original of all the women internees'.[292] It is interesting to note that any complex medical cases, or those that required surgical intervention, were referred as a matter of routine to the male doctors held in Changi.[293] Though women doctors often held positions of authority in internment camps on account of their professional standing, the medical duties they undertook largely centred on welfare and education. It is possible that medical women were reluctant to expand the scope of their roles because they felt underqualified, having spent the majority of their careers practising medicine outside of the United Kingdom.[294] Williams recalls that she spent the majority of her internment consumed by thoughts of food: 'hunger was not only distressing as a sensation, but was generally accompanied by feelings of insecurity and anxiety. There was […] an inescapable obsession with fantasies of nice food – a perpetual occupation and therefore a perpetual frustration'.[295] Like Sydenham,

[288] Whilst working with acutely ill children in Ghana between 1929 and 1936, Williams had caused controversy in the *Lancet* by asserting that Kwashiorkor [severe protein malnutrition], rather than Pellagra [severe vitamin B3 deficiency], was the primary cause of child mortality in the region.[288] In 1939, she famously condemned the nefarious actions of condensed milk companies in a lecture entitled 'Milk and Murder' in 1939.[288] For more on Williams, see: Ann Dally, *Cicely, The Story of a Doctor* (London: Gollancz, 1968).

[289] Three of the medical women were British - Helen Isobel Worth (1899-1969), Margaret Elinor Hopkins (1899-1974) and Patricia Ruth Elliott (1887-1950).

[290] MWF, 'Work of British Medical Women in Internment Camps', typed manuscript, SA/MWF/C.197.

[291] Mary Thomas, *In the Shadow of the Rising Sun* (Singapore: Maruzen, 1983), p.44.

[292] Ibid., p.46.

[293] MWF, 'Work of British Medical Women in Internment Camps', typed manuscript.

[294] One of the key concerns of the MWF's overseas Association was that medical women found it difficult to stay informed of the latest clinical developments whilst practising outside the United Kingdom.

[295] Cicely D. Williams, 'Nutritional Conditions among Women and Children in Internment in the Civilian Camp at Singapore', *Proceedings of the Nutrition Society*, 5 (1946), 359-61 (p.360).

Williams found that female internees suffered from vitamin deficiencies, diarrhoea, giddiness, nocturnal enuresis [involuntary urination], disrupted menstruation, and anaemia as a result of their poor diet.[296] In October 1943, Williams was arrested without explanation and taken to the Kempeitai headquarters where she was imprisoned for six months.[297] Though she was not physically tortured, Williams was kept in a filthy cell close to those who were: 'I do not think there was half-an-hour without the screaming of men and women […] the feelings of claustrophobia were overwhelming […] one felt that nothing could ever make life normal and wholesome again'.[298] On her release from Changi in September 1945, Williams had lost a third of her body weight, and suffered from the effects of beriberi [severe vitamin B1 deficiency] for the rest of her life.[299] Like Sydenham, she refused to give up her overseas work, returning to Malaya in 1948.[300]

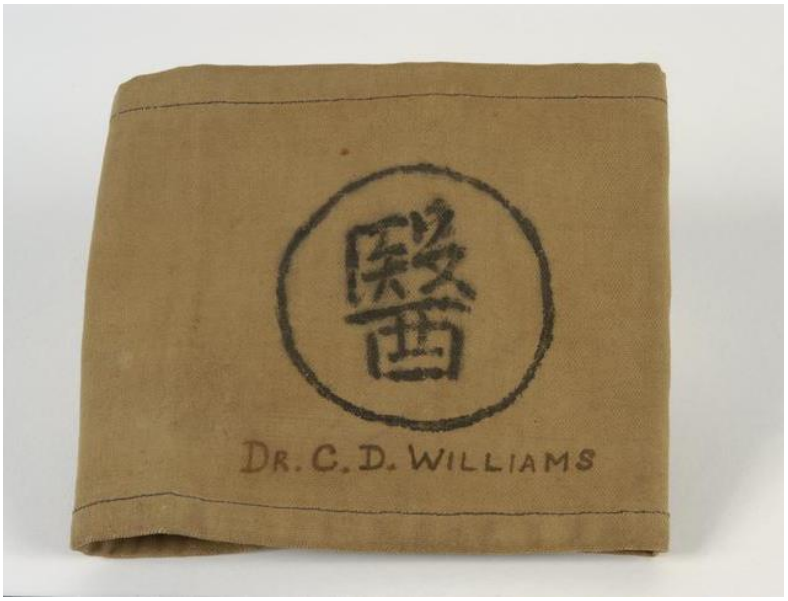

Figure 4.4 Arm band worn by Cicely Williams in Changi internment camp (Imperial War Museum).

Whilst it is arguable that medical women played a far more influential role overseas during the First World War, tending to the injuries of thousands of allied soldiers, the work undertaken

[296] Ibid.

[297] MWF, 'Work of British Medical Women in Internment Camps', typed manuscript.

[298] Ibid.

[299] Ibid. Williams was appointed as head of the maternal and child health division of the World Health Organization in 1948, and later oversaw an international survey into the effects of Kwashiorkor. She was awarded the Companion of the Order of St. Michael and St. George in 1968 in recognition of her life's work.

[300] Ibid.

by their successors in Europe and the Far East between 1939 and 1945 was by no means insignificant in comparison. In many ways, it served to prove that the successes of women doctors during the First World War had not been fortuitous – female practitioners were eminently capable of assuming typically masculine roles. Medical women serving with the army effortlessly integrated themselves within the military establishment, demonstrating their ability to co-operate with their male colleagues. Similarly, as prisoners, women doctors such as McAll, Sydenham, and Williams displayed the same unwavering tenacity and fortitude as their male counterparts, refusing to be defeated in the face of extraordinary suffering. Though medical women captured as prisoners were, for all intents and purposes, left to their own devices, it is telling that few deviated from their primary areas of expertise. Unlike their predecessors who had boldly operated across Europe with varying levels of experience, women doctors interned in the Far East were reluctant to expand the scope of their practice. This could have been for personal or professional reasons; continuing to carry out familiar work whilst living under brutal conditions may have been used as a form of self-preservation. Similarly, it is likely that medical women with established overseas careers were unwilling to jeopardise their reputations by carrying out unfamiliar procedures, especially in situations where more qualified practitioners were readily available.

Conclusion

The Second World War presented the MWF with a unique opportunity to reassert its dominance as a professional organisation. Having been founded in the midst of the First World War two decades previously, the Federation had struggled to come to terms with its failure to secure full commissions for women doctors in the army. Facing another impending national crisis, the MWF were determined that the services of women doctors would not be overlooked by the government again. In spite of the MWF's best efforts, the government refused to clarify what role, if any, medical women would play in the conflict, dismissing the authority of the Federation in favour of the BMA. In an effort to remain abreast of the latest developments, the Federation were forced to rely on 'insiders' such as Fairfield for fragments of information, placing additional pressure on the already strained relationships between senior medical women. Individual members of the War Services Committee became increasingly desperate, attempting to involve themselves in classified proceedings in spite of their limited military experience. Though the misguided actions of Sandes and Shelley never became public knowledge, their frivolous disregard for the Federation's reputation led to disunity festering within the highest ranks of the organisation.

The majority of female practitioners were in favour of accepting commissions in the women's services; however, senior members of the Federation refused to accept anything less than complete equality for women doctors in the RAMC. In failing to learn from its previous mistakes, the MWF alienated many of its younger members, undermining its position as the representative body of women doctors. The Federation demonstrated dogged determination in its pursuit of commissioned rank for medical women, but ultimately remained blind to the fact that achieving meaningful change within the masculine military establishment could not be rushed, and had to be tackled with a measured approach. Following further negotiations between the MWF, BMA, and the War Office, short-term commissions in the army's medical services were eventually granted to female practitioners in June 1950.[301]

In spite of the MWF expending the majority of its focus and energy on pressuring the War Office into action, the Federation recognised the importance of adapting to meet the changing needs of its membership during wartime. Local Association meetings and the *Quarterly Review* proved to be lifelines for medical women across the country, allowing them to stay connected with their colleagues and professional organisation during a time of extraordinary change. As had been the case in the First World War, medical women fulfilled an integral role on the home front during the Second World War. They were exposed to the realities of frontline warfare for the first time, often overlooking their own personal safety in the service of their local communities. Unsurprisingly, given the sheer scale of indiscriminate civilian bombing, women doctors were among the thousands of victims of air raids; between October 1940 and June 1944, 12 medical women lost their lives on the home front.[302]

The testimonies of medical women highlight that many did not view the Second World War as a watershed moment in their careers; after the bombs had ceased to fall, they continued their professional lives as normal. There are multiple possibilities as to why the sacrifices made by women doctors were not widely recognised either during or after the War.[303] Unlike ambulance

[301] Short-term commissions in the RAMC lasted eight years. Women doctors were awarded the same rank and titles as men.

[302] 'Names of Medical Women who lost their lives in the Second World War', undated typed list, SA/MWF/C.189. In addition to those who were killed in air raids, five women doctors died at sea, and five were killed during active service with the RAMC. In contrast, 542 medical men lost their lives. A war memorial for medical practitioners was unveiled at the BMA headquarters in November 1954, with representatives from the MWF attending the dedication.

[303] See: Debra Marshall, 'Remembering Women: Envisioning More Inclusive War Remembrance in Twenty-First-Century Britain', in *Lest We Forget, Remembrance & Commemoration*, ed. Maggie Andrews, Charles Bagot Jewitt and Nigel Hunt (Stroud: The History Press, 2011), pp.197-202.

drivers, munitions workers, and members of the Auxiliary Territorial Service (ATS), the work of medical women on the home front was far more understated and less publicly visible. Similarly, medical practitioners, whether male or female, were expected to simply get on with the task at hand – namely safeguarding the health of the civilian population. Mental and physical exhaustion were at the forefront of women doctors' experiences. In 1951, 60 per cent of retired medical women were aged less than 55, suggesting that the gendered impact of the War, along with a lack of professional opportunities, may have contributed to some extent towards early retirement.[304]

Unlike in the First World War, the medical work undertaken by women doctors overseas was not defined by daring exploits or complex surgeries. Due to increased gatekeeping by military authorities and the drastically different political situation which existed across Europe, medical women had very few opportunities to practise frontline medicine during the Second World War. Those who were selected to serve with the RAMC or civilian relief organisations often found themselves with nothing to do, as military priorities were constantly changing. Though there were limited opportunities for women doctors to expand the scope of their work whilst overseas, they proved themselves to be equal to their male colleagues in other ways. Medical women who were already practising in the Far East at the outbreak of war faced an impossible decision – remain where they were and find themselves at the mercy of the advancing Japanese forces, or abandon their work and risk the perilous journey back to the United Kingdom. The women doctors who were either unwilling, or unable, to escape their adopted communities paid a heavy price; conditions in prisoner of war camps were appalling, leaving internees with a variety of long-term health conditions.[305]

Having represented the rights and interests of medical women for almost seven decades, the MWF arguably faced its most demanding challenge to date as the Second World War drew to a close. As the Afterword to this thesis examines, proposals for a new system of free and universal healthcare promised to drastically transform the British medical profession, and the extent to which the views of women doctors would be taken into consideration by the government relied heavily upon the Federation's diminished negotiating power.

[304] Elston, 'Women doctors in the British Health Services', p.55.

[305] See Archer (2004).

Afterword

This thesis reveals the work undertaken by the MWF over a seventy-year period, offering unique insights into the experiences of the first, second, and third generations of medical women. In doing so, it redresses many of the gaps in knowledge that currently exist in the history of medicine, and, more generally, makes an original contribution to the field of women's history. Whilst the Federation played an important role in the personal and professional lives of women doctors, it ultimately failed to become capacity building and to significantly increase its membership. There are many possible reasons as to why the MWF remained unable to fulfil its potential. Senior members such as Jane Walker remained in place for decades, leading to a lack of new voices and a tendency for outdated ideals to remain unchallenged. Similarly, it is likely that some medical women remained unconvinced that membership of the Federation was worthwhile, as the organisation's influence within the profession and wider society was negligible in comparison to the BMA. The MWF never fully abandoned its self-conscious ambition to replicate the reputation and standing of the BMA, which often led to the needs and views of its younger members being overlooked. Furthermore, the Federation's leadership were selective when it came to the issues that they were willing to publicly address, and it is clear that the organisation did not go far enough when it came to tackling controversial subjects such as women's suffrage and birth control. Factionalism within the MWF remained an ever-present issue, as senior medical women struggled to balance the tensions between self-interest and collaboration. This being said, the Federation remained committed to achieving equality for women within the medical profession, and whilst progress was slow, the organisation made significant inroads in expanding the professional opportunities available to women doctors.

At the beginning of the period covered by this thesis there were 10 members of the ARMW, and the names of just 15 women were present on the British Medical Register.[1] In 1948, the MWF boasted over 2000 members, and approximately 8000 women were qualified to practice medicine in the United Kingdom.[2] This thesis sheds new light on the complex struggle that lies behind these statistics. The difficulties which women doctors faced in their efforts to integrate

[1] Minutes of the Annual Meeting, 4th May 1880.

[2] Mary Ann Elston, 'Women Doctors in the British in the British Health Services: a Sociological Study of their Careers and Opportunities', unpublished doctoral thesis, University of Leeds, 1986, p.57. In May 1947 the MWF's membership stood at 2177, and this had increased to 2227 by October 1949. It is likely that the formation of the NHS led to this not insubstantial increase in membership.

themselves within the profession have been implicit throughout this thesis, and the strategies which they adopted to overcome these barriers have been discussed. The ARMW was crucial to supporting the careers of the first generation of women doctors who qualified in the late nineteenth century. Having been barred entry to the BMA, female practitioners found themselves isolated from their professional colleagues, and were unable to participate in, or benefit from, exchanges of medical knowledge. By forming their own professional Association, women doctors solidified their position within the field, refusing to be defeated by their male colleagues' exclusionary tactics. As this thesis demonstrates, the ARMW struggled to fulfil its aims of establishing itself as an authoritative body within its first 30 years, with concerns over the professionalism of publicity restricting the organisation's response to political matters. Though the Association's early achievements were limited, the organisation was by no means ineffective. The ARMW's continued presence within the profession after women were eventually accepted into the BMA in 1892 was immensely important; female practitioners remained a minority within the profession, and there was still much work to be done.[3]

The case studies interweaved throughout the chapters of this thesis provide a collective biographical account of the lives of ordinary medical women at different stages of their careers, illuminating aspects of medical history which had yet to be explored. In Chapter One, the case studies of Eliza Frikart and Annie Reay Barker offer new perspectives on the experiences of first-generation medical women. Narratives of success have, until recently, dominated discussions of early women doctors. By refusing to follow this trope, and by considering the 'failures' which have previously been erased from the historical record, this thesis takes into account the wider issues which affected early women doctors. Similarly, in Chapter Two, the diaries and letters of Muriel Lloyd shed new light on the experiences of medical women who graduated during the First World War. Whilst the daring feats of the WHC and SWH are well documented, comparatively little was known about the unremarkable medical women who were left behind, or how they viewed the work being undertaken by their colleagues across Europe. Lloyd's letters reveal that she felt a number of conflicting emotions when she narrowly missed out on being selected to serve with the WHC – jealousy, anger, and perhaps, in a small part, relief.

As Chapter Two investigates, the First World War marked a defining turning point for medical women; posts which had previously been closed became available, allowing female practitioners to expand the scope of their practice. For many women doctors, the increased responsibility which they were given during the War was both terrifying and exhilarating in equal

[3] Tara Lamont, 'The Amazons Within: Women in the BMA 100 years Ago', 1531.

measure. Letters written by members of the Association reveal not only the variety of work undertaken by female practitioners during the War, but also the extent to which their services were taken advantage of by the government. Whilst the War Office were reluctant to employ the services of medical women in any official capacity, women doctors played an instrumental role in keeping civilian medical services running, a fact which remained the case two decades later when the country faced its second international conflict. In an effort to safeguard the future of the organisation, the ARMW evolved into the MWF in 1917.[4] This thesis corrects many of the misguided assumptions that existed in relation to how, and perhaps more importantly why, the Federation was formed. Whilst the ARMW were eager to capitalise on the momentum created by the unequal treatment of medical women by the War Office, it was not the primary impetus behind the new organisation. Senior members of the organisation were anxious that membership numbers remained low, and feared that the organisation's influence in matters of public policy would be thwarted if women doctors did not join together as one. The MWF's failure to secure commissions for women doctors proved to be a devastating blow, one which undoubtedly affected the confidence and authority of the organisation in the decades which followed.

Through its chronological structure, this thesis not only charts the evolution of the MWF as a professional organisation, but also outlines the shifting political and social contexts with which medical women had to contend. Following the end of the First World War, nearly all of the professional freedoms which women doctors had previously enjoyed disappeared. The interwar years were defined by widespread inequalities within the profession, and the return of male doctors from the front was used as justification for the reinstatement of marriage bars and unequal pay in public health appointments. In response to the difficulties which medical women faced, the Federation made significant efforts to advance the careers of its members through advocacy and financial support. Having learnt from its previous mistakes, the MWF showed greater understanding when it came to the difficulties facing its membership. Rather than ostracising members who accepted positions with insufficient remuneration, the Federation instead focused its efforts on educating new graduates on the importance of not undercutting their male colleagues. As this thesis highlights, the 1920s and 30s represented a period of unprecedented change for the medical profession. Pioneering research conducted by women doctors sought to undermine the outdated assumptions which pathologised the female body. Whilst the MWF had a vested interest in changing both medical and social perspectives of women's health, professional disagreements

[4] Annual Report, 1917-1918, SA/MWF/B.1/1.

between local Associations diminished the Federation's efforts to be at the forefront of menstrual re-education.

One of the most unique aspects of this thesis is its wide-ranging period of enquiry. By choosing to go beyond the 1920s and 30s, it interrogates previously uncharted territory – namely the experiences of the third generation of medical women during the Second World War. As Chapters Two and Four demonstrate, a number of similarities can be drawn between the government's treatment of medical women during the First and Second World Wars. In spite of the progress that had been made within the profession, women doctors were still viewed by the government as being incapable of coping with the realities of war. Before the outbreak of the Second World War, the MWF had carefully planned how it was going to continue to support its membership during a time of extraordinary change. By ensuring that local Associations continued to meet, and by continuing to publish the *Quarterly Review*, the organisation helped medical women to navigate the uncertain times that they were living through. Both at home and overseas, women doctors carried out their work without complaint, proving themselves, once again, to be capable and diligent practitioners. Similarly, as prisoners in the Far East, medical women displayed remarkable bravery, maintaining the health of their fellow countrywomen until their release. The personal and professional sacrifices of women doctors both at home and abroad went largely unrecognised by the government, and have, until now, not received the attention that they deserve. By shedding new light on the experiences of medical women during wartime, this thesis has done much to redress the gender imbalance which has previously existed within military history.

Another important aspect of medical history which this thesis addresses is the MWF's relationship with the BMA. Though the Association eventually grew to accept and acknowledge the Federation's presence within the profession, a harmonious partnership between the two organisations was never truly realised. As Chapters One and Three investigate, the BMA and the MWF worked together to tackle the issue of unequal pay in the early twentieth century. Although the BMA banned the publication of advertisements with insufficient remuneration in the *BMJ*, the Association did not use its influence to tackle the systemic prejudices that continued to exist against women doctors within the profession. Similarly, Chapters Two and Four analyse the MWF's efforts to gain commissions for women doctors serving with the RAMC. Whilst the BMA assisted the Federation in winning tax relief for its members in 1918, the Association did relatively little to advance the cause of equality within the armed services during either of the World Wars.[5] The

[5] Whitehead, *Doctors in the Great War*, p.113.

BMA had a close working relationship with the War Office, but ultimately did not share the MWF's belief that the services of medical women should be utilised within the masculine theatre of war.

The underrepresentation of medical women on the various professional committees organised by the BMA remained an ever-present issue during the post-war years; in the Association's opinion, the views of medical women were not requiring of special consideration. As early as October 1940, the BMA had formed a planning commission to discuss how the War would affect the future provision of medical services.[6] The commission consisted of 72 members with representatives from each of the royal colleges; however, the MWF were only permitted to appoint four members, making up just five per cent of the committee.[7] In September 1944, a further negotiating committee was set up by the BMA to debate the terms of the new National Health Service (NHS) with the Minister for Health, Aneurin Bevan.[8] The committee consisted of 32 members, half of whom were representatives from the BMA.[9] Whilst each of the royal colleges were permitted to appoint between two and three members to sit on the committee, the MWF was only invited to appoint one.[10] Once again, women doctors made up less than five per cent of the committee's membership. It further transpires that Mary Esslemont, who was chosen to act as the Federation's representative, was excluded from a number of private dinners attended by Bevan and select members of the negotiating committee in 1945.[11] In spite of the fact that the MWF represented the rights and interests of approximately 16 per cent of the medical profession, the BMA remained reluctant to join forces in any meaningful way, instead choosing to dismiss the specific issues which would affect female practitioners by monopolising the profession's response to the NHS bill.[12] Ultimately, the BMA exuded a clubbable male culture and this proved difficult for the MWF to penetrate.

As this thesis evidences, one of the MWF's greatest deficiencies during its early years was its refusal to publicly respond to issues that it deemed to be too controversial. Concerns over safeguarding the Federation's public image led to the organisation remaining silent on a number of political and medical matters which directly affected its membership. Chapter One investigates the ARMW's reluctance to engage with the women's suffrage movement in the medical and lay

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[6] MWF Council Minutes, 25th October 1940.

[7] Ibid., 26th March 1942.

[8] Ibid., 22nd September 1944.

[9] Kate Harrower, 'The BMA and the National Health Service Act', *MWF Journal*, April 1947, 20-23 (p.23).

[10] Ibid.

[11] Marvin Rintala, *Creating the National Health Service* (London: Taylor and Francis, 2004), p.99.

[12] Elston, 'Women Doctors in the British Health Services', p.63.

press. Similarly, Chapter 3 scrutinises the MWF's unwillingness to make any public statement on the subject of birth control. Whilst the Federation displayed an unwavering commitment to its public battle of wills with the War Office, the organisation evidently felt that it would be unwise to engage with matters that fell outside its immediate sphere of influence. This remained the case in the post-war years; although the government's NHS bill promised to revolutionise the provision of medical care in the United Kingdom, the MWF decided against making any public statements on the proposed plans. Given that the Federation had spent the past 70 years advocating for issues which affected its membership, its decision to remain silent on such an important subject is staggering. Concerns regarding the geographical restrictions placed on general practitioners, the availability of part-time work, and the retirement age of women doctors were discussed in private meetings of the Executive Council, but as they were not raised in the public sphere, they remained, for the most part, inconsequential.[13]

As had previously been the case, it was left to individual members of the MWF to take decisive action on behalf of their professional colleagues. Reflecting the modernisation of the professional ideals which had previously sought to supress public expressions of opinion, medical women were amongst the hundreds of practitioners who chose to comment on the proposed NHS in the correspondence section of the *BMJ*.[14] Zoe Harris, a general practitioner from Norfolk, argued that if doctors refused to sign certificates for patients, the government would be forced into amending the act: 'we feel confident that the government could not hold out for more than one or two weeks because of the resulting chaos'.[15] Ethel Vaughan Williams, a long-standing member of the Federation, was similarly critical of the BMA's handling of the situation, stating that the organisation's weakest chain in its opposition to the proposed scheme was that they had failed to draw up a coherent alternative plan – 'what is to take its place?'.[16] Betty Hill, a general practitioner from Reading, likened the threat posed by the act to 'the hot breath of some devouring animal upon us'.[17] Whilst members felt that their professional freedoms would soon be ravaged by the government, the MWF ultimately offered very little protection against the 'devouring beast'. Thus, women doctors played a relatively insignificant role in the formation of the health service in 1948. As Mary Ann Elston notes, once the NHS was established, female practitioners faced an

[13] MWF Council Minutes, 6th April 1946; Ibid., 10th April 1948.

[14] Between the 1st January 1948 and the 5th July 1948, over 1000 letters on the subject of the NHS were published in the *BMJ*.

[15] Zoe Harris, 'The National Health Service', *BMJ,* 1 (7th February 1948), 272.

[16] Ethel Vaughan Williams, 'The National Health Service', *BMJ*, 1 (21st February 1948), 272.

[17] Betty Hill, 'The National Health Service', BMJ, 1 (27th March 1948), 613.

uphill battle to progress their careers.[18] An initial surplus of practitioners led to concerning levels of unemployment in the early 1950s, meaning that the lack of opportunities available to medical women were not viewed as a priority.[19] In spite of the progress which had been made since women first entered the profession in the late nineteenth century, medical women remained a minority, and continued to face many of the same prejudices and barriers within the new healthcare system.

Beyond the history of women in medicine, this thesis also makes a wider contribution to the study of gender ideology and feminism by providing new insights into the changing status of women in society during a period of unprecedented change. It charts the issues which medical women engaged and negotiated with both publicly and privately over a seventy-year-period, interrogating the influence of factors such as gender, class, and the ideals of professionalism. As a result, innovative connections have been made between medical women and other female professionals, advancing the field of gender studies. Like female teachers, women doctors sought to both expand and exploit the binary opposition of gender equality versus gender difference, arguing that they were both intelligent individuals worthy of pursuing a medical education, and at the same time, the most appropriate medical attendants of their own sex.[20] The case study of the MWF and the experiences of first, second, and third generation medical women further elucidates the strategies employed by women seeking to establish themselves within a stereotypically masculine sphere of work, and demonstrates how these strategies evolved over time in response to the issues that they faced. In doing so, it sheds new light on the intricate balance between politics, feminism, and professionalism with which women had to contend, and the complexities behind challenging ingrained gender stereotypes whilst attempting to forge new professional identities. This thesis lays the foundation for future research to be conducted on women's entrance into different fields of work, and the ways in which women navigated both homosocial and heterosocial communities.

Through its analysis of the tensions which existed within this group of women, this thesis also provides novel perspectives on the history of power and organisational cultures. As was the case with other female-led organisations formed in response to women's exclusion by men, the MWF relied heavily on male models of procedure and internal relationships.[21] On the surface,

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[18] Elston, 'Women Doctors in the British Health Services', p.384.

[19] Ibid.

[20] Dina Copelman, *London's Women Teachers: Gender, Class, Feminism, 1870-1930* (London: Taylor & Francis, 2013), p.9.

[21] See, for example: David Doughan and Peter Gordon (eds*), Dictionary of British Women's Organisations, 1825-1960* (Oxon: Routledge, 2001).

women doctors united against the male medical establishment; however, this thesis evidences the fact that a less convivial atmosphere was also present behind closed doors. Far from being a sympathetic sisterhood, the MWF experienced widespread division, exacerbated by the rigid hierarchy of power that was present within the organisation. The study of medical women thus raises important issues in relation to conflict, especially conflict between women and professional colleagues. As this thesis has demonstrated, the Federation's influence and effectiveness was ultimately limited by its refusal to acknowledge the tension which existed within its ranks, which further amplified the polarisation between male and female doctors. The MWF offers a unique lens through which to scrutinise how middle-class women navigated conflict and competition in a newly formed professional marketplace, and the power dynamics at play within female-led organisations. Furthermore, wider conclusions can be drawn in relation to organisational cultures in general and the self-limiting effects that factionalism can inevitably have on a movement's ability to become capacity building.

This thesis scrutinises how the MWF aided the integration of medical women within the profession, how the barriers the organisation faced changed over time, and how changing political and social contexts affected the professional lives of female practitioners. These efforts notwithstanding, there remain areas of enquiry that still require further consideration. This thesis has been limited to the centralised work of the Federation within the United Kingdom, but future studies of specific local Associations, such as the Yorkshire or Liverpool branches, would offer new regional perspectives on the experiences of women doctors during this period.[22] There are other specific subjects which this thesis has only touched upon that would similarly benefit from closer examination. The Federation's engagement which issues such as the National Insurance Act, venereal disease, prostitution, maternal mortality, and co-education would add useful context to wider enquiries into both the provision of medical care and medical education during the early twentieth century.

By providing an in-depth examination of the MWF's formative history, this thesis lays the groundwork for future studies of the organisation post-1948. Examining how the organisation responded to professional issues such as part-time work and postgraduate training would further understandings of the difficulties faced by medical women in the NHS. Furthermore, research into the extent to which the Federation engaged with emerging issues such as artificial insemination,

[22] Records of the Liverpool Association (1909-1976) are held at the Liverpool Medical Institution Archive. Records of the Yorkshire Association (1912-2003) are held at the Borthwick Institute for Archives.

abortion, and the AIDS pandemic would offer useful insights into the organisation's evolution during the late twentieth century.

This thesis importantly provides a historical framework for contemporary investigations into the inequalities being experienced by medical women today. Significant gender pay gaps still exist in the majority of NHS Trusts, and there continue to be issues of underrepresentation in senior roles and certain specialisms within the NHS.[23] The ways in which the MWF has adapted to meet the evolving needs of its membership in the twenty-first century is another area of enquiry which would benefit from the historical context illuminated by this thesis. In 2019, the MWF's president, Henrietta Bowden-Jones, welcomed male honorary members for the first time in the organisation's 140-year history.[24] This decision to modernise the Federation's vision is not, perhaps, as revolutionary as it may seem. Speaking at her presidential address in October 1928, Catherine Chisholm anticipates the change that would soon be on the horizon:

> Our movement has passed its early days of childhood and adolescence, and is now having to justify its adult life. Its early growth has been rapid, its adolescent achievement […] brilliant and successful. What of now? […] to carry on, - that is the labour and the burden! We have to decide whether we are holding the position that has been won, whether we are making good and advancing, and if not, why?[25]

Utilising the metaphor of the life-cycle, Chisholm highlights the fact that the Federation's continued survival would depend on its ability to evolve and advance with the times. In order to survive 'the labour and the burden', and to 'justify its adult life', the MWF would have to remain relevant.

From its beginnings, the MWF remained immoveable in its opinion that progress would not be made within the medical profession unless male and female practitioners worked together. This being said, the Federation also remained adamant that it fulfilled a vital role by offering professional sanctuary and support to medical women. One of the central tenets of the MWF from its beginnings as the ARMW in 1879 was that men and women held fundamentally different points

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[23] Anna Baldwin and Pamela Duncan, 'More than 100 NHS trusts have a worse gender pay gap than a year ago', *Guardian*, 3rd April 2019, <www.theguardian.com> [accessed 28th April 2021]; GMC, 'The State of Medical Education and Practice in the UK, 2020 Report', <www.gmc-uk.org> [accessed 28th April 2021].

[24] MWF, 'MWF Honorary Membership 2019 - Nominations Now Open!', <www.medicalwomensfederation.org.uk> [accessed 24th April 2021].

[25] Catherine Chisholm, 'A Retrospection and an Anticipation', MWF *Newsletter* (November 1928), 19-23 (p.19).

of view on professional matters, which is why the organisation's work was so important. Inviting men to join the MWF, albeit in a limited capacity, marks the beginning of a new era for the organisation. The fact that there remains a separate professional body for women doctors highlights that there remains work to be done to achieve equality within the field. Only time will tell the extent to which the allyship of male practitioners will benefit the Federation's work over the next seven decades.

Appendix One - Biographies of the founding members of the ARMW

Elizabeth Blackwell

Elizabeth Blackwell, c.1877 (Library of Congress).

Elizabeth Blackwell (1821-1910) was the first woman to have her name placed on the British Medical Register on the 1st January 1859.[1] In 1847, Blackwell began her studies at the Geneva Medical College in New York, having been unanimously voted in by the male students.[2] Blackwell opened a dispensary for women and children in 1853, which later became known as the New York Infirmary for Women.[3] In 1868, the infirmary opened its own medical school for women, with Blackwell teaching obstetrics and the diseases of women.[4] She returned to England a year later, becoming a member of the council of the LSMW when it opened in 1874.[5] In 1879, she was a founding member of the ARMW, and remained active within the Association until 1897.[6] Blackwell published extensively on the medical education of women, as well as topics such as morality and social evil.[7] Blackwell died at the age of 89 in May 1910, having suffered a stroke.[8]

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[1] Mary Ann Elston, 'Blackwell, Elizabeth' <https://www.oxforddnb.com> [accessed 14th August 2019].

[2] Ibid.

[3] Ibid.

[4] Barbara A. Somervill, *Elizabeth Blackwell: America's First Female Doctor* (New York: Gareth Stevens, 2009), p.99.

[5] Louisa Garrett Anderson, *Elizabeth Garrett Anderson* (London: Faber and Faber, 1939), p.206.

[6] Annual Meeting Minutes, 1st June 1897.

[7] Somervill. *Elizabeth Blackwell*, p.91.

[8] Ibid., p.93.

Elizabeth Garrett Anderson

Elizabeth Garrett Anderson, c.1900 (National Portrait Gallery)

Elizabeth Garrett Anderson (1836-1917) was the first woman to qualify to practice medicine in Britain in 1865.[9] She embarked upon her medical career at the Middlesex Hospital in 1860, under the guise of gaining nursing experience.[10] Having been refused admission by a number of medical schools, Garrett Anderson was eventually permitted to sit the licensing examinations of the WSA in 1865.[11] Shortly afterwards, she founded the St. Mary's Dispensary for Women and Children, which became known as the New Hospital for Women and Children in 1872.[12] Having obtained her medical license from the WSA, Garrett Anderson went to Paris to attain her M.D, graduating in 1870.[13] Four years later, Garrett Anderson was involved in the founding of the LSMW alongside Jex-Blake.[14] In 1879, she was a founding member, and likely primary organiser, of the ARMW.[15] She remained an active member of the Association until 1901.[16] Garrett Anderson was an outspoken supporter of the women's suffrage movement, and was elected Mayor of Aldeburgh in 1908.[17] She died in 1917, aged 81.[18]

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[9] Jo Manton, *Elizabeth Garrett Anderson* (London: Butler and Tanner, 1965), p.163.

[10] 'A Lady Amongst the Students', *Lancet*, 2 (6th July 1861), 16.

[11] Manton, *Elizabeth Garrett Anderson*, p.163.

[12] Garrett Anderson, *Elizabeth Garrett Anderson*, p.120.

[13] Ibid., p.132.

[14] Ibid., p.234.

[15] Annual Meeting Minutes, 6th May 1879.

[16] Annual Meeting Minutes, 4th June 1901.

[17] Garrett Anderson, *Elizabeth Garrett Anderson*, p.273.

[18] Manton, *Elizabeth Garrett Anderson,* p.350.

Sophia Jex-Blake

Sophia Jex-Blake, c.1880-90 (National Portrait Gallery)

Sophia Jex-Blake (1840-1912) matriculated at the University of Edinburgh in 1869.[19] Unable to follow in Garrett Anderson's footsteps, she was forced to find another route into medicine.[20] Following a lengthy legal process, Jex-Blake began her studies in Edinburgh alongside nine other women.[21] After years of hostilities, the university closed its doors to women in 1873.[22] Jex-Blake founded the LSMW alongside Garrett Anderson in 1874.[23] Three years later, Jex-Blake graduated from the University of Bern, and received her medical licenses from the KQCPI.[24] Having been snubbed for the position of secretary at the LSMW, Jex-Blake returned to Edinburgh, opening a private medical practice for impoverished women and children.[25] In 1883, Jex-Blake resigned from the ARMW. Jex-Blake's dispensary expanded to become the Edinburgh School of Medicine for Women in 1886.[26] The school closed 12 years later.[27] Jex-Blake retired to Sussex, where she died in 1912.[28]

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[19] Margaret Todd, *The Life of Sophia Jex-Blake* (London: Macmillan, 1918), p.260.

[20] Ibid,, p.246.

[21] Ibid., p.260.

[22] Ibid., p.153.

[23] Knox, *The Lives of Scottish Women*, p.86.

[24] Todd, *The Life of Sophia Jex-Blake*, p.440.

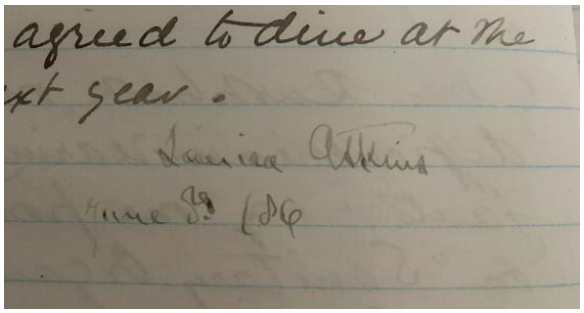
[25] Ibid., p.459.

[26] Knox, *The Lives of Scottish Women*, p.88.

[27] Ibid., p.90.

[28] Todd, *The Life of Sophia Jex-Blake*, p.541.

Louisa Atkins



Louisa Atkins' signature, c.1886 (Wellcome Library).

Louisa Atkins (1842-1924) matriculated at the University of Zurich in 1867, receiving her medical degree five years later.[29] Her thesis explored the presence of lung disease in children.[30] In July 1872, Atkins was controversially appointed to the BMHW as the country's first female house surgeon.[31] In 1876, Atkins joined the staff of the NHW, and in May 1877 she received her medical license from the KQCPI.[32] In 1883 and 1886, Atkins was elected president of the ARMW.[33] Amidst a disagreement over Garrett Anderson's surgical competency, Atkins resigned from her position at the NHW in April 1888.[34] The following year she similarly resigned from the ARMW.[35] Atkins subsequently withdrew from public life; however, she continued to practice privately at her home in Northwood and in London.[36] Atkins' death at the age of 82 was remarked to have been characteristic of her proud humility, 'which valued itself at small price and eschewed the ways of publicity'.[37] She was described as having been 'an earnest student, an able physician, very human, very kind'.[38]

[29] 'Louisa Atkins', *BMJ*, 2 (1st November 1924) 836-837 (p.836).

[30] Ibid.

[31] BMHW Annual Report 1873, HC/WH/1/10/1, BCA.

[32] 'Louisa Atkins', p.836.

[33] Annual Meeting Minutes, 12th June 1883; Annual Meeting Minutes, 8th June 1886.

[34] Brock, *British Women Surgeons*, p.37.

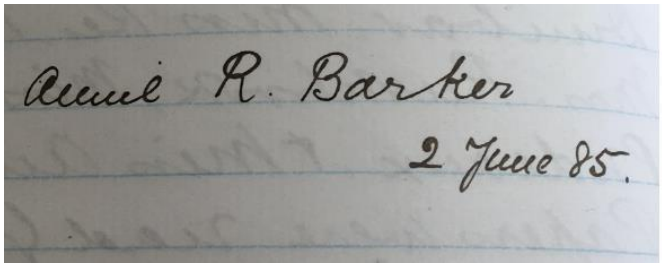
[35] Annual Meeting Minutes, 11th June 1889.

[36] 'Louisa Atkins', p.837.

[37] Ibid.

[38] Ibid.

Annie Reay Barker



Annie Reay Barker's signature, c.1885 (Wellcome Library)

Annie Reay Barker (1851-1945) matriculated at the University of Edinburgh in the summer of 1870.[39] In 1874, she continued her studies at the Universitié de Paris, graduating two years later.[40] Her thesis outlined the care of women during childbirth.[41] In July 1876, Barker joined the BMHW as a house surgeon and secretary.[42] She later became the first woman in the country to be appointed to a senior hospital position when she joined the outpatient department at the BMHW in 1878.[43] In 1881, Barker gave the inaugural address at the LSMW.[44] Two years later, she resigned from the BMHW due to ill-health.[45] Barker continued to privately practice medicine in London, and was elected president of the ARMW in 1885 and 1888.[46] Barker's health deteriorated, and she subsequently withdrew from public life. On the 23rd March 1896, Barker was brought to the Holloway Sanatorium, Virginia Water, with a diagnosis of 'Chronic Mania'.[47] She remained a patient for nearly 50 years, and died in 1945 at the age of 93.[48] Her place of burial remains unknown.

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[39] First Matriculation Album 1869-1870, Centre for Research Collections, University of Edinburgh, EUA IN1/ADS/STA/1.

[40] BMHW Annual Report 1876.

[41] 'Amice Reay Barker', <https://www.biusante.parisdescartes.fr/> [accessed 15th August 2019].

[42] Board of Governors Minutes, 6th July 1876.

[43] Board of Governors Minutes, no date recorded, p.190.

[44] C. A. Biggs (ed), *The Englishwoman's Review of Social and Industrial Questions, Volume XI, January to December 1881* (London: Englishwoman's Review, 1881), pp.466-67.

[45] Board of Governors Minutes, 6th February 1883.

[46] Annual Meeting Minutes, 2nd June 1885; Annual Meeting Minutes, 12th June 1888.

[47] Holloway Sanatorium Patient Admission Register, Surrey History Centre, Patient number 1591, 3237/5/1.

[48] 'Annie Reay Barker', English Newspaper Index Cards, 1790–1976, www.ancestry.com [accessed 16 November 2018].

Annie Clark

Annie Clark, date unknown (*BMJ*)

Annie Clark (1844-1925) briefly studied at the University of Edinburgh alongside Jex-Blake in the early 1870s; however, she never officially matriculated.[49] In 1874, she joined the newly-opened LSMW, but found herself unable to obtain her M.D.[50] Clark subsequently went to study at the University of Bern for two years, graduating in 1877.[51] The following year, Clark received her medical license from the KQCPI.[52] In 1878, she was appointed to the BMHW as a resident medical officer, and later became assistant to the revered surgeon Lawson Tait.[53] Clark also worked at the Birmingham Children's Hospital, where she specialised in the diseases of women and children.[54] In 1889, Clark was elected president of the ARMW.[55] Nearly a quarter of a century later, Clark retired from her position at the BMHW.[56] In her obituary, she was said to have shown 'an unfaltering support of all movements calculated to raise women physically, intellectually, and morally', and was described as being 'a woman of ripe wisdom and sound common sense'.[57]

[49] 'Ann E. Clark, M.D', *BMJ*, 1 (15th March 1924), 502-503 (p.502).

[50] Ibid.

[51] Ibid.

[52] Ibid.

[53] Ibid., p.503.

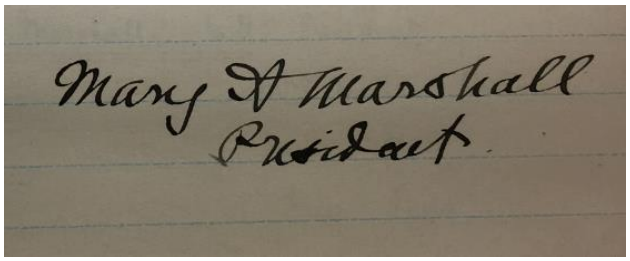
[54] Ibid.

[55] Annual Meeting Minutes, 11th June 1889.

[56] 'Ann. E Clark', p.503.

[57] Ibid.

Mary Marshall



Mary Marshall's signature, c.1890 (Wellcome Library)

Mary Marshall (1837-1910) matriculated at the University of Edinburgh in the summer session of 1869-70.[58] When the university closed its doors to women, she attempted to complete her studies at the LSMW.[59] Finding herself unable to obtain the M.D., she completed her studies at the Universitié de Paris, graduating in 1880.[60] In the same year, Marshall received her medical license from the KQCPI.[61] Marshall practiced privately in London, and also worked as a senior physician at the NHW.[62] In 1888, she published an article on 'Medicine as a Profession for Women' in *Woman's World.*[63] Marshall served as president of the ARMW from 1890 to 1892.[64] In 1895, Marshall moved to Cannes, and continued to practice privately.[65] She was described as being 'immediately kind to everyone who came into her circle, and to her patients above all'.[66] Marshall contracted pneumonia on her return to London, and died in 1910 aged 73.[67]

[58] M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), p.39.

[59] 'Mary Adamson Marshall, M.D. Paris', *BMJ*, 1 (1910), 498.

[60] Ibid.

[61] Ibid.

[62] Ibid.

[63] Mary A. Marshall, 'Medicine as a Profession for Women', in *The Woman's World*, ed. by Oscar Wilde (London: Cassell and Company, 1888), pp.105-110.

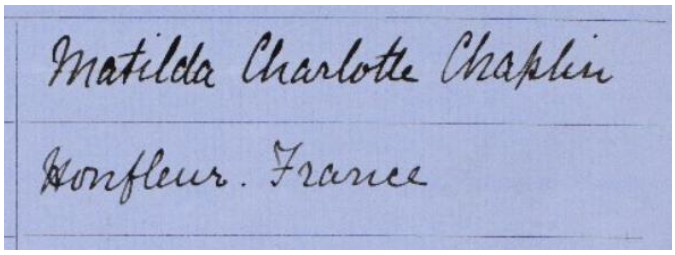
[64] Annual Meeting Minutes, 3rd June 1890; Annual Meeting Minutes, 2nd June 1891; Annual Meeting Minutes, 9th June 1892.

[65] 'Mary Adamson Marshall, M.D Paris', p.498.

[66] Ibid.

[67] Ibid.

Matilda Chaplin Ayrton



Matilda Chaplin Ayton's matriculation record, c.1869 (University of Edinburgh)

Matilda Chaplin Ayrton (1846-1883) commenced her studies in 1867 at the Ladies Medical College in London.[68] Having passed the preliminary examinations at Apothecaries Hall, she presented herself for examination in 1869, but was refused admission on the ground of her sex.[69] Undeterred, Ayrton matriculated at the University of Edinburgh alongside Jex-Blake, achieving high honours in anatomy and surgery.[70] In 1871, she chose to complete her medical education in Paris; however, her studies were interrupted by her marriage and subsequent relocation to Japan with her husband.[71] In Japan, Ayrton opened a school for native midwives, aided by her certificate in midwifery from the London Obstetric Society.[72] Illness forced Ayrton to return to Europe in 1877.[73] Two years later, she defended her thesis – based on her experiences in Japan – in Paris.[74] Ayrton received her license from the KQCPI in 1880, and subsequently studied diseases of the eye at the RFH.[75] Ayrton died of tuberculosis in 1883, aged just 37.[76] Her book *Child-Life in Japan and Japanese Child Stories* was published posthumously in 1909.[77]

[68] 'Matilda Chaplin Ayrton, M.D.', *Englishwoman's Review*, 1883, 343-350 (p.344).

[69] Ibid, p.345.

[70] Crowther and Dupree, *Medical Loves in the Age of Surgical Revolution,* p.38.

[71] 'Matilda Chaplin Ayrton, M.D', p.347.

[72] Ibid., p.348.

[73] Ibid., p.349.

[74] 'Matilda Chaplin Ayrton' <https://www.biusante.parisdescartes.fr/> [accessed 16th August 2019].

[75] 'Matilda Chaplin Ayrton', p.348.

[76] Ibid.

[77] Matilda Chaplin Ayrton, *Child-Life in Japan and Japanese Child Stories* (Boston: D.C. Heath and Co, 1909).

Eliza Frikart

Eliza Frikart, c.1893 (*Fair Play*)

Eliza Frikart (1851-?) graduated from the University of Zurich in 1877.[78] She received her licenses from the KQCPI two years later.[79] Frikart left her position as house physician at the NHW in 1880 to practice medicine in Europe.[80] Having spent 10 years in Switzerland, she sailed to Australia in 1893.[81] Frikart was reprimanded by the KQCPI for professional misconduct in 1892; however, she ignored the college's warning.[82] Between May 1893 and August 1894, over 907 of Frikart's advertisements featured in New Zealand newspapers.[83] Subsequently, Frikart had her KQCPI license removed in December 1893, and was struck off the Medical Register by the General Medical Council (GMC).[84] She became the only member ever to be expelled from the ARMW on account of her unprofessional behaviour.[85] In 1895, Frikart's name became embroiled in an abortion case, and following her return to England, she was tried for 'falsely using the title of doctor of medicine' at the Cardiff Police Court.[86] Frikart was also tried for cheque fraud at the Old Bailey in 1903.[87] Frikart's date of death and place of burial remain unknown.

[78] 'Medical Education', *Englishwoman's Review*, 1880, p.22

[79] Ibid.

[80] Ibid.

[81] 'Registered Medical Women', *Englishwoman's Review*, 1882, p.88.

[82] Letter from G.P.L Nugent to Eliza Frikart, 8th December 1892, College minute book, RCPI/2/1/1/22.

[83] National Library of New Zealand, 'Dr Frikart' <https://natlib.govt.nz > [accessed 25th June 2019].

[84] 'The General Medical Council of Medical Education and Registration', *Lancet*, 2 (1st December 1894), 159.

[85] Minutes of the General Meeting, 19th December 1893

[86] Ibid.

[87] Ibid.

Eliza Walker Dunbar

Eliza Walker Dunbar, date unknown (*BMJ*)

Eliza Walker Dunbar (1845-1925) graduated from the University of Zurich in 1872.[88] After a year's postgraduate study in Vienna, Dunbar took up a post as house surgeon at the Bristol Royal Hospital for Sick Children in 1873.[89] Following a disagreement with a senior consultant, who accused Dunbar of impertinence, all of the remaining male members of staff resigned from their positions.[90] Dunbar was left in sole charge of the hospital for five days.[91] She subsequently resigned from her post at the hospital, in spite of the fact that the hospital's lay committee did not want her to leave.[92] Dunbar went on to set up a private practice in Bristol, founding the Read Dispensary for Women and Children in 1874.[93] Three years later, she became the first woman to receive a medical license from the KQCPI.[94] In 1884, Dunbar was elected president of the ARMW.[95] Dunbar later founded the Bristol Private Hospital for Women and Children in Clifton in 1895, fulfilling her life's ambition.[96] She practised medicine up until her death at the age of 80 in 1925.[97]

[88] 'Eliza Walker Dunbar, M.D.', *BMJ*, 1(12th September 1925), 496-497 (p.497).

[89] 'Eliza Walker Dunbar, M.D.', 497.

[90] Elston, 'Women Doctors in the British in the British Health Services', p.213.

[91] 'Eliza Walker Dunbar' <https://www-oxforddnb-com> [accessed 16th August 2019].

[92] Ibid.

[93] Elston, 'Women Doctors in the British Health Services', p.209.

[94] Kelly, p.10.

[95] Annual Meeting Minutes, 4th June 1884.

[96] 'Eliza Walker Dunbar, M.D.', 497.

[97] Ibid.

Appendix Two - Presidents of the ARMW and MWF, 1879-1948

Year	President	Year	President
1879	-	1906	Louisa Aldrich-Blake (1865-1925, qual.1892)
1880	Elizabeth Blackwell (1821-1910, qual. 1849)	1907	Louisa Aldrich-Blake
1881	Elizabeth Garrett Anderson (1836-1917, qual.1865)	1908	May Thorne (1860-1951, qual.1895)
1882	Edith Pechey (1845-1908, qual.1877)	1909	May Thorne
1883	Louisa Atkins (1842-1924, qual.1872).	1910	May Thorne
1884	Elizabeth Dunbar (1845-1925, qual.1872)	1911	Constance Long (1867-1923, qual.1896)
1885	Annie Reay Barker (1851-1945, qual.1877)	1912	Frances Ivens (1870-1944, qual.1900)
1886	Louisa Atkins	1913	Jane Walker (1859-1938, qual.1884)
1887	Edith Pechey	1914	Jane Walker
1888	Annie Reay Barker	1915	Jane Walker
1889	Annie E. Clark (1844-1924, qual.1877)	1916	Jane Walker
1890	Mary Marshall (1837-1910, qual.1879)	1917-20	Jane Walker
1891	Mary Marshall	1920-22	Mary Sturge (1862-1925, qual.1885)
1892	Mary Marshall	1922-24	Florence Barrett (1867-1945, qual.1900)
1893	Mary Emily Dowson (1848-1941, qual.1884)	1924-26	Frances Ivens
1894	Florence Nightingale Boyd (?-1910, qual.1888)	1926-28	Christine Murrell (1874-1933, qual.1899)
1895	Julia Cock (1860-1914, qual.1877)	1928-30	Catherine Chisholm (1878-1952, qual.1912)
1896	Elizabeth Garrett Anderson	1930-32	Louisa Martindale (1873-1966, qual.1906)
1897	Elizabeth Garrett Anderson	1932-34	Mabel Ramsay (1878-1955, qual.1906)
1898	Julia Cock	1934-36	Ethel Williams (1863-1947, qual.1891)
1899	Julia Cock	1936	Mona Chalmers-Watson (1872-1936, qual.1896)
1900	Mary Scharlieb (1845-1930, qual.1888)	1936-38	Ellen Orr (1885-1972, qual.1911)
1901	Mary Scharlieb	1938-40	Elizabeth Bolton (1878-1961, qual.1904)
1902	Florence Nightingale Boyd	1940-42	Janet Aitken (1886-1982, qual.1924)
1903	Florence Nightingale Boyd	1942-44	Clara Stewart (1882-1973, qual.1924)
1904	Helen Webb (?-1926, qual.1888)	1944-46	Janet Campbell (1877-1954, qual.1901)
1905	Helen Webb	1946-48	Mary Lucas Keene (1885-1977, qual.1911)

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