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Women Doctors and Lady Nurses:

Class, Education, and the Professional Victorian Woman

VANESSA HEGGIE

SUMMARY: The lives of the first women doctors in Britain have been well studied by historians, as have the many debates about the right of women to train and practice as doctors. Yet the relationship between these women and their most obvious comparators and competitors—the newly professionalized hospital nurses—has not been explored. This article makes use of a wide range of sources to explore the ways in which the first lady doctors created “clear water” between themselves and the nurses with whom they worked and trained. In doing so, it reveals an identity that may seem at odds with some of the clichés of Victorian femininity, namely that of the intelligent and ambitious lady doctor.

KEYWORDS: women, nursing, medical education, professions, professionalization, autobiography

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In 1860 Elizabeth Garrett (later to become Elizabeth Garrett Anderson) began her struggle for a medical education in Britain. She called on the country's leading consultants in Harley Street, accompanied by her bemused but supportive father, Newson Garrett, to ask about training and apprenticeship opportunities. No one took her on, and instead Garrett Anderson enrolled in a nurse training course at the Middlesex Hospital. This was the beginning of a five-year educational path that led to her passing the License of the Society of Apothecaries in 1865, and becoming the first British-qualified woman to be entered on the Medical Register. According to Garrett Anderson's daughter, one "Harley street doctor asked the twenty-four year old why she was so set on becoming a doctor rather than a nurse. 'Because,' she said 'I prefer to earn a thousand, rather than twenty pounds a year.'"¹

This tension, between women's possible roles as nurses rather than as doctors, is at the heart of this article. Nursing was both a problem and a pathway for women's entry into professionalized medicine. On the one hand nursing provided a direct route into medicine for many women, both rhetorically and practically: rhetorically because the presence of nurses in sickrooms, prisons, workhouses, asylums, and even military hospitals provided an obvious counterargument to the idea that women should be barred from such sites because of the weakness and sensibility of their gender.² Practically, some of the first women doctors started their training, just like Garrett Anderson, by enrolling in a nursing course. On the other hand the professionalization and gentrification of the nursing role in the second half of the nineteenth century meant that nurses became increasingly idealized as an archetypal, acceptable, and middle-class ideal of femininity.³ The question "why not be a nurse" was therefore a constant threat to the precarious identity and existence of women doctors.

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The opening of the medical profession to women has received considerable interest from historians, especially since the epochal feminist reconsiderations of the 1970s. Existing scholarship explores the multiple arguments for women's right—and in some cases obligation—to practice as doctors,⁴ the fractious relationships between the first female doctors,⁵ the many conflicts between male and female doctors,⁶ the tensions between voluntary and paid nurses,⁷ and the power struggles on the wards between male doctors and nurses.⁸ The relationship between women doctors and female nurses has received less attention.⁹ This is a significant omission, as this article demonstrates, as the shared gender of women doctors and nurses enables historians to look more closely at confounding factors (such as social status) in the construction of professional identities.

This article focuses on the ways the first women doctors, practicing when their profession was at its most precarious, sought to put “clear water” between themselves and the nurses they worked with. One reason this relationship has been neglected may be the practical challenge of finding relevant evidence. The first women doctors have left surprisingly scant records concerning their attitude toward either individual nurses or nursing as a profession. Aside from Garrett Anderson, few have left us specific justifications for their choice of the more challenging ambition of surgical or medical qualification rather than the apparently more natural path for a woman into the nursing profession. The scarceness of evidence is one reason this article focuses its attention on the voices of the women doctors themselves rather than symmetrically considering female nurses' opinions of the new women doctors.

More extensive archival material (including oral history) makes it easier to study women's involvement in medicine in the early twentieth century; but it is still possible to consider the period ca. 1880–1905, when women's medicine was most novel and vulnerable. As

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this is a formative moment, it deserves a more thorough investigation. Therefore this article uses a patchwork of sources—(auto)biographies, institutional archives, journal articles, and newspaper cuttings—in an attempt to reconstruct the attitudes of the first women doctors in Britain to the nurses (paid and voluntary) with whom they not only had to work, but at times also had to train. Doing so is worthwhile, despite the challenge, as what emerges is a quite distinctive professional voice, an unapologetic self-identity as intelligent and ambitious, in distinct comparison to the allegedly less academic nurse. It also becomes clear that this apparently confident identity belied a more vulnerable and complex reality.

Garrett Anderson's assured self-valuation at a thousand pounds a year is a good place to start uncovering this identity; this is clearly a mark of ambition, not least because such an income would be limited to extremely successful doctors in the 1860s; general practitioners would not routinely earn this amount until well into the twentieth century.¹⁰ As her comment was a self-reported retort, we cannot be sure that the young Garrett Anderson ever said precisely this, but the tone of this reply certainly reflects the opinions and attitudes of the older, qualified Garrett Anderson about her own worth, and the issue of nursing as an alternative profession. Consistently she stated that one should work to the highest level of which one is capable, and be appropriately and adequately paid; Garrett Anderson is aiming for a consultancy position at a thousand a year, not a regular general or midwifery practice. The interest in income also somewhat contradicts the retrospective suggestions by early women doctors, such as Mary Scharlieb, that medical women were motivated by "higher" (or at least less pecuniary) considerations: "The [early] women were all enthusiasts, they were all volunteers ... they were endeavouring to qualify to please themselves, generally with a view to philanthropic or missionary work."¹¹

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By the time Garrett Anderson was presenting herself in Harley Street the vocational opportunities open to unmarried middle-class women were beginning to broaden.¹² Even so, compared to working-class women the range of occupations available was extremely limited. Particular pressure was therefore brought to bear on vocations that were suitable, or could be made suitable, for respectable ladies. Such work was predominantly located in health and welfare,¹³ particularly fields such as nursing, teaching,¹⁴ sanitary reform,¹⁵ and missionary activity.¹⁶ Later these roles were supplemented with secretarial and administrative work. In the existing historiography, stories of the reform and reinvention of these activities, as jobs suitable for ladies, tend to concentrate on two distinct arguments: either for the reentry of women into a profession from which they had been excluded, or the more challenging “argument from difference.”

Reentry arguments highlighted the changing status of jobs that used to be available to women, reacting particularly against the closing of ranks that seemed to come with professionalization. With licensing, formalized educational requirements and institutionalization, women (and other marginalized groups) were increasingly excluded from a range of vocations, including medicine. Campaigns for the reentry of women into such professions were usually based on notions of equity, fair representation, or human rights, and such arguments were more common in legal and political professions than those touching on health, welfare, and education.¹⁷ The other major line of argument, and the one more common to medicine, was the argument from difference.¹⁸ In this construct campaigners explicitly accepted that women were naturally and inherently different from men, but then used this difference to justify their presence in a profession. This difference, if properly used and trained, could provide valuable services and skills that would be complementary to, rather than in competition with, work done by men. The

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special abilities of women could be relevant because of the people (patients) they were working with—women or young children in particular—or because their nurturing, sympathetic, domestic skills were vital to a particular job, and lacking in male practitioners.¹⁹ Such ideas are extraordinarily persistent: the principle that school teachers should be “a mother made conscious” was an argument used by educational reformers in the 1840s, and as Carolyn Steedman has demonstrated it remained central to some pedagogical theories well into the twentieth century.²⁰

Women also proved useful in blurring the boundary between private and public spaces, by extending the gaze of local councils, charities, or central government; as Helen Jones has demonstrated, female factory inspectors were considered particularly useful because as women they were able to enter spaces—changing rooms, bathrooms—their male colleagues could not.²¹ Likewise early women health visitors were praised for their ability to go where the local corporations could not: into the homes of the poor.²² Consequently it is crucial to understand this argument about difference as also being an argument about class—although these special skills were thought to be natural to women, they were not the inherent possession of *all* women. It was the educated middle-class woman who was needed to instruct, assist, treat, and supervise the inadequate mothers and wives of the poor.

In nursing, this shift to a professionalized, trained, ideally middle-class identity was not straightforward.²³ In many cases a two-tier system developed in community and hospital nursing, where wealthy ladies acted as supervisors, funders, and sometimes matrons on a philanthropic basis, while the nurses were often drawn from the respectable poor.²⁴ Nursing reformers, particularly Florence Nightingale, were as critical of these “Lady Bountifuls” as they were of the clichéd “Sarah Gamp”—style unprofessional nurse, and the system of formally educated, paid,

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professional women was intended to replace both these extremes.²⁵ By the end of the century medical men also began to realize the value of paid professionals over the sometimes inconsistent and willful Lady Bountifuls. Changes in the practices of medicine, including more intensive drug regimens and the demands of anesthesia-enabled surgery and antiseptic principles, meant that many doctors asked for better trained (and more easily disciplined) professional nurses, not least to relieve medical students of the responsibilities of basic patient care.²⁶ Whatever the reality of the state of nursing, there was clearly a rhetorical reinvention of the job as a form of idealized femininity: the mother in the ward to a family of infantilized patients. When the first women doctors began to work next to nurses, especially in their own female-only institutions, there was a danger that in comparison to the “naturally” feminine nurse, a woman doctor might look even less appropriately feminine.

The two common justifications for women’s employment—reentry and the argument from difference—were difficult to deploy to explain why one should be a doctor rather than a nurse.²⁷ Instead women doctors identified themselves as doctors first and women second, so that their relationships with nurses were modeled closely on those of male doctors. Where possible, women doctors highlighted differences in social status between themselves and working-class nurses, but significantly also relied on the difference between a doctor’s superior intellect and education and that of all kinds of nurses, including the well-bred lady reformer. Garrett Anderson’s response to the question “why not be a nurse” makes more sense when this story is told: while lady nurses might be the ultimate representations of fully professionalized Victorian womanhood, what distinguished the woman doctor was—however unwomanly it might seem—her intelligence and ambition.

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What Makes A Nurse

Medicine and nursing were (re)invented as professions suitable for respectable women in parallel with one another. For nursing this was a double task: First, successful attempts were made to improve the standards and educational level of the paid nurse, thereby raising nursing's status from a low form of domestic service to a respectable vocation.²⁸ Second, there was a concomitant need to regulate the amateur work of lady volunteers, depicted by Nightingale and others as well-intentioned women who turned out to be unable to do the hard work, and unwilling to do the dirty work, that nursing required. The first women doctors in the United Kingdom engaged with these reform puzzles, commenting on and complaining about both the undereducated domestic servant as well as the underskilled Lady Bountiful. A generational difference does seem evident in their writing though, as women doctors' experiences of nursing varied according to the progress of nursing reform at the time they trained.

Elizabeth Blackwell, the first woman on the British Medical Register, started her medical career (and made her first visits to the United Kingdom) at exactly the time that the first major campaigns to reform nursing were launched. Consequently her discussions of nursing tend to focus on the prereform, lower-status nurse and midwife. As Peggy Chambers points out, Blackwell declared her intention to study medicine at a time when "no nice woman ... became even a nurse."²⁹ Blackwell's autobiography paints a stark and negative picture of most of the nursing staff she encountered, with one striking exception, the champion of reform, Florence Nightingale.

Although Blackwell managed largely civil relationships with the other medical women she encountered, she is fairly consistent in her description of nurses and midwives as women of relatively low intelligence. Her first sustained contact with nurses was in the late 1850s when she

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worked at the Blockley almshouse in Philadelphia; here she interviewed the nurses, writing later to her sister Anna that these women were “mere hands and never think.”³⁰ She had a similarly dismissive attitude toward the trainee midwives (*sages-femmes*) she encountered in Paris in the following years. Blackwell worked at La Maternite in Paris between 1848 and 1851, a deliberate career move as she intended to “remain [there] until [she had] succeeded in [her] first object—viz. to become an accomplished obstetrician.”³¹ To Blackwell’s annoyance she could not arrange to have special treatment or negotiate “the smallest modification to suit the very different status with which [she entered] from the young French *sages-femmes*.”³² (Blackwell had graduated with a medical degree from the Geneva Medical College in 1848.) The “girls,” although friendly, are described by Blackwell as childish, relatively uneducated, and often frivolous. Their training was repetitive and simplistic, and “would have been intolerable” for Blackwell had it not been for the fact that she could use these lessons as an opportunity to improve her French.³³ Her different status prevailed though, as even the trained *sages-femmes* turned to Blackwell for advice and help, and the Parisian student allocated to Blackwell as a “Chief of Theory” ended up “ask[ing Blackwell] in the sweetest manner if [Blackwell could] come sometimes to her lessons and explain to the girls what she does not understand.”³⁴

Blackwell was unable to follow through on her second goal, “viz. surgery,” after an accidental infection resulted in the removal of one eye. But she did go from Paris to London and spent some time in Britain mixing in relatively high society, where she was cordially received by medical men. It was during this trip that, in 1850, she first met Florence Nightingale, with whom Blackwell maintained a complicated relationship. Blackwell’s own memoirs describe a close and friendly partnership, and repeatedly state the high regard in which she held the great nursing reformer. Her personal letters and diaries, however, suggest a more antagonistic relationship,

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especially by the 1860s when it was clear that Nightingale would remain opposed to women doctors.

This antagonism stretched to literary criticism: “Florence cannot write a book in the usual meaning of the word. She can only throw together a mass of hints and experiences which are useful and interesting, but she is not able to digest them into a book which will remain as a classic.”³⁵ This was Blackwell’s assessment of *Notes on Nursing*, which, despite her criticism, she used extensively to organize the emergency training of nurses during the American Civil War. It was probably the war that first exposed Blackwell to the other puzzle of nursing reform, the Lady Bountiful. According to Blackwell there was a “perfect mania amongst [Northern women] to act Florence Nightingale.”³⁶ Blackwell’s way of dealing with this, as Julia Boyd points out, was to rely partly on Nightingale’s own criteria: “The formidable set of conditions that these women had to meet in order to pass Elizabeth’s selection board reflected Florence Nightingale’s views. Each woman had to be between thirty and forty-five years of age and of a strong constitution. She had also to present testimonials to her morality, sobriety, honesty and trustworthiness, accept subordination to [the superintendent] and the medical authorities—and wear a dress without a hoop. It was greatly in an applicant’s favour if she were physically plain.”³⁷ Blackwell’s low opinion of women did not stop at nurses and midwives, as she was consistently critical of the general state of womanhood. “I believe that the chief source of the false position of women,” she wrote in 1852, “is, the inefficiency of women themselves. The deplorable fact [is] that they are so often careless mothers, weak wives, poor housekeepers, *ignorant nurses*, and frivolous human beings.”³⁸ Acting on the conviction that so-called inherent female skills were far from commonly possessed, Blackwell engaged in much work in the 1860s

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and 1870s to bring about improvements in female education, including schemes for adequate physical exercise for girls.

Blackwell's medical degree made her eligible to have her name entered on the newly introduced Medical Register in 1859, so that she became the first woman officially recognized as a medical practitioner (this loophole to female practice was subsequently closed). The second woman to be listed on the British Medical Register, Elizabeth Garrett Anderson, started her medical career after the Crimean War, and therefore in the middle of the major reform of British nursing, embodied by post-Crimea Nightingale. These reforms worked in Garrett Anderson's favor, as she gained her initial medical training by entering the Middlesex Hospital, ostensibly as a trainee nurse; as Jo Manton frames it, "The Medical School was, of course, the goal of her ambition. ... The fiction that she was a nurse satisfied the conventions and [had to be] be maintained."³⁹

The nurses Garrett Anderson worked with were not yet the products of Nightingale's reformed nurse training schemes, as the first of these only started at the nearby St Thomas's Hospital in 1860, the same year Garrett Anderson entered the Middlesex.⁴⁰ Nonetheless, Garrett Anderson maintained a reasonable relationship with the nurses and—possibly more important—the matron who upon "realis[ing] that Elizabeth was not a young lady who gave herself airs ... set the tone among the nurses [who then] welcomed her and were willing to teach her what they knew."⁴¹

Garrett Anderson could afford to work as a nurse for free, but what she was really chasing at the Middlesex was medical training, which she managed to negotiate on individual terms from the house surgeon and physician, and later the hospital's apothecary. Her attempts to regularize her situation—"Dr Willis treats me as a pupil and the house surgeons do the same and

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I am ... getting the teaching and practice gratis for which the students pay a fee”—by being formally enrolled as a medical student were rebuffed by the treasurer of the Medical School, who would not accept a woman as a student.⁴² She attended lectures and excelled in the examinations, but by June 1861 the sentiment of the hospital had turned against her, not least because her presence as a de facto student had become more widely known and “the Middlesex students found themselves the butt of rival hospitals for allowing a girl to share their masculine privileges.”⁴³

To get one’s name on the Medical Register, a legal necessity for medical practice after 1858, a candidate had to fulfill the criteria of the Royal College of Surgeons, the Royal College of Physicians, or the Society of Apothecaries; and in the regulations of the latter there was no specific rule barring women from holding an Apothecaries’ License. This was the route Garrett Anderson successfully completed in 1865, having gained certificates in all the necessary areas of study from private tutors, and passing the Apothecaries’ Examination. Shortly afterward the society changed its rules to close this loophole.⁴⁴ Garrett Anderson went on to gain an MD at the University of Paris in 1870 and founded a dispensary (1866) and then a hospital (1872) for the diseases of women and children in London, for which she had to hire her own nurses.

Garrett Anderson’s nursing experience appears to have reinforced her conviction that this was *not* an appropriate job for a lady; in 1866 she presented a paper to the National Association for the Promotion of Social Science in Manchester on “Volunteer Hospital Nursing,” which clearly states her preference for paid, trained, nurses of the “middling sort.” There was no room for the volunteer Lady Bountiful—and the intelligent lady who desired a career in medicine would, perhaps, be better suited to doctoring than nursing. “The nursing staff consists of two classes,” she wrote, “head nurses ... [who] are in some hospitals called sisters ... [who a]s a rule

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. . . are skilful, experienced, kindly people, very well suited to their work. They usually belong to the lower section of the middle class, are the widows of small tradesmen or clerks, or less frequently they have been confidential domestic servants. Their salary varies from 20*L* to 30*L* a year, with board and residence.”⁴⁵ These women compared favorably to the undernurses who were “as a rule, vastly inferior to the head nurses both in intelligence and character. They are commonly below the class of second or even third rate domestic servants.”⁴⁶

When ladies went to work in hospitals it was usually to do the work of head nurses and sisters, work they no doubt could do, and which hospitals would like them to do, since they often worked for free. But just because they *could* do the work it was not necessarily the case that they *should*. In fact, Garrett Anderson argued, “Admirably as ladies can nurse, the actual work of nursing is not much more appropriate to them than that of cooking or dusting in their own homes. It is not true that hospital nursing cannot be well done by women of inferior rank and culture, and therefore it cannot be entirely desirable that those of a higher class should spend their time in doing it.”⁴⁷ Nursing reform, according to Garrett Anderson, did not require gentrification or a stronger voluntary tradition but rather decent pay (“wages should be sufficient to attract respectable women of the rank of good domestic servants”) and full nighttime supervision of the undernurses.⁴⁸

Garrett Anderson admitted that it might be possible to attract “lady superintendents” for a salary of a hundred fifty pounds a year with board and rooms, and these would be “trained and qualified” persons; but even the creation of a two-tier nursing system could not solve the problem of providing adequate professional avenues for women, not least because “two hundred such situations represent the maximum number ever likely to be offered, and the probable

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number would be very much below this” which was “too limited to justify its advocates in thinking of nursing as a profession for ladies.”⁴⁹

When Garrett Anderson converted her St Mary’s Dispensary into the New Hospital for Women (NHW) in 1872 she initially appointed just one nurse for the entire institution. This nurse was hired at thirty pounds per annum and board, toward the lower end of the payment scale Garrett Anderson had recommended in her article about nursing quoted above.⁵⁰ Even with this pay, a good nurse was hard to find; the original hire, Mrs. Yates, resigned after just three months, and her replacement, Mrs. Bond, was hired on probation for a month and then dismissed as “not quite suitable.”⁵¹ Mrs. Sexton was hired to replace her, only to be replaced in June by Mrs. Perry, who in turn resigned in October and was replaced by Miss Proctor.⁵² Through the decade the team of nurses gradually expanded (with many replacements and short-term hires) and by the late 1870s the nursing team consisting of a head nurse/matron and two undernurses who were earning thirty-six to fifty pounds and twenty to twenty-six pounds per annum, respectively.

Nursing was a vocation in flux at the end of the nineteenth century, and its processes of professional and social invention sometimes led to fractious encounters between nurses and doctors of both genders. Some of this historiography of reinvention and gentrification is being reconsidered, particularly in the light of Sue Hawkins’s study of Victorian and Edwardian nurses at London’s St George’s Hospital, which demonstrates how many of them remained working class even through the process of professionalization.⁵³ As some critics have pointed out,⁵⁴ Hawkins’s study is a single case and might not be representative of broader hospital nursing experience, some features of her story seem to be reflected in two other hospitals: Guys and NHW.

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Nurses' concerns for pay and conditions, their deliberate and active choice of nursing as a vocation, and the clash between existing (probably working-class) staff and newly brought-in, trained, middle-class superintendents are obvious in nursing disputes in both male and female-run hospitals at the end of the nineteenth century. It is important to note how similar the disputes were; it is significant that women doctors faced similar challenges in managing nurse hierarchy and organization to their male counterparts. While there were also gender specific challenges (see below), the disputes at Guys and NHW show some strikingly similar characteristics. The dispute at the NHW is less well known than that at Guy's, as it was kept quiet and in-house, while the Guy's dispute ended up in the *Times* and the medical press. The all-female dispute is, however, the first, as it erupted in 1878, a year before the Guy's controversy.⁵⁵ The similarities are obvious: both started with the loss of a long-standing senior nurse and the desire by the management of the hospitals to replace her with a trained lady matron or nursing superintendent; this was resisted by both the existing nurses and the medical staff. While the Guy's dispute also had a clear religious edge that is not evident at the NHW, both debates centered around the difficulties of managing two hierarchies: nurses were to work under both the doctors and the matron/superintendent, and these relationships had to be carefully negotiated in order not to undermine either power base.⁵⁶

Just before Christmas 1877 Mrs. Gent, the NHW's "nurse of the upper wards," passed away, prompting the Hospital's Management Committee to institute a rearrangement of the nursing work in the hospital.⁵⁷ The existing nurse, Mrs. Parsons, was given a month's notice and asked to leave in a fortnight with a five-pound payoff "as a mark of [the committee's] satisfaction with her services for the past five years."⁵⁸ In her place Miss Vincent, a Nightingale Fund-trained nurse with several years' experience, was hired at a salary of fifty pounds to act as

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matron, while two similarly trained nurses at salaries of twenty-six and twenty pounds were taken on to work under her.⁵⁹ The imposition of Miss Vincent and her undernurses did not proceed smoothly, as by May it was reported to the Management Committee that all three nurses, the chief medical officer, and the hospital's secretary were at loggerheads, apparently about authority, organization, and administrative procedures. Garrett Anderson had to create a management subcommittee to specifically "consider how the relations between these officers may be better adjusted."⁶⁰ The result was a clarification of the rules for various roles in the hospital, clearly establishing a hierarchy:

1. The matron must have the control of all matters relating to the discipline of nurses and to the management of the hospital in general; she must see that the nurses carry out the orders of the House Doctor relating to the medical treatment of patients in which the Doctor is the superior authority under the physicians.
2. The nurse of each ward must attend the House doctor in her round of the hospital at 9am and one of them must be at hand to receive her orders for the night.⁶¹

Clearly the relationships between female doctors and nurses faced some of the same challenges as those between male doctors and nurses. But there were particular problems women faced in these scenarios that men did not. For example, there was an available power model to help order the pseudo-domestic space of the hospital, and that was the (middle-class) home. Domestic service was a near-ubiquitous experience, as working-class hospital employees would almost certainly have at least known a family member or friend who was in service, and most of those of higher status would have kept at least one servant of their own. So it is hardly surprising to find suggestions that the hospital should be modeled on the home, with male doctors as *pater*

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familias, matrons as watchful mother figures, and nurses sitting in a hierarchy not unlike that of household servants. Women doctors held ambiguous positions in this system; to be “mother” of the hospital they must displace the matron, while still appearing inadequate to the male doctor who would take the natural role of head of household/hospital. But to be *pater familias* themselves would require an overturning of social and domestic power structures—a challenge male doctors did not have to face.⁶² Given that most of the first and second generation of women doctors were clearly *lady* doctors—that is, with parents who were in elite professional careers, if not independently wealthy—it is unsurprising that they too favored a trained but explicitly socially inferior nurse to a challenging “Lady Bountiful.”⁶³

Resentment was not a one-way street; the increasing number of middle-class women who trained as nurses may well have been comfortable working under the direction of a man—a natural head of an institution—while baulking at being given instructions by women doctors who were social peers.⁶⁴ In the writings of women doctors we find occasional references to nurses and matrons resisting women doctors’ authority,⁶⁵ which extends to complaints that male doctors do not support women doctors when nurses rebel.⁶⁶ This friction contributed to the self-identity of women doctors in the period; as discussed above, nurses are regularly described as intellectually as well as (or instead of) socially inferior. In Barbara Brookes’s examination of a group of women doctors’ correspondence, when one woman doctor experienced resistance with the nurses, another responded, “I’m glad I never became a nurse ... they do get small and narrow.”⁶⁷

What Makes a Doctor

Despite such conflicts, qualified nurses are frequently also represented very positively in the writings of women doctors, as caring or dedicated workers. That said, trainee nurses (and

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midwives) are often infantilized as childish or naive, particularly in order to contrast with the more emotionally and intellectually mature female medical student or would-be student. It is a common trope in (auto)biographical accounts for older matrons or male doctors to recognize the moral and personal worth of a would-be lady doctor and ensure her smooth passage through training.

The actual work of nursing is generally represented by women doctors as hard domestic work, even drudgery. Why, asked Sophia Jex-Blake in 1872, should women “be limited to merely the mechanical details and wearisome routine of nursing, while to men is reserved all intelligent knowledge of disease?”⁶⁸ The less radical Elizabeth Blackwell represented nursing work as an ordeal or test of faith through which the would-be doctor should pass, arguing that if women really wanted to be doctors they should not turn up their noses at nurse training as “no-one who has the true spirit for this work in her will hesitate to accept the wearisome detail of the nurse’s duty, for the sake of the invaluable privilege of seeing disease on a large scale.”⁶⁹ This “wearisome activity” was necessary, of course, only because women were denied access to the sites of training and experience open to male medical students.

It was not just female doctors who made this distinction. An article in the short-lived London periodical *Time* published in 1888 by Mr. Arthur T. Vanderbilt discusses all the medical careers open to women, including dispensing, midwifery and massage (discouraged) as well as the roles of “lady doctor” and “lady nurse.” This covered possible qualifications, different training institutions, the course of study, and career paths after qualification. Vanderbilt points out that in the case of nursing

the woman who would enter upon [nursing as a career] must have considerable “nerve” ... at the same time, whilst possessing the necessary amount of self-

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control to go through her duties properly, she must be possessed of that gentleness, forbearance, and good temper, without which the most scientific nursing will be of little avail. ... The nurse will soon get used to such unpleasant sights, and will feel the importance, the—shall we say?—solemnity of the situation she has undertaken, and will look upon it not as for the mere love of gain, or as an ordinary livelihood, but as a *vocation*, a “calling,” and as one of the holiest of missions.⁷⁰

This passage is absent in the section on lady doctors: here the needs for “nerve,” forbearance, and patience for drudgery are absent, as is the idea of a “calling” or a holy mission. Instead the article concentrates on the right to practice, the good they can do in England and the colonies, and the costs and expenses of training and setting up in practice. The last point is significant: an important difference between nursing and medicine is the fact that the latter offered the hope of self-employment, while most nurses were employees. Most British medical graduates made a living from private practice, supplemented with income from institutions (like hospitals) or organizations (like medical insurance charities). Oddly, there is little emphasis on the issue of self-determination in the writing of the early female doctors, although they do talk of independence. Perhaps the difficult reality of founding a successful practice meant the opportunity to be an “independent businesswoman” was a double-edged sword.⁷¹ Comparatively nursing had the advantage of being a relatively stable career, which did not require so much financial investment up front.

Sophia Jex-Blake specifically contrasted the work of the nurse and the doctor in similar terms to Mr. Vanderbilt when making the case for women practitioners in 1872. It was in her

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Medical Women: Two Essays where she complained (to quote in full), “I do not know who has the right to say that [women] shall not be allowed to make their work scientific when they desire it, but shall be limited to merely the mechanical details and wearisome routine of nursing, while to men is reserved all intelligent knowledge of disease, and all study of the laws by which health may be preserved or restored.”⁷² What made the woman doctor different from the nurse was that she put up with the drudgery and repetitiveness of the nurse’s work not for its own sake, but for a higher ambition: qualifying as a physician or surgeon.

In both their immediate and retrospective accounts of their training experiences the first woman doctors repeatedly highlight the importance of an above average intellectual capacity. They discuss this criterion as a general requirement for doctors, but they also—particularly in personal correspondence and autobiographies—suggest that they as individuals are particularly blessed with brains or intellect. For example, there is the common trope of the process of “recognition” by senior medical personnel that is often encountered in the (auto)biographies of early women doctors; usually a matron/sister notices the young woman’s intelligence and enthusiasm as somewhat above that of her nursing student peers. On occasion the senior medical professional was a male doctor or surgeon, who would recognize the woman’s precociousness not only above nurses, but also above the rowdier, less motivated male medical students

Given the frequency with which women doctors represented themselves as clever or ambitious, it seems this cannot be seen by them as a serious liability, at least not in front of more sympathetic audiences. However, this emphasis on ambition might have contradicted traditional forms of idealized Victorian womanhood, it was apparently not necessary to present the woman doctor (unlike the nurse) as solely motivated by love, faith, or devotion. Women doctors could be intellectually curious, professionally ambitious, and academically driven. Of all the early women

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doctors, Elizabeth Blackwell was perhaps the one who most emphasized the sacred, spiritual, and moral nature of her calling, linking women's higher moral instincts to their ability and right to practice medicine. But even she linked morals to intellect: "Women are called upon very specially to judge all practical action as right or wrong, and to exercise influence for this high morality in whatever direction can be most powerfully exerted. ... With sound intellectual growth, the range of moral influence increases."⁷³

Blackwell admired intelligence in her female friends as well as bemoaning its lack in her nursing colleagues.⁷⁴ Although she figured women's entry to medicine as reentry, she acknowledged that "it was a revival in an *advanced form*, suited to the age and to the enlarging capabilities of women." And while she may have admired Nightingale's dedication and reforming principles, her work was not stimulating enough for Blackwell, whose criticisms of *Notes on Nursing* were not just literary: "I see ... how impossible it would have been for me to do her work. The character of our minds is so different, that minute attention to and interest in details would be impossible to me, for the end proposed—nursing. I cultivate observation with much interest for medicine—but I have no vocation for nursing and she evidently has."⁷⁵

The young British women who followed in Blackwell's shoes were even more explicit about their interests and skills. Garrett Anderson wrote to Blackwell in 1861 expressing her personal surprise at how much she was enjoying the intellectual part of training: "I feel anxious to tell you how very much I enjoy the work and study, as this is to a great extent unexpected to me. As I had not any very strong interest in the subjects, and was led to choose the profession more from a strong conviction of its fitness for women than from any absorbing personal bias, I was prepared to find the first year's preparation work tedious and wearing."⁷⁶ (Again, here, Garrett Anderson contradicts Scharlieb's suggestion that all the early women doctors were

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“enthusiasts,” but confirms Elston’s thesis that many women doctors chose medicine for more socio-political reasons.)

Sixteen years later, giving the 1877 inaugural address to the London School of Medicine for Women, Garrett Anderson argued that women did not have any special or unique ability in medicine, that the argument that women’s ailments needed women doctors was hollow, and that women’s supposed greater “sympathy” would be a liability for medicine, not an advantage, were it to exist: “Probably the truth is that medical women will differ as much with each other in this respect as medical men do. ... I would venture to assert ... that in many cases it may be doubted whether the most obviously sympathetic doctor is the best.”⁷⁷ Rather, what was crucially important was that a woman who wanted to be a doctor should possess “brains and cultivation.”⁷⁸

When Dr. Edith Pechey (later Pechey Phipson) gave the 1878 Inaugural Lecture at the London School of Medicine for Women, she emphasized the scientific curiosity that motivated some women’s medical interests. (Pechey was a friend of Jex Blake’s and had been one of the first women to be allowed to attend medical lectures in Britain.) Pechey suggested that “amongst earnest medical students one recognizes always ... two classes or types of mind ... those who have been drawn to the study of medicine by the interest they feel in the sciences with which it is allied and surrounded” and those who “are attracted by what is popularly called ‘the love of doctoring’—the immediate hope of mitigating and curing disease.”⁷⁹ Listeners may have interpreted this as the male and female mind, respectively, but it is notable that Pechey makes no such distinction and rather seems to be suggesting that both these kinds could be found among the intake of the School for Women.

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These two types of student are later revealed as the dogmatists and empirics, and a balance of both characters is ideally what is needed to make a successful doctor. Pechey's entire inaugural speech was a eulogy to the new scientific medicine of the nineteenth century, describing its superiority to either the dogmatic or empirical approaches of the past: "if Hippocrates and Galen—or even Hunter and Cullen, and the other teachers of last century—could advocate the importance of an intimate knowledge of science in their days, how much more may we impress upon you the same necessity now in the latter end of the nineteenth century, an age which has seen the birth of not a few sciences."⁸⁰ In describing the studies that awaited the incoming students, the basic sciences loom large—not just biology and chemistry, but also physics.⁸¹ None of this is particularly striking if we read it as an inaugural speech for one among many medical schools. Any such speech could be expected to emphasize the changing nature of medical education, which within a generation's memory had shifted from an emphasis on guild-like vocational, apprenticeship training to a system that required a university-based education in preclinical sciences and laboratory practice as well as extensive medical training and hospital experience.⁸² Women doctors were clearly keen, perhaps given their still precarious status, to write themselves firmly into this new modern system of medical training and practice.

Pechey's talk was also a warning to dilettantes—that is to women who thought they could dabble in medicine and fail to complete the whole, exacting course of training and registration. While the bane of nurse training was the Lady Bountiful, the bogeywoman for the first women doctors in Britain was the undertrained medical missionary. Here too was another fine line between acceptability and limitation that the first women doctors had to negotiate: whatever the criticism of medical missionary work, the reality was that missionary—or at least overseas—

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medical work was undertaken by around a third of the first and second generation of women doctors.⁸³

The apparently pressing need for women doctors to mediate between Hindu or Muslim women and Western medicine was a powerful justification for female medical training.⁸⁴ Even sometime opponents of women's entry into professional medicine could be keen supporters of the need to train women for service in the empire, as medical missionary work was rhetorically framed. When in the late 1880s the NHW put out an appeal for extra funds to allow a relocation to larger premises (as it was now training doctors from the London School of Medicine for Women), Nightingale responded with a donation of fifty pounds, since "you want efficient women doctors, for India most of all, whose native women are now our sisters, our charge. (There are at least 40 millions who will only have women doctors, and who have none)."⁸⁵

On the other hand, "doctors for India" could also pose a threat to the reputation of women doctors (at least, according to women doctors themselves). Both the London and Edinburgh Schools of Medicine for Women found that they had to institute special rules to deal with would-be medical missionaries. In 1888 Jex Blake wrote that the Edinburgh school was faced with the problem of young women who "fancied that after taking 'a few classes' they might consider themselves competent to practice as medical missionaries or otherwise."⁸⁶ This was a variation on the problem of the *Lady Bountiful*, that is, the undertrained (but presumably dedicated) volunteer—keen to start missionary work and unconvinced that the whole vigorous course of instruction was necessary to do "good work."

One way to deal with this problem was institute stricter screening for candidates. Just as Nightingale weeded out women she suspected might be enrolling as nurse trainees in order to become doctors, so the two women's medical schools introduced regulations to discourage

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women who might not complete the full course of medical education. Every student was required to “sign a declaration stating her intention to go through the whole course of study, with a view to admission to the [Medical] Register.”⁸⁷ Apparently a little knowledge could be a dangerous thing, and some commentators did emphasize that India needed, and its women deserved, fully trained women doctors, not medical dilettantes.⁸⁸

These sorts of medical women were a threat to the identity and professional integrity of the woman doctor in Britain. A desire to police the boundaries, and therefore the reputation, of a profession is by no means unique to medicine, let alone to medical women, and the struggles of male doctors between orthodox and unorthodox, mainstream practitioner and “quack” are well documented.⁸⁹ Such struggles, however, are going to be more pronounced and more significant for marginal professionals, and medical women definitely were marginal in the late nineteenth century. Not only did they have to distance themselves from nurses, but they also had to make sure these half-trained “medical missionaries” did not give the impression that lady doctors had less rigorous training than men. It was important that the still-controversial medical schools for women were not blamed for producing inadequately trained doctors: “neither of the special schools for women” insisted Jex Blake “can be held in any degree responsible if ill-educated women creep surreptitiously into the profession.”⁹⁰

Another possible threat was the midwife. The professionalization and specialization of the midwife was an acrimonious process in the late nineteenth century, with the male medical profession anxious about the balance between training and power. Many wanted a better-trained workforce of birth attendants to deal with routine pregnancies, particularly among the poor, given the stagnancy of British infant mortality rates; but many also feared the independent midwife with semimedical, semisurgical training.⁹¹ Local studies, such as those by Tania

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McIntosh, seem to show that in fact midwifery remained a profession for older, part-time married or widowed women largely drawn from the working class, rather than being “tak[en]over . . . by an educated elite.”⁹² Female doctors, of course, had the same hopes and anxieties as male doctors, but were in addition aware that badly trained “medical women” in any field reflected badly upon them in general.

At the same time, the very existence of highly trained midwives provoked the idea that perhaps smart, medically inclined young women would be better placed to specialize more directly in the diseases of women, to become specialized nurses, midwives, or semitrained “medical missionaries” (among the poor as well as overseas) rather than “proper” doctors. Since the first generation of women doctors (and probably most of the second generation) treated *only* women and children as patients, and many *did* specialize in gynecology, obstetrics, and midwifery, the presence of another female-appropriate profession in the same vocational area was a source of confusion for women doctors’ identity and their claims to be addressing a special need.⁹³

Given the tendency of female doctors to specialize in female subjects, it is interesting to find that there was still some resistance to this path. The desire to put clear water between the woman doctor and the midwife was an act of self-protection, and common enough to lead Elizabeth Blackwell to complain that young British, American, and French women were not willing enough to specialize in midwifery and related areas: “I do not know . . . whether this proceeds from indolence as midwifery is the most fatiguing and enchaining branch of the profession: or whether the neglect arises from failure to perceive the reason of our refusal to be simply midwives, for our insistence on a complete education really means our determination to elevate, not to repudiate midwifery.”⁹⁴

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While male doctors may have encountered practical professional difficulties (and possibly direct financial competition) when dealing with the newly reformed hospital and community nurses, including midwives, these new female professions could not impinge on the identity of the male doctor in the way they could the female doctor. The nurturing nurse, the angelic missionary, and the reproductively orientated midwife all provided more conventional medical roles for women to take, and therefore posed challenges to the first lady doctors.

Conclusion

Various campaigners and commentators used a rhetorical appeal to women's "natural" skills to justify their increasing presence in paid employment, and their (re)entry into male-dominated professions. This approach was not without its pitfalls, the obvious one being its tendency to limit the professional work of women to spheres that could be represented as appropriately feminine (a "separate but equal" distinction). A second complication was that such an argument often also included a measure of gentrification, where middle-class women refigured an existing female profession to make it respectable; in many cases this could be achieved only by arguing that some women—and that was nearly always the working classes—lacked the necessary female skills and needed to be taught them by more appropriate female role models (this was a crucial model for health visiting and domestic education).⁹⁵

I suggest that the argument for women as doctors was made more complicated by the existence of a parallel medical vocation that was clearly feminized, and that was undergoing significant changes in the second half of the nineteenth century. These changes included both a gentrification (that is, the changing status of the nurse from domestic servant to a ward-managing mother-figure) and a difficult professionalization (including the removal of Lady Bountifuls),

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which was driven as much by the demands of male doctors as it was by nursing reformers. Left without the ability to appeal directly to either their feminine skills or to their superior class, women doctors answered the question “why not become a nurse” with the answer “because I am cleverer, and more ambitious than that; because it would be a waste of my talents to settle for less.”

Intelligent, practical, and ambitious was a coherent self-representation for most of the first women doctors who have left written records. While they were also women, and specifically, ladies, they were able to distinguish themselves from nurses (and midwives) through their education and intellectual skills. To an extent, women doctors’ views on nurses mirrored those of their male colleagues. They universally approved of practical and academic training for nurses, as well as rigorous selection for good character; they also disapproved of volunteers, and Lady Bountifuls. But while the nurse might be the perfect housewife, in the writings of the women doctors she is also often slightly dull or stupid, her vocation a demanding but fundamentally intellectually unchallenging one; her training is mundane and tedious, and to be undergone by a chosen few only as a path to a vocation clearly represented as a higher ambition: medicine.

The first women doctors therefore had to articulate a three-layered identity, and to fight on three fronts to maintain boundaries: class, gender, and intellect. Not one of these categories was sufficient: nurses were more feminine, Lady Bountifuls often of equal or higher social status, and trainee missionaries and midwives made claims to professional training that the lady doctor had to represent as inferior to her own. When they talked about other medical professions women doctors appeared as doctors first and women second—that is their rhetoric often appears indistinguishable from that of male colleagues (especially in regard to training nurses). If

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anything they had to be more conservative about other female professions, showing more skepticism about the training of midwives and the skills of nurses, in order to maintain the necessary distance they had placed between medicine and other branches of the healing arts. Within these discourses we see all the familiar tropes of class, gender, and imperial rhetoric, and perhaps these can sometimes obfuscate the centrality of intellect, brains, and ambition in the self-identity of the first women doctors.

That this identity was tenuous is clear; the reality was that a third of first- and second-generation women doctors worked as medical missionaries or in secular philanthropic positions overseas; the majority of the rest struggled to maintain a general practice, a challenge in a competitive medical marketplace for any doctor, but more so for women whose pool of patients was often reduced to only women and children.⁹⁶ Some left the profession after marriage, many had to juggle their careers with obligations to care for (or nurse) husbands, children and other family members. Being a nurse was certainly a far less risky career choice—the training was easier to find and cheaper, and there was some guarantee of regular, reasonably remunerated work. The choice to become a doctor was clearly a political and social act, not merely a financial one; and the self-identity these women constructed worked, more or less, as an explanation for that risky choice.

The way class and social status add complexity to women doctors' identities would seem to make this a stereotypically British story, despite the Anglo-American Blackwell featuring so prominently. In fact, most of the early female doctors traveled outside Britain, training in Paris or elsewhere in Europe, visiting or living in America or the colonies; Ireland and Scotland also played important roles in the early education and qualification of British women doctors. One wonders how the first French female doctors responded to the sages-femmes Blackwell

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dismissed as childish, or how the younger Emily Blackwell (who remained in the United States when her older sister Elizabeth left permanently for the United Kingdom in 1869) related to the post–Civil War nursing profession. In other countries, other identities, perhaps more strongly based on race, ethnicity, or religion, may have developed. There is clearly more to be discovered about the (re)entry of women into the professions—and one profitable angle is to examine, as this article does, women’s attitudes and relationships not to men, or to male-dominated institutions and societies, but to other women.

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2. Catriona Blake, *The Charge of the Parasols: Women’s Entry to the Medical Profession in Britain* (London: Women’s Press, 1990), 76–79.

3. Susan Reverby, “A Caring Dilemma: Womanhood and Nursing in Historical Perspective,” *Nurs. Res.* 36 (1987): 5–11.

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41. Mary St. John Fancourt, *They Dared to Be Doctors: Elizabeth Blackwell, Elizabeth Garrett Anderson* (London: Longmans, Green, 1965), 104.

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