Sairey Gamps, Feminine Nurses and Greedy Monopolists: Discourses of Gender and Professional Identity in the *Lancet* and the *British Medical Journal*, 1886-1902

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**Abstract.** The British debate over midwife registration in the late 19th and early 20th centuries was highly gendered. Focusing on the period between the 1886 Medical Act and the 1902 Midwives Act, this article uses the content from the *Lancet* and the *British Medical Journal*, the two main general medical publications of the time, to explore the complex ways that gender works through other categories such as class and race to create professional identity. Specifically, this article demonstrates how man-midwives used gendered language to help create identities for themselves, female midwives, and other rivals in order to legitimize their own professional identity and practice and to delegitimize the professional identities of their competition.

**Keywords.** midwives, gender, doctors, identity

**Résumé.** Le débat britannique sur l’enregistrement des sages-femmes au tournant du 20e siècle, précisément entre la loi médicale de 1886 et celle de 1902 sur les sages-femmes, a été fortement genré. Cet article utilise le contenu des revues *The Lancet* et le *British Medical Journal*, les deux principales publications médicales générales de l’époque, pour explorer comment la catégorie du genre parmi celles de la classe et de la race est complexe et participe à créer une identité professionnelle. Spécifiquement, cet article dévoile comment les hommes accoucheurs ont utilisé un langage genré pour l’aider à se créer une identité tout comme les sages-femmes et les autres intervenants rivaux afin de légitimer leur propre identité professionnelle et leur pratique au détriment de leurs concurrents.

**Mots-clés.** sage-femme, genre, médecins, identité

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Throughout the 19th century, British medical men actively sought to raise the standing of the medical profession from that of a tradesman to a vocation imbued with ideals of education and gentlemanly status. However, men who involved themselves in childbirth—usually called man-midwives—lagged behind in gaining the prestige of other medical men and indeed were often looked down upon by other medical specialists. As Sir Henry Halford, President of the College of Physicians, noted in 1827, midwifery was seen as manual in nature, largely practised by lower-class women, and was thus “deemed foreign to the habits of Gentlemen of enlarged academical education.”¹ The general public also had a complex and often negative view of man-midwives. In the 17th and early 18th centuries, the presence of a man-midwife at childbed usually foreshadowed the death of mother and/or child; at that time man-midwives’ primary function was to perform either a caesarean section where the mother would die or a craniotomy where the child was removed from the womb in pieces.²

Yet, despite these obstacles, by the 20th century, man-midwives had elevated their status from lower-class professionals and bedside butchers and had made attending a woman in normal childbirth a respectable undertaking for both obstetricians and general practitioners.³ One way that man-midwives attempted to raise their status was to gain legitimacy as medical authorities by removing or encapsulating what they saw as untrained professionals, or “quacks,” who also worked in childbirth. Unsurprisingly, one of their main targets was female midwives who, by their very presence, lowered the status of man-midwives, especially amongst the larger medical community.⁴ This was not a particularly innovative strategy as the medical profession had managed to enfold both apothecaries and dentists into wider medical control through the regularization of their medical practices via the 1815 Pharmacy Act and the 1878 Dentists Act, both of which passed fairly smoothly.⁵ Medical men themselves, including man-midwives, were already regulated under a series of medical acts governing their training and practice.⁶ However, despite exhaustive attempts to regulate female midwifery throughout the 19th century, it was not until 1902 that the first Midwives Act was passed. This extended debate over the role of female midwives and their relationship to male practitioners has been a fruitful source for medical historians interested in the process of standardization and medicalization of the profession of both female and male midwifery.

Initially, the historiography of the midwives debate was split between what Lisa Forman Cody has referred to as “medical glory versus gory misogyny,” alluding to early works which either lionized the medical profession for saving women from the untrained charlatan midwives, or damned them for ruthlessly stamping out a valid female-based tradi-
tional practice. Some of the “medical glory” histories pointed to the advent of forceps and other techniques and the impetus for some upper-class women to switch to male practitioners, with other women following their elite example. However, recent historians have rejected such oversimplified explanations. Adrian Wilson has demonstrated how the collapse of traditional female networks contributed to changes in female midwifery. Other authors such as Cody and Lianne McTavish have examined the mechanisms, often tied to concepts of gender and language, which both male and female midwives deployed to increase their prestige, usually by demonizing the actions of the other group. This article seeks to add to this historiography. Moving away from attempts to redeem or damn either male or female midwives, it illuminates one aspect of how man-midwives sought to use the discourse surrounding the midwives debate in order to increase their status. To do so it focuses particular attention on the intense period between the 1886 Medical Act, which increased man-midwives’ authority by requiring all medical practitioners to receive some training in midwifery, and the 1902 Midwives Act, which finally settled the debate. The significance of this 16-year period is amply demonstrated within the two main medical magazines of the time, the _Lancet_ and the _British Medical Journal (BMJ)_ , as both devoted hundreds of pages of articles, letters, editorials and reports to the “midwife question.”

In paging through the _Lancet_ and the _BMJ_ during this 16-year period it becomes clear that man-midwives, as well as other medical practitioners, utilized the midwife question to create and fortify their own professional identity and authority by creating a series of “other” versus “self” binaries. These binaries were based around complex ideas of how gender interacts with other signifiers such as class and age to create identity. These binary discourses were first and most effectively mobilized against the “untrained” midwife. However, as professional competition and inter-professional rivalries worsened, some man-midwives turned their attention to delegitimizing the “trained” midwife—those who had biomedical and institutionally based training under the administration of medical men. In focusing on trained midwives, man-midwives utilized popular ideals of Victorian and Edwardian femininity and their relation to women in the workforce. Finally, as the rift within the profession over the female midwife question widened, man-midwives turned these discursive weapons against each other. Rival groups of man-midwives tapped into new concepts of middle-class masculinity to both build up their profession and tear down rival practitioners; in doing so they provide historians a window into changing ideals of masculinity and professionalism.
CASE 1: THE PROFESSION AGAINST THE UNTRAINED MIDWIFE

Most of the male medical profession was united in attempting to rid themselves of what they termed the “untrained” midwife. However, their use of the term “untrained” is misleading as this designation was applied to all midwives who were not trained in a medically controlled institutional setting. The designation “untrained” therefore included the many safe and effective midwives, who had traditional apprenticeship training under an established and respected midwife, as well as the very dangerous and largely ignorant women who dabbled in midwifery as part of a wider career in baby farming, sick nursing, and laying out the dead. However, the male medical profession rarely took notice of this heterogeneity of practice, instead reducing all untrained midwives to the lowest common denominator. They did this by appropriating the character of Sairey Gamp from Charles Dickens’s Martin Chuzzlewit, published in 1843-1844; Dickens described Sairey Gamp, a midwife and monthly and sick nurse, as:

a fat old woman, this Mrs. Gamp, with a husky voice and a moist eye, which she had a remarkable power of turning up and only showing the white of it. Having very little neck, it cost her some trouble to look over herself, if one may say so, at those to whom she talked. She wore a very rusty black gown, rather the worse for snuff, and a shawl and a bonnet to correspond ...The face of Mrs. Gamp—the nose in particular—was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits.

However, whereas Dickens’s Sairey Gamp was a fully fleshed out character with both negative and redeeming features, the man-midwives’ “Gamp” was a flat caricature, a trope associated solely with sloth, greed, alcoholism, and filth. Indeed, as the “Gamp” trope was repeatedly deployed in both the Lancet and the BMJ, it deviated significantly from Dickens’s character until it became a medical creation in all but name. The Gamp midwife, as described in the Lancet and the BMJ, was created as a foil, an “other,” against which the man-midwife could positively define himself and his practice.

The first disqualification of the medical Gamp midwife was her gender. As a woman she was seen as inherently—biologically—divorced from modern scientific practice; her knowledge and skills were based on orally transmitted tradition and tricky intuition rather than recognized medical information. Victorian gender schemas already deemed men to be naturally reasonable and empirical and thus also modern and scientific, while women were viewed as closer to nature and thus more emotional and intuitive. Characteristics such as emotion and intuition which were seen as changeable and unreliable, were given lower value
and could only be tamed by masculine reason. Further, though both men and women might aspire to reason through advanced education, only men could actually achieve it. Medical men applied this assumed gender opposition to their advantage. For example, William Smyly, in his 1894 address at the annual meeting of the British Medical Association, clearly differentiated between the authoritative knowledge of the medical profession and the knowledge of midwives when he opened his speech with the following words: “the struggle between science, and nescience, [sic] represented by medical practitioners and midwives commenced in the sixteenth century.” This binary between the scientifically educated man and the untrained natural woman was repeated and tied more securely to the Gamp identity in an 1889 article in the BMJ which discussed the ways of preventing ophthalmia neonatorum which caused blindness in infants. In Ireland some efforts had been made to provide informational cards to educate untrained midwives in the prevention of the disease by wiping the infant’s eyes with a clean cloth. However, the article concluded that this was a largely ineffective measure as the scientifically based language on the card was “couched in terms which we think might rather puzzle the Sairey Gamp.” Many doctors went even further, suggesting that the Gamp midwife would be unable to read the card at all.

Indeed, numerous articles and letters in the Lancet and the BMJ focused on illiteracy as a classic characteristic of the Gamp identity and a factor in her disqualification for future training. Illiteracy was thus a hurdle that kept the Gamp from attaining higher status, as she, unlike medical men, could not educate herself through the use of recognized medical texts within an institutional setting. The apprenticeship model, which the male medical community itself had utilized prior to the mid-19th century, was increasing portrayed by the medical profession as a relic of the dark ages, especially since there were no outside powers ensuring a homogenized quality of practice. Instead the medical community legitimized science-based learning within a standardized institutional (hospital and college) setting. The untrained midwife was thus unfit for the practice of midwifery both due to her lower class and assumed illiteracy, and because of those handicaps was unable to accumulate the formal training that doctors deemed acceptable. This “ignorance” was repeatedly deployed in the Lancet and the BMJ. For example, when the Lancet editors censured a midwife, Mrs. Speakman, for her involvement in the improper burial of an infant, they connected her “improper training” to her illiteracy and deemed her “ignorant.” “Here we have an elderly woman induced to become a midwife because her mother was one before her, ignorant to the depth of not being able to write her own name and unscrupulous enough to certify what she and others knew to be a falsehood.” The “falsehood” that Mrs. Speakman
committed was certifying an infant, who had lived a very short time, as stillborn. She later testified that as soon as it was born she knew it would not live. Despite the fact that in that same article the *Lancet* noted that the cost of burying a stillborn in Mrs. Speakman’s parish graveyard was 1s. 6d., while the cost of burying an infant which was born alive was 9s. 4d., a considerable difference for a poor family, they did not see the cost as a possible reason for her lying. In fact the journal actually hinted that Mrs. Speakman had colluded in infanticide and was attempting to cover her crime.

Contributors to the *Lancet* and the *BMJ* used criminal abortion and infanticide as a key characteristic of the Gamp midwife and deployed it often. Sometimes they reported on actual cases as some midwives were involved in illegal baby farming, abortion, and infanticide. However, just as often the journals would twist the evidence or use it out of context to suggest guilt where it had not been proven or was improbable. For example, in 1895 the *Lancet* published an article entitled “Murder Made Easy” about an untrained midwife and the death of an infant. The body of the article actually admitted that the infant died of overlaying, and so was accidentally smothered. Despite the sensationalist title, the midwife’s only crime was to take the body of the infant directly to the graveyard caretaker without first informing the authorities. Most doctors were very focused on maintaining standards of public health and order and so were concerned with issues of documentation and collection of statistics; such data was important to the state’s operation and gave doctors an increased authority as both accumulators and interpreters. Conversely, many untrained midwives were more aligned with their patients’ needs, including their inability to pay funeral expenses for an infant who had lived only a short time. Such cases demonstrate the class barriers between many doctors and their poorer patients and the congruence of class between many untrained midwives and their clientele.

Doctors also focused on the Gamp midwife’s age to emphasize the gap between the modernity of science and medicine, as practised by doctors, and the backwardness of traditional female midwifery. Though Dickens’s Sairey Gamp was not particularly aged, the medical Gamp midwife certainly was. Prior to the mid-19th century the public and the medical profession had considered age a necessary qualification for a good midwife, as this meant she had steadiness, experience, and had likely borne children herself, which gave her additional authority. Conversely, in the latter years of the 19th century, the medical profession redeployed advanced age as a disadvantage of the Gamp midwife. Older midwives were seen as fundamentally backward as they could not possibly be aware of recent advances in obstetric medicine. At an 1898 coroner’s inquest in Yarmouth this connection between age and inability to understand new innovations in medicine was made explicit. “The mid-
wife stated that she had been in practice for thirty-eight years. Therefore she had begun her practice when antiseptics were unheard of; and had probably passed the teachable age before their utility in midwifery practice had been demonstrated.”23 In another, more colourful, example a doctor described the midwife in question as a “drunken old hag” and in almost every report of an inquest involving an untrained midwife of advanced years her age was not only mentioned but the number of years was actually reported.24 By implying that the only qualification of the real life Gamp midwife was her age, doctors further distanced her knowledge from that of the medical profession.25 Of course this conception of age as a negative quality was not extended to older male medical professionals; there were no critiques of their practice to be found in either journal. Age was a gendered construct.

Medical men did not create these gender roles or the association of class, age, and ignorance; they were part of an intricate schema based on Victorian ideas of science and empire, which gave meaning to gendered categories and did so both within the boundaries of Britain and within the British colonies. In the latter case the schema often included racial considerations. As was noted earlier, white men were seen as more modern, scientific, and rational than women who were portrayed as natural and intuitive; the same schema also was used to devalue the knowledge and rationality of non-white men who were considered to be “naturally” feminine and thus divorced from scientific progress. The result was a metaphorical hierarchy with white men at the top as the most modern, the most fit for positions of authority, and non-white women at the bottom. White women and non-white men were in the middle and had an ambiguous position in relation to each other.26

Though in the case of the British midwives debate both the medical men and the midwives were white, there is still evidence of this schema in action. This is because, as authors such as Anne McClintock in Imperial Leather have noted, in the colonial British Empire categories of race, gender, and class intertwined and were expressed through each other in order to create hierarchies where women and racial minorities were “collectively figured as racial deviants, atavistic throwbacks to a primitive moment in human prehistory.”27 Drawing on these schemas of race and gender, many medical men in the Lancet and the BMJ attempted to portray female midwifery as archaic and suitable only for non-white conquered colonials. These connections were enhanced by the fact that many medical men, unable to set up and sustain a practice in Britain due to high levels of competition and a flooded practitioner market, worked in India or other British colonies for at least a period of time.28 Dr. Mary Scharleib, one of the few pioneer women physicians,29 talked about her experiences as a doctor in India where “Mahamedan and Hindoo [sic] ladies were never attended by men in their confinements.”30
In articles focusing on colonial midwifery, particular attention was usually paid to sensational or gory details gleaned from viewing the experience through a colonial lens. For example, in an 1892 article entitled “Barbaric Midwifery,” Dr. J. K. Simpson gave his observations on the birth process amongst Alaskan Indians. According to Simpson a hole was dug in the ground and the labouring mother, attended by three “squaws,” one of whom he identifies as a midwife, “squats over the hole, as in the act of defaecation.”31 Simpson also focuses on the lack of sanitation, the “foul smelling mass” of herbs applied to the umbilical cord stump, and the fact that the child, in being born in a hole, often sustained injuries from the fall from his mother’s womb.32 These descriptions of “barbaric midwifery” were designed to relegate midwives to both Britain’s less developed past and the present of countries deemed less civilized and less modern, and to suggest that female midwifery was a bestial affair.

CASE 2: THE TRAINED MIDWIFE UNDER ATTACK

Though the medical profession was fairly united in its condemnation of the untrained midwife, a major rift occurred when it came to deciding who should replace her—this issue became the crux of the midwife question.33 The majority of medical men were what I term “registrationists.” As a group, they wanted to see the female midwife brought under wider medical control through a system of training and licensing similar to that which occurred regarding dentists and apothecaries. However, there was a smaller, though extremely vocal, group of medical men, whom I term the “oppositionists.”34 The members of this group felt that all cases of childbirth should be overseen by a medical man. They attacked the trained midwife and her supporters in the hopes of reframing her in such a way as to either severely limit her practice or to eliminate it entirely.35 They felt that the very existence of trained female midwives would call their own professional prestige into question. As one oppositionist put it, to tolerate even trained midwives was risking “returning with a vengeance to the early days of the century when obstetrics were thought unworthy of the study by learned men.”36

However, the oppositionists could not attack the trained midwife’s knowledge base as they had done with the Gamp midwife; to do so would be to attack their own training and practice methods especially as some doctors and organizations, most importantly the London Obstetrical Society, had created non-regulatory training programs which certified midwives. Though these certification programs did not have any legal bearing, midwives used the prestige of their certificates to build up their practices.37 Instead, medical men attacked the trained midwife’s ability to understand what she had learned and suggested that what
she did manage to absorb was the wrong type of knowledge. For example, William Fraser opined, “it is neither necessary nor desirable that these women should aspire to be amateur doctors or even specialists in their own department although no doubt some advances have already been made in this direction.” Fraser recounted overhearing one midwife who had formal institutional training say to a patient, “You are suffering from inflammation of the overtures.” Thus, in order to devalue the knowledge that the trained midwife had worked so hard to obtain, midwifery practitioners suggested that trained midwives had learned nothing more than a few technical terms only good for “impress[ing] those more ignorant than themselves.” In the eyes of her opponents, the trained midwife’s knowledge was in many ways as worthless as the so-called intuitive knowledge of her untrained colleagues. Furthermore, in the same way as her Gamp sister, a trained midwife’s very womanhood disqualified her for higher levels of practice. As a female, she was considered inherently irrational, unable to think scientifically, and prone to gossiping and other thoughtless behaviour. One medical man considered midwives’ “frivolous nature” among his primary concerns regarding their registration. “Among the objections was this, that there was a great deal of idle talk among females, who often did harm with their tittle-tattle.” It should be noted that these same tactics were used to delegitimize female physicians and female medical students. Ultimately, these attacks on the knowledge base of the trained midwife failed to gain extensive support amongst the medical profession as a whole and with the public. This is likely because influential bodies such as the London Obstetrical Society championed the trained midwife and believed firmly that, through legislation, the medical profession would be able to gain enough control over female midwives to direct their practice to suit the professional needs of man-midwives and the medical profession.

A much more popular tactic—indeed, even the General Medical Council supported the idea—was to neutralize some of the power of the trained midwife by using language to re-signify her as a nurse. The Victorian period was a time of great change for nursing, resulting in the splitting of the profession between two types. The first type was the old conception of a nurse who was more of a domestic servant and was often subjected to the same stereotypes of laziness and drunkenness as the Gamp midwife. However, a new type of nurse was also developing which fit the ideals of turn-of-the-century womanhood, especially since Florence Nightingale had been transformed into the caring “lady with the lamp” during the Crimean War. Many doctors had also started employing these nurses as monthly nurses who were trained to fulfill any domestic tasks associated with birth, such as washing the mother and baby and relieving the doctor of some of the tedious hours waiting
for active labour to begin.\textsuperscript{44} Whether she was a glorified domestic servant or a young, feminine caregiver, nurses rarely worked as independent practitioners; they typically acted under the supervision of doctors or the authority of a religious order. Even nurses who worked privately as sick nurses in their patient’s homes were forced to maintain certain levels of conduct and deference to keep their employment and secure future references. Thus, contributors to the \textit{Lancet} and the \textit{BMJ} realized that while the public was unsure whether a midwife was subordinate or equal to a doctor, they would know that a nurse was definitely subordinate; doctors sought to capitalize on that fact.

The first way in which the medical profession attempted to linguistically transform the midwife into a nurse was simply to refer to a midwife as a nurse whenever possible, especially when framing the language of prospective Midwives Bills.\textsuperscript{45} Dr. Charles J. Cullingworth noted that the use of the title of nurse, “signifying a limitation of responsibility” had specific effects in the minds of the public, as to them “a nurse always means someone who is subordinate to the medical man, who acts under his orders, and has no independent responsibility.”\textsuperscript{46} In a letter to the editors of the \textit{BMJ} a doctor, who identified himself as a “Senior G.P.,” wrote the following: “What a lying-in woman requires, above all, next to a bed in sanitary surroundings, [is] a nurse.”\textsuperscript{47}

One of the reasons that the nurse trope was so popular within the medical community was that many medical men in the \textit{Lancet} and \textit{BMJ} were concerned that female midwives were beginning to act like male practitioners in their adherence to modern medical theory. To widen the ideological gap between their practices they attempted to focus attention onto aspects of midwifery that were associated with more general care giving and not with the actual delivery of the child. They especially wanted to separate midwives from more technical procedures such as prescribing drugs or mixing antiseptics.\textsuperscript{48} Medical men connected the idea of midwives as caring nurses to ideals of Victorian womanhood and ascribed to midwives a nature that focused on care giving as a natural extension of feminine sensibility. Doctors spoke of midwives as drawn to their calling from “womanly sympathies [which] prompt them to do the best they can for their patients.”\textsuperscript{49} Properly trained midwifery nurses “shrank from more serious operations.”\textsuperscript{50} In this they were trying to create a binary between midwives and male practitioners, with the latter framed as active agents doing more than just waiting for nature to take its course. However, historians such as Jean Donnison have demonstrated that the idea that midwives were ever purely non-invasive and merely waited on nature to take its course is a fallacy. Despite the fact that they were not allowed to use instruments such as forceps, some midwives engaged in other aggressive practices such as stretching the vulva, putting pressure on the top of the stomach, and even tying the
mother to the birthing chair and forcing her to push before she was fully dilated.51

Though the idea of the midwife reframed as a nurse was very popular with the medical profession as a whole, it was not as popular with members of Parliament; MP’s saw the strategy for what it was and refused to confuse the public on the issue of midwives by changing their name within draft midwives bills.52 One MP, Walter Foster, angrily took the medical profession to task, stating that “the adoption of the term ‘midwifery nurse’… [is] the preliminary to placing the midwife under the direct superintendence of a medical practitioner and the term was avowedly coined with this intention.”53 Despite attempts made by male medical practitioners to reify the midwife into a subordinate, more appropriately passive feminine role, the history of female midwives as independent practitioners seems to have protected their claims to autonomy.54

CASE 3: THE PROFESSION DIVIDED: COMPETING SELF-IDENTIFICATIONS

The oppositionists never could convince all medical men that midwives should be “ended” rather than “mended.” The oppositionists did, however, succeed in gaining enough converts to their cause to split the medical profession over the issue of midwifery registration. This split was one reason why the midwives debate dragged on for so long. In turning their attention from delegitimizing midwives towards delegitimizing one another, both the registrationists and oppositionists readily attacked each other with linguistic weapons and gendered ideas. In fact, in many ways these gendered concepts become sharper and more complex during the internal debate between medical men than they had been when the enemy was simply female midwives.

As in the case of the trained midwives, the oppositionist faction could not assault the actual education of their rival registrationists, nor could they attack their right as men to claim authoritative modern scientific knowledge on grounds of gender. Instead, the oppositionists sought a new, positive trope, an ideal, with which they could counter registrationist claims. Medical men’s earlier professionalization attempts had focused on raising their status to that of gentlemen, tapping into ideals of upper-class masculinity and they were facilitated in this by a general lack of competition within medical practice.55 Man-midwives, professionalizing later, took advantage of new middle-class ideals of masculinity that centred on self-reliance, a muscular work ethic, and self-advancement, though the latter was to be cloaked in an image of Christian morality towards the poor. However, this benefice to the impoverished was not the same noblesse oblige of the upper classes; it was a mission-oriented approach toward the working classes.56 Thus,
there was a generational divide within the profession. Further, while still wanting to raise the image of the medical practitioner, man-midwives in the late 19th-century faced a great deal of competition both from other medical men—there was a glut of newly qualified practitioners—and from non-doctors such as midwives. Thus, younger medical men often focused more on the business aspect of medicine and the difficulties in making a medical living. Searching for a trope that reflected this new masculine ideal as well as a new business-focus of the young medical profession, the oppositionists settled on the figure of the eager young general practitioner.

Many registrationists supported female midwifery because they did not want to deal with the time consuming and poorly remunerated midwifery cases amongst the poor. Yet, many young general practitioners relied on those cases to build their practices, especially in a time of intense professional competition. In 1895 the *Lancet* reported that, at a special meeting of the British Medical Association, the general practitioners present were angry because they believed that “this movement [for the registration of midwives] is ruining their practice, the importance of which as the surest stepping stone to family practice has long been acknowledged.” The delivery of a healthy baby was seen as the best way to recruit the rest of the family as future patients. The oppositionist faction further argued that the trained midwife would assault the dignity of the poor general practitioner; she would undermine him, forcing him to “cover” her mistakes and be at her beck and call. Frank Greeves contended that not only would midwives force the general practitioner to come to their aid—to the detriment of his own practice and health—but also that certain midwives would force the general practitioner to become an unwitting advertisement for her as she would use his good reputation to increase her own business.

I [do not] consider it fair that the shortcomings of both the midwife and the Legislature should have one common ending—the overtaxed generosity of the harassed and badly-paid general practitioner. Apart from these considerations, there is another one that the doctor who habitually assisted a midwife in her abnormal cases would soon become a local advertisement for that midwife—a fact that she, with true feminine loquacity, would not fail to avail herself of; and the more skilful the doctor the more so this would be.

Thus, the oppositionists drew attention to the differences between the young general practitioner and those doctors whose practices were lucrative and well enough established to allow them to be active in the medical societies and voluntary organizations that were agitating for midwife legislation.

This binary between the “old school” gentlemen doctor and the valiantly struggling young medical man was made even clearer in a let-
ber to the editor of the BMJ, signed only as a “Young GP.” It stated: “When I am short of money to pay my butcher and baker I confess that ‘the noble ideals of a grand profession’ begin to appear to me like suicidal nonsense … Exaggerated notions of ‘duty to humanity’ which are invented and taught by a few wealthy leaders of the profession, have to be practiced equally by the struggling poverty-stricken mass at the foot of the ladder.”62 Such testimony was welcomed by oppositionists who were eager to make the “wealthy leaders of the profession” into arrogant villains bent on denying their young brothers a chance at making a living. The oppositionist faction thus attempted to create a binary between the doctors who were pushing for midwife registration as decadent, lazy, and disconnected from the rigors of everyday practice, and the young general practitioner who met the central tenets of middle-class masculinity by working hard to establish a practice. The registrationist doctor was placed in a metaphorical ivory tower and was thereby portrayed as unqualified to express any opinion on the issue of registration and its effect on the average medical man.63

The oppositionist faction also often implicitly feminized the image of wealthy registrationist specialists. The former portrayed the latter as lecturing to interfering society ladies who had an interest in midwifery due to its impact on the poor and women’s rights. Prominent oppositionist Lovell Drage attacked the president and council of the London Obstetrical Society by stating:

The small clique who are quite willing to lecture to ladies in drawing rooms, and to make presidential addresses when no debate is possible, dare not open a debate upon the subject of midwives’ registration when it is possible for an answer to be given. Did not the President and Council of the Obstetrical Society refuse a special general meeting last summer though they were properly requested to do so?64

Drage used the metaphor of the drawing room not only to accuse the members of London Obstetrical Society of cowardice but also to suggest that, instead of debating the issue among their peers as they should—that is, facing the issue like men—they had brought in outside interested parties, thus further diluting medical authority over the issue of midwifery. Therefore the registrationist faction had chosen to side with, or even hide behind, society women.

Both registrationists and oppositionists accused each other of false philanthropy toward to the poor. Making sure the poor had adequate healthcare was the kind of project supported by new ideals of middle-class masculinity.65 Both registrationists and oppositionists argued that their solution, whether the advent of trained and licensed midwives, or the presence of doctors at each birth, was beneficial to the poor and provided them with quality healthcare.
There were other connections between issues of money and masculine gender identities. Oppositionists accused registrationists of backing registration because they saw it as a way to make money from the training, examination, and certification of midwives, which was, for some, a lucrative business. Further, oppositionist G. H. Broadbent accused registrationists of linking themselves to midwives in order to increase their individual practices by ensuring that such midwives would call on them to deal with difficult births.

Some of us know what it is to be treated somewhat coolly even by some of our brethren who are not connected with the teaching of midwives. And how is this? Simply because of our opposition to midwives who give them the advantage of their “patronage and support.” If these women are the feeders of their practices it is not surprising that they should turn the “cold shoulder” to those who would injure their patronesses!

Here Broadbent not only accused the members of the registrationist faction of looking after their own financial health as opposed to the health of the poor, but he also suggested that they were dependent upon women to secure their medical practices and were, in fact, emasculated. His use of the term “patronesses” in particular suggests that these men could not survive on their own merits and so sought additional assistance.

Finally, the oppositionists portrayed the registrationists as being duped by wily female midwives and their supporters, further eroding their masculinity and professional power. In one particularly lyrical statement, Dr. Lovell Drage compared the registrationists to the Brahmins of fable, who, according to the story, were eaten for their gullibility: “It appears to me that the earnest female workers in social subjects having taken the Brahmins of the Obstetrical Society for a ride on their backs have returned home with the Brahmins inside and the smile on their faces.”

In return registrationists attempted to frame oppositionists as “greedy … over-zealous [and] selfish” and “a lot of greedy, jealous, monopolists” whose concern over their own practice was cheating the poor out of affordable medical care and midwives out of a job. The accusation of setting up a monopoly, like the idea of using midwives to bring in new patients, called into question the ability of oppositionists to fulfil their masculine duty to create a practice on their own merits.

CONCLUSION

By moving beyond questions of whether midwives or doctors were better practitioners or who had the correct argument for registration, the British midwives debate becomes a rich source to uncover the ways in
which man-midwives, a profession struggling to gain its niche, used linguistic binaries to identify themselves in a positive light. Elements of gender are still clear in the debate but it is important to focus not just on questions of female midwives or male man-midwives but to see how gender politics work with, and through, issues of class, race, empire, knowledge, and ideals of science to create professional identities. Further, these concepts were made real and given authority through linguistic devices such as tropes. Within the pages of their journals medical men populated their world with dirty Gamp midwives, frivolous trained midwives, and re-signified each other as emasculated dilettantes and greedy monopolists. In turn they could position their own identities in relation to these ideas in sets of interlocking dualities that were used to formulate identity. That is, by creating who and what they were not, they created who they were.

This use of identity politics had real consequences. As the debate dragged on, the members of the House of Commons and of the House of Lords became increasingly annoyed with man-midwives’ bid for power. They consulted the medical profession less and less. When the Midwives Act was finally passed in 1902 it stripped medical men of much of the power and control over female midwives that they had possessed in earlier draft bills. Indeed, in the end, many medical men felt that they had been emasculated by the whole procedure. Dr. W. J. Sinclair, after the 1902 Bill passed the second reading, stated that, “there has probably not been in recent times an episode more humiliating to the medical profession than the second reading of this Bill.” Man-midwives’ bid to make the delivery of parturient women a masculine profession, worthy of both public respect and prestige among their medical colleagues was, at best, a mixed success. Their attempts to do so, however, provide a fascinating window in how gendered concepts of identity were used to create professional identity—a factor in the professionalization of both midwives and man-midwives that deserves further attention.

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NOTES


2 Adrian Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660-1770* (Cambridge: Mass: Harvard University Press, 1995), p. 50, 96. Wilson notes how women would delay calling in the man-midwife due to their dread. This connection of man-midwives to death slowly changed, however, as innovations such as the forceps
allowed for increasing numbers of live children to be born in difficult situations. This reversal of fear aided man-midwives in transitioning from emergency practitioners to practitioners who would oversee normal births.


4 Man-midwives went by many names during this time and the term obstetrician was used only sporadically; others used the French term accoucher or other titles. However, the term “man-midwifery” was still often used. For the sake of clarity I will be using the title “man-midwife” to refer to any medically trained man whose practice focused on the care and delivery of parturient women. General practitioners also delivered babies and so are included in the term man-midwives. Though midwifery was only a part of their practice, many general practitioners were very involved in the debate. Further, many medical practitioners not involved with childbirth were interested in the midwife question as it pertained to the professionalization and prestige of the profession as a whole.

5 Donnison, *Midwives and Medical Men*, p. 56, 175.

6 These included the Medical Acts of 1858 and of 1886. The latter made it a requirement that all persons accepted to the Medical Register had to have qualification in midwifery as well as medicine and surgery. Donnison, *Midwives and Medical Men*, p. 67, 117.


9 This archive is not without bias as it only records the testimonials of medical men who either were involved with the publication of the journals, as writers or editors, or who felt strongly enough about the issue to write to the journals themselves. However, both the *Lancet* and the *British Medical Journal* (hereafter BMJ) took pains to publish letters from all sides of the debate though both journals were, based on the editorials, initially biased in favour of registration of midwives. Towards the end of the midwife debate both journals became more neutral. For more information see, P. W. J. Battrip, *Mirror of Medicine: A History of the British Medical Journal* (Oxford: Clarendon Press, 1990), p. 7, 68.

10 The untrained midwife did have a small number of champions within the *Lancet* and the BMJ though occasionally they benefited from positive testimony. For example, Clement H. Sers: “It will be interesting … to watch what the poor in the agricul-
tural districts will do cut off from their succour and supply of Gamps."


13 BMJ, 11 August 1900, p. 337.


15 Lancet, 16 September 1893, p. 717.


19 Lancet, 10 October 1896, p. 1024.


22 BMJ, 5 March 1898, p. 668.


24 Lancet, 22 November 1890, p. 1126.


28 Most women doctors did not feel a sense of kinship with female midwives and, like male doctors, they saw them as a source of competition. See Digby, *The Evolution of British General Practice*, p. 153. The voices of female doctors were severely limited during this time. Mary Scharleib’s statement was one of the only ones I found in either the *Lancet* or the *BMJ*.

29 Lancet, 10 September 1892, p. 633; BMJ, 22 January 1887, p. 158-159; and 30 April 1892, p. 927.

30 BMJ, 30 April, 1892, p. 927.

31 BMJ, 30 April, 1892, p. 927.


33 Both the registrationist and oppositionist factions contained man-midwives, general practitioners, and other interested medical practitioners.

34 By limiting their numbers I am referring to those medical men within the oppositionist group who refused to countenance any working-class midwife. By defining
their acceptable midwife so narrowly, these oppositionists were, in reality, calling for the end of the majority of female midwifery. BMJ, 22 June 1895, p. 1418; 17 July 1895, p. 249; 9 May 1896, p. 1156; 18 November 1889, p. 1447; 25 November 1899, p. 1517; 9 December 1899, p. 1618; Lancet, 24 May 1890, p. 1149; and 10 September 1892, p. 631.


The oppositionists argued that the London Obstetrical Society was primarily interested in the money they made from the program and not for the welfare of the poor. Dr. Francis Henry Champneys, President in the London Obstetrical Society, countered this stating, “We began the work because there was no other competent body to begin it and we have continued it purely from public spirit.” Lancet, 12 April 1985, p. 1039.

Lancet, 30 May 1896, p. 1522.


BMJ, 4 June 1892, p. 1205.


Donnison, Midwives and Medical Men, p. 94.


There were variations on that same theme, including: “midwifery nurse,” “monthly nurse,” and “obstetric nurse.” BMJ, 4 August 1894, p. 282; 3 November 1894, p. 1015; 25 May 1895, p. 1176; 1 June 1895, p. 1240, 1244; 15 June 1895, p. 1356; 22 June 1895, p. 1417-18; 19 September 1896, p. 794; Lancet, 27 April 1895, p. 1068; 18 May 1895, p. 1282; 25 May 1895, p. 1339; 8 July 1895, p. 1472, 1474; and 28 July 1900, p. 295.

Lancet, 2 April 1898, p. 957-58.


The Apothecaries Act of 1815 did place the preparation and dispensing of drugs under medical purview but most midwives continued to use drugs and make up cordials to treat both the mother and child. Medical men saw this as a form of unqualified practice. BMJ, 27 February 1897, p. 567; 1 December 1900, p. 1563; Lancet, 13 February 1897, p. 468; 22 October 1898, p. 1074; and 2 December 1899, p. 1542. Doctors were also concerned about the use of antiseptics which, in their pure, undiluted, form were usually poisonous. Lancet, 23 June 1888, p. 1276; 13 February 1892, p. 374.
Sairey Gamps, Feminine Nurses and Greedy Monopolists

49 BMJ, 3 June 1893, p. 1183.
50 BMJ, 3 June 1893, p. 1183; 11 June 1892, p. 1259; and BMJ, 11 June 1892, p. 1260.
54 Summers, “The Mysterious Demise of Sarah Gamp”; Young, “‘Entirely a Woman’s Question?’”
59 BMJ, 22 June 1895, p. 1419; 22 July 1899, p. 251; 29 July 1899, p. 313; 17 November 1900, p. 1478; and Lancet, 2 October, 1897, p. 882. Covering was a semi-legal term used by the General Medical Council and the medical profession to denote a situation where a medical practitioner used his or her position to support an unqualified practitioner. A doctor would “cover” the unqualified practitioner by signing off on his/her cases and signing any death or other certificates as necessary. This action was banned by the profession as “infamous conduct” and a medical man found “covering” was liable for removal from the Medical Register.
56 BMJ, 22 July 1899, p. 251-52.
51 BMJ, 25 May 1895, p. 1175; 20 March 1897, p. 755; 22 July 1899 p. 251; 29 July 1899, p. 313; 18 November 1889, p. 1447; and Lancet, 2 February 1895, p. 312. It is interesting that the general practitioner was chosen to be the heroic trope for oppositionists. As Anne Digby has noted, general practitioners did not enjoy high status amongst their medical peers. However, Digby also demonstrates that for general practitioners, walking the tightrope between trade and business-oriented medical practice and the appearance of gentility were more important and more difficult. See Digby, *The Evolution of British General Practice.*
62 BMJ, 22 August 1896, p. 476.
64 BMJ, 4 April 1896, p. 881.


70 *BMJ*, 7 June 1902, p. 1450.