



NUI MAYNOOTH

Oilscóil na hÉireann Má Nuad

**The *Dublin Medical Press* and medical authority in Ireland
1850 – 1890**

By

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Ann Daly
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This is for my mother

Catherine Ann Magner Daly

My promise true.

INTRODUCTION

Nineteenth-century Ireland saw the rise of modern Irish nationalism, sweeping changes in land reform, the growth of a new bourgeois class and the parallel decline and collapse of eighteenth-century social structures. In short, it was a period that crystallised the major social features of modern Ireland. R.V. Comerford asserts that the preoccupation with the ‘mythic march of the nation’ has detracted from the importance of the latter half of the nineteenth century.¹ This study seeks to highlight the significance of this time period in relation to laying the foundation stones for a centralised and modern health-care system. This system in turn would ensure that the figure of the doctor was a real presence in the lives of the public and, as the *Dublin Medical Press* indicates, it bolstered the perception of the medical practitioner as moral guardian of society in general.

This thesis is not a study of the medical profession in Ireland in the nineteenth century. Though the structures and the hierarchical and elitist nature of the medical establishment are explored, it is the doctors’ widening perception of their role in society, so carefully documented in the *Dublin Medical Press*, that the study seeks to highlight. That is not to say that the thesis is the study of the *Dublin Medical Press* itself.² Rather, the *Dublin Medical Press* is examined in this study as a framework of

¹ R. V. Comerford, ‘Ireland 1850–70: post famine and mid Victorian’ in W. E. Vaughan (ed.), *A new history of Ireland v: Ireland under the Union, 1 1801–70* (Oxford, 1989), p. 372.

² A notable study of this publication has been done. See Robert J. Rowlette, *The Dublin Medical Press and Circular, 1839–1939: a hundred years in the life of a medical journal* (London, 1939).

the developing moral role of the medical profession in Ireland in this period. Unlike other contemporary Irish medical publications (see below), the *Dublin Medical Press* defined itself as a 'medico-legal' publication, an ambiguous term that legitimated discussion on a broad range of topics but with particular emphasis on public morality. Essentially, it is the profession's preoccupation with matters unrelated to health that forms the bulk of this study. Gender roles, lifestyle choices, customs and habits were all given generous column inches in the journal. This study seeks to explore the evolving moral role of medicine and, more importantly, how medicine became a formidable force as a moral authority in Ireland in the second half of the nineteenth century.

To address the question of medical authority in Ireland properly, one must examine the position of the profession at the beginning of the nineteenth century, before the catastrophic effects of the Great Famine. By 1841 the population of Ireland had increased at an alarming rate: the population was estimated at 8,000,000.¹ The disparity between the British and Irish economies was considerable and was reflected in the fact that one-third of the Irish population was dependent solely on potato farming.² Industry remained largely undeveloped, with the exception of the north of the country where the linen industry flourished. The demographic increase was concentrated in the poorer sections of society, mainly the cottier class.

Thus, in this context of a burgeoning landless peasantry, medical care for the poor was becoming burdensome for Ireland's relatively small group of gentry and middle

¹ R. B. McDowell, 'Ireland on the eve of the famine' in R. Dudley Edwards and T. Desmond Williams (eds), *The Great Famine: studies in Irish history, 1845-1852* (Dublin, 1994), 2nd edition, pp 3-4.

² Oliver MacDonagh, 'Ireland and the Union, 1801-1870' in Vaughan, *New history of Ireland v*, pp liv-lvi.

classes. There was a need for a national system of medical charity that would provide health care for a substantial element of the population that could not afford to pay for it. Unlike its near neighbour, Ireland in the nineteenth century did not have a considerable stratum of landed gentry who could shoulder the weight of charitable health care.

By the 1840s the foundations of a centralised health care system had been laid in Ireland. The Act of Union had had little impact on the administration in Dublin. R. B. McDowell points out that from the beginning of the nineteenth century there were persistent efforts in parliament to secure a systematic and structured civil service in Ireland.¹ Much responsibility was placed in the hands of the grand jury, a group of landed gentry of the county, who, with little or no training, presided over such matters as the support of hospitals, asylums and dispensaries as well as repair of roads, construction of buildings in the county and imposing taxation in the form of grand jury presentments.

Three different types of medical institution were founded: dispensaries, infirmaries and fever hospitals. In 1805, legislation stated that if a dispensary was set up voluntarily, the grand jury could annually make a grant equal to its subscriptions. As a result dispensaries increased rapidly in the 1830s.² Similarly, the Infirmaries Act of 1765³ stipulated that an infirmary be set up in every county, and the Fever Hospital Act 1807 provided that grand juries could present up to £100 at each assize.⁴ Thus, on the eve of the Famine there existed the rudiments of a national health-care system,

¹ McDowell, 'Ireland on the eve of the famine'.

² Ronald D. Cassell, *Medical charities, medical politics: the Irish dispensary system and the Poor Law 1836-1872* (London, 1997), pp 2-3.

³ 5 & 6 Geo. III, c. 20 (1765).

⁴ Cassell, *Medical charities*, pp 15-16.

which, unlike the British equivalent, was already heavily dependent on government subscriptions. Moreover, those receiving gratuitous medical aid were not limited to impoverished beggars, as was the case under the English Poor Law; rather, due to the impoverished condition of the population, medical charities on Ireland incorporated a much larger portion of society. This facilitated the growing sphere of influence of the medical profession.

The sheer magnitude of the Famine illustrated clearly the need for this health-care system, already partly subsidised by the government, to be centralised into a national framework. This would become a reality in 1851 with the Medical Charities Act.¹ The Irish medical profession was determined that an outside authority, such as the Poor Law Commissioners, would not dominate, and doctors ensured that their voice was heard in all legislation related to medicine. Irish medical men were determined that nothing should jeopardise their position and reputation in society. The ensuing legislation allowed the Irish medical establishment considerable sway, and thus established the profession as a force to be reckoned with. The Medical Charities Act of 1851 enabled a total of 723 dispensary districts to be created with 960 dispensaries, and in the next twenty years the system continued to expand.² Thus it is not difficult to imagine the scale of medical influence in the lives of ordinary Irish people in the nineteenth century.

As that century progressed, a medical authority replaced the power of the ascendancy in medical institutions and this added to the public profile of the profession. The Medical Registration Act of 1858 made mandatory the registration of all licensed

¹ 14 & 15 Vict., c. 68 (1851). For discussion of the significance of this act see Chapter 2.

² Cassell, *Medical charities*, pp 92–93.

medical practitioners and set up the General Medical Council to set minimum standards. The act primarily introduced a single medical register for all qualified practitioners, reflecting further movement towards unification and standardisation of training. This emphasis on credentialism and qualification fortified the authority of the profession in the eyes of the public. Consequently, the confidence of the profession in Ireland was strengthened until it perceived its role to extend far beyond the healing art. This study seeks to explore how the medical profession in Ireland, bolstered by such legislation as the 1851 Medical Act and the 1858 Medical Registration Act, came to view itself as the moral guardian of society.

By the latter half of the century the medical profession was involved in almost every institution in the state. The increasing importance of clinical teaching in medical education¹ added further to the profession's interaction with the public. The influence of medical men infiltrated lunatic asylums, dispensaries, county infirmary hospitals, fever hospitals, schools and indeed the private homes of their patients. Perhaps it was the sheer scope of their influence that enabled them to be accepted as authoritative voices in Irish society in such a short space of time. This authority was further bolstered by the rise of the middle classes.

The aftermath of the Famine saw the gradual rise of the substantial farmer whose difference from the landlord class was subtler. Hoppen points out that the decades after the Land War saw the dramatic relative advance of the farmer.² Farmers were able to combine their land acquisition to enable them to aspire to new economic

¹ Tony Farmer, *Patients, potions and physicians: a social history of medicine in Ireland* (Dublin, 2004), pp 83–84.

² K. Theodore Hoppen, *Ireland since 1800 – conflict and conformity* (New York, 1989), 2nd edition, p. 105.

standing. The horrors of the Famine ensured that this class of wealthier farmers endured by stressing the need not to fragment their farms but to extend them.¹ These farmers, the highest in the strata of tenant farmers, could urge their sons to professional careers and provide substantial dowries for their daughters. Therefore the attitudes of this emerging social group within the context of nineteenth-century society is significant, especially given that the emerging middle classes throughout Europe were struggling to define themselves – socially, politically and morally – at this time. F.S.L. Lyons reiterates this view of a better class of tenant farmer in the nineteenth century – he points out how, after the 1881 Land Act, the tenant farmer’s legal position was protected.² The precariousness of tenure of pre-Famine days was making way for a new stratum of middle-class farmer. It was now that a number of these tenant farmers could raise their sights socially and economically. The growth of towns and industrial opportunity, particularly in the north of the country, was beginning. Middle-class discourse on what was respectable and moral was more important than ever to a social group that struggled to define itself. The emphasis on educational credentialism and the conservative discourse of the medical profession as documented in the *Dublin Medical Press* found a sympathetic ear with this emerging social class. The set code of acceptable behaviour, rigid in its support of tradition, so espoused and legitimated by the medical profession had its origins in middle-class discourse. The prevailing ideologies promulgated by the medical profession would suggest a medical authority that would be acceptable to a significant portion of Irish society in the second half of the nineteenth century.

¹ G. O Tuathaigh, *Ireland before the famine* (Dublin, 1997), p. 51.

² F. S. L. Lyons, *Ireland before the famine* (London, 1973), pp 50–51.

1. The medical charities debate 1837–1838

Medical reform took on a new impetus when the medical charities of Ireland came under close scrutiny by the government. By 1837 the government had devised a bill whose basic provision was that the Lord Lieutenant was to appoint four salaried medical inspectors who were to be responsible for all the medical charity institutions and were to inspect each institution on a twice-yearly basis. All institutions were to make annual returns expounding all expenses and the Grand Juries were to continue to provide funds for the medical charities, but now at the behest of the lord lieutenant.¹ The bill stipulated that the English Poor Law Commission was to oversee all the medical charities and the inspectors. Almost immediately, Thomas Wakley (see below), fuelled no doubt by his dislike of the Poor Law Commission, slated the bill in the columns of *The Lancet*. The English experience of the Poor Law Commission had seen the medical capacity within the Poor Law reduced, poor remuneration for doctors, and no medical representation on the commission itself.² *The Lancet* particularly pointed to the eighth clause of the bill, which suggested Poor Law Commission dominance. The pertinent factor for this study is that Wakley and his medical journal proved a proficient opponent and consequently the Irish medical profession rejected the bill.

The next attempt at dealing with the medical charities of Ireland came the following year, and on this occasion the Royal College of Surgeons contributed to its content with elaborate and complicated qualifications for medical officers.³ Wakley, who viewed the Royal Colleges as institutions where nepotism and corruption were rife,

¹ Cassell, *Medical charities*, pp 42–43.

² *Ibid.*, p. 44.

³ *Ibid.*, pp 48–49.

once more launched an attack in the pages of *The Lancet*. Once again, *The Lancet* proved itself a force to be reckoned with.

The failure of the 1837 and 1838 Medical Charities bill reflected, perhaps for the first time, that medicine – physicians, surgeons and apothecaries alike – had reciprocal concerns and also that it could be a powerful integrated force against a centralised government body. Moreover, the success of *The Lancet* in this campaign highlighted the lack of a medico-political publication in the Irish scene.

2. Methodology

The main primary source for this study is the *Dublin Medical Press*, which can be found in three locations: the Royal College of Surgeons, the Royal College of Physicians and Trinity College, all in Dublin. In beginning my research I wanted to explore the main preoccupations of the medical profession in Ireland. My perusal of the bound, weekly medical journal began to identify recurring themes in this period. I began to discover, particularly in the editorial sections of the *Dublin Medical Press*, that the emerging medical profession was identifying all areas of public life as being within the realms of its authority. It became increasingly clear that the medical profession in the second half of the nineteenth century was at pains to establish itself as a respectable profession, on a par with the more established occupations of law and the church. Unlike other medical publications, the *Dublin Medical Press* did not limit discussions to topics of scientific medicine but rather appeared to try to advance the profession and expand the authority of its influence. Simultaneously, the medical profession sought to aggrandise the public perception of doctors and the practice of

medicine by establishing it as a highly specialised occupation, elitist in its selection process and exclusionary in nature.

This thesis seeks to underline the fact that the *Dublin Medical Press* has been underestimated as a source in the study of the history of medicine in nineteenth-century Ireland. While *The Lancet* has been widely used in the interpretation of British medical history, the *Dublin Medical Press* (almost identical in its approach) has been largely overlooked. The journal serves as a qualitative review of the social changes in Irish society. In the same way as medical history is a useful lens through which social history can be examined, the *Dublin Medical Press* provides historians with an excellent basis on which to interpret the evolving position of a profession. While this study is not a history of a medical journal, it is an exploration of how that journal interpreted the role of the profession. In my detailed and lengthy research, it became increasingly clear that the *Dublin Medical Press* identified morality as a major medical preoccupation in Ireland in the second half of the nineteenth century. The journal reflected how doctors were increasingly viewing themselves as an authority on emerging definitions of respectability. Editorial discussion in the journal identified clear ideological systems and was rigid in its support of tradition; it gradually evolved so that all areas of morality were deemed to be within the jurisdiction of the medical profession.

Its preoccupation with defining acceptable codes of behaviour gradually led to the medical establishment in Britain and Ireland making significant contributions to government social policy. This was a clear indication of the profession's rising influence in society. Its input to the mid-century medical charities debate and the

significant role it played in the Contagious Diseases Acts¹ of the 1860s are clearly documented in the *Dublin Medical Press*, and the instrumental contribution of medicine in government social policy outlines.

Even a cursory study of the *Dublin Medical Press* will highlight how the female was a subject of fascination for the emerging medical profession. The intricacies of her biological functions were debated and expounded despite the lack of any significant scientific advances in the medical understanding of the female body. Moreover, the *Dublin Medical Press* promoted ideal social characteristics of women, assuming nurturance and domesticity to have a deep biological basis in females. The journal illustrated how the medical profession constructed set codes of feminine conduct, in line with conservative and middle-class thinking, and associated that conduct with social stability, public order and the proper functioning of society. Women that failed to conform to these rigid definitions were invariably labelled and castigated. This was to have a profound effect on how doctors treated and responded to their female patients and shaped their contribution to social policy. It was a recurrent theme throughout the *Dublin Medical Press* in this period, and consequently shaped the direction of my research.

From the outset of my research, I have steadfastly ignored the elephant-in-the-corner that is the religious division in Ireland in the second half of the nineteenth century. I believe that to encompass religious conflict in the context of the rising influence of the medical profession in this period would ultimately deflect from the true purpose of this thesis. The *Dublin Medical Press* made scant reference to religious issues,

¹ 27 & 28 Vict., c. 85 (1864); 29 & 30 Vict., c. 35 (1866); 31 & 32 Vict., c. 80 (1868); 32 & 33 Vict., c. 96 (1869).

possibly because Catholics were a rarity in the upper echelons of the medical profession at the time. Moreover, other historians, most notably Peter Froggatt, have admirably covered the religious conflicts of the medical profession.¹ Consequently, the sectarian issues that emerge throughout Irish medical history are not alluded to in this thesis. Rather the study focuses on charting the increasing influence and authority of medical practitioners in the daily lives of the public in post-Famine Ireland.

Though the period of this study begins in 1850, in order to understand the preoccupations of the *Dublin Medical Press* at that time one needs to examine the period in which it first appeared. This primary discourse – that medicine in England and Ireland could benefit from a united front and recognition of shared interests – was prompted by the failure of the medical charities bills of 1837 and 1838 (see above). The nineteenth century would never see a unification of physicians, surgeons or apothecaries but the *Dublin Medical Press* for the next twenty years discussed the hypothesis of medical integration. This involved detailed examination of the four corporations that conferred medical, surgical or pharmaceutical qualifications – the University of Dublin, which conferred degrees in medicine only; the Royal College of Physicians; the Royal College of Surgeons; and the Apothecaries Hall. These corporations were always in dissension, with the physicians looking down on surgeons, the latter vying for the same privileges as the former and both the royal colleges viewing the apothecaries as their professional and social inferiors. To

¹ See Peter Froggatt, 'Competing philosophies: the "preparatory" medical schools of the Royal Belfast Academical Institution and the Catholic University of Ireland, 1835–1909' in Elizabeth Malcolm and Greta Jones (eds), *Medicine, disease and the state in Ireland 1650–1940* (Cork, 1999); Farnar, *Patients, potions and physicians*; Laurence M. Geary, *Medicine and charity in Ireland 1718–1851* (Dublin, 2004). See also Peter Froggatt, 'Irish students at Leiden and the renaissance of medicine in Dublin' in *Journal of the Irish Colleges of Physicians and Surgeons*, xxii, no. 2 (1993). Work done on the history of nursing has also detailed the nature of the religious divisions in the history of medicine. See Pauline Scanlon, *The Irish nurse: a study of nursing in Ireland: history and education 1718–1981* (Manorhamilton, 1991).

complicate matters of qualification further, there were many medical graduates from the Scottish universities. The *Dublin Medical Press* deplored the lack of cohesion but conversely, epitomised the professional division by flagrantly supporting the College of Surgeons.

The Famine had illustrated all too well the immediate need for a review of the medical charities in Ireland and consequently, the 1850 Medical Charities Bill and the subsequent Medical Charities Act dominated many of the columns of the *Dublin Medical Press* throughout the 1850s. The bill proposed to divide each Poor Law Union into dispensary districts, with the appointment of one or more medical officers for each one for medical treatment of the poor. Again, the bone of contention with this proposed legislation was the make-up of the central authority and its supposed threat to the position and control of the medical profession in Ireland. The resulting act¹ was hurriedly pushed through; it was confined to the dispensaries and as such did not address the broader medical charities system. Although it provided for the appointment of a qualified medical man on a board of health and it developed a modern and centralised network of dispensaries, the *Dublin Medical Press* for the next twenty years lamented the indeterminate nature of the act, which invited exploitation of doctors.

The 1858 Medical Act² was of huge interest to the *Dublin Medical Press*, in particular because it created a single register of medical practitioners and thus granted legal status to the profession. But the failure of the act to disqualify alternative medicine or quackery retained the attention of the journal until the end of the century. The fact that

¹ See Geary, *Medicine and charity*, pp 210–216.

² 21 & 22 Vict., c. 90 (1858).

the act put physicians and surgeons on an equal footing with apothecaries further fuelled the indignation of the *Dublin Medical Press*.

Therefore the time period of this study, 1850 – 1890 creates a rather neat framework in the period of Irish medical history. The influences of the 1851 Medical Charities act (itself prompted by the horrors of the Famine in the 1840s) and the 1858 Medical Registration Act in unifying the medical profession (albeit a limited form of unification) remains significant in determining how the Irish medical profession defined itself. The preoccupation of society (pre-empted by state intervention on sanitary measures) in matters of public sanitation particularly in the 1860s formed a backdrop to the medical interest in matters of public morality. This in turn influenced the medical discourses surrounding the Contagious Diseases Acts of the 1860s, which sought the forcible examination and detention of women suspected of carrying venereal disease. This identification of female bodies as sites of infection perhaps explains the wave of interest in gynaecological surgery that reached its height in Britain and Ireland in the decade following 1870. The medical preoccupation with the biological functions of the woman prompted the definition of all women by their reproductive role and the consequent labelling of non-conforming women as hysterical which reached its zenith towards the end of the nineteenth century. This time frame of forty years is at all times punctuated by the anxieties and struggles of a profession eager to establish themselves as a reputable profession in the eyes of the public.

In this thesis I seek to examine the evolving role of medicine as a profession in nineteenth-century Ireland as documented by a medical periodical. The study focuses on how the *Dublin Medical Press* mapped the struggle of medicine to establish itself

as a respectable and influential profession. The *Dublin Medical Press* was a ‘weekly politico-medical periodical’¹ and unique among medical publications of the time in that it was an outspoken advocate of the medical profession and an adversary of anyone or anything that sought to restrict or undermine the profession’s growing authority. As a medical journal, there is a distinct lack of original medical articles, many studies on medical advances were reprinted from *The Lancet*. Rowlette, the author chosen to pen the biography of the *Dublin Medical Press*² in its centenary year, conceded that its editor’s aim was to produce an informative newspaper rather than a repository of medical knowledge.³ For the purposes of this study however, the lack of original contribution on medical matters was, essentially irrelevant. The column space devoted to interpretation of contemporary non-medical issues and how the journal defined medical authority in such issues was much more important.

Rowlette highlights that the *Dublin Medical Press* was well received and read by the medical profession in Ireland by pointing to its wide circulation. A statement made at the end of the first quarter in the first year of the journal pointed to a circulation of one thousand copies a week.⁴ This circulation increased and its popularity was further indicated by the fact that the journal itself grew larger in volume, allowing for more space for advertisements. Though we cannot be prescriptive about how much the *Dublin Medical Press* reflected the opinions of Irish doctors, the journal’s fastidious preoccupation with the anxieties of the profession at this time period suggest that the focus of this ‘medical newspaper’ was to protect the interests of the medical profession. Professional competition, medical legislation, the role of medical men in

¹ William Wilde (ed.), *The Dublin Quarterly Journal of Medical Science*, i (1846), p. xliv.

² From 1866 on, the *Dublin Medical Press* became known as the *Dublin Medical Press and Circular*.

³ Rowlette, *Dublin Medical Press and Circular, 1839–1939* p. 53

⁴ *Ibid* p. 12

state intervention on health provision for the poor, the social position of the profession are the key areas that the *Dublin Medical Press* concentrated on and in doing so, point to the desire of the journal to reflect the interests and aspirations of the medical profession in Ireland.

This study is not an analysis of the publication itself but a study of its substance as a source in interpreting medical opinion in the period. In order to understand the distinctive nature of the *Dublin Medical Press*, it is important to examine, firstly, contemporary medical publications and secondly, the editors that published it.

3. Contemporary medical publications

The *Dublin Medical Press* was first published on 9 January 1839, and Rowlette¹ points out that only two other ‘medical newspapers’ were published in the British Isles at that time – *The Lancet*, founded by Thomas Wakley in 1823, and the *London Medical Gazette*, founded in 1827 and amalgamated with the *Medical Times* in 1852, subsequently appearing under the title *Medical Times and Gazette*.²

Rowlette refers to the only other Irish medical publication at that time – the *Dublin Journal of Medical and Chemical Science*,³ founded in 1832 – as merely a medical journal. Perhaps he had a point – from the beginning the *Dublin Journal of Medical Science*, as it was later known, rejected any reference to medical politics. Sir William

¹ Rowlette, *Dublin Medical Press and Circular, 1839–1939* p. 64

² *Ibid.*, p. 2.

³ This journal is now known as the *Irish Journal of Medical Science*.

Wilde,¹ editor from 1845 to 1849, stated ‘As an effect of the interest in pathological science, as well as the valuable discoveries in practical medicine which arose ... sprung the *Dublin Journal of Medical and Chemical Science* ... it was the first successful periodical, whether scientific, literary or medical that emanated from the Irish press during the present century’.² Wilde is anxious to point out that the *Dublin Journal of Medical and Chemical Science* ‘never admitted any subject extrinsic to matters to matters of practical or scientific import’.³

It would seem that this medical journal saw itself as above the clamour and noise of medical reform and, perhaps more significantly, it was very much linked to the College of Physicians, an institution raised on privilege and prerogative. Established in 1832 by a Dr Robert Kane, initially to deal with ‘chemical investigations’, it never showed any interest in medical politics. In 1831 Kane had been appointed to the newly established Chair of Chemistry in the School of the Apothecaries Hall and the following year he became a licentiate of the College of Physicians.⁴ He was persuaded to include medicine within the journal’s scope and thus obtained the support and help of his teachers, the famed Dr Graves and Dr Stokes, who acted as co-editors.⁵ Consequently, the *Dublin Journal of Medical and Chemical Science* had an exclusive beginning and Wilde, without modesty, acknowledges that it was ‘the best record of the modern school of medicine in Dublin; for, without distinction of persons, we may safely say, that there is no medical man in this city, or indeed in Ireland, who has not

¹ Sir William Wilde, father of Oscar Wilde and leading eye and ear surgeon. He became editor in July 1845 and almost immediately increased the size of the journal and its periodicity to that of a quarterly. Wilde, a keen medical historian, included a history of the medical journal in his editor’s preface. See T. P. C. Kirkpatrick, ‘Irish medical journals’ in *Irish Journal of Medical Science*, 6th series, cxxxix (1932), pp 243–245.

² *Dublin Quarterly Journal of Medical Science*, i (1846), pp xlii–xlili.

³ *Ibid.*, p. xliv.

⁴ Kirkpatrick, ‘Irish medical journals’, pp 251–252.

⁵ *Ibid.*

contributed to its pages'.¹ Rowlette confirms that it was a journal devoted to the advancement of scientific knowledge and not concerned with the particular interests of the profession or with anything of a medico-political character.²

The true test of its eschewal of all political intercourse arrived when Kane, due to his acceptance of the chair of Natural Philosophy in the Royal Dublin Society, resigned as editor.³ It would appear that Graves and Stokes engaged the services of Dr Arthur Jacob, professor of anatomy in the school of the Royal College of Surgeons, Ireland.⁴ The exact dates of Jacob's editorship of this journal unclear, but one of the articles published in March 1836 dealt with medical politics and this effectively ended Jacob's connection with the journal. His dismissal is significant in that it shows that despite his high standing in the medical world, the *Dublin Journal of Medical Science* was avowedly against any articles that alluded to reform. Jacob's offending article referred to the *British and Foreign Medical Review*, which was deeply offended, and the co-editors' apology begged that 'the harmony, so essential to the progress of truth, may be restored, and that both works, having for their object, the furtherance of science will continue in the mutual good understanding which has hereto existed between them'.⁵ Thus, the journal sought to promote itself as an exclusively scientific and educational journal which feared that any allusion to medical reform – a subject of major importance to all medical men at this period – would affect scientific respectability. The fact that medicine was struggling to establish itself as a respectable and serious profession perhaps explains the medical elite's reluctance to involve itself in heated political debate. However, its continued eschewal of medical politics led, of

¹ *Dublin Quarterly Journal of Medical Science*, i (1846), p. xliii.

² Rowlette, *Dublin Medical Press and Circular, 1839–1939*, pp 3–4.

³ Kirkpatrick, 'Irish medical journals', pp 253–254.

⁴ *Ibid.*

⁵ *Ibid.*

course, to a gap in the market, which the recently spurned Dr Jacob was most eager to fill.

In order to comprehend fully the context of nineteenth-century medical journalism one needs to look to *The Lancet* and its editor, Thomas Wakley. The fact that *The Lancet* was very similar in layout and tone to the *Dublin Medical Press* also makes it relevant to this study. Wakley was born in 1795 in Devonshire, the eighth and youngest son of a wealthy farmer, who chose medicine as a career and became an apprentice to the local apothecary when he was fifteen.¹ Wakley, ambitious from an early age, transferred to a London hospital in 1815 and two years later he became a member of the Royal College of Surgeons.² His experience of the system of education and promotion in London was to have a life-long effect on Wakley and would fill him with resentment towards the medical elite. Wakley's realisation that he would never rise through the professional ranks, simply because he did not have the money required for apprenticeship to a leading surgeon, made him a radical thinker.³ He interpreted the medical profession as a body that was steeped in nepotism, monopoly and privilege.

He established his medical journal in October 1823. From the outset *The Lancet* created a storm of controversy, often resulting in libel action, as Wakley attacked what he perceived as the corrupt elements of the medical profession. His publication without permission of hospital reports of clinical cases invited hostility from almost

¹ Martin Fallon (ed.), *The sketches of Erinensis: selections of Irish medical satire 1824–1836* (London, 1979) pp 2–3.

² Ibid.

³ Ibid., pp 4–5.

every surgeon in London.¹ *The Lancet* editorials contained polemic views and personal attacks on anything or anyone who was in discord with Wakley's viewpoint. The ferocity of language had never been used before in a medical journal but *The Lancet*'s popularity among rank-and-file practitioners was undisputed. It had come, according to Wakley, 'at a time when a Medical Journal had become not merely a luxury but a necessity to the busy practitioner'.² *The Lancet* was to prove a formidable weapon for Wakley in his attack on the Irish medical charities bills of 1837 and 1838 (see below), and there can be little doubt that it was in the wake of his triumph that the idea of the *Dublin Medical Press* was born.

The Lancet has also significance to this study in that it had an Irish correspondent with the pseudonym Erinensis. The author could not give his real name due to the risk of litigation as Erinensis poured scorn and derision on the Irish medical scene during the period 1824–1836. He was Dr Peter Hennis-Green, educated at Trinity College and an assistant and demonstrator to Professor James Macartney in the University of Dublin.³ In this post he succeeded none other than Dr Arthur Jacob, the future editor of *The Dublin Medical Press*. Erinensis was as scathing in his criticism of the Irish medical profession as Wakley in London was of the English medical scene, and filled a necessary function. Essentially, this revealed that the press was a potent and vigorous force in the ambivalent and contentious area of nineteenth-century medical reform.

¹ Ibid., pp 5–6.

² *The Lancet*, ii (1854), p. 173.

³ Fallon, *Sketches of Erinensis*, pp 8–9.

4. The birth of the *Dublin Medical Press*

Sir William Wilde stated that there was ‘a favourable opening for a second medical periodical in Dublin, particularly, as ... our own Journal never admitted any subjects extrinsic to matters of practical or scientific export’.¹ The *Dublin Medical Press*, ‘a stamped weekly politico-medical periodical’,² was first published on 9 January 1839 under the editorship of Dr Henry Maunsell and Dr Arthur Jacob. The opening words of the editors’ introductory address were: ‘The press which exercises so powerful an influence on the whole frame of society, has never yet been made available for the service of the medical profession of Ireland’.³ This medical publication was ‘directed to educated and cultivated minds’ and thus would ‘encourage honesty, bridle folly, and resist oppression’.⁴ The *Dublin Medical Press* had no intention of dedicating itself exclusively to matters of a medico-political nature, as the editor’s preface in the first issue reveals:

to diffuse useful knowledge, and to afford others an opportunity of doing so; to rouse the slumbering energies of the Irish practitioner; to preserve the respectability of the professional character; to instil honourable principles, and foster kind feelings in the breast of the student; and to protect the institutions of the country against the attacks of those interested in its destruction.⁵

These were impassioned words, with strong emphasis on the respectability and reputation of the profession. Though the layout was almost identical to that of *The Lancet*, the *Dublin Medical Press* had little of the former’s radical, left-wing attributes. Whereas *The Lancet*, directed by Wakley, attacked the weaknesses and perceived corruption of the medical establishment in England, the editors of the

¹ *Dublin Quarterly Journal of Medical Science*, i (1846), p. xlv.

² *Ibid.*

³ *Dublin Medical Press (D.M.P.)*, i (1839), p. 1.

⁴ *Ibid.*, p. 2.

⁵ *Ibid.*

Dublin Medical Press bolstered the position of the medical elite and corroborated many of its privileges. This is hardly surprising given that the editors were leading professors of the Royal College of Surgeons in Ireland.

Arthur Jacob

Unlike his counterpart Thomas Wakley, Jacob was born into medicine – both his father and his grandfather were surgeons. His father, John Jacob, was surgeon to the Queen’s County Infirmary and had a large practice in the midland counties.¹ The young Arthur Jacob was an apprentice with his father and at Dr Steevens’ Hospital, by 1813 he was a licentiate of the Royal College of Surgeons and in the following year he graduated as doctor of medicine in Edinburgh². Jacob experienced none of the educational struggles of Wakley, born to a farmer, and Erinensis was keen to point out Jacob’s familial advantages in *The Lancet*: ‘He [Jacob] is the son of a county physician, who, it appears, has been so well pleased with his own success in the profession, that he has given it, as a fortune, to no less than three of his sons ... the salvation of bodies is likely to become a hereditary property in the house of Jacob’.³ Jacob shared none of Wakley’s bitterness and disillusionment with the system of hierarchy within medicine in England and Ireland.

Jacob soon established himself in surgical practice as an ophthalmic specialist and in 1824 took part in the setting up of the Park Street School of Medicine. In 1826 he was elected Professor of Anatomy and Surgery in the school of the Royal College of

¹ Charles Cameron, *History of the Royal College of Surgeons in Ireland* (Dublin, 1886) pp 390–391.

² Rowlette, *Dublin Medical Press and Circular, 1839–1939*, pp 3–4.

³ Fallon, *Sketches of Erinensis*, pp 78–79.

Surgeons, which position he held for forty-one years.¹ He was also elected President of the College in 1837 and 1864.

Jacob was also a medical scientist of some renown. He published a paper in 1819 in which he outlined his discovery of the bacillary layer of the retina – which was known for some time afterwards as the membrana Jacobi.² He was also responsible for the discovery in 1827 of an ulcer of the eye, known as Jacob's ulcer in the nineteenth century and now known as a rodent ulcer.³ *Erinensis* was less than complimentary to Jacob's prowess as a medical researcher: 'As an author, Mr Jacob is not wholly unknown. In some papers published in one of the periodicals, he lays claim to the discovery of an undiscovered something in the eye; but not a creature, we believe, gives credit to the assumption'.⁴ Jacob took great pride in his discoveries and never failed to remind subsequent writers of them when they failed to mention his work.⁵ He is also known for his invention of a curved needle for eye surgery; once again, *The Lancet's* man in Dublin – *Erinensis*⁶ – saw an opportunity to belittle Jacob: 'He [Jacob] also claims the invention of an aneurysm needle ... We certainly saw an engraving of an instrument somewhat similar to the one in question, and circulated by Mr Jacob; but there is reason to suppose, from the silence on the subject, that the invention is neither the property of Jacob'.⁷ Jacob, perhaps, represented all the elements of prestige and privilege that Wakley despised in medicine and, for his part, Jacob could never forget Wakley's criticism of the College of Surgeons' monopoly of

¹ Rowlette, *Dublin Medical Press and Circular, 1839–1939*, pp 3–4.

² Davis Coakley, *Irish masters of medicine* (Dublin, 1992) p. 73.

³ *Ibid.*

⁴ Fallon, *Sketches of Erinensis*, p. 78.

⁵ Coakley, *Irish masters of medicine*, p. 74.

⁶ *Erinensis* (Dr Peter Hennis Green) took over from Jacob as demonstrator to Dr James Macartney in Trinity College and so it is likely that the two men would have met.

⁷ Fallon, *Sketches of Erinensis*, p. 79.

county infirmaries in the 1838 Medical Charities Bill.¹ Despite the personal and political animosity, Wakley and Jacob were both outspoken and often polemic in their differing views on what form medicine and medical practice should take, and were fervently committed to the advancement of medicine and medical practitioners in the eyes of society.

Jacob married Sarah Carroll, with whom he had six children – five boys and a girl who died in infancy.² One of his sons, Archibald, was to succeed him as editor of the *Dublin Medical Press*. Jacob was well known for being a highly disciplined scholar and for his unwillingness to take time from his busy work schedule. He continued as Professor of Anatomy and Physiology until he was seventy-seven years old and he resigned as editor of the *Dublin Medical Press* when he was seventy, to allow his son Archibald to take over – how much involvement he had in the journal after this is impossible to gauge. In 1860 there was an attempt by members of the College to present Jacob with a testimonial but he refused it.³ He eventually was persuaded to accept a medal crafted in his honour. Cameron, who must have known Jacob in person, had this to say of him:

He was an uncompromising champion of the College School. In the debates, which occurred at the meetings of the College, he always took a leading part, and was by no means 'mealy mouthed' in referring to those from whose opinions he differed. As a writer he was much given to drastic polemical articles, which frequently irritated those against whom they were directed. He rarely indulged in even the mildest festivities, but devoted himself wholly to his professional and editorial work, and to original research. He remained up till long after midnight as a rule, nevertheless he was always punctually at work early in the day. He had an intense dislike to charlatanism and humbug of every kind. He took a deep interest in the success of his pupils, and he laboured hard to instruct them. One of his few weaknesses was his notion that

¹ Cassell, *Medical charities*, pp 52 - 53

² Cameron, *History of the R.C.S.I.*, pp 390–391.

³ *Ibid.*, p. 392.

he alone of the professors should always give the introductory lecture at the commencement of the session at the College School.¹

Jacob was the editor of a very outspoken and controversial publication that in many ways mimicked *The Lancet* and certainly he hoped to use the *Dublin Medical Press* as a tool for medical politics as *The Lancet* was used in the medical charities controversy in the 1830s. But there the similarity ends – Wakley was a radical thinker, who used the columns of *The Lancet* to highlight the perceived inequalities of the medical system of England. Wakley did not represent the medical elite of London but rather, the more humble, provincial practitioner. Jacob, on the other hand, was not a radical thinker but an upholder of the medical *status quo*, deeply interested in promoting medicine as a respectable but elitist organisation. In his study of the *Dublin Medical Press*, Rowlette refers to Jacob as a reforming radical,² but Jacob never supported any radical change – rather, he fought for an equal footing with physicians and resented attempts by the apothecaries to do anything other than dispense drugs. He possibly saw the advantages of medical unification in the 1830s when the threat from a central government body (the Poor Law Commission) loomed large, and he was a key figure in the setting up of the Medical Association in 1840, but Jacob embodied the intra-professional rivalry that dominated Irish nineteenth-century medicine. He sought primarily to protect, enhance and bolster the position and reputation of qualified medical practitioners in Ireland.

Henry Maunsell

It is impossible to distinguish between the work of Arthur Jacob and Henry Maunsell in the *Dublin Medical Press*, both having founded the weekly publication in 1839.

¹ *Ibid.*, pp 391–392.

² Rowlette, *Dublin Medical Press and Circular, 1839–1939*, p. 53.

Maunsell was also a professor in the school of the Royal College of Surgeons. He was born in 1786 and was apprenticed at the age of fifteen to the surgeon Charles Johnson, who was later Professor of Midwifery at the college school.¹ In 1832 he graduated as Doctor of Medicine from Glasgow University and he became a member of the Royal College of Surgeons the following year. His speciality was midwifery and in 1835 he was elected to that chair in the College.² In 1841 he was elected the first Professor of Hygiene, or 'political medicine' as it was called.³ Importantly for this study, Maunsell was appointed secretary to the council of the College of Surgeons⁴ – a role that demanded that he spend much time in London representing the College. In 1860 he bought the *Dublin Evening Mail*, which he ran until his death in 1879. Rowlette points to the fact that he was more interested in journalism and public affairs than in professional matters,⁵ which is significant to this study because the columns of the *Dublin Medical Press* are filled with public, non-medical issues affecting the population.

Archibald Jacob

Archibald Jacob took over the editorship of the *Dublin Medical Press* in 1860. He was the fourth son of Arthur Jacob and his wife, born in Dublin in 1837, and was educated at St Peter's School, York and Trinity College.⁶ He graduated as Medical Doctor in 1862, studying diseases of the eye and ear under his father in the Royal College of Surgeons.⁷ In 1866 he succeeded his father as ophthalmic surgeon to the

¹ Ibid., pp 5–6.

² Cassell, *Medical charities*, pp 52–53.

³ Rowlette, *Dublin Medical Press and Circular, 1839–1939*, pp 5–6.

⁴ Ibid.

⁵ Ibid., p. 7.

⁶ Ibid., p. 60.

⁷ Cameron, *History of the R.C.S.I.*, pp 477–478.

City of Dublin Hospital and in 1882 was elected Professor of Ophthalmology in the College of Surgeons; he held that post until his death in 1901.¹

To what extent Arthur Jacob bowed out of the editorship of the *Dublin Medical Press* after he handed that duty to his son is impossible to say, but Rowlette points to the fact that there was little difference in the style of the editorial writing from that in the volumes of the preceding few years.² This is also my viewpoint and thus it would appear that Arthur Jacob maintained a significant presence in the *Dublin Medical Press* until the 1870s. What is perhaps most pertinent to this study is the fact that from its beginning in 1839 until the year of Archibald Jacob's death, the *Dublin Medical Press* was dominated by one family and, more specifically, two men. In order to measure this significance of this we need to examine, in a general sense, the dominating subjects that preoccupied the editors in the time frame of this study.

In 1901 Archibald Jacob died, and with him the Jacob tie to the *Medical Press and Circular* as it was then called. From then on the periodical ceased to be an Irish medical journal. Archibald Jacob's editorial role had decreased significantly in the years before his death, and the English editor took over completely afterwards. Thus, the only Irish periodical produced primarily to examine the evolving role of the medical profession in nineteenth-century Ireland came to an end. Its importance as a historical source cannot be overestimated because it was precisely its outspoken, polemic views that give us an indication of how medical men viewed their position in Irish society. Men like Arthur Jacob, Henry Maunsell and Archibald Jacob represented a social division who, in a relatively short space of time, rose through the

¹ Ibid.

² Rowlette, *Dublin Medical Press and Circular, 1839–1939*, p. 59.

ranks to become serious contenders in public matters. The *Dublin Medical Press* represents their frank communication with members of their profession – this was not a periodical for public perusal – and their attempts to establish, and then reinforce, the authority of medical men.

The 1860s saw Arthur Jacob handing over of the editorship of the *Dublin Medical Press* to his son Archibald – although, as mentioned earlier, there was no discernible change in the editorial comment for the next decade. This period also saw the beginnings of the sanitary movement in Ireland as Dr Edward Mapother was appointed the first Medical Officer of Health. His responsibilities included ‘advising the authorities on the measures for preventing disease, and submitting weekly reports of the causes of death within the city’.¹ The medical preoccupation with sanitary control is of considerable importance to this study for two reasons: first, the link between the public sanitation movement and nineteenth-century moral issues (which will be dealt with in Chapter 3), and secondly because it marked the crucial shift of medical discourse from specific medical matters to subjects of public interest. The *Dublin Medical Press* reflected this adjustment in its commentary on issues concerning public morality, anthropological issues and eugenics. These preoccupations reflected the widening sphere of medical influence and authority that this study aims to focus on.

In 1866 the *Dublin Medical Press* amalgamated with an English medical journal – the *Medical Circular* – to become the *Dublin Medical Press and Circular*. The combined journal was to be bigger, with more space given to original reporting, and was to be

¹From the *Dublin Medical Press and Circular (D.M.P.C.)*, 1867, cited in Rowlette, *Dublin Medical Press and Circular, 1839–1939*, p. 62.

devoted to Irish interests.¹ It would appear that Archibald Jacob was editor-in-chief and the contents were of mainly Irish interest for the next few years. The printing of the periodical was transferred to England in 1868 and a supplement, issued weekly, was added to deal specifically with matters of the Irish Medical Association.² The reasons for amalgamation were probably financial and from that point of view the journal enjoyed unprecedented success.³

The 1870s saw the journal focus once again on the question of reform, with a government legislative bill that focused on a three-portal system for admission into the medical profession – one from each medical division. Unsurprisingly, the age-old intra-professional enmity prevailed; again, the attempt to unify medicine was doomed to failure. The 1880s and 1890s were dominated by medical interest in public morality issues as medical men became increasingly confident and assured of their position in society. The pages of the periodical increasingly reflected the profession's growing assertiveness in matters public and moral and consequently, its influence in the public arena proliferated. It is this area that this study ultimately seeks to explore.

5. Contributors and tone of the *Dublin Medical Press*

The first half of the nineteenth century is viewed as the most prestigious period in Irish medicine to date. William Stokes, John Cheyne, Robert Graves, Dominic Corrigan, William Wilde and others procured international renown for medical discoveries. Tony Farmar points out that, in one compendium of eponyms, there are nine Irish (male) surnames among the 2,500 male and female doctors mentioned and

¹ Rowlette, *Dublin Medical Press 1839–1939*, p. 80.

² *Ibid.*, pp 88–89.

³ *Ibid.*

seven of these were born between 1790 and 1810.¹ That is not to say that the first half of the nineteenth century (or indeed the second half) was a period of medical breakthrough. These names, known collectively as the Dublin School of Medicine, were not famous, unfortunately, for curing patients but rather for introducing new methods of bedside clinical teaching. Farmar notes that countries in the English-speaking world, especially Ireland, believed that medicine was an art, not a science, and was best taught at the bedside.² Despite the prestige and international renown of the 'Dublin School', no-one in Ireland was teaching or carrying out original research in histology or pathology by the use of the microscope. Medical men, by and large, remained confused as to the aetiology of illness.

The school did boast of inventions of medical instruments, such as Wilde's aural tools, Corrigan's pulse, Stokes studies on surgery of the chest. There are so many studies detailing the particulars of the 'golden era' of Irish medicine that to catalogue them here again would seem superfluous. In any case, this study is concerned with the developing role of medicine in society and consequently, the largely academic success of the Dublin School has little bearing on it. Nonetheless, there is little doubt that the profile of medicine was changing for the better and medicine itself was, by the mid-century, a lucrative career. Furthermore, Stokes, Corrigan and Graves were famous for their clinical lectures and these were often reproduced in the *Dublin Medical Press*. Rowlette points out that from the beginning it was the custom to print in each copy either a professional lecture or an original paper by a writer of standing.³

¹ Farmar, *Patients, potions and physicians*, pp 80–81.

² *Ibid.*, pp 99–100.

³ Rowlette, *Dublin Medical Press and Circular, 1839–1939*, p. 15.

Much space in the journal was given to reports of ‘scientific’ meetings from a variety of Irish, European and sometimes American medical societies. Jacob and Maunsell undoubtedly wanted to create a ‘scientific’ periodical, but unlike its more prestigious peer, the *Dublin Journal of Medical Science*, the emphasis in the *Dublin Medical Press* was most definitely medico-political and as a historical source, the wealth of information lies in the columns of the editorials where Jacob and Maunsell vented their frustrations.

This brings us to the subject of the tone of the *Dublin Medical Press*, for which the periodical is arguably most famous. Most blame is apportioned to Arthur Jacob for this, despite there being little evidence to suggest that he had a greater editorial role than Maunsell. Rowlette concedes:

The energy which the reformers [Jacob and Maunsell] promulgated their views is deserving of all praise, but not so much can be said of their methods. They were intolerant of all opposition and treated all critics as enemies. They imported personal attacks into all their advocacy.¹

Cassell describes the tone of the *Dublin Medical Press* as ‘articulate’ and ‘abusive’² while Geary refers to the ‘abusive and personalised opposition’.³ ‘Puffery’ or advertising was strictly frowned upon by the *Dublin Medical Press*, which was determined to shake from medicine any remaining ties with the concept of trading, and this resulted in a ‘naming and shaming’ of various highly positioned doctors such as William Stokes and Sir William Wilde (notable fellows of the College of Physicians). There was a review in 1839 of the soon-to-be-renowned classic, *Clinical Medicine* by Dr Robert Graves, that cites ‘the cool effrontery with which he attempts

¹ Ibid., p. 22.

² Cassell, *Medical charities*, p. 53.

³ Geary, *Medicine and charity*, p. 163.

to depreciate the whole mass of the profession in order to elevate himself and those whom he wishes to promote as jackals to him'.¹ Given Graves's subsequent rise to fame, this review must have cost the *Dublin Medical Press* some embarrassment. However, given the acute rivalry at the time between the College of Surgeons, represented by Jacob and Maunsell, and the College of Physicians represented by Graves, Stokes, etc., the comments are not astounding. The fact that Jacob had most likely ended on a sour note in his editor role with the *Dublin Journal of Medical Science* (see above), where Graves and Stokes were co-editors, also serves to explain any animosity. Wilde, in his editorial preface of the same journal in 1846, had this to say:

Were we writing as historians simply, and not in our editorial capacity, we might offer some remarks on the tone and style of the *Dublin Medical Press* – but, under existing circumstances, we deem it more proper to refrain.²

Realistically, the periodical reflected excellently the rancorous and petty relationship between the divisions of the medical professionals in the nineteenth century.

The fact that the *Dublin Medical Press* was the only Irish medical publication permitted to comment on medico-political issues serves to explain in some way the direct tone of the journal. Jacob and Maunsell made no secret of the fact that this journal was primarily to bolster the respectability and status of the profession and consequently, they attacked without mercy any threat to that mission. The fact that – unlike *The Lancet*, which saw Wakley appear in court from its very beginning – the *Dublin Medical Press* did not have a libel case until 1876 suggests that outrage at its direct tone was limited and contained. The acerbic tone is significant in that it reflects

¹ Rowlette, *Dublin Medical Press and Circular, 1839–1939*, p. 35.

² *Dublin Quarterly Journal of Medical Science*, i (1846), p. xlv.

the energy and passion behind the medical profession's desire to better itself in the eyes of society, and it is this that is a pertinent part of this study.

6. Literature review

Promoting a profession

There is a considerable amount of literature on the subject of medical history in Ireland.¹ However, much of this work is narrowly focused, asserting the central role played by the doctor and presenting the history of the profession in a factual manner. These traditional studies do not criticise or analyse the developments in medical history. The patients seem altogether subordinated to the quasi-god-like figure of the doctor and the impact or influence of the profession in the lives of the ordinary people is not explored at all. Traditionally, medical history has been presented predominantly by historians who themselves are doctors or employees in the field of medicine, and as a result the interpretation of sources can be limited and biased. The traditional histories of Irish medicine appear to be congratulatory exercises, bent on mapping the story of 'great men', and promoting nineteenth-century Irish medicine as enlightened and progressive. The reality of a profession struggling to understand the nature of disease is rarely emphasised; the self-serving zeal that was an inherent part of the medical establishment in the second half of the nineteenth century is largely ignored. The fact that medical men were, in this period, predominantly preoccupied with establishing themselves as a respectable profession in the eyes of the public is not explored satisfactorily.

¹ For detailed and traditional studies of Irish medical history, see John Fleetwood, *The history of medicine in Ireland* (London, 1963); Eoin O'Brien, Anne Crookshank and Gordon Wolstenholme (eds), *A portrait of Irish medicine* (Dublin, 1984); B. P. Kennedy and Davis Coakley (eds), *The anatomy lesson: art and medicine* (Dublin, 1992). Farmar, *Patients, potions and physician* (Dublin, 2004).

The narrow focus of these works is principally on the promotion and aggrandisement of the medical profession without exploring the impact of medicine on the lives of their patients. Traditional medical historians offer valuable insights into the construction and development of the Irish medical schools, but inherent in their assertions are their obvious prejudices regarding the institutions they are attached to. They laud the achievements of the main colleges and medicine in Ireland as a whole. They examine the Irish medical profession in isolation – detailing curriculum changes, entry requirements and the evolving nature of medicine. They direct their discourses along the path of admiration and praise, and unfortunately show little evidence of the critical and analytical eye that, say, Roy Porter had in the English context. They make scant reference to the society that these medical men of the nineteenth century were being trained to cure or the effect that medical legislation was to have on people's daily lives.

Doctors in the Great Famine

The Famine highlighted all too clearly the inadequacies of the medical charities in Ireland, underlining the necessity of state intervention rather than a reliance on the philanthropy of the gentry. Traditional studies of this period, while valuable from the perspective of charting the events of this cataclysmic event in Irish history, are nonetheless a continuation of the heroic mode, presenting Irish doctors as intrepid and Herculean figures willing to sacrifice themselves for the good of humanity. R. Dudley Edwards and T. Desmond Williams (eds) work, *The Great Famine: studies in Irish history* (Dublin, 1956) explores the political background to the Famine and the organisation and distribution of relief. William McArthur's study on the medical

history of the Famine concentrates on the medical organisation and the characteristics of disease. The doctor is cast as a selfless figure, ignoring the threat of endemic diseases in order to treat his patients. The negligence and poor judgements of the medical profession, particularly the Central Board of Health, at this time are not examined. The analysis is uncritical and is not placed in the context of Irish medical history as a whole. This failing in such an important study of the period is a reflection of the gaps in Irish social history in general.

Joseph Robins' *The miasma: epidemic and panic in nineteenth century medicine* (Dublin, 1995) is an excellent study of endemic diseases in the nineteenth century. While it doesn't specifically concentrate on the Famine, Robins' critical examination of the disarray and division of the doctors at this period begins to address the deficiencies of traditional interpretation of the Famine. Robins clearly illustrates how lack of medical knowledge and professional cohesion seriously impinged on the work of the medical profession. He offers a critical interpretation of doctors' understanding of the transmission of disease rather than depicting, as traditional histories have done, the medical profession as a group of heroic saints. Though this work is narrow in focus – it concentrates primarily on endemic diseases – it paves the way to a more critical and analytical approach to the history of medicine in Ireland.

Authoritative histories of medical institutions

There is a wealth of written materials on individual medical institutions¹ such as hospitals, medical schools and the royal colleges. Ireland by the mid-nineteenth century was a centre for medical education, boasting medical schools and clinical teaching comparable to London and Edinburgh. These studies tend to be very narrowly focused, concentrating on a specific hospital or medical school without examining its broader context in Irish medical history. The impetus behind the writing of many has been to mark anniversaries or closing dates. Very often, the authors have been employees of the institution and therefore it is not surprising that the study is lacking in critical analysis or perspective. Questions regarding the wider place of the institution, its functions in society and its subsequent role in the broader climate of Irish medical history remain unanswered.

Medical historians

Laurence M. Geary's *Medicine and charity in Ireland 1718–1851* provides an interesting and valuable background to the medical charity debate of the 1830s. He examines in detail the eighteenth-century discourse on poverty; essentially the division of the poor into the deserving and non-deserving poor. He highlights the essential difficulty behind the medical charities set-up in Ireland – the fact that it was philanthropy-based, thus depending hugely on voluntary contributions. Geary also underlines the significance of extending the English Poor Law to Ireland in 1838,

¹ Alan Browne, *Masters, midwives and ladies in waiting: the Rotunda Hospital Dublin 1745–1995*; F. O. C. Meenan, *Saint Vincent's Hospital 1834–1894* (Dublin, 1905); Ronan O'Rahilly, *A history of the Cork Medical School 1849–1949* (Cork, 1949); T. P. C. Kirkpatrick, *The history of Doctor Steevens Hospital Dublin 1720–1920* (Dublin, 1924); J. D. H. Widdess, *The Charitable Infirmary Jervis Street, 1718–1968* (Dublin, 1968); Peter Gatenby, *Dublin's Meath Hospital, 1753–1996* (Dublin, 1996); Eoin O'Brien, Lorna Browne and Kevin O'Malley (eds), *The House of Industry Hospitals 1772–1987* (Dublin, 1988); Davis Coakley, *Baggot Street: a short history of the Royal City of Dublin Hospital* (Dublin, 1995); E. T. Freeman, *Mater Misericordiae Hospital: centenary, 1861–1961* (Dublin, 1962); F. O. C. Meenan (ed.), *The Children's Hospital Temple Street Dublin, 1872–1972* (Dublin, 1972); Tony Farmer, *Holles Street 1894–1994: the National Maternity Hospital* (Dublin, 1994).

reflecting the gradual transgression of the government from *laissez-faire* policies to a more centralised role and the far-reaching implications this was to have on public health.

Ronald D. Cassell's *Medical charities, medical politics: The Irish dispensary system and the Poor Law, 1836–1872* (London, 1997) is valuable to this study because it focuses on medical politics in Ireland during this period and the irate contention of medical men over standards of education and professional status, both with laymen and with each other. Cassell also examines the relationship of the profession with the state and various forms of state-subsidised medical relief, specifically the relationship of the Irish medical man with the Poor Law authority. This turbulent relationship is significant to this study in that it reflected the power of Irish doctors to delay social legislation and unite against a government central authority. Cassell's work does not examine medical influence on Irish society in this period; nor does the study explore how medicine established itself as a formidable and respected profession.

Tony Farmar's work *Patients, potions and physicians – A social history of medicine in Ireland* gives us an insight into the struggles that nineteenth-century medical men experienced in trying to understand disease, a definite problem given the fact that infectious disease was the biggest killer in Ireland. Farmar also underlines that despite the social and economic gains of middle-class Catholics, the medical world was still dominated by Protestants – particularly at the top levels. He points out that according to the 1861 census, Protestants represented 66 per cent of physicians and 70 per cent of surgeons in the country.¹ He also highlights the socially isolating role of the

¹ Farmar, *Patients, potions and physicians* pp 32

dispensary doctor, who often worked on his own in country districts, far from colleagues. This points to the fact that apart from the priest, the local medical man was often the only educated person in the vicinity, adding to his position of authority in the community. Farmar, though he produces an admirable snapshot view of the medical account of the social history of medicine, does not address the impact of this medical authority on the lives of ordinary people and nor does he discuss the experience of the patient. The fact that Farmar's work was published to mark the three hundred and fiftieth anniversary of the Royal College of Physicians of Ireland perhaps explains the lack of clear critical analysis of Irish medicine.

Greta Jones '*Captain of all these men of death*': *The history of tuberculosis in nineteenth and twentieth century Ireland* (New York, 2001) is an important contribution to the history of Irish medicine. While it is an insightful study on the history of a disease, it also points to the distinctions between Ireland and Britain in matters of health and underlines the marked social differences between the two countries. This refreshing view of Irish medicine is a much-needed break from the congratulatory and uncritical studies of more traditional historians. The unique socio-economic background of nineteenth-century Ireland and, as a consequence, its susceptibility to certain diseases ensured that the practice and organisation, and indeed discourse, of medicine would be peculiar to the country.

Inter-disciplinary approaches to medical history

Traditionally, Irish medical history has been narrowly focused, concentrating primarily on elite medical staff and factual descriptions of medical institutions. Some

studies¹ have acknowledged the necessity of a broader approach in the study of medical history in Ireland. To glean a clear perspective of the context of medical history it is necessary to incorporate economic, social and political history.

Jo Murphy Lawless' work titled: *Reading birth and death: A history of obstetric thinking* (Cork, 1998) outlines the issue of who should control childbirth. She emphasises that obstetric discourse from the nineteenth century has had a decisive impact on women's experience of childbirth. Murphy Lawless maps the rise in power of the medical profession and asserts that women were usurped in the process of childbirth by the newly established medical authority. Though this work is polemic in its radical feminism, this acknowledgement of the force of medical authority in nineteenth-century Ireland and its impact on the lives of ordinary people is a refreshing perspective in the study of medical history to date.

Leslie Clarkson and E. Margaret Crawford's *Feast and famine: A history of food and nutrition in Ireland 1500–1920* (Oxford, 2001) traces the history of food and famine in Ireland from the sixteenth to the twentieth century. From a social historical perspective, this study examines the economic and social forces behind what people ate and drank and the authors explore the relationship between eating, health and disease. This study is a pioneering and valuable addition to the understanding of medical history in Ireland and illustrates how food, nutrition and health are inextricably connected.

¹ Most notably Malcolm and Jones, *Medicine, disease and the state*.

Medicine, disease and the state in Ireland, 1650–1940 (Cork, 1999), edited by Elizabeth Malcolm and Greta Jones, is a wide-ranging work that attempts to bridge the yawning chasm of Irish social history. Unlike the traditional and narrowly focused medical histories, this study recognises the necessity to examine the political and social contexts in order to glean a clear picture of medicine in Ireland. The book is divided into three sections – medicine, disease and the state – and gives an excellent indication of the huge scope of medical history in this country. Crucially, it shows that medicine cannot be examined in isolation and draws on social, political and economic history to highlight the inherent link between medicine, disease and the state. This work acts as an anchor text to the study of medical history in Ireland by asserting the primacy of not one area, but many. Encompassing irregular practice, state intervention, nurses, midwives, the effects of public vaccination, the role of lunatic asylums in society and the regulation of sexuality within the remit of medical history, it essentially underlines the interdisciplinary prerequisite that shapes the future of the study of Irish medicine.

7. Chapter outlines

This study ultimately seeks to examine the impact of medicine and its evolving power on the lives of ordinary Irish people and more specifically, women. It is not a study of a periodical, namely the *Dublin Medical Press*, but rather a critical analysis of its interpretation of medical preoccupations in this time period. To do this I have divided the study into six distinct areas: prestige; exclusion; morality; contagion; gynaecology; and hysteria. Each section examines the evolving role of medicine and its power and how this impacted on the lives of its patients, specifically its female patients.

The first chapter looks at the efforts of medical men to establish themselves as a class. The weakness of the 1858 Medical Act was that it failed to outlaw unqualified practice and this resulted in a fiercely competitive market. Medical men also felt the need to distance themselves from the uneducated quack and so medical education in Britain and Ireland took on new importance. At the beginning of the nineteenth century only physicians required an M.D. – but even this did not suggest homogeneity of education because of the variable requirements and standards of the universities. This diversity of criteria was a feature of medical education throughout the nineteenth century, with the main colleges raising the levels of entry in the race for prestige. Medical education tended to emphasise the importance of a classical education, whereby a knowledge of Greek and Roman and indeed literature would make doctors welcome at drawing-room gatherings. This section highlights the fact that there was little to no collaboration between the groups. Physicians, highest on the rung of medical hierarchy, shunned the surgeons because of their links with medieval guilds and butchery. Surgeons sniffed at the humble apothecary, whom they perceived as little more than a glorified shopkeeper. All factions of Irish medicine spent a century in inter-professional bickering.

The second chapter examines the exclusionary nature of medicine. It explores the monopoly of medicine by medical men, juxtaposing the ‘open market’ that typified the practice of healing in the eighteenth century where popular medicine flourished in the form of wise women, herbalists, nurses and caring family and neighbours. Essentially, women were intimately involved in medicine. As the nineteenth century progressed this was to change dramatically. The *Dublin Medical Press* portrayed lay

people involved in the healing art as mindless, ignorant and dangerous. Its attack on popular medicine was an attack for the most part on women, whom it branded as 'irresponsible pretenders'. It also ensured that only qualified practitioners carried out the practice of midwifery. This in itself had catastrophic results for mothers as thousands died as a result of recurrent epidemics of puerperal fever. Nurses did not escape the wrath of the *Dublin Medical Press*, and it becomes progressively clearer that medical men required nurses but only in a position of subordination. The group to attract the greatest backlash from the medical profession was women who dared to aspire to careers in medicine. Medical men were sexually discriminating, offering biological arguments (for example, that the occupation of medicine would unsex a woman) in their efforts to prevent female entry into medical schools. The main thrust of their discourse was that women were naturally incapacitated for the general practice of medicine.

The third chapter deals with the expanding interest of nineteenth-century medical men in the moral lives of their patients. This chapter examines firstly the extent of medicine in Ireland – by 1852 there were 960 dispensaries, a substantial medical presence to a shrinking population. As the ravages of the Famine dissipated, these dispensaries metamorphosed into areas of medical care rather than strictly Poor Law agencies. The Medical Charities Act of 1851 had ensured that doctors played an influential role in these dispensaries. The chapter also looks at the changing remit of the doctor. The new scientification of medicine gave enormous prestige to doctors that in turn heightened patients' confidence. Gradually, medical men of the nineteenth century became involved in the counselling of their patients as the doctor began to be seen as the new saviour of humanity. This chapter emphasises the growing

significance of middle-class values in the nineteenth century and how these values placed new substance in the outward signs of respectability. Medicine in Ireland was to create a new categorisation of moral health.

No aspect of life escaped the watchful eye of the nineteenth-century medical man. The way the public dressed, the food that they ate and the books that they read were all subjects deemed within the sphere of medical authority. However, it was the manner in which people occupied their leisure time that attracted the most vocal commentary from the *Dublin Medical Press*. Coffee houses and shows in particular were viewed with particular outrage as theatres were dismissed as dens of sexual excess. The medical profession documented in the pages of the *Dublin Medical Press* established a code of acceptable behaviour, rigid in its support of traditional middle-class values, and linked these constraints to social stability, public order and the proper functioning of society.

This chapter also explores the area of reproduction, and in particular how medicine denounces any notion of contraception. The chapter looks at how motherhood was idealised and elevated by medical discourse as the central role of the woman. Medical men similarly resisted attempts to make areas of sexual health subjects for the public arena. The power of medicine is explicit when the *Dublin Medical Press* involves itself in what it terms 'the purification of the press'. Essentially, this was a campaign of censorship, a 'naming and shaming' of publishing houses that endorsed publications on reproductive matters.

Finally, this chapter examines the area of sexual morality in nineteenth-century Ireland and how medicine played an influential role in this. Medical men, supported by middle-class discourse of the time, defined people by how they conducted themselves sexually. The medical profession, through the pages of the *Dublin Medical Press*, was vociferous in promoting its new categorisation of moral health, reflecting the all-inclusive power of medicine – involved with the physical body and also the guardian of the moral values of patients.

The fourth chapter opens with the focus on how the spread of venereal disease was becoming a national problem in the second half of the nineteenth century. The fact that mortality figures were available to the public for the first time in the shape of the 1831 census and the Register General of 1837 exacerbated the fear of venereal disease. The government could no longer ignore the problem, particularly as cases within the armed forces began to soar, and looked to the medical establishment for guidance. Medical men were to seize the opportunity to aspire to previously unattained levels of power. This opportunity came in the shape of the most pitiless and draconian social legislation of the century – the Contagious Diseases Acts.

Before examining the Contagious Diseases Acts and their legacy, the chapter focuses on a medical discourse of venereal disease that was decidedly punitive – a just retribution for ‘illicit’ intercourse. It also examines how doctors knew relatively nothing about the disease or its cure. The chapter then examines how medical men identified the prostitute as the sole vessel of contagion. Increasingly she is referred to in the *Dublin Medical Press* as a ‘social evil’ synonymous with the term ‘social disease’ when referring to syphilis. This chapter examines how medical discourse

identified the female body as naturally predisposed to infection and sinfulness – licentiousness and pride were inherent parts of female disposition. The chapter also examines the medical dismissal of the notion of seduction as a primary cause for prostitution, emphasising that the main recruiters of prostitutes were women themselves, urged on by ‘vanity’ and a ‘love of dress’. The nature of this discourse was aimed to dehumanise the prostitute so that the legislation that medical men clamoured for, that would forcibly examine and detain her, might be more palatable to public opinion.

This section of the chapter looks at how medical men demanded the regularisation of prostitution and therefore women. They sought not to legalise prostitution but to control it. In doing this, medical men were essentially upholding the middle-class idea of the double standard of sexuality. They were victorious and the radical legislation that was the Contagious Diseases Acts was passed. The Contagious Diseases Acts of 1864, 1866 and 1869 were introduced to control the spread of venereal diseases among the armed forces. In Ireland the designated areas were Cork, Cobh and the Curragh. Essentially the acts subjected women on the streets to arbitrary and compulsory medical examination. This chapter explores the broad social questions that the Contagious Diseases Acts promulgated – such as the celibate state of the armed forces and the structure and organisation of prostitution in military areas. The state’s answer to these issues was effectively to sanction medical control of prostitution. Now, more than ever, medicine was a moral force worth reckoning with.

This section examines how medicine fought tirelessly against the repeal of the acts and used *The Dublin Medical Press* to actively promote the extension of the acts to

the civilian community. The arguments borrowed heavily from the language of public sanitation, claiming that such a system would end public depravity and public disturbance while securing disease-free women for the pleasure of men in the armed forces.

The fifth chapter explores the growing medical interest in the female body. As the nineteenth century progressed, medical discourse would increasingly see the entire workings of the female body as inextricably linked with her reproductive system. Darwinian science offered expert evidence on the evolutionary differences between the sexes – women were ultimately defined as carers and nurturers while men evolved aggressive and ambitious traits that made them ideal candidates for public life. This contributed in no small way to the medical discourse that viewed females as inherently weak.

This chapter focuses on the medical discussion that supported the notion of the smaller brain, emphasising that women were simply less capable than men. It then set about promoting the figure of the fragile woman who must not exercise or study or socialise to the same extent as her male counterpart. Indeed, nineteenth-century doctors proposed that indoors was the best place for females, where they lessened the risk of endangering reproductive potential. Medical men were adamant that menstruation was ultimately debilitating and thus, a disqualification for women to pursue goals outside their traditional roles.

This chapter also examines the medical opposition to female education. In fact as the century progressed females were achieving academically, thus making the earlier

anthropological theory of women with smaller and therefore weaker brains defunct. Medicine was now under pressure to come up with stronger arguments, and so it championed the idea that gynaecological dangers awaited the university-educated female. It emphasised that education would effectively endanger the health of the female and have such an adverse affect on her femininity as to render her androgynous and infertile.

The second section of this chapter explores the disturbing upsurge of gynaecological surgery in the second half of the nineteenth century. The idea that women belonged in nature while men belonged to culture was tacit in nineteenth-century beliefs. Doctors viewed femininity as inherently sick, and this section look at how medical men saw this sickness as invariably linked to her sexual system. The medical link between mental illness and diseases of the reproductive system is also examined, as are the consequences of that link: the increase of gynaecological surgery on women.

The final chapter of this study brings many of the concepts raised in previous chapters together. Hysteria incorporates the medical notion of women being inherently weak and the discourse that women were ruled by their biological functions. It examines medicine's implicit fear of women as irrational and unreasonable beings ruled by their impressionable nervous systems.

Initially, this chapter examines the contracting role of the Irish female in the nineteenth century. In a changing society, marriage was no longer a certainty and the possibilities of finding a suitable occupation lessened as the century progressed. Also, the gradual withdrawal of women from the process of farming was inevitably going to

have an effect on their status and importance in society. What was to become of these heretofore busy, motivated women whose spinning was once the mainstay of the household economy? This chapter seeks to show how the medical discourse of the biological basis of female inadequacy took on new significance.

According to nineteenth-century medicine the female reproductive function was the key to comprehending women. Medical practitioners placed such stress on the role of reproduction in a woman's life that the idea that her biology would invalidate her individual will seems hardly surprising. Doctors promoted the discourse that women's nature was determined only by their reproductive functions.

This chapter also examines the idea promulgated by nineteenth-century medicine of female infantile evolution and the discourse of the child-woman – all of which authorised the doctors' dominant role. The medical anxiety of female sexuality that has shaped much of this study is examined in the context of the contrasting images of the vital role of female reproduction juxtaposed with the discourse of her asexuality. Ultimately, this medical anxiety reveals the implicit lurking notion of the sexual prodigality of women. Finally, this section explores the medical stake in the treatment of hysteria and how the reality of the cult of female hypochondria suited the financial interests of the doctor. The moral treatment of hysteria also placed the doctor in a position of supreme authority and his female patient was his undoubted subordinate. The ambiguity of the term 'hysteria' enabled doctors to diagnose indiscriminately, adding to the vulnerability of the patient.

CHAPTER 1: PRESTIGE

This chapter seeks to explore how the *Dublin Medical Press* followed the attempts of Irish medicine to rationalise itself into a select and influential profession. The journal illustrates the inter-professional rivalry and elitist practice of medicine in the nineteenth century. This elitism pivoted on the traditional distinctions of medicine: physician versus surgeon versus apothecary. In order to elucidate the impetus behind the medical drive to exclude unqualified persons from the practice of medicine, this chapter seeks to explore the internal mechanisms of the medical profession.

As the nineteenth century progressed, medicine increasingly became perceived as a reputable and, indeed, gentlemanly occupation. As the profession became increasingly popular, medical men jealously guarded privileges and monopolies and inter-professional rivalry dominated. This chapter will examine the divisions within the profession in Ireland in the second half of the nineteenth century. Essentially, it will explore the struggle of the Irish medical establishment to establish a professional reputation of distinction and authority, as documented by the *Dublin Medical Press*.

The first theme of this chapter will be the social context of post-Famine Ireland and how the rising middle class erected new pillars of respectability. This leads on to an exploration of the new emphasis placed on professionalism in this period, and of how *Dublin Medical Press* outlined the efforts of the profession to be on an equal social footing with other professions. The articles in the journal reflect the medical desire to

raise their social ranking in a variety of ways – from the addition of classical texts to their curriculum to the choice of marriage partners. They strove to maintain high fees for medical courses to exclude students from poorer backgrounds, and outlined codes of etiquette for their members.

For medicine to remain powerful, it had to remain an elitist and privileged occupation. In the second half of the nineteenth century, the medical elite grew concerned that unsuitable people would enter the profession, and began to view one another with suspicion. Another key theme of this chapter is the intra-professional rivalry that punctuated much of the medical discourse in the *Dublin Medical Press* at this period. This rivalry manifested in the domination of the established colleges (namely the Royal Colleges of Surgeons and Physicians in Dublin) and the controversy over what was deemed to be a suitable qualification. This squabbling continued well into the twentieth century; physicians and surgeons battled for top medical positions and apothecaries battled for equality against the oligarchical Royal Colleges. This rivalry was exacerbated by the many private schools and the popularity of the Scottish universities, such as Edinburgh, as centres of medical education; consequently they too play a role in the study of Irish medical education.

1. The economy and society

The second half of the nineteenth century appears markedly different from the period that heralded it. At least 800,000 people died in Ireland from hunger and disease between 1845 and 1851,¹ and this tragedy was to shape the social, political and economic outlook of the country well into the next century. R.V. Comerford outlines

¹ Lee, *Modernisation*, p. 2.

how the period after the Famine has in the past been depicted as gloomy, and points to the economic growth and unparalleled expansion in communications of the period.¹ Present-day historians have shown how all but the very poor were much better off, in terms of clothing, housing and food.² They discuss the rise and ultimate triumph of the farmer, and a confidence bolstered by the growing assurance and fortitude of Catholics. In the course of the 1850s, pauperism declined markedly across Ireland.³ Lombe Athill notes that before the Famine 'the country was greatly over-populated by a mass of pauper and semi-pauper inhabitants. Beggars were met on every road and seen at every door.'⁴ Ireland was to show an undoubted economic improvement as a rising middle class began to emerge and flourish; growing with them were their aspirations and prospects for betterment.

Labourers were a diminishing group in the second half of the nineteenth century,⁵ and the decades succeeding the Land War confirmed the commensurate progress of land-owners when, as a result of Gladstone's measures,⁶ they were able to enjoy new procurement of land in addition to an improved social status. As the average size of farms increased (those of more than thirty acres had come to constitute one third of all farms⁷), so did the ambition and aspirations of the farmers. An equivalent and related growth in retailing accompanied this economic improvement of farmers. Shops benefited from the improved agricultural yields and consequently, an accommodating relationship of shared interests emerged. Imports increased dramatically after 1850;

¹ Comerford, 'Ireland 1850–1870', pp 372–373.

² See Comerford, 'Ireland 1850–1870'; Hoppen, *Ireland since 1800*; Lee, *Modernisation*; C. O Grada, *A new economic history of Ireland 1780–1939* (Oxford, 1994).

³ Cassell, *Medical charities*, pp 78–79.

⁴ Lombe Athill, *Recollections of an Irish doctor* (London, 1911), pp 40–41.

⁵ Hoppen, *Ireland since 1800*, pp 89–90.

⁶ *Ibid.*, pp 108–109.

⁷ Lee, *Modernisation*, pp 6–7.

this extended the scope of commercial activity and retailing experience.¹ With goods such as tobacco, tea and maize, people were no longer at the mercy of subsistence living.

Few locations witnessed a growth in industry, and the urban development that was thriving in Britain saw no correlation here. In this respect, the gulf between Ireland and Britain widened as the century wore on. Irish towns became inextricably linked to the progress of agriculture, resulting in a strong rural mentality within the towns.² This set Irish society apart from Britain, with its thriving urban centres and rising metropolitan middle classes. The politics, economy and society of Ireland were to be impacted by agrarian matters – and so too were the emerging Irish middle classes.

Communications witnessed an unprecedented growth from 1850 on. That year saw the opening of 400 miles of railway; by 1870 the length of railway lines in Ireland was almost 2,000 miles.³ Consequently, horizons were broadened, ideas exchanged. Literacy levels increased throughout the country, while school attendance numbers kept pace with this general improvement in education.⁴ This new national literacy created a market for newspapers and periodicals. Lombe Athill remarks on ‘the marvellous evolution of the newspaper and the extension of the press’.⁵ The number of newspapers and periodicals rose from 109 in 1853 to 230 in 1913.⁶ At the same time, newspapers were becoming cheaper as the compulsory stamp on newspapers

¹ Comerford, ‘Ireland 1850–1870’.

² Lee, *Modernisation*, pp 97–98.

³ Comerford, ‘Ireland 1850–1870’.

⁴ Hoppen, *Ireland since 1800*, pp 106–107.

⁵ Athill, *Recollections*, p. 107.

⁶ Lee, *Modernisation*, pp 13–14.

was abolished, and in 1860 tax on newspapers disappeared.¹ Ideas and concepts could be passed on more easily, the horizons of people were broadening and the press was increasingly viewed as a practicable vehicle to expound positions and perspectives.

2. The rise of professionalism

Ireland's overwhelmingly rural character set her far apart from her substantially urbanised neighbour, Britain, in the second half of the nineteenth century. By 1881 only 18.8 per cent of Ireland's occupied population worked in the industrial sector, compared to 42 per cent in England and Wales and 45 per cent in Scotland.² Though industry did not flourish, the bigger cities developed elegant residential areas – evidence that a certain proportion of the population enjoyed wealth.³ It would seem that the entrepreneurial drive, seen so clearly in the success of Belfast industry, was eclipsed elsewhere in Ireland by the desire for professionalism.

The idea of a gentleman came to be defined by cultural education and intellectual interests, far removed from mere financial gain.⁴ The professions of law and, increasingly, medicine became synonymous with success and social prestige. A Dr Taylor of the Royal College of Surgeons, in his introductory address to medical students in 1854, is clear in his view of the ideal gentleman:

Our profession is the one of all others most powerfully adapted to develop our mental faculties, and those grand cardinal points of manly feeling, true courage, kindness and gentleness ... the medical man must be possessed of a remarkable intellectual range.⁵

¹ Comerford, 'Ireland 1850–1870', pp 376–377.

² K. T. Hoppen, *The mid-Victorian generation 1846–1886* (Oxford, 1998), p. 580.

³ Comerford, 'Ireland 1850–1870', p. 384.

⁴ Hoppen, *Ireland since 1800*, pp 106–107.

⁵ Harold Perkin, *The rise of professional society: England since 1880* (London, 1989), pp 120–121.

⁵ *D.M.P.*, xxxi (1854), p. 13.

As early as 1834, Sir Astley Cooper, the Sergeant Surgeon to the King, told the parliamentary committee on medical education that: 'The more a man is educated and the higher he is in society, the more he will maintain the dignity of the profession'.¹ Education was increasingly becoming the key to social mobility, particularly for the medical profession, which was anxious to establish a prestigious professional reputation.

The profession of medicine appeared to fill the criterion of what a true gentleman should aspire to, and to meet the intellectual requirements that marked a professional gentleman as above and distinct from a man of commerce. In keeping with this idea, R.V. Comerford outlines the implications of respectability in Victorian Ireland, where the social position of a person was largely dependent on a recognisable code of moral conduct 'that was inseparable from specific forms of social accomplishment and material attainment'.² It is thus not unreasonable to view the struggle of medical men to establish themselves as a respectable profession in terms of a wider struggle of the middle class in nineteenth-century Ireland.

The emerging middle classes began, more and more, to express their identity in terms of professional status.³ The professional middle classes viewed themselves as superior to the business class and saw themselves as having much more in common with the aristocracy and gentry in terms of common education and the emerging new concept

¹ *Report of the select committee on medical education*, pts i and ii, p. 195.

² Comerford, 'Ireland 1850–1870', p. 384.

³ Perkin, *Rise of professional society*, p. 27.

of an educated gentleman.¹ In 1864 the *Dublin Medical Press*, in an editorial entitled ‘Middle Class Education’, illustrates the importance of education for medical men:

A doctor who has six children to educate and a practice of £700 a year cannot well spare more than £200 for his children’s training, or something less than £35 a year each. Where is he to send his boys?’²

Education, increasingly desirable and expensive, was fast becoming the key that would open doors for expanding middle-class male occupations. Consequently, as the century progressed, medicine would increasingly emphasise the importance of education, and its calibre, cost, location and length would define a doctor’s position in society.

Joseph Lee points out that the emerging Irish middle class looked to their Protestant social betters and were influenced by their emphasis on the social primacy of the professions – particularly the church, law and medicine – over trade.³ The professions promised certain income and a façade of respectability and prestige, once monopolised by the landed gentry. It is worth noting that by 1900, lawyers’ and doctors’ annual incomes averaged close to £1,000 – over ten times that of skilled workers.⁴ Thus, professional careers promised financial reward and social betterment as demand for their services increased – £2.3m per annum was being spent on both law and health in the second half of the nineteenth century.⁵ This reflected the government’s move from the traditional *laissez-faire* policy of the previous century. Opportunities for the professional classes were increasing.

¹ *Ibid.*, pp 83–84.

² *D.M.P.*, xii (1864), p. 18.

³ Lee, *Modernisation*, pp 107–108.

⁴ O Grada, *New economic history*, p. 114.

⁵ *Ibid.*

3. The cost and mode of qualification

In order to be suitably qualified, one had to have money. As early as the 1834 parliamentary report on medical education, when asked by the committee about the fees of the main medical schools in Britain and Ireland, Sir Astley Cooper, sergeant-surgeon to the king, replied:

I hold that it would be the greatest possible evil to the profession that a medical man should be educated almost without expense. I think under those circumstances, you would have persons of all descriptions coming into the profession, and that would be exceedingly degraded. You would not have gentleman's sons enter it, as you have now, or any of the better orders of society.¹

By increasing the costs of education, the medical establishment could ensure that medicine attracted students from a select group of society, and that an elitist and prestigious character would define the profession. Rivington pointed to the differences in the cost of qualification: in Ireland the diplomas to the Colleges of Physicians and Surgeons cost £37, and the 'cheapest licence of all was that of the Apothecaries Hall in Ireland which could be had for 10 shillings'.² Thus, the cost of qualification reinforced and perpetuated the deep divisions in the medical profession and ensured that there was a clear hierarchy in the structure of medicine.

An important social constraint in medical recruitment was the length of training, which entailed high costs. Importantly, the cost of qualification was substantially lower than that for a solicitor or a barrister,³ perhaps resulting in a higher proportion of middle-class students in medicine. Mapother pointed out that:

¹ *Report of the select committee on medical education to inquire into, and consider of the laws, regulations and usages regarding the education and practice of the medical profession in the United Kingdom* 1834, p. 2, H.C. 1835 (142) xiii, 118.

² Rivington, *Medical profession*, pp 252–253.

³ Digby, *British general practice*, pp 42–43.

Although there should be abundant opportunities to enable the needy but industrious to the profession, too great cheapness of the education is an evil ... If by talent and industry they could not conquer the disadvantage of poverty at the start, their parents should be content to put them to some humbler calling.¹

It was important that medicine attracted the right class of student – lower fees would attract students from the lower orders.

Medical training was often centred on apprenticeships with an individual practitioner, pupilage and unqualified assistantships, followed by practical experience in a hospital.² The medical student could expect to pay up to £200 to work under a doctor, and the *Freeman's Journal* advertised lectures in the College of Physicians at three guineas each³. Lombe Athill was apprenticed to Mr Maurice Collis, a surgeon attached to the Meath Hospital, and stated that:

Apprenticeship at this time [mid-century] had ceased to be compulsory, but it was still not uncommon for medical men to be bound by leading surgeons and to me it proved to be a great advantage.⁴

Athill had previously begged his father to be apprenticed to the local dispensary doctor, but his father 'very wisely objected'⁵ – Mr Collis, as a leading hospital surgeon, would possess much more prestige and ultimately would open more doors for the young man than the humble dispensary doctor. The cost of being apprenticed to a leading surgeon was a pressing matter for Athill because on the occasion of his father's death, he could not afford to maintain his association with Collis and had to end it abruptly, having served a little over half of the stipulated five years.

¹ E. D. Mapother, *The medical profession and its educational and licensing bodies* (Dublin, 1868), p. 118. Edward Dillon Mapother (1835–1898) was Professor of Anatomy and Physiology at the Royal College of Surgeons and was the first medical officer of health appointed under the provisions of the 1861 Medical Charities Act. He would later become president of the Royal College of Surgeons.

² *Ibid.*

³ *Freeman's Journal*, 7 Oct. 1864.

⁴ Athill, *Recollections*, pp 130–131.

⁵ *Ibid.*

As soon as I had completed the three years curriculum of lectures and hospital attendance required by the college of surgeons from candidates for their diploma; I explained to Mr. Collis my position and begged time to sanction my presenting myself for examination.¹

Athill's preoccupation with advantage within the profession indicates the hierarchical nature of nineteenth-century medicine. His experience underlines the necessity of having money in order to complete a medical education successfully.

Kirkpatrick points out that 'matriculated' students in Steevens' Hospital School,² by mid-century, were required to pay a fee of seventy guineas; for this they were entitled to all the privileges of an apprentice, and to receive every certificate required by the Royal College of Surgeons in Dublin or by other licensing boards.³ At this time the fee for each course of lectures in the school was fixed at two guineas; by 1876 the fee for many of the courses was five guineas.⁴ Given that the average salary of unskilled labourers was seven shillings a week, one guinea was worth three weeks' wages,⁵ intimating that medical education in Ireland in the second half of the nineteenth century was strictly for the better-off classes.

As the nineteenth century progressed, the *Dublin Medical Press* looked negatively at the availability of cheaper medical education (for example at Edinburgh) that was becoming increasingly popular among students. The fear promoted by the journal was that cheaper means of qualification would attract students from the lower classes in

¹ Ibid., p. 131.

² Steevens' School was recognised by the College of Physicians in Dublin and Trinity College as a place where students might receive clinical instruction.

³ Kirkpatrick, *History of Steevens' Hospital*, pp 249–250.

⁴ Ibid.

⁵ Lee, *Modernisation*, pp 107–108.

society, threatening the social power, prestige and, especially, the earning potential of the medical profession in Ireland.

In 1867, a Dr Moore of Mercers Hospital, in an introductory lecture to medical students, pointed out: 'if the medical man was to maintain his position and influence in society, his general education should, at least be equivalent to that of students entering the clerical or legal professions'.¹ The practice of medicine by mid-century was viewed as a respectable profession; indeed, an occupation fit for gentlemen, and as a result, practitioners expected the same benefits and advantage as their legal counterparts. William Stokes's son said that Stokes,

filled with a sense of the greatness of his profession ... insisted again and again on the means he deemed best fitted to elevate it in general estimation and in social position, and maintained that the training of the physician and the surgeon should in no way be inferior to that required for candidates for the church or bar.²

The insistence on equality with the other professions illustrates the medical aspiration for social recognition and prestige.

In 1877 the *Dublin Medical Press* described with 'disgust and humiliation' an incident where two doctors in Listowel, County Kerry were involved in a fight and one faced trial for assault. 'The fight it appears arose out of a discussion which took place in a common public house, where these members of our profession were drinking, side by side with the canaille of their own constituencies.'³ The article manages to ascribe the entire incident to the existence of 'cheap universities':

¹ *D.M.P.C.*, lviii (1867), p. 395.

² Stokes, *William Stokes*, pp 158–159.

³ *D.M.P.C.*, lxxv (1877), p. 49.

by the facility which government grants afford for giving a cheap and low class medical education, doctoring has been brought within easy reach of the sons of cottier farmers, small shopkeepers, and even of working class artisans and thus it happens that boys who have been brought up in association with the public house are to be found there only too often when they have reached the age of men and the rank of doctor.¹

The *Dublin Medical Press* illustrated the fear that the reputation of medical men as gentlemen would be under threat if entry into medicine was open to members of the lower orders. The article certainly suggests a discourse that desires an elitist if not exclusionary education, fit only for gentlemen:

If the selling of university degrees at the same rate as druggists' licences is not put to a stop, the practice of medicine in the Irish provinces will, before the century ends, be a pursuit unsuitable for a gentleman.²

This discourse is in keeping with the Victorian adherence to strict rules of conduct that define a gentleman. The tavern brawl highlighted by the *Dublin Medical Press* certainly breached the code of a gentleman.

In 1870 the *Dublin Medical Press* had highlighted its disapproval of economising with regard to medical qualifications. It pointed to a hypothetical student – ‘an ideal person’ – whose name is Master Robert Sawyer. Master Sawyer’s father was willing to spend £130 on his medical education, and the journal points out that the choice of college will determine his social status:

If he is intended to make a fortune and enlighten his generation as a metropolitan practitioner, and if money and education are plenty he will probably take university degrees in Arts and in his profession.³

¹ Ibid.

² *D.M.P.C.*, lxxv (1877), p. 49.

³ *D.M.P.C.*, ii (1870), p. 205.

Affluence, it was believed, was associated with an education and a suitable qualification, and thus was open only to the elite of society. The *Dublin Medical Press* calculated that at the very minimum, a medical student would need £155 a year¹ – an impressive, and for many an impossible, sum. Alternatively, Master Sawyer could opt for qualification from the licensing bodies ‘if cheapness and the obtaining of a license to practise without much trouble or severe study be the object’². By pushing the cost of medical qualification upwards, the medical establishment ensured that the entrance into medicine would be limited, adding to the already exclusionary nature of nineteenth-century medicine. This is also in keeping with the professional ideal of specialisation, education and expertise – whereby middle-class parents increasingly saw the necessity of spending on education in order to ensure that their children would be equipped to fill the professional roles of the future.

The *Dublin Medical Press* feared the type of graduate that the cheaper licensing bodies would attract. Sir James Graham MP, ‘a loyal advocate of medical reform’, alluded in a House of Commons address to the dangers of cheap qualification:

There was naturally, rivalry existing among them [the medical colleges in the UK]; and being rivals, and each having particular interests, their tendency, if unchecked was to underbid each other. If these colleges did not require any fees, this rivalry might be a matter of comparative indifference, but the desire was by adopting a low rate for fees to attract students. In proportion as the fees were low, and the standard of knowledge was relatively low, the greater became the attraction to the students.³

According to the *Dublin Medical Press*, the less education cost, the poorer would be the standard; hence the creation of an inferior class of medical men. Or was it the case that cheaper education would attract students lower down the social scale? Thus, the

¹ Ibid.

² Ibid.

³ *D.M.P.*, xiii (1844), pp 107–108.

determined struggles of the medical men to raise the profession to one suited to a gentleman would be for nothing. In an introductory lecture to medical students, Arthur Jacob (editor of the *Dublin Medical Press*) stated: 'If a man be so poor that he cannot afford to educate his son for our profession, he should not attempt to force or insinuate him into it without education.¹ He stresses that it is 'reprehensible' to attempt to enter medicine through the licensing bodies (the cheaper options):

That a man in an humble station should aspire to the privilege of placing his son in a learned profession is praiseworthy but to attempt to place him there by subterfuge is reprehensible ... he should do much better for the boy to make a good shoemaker or tailor of him.²

The *Dublin Medical Press* believed that there was a need to inform society at large about what exactly a qualified practitioner was, for the purpose of 'securing properly qualified practitioners for the public service'.³ What better vehicle to promote suitable qualification than the journal itself? It stressed the importance for medical practitioners to use the 'length of time and expense between the best education now required'⁴ as a yardstick for respectable qualification. This is an implicit criticism of the smaller colleges, such as the Scottish colleges, whose courses were shorter and cheaper than those of the Royal Colleges. The more expensive the education, the more suitably qualified was the practitioner.

A parent may perhaps save three or even six months in time, and ten or even twenty pounds in money by forcing a child in a hurried manner through schools and denying him the best instruction, but does not consider that by so doing, he sends him into professional life incapable of availing himself of the opportunities afforded him and disabled from competing with those around him.⁵

¹ *Ibid.*, p. 278.

² *Ibid.*, p. 279.

³ *D.M.P.*, viii (1842), p. 283.

⁴ *Ibid.*

⁵ *Ibid.*, p. 284.

The promotion of extensive preparatory education and the reserves to withstand even longer periods of study would serve to narrow the entry into medicine, thus adding to the prestige of the profession.

4. Medical preoccupations

A classical education

As the nineteenth century progressed, medical treatment moved from being the privilege of the wealthy to being increasingly accessible to all the population. This was reflected in the growing number of hospitals and dispensaries. By mid-century, medical education was firmly centred on a small number of prestigious teaching hospitals concentrated in London, Edinburgh, Glasgow and Dublin.¹ Despite this popularisation of medicine, medical men remained very much in the dark in terms of actually curing people. Disease continued to baffle doctors well into the nineteenth century – this was especially unfortunate for Ireland, where, due to damp climate and living conditions, infectious fever was rampant.² In 1848 Robert Graves based twenty-three of seventy chapters on fever in his *Practice of Medicine*.³ Even though Pasteur had established by mid-century that micro-organisms were responsible for fever, medical men struggled to believe the germ theory until the close of the century.⁴

The nineteenth century did not see significant advances in science – doctors never thought of examining the results of their treatments and they very often did their

¹ Irvine Loudon, 'Medical education and medical reform' in Vivian Nutton and Roy Porter (eds), *The history of medical education in Britain* (Atlanta, GA, 1995), pp 229–230.

² Tony Farmer, *Patients, potions and physicians*, pp 71–72.

³ *Ibid.*

⁴ Geary, *Medicine and charity*, pp 70–71.

patients more harm than good.¹ Nonetheless, the *Dublin Medical Press* was anxious to promote the occupation of doctor as one of innovative progression. It would seem that the reputation and the social standing of the profession was more pressing to the journal than transformation of the medical curriculum that might have allowed for greater scientific progress.

By mid-century some of the licensing boards in Britain and Ireland were insisting on a definite curriculum for those who sought degrees, but this was not the case with all. Kirkpatrick points out that few universities actually compelled students to attend lectures; even the stricter ones, such as Trinity College in Dublin and Edinburgh University, could sometimes procure permission to enable a candidate perform the acts required for a degree without producing any evidence of study.² Despite new emphasis on clinical teaching, the increasing number of medical schools made it difficult to establish any real sense of uniformity for the students. Communication between the licensing bodies and the schools did not allow for a clear record of student attendance at medical lectures. For example, in 1859 the Board of Trinity College agreed to recognise the classes at the hospital school at Steevens' Hospital provided senior lecturers agreed to take a roll, with a duly certified return of attendances at not less than three-quarters of the lectures. However, even when in 1865 the Board of Trinity College threatened to withdraw its recognition, attendance was never strictly enforced.³

¹ Eoin O'Brien, 'Irish medicine: a visual perspective' in the Royal College of Physicians and the National Gallery of Ireland, *The anatomy lesson: art and medicine* (Dublin, 1992), p. 113.

² Kirkpatrick, *History of Steevens' Hospital*, pp 236–237.

³ *Ibid.*, pp 263–264.

Classical education and literature were still emphasised as important parts of medical training. In the session 1849–1850 the medical curriculum in the Cork Medical School emphasised in the first year the study of Greek, Latin and French; the only scientific subjects were chemistry and physics.¹ The 1834 Report of the Select Committee reflected this emphasis on the classics by asking: ‘Is not an accurate and extensive acquaintance with Classical literature and philosophy of importance with regard to the cultivation of medical science, and a great advantage in the exercise of the medical profession?’² Essentially, the medical establishment in Britain and Ireland viewed a classical education, with its academic associations, as pivotal in the drive to establish a prestigious profession on a par with the law and the church.

In 1868, Isaac Ashe, an upcoming surgeon, also promoted the classics in his Carmichael Prize-winning essay on medical education:

Unlimited quantity of Latin and Greek verses is regarded at all our schools as the highest evidence of a cultivated mind and sound education, and as the best preparation for the business of our energetic, earnest, practical and scientific nineteenth century life.³

The focus on the languages of Latin and Greek would ensure that the public perception of the study of medicine would be that it was a profession for a gentleman. Ashe was careful to stress that: ‘Ablar voices than mine have urged the importance of the consideration that every medical man shall still possess that first proof that he is a gentleman, that first passport to position and society: a good education’.⁴ In 1867, a

¹ Ronan O’Rahilly, *A history of the Cork Medical School 1849–1949* (Cork, 1949), p. 12.

² *Report of the select committee on medical education to inquire into, and consider of the laws, regulations and usages regarding the education and practice of the medical profession in the United Kingdom* 1834, p. 2, H.C. 1835 (142) xiii, 118.

³ Isaac Ashe, *Medical education and medical interests* (Dublin, 1868), pp 6–7.

⁴ *Ibid.*, pp 30–31.

Dr Moore in his introductory lecture to medical students at Mercers Hospital, printed in the *Dublin Medical Press*, stressed:

that if a medical man was to maintain his position and influence in society, his general education should, at least, be equivalent to that of the students entering the clerical or legal professions.¹

The emphasis on medical education was therefore on a 'classical' education, where, in the social stakes, the doctor could compete with his professional brethren. As the nineteenth century progressed the stress on clinical teaching was becoming a serious handicap to the development of experimental science, as medicine in England and Ireland was being pursued as predominantly a professional activity.² The fact that there was little medical discovery and advancement in Ireland and England at this time reflected the fact that medical education was predominantly in the hands of medical men rather than university professors, and stressed the importance of humanistic and classical education rather than the laboratory study of physiology.³ Ultimately, Irish medicine's assertion of scientific status had little basis in reality.

Qualification would ensure that medical men were in the correct social ranking, and the stipulation of 'preliminary education' (1858 Medical Act) in mathematics, French and classics would achieve this. The *Dublin Medical Press* pointed in 1850 at medical men who:

sought diplomas in England and Scotland because the College of Surgeons of Ireland excluded them unless they paid a large apprentice fee to one of its members ... we avow our determination to probe to the bottom the system of operations which enables the ignorant and the idle, with doubtful or defective

¹ *D.M.P.C.*, lviii (1867), p. 395.

² Thomas Neville Bonner, *Becoming a physician – medical education in Great Britain, France, Germany and the United States 1750–1945* (Oxford, 1995), p. 240.

³ *Ibid.*, p. 235.

certificates of education, to obtain diplomas elsewhere which they dare not seek at home.¹

Again, the prestige and position of the medical profession was, as perceived by the *Dublin Medical Press*, under threat. Medical qualification must not be cheap and easily achieved; its prestigious and exclusionary nature must be upheld.

In 1880 the emphasis on preliminary education had not waned, as the journal called for more stringent checks:

That inasmuch as the general education and culture of the great majority of medical men depend upon the test to which they are submitted in the preliminary examination of the licensing bodies, those examinations ought to be subjected to visitation and supervision as stringent, at least, as that to which the professional examinations have been submitted.²

In 1885 the journal stressed the necessity for stringent preliminary education ‘for its protection against the ingress of uneducated persons’.³

Preliminary examinations were in arts and classics, and so were the true test of a liberal and genteel education. Mapother wrote: ‘The cultivation of music and such refining arts should be also encouraged’⁴ Lombe Athill pointed out that his entry examination into Trinity College was a test of his classical knowledge:

Having read the six books of Virgil, we went on to Horace, then to Juvenal and the Latin plays in succession and then some Greek – Xenophon, Homer, Greek plays etc., indeed every book named in the curriculum for the entrance examination of the University of Dublin.⁵

¹ *D.M.P.*, xxiii (1850), p. 29.

² *D.M.P.C.*, xxx (1880), p. 395.

³ *D.M.P.C.*, xxxix (1885), pp 34–35.

⁴ Mapother, *Medical profession*.

⁵ Athill, *Recollections*, pp 82–83.

The course in Trinity 'entailed the double work of reading for the term examinations in classics, mathematics etc, and studying medicine in all its branches'.¹ Dr Robert Thompson² outlines how he studied for acceptance into university: 'I read all the college entrance course; the first two books of Euclid, Murray's Logic, and the classics'.³ Again, the emphasis is on classical education that would add to the prestige of medicine.

But how could a medical practitioner call himself a gentleman if his education was not broadly based? Medical men had to be familiar with literature, believed a professor of anatomy – William Mitchell Banks, in his lecture to medical students in the Royal College of Surgeons in 1893 entitled 'The medical profession and the world of letters', stated:

in the course of considering what professional training was best suited for a youth so as to make him a well educated doctor, I have been tempted to go further and enquire into the position of the said doctor as a well educated man.⁴

To be well read was the key to upward social mobility. Banks added:

I look forward with confidence to the time when important public duties will fall to the lot of members of our profession and when many posts of honour and distinction will be filled by them.⁵

Alas, the same could not be said of the medical practitioner who had to make his own social position. The importance of the inclusion of the arts in the education of a medical man is clearly evident in this lecture. Indeed, one of the stipulations of the

¹ Ibid., p. 90.

² Robert Thompson, 'Diary of an Irish medical student 1831–1837', in *Dublin Journal of Medical Science*, i (1913).

³ Ibid., p. 361.

⁴ *D.M.P.C.*, cvi (1893), pp 482–485.

⁵ Ibid.

Royal College of Physicians was that a doctor could not become a fellow of the college without graduating in arts.¹ This was to be a problem for even the eminent Stokes, who gained his M.D. in Edinburgh without arts. It seems reasonable, therefore, to assume that nineteenth-century Irish medicine placed the greatest importance not on the scientific nature of education but on its prestige in society.

Banks concludes:

No man commands more social respect than a man who is a well-bred, well-read doctor. Thus literature makes him a more entertaining and companionable friend, a more valued and respected guest ... thus take up with Shakespeare and Byron and Tennyson, with Scott and Dickens and Thackeray, with Carlyle and Macaulay and Prescott ... even the humblest doctor should be able to draw some sun into his soul.²

The article clearly indicates the medical desire for social recognition, and the pursuit of medicine as an opportunity for social betterment.

The desire of medical men to distance themselves from the illiterate trappings of medicine's humble origin can be gleaned from the following article in the *Dublin Medical Press* in 1862:

But it is not only for the aggrandizement of our profession in the abstract ... it is desirable that each member should have acquired at least a tolerable acquaintance with the languages of antiquity and their literature ... the rustic gait exhibited in the drawing room is not more awkward than the want of scholarship among the educated.³

The emphasis on a classical education would, according to the profession, distinguish the doctor as a true gentlemen. The *Dublin Medical Press* states firmly: 'the study of language is part of the education of a gentleman and will improve your style, elevate

¹ Coakley, *Irish masters of medicine*, p. 126.

² Ibid.

³ *D.M.P.*, i (1862) p. 132.

your task and afford you the highest sense of intellectual enjoyment'.¹ Mapother concurs with this view – 'A knowledge of Latin would enable the student to read the elegant writers of antiquity' – adding that prescriptions written in Latin were advantageous, as 'it is not always desirable the patient should know what is prescribed'.²

Thus, it would seem that England and Ireland continued to view medicine as an art, not a science. *The Lancet* pronounced in 1863: 'A certain amount of classical and mathematical knowledge is absolute requisite; the more modern languages and general literature also has its claims'.³ In 1854 in 'Apology for the microscope', a lecture delivered to medical students in Dublin, the speaker deplored that there was nobody carrying out original research in histology and pathology by the use of the microscope in Ireland.⁴ Original research was minimal, even in the so-called 'golden' age; the research of the main medical players was at best questionable.⁵ The struggle for social recognition and acceptance within the professional classes influenced the nature of medical education in the nineteenth century, so that there was a distinct emphasis on the arts and bedside learning, rather than the histological research that was occurring elsewhere in Europe.

¹ Geary, *Medicine and charity*, pp 132–133.

² Mapother, *Medical profession*, pp 107–108.

³ *The Lancet*, ii (1863) p. 326.

⁴ Farmer, *Patients, potions and physicians*, p. 99.

⁵ For more on this see Gordon Wolstenholme, 'The Victorian era' in Eoin O'Brien and Anne Crookshank (eds), *A portrait of Irish medicine* (Dublin, 1984).

The Golden Age of medicine

Historians' traditional view of nineteenth-century medicine has focused on the achievements of elite doctors, namely Robert Graves,¹ William Stokes,² William Wilde³ and Dominic Corrigan.⁴ Therefore, there is little need for this study to expound once again the lauded accomplishments of these men. Indeed, this period has been named the 'golden' or 'heroic' age of medicine. The 'Dublin School' gained international recognition for, as Froggatt puts it, 'practical methodology and its application rather than theoretical context',⁵ namely in the promotion of bedside responsibility for medical students. The 'practical methodology' of the 'four greats' did not extend to advancement of medical knowledge. In fact, the clinical medicine extolled by Graves and Stokes could, arguably, have acted as a bulwark against scientific research and progress. I would suggest that the achievements of the 'Dublin

¹ Robert Graves (1796–1853) studied medicine in Trinity College and attended clinical lectures in Sir Patrick Dun's Hospital. He graduated in 1818 and travelled all over Europe studying medicine. In 1820 he was appointed physician to the Meath Hospital. He first introduced the stethoscope to Dublin medicine. Primarily famous for his identification of exophthalmic goitre, but this was probably first described by Caleb Hillier Parry of Bath ten years earlier. For more see Denis Coakley, *Robert Graves – evangelist of clinical medicine* (Dublin, 1996).

² William Stokes (1804–1877), son of famed Whitley Stokes, Professor of Surgery at Royal College of Surgeons and Regius Professor of Physic at Trinity College. In 1835 William Stokes obtained his M.D. from Edinburgh and the following year he joined Graves in the Meath Hospital, where they both promoted the idea of clinical medicine. He became a fellow of the College of Physicians. Stokes was by now a leading physician and in 1854 he published *Diseases of the heart and aorta* which would give him international renown. He was appointed Regius Professor of Trinity College in 1845 and President of the College of Physicians in 1849. For more see Coakley, *Robert Graves*.

³ William Wilde (1815–1876) began his medical studies in Dublin when he became apprenticed to Abraham Colles at Dr Steevens' Hospital, where he studied midwifery. He later specialised in eye and ear and opened his own Hospital in 1844. He is famous for introducing new instruments such as the aural snare. In 1853 he published *Practical observations on aural surgery and the nature and treatment of the ear*. He was editor of the *Dublin Quarterly Journal of Medical Science* 1845–1850. Wilde was appointed medical adviser and compiler of the tables of the causes of death in the census of 1841. He was knighted in 1864 for his census work. For more see Coakley, *Robert Graves*.

⁴ Dominic Corrigan (1802–1880) studied medicine in the School of Physic in Trinity College, then in Edinburgh, where he graduated in 1825. On his return to Dublin he became physician to the Sick Poor Institute, Meath Street where he made significant contributions to cardiology. In 1840 he was made Physician of the Richmond Hospital. In 1849 he became a licentiate for the College of Physicians and a year after, a Fellow. In 1859 he was elected its president. He also had a very lucrative private practice in Dublin. For more see Coakley, *Robert Graves*.

⁵ Froggatt, 'Irish students in Leiden', pp 130–131.

School' were questionable and pivoted on the prestige of the established medicine rather than advances in the knowledge of disease and illness.

In 1873, the *Dublin Medical Press* printed a letter from a Dr James Martin of Portlaw, Co. Waterford, complaining that English medical publications in general failed to laud the 'achievements' of the Dublin School. Dr Martin emphasises that Ireland should be acknowledged as 'the country that has given such a brilliant galaxy of stars to the profession'.¹ The letter attests that 'English medical publications' (a veiled allusion to *The Lancet*?) 'need not grudge a fair acknowledgment of the services rendered to mankind by the Irish contingent of the profession'.² This expression of desire for acclaim on the international stage intimates the deeper aspiration among the Irish medical establishment for recognition as an esteemed and noble profession. Graves and his peers, living in fashionable Merrion Square, in houses vacated by the aristocracy after the Act of Union, represented all that was grand and distinguished in medicine. It was precisely this elitism that the profession sought to uphold and expand in the second half of the nineteenth century.

Early nineteenth-century doctors were not the only medical group that the *Dublin Medical Press* looked to as the paradigm of prestige. The journal printed a paper entitled 'On the position in society of physicians amongst the Greeks and Romans' that a Dr Michael Donovan read before the Royal Irish Academy. The paper seeks to refute the belief that doctors in Ancient Greece and Rome were slaves or at best, members of the servile class. Donovan asserts that: 'Some learned physicians, for the honour of their profession, have discussed it more extensively' and points out that 'we

¹ *D.M.P.C.*, xvi (1873), pp 149–150.

² *Ibid.*

find Greek and Roman physicians mentioned in ancient history, who certainly had never been of the servile class, and who maintained the highest rank of citizens'.¹ The doctor is eager to point out the 'gentle' accomplishments of his professional predecessors:

The class of regularly educated practitioners were men of learning and elegant accomplishments. To the ordinary professional acquirements in philosophy, medicine, surgery, material medica, and pharmacy, they frequently superadded rhetoric, oratory and poetry.²

The preoccupation of the *Dublin Medical Press* with using the past as a testimony to the prestige of the profession in general suggests that it was not the progress of science or the development of innovative medical techniques that absorbed doctors in the second half of the nineteenth century. Rather, it would appear that the kudos and standing of medicine as a distinguished occupation became a pivotal concern.

5. The drive for prestige

The prospect of becoming distinguished in the sight of men is one of the most honest and natural of the incentives of aspiring youth.³

In nineteenth-century Ireland, there wasn't a surplus of gentlemanly career opportunities for ambitious middle-class men. Medicine, as the nineteenth century progressed, was progressively becoming a respectable profession. Leading practitioners continued to insist on the importance of a classical education, good manners and, above all, the wherewithal to relate to the privileged classes.⁴ The medical profession proffered to its members a position in society and an opportunity

¹ *D.M.P.*, xxv (1851), pp 3–6.

² *Ibid.*, p. 4.

³ *The Lancet*, ii (1863), p. 406.

⁴ Bonner, *Becoming a physician*, pp 204–205.

to interact with the gentry of the country.¹ Robert D. Lyons, Professor of Medicine at the Catholic University, in his introductory address had the following message for the newest members of the profession:

The man who, from inferiority of general and professional education, discharged his duties in doubt and uncertainty to himself, not alone failed to win public esteem and confidence, but often took a low and sometimes, a degrading view of his own services and occupation, and dragged himself and his profession to the level of the meanest trades.²

Public perception of the medical establishment was a theme that was to reappear again and again in the pages of the *Dublin Medical Press*. Mapother pointed out that:

the literary and scientific work of physicians has always had, and will continue to have, with the educated public, a large effect in elevating their profession and removing them from the character of mere successful traders.³

This statement underlines the deep anxiety of nineteenth-century medical men to be considered men of learning by the general public and to distance themselves from their links with trade.

The Act of Union 1800 witnessed, for medicine, the departure of wealthy patrons – but in due course the doctors themselves and their professional peers would inhabit the fine houses of the aristocracy.⁴ This could not be better reflected than in the fashionable homes of the medical elite – Graves, Stokes, Corrigan and Wilde all lived in close proximity on the elegant Merrion Square. Traditionally, medical historians have referred to these men as the heroes of Irish medicine and much has been written on their medical achievements. Historians have also looked at their lifestyles,

¹ Geary, *Medicine and charity*, p. 151.

² *D.M.P.C.*, xvii (1873), pp 411–412.

³ Mapother, *Medical profession*, p. 3.

⁴ Geary, *Medicine and charity*, p. 61.

believing that their pursuits and interests played as big a part in the creation of a 'Medical Renaissance' as their medical attainments (often of questionable origin). William Stokes 'provided much of the inspiration for a renaissance in Irish intellectual life; in art, literature and music'.¹ We are told that Sir William Wilde's dinner parties 'were attended by the best of the literary and professional society in Dublin'.² The fact that Robert Graves had a flair for languages, that Corrigan was a skilled horseman, Wilde's interest in ancient history – all suggest that these medical 'greats' are celebrated for their prosperity and prestige as much as their medical achievements.

Stokes's son, in his biography, is eager to recount his father's artistic leanings:

The tie that bound William Stokes to these men [well-known artists] was something more than ordinary friendship ... it was yet wonderful what sympathy and support these men derived from him, with what ardour his genius could reverberate to theirs.³

Stokes adds that 'his love of poetry and art seemed to be innate with him'.⁴ These elite medical men epitomised the medical aspiration for social betterment in their associations with intellectuals, their interest in non-medical subjects and their gracious homes. As the nineteenth century progressed, it was the successful professional classes – and especially the successful doctors and lawyers – that became the nobility of Dublin society.

¹ Wolstenholme, 'Victorian era', pp 122–123.

² T. G. Wilson, *Victorian doctor: being the life of Sir William Wilde* (London, 1942), p. 40.

³ Stokes, *William Stokes*, pp 78–79.

⁴ *Ibid.*

A scientific authority was lent to the medical profession in the nineteenth century, raising the estimation of medical men in the eyes of the public.¹ The *Dublin Medical Press* in 1853 reflected this thinking, as it discussed with reverence and no little conceit the 'advanced scientific man'.² It was an ongoing battle among medical practitioners to remove themselves firmly from any association with the medieval guild ties they had with the barbers. 'Think further of the lofty, nay, almost sacred character of the medical man. The power his science possesses.'³ In particular, attempts to raise the medical practitioner to at least the same status as the lawyer were prevalent: the medical practitioner did not engage in 'the stormy eloquences of the senate or the bar but the calm and dignified address of the educated man'.⁴

Invitations into the houses of the privileged classes meant gaining lucrative upper-class patients and the medical practitioner's best hope of generous remuneration. To achieve this upward mobility, medical men of the nineteenth century looked to their professional peers and the landed gentry, and so placed huge importance on the arts rather than physiology to prove their worth. Mapother emphasises that 'An increased literary and professional course, would exercise a beneficial check on overcrowding, an evil often anticipated'.⁵ A 'literary' education for medical men would increase their public standing while ensuring that the appropriate class of student was attracted to the profession.

There was also an inherent fear that the medical profession would attract students of the wrong class and thus damage the struggles of the medical men to establish

¹ Digby, *British general practice*, p. 99.

² *D.M.P.*, xxix (1853), p. 78.

³ *D.M.P.*, xxxi (1854), p. 15.

⁴ *Ibid.*, pp 14–15.

⁵ Mapother, *Medical profession*, p. 107.

themselves firmly in the upper echelons of society. The *Dublin Medical Press* in 1855 had this to say:

We are invidiously designated as not belonging to the class of society usually termed gentlemen but as belonging to other classes of the community. While we conduct ourselves honourably; it matters little with what families we are connected to; but we contend that of the commissariat, as a body, do belong to the class termed 'gentry', and that we are as well educated, as well informed, and as honourable and upright in every respect.¹

Social rank became the *raison d'être* of the medical profession. The medical men needed to ensure that the profession attracted students from the right classes: 'The possession of property, superior general education and honourable connections are, but adjuvant, though highly desirable additions to professional ability'.² The medical world was increasingly becoming a middle-class institution and, coupled with the rise of this class, new demands were being voiced.

The *Dublin Medical Press* pointed out in 1895:

There is not a single instance in history of medicine ... as a medical man having been raised to the dignity of a British Peer, nor even of an offer in this respect recorded as having being made by as English sovereign.³

Mapother also decried the lack of honour afforded to medical men:

it is almost universally acknowledged that educated and enlightened classes are not adequately represented in our country's senate ... the other learned professions are most amply represented in both upper and lower houses.⁴

¹ *D.M.P.*, xxxiii (1855), p. 265.

² *The Lancet*, i (1842–43), p. 72.

³ *D.M.P.C.*, cx (1895), pp 389–391.

⁴ Mapother, *Medical profession*, p. 7.

How could medical practitioners hope to promote themselves as a respectable profession if there was a seemingly concerted effort by others to exclude them? The *Dublin Medical Press* asked:

What is it that disqualifies members of the medical profession from such an honour? Surely no incapacity exists from the point of view of social distinction nor can it be said that medical men are less educated as a body than the members of other learned professions?¹

Thus, education was the all-important key to professional respectability, in a world where professionalism was viewed as the means of achieving social mobility.

In 1897 *The Lancet* printed a story that illustrates the deep-rooted desire of medical men to improve their social ranking and the possible impediments. The article outlines an incident of a surgeon and a nurse to whom he was engaged.² The nurse had told the surgeon that she was the daughter of an affluent Australian gentleman, who was of 'independent means', that her brother was an engineer and that she herself had taken up nursing on philanthropic grounds, as something to do. To the surgeon's horror, his nurse turned out to be the daughter of a mere gravedigger and the sister of a paltry artisan, and her vocation as a nurse was actually to make a living. He ended the engagement. The court decided favourably for the nurse and she was allowed £300 in damages. *The Lancet* pointed out that:

if the facts alleged by the defence be true, then the doctor has probably acted wisely by throwing away a bad bargain and may regard his money as well spent. Nothing can be more disastrous to the career of a medical man than an ill-assorted union with a woman beneath his own social rank.³

¹ *D.M.P.C.*, cx (1895), pp 389–391.

² *The Lancet*, cxiv (1897).

³ *Ibid.*, p. 317.

Thus, for a practitioner to marry beneath him was to place his position in society at risk. If the doctor was to be perceived as a gentleman of culture and education, he needed to marry (at least) his social equivalent.

In 1870 the *Dublin Medical Press* pointed out that ‘Irish men pride themselves on holding a higher social position than the English medical practitioner. They are entitled to meet the gentry of their locality on terms of equality.’¹ The onus was on Irish practitioners to establish themselves as a respectable, educated class; in order to achieve this, any ties to the notion of lowly craftsman or, worse, petty shopkeeper had to be eroded. Under the guise of educational and scientific advance, nineteenth-century medical men’s discourses pivoted on the central themes of rank, title and status and, consequently, on the potential of social and professional respectability.

6. The threat of the quack

Of old we tried disease to know
And sought out drugs to cure it,
But now that’s voted all too slow,
And no one will endure it.
We treated patients low and high,
And with our physics filled ’em;
But now we let the people die
For fear they’d say we killed ’em
And ’tis the best way I maintain,
No matter what you say sir;
Whatever Quackery may reign
I will be Quack of the day, sir.²

In the eighteenth century, the physician was the only medical practitioner with even a smattering of scientific training. The surgeons and apothecaries received their professional education as apprentices. Regulations in terms of qualifications and the right to practise were rarely enforced. Outside Dublin, any quack could start a practice

¹ *D.M.P.C.*, ii (1870), p. 205.

² *D.M.P.C.*, xvi (1867), p. 432.

and reap a rich reward.¹ Indignation seethed among rank-and-file practitioners in Ireland and England, who felt that they were denied control over their own professional lives. They resented being undercut by untrained chemists, druggists and quacks, against whom the state afforded them no protection. This was an obvious threat to the prestige of the medical profession in nineteenth-century Ireland.

Rivington blamed the government, believing that the 1858 Medical Act should have outlawed irregular medicine:

It will legislate against gambling and thimblejigging and cardsharpping – but against the quack who will delude the inexperienced by raising false fears, encouraging delusive expectations and robbing his patient of every available penny he may possess – it will do nothing.²

Rivington branded quacks as ‘the lowest swindlers that ever disgraced humanity’ and reflected the fear of regular practitioners that the public would have difficulty in distinguishing educated doctors from these ‘pests of nature’.³ Ostensibly, this drive to outlaw irregular medicine was propelled by the medical establishment to protect the public, but in reality quacks, with their association with back-street traders, represented a major threat to the prestige of the profession.

The *Dublin Medical Press* reflected this medical concern in 1892:

If education among the classes was not a quantity to be reckoned with and medical men with substantial scientific knowledge of their profession were conspicuously absent in the land, it might be possible to understand some of the instances of persons straying from the path of regular medical treatment and trying to make their escape from a mortal malady through the boggy, treacherous ground of quackism.⁴

¹ Fleetwood, *History of medicine*, p. 114.

² Rivington, *Medical profession*, p. 79.

³ *Ibid.*

⁴ *D.M.P.C.*, i (1892), p. 104.

With growing central and professional regulation after 1800, the term ‘quackery’ had negative connotations and was to be replaced by the more dignified term ‘alternative medicine’ that flourished despite the outrage of established medicine.¹ Medical men were increasingly irked by the lack of legislation that would outlaw alternative or quack practice. The *Dublin Medical Press* in 1854 complained: ‘It is no easy matter to draw a line of demarcation between the sincere cultivator of science and the disguised pretender’.² Therein lay the problem: how to communicate to the public who was a genuine man of science and who was not. The uneducated quack was a threat to the respectability and social prestige of the medical practitioner. It was therefore of utmost importance to prohibit his practice and prevent him from what the medical establishment perceived as unlawful practice.

The new scientific backdrop to medicine generated counter-trends – a populist, anti-elitist backlash.³ The open medical marketplace of the eighteenth century, where people could pick and choose their medical treatment, was well and truly over. Nineteenth-century medicine, in its struggle for respectability, emphasised third-level education and pressured for state legislation – effectively closing its doors to alternative medicine.⁴ The new medical headquarters became defined within the supposedly sterile confines of the hospital rather than the commercial marketplace of the eighteenth century where medical services were peddled.

‘What is a quack?’ asks a letter to the *Dublin Medical Press* as early as 1842. The author chooses to remain anonymous, signing off as ‘anti-humbug’:

¹ Roy Porter *et al.* (eds), *The Western medical tradition: 800 BC to AD 1800* (Cambridge, 1995) p. 460.

² *D.M.P.*, xxxi (1854), p. 136.

³ Roy Porter, *The greatest benefit to mankind: a medical history of humanity from antiquity to the present* (London, 1999), p. 396.

⁴ *Ibid.*, p. 489.

That the man who, to get practice proclaims himself a philanthropist, desirous of benefiting his species, not anxious for money, who gulls by his professions and gratuitous attendance the most credulous of the community but who, when he finds himself established by the recommendations of his dupes, charges the poor working man exorbitantly for his advice ... is a quack.¹

The fact that medical men made every effort to promote the elitist nature of their craft did not mean that the public's demand for the services of alternative medicine diminished or went away. This stubborn coexistence of fringe and established medicine would be the greatest thorn in the profession's side.

7. Reform: the 1858 Medical Act

As we have seen, at the beginning of the nineteenth century there was practically no legal restriction on the practice of medicine and surgery in Britain and Ireland.² Rank-and-file practitioners in Ireland and England resented being undercut by untrained chemists, druggists and quacks, against whom the state afforded them no protection. As the century progressed the medical establishment in Britain and Ireland looked to change this by adopting an exclusionary character. It became increasingly clear that to remedy the problem of quackery medicine required reform, and that reform would need to insist on a new system of medical registration. Only then would there be a clear distinction enabling the public to distinguish quacks from regular practitioners.

In the social stakes doctors fared less well than lawyers, who had more opportunity for making profits.³ Moreover, elite members, such as specialist surgeons and physicians, sought to create a professional monopoly bolstered by collegiate dominance and educational credentialism. It is likely that the emphasis on

¹ *D.M.P.*, i (1842), p. 159.

² Kirkpatrick, *History of Steevens' Hospital*, p. 236.

³ Porter, *Greatest benefit*, p. 350.

overcrowding in the profession was also a means for established medicine to convince legislators to limit entry into medicine.

The Great Famine of the mid-nineteenth century forced the government to abandon or at least loosen the *laissez-faire* approach to medicine. Sir James Graham, secretary of state for the home office, had put forward a proposed bill in 1844 that sought to:

prohibit any person from practising Physic or surgery in any place without such examination, certificate, licence or qualification as is mentioned in such act or charter respectively or as imposes any restrictions on the practice of physic or surgery other than is contained in this act.¹

The bill never came to fruition— the government, at this stage, was unwilling to become involved in the inner dissensions of the medical profession. This was all to change. In light of the Medical Charities Act of 1851, the government did need to appoint medical practitioners for dispensaries but as no formal register existed, the qualifications necessary for employment were vague. There was little cohesion among medical practitioners and the tripartite system of physicians, surgeons and apothecaries prevailed.

The Medical Act made mandatory the registration of all licensed medical practitioners and set up the General Medical Council to set minimum standards. The act primarily introduced a single medical register for all qualified practitioners, reflecting further movement towards unification and standardization of training. The act was the result of half a century of clamouring by the medical profession to bring some level of legal equality to the profession of medicine. Practitioners could register on the basis of a

¹ *D.M.P.*, xiv (1845), pp 113–118.

single qualification in either medicine or surgery. Public appointments were limited to those on the register.

The single medical register undoubtedly lent a veneer of respectability and added to the social prestige of medical men. It also, arguably, strengthened the exclusionary discourse of the doctors, as they fought valiantly to close their ranks against all persons involved in medicine that were not doctors. The impetus for medical reform was in part a reflection of the rise of the middle classes and the growth of professionalism¹ as doctors struggled for the level of respectability and social prestige enjoyed by their professional peers.

But the act failed to satisfy medical practitioners. Significantly, there was no imposition of single qualification and no single licensing body and, to the chagrin of established medical practice, there was no debarment of unqualified practitioners. The *Dublin Medical Press* stated in 1859:

we do not want registration merely to exclude pretenders from practice, but active measures to disable unqualified persons from becoming medical practitioners by means of illegal registration. We want protective and defensive associations to prevent the physicians and surgeons of Ireland from being degraded by identification with the holders of disputed diplomas and licences.²

The act therefore did not outlaw unqualified practice and create a uniformity of qualification; it merely made it illegal for a practitioner to misrepresent his title or qualification.³ This rather optimistic hope that the public would ultimately reject

¹ Andrew Wear (ed.), *Medicine in society: historical essays* (Cambridge, 1992), p. 229.

² *D.M.P.*, xlii (1859), p. 25.

³ Tony Gelfand, 'The history of the medical profession' in W. F. Bynum and Roy Porter (eds), *Companion encyclopedia of the history of medicine* (London, 1994), ii, p. 1134.

unqualified practice was soon dashed, as quacks flourished throughout the nineteenth century. Rivington outlines the failure of the legislation:

Quacks have continued to abound and flourish and unqualified persons have continued to practise and prescribe. It cannot be otherwise so long as the legislature proceeds upon the principle, which it at present professes.¹

Consequently, the conflict between medical men and quacks was to rage unabated throughout the century, underlining the anxiety of the medical establishment that it might lose its newly won position of respectability in society. To differentiate themselves from unconventional medicine, practitioners had to promote the middle-class ideals of education, culture and gentlemanly traits. In short, the war against quackery signified the determination of the medical profession to maintain its social position.

However, the General Medical Council created to enforce the act remained dominated by representatives of the elite corporations, namely the surgeons and physicians.² It failed to establish a single opening of entry into the profession and continued to accept a variety of licensing authorities for separate practice of medicine. In 1860, *The Lancet* pointed to 'the endless schemes employed, in order to avoid operation of the medical act, and to enable uneducated and unprincipled men to defraud the public'.³ The medical profession felt unprotected by the 1858 act. Despite the barrage of complaints, the act did succeed in what it set out to do – namely, to establish a register of qualified practitioners – and this added in no small way to the prestige of medicine.

¹ Rivington, *Medical profession*, pp 296–297.

² Gelfand, 'History of medical profession', p. 1134.

³ *The Lancet*, ii (1860), p. 254.

The failure of the act to prohibit quackery was not the only bone of contention among medical men. They were indignant that the status given to apothecaries was to be equal to that given to physicians and surgeons, highlighting the deep division within the medical profession, which was illustrated in 1859 by the *Dublin Medical Press*'s reaction to 'this most absurd proposition':

Ridiculous, however, as it is, we must deal with it seriously, seeing that certain official authorities perversely encourage them to persevere in their foolish demands.¹

The act failed to adhere to the hierarchical lines of demarcation of the Royal Colleges. The only stipulation to be accepted onto the registered list was of qualification; consequently, the place of qualification was unimportant, much to the chagrin of physicians and surgeons, by now accustomed to collegiate privileges.

Later that year, an editorial in the *Dublin Medical Press* mirrored this vexation:

they are preparing a mere list of persons who have obtained any description of medical, surgical, or pharmaceutical licence whatever, and refusing to record any distinction arising from superiority of qualification.²

The Lancet concurred, stating in 1860 that:

While the degrees of M.B. and M.D. are given by the different universities of the United Kingdom, after very different courses of education, both general and professional, the Act has classed them altogether.³

In 1859 the *Freeman's Journal* underlined the importance of the register of qualified doctors:

¹ *D.M.P.*, xlii (1859), pp 185–186.

² *D.M.P.*, xii (1859), p. 89.

³ *The Lancet*, ii (1860), pp 301–302.

It is so important to medical practitioners and to the public that we say a word in order to draw attention to it ... No medical practitioner who is not registered can hold any public medical office whatsoever; and no certificate signed by a medical practitioner who is not registered, is of any force or effect.¹

Of course, from the public's point of view, the Medical Act had succeeded in establishing a list of qualified medical personnel, but this was not adequate for the profession.

Nonetheless, the 1858 Medical Act, in its essence, worked: the General Medical Council had the right to formulate an ethical code to which all medical practitioners had to conform. This raised the social prestige of the doctor in public estimation.² The act did nothing to narrow the diverse and numerous portals of access to the profession, a subject 'of no ordinary complication and difficulty, and one which the medical act of 1858 has tended to involve more hopelessly than ever',³ said *The Lancet* in 1860. Thus, for this study, the significance of the 1858 Medical Act is in its perceived failures, which accentuated the deeply exclusive nature of nineteenth-century medicine and the subsequent struggles for recognition and prestige.

8. Division

Setting brother against brother,
To claw and curry one another
Have we not enemies *plus satis*
That *cane et angus perjus* hate us
And shall we turn our fangs and claws
Upon ourselves without a clause.⁴

¹ *Freeman's Journal*, 10 Dec. 1859.

² Froggatt, 'Competing philosophies', p. 50.

³ *The Lancet*, ii (1860), pp 301–302.

⁴ Anonymous poem printed in the *D.M.P.*, i (1848), p. 172. The *D.M.P.* merely states that it is the opinion 'of a junior member of our profession'.

There was a growing anxiety that medicine was becoming increasingly overcrowded, and it became increasingly defined as a competitive business as practitioners jostled for an affluent clientele. Investment in a prolonged education by middle-class parents was not unusual in the nineteenth century, as family size shrank.¹ Similarly, a professional career was increasingly attractive in that it evinced the veneer of gentility and improved potential for social climbing. Consequently, factions attacked each other as each division of established medicine scrambled for the higher rungs on the prestige ladder. In a letter to the editor of the *Dublin Medical Press*, the anonymous writer highlights the trepidation of the medical profession:

the profession of medicine, unlike that of law or divinity, is at present overstocked and in numbers far beyond the wants of the public ... the practice of medicine and surgery has, in a great measure fallen into other hands ... and unfortunately for the public, into hands not duly educated for the purpose.²

This fear of being ousted or pushed out prompted nineteenth-century practitioners to look inwards, and to see fellow practitioners as rivals on an opposing team. This bolstered the hierarchical nature of medicine and dashed any hopes of medical unification in the nineteenth century.

There was three quite separate medical corporations: the Royal College of Physicians, the Royal College of Surgeons and the Society of Apothecaries. Each had its own charters and by-laws; each granted licences to practise in the particular branch of medicine or surgery for which it was responsible.

In Ireland there were four corporations that conferred medical, surgical or pharmaceutical qualifications: the University of Dublin conferred degrees in

¹ Digby, *British general practice*, pp 23–24.

² *D.M.P.*, i (1839), p. 118.

medicine; the King and Queen's College of Physicians had two orders of qualifications – the licence and the fellowship. The Royal College of Surgeons also had two orders of qualifications: that of licentiate and member. The Apothecaries Hall conferred licences for apothecaries. Froggatt maintains that by the nineteenth century education and training were haphazard and regulation was ineffective.¹ Only physicians required a university qualification – an M.D. – but even this qualification did not suggest any homogeneity of education due to the variable standards and requirements of the universities.² This lack of uniformity added to the already deeply divided nature of the medical profession and exacerbated the intra-professional discord. The argument of an overcrowded profession justified the increasingly elitist nature of medical education. Rivington emphasises this point:

The subject of the proper proportion of medical men to the general population is one of considerable importance, because any decrease in the supply is at once used as an argument against increasing the efficiency of professional examinations and raising the literary and scientific culture of those who are seeking to enter the portals of the profession.³

The type of qualification a medical man had and the place he was educated now became of key significance to the medical profession, as institutions jostled to attract the better sort of student.

The Universities of Edinburgh and Glasgow were also popular places of qualification. In all, there were twenty licensing bodies and sixty-one qualifications from medical corporations in Scotland, England and Ireland.⁴ Anatomy, physiology, chemistry,

¹ Froggatt, 'Competing philosophies', p. 59.

² Ibid.

³ Rivington, *Medical profession*, p. 225

⁴ Digby, *British general practice*, pp 50–51.

materia medica and the theory of physic were common in all curricula.¹ The portals of entry into the profession were wide and varied, and rivalry prevailed between hospital schools and universities. Once the teacher's qualifications had been recognised by a licensing body, students with the requisite course and hospital credits could sit that body's examinations.²

As the nineteenth century progressed the professional scene of a hundred years before had been completely transformed: the apothecaries, once mere tradesmen, had become practising doctors; the surgeons had disassociated themselves from the barbers; and the 'pure' or hospital surgeon had become a specialist of high reputation; while the physicians, originally few in numbers and of good social position, had received an influx of hard-working middle-class graduates from Leiden University and Edinburgh.³ Now, not only were the dissimilarities between physic and surgery rapidly changing, but it was hard to see where physic ended and surgery began.

Despite the diminishing of differences between the three sections of medicine, intra-professional rivalry prevailed throughout the nineteenth century and any move towards unification would not occur until the twentieth century. The *Dublin Medical Press* refers to the 'brutal and degraded condition of the lower order of medical tradesmen'⁴ in reference to apothecaries, the difficulty being that apothecaries were the new general practitioners – a generation of educated medical men that did not slot

¹ Froggatt, 'Irish students at Leiden', pp 130–131.

² Peter Froggatt, 'The people's choice: the medical schools of Belfast "Inst" (1835–1849) and the Catholic University (1855–1908)' in *Journal of the Irish Colleges of Physicians and Surgeons*, xx, no. 1, Jan. (1991), p. 49.

³ Bernice Hamilton, 'The medical professions in the eighteenth century', in *Economic History Review*, second series, iv, no. 2 (1951), pp 141–164.

⁴ *D.M.P.*, xiii (1845), p. 13.

into the category of physician or surgeon and now joined in the struggle for respectability.

The 1858 Medical Act did little to stem the professional rivalry between the different groups. The *Dublin Medical Press* in 1854 dismissed it as a 'mere alphabetical list of persons',¹ believing that the legislation was not sufficient in that it made no distinction between apothecary, surgeon or physician.

We find this bill grouping together in one alphabetical list physicians, surgeons and apothecaries, under the common title of medical practitioners, thus holding them up to the public as equal in every respect.²

Irish medicine sought to uphold the division and hierarchical character of medicine, because it was this hierarchy that gave medicine the prestige it so desperately wanted.

9. Physicians close ranks

By the 1858 Medical Act physicians and surgeons had established themselves in new, secure and lucrative positions of distinction and dominance, and were unwilling to relinquish these to apothecaries and the increasing numbers of surgeon-apothecaries (later to be termed 'general practitioners').³ In the nineteenth century it was only the physicians who possessed a regular formal qualification in the form of a university degree, and as a result they believed themselves to be at the pinnacle of the medical hierarchy in the nineteenth century. The oldest medical teaching institute in Ireland was the School of Physic at the University of Dublin, more popularly known as

¹ *D.M.P.*, xxxi (1854), p. 216.

² *Ibid.*

³ Roy Porter, *Disease, medicine and society in England 1850–1860* (Oxford, 1987) pp 50–54.

Trinity College. Elizabeth I had established the university in 1591, and though its charter included provision for the granting of medical degrees, it did not do so until 1674 and a medical school was not established until 1711.¹ In 1800 the School of Physic was open to all students of medicine, but the regulations under which it was governed restricted it almost entirely to those who could afford a medical degree; this, combined with the fact that the final examination for the medical degree was conducted in Latin, ensured that the school attracted only an elite group of students.² This elitism was to characterise the physicians throughout the nineteenth century as they struggled to ensure that they maintained their hierarchical position in the increasingly competitive medical market.

This medical school required students to take firstly a B.A. degree and then a degree of Bachelor of Physic. The conferring of this degree was under the control of the physicians³ and admitted the bearer to the highest rank in the profession. This did not, however, signify a proper medical education, and the quality and uniformity of university medical education at the beginning of the nineteenth century was questionable.⁴ In 1873 the *Dublin Medical Press* pointedly referred to the reputation of Trinity College (University of Dublin):

The Queen's University places at the disposal of the student a cheap University Degree, and thereby attracts many applicants, but it is burdened by the necessity for the residence of the student for a time at Galway, Cork or Belfast, and, in the question of prestige, can hardly pretend to compete with the time-revered University of Dublin.⁵

¹ T.P.C. Kirkpatrick, *History of the medical teaching in Trinity College Dublin and the School of Physic in Ireland* (Dublin, 1912), pp 56–57.

² *Ibid*, pp 237–238.

³ *Ibid*.

⁴ Loudon, 'Medical education', p. 230.

⁵ *D.M.P.C.*, xvii (1873), pp 201–202.

The physician, with his associations with Trinity College, represented the elite of the medical profession. Though this elitism was less distinguishable as the century progressed and the reputation and status of surgeons grew, the university-educated physician was the aristocrat of medicine.

Before the nineteenth century a physician was perceived as an educated gentleman, while apothecaries and surgeons were mere craftsmen; as the century progressed, the distinctions between them blurred and society began to see them all as part of the new professional classes.¹ But Trinity College jealously guarded its supremacy and feared the influx of doctors from Edinburgh and other colleges. Graduates of Trinity College saw themselves as champions of the English universities and of proper qualifications for all governing bodies; they regarded the licentiates as alien and unpatriotic.² At the turn of the nineteenth century the physicians differed in every respect from the surgeon-apothecaries – as university men entitled to be called ‘doctor’, untarnished by the labouring aspects of surgery, midwifery, or pharmacy, they provided professional advice for fees to patients who were usually the more affluent members of their communities.³

Trinity College strongly attacked the bad education and low birth of the licentiates of Edinburgh, and their ‘democratical and levelling spirit’.⁴ In 1806 the by-laws of the Dublin College of Physicians bound its fellows and licentiates on oath not to meet a surgeon in consultation on a case that the physician deemed medical, and the law was equally necessary even when the surgeon was a graduate of Oxford, Cambridge or

¹ Hamilton, ‘Medical professions’, p. 141.

² *Ibid.*, p. 146.

³ Joan Lane, ‘The medical practitioners of provincial England in 1783’ in *Medical History*, xxviii (1984), p. 354.

⁴ Hamilton, ‘Medical professions’, p. 147.

any University in Europe.¹ This jealous tactic of upholding medical hierarchy is suggestive of the physicians' anxiety regarding their position in society. In order to maintain their privileges, physicians distanced themselves from the other branches of medicine.

The *Dublin Medical Press*, with its obvious allegiance to surgeons, unsurprisingly was hostile to the College of Physicians' claims of superiority:

Of the intrinsic value of the Bachelor of Medicines degree as now granted by Trinity College Dublin, we do not care to say much, and of its legal value of qualification to practise we would say still less; but when those who supply it endeavour to exalt it over other diplomas, we must be permitted to express dissent.²

This snub to the physicians made even the mildest overtures towards reconciliation between the two groups impossible. The position atop the medical hierarchy was one that physicians were unwilling to relinquish despite the efforts of the surgeons. As a result, the physicians allied themselves even more closely to Trinity College and turned away from the College of Surgeons.³ Trinity possessed the only school of medicine in Ireland until the mid-nineteenth century, and this school was connected to the College of Physicians.⁴ As we have seen, physicians saw their education and practice as being very far removed from surgeons and apothecaries, with their links to barbers and shopkeepers – craftsmen rather than gentlemen.⁵ The status of physicians rested on a liberal university education rather than a scientific training in medicine.⁶

This hierarchical control could not be maintained for much longer as the numbers

¹ J. D. H. Widdess, *The Royal College of Surgeons in Ireland and its medical school 1784–1984* (Dublin, 1949), p. 84.

² *D.M.P.*, xxviii (1852), p. 59.

³ Fleetwood, *History of medicine*, pp 132–133.

⁴ Peter Froggatt, 'Irish students of medicine in Leiden' in *The anatomy lesson: art and medicine* (Dublin, 1992), p. 135.

⁵ Cassell, *Medical charities*, pp 25–27.

⁶ Wear, *Medicine in society*, pp 236–237.

graduating from Edinburgh and other colleges increased and their demands to be recognized as a professional body became harder to ignore.

10. The rise of the surgeon

Until 1745, the surgeons had been joined in one company with the barbers. The growing disparity of status between the two crafts was the main reason for the surgeons' seeking a separation.¹ The Dublin Barber-Surgeons guild was an old one, having been incorporated in 1446 by Henry VI.² The reason for the barbers' and surgeons' association was that in the Middle Ages the common people were treated medically at the monastery's surgery, which involved the shedding of blood. This was deemed an unseemly practice for monks and so was consigned to lay servants/monastic barbers who attended to the tonsure, bleeding, extraction of teeth and care of less serious wounds. Surgery was the one branch of medicine that successfully broke free of its ancient chains; it changed more in the nineteenth century than in the previous two thousand years.

From the eighteenth century, then, surgery began a persistent and enduring rise.³ Lombe Athill refers to 'the revolution in the practice of surgery'⁴ that the discovery of anaesthesia prompted. Essentially, this period saw the surgeon evolve from a blood-spattered tradesman, to a medical man of education.

¹ *Ibid.*, p. 149.

² Widdess, *Royal College of Surgeons in Ireland*, p. 3.

³ Roy Porter, *Blood and guts: a short history of medicine* (London, 2002), p. 115.

⁴ Athill, *Recollections*, p. 192.

Rivington outlines how the surgeons and the barbers were separated in 1684, thus enabling the surgeons to be 'exempted from the several offices of constables, scavengers, overseer of the poor'.¹ The severance of the guild emancipated medical men from ignorance and amateurs and allowed them to become 'the true professors of surgery'.² The trappings of trade were an obstacle for those who desired social mobility, and the College of Surgeons were anxious to prove their worth:

it is the opinion of this college that the service of an apprenticeship to the profession of surgery is derogatory to the honour and dignity of a learned profession and injurious to the interests of science and the public.³

The attempt at replacing apprentice and guild certification with college or university courses gave the profession the polish and distinction it craved. Apprenticeship was not necessary for obtaining a surgical diploma from 1828,⁴ but the practice of students working under an established surgeon did continue throughout the nineteenth century. In the schools of the College of Surgeons in Dublin there were Chairs of Anatomy, Physiology, Surgery, Midwifery, Surgical Pharmacy and Botany, but there was none of medicine until 1813, and chemistry received one in 1843.⁵ By mid-century surgeons were anxious to establish themselves on an equal footing to physicians.

In order to enhance the public perception of their craft, surgeons were also anxious to sever any association with the apothecaries; Cameron notes that in 1838 the Royal College of Surgeons 'in a most voluminous petition to Parliament, formulated a terrible indictment against the apothecaries. They denounced the apothecary as an

¹ Porter, *Blood and guts*, p. 49.

² *Ibid.*, p. 64.

³ Cameron, *History of the R.C.S.I.*, pp 146–147.

⁴ Mapother, *Medical profession*, p. 118.

⁵ Kirkpatrick, *History of Steevens' Hospital*, pp 237–238.

imperfectly educated person.’¹ Cameron states that ‘It cannot be denied that the diplomas of the Irish College [of surgeon] were held in high estimation about this time’.² The candidates by mid-century were expected to pass an examination in both Latin and Greek,³ and thus the status of surgeons continued to rise. Professor Robert Lyons of the Catholic University of Ireland praised surgeons in an introductory address to medical students:

The surgeon who grasps, in his forceps the stone extracted from the bladder of him whom the law designates a pauper, is as much a hero as the general who waves his sword in pursuit of a routed foe.⁴

The surgeon, as the century progressed, was increasingly gaining the reputation of a gentleman, far removed from his humble origins.

Surgeons struggled and succeeded in raising their status by ensuring that their education corresponded to the education of a gentleman. Cameron informs us that as early as 1814, the Royal College of Surgeons decided that candidates should be examined in the following books – Sallust, six books of Virgil’s *The Aeneid*, the Epistles of Horace, the Greek Testament, Murphy’s *Lucan* and four books of Homer’s *Iliad*.⁵ Surgeons felt that the ancient route of qualification – apprenticeship – was a barrier to their prestige, and the Royal College of Surgeons in Ireland was the only college that made obligatory before apprenticeship an examination in classical literature.⁶

¹ Cameron, *History of the R.C.S.I.*, pp 190–191.

² *Ibid.*, p. 171.

³ *Ibid.*, pp 212–214.

⁴ *D.M.P.C.*, xvi (1873), p. 2604.

⁵ *Ibid.*, pp 146–147.

⁶ Widdess, *Royal College of Surgeons in Ireland*, p. 53.

It was not until 1754 that surgeons established their own college, the Royal College of Surgeons (R.C.S.I.), which erected its school in Stephen's Green in 1810. This ambiguous beginning enabled the physicians to dominate for some time, but certainly by the turn of the nineteenth century surgeons were gaining valuable ground. The R.C.S.I. protected its new position by creating a closed elite of hospital surgeons. They, rather than the physicians, tended to dominate the teaching hospitals and often commanded high fees and large incomes.¹ Their determination to develop an enlightened and liberal educational policy brought about a considerable improvement in the social and professional status of Irish surgeons. The college's aim was the education of surgeons, where the young surgeon apprentice could receive organized training in the fundamental principles of his craft – anatomy, physiology and surgery.² The tradition of apprenticeship was not entirely dispensed with, as this advertisement in the *Dublin Medical Press* in 1873 attests:

An Ophthalmic and Aural Hospital surgeon in Dublin is prepared to receive the son of a gentleman as a pupil, who will reside with him, for whose medical and surgical studies he will arrange and superintend, and whose education in his own special department, he will himself undertake.³

The advertisement is careful to stipulate the required social ranking of the potential student and points to the significance of rank and distinction among surgeons in Ireland in the second half of the nineteenth century.

The fees for becoming a surgeon were also increasing by mid-century. The fee for an apprenticeship was £170, with a further £60 for attendance at lectures.⁴ By 1839 the college were hosting 'scientific' meetings. Cameron mentions that one such meeting

¹ Wear, *Medicine in society*, p. 237.

² Widdess, *Royal College of Surgeons in Ireland*, p. 73.

³ *D.M.P.C.*, xvii (1873), pp 411–412.

⁴ Widdess, *Royal College of Surgeons in Ireland*, p. 73.

'came off with great *éclat* – the Lord Lieutenant and 89 other persons, many of them noblemen and high officials, were present. The cost of the entertainment was £28 12 Shillings'.¹

The College of Surgeons protected its position by creating a closed elite of hospital surgeons. They, rather than the physicians, tended to dominate the teaching hospitals. But any surgeon that practised midwifery or pharmacy – i.e. a general practitioner – was excluded from office or privilege within the college.² In other words, only 'pure' surgeons could become fellows, thus ensuring an elitist group within the college. The college's monopoly over county infirmary positions ensured that it would attract the best students. Consequently, though the surgeons might accuse the physicians of elitism, the surgeons were at least as guilty.

The popularity of surgery increased throughout the nineteenth century. Its appeal lay in the fact that it was new, quick and, supposedly, painless and safe. The introduction of anaesthesia in the 1840s had made an immediate impact on patients: surgery was no longer associated with gruesome agony, further boosting the reputation of surgeons in the eyes of the public. Lombe Athill observed that:

Formerly the patient would most probably have walked to the operation room, would have been terrified by seeing the needful preparations made, and been in agony of fear at the thought of the suffering to be endured ... A few, but only a few, bore heroically the pain which must be inflicted.³

The analogies of blood and butchery gave way to a new respect for surgeons as accomplished, educated gentlemen. At long last the craft had thrown off its negative

¹ Cameron, *History of the R.C.S.I.*, pp 190–191.

² Wear, *Medicine in society*, p. 237.

³ Athill, *Recollections*, p. 119.

associations and become linked by the public and the press with science and life-saving capabilities. Gone was the mentality of the eighteenth century that interference with the body cavities was to be avoided owing to the high mortality that followed.¹ By 1820 the revenue for the College of Surgeons in Dublin was £1,711, and £8,200 in stocks.² It had become a rich corporation.

11. Exclusion of the apothecaries

Traditionally, licentiates of the Irish Colleges of Physicians and Surgeons had dissented over what each group had identified as impingements on their respective areas of expertise. However, in the nineteenth century the two groups were for once united in their denigration of the apothecary, whom they saw as not only a threat to their own practices but also as a defiler of the respectability of medicine. They saw themselves as superior to the apothecaries socially and were offended by the potential threat of this lowly order rising above its perceived station.³

The Apothecary Act of 1815 was the first attempt by the government to standardise medicine, initially perceived as a backlash by the Royal Colleges to keep the apothecaries in a constant state of inferiority by stressing the apprentice element within the society. Nonetheless, it gave the apothecaries a legitimate status in the increasingly competitive world of medical practitioners. Originally drug merchants, apothecaries had been allowed to visit the sick and also prescribe drugs as well as dispense them since the House of Lords provided a ruling in 1704. However, they were permitted to charge only for the drugs they dispensed and not for their medical

¹ Widdess, *Royal College of Surgeons in Ireland*, p. 42.

² Cameron, *History of the R.C.S.I.*, p. 152.

³ Cassell, *Medical charities*, pp 26–27.

advice.¹ In the course of the eighteenth century apothecaries multiplied so rapidly in Britain that they outnumbered physicians by ten to one by the middle of the century.² Increasingly they obtained surgical certification as well – paving the way for the advent of the general practitioner of the later nineteenth century.

As early as 1700, middle-class people of substance were beginning to consider the apothecary's trade as a reputable career.³ The small amount of money required to become an apothecary, the relatively low apprenticeship fee, and the low prices of materials were appealing to hard-up gentry and to respectable but poor middle-class families.⁴ Given that the fees in Britain were similar to those in Ireland, coupled with the negative reaction regarding apothecaries (see below) of the *Dublin Medical Press*, it is not unreasonable to assume that the Irish apothecaries were also growing in numbers. This struggling, but increasingly powerful class was anxious to discard the stigma of tradesman that had clung to apothecaries for so long.

The Apothecary Act of 1815 stated that all apothecaries must possess the licence of the Society of the Apothecary (L.S.A.). Candidates were now required to attend lectures on anatomy, botany and chemistry. This gave a level of prestige to apothecaries but added to the rivalry in the medical profession as medical men struggled for patients. Loudon emphasizes that pharmacy – the art of compounding and dispensing drugs – was the major source of income of all practitioners.⁵ In towns the practising apothecary was of low status, but in the country he was sometimes a

¹ Ibid.

² Ibid., pp 26–27.

³ Hamilton, 'Medical professions', pp 160–161.

⁴ Ibid.

⁵ Wear, *Medicine in society*, p. 226.

man of good family who had qualified in the cheapest and most useful way.¹ In nineteenth-century Ireland, predominantly a rural country, it would seem likely that apothecaries were the only medical representatives in certain rural villages. Thus, the boundaries between the different fields of medicine, particularly surgeons and apothecaries, became increasingly blurred as the nineteenth century wore on. This would only add to apothecaries' call for increased professional status within the medical profession.

Essentially, the deep-seated rivalry before the 1858 Medical Act arose because physicians wanted to maintain their position at the top of the medical hierarchy, surgeons wanted the same recognition (and salary) as the physicians, and apothecaries sought any form of recognition within this group that they could get. There was concern among physicians and surgeons that apothecaries were venturing

beyond [the trade's] precincts ... to boldly undertaking the treatment of every disease to which the human body is subject ... it is neither prudent or wise of the public to trust their health and lives to a body of men decidedly unfitted for this.²

The apothecary was to dispense drugs, and any attempt by him to administer medical aid to a patient was encroaching onto the territory of the surgeon and physician.

Irish surgeons were squirming at the possibility of increased power for the apothecaries under the whole medical charities reform question, whereby some apothecaries were serving as dispensary medical officers.³ In 1845 Sir James Graham introduced a Medical Reform Bill to the House of Commons; the Royal College of

¹ Hamilton, 'Medical professions', p. 160.

² *The Lancet*, i (1860), pp 400–401.

³ Cassell, *Medical charities*, pp 27–28.

Surgeons in Dublin opposed many of the clauses, particularly the one that recognized the apothecaries as medical practitioners. The college suggested that the apothecaries should be restricted to the practice of pharmacy.¹ Graham's bill did not become a statute.

The idea that an apothecary should venture beyond his shop counter and the business of dispensing drugs not only would be catastrophic for the public but also would add to the flurry of competition for patients, according *The Lancet* in 1860:

Numbers of highly informed medical men, both physicians and surgeons, the sons of gentlemen liberally educated with gentlemanlike feelings and demeanour, and excellent moral character who have expended large sums and great labour in acquiring a knowledge of their profession thrown out of that honourable path which they vainly hoped would lead to competence and independence; and that too by a set of men totally unfitted, either by general or professional education.²

For once, the squabbling physicians and surgeons had a joint grievance; this article reflects the importance practitioners placed on 'liberal' education (a euphemism for a polished education) – the mark of a true gentleman.

The *Dublin Medical Press* in 1852 printed a review of a publication entitled *Wholesome advice to apothecaries* (a 'document worth perusing'), which outlined a code of ethics for apothecaries. It is interesting in that it illustrates how keen the journal is to emphasise the inferiority of the apothecary. The advice ranged from how the apothecary could 'by his language and demeanour' avoid disrespecting the doctor to outlining the limits of the apothecary's responsibilities:

the apothecary is not justifiable in making inquiries relative to the patient or his disease ... when an apothecary is asked his opinion of a physician's

¹ Cameron, *History of the R.C.S.I.*, pp 216–217.

² *The Lancet*, i (1860), p. 119.

prescription in a manner that indicates want of faith in the prescriber, he should waive the question.¹

The journal makes clear its viewpoint that the apothecary is on the lower rungs of the medical hierarchy. The apothecary remained an inferior order of medical practitioner – he was not allowed, for example, to compound drugs if asked to do so by a physician but, conversely, he was a medical practitioner, with rights to charge fees for attendance, and a right to demand those fees by law if he needed to.

Medical practice was to be a profession for a gentleman, and apothecaries simply did not fit the bill:

if he keeps an open shop, and compounds the prescriptions of other men, he is to all intents and purposes in law and in fact, an apothecary and consequently, not a member of our profession.²

His affiliation with shop counters and sundry goods was more than the physician and surgeon could tolerate.

More significantly, the apothecary was advised in 1852: ‘in justice to his sense of the proper limits of his vocation to the medical profession, and to his customers, [to] abstain from prescribing for diseases’.³ The lines of demarcation with regard to who was the practitioner and who prescribed are clearly drawn. The fear was that the apothecary might adopt the role of the doctor and, given that there was an apothecary shop at every dispensary in Ireland,⁴ it seems reasonable to assume that surgeons in particular feared a possible usurpation of medical responsibilities.

¹ *D.M.P.*, xxviii (1852), p. 363.

² *Ibid.*

³ *Ibid.*

⁴ Geary, *Medicine and charity*, p. 59.

In a letter to the *Dublin Medical Press* in 1850, the apothecary was defined as

the physician of the poor in all cases and of the rich when the distress or danger is not very great ... the mere compounding of prescriptions was never what the public or the profession required of them.¹

This supports the view that in the early part of the nineteenth century, the apothecary was the only feasible medical representative for many people in the Irish countryside. The established medical profession saw the apothecary as a threat to the power and respectability of surgeons and physicians and so sought to curb his powers. The apothecary would continue as the medical underdog throughout the nineteenth century; it would not be until the twentieth century and the rise of the general practitioner that he had the opportunity to come into his own.

12. The private schools and the Scottish universities

The portals to the profession of medicine were varied in the nineteenth century. Once the qualifications of the teachers of a given medical course had been recognised by a licensing body, students with the necessary courses and hospital credits could sit that particular body's examinations. As a result, private schools flourished,² making effective supervision by the relevant licensing bodies almost impossible.³ Once the teachers had the requisite qualifications, they could open a school. Many of the schools were reputable and medical-practitioners-turned-teachers stood to gain much

¹ *D.M.P.*, xiii (1850), p. 76.

² The best known private medical schools included the Kirby Theatre of Anatomy (1809); the Jervis Street School (1820); the Park Street School (1824) where Arthur Jacob taught anatomy and physiology; the School of Anatomy, Medicine and Surgery of the Richmond Hospital (1826) where Richard Carmichael gave lectures on surgery. For more see Fleetwood, *History of medicine*, pp 191–206.

³ Fleetwood, *History of medicine*, p. 199.

prestige from their students and the hospitals they attached their schools to. Such affiliation helped to establish a doctor's reputation, often bringing them into contact with fee-paying patients.¹ In 1873 the *Dublin Medical Press*, in an editorial, outlined the importance of the private schools for medical education in Ireland:

It must not be supposed that a student who intends taking a degree or diploma in any college must take his lectures in the school attached to that college. On the contrary, with few exceptions, all certificates of attendance on lectures are interchangeable, and a student, no matter what medical school he may have studied in, will be admitted to any university or college.²

There were many private schools; the principal ones included the Jesus Street Hospital School, Kirby's School (known officially as the Theatre of Anatomy), the Medical School of the House of Industry Hospital, the Theatre of Anatomy at Moore Street, and the Apothecaries Hall.³ These private colleges were not able to grant qualifications prior to the Medical Act of 1858, but they were becoming increasingly popular and the College of Physicians, even more than the College of Surgeons, was a body mainly concerned with examining and administration rather than with actual teaching.

The private schools offered hands-on experience and anatomy lessons at a time when cadavers were often difficult to obtain.⁴ Much of the initiative in both hospitals and private schools came from Scots or graduates of Edinburgh.⁵ Arthur Jacob was linked to the Park Street School, called the Medico-Chirurgical School, where he gave lectures on anatomy and physiology. William Wilde later bought it, and it became

¹ Geary, *Medicine and charity*, pp 124–125.

² *D.M.P.C.*, xvii (1873), pp 261–262.

³ Cameron, *History of the R.C.S.I.*, pp 513–543.

⁴ Fleetwood, *History of medicine*, p. 195.

⁵ Hamilton, 'Medical professions', p. 149.

famous as an eye hospital.¹ These private and professional schools added prestige to the study of medicine over time. The lecturers were associated with the schools, and gained further kudos by gathering pupils, making a scientific name for themselves and ultimately winning public recognition.² This distinction of being a teacher, twinned with having a lucrative practice, with patients recommended by former pupils, ensured that medicine remained hierarchical. The majority of teachers in the Park Street School, for example, were professors in the College of Surgeons.

The private schools often served as ‘grind’ schools for medical students anxious to pass examinations. In 1879, night lectures were given in the Carmichael School for students too busy to study during the day.³ Lombe Athill said that:

I never failed an examination, though, as I have already said, I never had the advantage of private tuition in either medicine or classics. The aid of a ‘grinder’ in medicine was so universal that for a man to obtain his diploma as a surgeon without the aid of one was most unusual.⁴

Medical education was increasingly becoming a costly business and consequently, as the profession had long hoped, a profession suitable for a gentleman.

Medical men seeking an education through English were increasingly drawn to Edinburgh in the nineteenth century; a medical school built on the premise and ideology of Leiden. ‘Physic is by no means taught so well as in Edinburgh’⁵ declared Oliver Goldsmith of Dublin. Edinburgh had many attractions in that it was cheaper, there were no religious restrictions (unlike Trinity College) and the lectures were in

¹ Fleetwood, *History of medicine*, pp 194–195.

² Porter, *Disease, medicine and society*, pp 52–53.

³ Fleetwood, *History of medicine*, p. 194.

⁴ Athill, *Recollections*, p. 91.

⁵ Froggatt, ‘Irish students of medicine’, p. 142.

English. Significantly, there was no obligation to graduate: students attended and paid for only the courses they desired and needed. The *Freeman's Journal* carried advertisements of lectures in private schools. An example of this from 1850: 'Doctor Jacob will commence his lectures on Diseases of the Eye in the City of Dublin Hospital on Monday, the 15th April at Four O'Clock'.¹ This advertisement appeared in the same newspaper in 1864:

School of Physic in Ireland, (Incorporated under 40 Geo. III, maintained and directed conjointly by the University of Dublin and the King and Queen's College of Physicians in Ireland) The winter courses of lectures will commence on the 7 November. Dissections will be supervised throughout the session, and every assistance given to the pupils, by the professor of anatomy and physiology.²

The advertisement assures its readers that 'Certificates from this school are received by all Licensing Bodies in Medicine and Surgery'.³ Such mentions in a public newspaper illustrated the public's perception of medicine as scientific and thus reputable, and added to the social ranking of the nineteenth-century medical man.

At the beginning of the nineteenth century the fees demanded by the universities were beyond many – making Leiden and Edinburgh popular choices. As the century progressed, the choice of eligible professions was limited and consequently medicine was fast becoming increasingly attractive for the rising middle classes. Edinburgh and Glasgow had a good reputation for diagnostic training and were held to give a more thorough training in the investigation of disease than the English and Irish equivalents.⁴ Consequently, the reputation of these colleges grew as the century progressed. It would seem that the colleges in Edinburgh (established in 1726) and Glasgow, and the

¹ *Freeman's Journal*, 12 Apr. 1850.

² *Freeman's Journal*, 7 Oct. 1864.

³ *Ibid.*

⁴ Digby, *British general practice*, p. 65.

continental colleges were more advanced than Trinity College, Oxford and Cambridge, as well as cheaper. Certainly by the mid-nineteenth century, the majority¹ of medical practitioners were graduates of these colleges (Froggatt pointed out that between the years 1790 and 1830 there were 1,347 Irish student enrolments for autonomy at Edinburgh and 1,389 at Glasgow University – some 13 per cent and 18 per cent respectively of total enrolments).² It was from these rank-and-file medical men that the impetus to gain respectability came.

In 1852 the *Dublin Medical Press* compared the exclusionary Trinity College and Edinburgh:

The Medical faculty of Edinburgh University is really a Medical faculty in the proper sense and no heterogeneous mixture compounded for the nonce of materials of doubtful nature; moreover, it has been constructed with little adherence to the University principles of affiliation, fraternity, nepotism and pupil-patronage.³

Well accustomed to criticising Edinburgh in the past, the journal had taken to praising the college in order to make deprecatory comments about physicians, who looked down on surgeons. Nonetheless, the point that Edinburgh was a teaching establishment that possessed none of the obstacles – religious or otherwise – was a valid one. However, the initial openness of the Scottish system to students of varying backgrounds prompted more stringent demands on students to come to the universities better prepared.⁴ As the century progressed, more rigorous preparatory education sought to keep the profession of medicine exclusive.

¹ See Hamilton, 'Medical professions', pp 141–169; Porter, *Blood and guts*, pp 68–69.

² Froggatt, 'People's choice', pp 49–51.

³ *D.M.P.*, xxviii (1852), p. 59.

⁴ Bonner, *Becoming a physician*, pp 263–264.

The emphasis in Edinburgh was on practical clinical teaching¹ and the foundations of Newton's physics,² but by 1826 the university commissioners determined to restore 'a regular and systematic course of study' in the arts³ and strongly supported the need for a preliminary examination to be conducted in the classics, mathematics and natural philosophy, with a new emphasis on Greek and logic⁴. By 1858, Edinburgh saw English literature as an essential part of liberal education and medical candidates had to reflect proof of knowledge of subjects such as Greek and natural philosophy.⁵ The nineteenth-century doctor may have had difficulties in diagnosing and have seen no ill-effects of bleeding, using leeches and other horrific procedures – but his knowledge of literature and the classics allowed him to hold his own in the fashionable dinner parties of the upper echelons of Irish society.

The influx of physicians and surgeons from Scotland encouraged the licentiates in their refusal to be relegated to a lower caste.⁶ In their wake, a new middle-class profession paved the way, clamouring for reform in order to gain respectability in a hierarchical profession and, crucially, bringing with them the middle-class morality and values that would have a lasting influence on nineteenth-century medicine.

The second half of the nineteenth century marked a period of organisation and development for the medical profession in Ireland. In a remarkably short period of time, the profession had established itself as one of the most prestigious groups in the

¹ See John Feeley, 'The Royal College of Physicians and Irish medicine' in the Royal College of Physicians and the National Gallery of Ireland, *The anatomy lesson: art and medicine* (Dublin, 1992) pp 96–97.

² C. J. Lawrence, 'Early Edinburgh medicine: theory and practice' in R. G. W. Anderson and A. D. C. Simpson (eds), *The early years of the Edinburgh Medical School* (Edinburgh, 1976), pp 84–85.

³ D. B. Horn, *A short history of the University of Edinburgh 1556–1889* (Edinburgh, 1967), pp 159–160.

⁴ *Ibid.*, pp 163–164.

⁵ *Ibid.*, pp 174–177.

⁶ Hamilton, 'Medical professions', pp 142–143.

country. This was achieved through an impressive drive for aggrandisement and bitter intra-professional wrangling, which in turn firmly established a tiered structure of power. The parliamentary-endorsed medical register enabled qualified practitioners to distance themselves from irregular practice, and thus set a precedent for the exclusionary nature of medicine in the nineteenth century.

CHAPTER 2: EXCLUSION

During the eighteenth century, medicine was in the hands of a variety of people – from midwives to healers – and popular medicine was practised widely. It was during the nineteenth century, as medicine became increasingly exclusionary, that medical men sought to monopolise the practice of medicine. Nurses, midwives, coroners, local government, dentists and ordinary people were actively limited, if not deliberately excluded, from participating in any aspect of medical practice. To consolidate their position, and despite inner rank squabbling, medical practitioners tried to monopolise medicine altogether. This exclusion was propelled by the fear that the Medical Act of 1858 had simply not been adequate to debar unqualified practice effectively. In 1864 the *Dublin Medical Press* outlined the concerns of the profession:

This confusion of the educated and the uneducated, the ignorant and the learned, the legitimate and the illegitimate and the honest and dishonest is a most heavy misfortune under which the profession will continue to groan as long as legislative interference is withheld for its benefit.¹

The medical profession sought, by virtue of its ‘scientific’ education, distinction from all other persons involved in healing the sick. Its attempts to monopolise medicine reflected the insecurity and jealousies of an emerging profession that, despite its claims to the contrary, did not have the back-up of scientific knowledge to sustain its authority.

¹ *D.M.P.*, ii (1864), p. 155.

This chapter seeks to explore the exclusionary nature of medicine. Eighteenth- and nineteenth-century medical science did not, unfortunately, have a reputation for successfully curing disease or alleviating major sickness, and so required a vehicle to promote the importance of scientific medicine to the public. The Medical Act of 1858 had failed to outlaw unqualified practice, and thus the medical profession needed to impress on their potential patients the disadvantages of what they termed 'non-scientific medicine'. This would effectively launch the careers of qualified medical men and ensure that medicine remained an exclusive profession based openly on elitist principles.

The vehicle to propel this exclusionary dictum came in the form of public health legislation, the Medical Charities Act of 1851. Essentially, the relatively novel state interest in the health of post-Famine society gave the medical profession a new status as the government sponsored schemes in public health. The Medical Charities Act was of key importance in bolstering the public perception of medicine in nineteenth-century Ireland. By mid-century the medical elite in Ireland was organising an ultimately successful resistance to legislation leading up to the Medical Charities Act of 1851, which it perceived as a threat to the prestige of the profession. The Poor Law Commission that would act as a central authority in the management of a network of dispensaries included a strong medical presence. This victory was in part a testimony to the tenacity and determination of the profession, which formed a formidable resistance to any attempt to replace medical practitioners with a central, bureaucratic authority. It also indicates the government's recognition of the central role of the medical profession in improving the lives of the people. The Medical Charities Act

bolstered the perception of medicine as a professional, specialised and scientific occupation, thus adding significantly to the prestige of the profession. Moreover, the Act of 1851 ensured that doctors played a significant role in the lives of ordinary people.

As its role in society expanded with government initiatives in public health, the medical profession, through the pages of the *Dublin Medical Press*, became increasingly exclusionary as regards the practice of medicine. This section of the chapter examines how the profession increasingly sought to create an aura of expertise and specialism around medicine. The *Dublin Medical Press* evinced strong disapproval of popular medicine, effectively dismissing the traditions of domestic healing. The inclusion of medical subjects in literature was also a cause of contention for the journal, which saw this as a slur on the prestige of the profession.

The second part of this chapter aims to examine the exclusionary nature of the medical profession, as documented in the *Dublin Medical Press*, towards other medical personnel, mainly women, such as midwives, nurses and female doctors. The study emphasises the profession's discomfort with the moves to formalise the training of the midwife (which would not take place until the twentieth century), whom they saw as a threat to the authority of the male doctor. Similarly, the reaction of the *Dublin Medical Press* to the advent of reformed nurses, precipitated by the sweeping sanitary changes of Florence Nightingale in the Crimean War, was hostile. Far from celebrating the trained and efficient nurses of the second half of the nineteenth century, the medical profession promulgated a suspicious and exclusionary attitude in the columns of the *Dublin Medical Press*. The journal revealed an anxiety that nurses

might forget their subordinate role and so impinge on the authority of the medical man. The group that the *Dublin Medical Press* reserved most of its ire for was the maverick group of women that not only sought to practise medicine but sought to practise it on the same level as their male counterparts. The emergence of the female practitioner revealed the underlying misogyny of the *Dublin Medical Press*. The profession, through the pages of the journal, constructed every possible argument in its struggle to discredit women in the practice of medicine.

1. Public health

The nineteenth century witnessed rising levels of endemic infections, and while little was produced in the way of cures, it did begin a discourse on the health of the population and government responsibility. The government's gradual relinquishing of its *laissez-faire* policy saw its involvement in domestic matters such as provision for the poor, embodied in the effective extension of the Poor Laws to Ireland in 1838.¹ This was effectively to lay the foundations for the position of medical practitioners in Ireland. The small number of hospitals, particularly outside the larger urban areas, highlighted the limitations of medical provision available in Ireland in the previous century.² Now hospitals were to become channels of medical power, formalising health care, providing a steady flow of patients and promoting the doctor as the expert. Eight hospitals were founded in the eighteenth century in Dublin alone: Jervis Street (1718); Dr Steevens' (1733); Mercers (1734); Incurables (1743); the Rotunda (1745), St Patrick's (1757) and the Meath (1756). These institutions were to become the foundation of modern medical practice. This is not to say that by the end of the

¹ See David Englander, *Poverty and Poor Law reform in 19th century Britain, 1834–1914* (Harlow, UK, 1998).

² James Kelly, 'The emergence of scientific and institutional medical practice in Ireland 1650–1800' in Malcolm and Jones, *Medicine, disease and the state*, p. 26.

eighteenth century there was a uniform and centralised system of health care – the institutions were run by poorly organised and inexperienced grand juries.¹ However, these medical charity institutions laid the foundations for a hospital-centred and state-funded administration that doctors could utilize for their own advancement.

In 1841 the Royal College of Surgeons created the position of professor of hygiene or political medicine,² an indication of the new emphasis on public health. The chair was first occupied by the co-founder of the *Dublin Medical Press*, Henry Maunsell, who asserted the responsibility of the profession of ‘protecting the public health and providing for the physical well being of the human race’.³ In 1864 Edward Dillon Mapother⁴ took over the chair; he published the *First annual report on the health of Dublin for the year 1865*. This preoccupation with the health of society prompted a flurry of new laws ranging from The Sewage Utilisation Act of 1865 to the 1871 Dublin Main Drainage Act. Mapother’s findings underlined the deep problems of sanitation in Ireland, particularly in Dublin. However, the medical profession was impeded by its fundamental lack of understanding of how disease spread. This will be discussed in more detail below.

By the 1840s the profession had become so overcrowded that many suggestions were suggested for thinning its ranks.⁵ Digby points to how trends in professionalization in

¹ Cassell, *Medical charities*, p. 17.

² Widdess, *Royal College of Surgeons in Ireland*, pp 86–87.

³ *Ibid.*

⁴ Edward Dillon Mapother (1835–1908) was born in Fairview in Dublin in 1835 and received his medical education at the Royal College of Surgeons. He was the first person to hold the position of Medical Officer of Health for the City of Dublin. He was a tireless campaigner for the improvement of public health. In 1866 he published *The unhealthiness of Irish towns and the want of sanitary legislation* (Dublin, 1866) and a year later he published his highly acclaimed *Lectures on public health* (London, 1867). His 1862 *Manual of Physiology* ran into three editions. Charles Cameron (1830–1921) succeeded Mapother in the chair of hygiene.

⁵ Farmer, *Patients, potions and physicians*, pp 20–21.

Europe led to problems of professional overcrowding¹ and certainly, from an Irish context, the *Dublin Medical Press* evinced an anxiety that there was simply not enough work to go round for the medical practitioner (see Chapter 1). The creation of a professional class that was in excess of the needs of the country had implications for medicine. As medicine became an increasingly desirable occupation for gentlemen, the opportunities for employment became depleted. Lombe Athill struggled to get a position when he first qualified in 1847; his first position offered no remuneration.² As the Irish middle class grew, professional opportunities for its sons became limited and the Dublin medical schools continued to produce a surplus of medical men, more than the country could absorb.³ Geary points out that despite the risks of infection from their patients, numbers of qualified doctors continued to soar,⁴ and so the initiation of a national, state-run system of medical care for the poor seemed to be timed perfectly for a profession struggling to find work.

The crisis of the Famine pointed to the glaring inadequacies of a medical system depending on philanthropy. O Grada asserts that many of the most lasting trends in modern life resulted from the Famine;⁵ the medical system was no exception. Essentially, the nineteenth century saw medical professionals increasingly preoccupied with the health of the community. In 1877 the *Dublin Medical Press* referred to the Irish Public Health Bill of that year as ‘The future of sanitation in Ireland’.⁶ The journal aligns these legislative developments with the prestige of the profession by asserting that ‘the medical sanitary officers should, with a view of

¹ Digby, *British general practice*, p. 23.

² Athill, *Recollections*, pp 132–133.

³ Farmar, *Patients, potions and physicians*, p. 84.

⁴ Geary, *Medicine and charity*, p. 151.

⁵ Edwards and Williams, *The Great Famine*, p. vii.

⁶ *D.M.P.C.*, ii (1877), p. 132.

improving their status, be called medical officers of health'.¹ The state intervention in economic and social affairs offered the medical authorities in Ireland possibilities to strengthen and consolidate their position in society by inflating their own importance. The Irish Poor Law² established the workhouse system in 1838 whereby the country was divided into 130 unions, each including a workhouse, infirmary and fever hospital. These proved woefully insufficient to deal with the demands of the Famine. A temporary Fever Act³ of 1846 empowered the lord lieutenant to appoint a central board of health that included three prestigious medical men: Sir Robert Lane, professor of chemistry at the Apothecaries Hall, Dublin and a fellow at the Royal College of Physicians; Sir Phillip Crampton, surgeon to the Meath Hospital and president of the Royal College of Surgeons; and Sir Dominic Corrigan, eminent physician.⁴ The inter-professional wrangling and disputes that followed not only mirrored the divisions within the Irish medical profession but reflected the urgent need for a reform of the health system. Denis Phelan, a Poor-Law Commissioner employed in 1840 to carry out an inquiry into the medical charity systems in Ireland, recommended extensive changes to their funding and management. Geary asserts that opposition to Phelan's report motivated the medical profession;⁵ essentially, it was alarmed that a central bureaucratic authority like the Poor Law Commission would diminish its power within the medical charities. The Famine had witnessed the relief effort placed under the authority of the Irish Poor Law Commission; the medical profession was determined that it would maintain a foothold within this organisation. The medical elite had to ensure that the profession had a stake in the orchestration of

¹ Ibid.

² 1 & 2 Vict., c. 56 (1838).

³ 9 Vict., c. 6 (1846).

⁴ William P. MacArthur, 'Medical history of the famine' in Edwards and Williams, *The Great Famine*, pp 280–281.

⁵ Geary, *Medicine and charity*, pp 159–160.

the Medical Charities Act of 1851. This act would effectively replace social reformers with professional administrators in the public health system, which in turn would give the profession power to demand change.

2. A scientific authority

The evolving realisation of the importance of public health on the part of the government and its resulting legislation encouraged new awareness in society of physical well-being in general. By mid-century, Mapother's research had uncovered the lack of effective public sanitation in the towns and villages of Ireland: 'the sewerage is very bad, the lanes filthy, the lodging houses overcrowded'.¹ But, fundamentally, the medical profession was as much in the dark about the causal factors for endemic diseases as ever before. Pasteur's germ theory and identification of the importance of micro-organisms would not be accepted fully by Irish medicine until the next century.² Ostensibly, the medical establishment, including Mapother, had difficulty in accepting the destructive possibilities of bacteria. Therefore, the profession's ability to deal competently with the issues of public health was seriously impaired. With the government increasingly looking to medicine as an authority on the spread of disease, coupled with the flurry of quack medicine to meet the demands of the public's new interest in personal health, there were new pressures on the profession in Britain and Ireland. *The Lancet* in 1843 outlined the anxiety of medical practitioners:

If medical practitioners, the professors of an art which touches the circle of sciences at almost every point, are not much further advanced in the

¹ Mapother, *Unhealthiness of Irish towns*, pp 7–8.

² Joseph Robins, *The miasma: epidemic and panic in nineteenth century Ireland* (Dublin, 1995), pp 226–227.

knowledge of natural causes and effects than the mass of the people ... that is much to be lamented.¹

It became increasingly important, despite the absence of medical knowledge, to promote the profession as a rational and scientific craft requiring university training and specialisation. The profession needed to draw a clear distinction between established medicine and those who were regarded as unqualified to practice. The *Dublin Medical Press* in 1892 emphasised the importance of science to medical authority:

Nothing is more astonishing than to reflect that in the declining days of this, the nineteenth century, there should be persons who can bring themselves to believe in what may be described as untruths in science ... If education among the classes was not a quantity to be reckoned with and medical men with substantial scientific knowledge of their profession were conspicuously absent in the land, it might be possible to understand some of the instances of persons straying from the path of regular medical treatment and trying to make their escape from a mortal malady through the boggy, treacherous ground of quackism.²

Thus, medicine was expressing its authority in terms of scientific knowledge. By making the practice of medicine an elitist and predominantly specialised authority, the profession ensured that it would play a key role in the implementation and application of public health procedures. In 1864, the *Dublin Medical Press* was at pains to underline the importance of medical education to distinguish doctors from other practitioners of health: 'every sluggard, fool and rogue enjoys as yet full liberty to style himself a doctor and prescribe for the sick. Can this be allowed to continue without detriment to the public interests?'³ Increasingly, the *Dublin Medical Press* sought to assert that science was a vital component of the practice of medicine. The reality of limited understanding of the causal factors of endemic diseases did not

¹ *The Lancet*, i (1842–43), p. 685.

² *D.M.P.C.*, I (1892), p. 104.

³ *D.M.P.C.*, ii (1864), p. 155.

appear to impede the profession's progressive rise, which saw it play an influential role in determining social policy in the second half of the nineteenth century.

3. The Poor Law & Medical Charities Act 1851¹

Throughout the nineteenth century, poverty remained a major social problem in Ireland. The Poor Law Report of 1836 estimated that 585,000 labourers were unemployed for thirty weeks of the year, and their dependants would number at least 1,800,000.² The pertinent question was – how would the government deal with this problem? It would seem that this preoccupation with poverty led to the extension of the English Poor Law of 1834 to Ireland. Essentially, this meant that in 1838, Ireland was divided into areas called unions. A board of guardians who were elected by landlords and large farmers governed a union. The guardians in turn decided on the poor rate, a tax paid by the local landowners and used to help the poor. In each union, a workhouse was to be established. It was thought that this system, which would administer aid within the workhouse only, would do away with outdoor relief. The 1838 Act also stipulated that a detailed study be carried out on the institutions of the medical charities.

George Nicholls, a member of the English Poor Law Commission sent to Ireland to see if the Poor Law could be extended there, commented that 'a very considerable portion of the population [is] considered to be out of employment'³. F.S.L. Lyons points out that the Famine verified with 'appalling clarity' the connection between poverty and sickness; it was no accident that the Medical Charities Act of 1851

¹ Medical Charities (Ireland) Act (14 & 15 Vict., c. 68 (1851)).

² Gearoid Ó Tuathaigh, *Ireland before the famine* (Dublin, 1990), p. 108.

³ Sir George Nicholls, *A history of the Irish Poor Law* (London, 1857), p. 96.

followed so close after.¹ The habitual motif that recurs in nineteenth-century medical and political discourse is the relationship between illness and poverty. In a country that remained significantly poorer than her English neighbour, this relationship was even more pronounced. Unlike England, Ireland did not have a sizeable backdrop of philanthropy. The gentry and middle class in Ireland were relatively small and comparatively poor.² Indeed, Lombe Athill said that as few as three to four families could afford private health care in his first dispensary job in 1847.³ He bemoaned the fact that 'there seemed to be absolutely no money in the county districts'.⁴ The absence of a large and affluent middle class twinned with a high level of subsistence farming made comparisons with health systems in England difficult. Thus, Ireland required a system of health provision for the poor that could cater not for the minority, but for the huge proportion of the population that simply could not afford medical care.

The 1851 Medical Charity Act is crucial in examining the advance of medical power in Ireland. From early in the eighteenth century a network of medical charities had developed in Ireland in order to offer medical care to the sick poor. The organisation of this help was heavily dependent on philanthropy, and consequently haphazard in its administration. The disunity of the philanthropic framework of the medical charity institutions of the early nineteenth century was replaced by an influential and wide-ranging centralised system, namely the Irish Poor Law Commission, which incorporated by 1861 nine poor law inspectors, four medical inspectors and four

¹ F. S. L. Lyons, *Ireland since the famine* (London, 1973), p. 79.

² Cassell, *Medical charities*, p. 3.

³ Athill, *Recollections*, pp 141–142.

⁴ *Ibid.*

auditors.¹ The number of medical inspectors was later increased to five. It is interesting to note that the English Poor Law Board was not much larger despite serving a population three times as great. Arguably as a consequence of the sobering realities of the Famine, the Medical Charities Act of 1852 developed a health system of central administration that was widespread and influential with extraordinary medical powers.

The medical profession formed a formidable obstacle to the passage of the Medical Charities Act. This struggle involving the Royal College of Surgeons, the Medical Association and the *Dublin Medical Press* has been admirably documented already;² suffice it to say that the debate amalgamated medical interest to exclude the Poor Law Commission from a position of total control over medical charity institutions. The profession, as voiced through the pages of the *Dublin Medical Press*, was determined that it should maintain a central role. In 1851 the journal, in an editorial entitled 'The impending medical charities bill', indicates the profession's anxiety that the Poor Law Commission would impose authority over medical men:

But be the central control what it may, we shall not cease to warn our brethren against any delegation of power to it, which will leave them at its mercy as regards their duties, salaries and tenure of office ... No arbitrary, unlimited or undefined authority should be given to any board by which the humblest medical officer can be subjected to dictation or coercion as to his practice or method of treating the sick committed to his charge.³

The editorial emphasises the determination of the profession to maintain its prestige and prevent any medical charity legislation from undermining it. This determination ultimately succeeded in ensuring that the Medical Charities Act of 1852 upheld the authority and the reputation of the medical profession.

¹ Cassell, *Medical charities*, p. 87.

² For example see Geary, *Medicine and charity* and Cassell, *Medical charities*.

³ *D.M.P.*, xxv (1851), p. 61.

4. Medical charities and medical victories

It could be argued that historians have overlooked the significance of the Medical Charities Act in relation to the expansion of medical power. The Medical Charities Act of 1851, also known as the Dispensary Act, maintained the monopoly that the R.C.S.I. had on the most lucrative medical charities appointments (the county infirmary positions). It provided a medical commissioner, John McDonnell,¹ who was a professor at the R.C.S.I. and the epitome of elitist medical authority, and ensured that medical personnel to the Poor Law inspectorate were given the authority to function as regular inspectors, i.e. to deal with non-medical Poor Law issues. All this was to ensure that the medical profession had a significant role to play in a central health system in Ireland.

The men of established medicine ensured that medicine played a significant role in the administration and discharge of the system.² The Medical Charities Act of 1851, after a decade of political wrangling between the government and medicine, was a triumph for established medicine. Rivington pointed out: 'One of the great drawbacks of the Poor-Law medical service is that there does not exist a good feeling between Boards of Guardians and medical officers'.³ Arthur Jacob, founder and co-editor of the *Dublin Medical Press*, fought a valiant battle to maintain a substantial medical authority within the Commission in the years building up to the Medical Charities

¹ Dr John McDonnell (1796–1892) was born in Belfast, the son of a doctor, and educated in Trinity College. He was apprenticed to Richard Carmichael, the founder of the Irish Medical Association. He received his M.D. in Edinburgh and also studied in Paris and London before settling in Dublin. In 1827 he was made a member of the College of Surgeons and in 1847 he became Professor of Anatomy there. For more, see Cameron, *History of the R.C.S.I.*, pp 614–615.

² For more on this see Teresa Mullen, 'Liberal reform and the medical profession in early Victorian Ireland' (M.A. thesis, NUI Maynooth, 1997).

³ Rivington, *Medical profession*, p. 370.

Act. By 1850 he warned that 'the board of Health has taken too much power'¹ but the medical profession was to maintain a powerful stronghold in the administration and governing of the Irish medical charities. Rivington refers to 'some of the half-bred committeemen who know nothing of the treatment fit for an educated gentleman', who might make the discharge of a medical man's duty 'simply unbearable'.² The uneasy relationship between the profession and the Poor Law Commissioners was compounded by the fact that medical men believed they were a cut above committee members and so despised the necessity of taking orders from them. Moreover, the dispensary system achieved a level of common interest among its medical officers, leading to a sense of solidarity traditionally lacking in established medicine. This expansion of public appointments gave the doctor a higher social profile as well as increasing the demand for practitioners.

The sphere of medical influence and authority of medicine was reinforced by the legislation as dispensary districts allowed more people to benefit from medical supervision, while simultaneously ensuring that Irish medicine had significant sway in the operation of the new centralised system. This new national network of dispensaries and infirmaries added to the increasing demand for doctors, reinforcing the high prestige of nineteenth-century medicine. Under the Medical Charities Act a total of 723 districts were created, comprising 960 separate dispensaries served by 776 medical officers. At its peak, the grand jury system had consisted of only around 668 dispensaries.³ The reduced population of Ireland ensured that the ratio of medical men to population increased more rapidly. The ultimately successful struggle of the

¹ *D.M.P.C.*, xii (1886), p. 482.

² Rivington, *Medical profession*, p. 376.

³ Cassell, *Medical charities*, pp 86–87.

medical profession to maintain an authoritative position within the Poor Law Commission ensured that medicine influenced the lives of the ordinary people.

The dispensary districts, each with its own doctor and apothecary, provided a steady income for the medical man. The act stipulated that the doctor was to provide free treatments for those whom the guardians decided deserved it. The work was relatively poorly paid (at first, doctors were expected to supply drugs and medical supplies themselves) and lacked prestige. Nevertheless, a newly qualified doctor might take on Poor Law work to augment his earnings from private practice, while a more experienced physician might see such work as a means to deter competitors.

Rivington pointed out that 'Despite the miserable salary dispensary appointments are generally eagerly sought for, because they afford a certain salary (£103 15s/year); to supplement his private earnings'¹. The fact that dispensary positions continued to be desirable is perhaps compelling evidence of their attraction to nineteenth-century medical men. From the point of view of the medical establishment in Ireland, this new system of health care for the poor provided not merely a regularisation of income but much more opportunity for state employment in an overcrowded profession. The middle-class dispensary doctor was placed in a position of authority and prestige, being the most educated person in the rural villages of nineteenth-century Ireland.²

Medicine was increasingly viewed as an occupation for a gentleman and an opportunity to fraternize with the privileged classes. Lombe Athill expressed sadness leaving a dispensary district 'where the few gentry in the neighbourhood had shown me much kindness'.³ The 1851 Medical Charities Act facilitated the spread of professional medical practitioners throughout the country, allowing the medical

¹ Rivington, *Medical profession*, p. 375.

² Farmar, *Patients, potions and physicians*, pp 86–87.

³ Athill, *Recollections*, p. 142.

profession to widen their client base considerably. It was in their struggle for public acceptance and professional respectability that the medical community closed ranks and excluded all but themselves in the practice of medicine.

The influence of the Irish medical profession in the dispensary system in the second half of the nineteenth century can be seen in the changing role of the workhouse after the Famine. From an English perspective, May asserts how the medical staff were crucial in the running of the workhouse, 'especially as the sick and infirm came to comprise the majority of workhouse inmates'.¹ Cassell corroborates this view from an Irish context by pointing out how an improving economy saw the workhouses increasingly become homes for the aged and chronically ill. In 1851 workhouse admissions show that 34.8 per cent of inmates were able-bodied men and women; by 1871 the proportion of able-bodied inmates had been reduced to 15.9 per cent.² This shift (in light of Ireland's changing economic climate) from a view of the poor as general to specific perhaps could be seen as a modification of Malthusian thinking, which redefined the genuine poor as the 'impotent' – i.e. the sick and the aged. This definition of poverty would place the medical practitioner in a central role in the administration of social reform. Consequently, the role of the medical practitioner became a key one in the medical charities system in Ireland as the profession sought to widen and develop its scope and influence in its determination to bolster the prestige and reputation of medicine.

¹ Trevor May, *The Victorian workhouse* (London, 1997), p. 15.

² Cassell, *Medical charities*, pp 103–104.

5. Medicine and literature

The *Dublin Medical Press* evinced a single-minded desire to uphold the eminence of the medical profession in Ireland in the second half of the nineteenth century. To achieve this, it sought to exclude those it believed to be a threat to the reputation and prestige of the profession.

Porter's assertion that 'Overall, the practitioner emerged in the Victorian novel and in Victorian art as a sympathetic and honourable figure, to be looked up to, or at least to be accepted socially'¹ suggests that the profession could have viewed the inclusion of medicine in fiction as a means to enhance its reputation; however, it would appear from examining the *Dublin Medical Press* that the opposite was true. Though it could be argued that the inclusion of sickness in fiction indicated that medicine was increasing in importance in society, medical men perhaps were concerned about the manner in which the profession might be portrayed. Their concern might also be interpreted as a fear that literature was outside their sphere of influence and control. Michael Neve points out how the medicine in fiction 'placed doctors back in the narrative, no longer as conquerors, but as full of doubt as the pre-bourgeois tradition had always seen them'.² Fiction was an arena where the medical man could be demoted from the position of authoritative all-knowing doctor to a fallible figure prone to human error. This was a bitter pill to swallow. It would seem that the *Dublin Medical Press* wanted to depict the medical profession as infallible, reflecting the insecurities of an emerging profession.

¹ Roy Porter, *Bodies politic: disease, death and doctors in Britain 1650–1900* (London, 2001), p. 262.

² Michael Neve, 'Medicine and literature' in W. F. Bynum and Roy Porter (eds), *Companion encyclopedia of the history of medicine*, ii (London, 1993), pp 1532–1533.

Medicine worried that its striving for recognition as a liberal profession would be hampered by the portrayal of doctors as ordinary people. Its anxiety for respectability became more acute as professional values and aspirations increasingly began to dominate nineteenth-century European culture.¹ An editorial in the *Dublin Medical Press* in 1864 describes a short story, popular at the time, as ‘flashy clap trap’ and ‘a ridiculous romance’.² The journal’s ire was aroused not from a literary perspective but because of a reference to the use of chloroform. The fact that chloroform was a controversial subject among qualified practitioners served to make them more annoyed that it was being widely read by an ignorant public. The journal was outraged at the fact that ‘much of this trashy mystery is copied out of our leading medical journals’.³ The fact that the story alludes to a medical error whereby the protagonist dies through misuse of chloroform is not discussed by the *Dublin Medical Press*, but it seems reasonable to assume it was the depiction of the errant doctor that triggered its wrath.

In 1888 the *Dublin Medical Press*, in an editorial entitled ‘Medicine in fiction’, suggested that if sickness was to be included in fiction, the advice and expertise of the medical practitioner was required:

The work of novelists must always of necessity carry them into regions in which unaided they will be apt to lose their way ... Perhaps the best, if not the only way of securing the correctness of the descriptions of the disease and medical statements is to submit to some trustworthy practitioner the pages of the manuscript which refer to these things, in order that discrepancies may be expunged when they are found to be present.⁴

¹ Lawrence Rothfield, *Vital signs: medical realism in nineteenth century fiction* (Princeton, NJ, 1992), p. xiii.

² *D.M.P.*, i (1864), p. 49.

³ *Ibid.*

⁴ *D.M.P.C.* xlv (1888), pp 94–95.

The editorial indicates that the knowledge and proficiency of the profession cannot be duplicated by the public and so emphasises the specialised and expert area of scientific medicine. It concludes: 'It is essential to recollect that the mass of the public know nothing of medicine'.¹ Consequently, the doctor is portrayed not merely as a learned professional but as an expert, beyond imitation.

'It is scarcely to be expected that novelists ... who introduce matters medical into their productions will take the trouble to make themselves correct in their statements'² announced the *Dublin Medical Press* in an editorial in 1893. This was in reference to a story by Arthur Conan Doyle,³ himself a medical practitioner but evidently not held in high regard by the *Dublin Medical Press*. The story in question discusses a wound and mentions that the weapon that inflicted the wound was 'a cataract knife'. The editorial states:

the reader is asked to believe that this delicate blade has been able to inflict a long clean wound. Anyone familiar with an ordinary cataract knife could not fail to admit the absurdity of such a suggestion.⁴

The journal's interest in even the smallest reference to medical matters is indicative of the profession's anxiety that popular fiction's impressions of medicine might have a damaging effect on the prestige of the profession. The editorial indicates that the mention of the knife is superfluous to the novel (medical man now as literary critic!) and suggests that Conan Doyle was merely showing off his limited medical training.

¹ Ibid.

² *D.M.P.C.*, cvi (1893), p. 17.

³ Arthur Conan Doyle (1859–1930) was born in Edinburgh to an English father and an Irish mother. He studied medicine at the University of Edinburgh and following his graduation in 1881 took up medical practice in Portsmouth. The practise was not initially successful and so while waiting for patients he began to write short stories. His first significant work, *A study in scarlet*, featured the first appearance of Sherlock Holmes, who was partly based on a university professor of Doyle's. In 1890 he studied the eye in Vienna and moved to London to practise as an ophthalmologist.

⁴ *D.M.P.C.*, cvi (1893), p. 17.

In 1897 *The Lancet* announced: ‘The physician must expect to be turned to account and made use of, if not to point a moral, at any rate to adorn a tale’.¹ This outward magnanimity belies the fact that *The Lancet* was as irked as its Irish counterpart by the inclusion of the profession in a work of popular fiction. On this occasion a playwright, Mr H.A. Jones, in his play *The physician*, went so far as to cast ‘a slur on the morality of the medical profession’² by the fact that the fictional physician was presented ‘as being in love with a lady, a married lady to boot’.³ The fact that the medical character, a Dr Carey, waited until the object of his affection’s husband died before declaring love, has little bearing on *The Lancet*’s sense of indignation. The journal also finds fault with the fact that a medical condition is discussed in the play – a fact almost as demeaning as the portrayal of a one of the profession’s members as an ‘adulterer’.

It would appear that literature encroached on medical ground at a period when medicine was endeavouring to establish itself as an exclusionary and elitist body. Essentially, if doctors desired to eliminate lay people from medical practice, it would appear that this included literature as well.

6. Popular medicine

Folk medicine, as distinct from established or ‘scientific’ medicine, has always been popular in Ireland.⁴ Lack of qualified practitioners, particularly outside the larger

¹ *The Lancet*, cxiv (1897), pp 338–339.

² *Ibid.*

³ *Ibid.*

⁴ Patrick Logan, *Making the cure: a look at Irish folk medicine* (Dublin, 1972), p. 2.

urban areas, led to popular medicine flourishing in the eighteenth century. In a predominantly rural society, people were not accustomed to calling in a doctor when they were ill. This was mainly due to the fact that much of the population had no access to trained medical personnel. In Dublin in 1805 there were eighty-seven physicians and ninety-three surgeons to serve a population of 200,000.¹ Outside Dublin the situation was much worse, and people became accustomed to managing their health without the profession. Kelly refers to 'the persistence of and extensive reliance upon non-scientific and extra-institutional health care'.²

Many rural dwellers in the nineteenth century could simply not afford the doctor. Old wives' tales, traditional herbal recipes and charms were the chief support of the sick. Even those who could afford to pay for the services of a medical practitioner did not necessarily choose to do so on a regular basis, for throughout the eighteenth century and early nineteenth, traditional folk medicine remained very strong and the use of unqualified practitioners was also very prevalent.³

As we have seen, there had been a low public perception of the craft of medicine in the eighteenth century. However, the massive increase in books advising on health throughout the century indicates that personal health was becoming increasingly important.⁴ The fact that the market was flooded with self-help patent medicines corroborates this view. But the inadequacy of actual medical knowledge among practitioners did not inspire confidence among the population – hardly any

¹ Farmar, *Patients, potions and physicians*, p. 63.

² Kelly, 'Emergence', p. 26.

³ Ivan Waddington, *The medical profession in the Industrial Revolution* (Dublin, 1984), pp 181–182.

⁴ Dorothy Porter, 'Public health' in Bynum and Porter, *Companion encyclopedia*, vol ii p. 1235.

eighteenth-century scientific advance actually cured patients directly.¹ Consequently, it would seem that for many in the eighteenth century, domestic care and folk medicine was the most available, and indeed reliable, form of medical care.

As the nineteenth century progressed, science was increasingly lending a veneer of learned professionalism. Science transformed medicine by giving it an air of proficiency and expertise. This transformation was not as a result, as one might expect, of increased medical knowledge (medical men remained helpless in face of many of the diseases of the nineteenth century),² but rather it drew medical men away from folklore and myth to a new, educated science. As discussed in the previous chapter, science was the new respectability of medical men – the learned mien that would allow them to mix in polite circles. Medicine was increasingly viewed as a career for gentlemen.³ Thus, the scientification of medicine distanced it from herbs, poultices and folk cures science.

Porter states that well into the eighteenth and nineteenth centuries the aid of friends, family, wise women or the priest was widely sought.⁴ Many households maintained manuscript recipes bulging with health advice. The *Freeman's Journal* of the time abounds with advertisements for self-medicating concoctions promising good health – their sheer number illustrating the interest in personal health. 'Be of Good Cheer! The Sinking May be Saved!' promised one advertisement in 1859,⁵ guaranteeing that 'Holloway's Pills' will 'provide great remedy'. In 1875 the same newspaper

¹ Roy Porter, *The greatest benefit to mankind: a medical history of humanity from antiquity to the present* (London, 1999), p. 266.

² Kelly, 'Emergence', p. 24.

³ Geary, *Medicine and charity*, p. 151.

⁴ Lawrence I. Conrad, Michael Neve, Vivien Nutton, Roy Porter and Andrew Wear, *The western medical tradition: 800 BC to AD 1800* (Cambridge, 1995), p. 443.

⁵ *Freeman's Journal*, 7 Dec. 1859.

advertised 'DuBarry's delicious Revalenta Arabica Food' which claimed success in no fewer than 78,000 cases¹ of:

cough, asthma, also diarrhoea, haemorrhoids, liver complaints, flatulency, nervousness, biliousness, fevers, sore throats, diphtheria, catarrhs, colds, influenza, noises in the head and ears, rheumatism, gout, impurities, eruptions, hysteria, neuralgia, irritability, sleeplessness, acidity, palpitation, heartburn, headache, debility, dropsy, cramps, spasms and nausea and sickness even in pregnancy and at sea, sinking fits, bronchitis, scrofula ...²

As recently as the mid-nineteenth century, physicians and hospitals occupied minor, peripheral roles and though disease was feared and stigmatised, it was rarely the object of ministrations by organised medicine, health care or health-care institutions.³ A wide variety of people practised healing without any view to reward, but rather out of neighbourliness, family ties or simple self-help.

The fact that popular medicine centred on women seems undoubted. Johanna Geyer-Kordesch points out that while food production, low income and poor health have been linked at one stage or another, the link created by the woman in the home as the decision-maker as to what food is bought, at what price, and how the customs of cooking relate to nourishment is not as easily made.⁴ Women, through their role as arbitrators of food, were naturally connected with medicine. Porter notes that women were intimately involved in medical practice, being greatly in demand for treating children, servants, family, friends and neighbours alike.⁵ Françoise Loux also points to the emphasis that popular medicine placed on women.⁶ However, if medicine was

¹ Ibid., 19 Jan. 1975.

² Ibid.

³ Bynum and Porter, *Companion encyclopedia*, i, pp 233–234.

⁴ Johanna Geyer-Kordesch, 'Women and medicine' in Bynum and Porter, *Companion encyclopedia*, ii, pp 888–889.

⁵ Porter, *Bodies politic*, p. 194.

⁶ Bynum and Porter, *Companion encyclopedia*, i, p. 672.

to be promoted as a professional and indeed expert occupation, the homely ministrations of unqualified and non-medical personnel needed to be dismissed. This exclusionary attitude would ensure that the reputation of the profession remained intact. The reality was that the profession, whose medical knowledge was scant, feared that the art of healing, far from being a calling for the expert and the elite, could be interpreted as within the reach and scope of ordinary people.

In 1863 the *Dublin Medical Press* cast a disapproving eye at an article that appeared in an Englishwoman's journal (the publication isn't named) on infant mortality.

It is totally devoid of interest to the medical profession, not containing one single word, original or instructive to a physician ... once and for all let it be understood that the columns of a periodical intended for the female portion of the community, is not the place in which to discuss the great question of infant mortality.¹

Thus, the wellbeing of children was an area to be discussed only by medical practitioners. Notably, with regard to infant welfare, the advice of grandmothers was violently attacked. In this case it is not even a question of folk medicine, but of 'superstition' and 'ignorance'.² Thus it would appear that medical men chose not to offer advice or work in tandem with the age-old practice of medicine, but rather sought actively to remove it altogether.

In 1854 the *Dublin Medical Press* in an editorial stipulated that lay people should not 'employ medicines with the properties of which they are, of course, entirely ignorant'.³ The medicines that the practitioners believed to be beyond the ordinary person included Calomel, James' Powder and wine. Self-medicating, so popular in the

¹ *D.M.P.*, xlix (1863), p. 92.

² *Ibid.*, p. 673.

³ *D.M.P.*, xii (1854), p. 174.

eighteenth and early nineteenth centuries, was now to be outside the remit of the ordinary person. The *Dublin Medical Press* alluded to a more pressing issue in relation to popular medicine – the potential loss of earnings: ‘upon escaping paying a fee to the doctor and an apothecary bill into the bargain’.¹ If potential patients were healing themselves, the medical man’s prestige was not the only matter of concern. The loss of revenue was a factor in the exclusion of the public from the practice of healing.

The practice of the healing art in the home was a matter of contention among medical practitioners. In 1880 the *Dublin Medical Press* asserted:

It is somewhat remarkable how fond the British public are of trying to do their own doctoring ... The art of medicine is one which possesses peculiar charms for the amateur, who, especially when of the female sex, is apparently never so happy as when pouring drugs of which he knows little, into the body of which he knows less.²

The journal makes reference to one of the many cheap books on domestic medicine and warns how folk medicine is woefully unsuited to deal with the demands of modern medicine:

some weapons are put in the hands of the public, which ought to be wielded only by those skilled in their use ... it is obviously impossible in such works as these (even if it were desirable) to impart a complete knowledge of the whole science and art of medicine.³

Is a mother incapable of looking after a sick child unless she is familiar with the ‘complete knowledge’ of the ‘whole science’ of medicine? ‘Manuals of domestic medicine for use in the homes of our own people in civilised countries are

¹ Ibid.

² *D.M.P.C.*, lxxx (1880), p. 269.

³ Ibid.

objectionable.’¹ Essentially, medical men were suggesting that if you practised medicine, no matter how basic, at home, you were endangering those you loved most.

The *Dublin Medical Press* in 1884 tells of a case where ‘an old man fell victim to his daughter’s zeal for doctoring every sufferer, from whatever ailment, on a common plan, that viz. of administration of calomel’.² The article points at the fact that the daughter accidentally mixed a packet containing strychnine, purchased for the destruction of a dog, with the calomel and this resulted ‘in the death of the unhappy old man who took it’.³ The article warns of ‘the almost certain risk run by every patient who submits himself to the treatment of irresponsible pretenders to medical skill’.⁴

This rather grim, didactic tone was also seen in *The Lancet* in 1853. The journal launches an attack on ‘pseudo-philanthropy’ in reference to an article that appeared in the Royal Agricultural Society’s journal ‘professing to be an essay on Cottage Economy and Cookery ... the best directions to enable the labouring population to prepare their food in the most economical manner’.⁵ *The Lancet* was unimpressed:

Away with such wish wash philanthropy! Medical men, who are the natural advocates of the rights of humanity and the natural law givers respecting the requirements of the animal frame, ought to rise and protest against the public cajolement by statements such as these. The task of indicating the amount of diet that is necessary for the well being of individuals belongs to them, and they ought not to suffer it to be taken out of their hands by mere amateurs.⁶

¹ Ibid.

² *D.M.P.C.*, lxxxviii (1884), p. 522.

³ Ibid.

⁴ Ibid.

⁵ *The Lancet*, i (1853), pp 840–842.

⁶ Ibid.

Clearly, the medical men wanted the monopoly on all aspects of medicine, including instructions for diet.

7. Midwifery

Johanna Geyer-Kordesch asserts that midwifery is the prime example of how an acclaimed field of expertise practised for centuries by women was changed into a medical speciality practised in hospital, mainly by men.¹ Medical men were closing ranks in every quarter of medicine. Porter, in an English context, notes that medical practitioners depicted the traditional midwife as ignorant and inept.² Loudon points out that the eighteenth century saw the birth of man-midwifery and that by the end of the century most practitioners were regularly delivering children.³ Medical men were increasingly realising that midwifery was an opportune way of building a practice and establishing professional standing.

However, the introduction of qualified, organised medicine into midwifery was catastrophic. Hospitals were a disaster throughout the western world, with recurrent epidemics of puerperal fever in which the risk of the mother dying in hospital was five or even ten times higher than it was for the poorest woman delivered in slum tenements by unprofessional midwives.⁴ In 1847, Semmelweis, a Hungarian obstetrician in the Vienna Maternity Hospital, demonstrated that doctors and students were going straight from post-mortem examinations to the maternity wards and were directly responsible for infecting the women in labour with 'morbid matter', which he

¹ Geyer-Kordesch, 'Women and medicine', p. 893.

² Porter, *Bodies politic*, p. 225.

³ Irvine S. L. Loudon, 'Childbirth' in Bynum and Porter, *Companion encyclopedia*, ii, pp 1050–1051.

⁴ *Ibid.*, p. 1055.

believed was the cause of puerperal fever.¹ But shouldn't this medical breakthrough have curbed the widespread deaths of women delivering in hospitals throughout the century? Semmelweis's theory was unpopular because it indicted medical practitioners as the transmitters of this terrible disease.

The dreadful losses of women in hospital births did little to stem medical criticism of the 'unqualified' midwives. It is worth noting that even after the 1858 Medical Act, students could qualify without any obstetrical training, and this lasted until 1886. Even then, the actual teaching was often cursory, and it wasn't until 1902 that there was legislative provision for the training and licensing of midwives.² Nonetheless, the profession continued to promote its own members as appropriate personnel to deliver babies.

The regulations respecting admission and examination 'of female candidates for the licence to practise as midwives and nursetenders' in the College of Physicians' charter (1879) included the following oath:

I hereby promise that I will not attempt to perform any of the operations of midwifery, unless it is impossible to obtain the attendance of a registered medical practitioner. And I further undertake that I will always endeavour to obtain the medical attendance of a registered medical practitioner whenever the symptoms, whether during labour or afterwards, are such as to lead me to believe that the life of the patient or her child is actually in danger.³

The oath reflects the desire of the college to draw a clear line of demarcation between the medical practitioner and the midwife. Clearly, the midwife is to be regarded as an aide to the doctor rather than a medical specialist.

¹ Ibid., p. 1060.

² Porter, *Greatest benefit*, p. 382.

³ Rivington, *Medical profession*, pp 527–528.

The charter also stipulates that ‘Fellows or Licentiates of the college may be admitted, without further qualification, to the special examination in midwifery, and if approved, are entitled to receive such licence, and to be distinguished as practitioners in midwifery’.¹ Consequently, without any specific training in midwifery, a medical man of the college could obtain the necessary licence to practise. For a doctor who was not a licentiate or fellow of the college to qualify he must simply have a degree or licence in medicine or surgery from ‘any University or College of Physicians and Surgeons in the United Kingdom’.² Attempts to gain professional recognition for individuals who were not doctors were effectively rejected by the medical profession.

In 1890 the Royal College of Physicians in Dublin became increasingly preoccupied with the debate on the registration of midwives. A parliamentary committee was set up the same year and Dr Lombe Athill, as former master of the Rotunda Hospital, Fellow of the College and member of the General Medical Council, was invited to represent the College of Physicians.³ The Midwives Bill ultimately failed to get the support of parliament due to the College of Physicians’ opposition, prompted by its fear that registration would put midwives on an equal footing to medical men. Athill stated:

I think it a pity to put the midwives on a par, in any way with medical men. Let them practise as much as you like, but I think you ought to make a difference between fully qualified practitioner and one who is only qualified in one department.⁴

¹ Ibid.

² Ibid., p. 527.

³ Anne McMahon, ‘Regulating midwives: the role of the Royal College of Physicians of Ireland’ in Gerald M. Fealy (ed.), *Care to remember: nursing and midwifery in Ireland* (Cork, 2005), p. 159.

⁴ Cited in *ibid.*

This exclusionary attitude to midwives was reflected in the pages of the *Dublin Medical Press*.

As early as 1842 the *Dublin Medical Press* asked ‘How many lives are to be sacrificed to the ignorance of these handy beings?’¹ The ‘handy beings’ were the neighbours that would help out at a woman’s birth in time-honoured tradition. A contradictory article in the journal outlines how a woman in labour died when ‘several’ practitioners refused to treat her because she could not afford their fee.² This tragedy prompted a Doctor Henry Bennet to suggest ‘that the introduction of skilled women into the practice of midwifery would prove an immense boon to the more scientific practice of the healing art’.³ The doctor was careful to point out that the introduction of women into the practice of midwifery would not affect the position of medical practitioners, stressing that his colleagues would ‘by no means lose in public estimation by the chance’.⁴ Despite this assurance, the nineteenth century would not witness the official registration of midwives and the *Dublin Medical Press* appeared anxious to portray them in as negative a light as possible.

In 1866 the *Dublin Medical Press* printed a letter from a ‘country practitioner’, Dr Maxwell, who details his experience of how he ‘found two uneducated women in charge of the patient [a woman in labour with her ninth child] who have been in the habit of taking upon themselves the responsibility of attending females in labour’.⁵ He recounts a grisly tale of how the labour went horribly wrong and warns ‘junior members of the profession to caution the public not to trust females in childbirth to

¹ *D.M.P.*, viii (1842), p. 250.

² *D.M.P.C.*, ii (1870), p. 10.

³ *Ibid.*

⁴ *Ibid.*

⁵ *D.M.P.*, iv (1866), p. 234.

ignorant hands'.¹ The journal is clearly attempting to discredit females in general and promote the concept of the necessity for a medical man to attend birth. The long history of females attending and aiding in the process of childbirth is dismissed, and women are depicted as a liability.

In 1875 a letter to the *Dublin Medical Press*, signed simply 'A country practitioner', warned young doctors against settling in the country, where midwives are 'usurping the place of doctors'² ... the public should be enlightened as to the 'true sphere' of the midwife, including her lack of scientific knowledge. This practitioner also emphasises a possibly more pressing grievance: 'that so many fees are taken out of the pockets of many country practitioners by midwives'.³ Midwives were overstepping their boundaries into the territory of medical practice.

It was never intended that these midwives should, no more than the more ignorant class which they were designed to supersede, ever undertake any case which called for more than mere nursing ministrations. The training which their limited education alone enabled them to receive, fits them for none other.⁴

Clearly midwives are portrayed as the inferiors to medical practitioners, who aimed to emphasise their subordination in order that they should not develop ambitions to compete directly with medical men. Consequently, their inferior education is illustrated, as is the menial nature of their position. The doctors are anxious to promote the position of midwife as low-status, unskilled and humble, and, more importantly, entirely dependent on the medical expertise of the medical man.

¹ Ibid.

² *D.M.P.C.*, lx (1875), p. 85.

³ Ibid.

⁴ *D.M.P.C.*, lx (1875), p. 299.

In 1873 the *Dublin Medical Press* reflected the fear that over-education of the midwife would result in a blurring of the lines of distinction between a midwife and a medical practitioner. The journal quotes a Dr Aveling as saying: 'The Obstetrical College of London aims too high. It teaches women, besides midwifery, the diseases of women, and to become ill-educated practitioners'. Essentially, though the lowly midwife might be castigated for her lack of education and qualification, the *Dublin Medical Press* did not seek an improvement of this.

In 1875 *The Lancet* reported that Dr Edward J. Tilt, President of the Obstetrical Society, announced the 'unanimous decision that women were not admissible to the Fellowship of the society'¹. According to *The Lancet*: 'This decision is really the expression of the deliberate opinion of the great majority of the fellows of the Society, that women are not by nature qualified to make good midwifery practitioners'.² This determination to make women redundant from midwifery betrays a realisation that midwifery was in fact a lucrative calling.

In a letter to the *Dublin Medical Press* in 1892, a Dr Adamson raged that midwives were allowed practise at all:

Other learned callings have escaped from old and evil associations. Why then is it proposed that a new order of midwifery practitioners should be established? Would the proposal for the formation of an inferior order of the clergy, or of barristers or solicitors be tolerated?³

Again, the old theme of social rank was ever-present to haunt the professional lives of medical men. The move to qualify non-medical personnel in the practice of midwifery

¹ *The Lancet*, i (1875), p. 138.

² *Ibid.*

³ *D.M.P.C.*, civ (1892), p. 652.

was viewed as a threat to the prestige and reputation of the profession. To create a distinct class of qualified midwives would encroach on the territory of medical men, particularly the country practitioners whose income was largely supplemented by the midwifery fee.

The Lancet in 1861 concurred with the *Dublin Medical Press*'s general dissatisfaction with midwives.

At this moment midwives are largely employed in every country in the world. But in civilized communities midwives have long given way to the superior energies, calmness of judgement and acquirements of their male competitors. As a rule, female practitioners are only employed by those classes whom circumstances forbid to place themselves in the hands of male practitioners.¹

The existence of the 'female practitioner' or midwife as a figure required by people who cannot afford the ministrations of the medical man is the thrust of this editorial. The 'calm' and professional doctor is the choice of 'civilised' people. The implicit message is the promotion of the practitioner as the medical expert and the midwife as an obsolete figure in the world of medical science.

In 1874 the *Dublin Medical Press* alluded to the medical fear that qualified midwives would threaten the occupation of a doctor. An editorial entitled 'The female medical candidates in Ireland' maintained that the Dublin College of Physicians had discussed the possibility of granting a midwifery diploma 'which would confer an authority to practise obstetrics, but would still not entitle the holder to appear in the Medical Register or to enter into practice as a qualified medical practitioner'.² It would appear that the reputation of the profession rested on the premise that medicine was an elitist,

¹ *The Lancet*, ii (1861), pp 117–118.

² *D.M.P.C.*, xvii (1874), pp 76–77.

expert and male-oriented occupation. The *Dublin Medical Press* consequently viewed any practice of medicine outside the medical establishment as a threat to the status of the profession.

8. Nurses

As the number of hospitals in nineteenth-century Ireland increased, so did the demand for medical staff, which included nurses. The Medical Charities Act of 1851 did not support a nursing system, mainly due to the fact that the cost of any developments fell to the local rate-payers.¹ As a result, two Catholic religious orders took up the slack in terms of caring for the sick poor – the Sisters of Charity (1815) and the Sisters of Mercy (1831).² Pauline Scanlon's admirable study³ details the history of nursing and reflects how general nursing care mirrored and extended the view of women's responsibilities in the domestic sphere. Social characteristics of nurturance, passivity, obedience and intuitive morality formed the basis of the requirements of the hospital nurse. As the century advanced, the need for lay nursing became more pressing. This was highlighted by the setting up of commissions to inquire into nursing in 1842 and 1855.⁴ Ostensibly, the responsibilities of the nurse were viewed as a continuation of her duties as a woman.

Between 1860 and 1900, nursing in England and Ireland was transformed from being small-scale, mainly untrained work for a few women into an organised and controlled occupation, employing a growing number of lower-middle-class and upper-working-

¹ Ann Wickham, 'The early years of district nursing in Ireland' in Gerard M. Fealy (ed.), *Care to remember: nursing and midwifery in Ireland* (Cork, 2005), p. 103.

² Ibid.

³ Scanlon, *Irish nurse*.

⁴ Ibid., p. 57.

class women.¹ There is little doubt that the Crimean war (1854–56) highlighted the need for change within nursing. Prior to the sweeping transformations that Florence Nightingale² brought about, popular fiction of the early nineteenth century portrayed nurses as ‘elderly slatterns, drunk and negligent’.³ In 1854, during the Crimean war, Nightingale ‘dramatically decreased the death rate from about 40 per cent to 2 per cent’.⁴ Farmar points out that the reputation of the average lay nurse in the 1850s was not positive, drunkenness being a common problem.⁵ This view of nursing was to change later in the century, largely due to a new impetus for education and training. Scanlon points out that in the second half of the nineteenth century hospitals controlled the training of nurses,⁶ inextricably linking the practice of nursing with the omnipresent authority of the male doctor. Judith Moore refers to the defensive nature of the medical profession as nursing developed as a respectable career for middle- and upper-class women; it saw the new class of trained nurses as interfering and critical.⁷ The *Dublin Medical Press*, which seemed determined to remind its readers that nurses were not on an equal level with medical men, did not welcome the formal training of

¹ Christopher Maggs, ‘A general history of nursing’ in Bynum and Porter, *Companion encyclopedia*, ii, p. 1311.

² Florence Nightingale (1820–1910) was named after the city in which she was born. She was educated at home by her Cambridge University-educated father. She developed an interest in social questions of the day and in 1851, despite family objections, she trained in Germany to be a nurse. In 1853 Nightingale took the post of superintendent at the Institute for the Care of Sick Gentlewomen in London but her most famous contribution came during the Crimean war. In 1854 at Selimiye Barracks in Scutari, Nightingale implemented new methods of sanitation, ventilation and care that were to reduce death rates among the soldiers and make her famous. She returned home a heroine in 1857 and in response to an invitation by Queen Victoria, played a central role in the establishment of the Royal Commission on the Health of the Army. By 1859 she had £45,000 at her disposal from the Nightingale Fund to set up a training school for nurses. In 1860 she published *Notes on nursing* that served as the cornerstone of the curriculum for the training of nurses. For more see Cecil Woodham Smith, *Florence Nightingale* (London, 1951).

³ Porter, *Bodies politic*, p. 195.

⁴ Porter, *Greatest benefit*, pp 377–378.

⁵ Farmar, *Patients, potions and physicians*, p. 92.

⁶ Scanlon, *Irish nurse*, pp 83–84.

⁷ Judith Moore, *A zeal for responsibility: the struggle for professional nursing in Victorian England 1868–1883* (Athens, GA, 1988) p. 45.

nurses.¹ The idea that a nurse should consider herself as anything more than the domestic servant of the doctor excited criticism.

This section of the study explores the response of the *Dublin Medical Press* to the increasing profile of nurses. Unsurprisingly, it looked on the successes of Nightingale as a threat to the reputation of medical men. In 1856 it referred to ‘the meddlesomeness of Miss Nightingale with the army-surgeons’ affairs in the Crimea’.² The fear that a female medical practitioner was impinging on the status of doctors was once again the discourse of the *Dublin Medical Press*.

Judith Moore points out that medical men were not concerned with the number of nurses, but rather with their change of status.³ In an Irish context, the *Dublin Medical Press* corroborated this view, reflecting a certain discomfort with the idea that nurses should be ‘scientifically’ trained. In an editorial entitled ‘Nurses and skeletons’, the journal tells how a ‘lady guardian’ objected to the board of an infirmary’s recommendation that a skeleton be bought for the instruction of the nurses. The lady guardian remarked ‘that the duties of the nurses were to look after their patients and not to study anatomy. In time the nurses would be such swells that they would not do their duty’.⁴ She objected to the fact that trained nurses were being viewed as a new order of saints, ‘only lacking the discipline and humility of saints’.⁵ The *Dublin Medical Press* is in hearty agreement, adding only that ‘the board of guardians have

¹ The formal training of nurses began with the establishment of St Patrick’s Home by Lady Plunkett in 1878; by 1890 it had affiliated with Queen Victoria’s Jubilee Institute for Nurses. For more on this see Wickham, ‘Early years of district nursing’.

² *D.M.P.*, xxxv (1856), p. 63.

³ Moore, *Zeal for responsibility*, p. 41.

⁴ *D.M.P.C.*, ci (1890), p. 18.

⁵ *Ibid.*

reason to be proud of their lady colleague'.¹ Thus, it was of ultimate importance that the role of the nurse was clearly defined as that of a carer, not as a practitioner of medicine.

The *Dublin Medical Press* appeared anxious to emphasise the subordinate role of nurses. Indeed, nurses were trained in principles of obedience and discipline based on male power and female support.² It was when a nurse over-stepped her boundaries of scrubbing, cleaning and caring that the doctors of the nineteenth century spoke up in a concerted effort to exclude her from scientific education. For example, in 1862 the *Dublin Medical Press* in an editorial was careful to underline what it viewed as the role of the nurse: 'Nursing is as absolutely the peculiar province of woman as any branch of housewifery. The qualities of a good nurse are vigilance, discretion, and gentleness'.³ This view of nurses conveniently echoes the social characteristics that defined women in the nineteenth century. The profession had no difficulty with nurses provided they conformed to the domestic and ultimately subordinate role doctors assigned them to.

This dogmatism was seen in 1855 when the *Dublin Medical Press* printed an editorial commenting on a nurse during the Crimean war, who appealed to the public for wine for her patients:

A good nurse, medically considered, is a nurse who endeavours to carry out to the letter, the directions of the physician or surgeon to whose care the life of the patient is entrusted. A bad nurse is always giving her advice, always striving to be the doctor.⁴

¹ Ibid.

² See Maggs, 'General history of nursing'.

³ *D.M.P.*, vi (1862), p. 344.

⁴ *D.M.P.*, xxxiii (1855), p. 11.

The nurse in question (obviously Florence Nightingale), in appealing to the public, was stepping beyond what the *Dublin Medical Press* considered her remit:

asking them [the public] to place in the hands of a female, altogether ignorant of medicine – a female, for whose judgement and skill, they have not the slightest guarantee – to place in her hands, we say, to be used at her discretion, without reference to the medical attendants.¹

Nightingale, due to her notoriety and sheer dynamism, was the reverse of the unquestioning submissiveness thought to be appropriate for nurses.

In 1856 the *Dublin Medical Press* referred to her again, also in reference to ordering medications without consultation with a medical man.

Miss Nightingale also, we regret to find, has been giving patients wine, in opposition to the medical officers, and her ill judged interference in all medical matters is beginning to be severely commented on. It is stated Miss Nightingale was about to receive a large donation of £1700 sent from Australia, through her Majesty Queen Victoria for the purchase of wine and other medicines for the sick.²

Nightingale was not conforming to the subordinate position that placed medical men at the helm of control. Her fame and authority were viewed as a threat to the status of doctors.

The Lancet in 1870 was critical of an unnamed author from the *Cornhill Magazine* who wrote an article 'On nursing as a profession'. *The Lancet* objected to the author's suggestion that nurses should be paid more in order to raise their social status.³ This increase would 'put ladies practising nursing on a social par with the physician', and might even lead to their earning more than the doctor: 'Let us imagine the position of

¹ Ibid.

² *D.M.P.*, xxxv (1856), p. 29.

³ *The Lancet*, ii (1870), p. 516.

the medical attendant ... when brought into contact with the “very superior woman” at double or treble his own rate of emolument’.¹

The matron was surely a responsible figure in a hospital. The nurse teachers and the matrons instituted regimes that created and sustained ideas of subordination, obedience, and respect for medicine.² The *Dublin Medical Press* corroborated this view from an Irish perspective when, in 1880, it complained in an editorial of the elevated position of matrons in workhouse infirmaries, which superseded the medical officer:

The maudlin sentiment that gives to a woman’s vagaries influence paramount over the right control of medical officers in hospitals has been successful now in transforming at least three important medical charities into centres of misrule.³

The misrule was, according to the editorial, a direct result of ‘female mismanagement and ecstasies’.⁴ The contentious issue for the *Dublin Medical Press* was not the existence of matrons, but that their position should be one of subservience to the doctor. In 1890, an editorial reflected the journal’s unease with the position of a matron in a hospital:

The system in vogue of placing the matron in supreme charge ... of the nursing department is not calculated to lead to the best results or to promote the interests of the institution. We cannot avoid expressing the conviction that the matron should be placed in a distinctly subordinate position to the principal medical officer.⁵

¹ Ibid.

² Maggs, ‘General history of nursing’, pp 1321–1322.

³ *D.M.P.C.*, lxxx (1880), p. 436.

⁴ Ibid.

⁵ *D.M.P.C.*, xvii (1874), pp 161–162.

The idea that the matron might develop ideas above her station appears to be the prevalent anxiety of the *Dublin Medical Press*. Far from seeing the newly reformed nurses as a welcome addition to a hospital, the profession seemed preoccupied with the threat to its own status and reputation.

In 1868 in an editorial entitled 'Lady Nurses', the *Dublin Medical Press* alluded to the medical profession's discomfort with the expanding role of nurses:

It is greatly to be regretted that the organisers of the system of nursing by a class of persons superior to those hitherto employed in hospitals, have not kept before them, the principle most essential to the practical working of the system – the distinct subordination of nurses to medical officers. Such a position does not imply the least degradation, it is simply and manifestly necessary to the discipline of a hospital.¹

The implication of this editorial is clearly that the profession feared that the improving status of nurses would dilute the authority of the doctor. This emphasis on the subordinate position of nurses reflects the medical preoccupation with the public perception of the profession. The editorial emphasises: 'A nurse who entertains and perhaps expresses her own opinion about the treatment of the case which she may be called upon to attend cannot be a good nurse'.² Despite the journal's claim in 1874 that 'Every medical man is interested in promoting good nursing', the defensiveness of the language used by the *Dublin Medical Press* in general suggests the belief that the duties of nurses consisted mainly in compliance with and deference to the medical man.

¹ *D.M.P.C.*, v (1868), p. 229.

² *Ibid.*

9. Female doctors

Perhaps the sharpest thorn in the side of medical men was the prospect and the eventual reality of female medical practitioners. In 1863 the *Dublin Medical Press* referred to 'a new form of quack, the female doctor'.¹ Geyer-Kordesch points out that the arguments against women practising medicine were highly sexually discriminating; medical men used gender-specific biological arguments, such as debility due to menstruation, lack of physical strength, infirmity due to pregnancy and lactation, and that academic study somehow 'unsexed' women.² The medical market was already seen to be in a congested state and the addition of women could only have aggravated medical anxiety regarding competition.

Ann Digby points out that the strong opposition of medical faculties was the key to the delaying of admissions of female medical students at universities.³ The *Dublin Medical Press* gave considerable space to the debate over female medical students, and for the most part it was polemical in its aversion to female doctors.

The biggest obstacle to females practising medicine was the strongly held view, especially on the part of doctors, that a woman's place was in the home. This view promulgated the discourse that a professional occupation would impede a woman's ability to reproduce. It was also felt that exposure to the axioms of medical knowledge would be detrimental to the natural virtuosity of women.

¹ *D.M.P.*, xlix (1863), p. 266.

² Geyer-Kordesch, 'Women and medicine', p. 899.

³ Digby, *British general practice*.

An American phenomenon

One woman who successfully managed to qualify as a doctor relatively early was Elizabeth Blackwell (1821–1910). Blackwell gained her M.D. in Geneva College, New York in 1849 but when her sister, Emily, applied to the college she was refused.¹ Blackwell was initially viewed by the profession in Britain and Ireland as an American oddity or a harmless novelty. She was, for example, warmly received as a visiting student in St Bartholomew's Hospital, London in 1850² – this would be unthinkable in twenty years' time when the reality of women entering medicine became apparent. In fact, the *Dublin Medical Press* printed an article in which she wrote: 'The reception I met from English physicians was as pleasant as it was unexpected'.³ Thus, the existence of female medical practitioners was initially a distant sensation for the *Dublin Medical Press*. The tone of the editorials is relaxed and calm. In 1849 the journal dismissed fears that women outside America would be attracted to the profession:

We have long been threatened with a Female Medical College in London but here, women seem little eager, and perhaps rightly so, to emulate their strong minded sisters across the Atlantic.⁴

As yet, women were not serious contenders in the medical marketplace, and the *Dublin Medical Press* reflected this. In 1850 an editorial responded derisively to Paulina Wright Davis, an American medical student who advocated women's right to study medicine in the *Boston Medical Journal*: 'She is evidently determined to have it all her own way, and we seriously advise our Boston brethren not to cross her'.⁵ The

¹ Shirley Roberts, *Sophia Jex-Blake: a woman pioneer in nineteenth century medical reform* (London, 1993) pp 70–71.

² *Ibid.*, p. 73.

³ *D.M.P.*, xxiii (1850), p. 204.

⁴ *D.M.P.*, xlix (1849), p. 589.

⁵ *D.M.P.*, xxiii (1850), p. 222.

Dublin Medical Press was as yet mildly amused by the American phenomenon of female doctors. The following demonstrates an equanimity and detachment not present in later articles:

But what is to come in the meantime of the woman's work: are the men to turn nurses? We would not for the world hint that nature has provided for the part which women are to act or to insinuate that there are many queer things in medical practice which they cannot handle.¹

However, the reality of females pressing for a medical education was to become a reality in Europe in the not too distant future.

In 1856, the *Dublin Medical Press* referred to the newly qualified Dr Emily Blackwell² as a 'physician in petticoats'; the editorial warned that 'physicians in breeches had better look to this'.³ The journal's reference to her abovementioned sister, the first woman to qualify as a doctor in the English-speaking world, is less than deferential: 'She has a sister who pursued her studies also in Paris, who is acting in a similar capacity in New York, under the title of Dr Elizabeth Blackwell'.⁴ The tone of mockery and ridicule was continued: 'Dr Emily may prove a formidable rival if not looked after in time. Would not a matrimonial partnership meet the difficulty?'⁵ The *Dublin Medical Press* is returning to the old adage, that a sexual relationship – marriage – would distract women from study. Nonetheless, the journal was still maintaining a tongue-in-cheek perspective. Sophia Jex-Blake (see below) and her

¹ Ibid.

² Emily Blackwell qualified in New York in 1854. Her sister Elizabeth was the first female doctor to qualify in an English-speaking country in 1849. Both women met with complete ostracism in New York State, as a result of their studies. In the liberal state of Zurich in 1867 a Russian woman, Nadhezhda Suslowa, graduated. Many more females would graduate in Zurich. Elizabeth Garrett Anderson graduated in Paris in 1870 and was able to enter the medical register in Great Britain in 1866 because she qualified as a licentiate of the Society of Apothecaries. This opening was closed shortly after.

³ *D.M.P.*, xxxv (1856), p. 159.

⁴ Ibid.

⁵ Ibid.

fellow students in Edinburgh University were about to bring the struggle a lot closer to home.

The first female doctors outside America

The 1858 Medical Act had stipulated that no foreign degrees would qualify anyone for medical registration and consequently, prior to this ruling, all medical qualifications awarded to women were foreign.¹ As a result, after the Medical Act, the issue of allowing women to study medicine in England and Ireland was becoming much more pressing. The King's and Queen's College of Physicians Dublin allowed women to sit for the licentiate of the college. Among its graduates was Sophia Jex-Blake,² who had battled for women's medical education at the University of Edinburgh in 1869. In 1886 the *Dublin Medical Press* quoted from the Irish College of Surgeons' *Student's Journal*, which strongly objected to 'the invasion of the medical preserves by women'.³ The reality of female medical practitioners was no longer a distant threat.

Rivington alludes to the growing reality of female doctors:

The honour of opening the Medical Profession in England to women belongs to a Miss Garret⁴ who obtained admission to the examinations of The Apothecary Society in 1862 and received the licence of the society in 1865. Since then the society has closed its doors to the lady doctors but other portals have been opened.⁵

¹ Geyer-Kordesch, 'Women and medicine', p. 898.

² Sophia Jex-Blake (1840–1912) is famed for her struggle to gain the right for women to enter the medical profession in Britain. Before entering medicine she studied women's education in Europe and America. She was involved in a five-year battle with the University of Edinburgh for the right of women to sit medical examinations. In 1874 she founded the London School of Medicine for Women. (Roberts, *Sophia Jex-Blake*).

³ *D.M.P.C.*, xciii (1886), p. 362.

⁴ Elizabeth Garrett Anderson (see above).

⁵ Rivington, *Medical profession*, p. 289.

His view of female medical students possibly reflects the growing dismay of the medical profession in Ireland as more women came forward to study medicine:

The profane attempt of ambitious women to enter the sacred precinct of the medical profession has aroused the warmest feelings of antagonism within the charmed circle of regular male practitioners.

In 1851, the *Dublin Medical Press* could barely conceal its sneering attitude in an editorial entitled 'Doctor Elizabeth Blackwell again'. In response to her planned visit to schools and hospitals in London, it stated: 'We incline to the belief that Doctor Betty is a conceited fool; and that those who chronicle her peregrinations in search of notoriety are little wiser'.¹ This overt misogyny reveals doctors' anxiety that the female practitioner might usurp their position in society and steal their potential patients. The fact that the figure of the female doctor flew in the face of the traditional definition of a subordinate position for women within the domestic sphere further incensed the profession.

The Lancet in 1885 voiced its concerns over the decision of the Royal College of Surgeons in Dublin to allow female students to study for the diploma.

the scheme which seeks the general and unrestrained admission of women to the various branches of medical education ... we refer to the Royal College of Surgeons in Ireland, which has, unsolicited, thrown open its doors to female candidates for their diploma.²

It seems unlikely that Elizabeth Blackwell would have been invited to do a tour of a hospital in either England or Ireland by this time. The article is clear in its disapproval of female doctors, outlining how unsuited they are to certain facets of the profession.

¹ *D.M.P.*, xxv (1851), p. 61.

² *The Lancet*, i (1885), p. 350.

A woman may be the fitting instrument to treat the ailments incidental to her sex and in her place by the bedside of a sickly child; but we doubt the propriety and policy of committing to her care grave surgical diseases and accidents.¹

The *Dublin Medical Press* in 1874 referred to the application of Irish females to study medicine as ‘a very alarming movement’.² The editorial warned its readers of the importance of paying close attention to the matter of female medical practitioners.

If it does not receive the earnest and immediate attention of Irish medical men, a complete success may be anticipated ... the profession in Ireland is, we have reason to believe – threatened.³

The article referred to Jex-Blake’s attempts to secure medical qualifications for women as a ‘gallant siege of the University of Edinburgh’ and warned of a similar ‘ambush’ on the College of Physicians in Dublin,⁴ to where ‘a lady holding the M.D. of Zurich’ had applied. This, according to the *Dublin Medical Press*, foreshadowed a surge of female doctors to Ireland. The medical profession had ‘a right to expect that they shall not be placed side by side in professional rank with any new class of practitioners without careful consideration of the result’.⁵

The belief that female doctors would be competitors in the medical marketplace underlay the fear expressed by the journal. Consequently, the medical profession sought to exclude female doctors. The *Dublin Medical Press* devoted many column inches to listing the many reasons why women should not study medicine.

¹ Ibid.

² *D.M.P.C.*, lxix (1874), p. 11.

³ Ibid.

⁴ As a direct result of the Medical Qualification Act of 1876, which removed restrictions on the granting of medical qualifications for registration on the grounds of gender, the Royal College of Surgeons in Dublin allowed women to sit exams for the licentiate of the college. The college was prepared to recognise the lectures of the London School of Medicine for Women.

⁵ *D.M.P.C.*, lxix (1874), p. 11.

Medicine and the female mind

The reasons why women should not become doctors was centred around nineteenth-century values that prevented women from venturing beyond the domestic confines of wife and mother. Serious study was believed to be beyond the ability of any female, and even injurious to her health.¹ Even if she proved clever enough to pass the medical exams, the practical course work was believed to be totally unsuitable for a woman and, above all, 'improper'. The *Dublin Medical Press* in 1869, in an editorial entitled 'Women's medical mission', was careful to point out that 'We have never opposed Female Doctoring on any plea of the incapacity of women to learn certain branches of medicine'. The fact that a growing number of women had already successfully graduated as doctors made that claim anachronistic. Rather, the *Dublin Medical Press* was at pains to outline the natural incapacity of women for medicine:

nor can any woman unfrock herself, however hard she may try, of softer, domestic and maternal instincts and hopes; and this mental constitution must, we believe forever disqualify the great majority of women, if not from medical practice, at least from anything like professional success.²

The references to the female's reproductive and domestic role reveal the profession's adherence to the Victorian ideals of femininity. This is also a convenient argument against women becoming professional rivals.

'The practical inconveniences, the improprieties and the anomalies attending the introduction of ladies amongst the classes of male medical students have been ...

¹ Roberts, *Sophia Jex-Blake*, pp 2–3.

² *D.M.P.C.*, lxii (1869), p. 504.

strongly felt',¹ reported the *Dublin Medical Press* in 1861. The unseemliness of a woman examining a male body was another reason why women should be prevented from practising medicine. The image of middle-class women as virtuous and innocent was a recurring one in the nineteenth century.² The journal is anxious to illustrate that natural female delicacy should disallow a woman to practise:

It is only an evidence of this perfect abstraction and scientific earnestness that this lady is able calmly to go through the manipulations of sounding for stone in the male bladder; and it is probable that she might voluntarily pass through ordeals of a yet more trying nature.³

The implication of this editorial is that the female student would not be able to endure the improprieties involved in medical examination – if, somehow, she could, what would that say about her femininity?

In 1869 the *Dublin Medical Press* printed a letter from a Dr Joseph Duggan of Turloughmore, County Galway. It begins sensationally: 'the admission of females to the Medical Profession will, if successful, be fraught with the most baneful results to the profession and the public in general'.⁴ He further describes himself as an opponent of the 'masculine and unsexing system of female education', and believes that the study of medicine is particularly dangerous:

All who have studied practical anatomy, dissections, surgery, medicine and the diseases of the human mind, know right well that a woman is not fit to go through those subjects without seriously destroying the finest qualities of her delicate nature, subjects that require the great strength of intellect and the stern wisdom of our own sex.⁵

¹ *D.M.P.*, xlvi (1861), p. 71.

² Françoise Barret-Ducrocq, *Love in the time of Victoria: sexuality and desire among working-class men and women in nineteenth century London* (Paris, 1989) pp 29–30.

³ *D.M.P.*, xlvi (1861), p. 71.

⁴ *D.M.P.C.*, lxii (1869), p. 506.

⁵ *Ibid.*

Duggan is at pains to suggest alternative occupations to medicine for the female student. The stereotypical nineteenth-century ideals of what a woman should conform to are inherent in his argument:

I cannot understand for the life of me how the softer sex could even think of making themselves doctors ... Providence has left her plenty of other useful occupations more becoming to her sex, subjects pregnant with all the lofty sentiments of refined thought, well adapted for the female student, viz., poetry, music, painting and the study and cultures of languages and literature.¹

The letter concludes with a nostalgic nod to the past, where women would not dream of 'infringing or encroaching on man's domain'.

Essentially, the discourse used by the *Dublin Medical Press* against women practising medicine borrowed heavily and conveniently from nineteenth-century beliefs that middle-class women belonged in the domestic arrangement of marriage and that their primary goal was one of reproduction. An article in the *Dublin Medical Press* in 1886 remarked: 'Why women should have been excluded from the knowledge of medicine at its earliest origin as a separate profession, it is not difficult to surmise, without having recourse to the notion of a superstitious prejudice, or of the superior qualifications of man intellectually'.

Similarly, *The Lancet* in 1861 questioned the natural ability of a woman to become a doctor: 'In the middle of the nineteenth century, the question of the fitness of women to fill the higher functions of medical practice has still to be determined'.² This argument could not survive for much longer, given the continued academic success of women medical students. But significantly, *The Lancet* reverted to the same

¹ Ibid.

² *The Lancet*, ii (1861), p. 117.

discourse, i.e. that of all professions, a woman was naturally least suited to that of medicine.

It has often struck us as remarkable that women should not have made an emphatic claim to share in the ministrations of the church, and in the practice of the law ... Here seems to be a far more fit arena for the exercise of the keen intuitive perceptions, the earnest convictions, the warm pertinacity, and the impulsive eloquence of a woman ... But in medicine, there is scant scope for intuition and impulse.¹

The promulgation of medicine as rational, logical and reasonable – ostensibly male traits – was another means to exclude women. *The Lancet* concluded: ‘The proper sphere of woman is home, that her proper duties are the nurture and training of domestic virtues’.²

Edinburgh

Edinburgh University was popular choice for Irish medical graduates, possibly on account of its reputation for low fees and quality teaching. *The Dublin Medical Press* had always taken an interest in developments at the university, and the question of female medical education was no exception. It is unlikely, however, that even the *Dublin Medical Press* anticipated the extent of male opposition in the university to the struggle of Sophia Jex-Blake and six other female students to receive a medical education. The reaction of the journal is of obvious relevance to this study.

In the early part of the nineteenth century, the university had offered a certain number of special courses of lectures for women given by individual professors on their own subjects, but attendance did not qualify one for a degree, so the practice was

¹ Ibid.

² Ibid., p. 118.

discontinued.¹ In 1867 the Association for the Higher Education of Women was founded in Edinburgh; it succeeded in holding women-only lectures during the winter sessions. Among the subjects offered were arts subjects and also physics, mathematics, zoology and physiology.² Again, however, the award was a ‘certificate in Arts’ as opposed to a degree. The possibility of females attending medical classes – even separate ones – created a much bigger problem.

In 1867, Sophia Jex-Blake applied to the university for permission to attend some medical lectures; the Senatus and University Court gave permission that any professor who so wished could deliver separate lectures on his given subject to women.³ However, it soon became evident that sentiments against the women ran high among both medical students and staff – at best these were hostile; at worst, openly violent. The *Dublin Medical Press* followed the events and, in its usual style, did not refrain from comment in the columns of its editorial.

In 1869 Edinburgh University began to accept females to medical study ‘inasmuch as it is expressly stipulated that the ladies are to study in separate classes from their brother medical students’.⁴ This prompted the letter from Dr Duggan of County Galway cited above. This created unrest among medical men in Ireland and England, although the profession remained reticent about criticising female medical practitioners openly, and argued that women practising in areas such as obstetrics were acceptable.

¹ Horn, *University of Edinburgh*, p. 191.

² *Ibid.*

³ Roberts, *Sophia Jex-Blake*, pp 85–86.

⁴ *D.M.P.C.*, lxii (1869), p. 78.

The *Dublin Medical Press* in 1870 reported a more aggressive reaction to female medical students. Two hundred male students in Edinburgh University demonstrated against the attendance of female students at an anatomy lecture: the female students had the gates of the university slammed in their faces and mud and debris thrown at them.¹ When the female students eventually arrived at the lecture:

the male students immediately took steps to prevent the lecturer from being heard by singing songs, beating all the while a deafening accompaniment with their feet ... having procured a sheep, they perpetrated a weak practical joke by thrusting the animal into the room where the anatomical class had met. After the breaking up of the class, the lady students delayed for a time their departure from the hall. Their appearance was the signal for a renewed outburst of booing, hissing and yelling which was continuous in the most outrageous manner.²

The riot is indicative of the strength of feeling of the male medical student body against their female counterparts. The reaction of the *Dublin Medical Press* to this violent disorder from a group of potential medical men is not one of outrage, as one might expect from a journal that held prestige as a most important part of the medical profession. The journal does criticise the violence of the riot, especially as the police had to intervene, but it suggests other means of intimidating the female students without causing so much of a public outcry:

If they [the male students] make martyrs of the female students, we shall ourselves almost be driven to argue in their favour. The proper method of manifesting their disgust of unwomanly and immodest tendencies would be to shun contact or speech, with female students as unworthy to be treated with the consideration and gallantry due to most ladies.³

¹ *D.M.P.C.*, xi (1870), pp 445–446.

² *Ibid.*

³ *D.M.P.C.*, lix (1874), p. 446.

So, the *Dublin Medical Press* did not entirely castigate the Edinburgh rabble. The women in question were deemed ‘unwomanly’ and ‘immodest’, and so thuggish behaviour did not excite moral indignation.

Medical support, a lone voice ...

Were there no advocates of female practitioners among medical men? At last, a letter appeared in the *Dublin Medical Press* in 1874 from Dr Charles R. Drysdale¹ (his name will appear frequently in this study), who underlines the difficulty for single or widowed women with no income – an economic reality ignored by the *Dublin Medical Press*.

Women are human beings like men, and require to eat and have clothes ... just as men do. Yet, they are, as a sex far poorer than men, and for a simple reason, that as yet the male sex does not give them a fair field in the industrial occupations of life.²

Drysdale was touching on the growing problem of a lack of employment opportunities for middle-class women. Many widows and single women in straitened circumstances had little opportunity to earn money. The occupation of governess was one of the few respectable jobs available to them, and that was overcrowded and poorly paid.³

Consequently, the idea of preventing women from qualifying in a well-paid profession appalled Drysdale:

Some ladies of rare education and enlightenment are now being compelled to leave the islands of Great Britain and Ireland and betake themselves to Paris to

¹ Charles Robert Drysdale (1821–1907) was a senior physician at the London Metropolitan Free Hospital. His common-law wife, Alice Vickery, was also a doctor. They launched a journal called *The Malthusian* in 1879, and Drysdale was president of the Malthusian League – both were devoted to promoting birth control.

² *D.M.P.C.*, lix (1874), p. 126.

³ Roberts, *Sophia Jex-Blake*, p. 3

study medicine under very great additional difficulties. I ask Mr Editor, is this not disgraceful?’¹

Unsurprisingly, the *Dublin Medical Press* did not agree with Dr Drysdale. The editor replied:

In the abstract we agree with Dr Drysdale, that it would be right to let women try their fortune on an equality with men with the reservation however, that their education should be conducted with due regard to decency and morality.²

Such due regard would disqualify women from studying anatomy, physiology, etc., and thus they would pose no professional threat to medical men. The *Dublin Medical Press* continued:

We have expressed our conviction that there is no want of female medical services sufficient to lead any dispassionate thinker to believe that any considerable number of female physicians would ever achieve financial success, and we consider that there are physical and social reasons ... why women should not – as a rule – arrive at even respectable mediocrity in the close and searching competition of the present day.³

So, it appears that the journal was in direct opposition to Dr Drysdale’s point of view.

The exclusionary nature of the medical profession in Ireland in the second half of the nineteenth century was characterised by its determined effort to eliminate or at least seriously curtail outsiders from the practice of medicine. This monopoly on health care was bolstered by the Medical Charities Act of 1851, which created public health positions for doctors to the exclusion of fringe practitioners. This campaign of exclusion ensured that nurses and midwives – predominantly female – would remain in a subordinate position to the doctor, and that it was made as difficult as possible for

¹ *D.M.P.C.*, lix (1874), p. 126.

² *Ibid.*

³ *ibid*

women to gain entry into the profession. This exclusionary mindset created a group of medical practitioners whose grandiose and imperious perception of themselves would lead to a broadening of their role into something far beyond the mere healing of the sick.

CHAPTER 3: MORALITY

This chapter aims to explore the expanding role of nineteenth-century medical men in Ireland through the pages of the *Dublin Medical Press*. It seeks to document how a new medical authority evolved in the second half of the century, increasingly defining the profession as appropriate commentators on the morality of the public. This section of the study will focus on how morality became progressively a class issue, with the *Dublin Medical Press* expounding depravity as an unavoidable facet of the lower classes. We will see how the journal looked to temperance as a moral issue and an area of social control, increasingly viewing the consumption of alcohol among the working classes as indicative of their intrinsic disorderliness and licentiousness. Alcohol and its consumption were discussed in the *Dublin Medical Press* in strictly class terms, revealing intrinsic prejudices: the journal asserted the lower orders' inherent susceptibility to excess while simultaneously promoting the use of alcohol among the upper classes.

The *Dublin Medical Press* also took exception to the growing popularity of exhibitions and shows in Ireland in the second half of the nineteenth century, labelling popular leisure outings such as the theatre as 'profane'. It attacked the existence of popular anatomical exhibitions because it believed that knowledge of the body was exclusive to the medical establishment.

This section of the study seeks to explore how the *Dublin Medical Press* increasingly portrayed the medical profession as the indefatigable guardians of public morality.

This new moral role for the profession enabled the journal to advise and reproach on every aspect of society, often far removed from matters of health. How the fashion of the day emphasised the shape of a woman's body was a continuing area of anxiety for the nineteenth-century medical practitioner. Under the guise of medical concern, the profession sought to control or at least condemn items of clothing that accentuated female sexuality. The journal's view on sexual morality validated middle-class ideologies on the double standard of sexuality. The profession's refusal, as reflected in the pages of the *Dublin Medical Press*, to be associated with the emerging issue of birth control was as much indicative of its safeguarding the respectability of doctors as its moral reservations. Essentially, the *Dublin Medical Press's* stance on sexual morality reveals the ever-widening scope of the medical practitioner, which extended to the view that doctors were the rightful custodians of public propriety, and ultimately served to augment their social position.

Overall, this chapter aims to examine how the *Dublin Medical Press* defined its evolving role as extending far beyond the mere healing of the sick, and advocated a role for the profession as guardians of public morality. Was this new focus on medical authority a substitute for medical knowledge? This chapter examines how the profession pushed the boundaries of its professionalism to exercise control over every area of human existence, and how, in the pages of the *Dublin Medical Press*, it construed its role as moral watchdogs of society.

1. A new medical authority

By mid-century, as medicine consolidated itself as a profession, the doctor no longer limited his area of responsibility to healing the sick. Isaac Ashe, in his Carmichael Prize-winning work¹ in 1868, asserts that 'higher public respect, social honour, and pecuniary emolument will be the direct results accruing to the profession'.² Shorter, in an English context, maintains that the new scientific basis of medicine lent enormous prestige to the medical practitioner in the eyes of the patient.³

Medical practitioners in the nineteenth century often involved themselves in counselling patients in intimate problems and presuming to advise society as a whole. *The Lancet* as early as 1842 alluded to the evolving role of the nineteenth-century medical man: 'the study of man, morally and physically, his animal nature and his intellectual as one aspect'.⁴ Medicine was clearly not limited to the business of healing; rather, it was to involve itself in a medico-moral discourse that would infiltrate every aspect of patient life, from how they dressed to how they chose to spend their leisure time.

By the nineteenth century, the doctor-patient relationship was no longer one in which the practitioner faced a wealthy and influential patron, but one in which the status of the patient was comparable to or lower than that of the doctor.⁵ Certainly, by the time Lombe Athill graduated in 1849, he distinguished between the various social levels of

¹ Ashe, *Medical education*.

² *Ibid.*, p. 3.

³ Edward Shorter, 'The history of the doctor-patient relationship' in Bynum and Porter, *Companion encyclopaedia*, ii, pp 789-790.

⁴ *The Lancet*, ii (1842-43), p. 349.

⁵ Waddington, *Medical profession*, p. 199.

his practice.¹ Also, with the advent of state-sponsored medical programmes such as the Medical Charities Act of 1851, doctors were working among their social inferiors – the poor. It would seem reasonable to assume that doctors, with their intrinsically middle-class views on morality, would look with disapproval on the lifestyles of the lower classes among whom they regularly worked.

In 1868 Ashe underlined the need for medical practitioners to be aware of patients' 'welfare and personal interests', and emphasised that the modern doctor must evince 'steadiness, forbearance, delicacy and discretion' at all times.² Ashe's viewpoint reflects the widening scope of nineteenth-century medicine. Porter, in an English context, notes that the century brought a closer rapport between medicine and the public, society seeing the doctor as a new 'saviour of humanity'.³ The more scientific and effective medicine appeared, the more the public became in awe of the figure of the doctor. The language of science alone was to concoct a figure of authority and adeptness in the medical practitioner. In nineteenth-century Ireland, recovering from the trauma of famine and struggling to define itself in what was essentially a new order, the doctor was far more educated than the average person, and his authority and social standing in what was mainly an agrarian society were substantial. Unlike the priest, the doctor had access to intimate information and medical details. Furthermore, at a time when fearsome infectious diseases such as cholera and relapsing fever were a clear memory, personal health gained new importance. This thesis seeks to underline the evolving view medicine had of its role in society, and how the *Dublin Medical Press* intimated this in its columns. Essentially, the journal reflected the fact

¹ Athill, *Recollections*, pp 141–142.

² Ashe, *Medical education*, pp 54–55.

³ Porter, *Greatest benefit*, p. 427.

that nineteenth-century medicine increasingly believed that it should pontificate on how ordinary people should live their lives.

In 1863, an editorial in the *Dublin Medical Press* outlined the importance of medicine in criminal cases, where there was a question of ‘moral insanity’, i.e. where the perpetrator might not be responsible for the crime due to insanity. The article is critical of legal cases that spurn the moral expertise of the medical man.

It has been for some time the mode with judges and juries, and the public generally to sneer at ‘mad doctors’, and to disregard the skilled evidence of scientific psychologists as unworthy of their attention.¹

The journal is anxious to emphasise the existence of moral insanity but is at pains to point out that the person to measure morality is the doctor, and not the presiding judge – or, as the *Dublin Medical Press* dubs him, ‘the judicial psychologist’.² Medicine should be the authoritative voice in cases where there is a question of insanity. This gives us an insight into the medical profession’s stake in its role as the ultimate arbiters of a person’s future – one that would raise the social profile and status of medicine. Moreover, in a world where there were strong feelings that the profession was overcrowded, it was sanctioning yet another post of responsibility for the doctor.

In 1854 the *Dublin Medical Press* printed an extract from a series of lectures entitled ‘The psychological vocation of the doctor’,³ where a Dr Forbes Winslow emphasises how practitioners are the ‘cultivators of medical science’ who must consider their ‘higher and more exalted functions’.⁴ Dr Winslow was at pains to highlight what he termed the *medicina mentis*, and how the capacity of the practitioner as a sage was as

¹ *D.M.P.*, xlix (1863), pp 301–302.

² *Ibid.*, p. 302.

³ *D.M.P.*, xxxi (1854), pp 100–102.

⁴ *Ibid.*, p. 100.

important as the role of healing the body. This great power, this *medicina mentis*, was an integral part of the duties of a medical practitioner according to Winslow:

We form but a low and grovelling estimate of our high destination -- of the duties of our dignified vocation, if we conceive that our operations are limited to a successful application of mere Physical Agents. God forbid that we should thus vilify ourselves, and degrade our noble science!¹

Of course, this broadening of the role of the doctor both added to the prestige of the profession and augmented its authority. To broaden the scope of medicine was essentially to push the boundaries of medical control and influence. The mundane exertions of life seemed not to escape the watchful and omnipresent eye of the medical practitioner. The jurisdiction and mastery of medicine was authoritative.

2. Morality and medical influence

Between the Famine and the Land War, Ireland adjusted as never before or after in an accommodation with English rule.² In trade, Ireland became increasingly oriented towards Britain – of every thousand pounds' worth of goods exported from the UK by 1870, a little over one pound's worth went from Irish ports.³ Given the increased communication with Britain together with the expansion of the railway, it is not difficult to conceive how Victorian values spread to Ireland from 1850. These ideas centred on propriety and morality and were mainly upheld by the middle classes. The medical profession, champions of the emerging middle classes, saw fit to recount, in the *Dublin Medical Press*, examples of immorality in the lives of patients.

¹ Ibid.

² Comerford, 'Ireland 1850–1870', p. 372.

³ Ibid., p. 377.

In the years 1850–1914 four million people left Ireland and the size of farm holdings increased – almost a third of all farms were of thirty acres or more.¹ With the increasing land agitation and agrarian outrages, the farmer began to emerge with new confidence. Gladstone’s 1881 Land Act allowed £86.1 million to be advanced by the state (1881–1915) to begin the process of buying back land;² this gave farmers, as opposed to proprietors or labourers, a victory and created an important stratum of Irish society. It was now possible for this new emerging middle class to contemplate a new standard of living, including the ability to enter a son into a profession. Comerford points to the newly prospering farmers, with money in the bank, land and cattle, and asserts that this new level of wealth brought new definitions of respectability.³ Consequently, socially defined codes of acceptable behaviour gained increasing importance in Ireland as the economy slowly recovered from the Famine.

However, one must be careful to recognise a distinct difference in the society and moral values of mid-Victorian Irish society when juxtaposed with Britain. Few places experienced industrial growth, and comparatively inexpensive factory-made English goods undermined the old established trades and domestic industry.⁴ Ireland was still a predominately agrarian population, still recovering from the ravages of Famine, and by mid-century was without a large aristocracy that would act as a buffer between the middle class and lower orders. How would Ireland thus interpret the new and specific moral guidelines of the Victorian age? The *Dublin Medical Press* at this time suggested a major medical preoccupation with non-medical matters – the sheer volume of articles devoted to ‘clean living’ and morality suggests that the medical

¹ Hoppen, *Ireland since 1800*, p. 92.

² *Ibid.*, p. 105.

³ Comerford, ‘Ireland 1850–1870’, p. 381.

⁴ R. V. Comerford, *The Fenians in context: Irish politics and society 1848–1882* (Dublin, 1985), p. 11.

profession increasingly saw its role in society as that of social commentator. It is perhaps reasonable to assume that the doctor, on a par with the clergy, was often the most educated (the national primary education system was in its infancy; widespread literacy wouldn't become a reality until the end of the nineteenth century) and 'gentle' member of an Irish village. Lombe Athill alludes to the 'gentry' who resided in the area of his first practice as people he could relate to, and bemoans the fact that there was so few of them living there.¹ The *Dublin Medical Press* became an important indicator of the moral preoccupations of nineteenth-century Irish medicine.

The dispensary system in Ireland meant that medical men probably had increasing access to ordinary people's lives. This access was not only to the poor. There were many complaints that the red-ticket system² was dispensed to those well able to afford medical treatment, and the fact that the doctors still charged a guinea for private patients meant that private medication was beyond even some of the middle classes (the average wage was 7 shillings per week; a guinea would constitute three weeks' wages).³

The public perception of expanding medical authority was bolstered by new ideas of respectability. We have seen how the 1852 Medical Charities Act ensured that the medical profession played a significant role in the administration of medical relief for the poor.⁴ They skilfully evaded the threat of subordination by a central authority –

¹ Athill, *Recollections*, pp 141–142.

² Under the Medical Charities Act tickets were distributed to poor people to authorise medical care. Tickets were of two types – E-1 and E-2, commonly known as black and red tickets because of the colouring of the letters. A black ticket allowed for treatment at the dispensary while the red ticket authorised treatment in the home for people who were too ill to travel to the dispensary.

³ Cassell, *Medical charities*, pp 100–101.

⁴ See Gerard O'Brien, 'State intervention and medical relief of the poor' in Malcolm and Jones, *Medicine, disease and the state*.

the Poor Law Commission – and ensured their voice in poor relief in Ireland. The act did not distinguish between paupers as did the English Poor Law, instead substituting the word ‘destitute’ for the more ambiguous expression ‘poor persons’.¹ All poor people were to be viewed in the same light and, given the poorer economy of Ireland and the far-reaching and confused red-ticket system of the dispensary system, the term ‘poor’ would arguably have far greater scope than in Britain. Consequently, when the medical profession referred to the poor in Ireland in this period, it was a reference to a large proportion of the population.

The discourse of the nineteenth century with regard to the poor was one of suspicion and fear. Malthusian and Darwinian thought was *à la mode*; the idea of degeneration of the species – that ‘the great unwashed’, the idle and weakened lower orders would overrun the human race – fuelled this fear. In this atmosphere of eugenics, the swarming masses of the poor and destitute were eyed with suspicion by the middle classes. Françoise Barret-Ducrocq points out: ‘In the moral symbolism of the nineteenth century foul air and evil blended together, impartially polluting bodies and souls’.² The nineteenth century placed new significance on the outward signs of respectability; for example, the *Dublin Medical Press* in 1877 voice its concerns as to the effects of bank holidays on ‘the health and morals of the working classes’,³ concerned about the ‘exodus of the population’ to places of amusement. The respectability of working men – and even more of working women – was measured by a set of easily seen qualities: sobriety, cleanliness and modesty of dress, institutionalisation of sexuality, religious observance, regulation of employment and prudence. The essentially middle-class values were promoted by medical men as

¹ Cassell, *Medical charities*, pp 92–93.

² Barret-Ducrocq, *Love in time of Victoria*, pp 8–9.

³ *D.M.P.C.*, ii (1877), pp 131–132.

important indicators of moral wholesomeness. Those that fell below the categorisation of moral health were seen as inherently sick and nuisances to society. *The Lancet* in 1858 referred to 'the intimate connexion which exists between moral depravity and physical degradation'.¹ This discourse of cleanliness and godliness prompted the profession to cast a disapproving eye on the lives of the working classes. The *Dublin Medical Press* in 1880 printed a 'most forcible letter' from a 'Recorder of the city'² to the Lord Mayor of Dublin, discussing the link between criminality and public sanitation:

I have grouped classes of crime, not merely as characteristic of the city, but because I believe they flow from the same original – the misery of their homes and habits of the poorer working classes.³

The letter is anxious to underline to the lord mayor that clean houses need to be built in Dublin city and only then can 'home happiness' be achieved 'through good conduct and self denial'. The *Dublin Medical Press* thus vindicates the argument that links dirt and disease with immorality, and looks to the sprawling tenements of Dublin as places of depravity and lawlessness.

Similarly Walkowitz suggests that the notions of respectability of the middle classes were markedly different to those of the poorer classes.⁴ But the altered standards of cleanliness propelled by the miasmatic theory, in vogue in the nineteenth century, that miasma or fouled air caused sickness were behind many medical arguments on morality. Cleanliness, or the lack of it, came to be associated with moral worth or with

¹ *The Lancet*, ii (1858), pp 456–457.

² An official working for the registrar general under the provisions of the 1878 Public Health Act.

³ *D.M.P.C.*, xxx (1880), p. 501.

⁴ Judith R. Walkowitz, *Prostitution and Victorian society: women, class and the state* (Cambridge, 1980) p. 29.

immorality. To be clean had a double meaning – the physical and the moral.¹ This was to form the backdrop of medical discourse on morality.

3. Temperance

In this context of middle-class moralities, the consumption of alcohol and where it was consumed was a particular anxiety of the medical profession. Alcoholism – a concept coined in 1852 by the Swede, Magnus Huss (1807–90) – provided an excellent model for a degenerative disease, since it combined the physical and the moral and was believed to lead to character disintegration.² The promotion of temperance reflected the atmosphere of the times, echoing middle-class fears in a mass society marked by proletarian unrest.³ This was specifically the case in Ireland when the agrarian unrest that pervaded the century took on a new significance in the economic slump of the 1870s. There was much support for the Land War (1879–82) not just from tenant farmers but from labourers too,⁴ as secret societies wreaked havoc on proprietors – who essentially represented the upper middle classes of nineteenth-century Ireland. Elizabeth Malcolm points to the link made by the upper and middle classes between Fenianism and alcohol consumption.⁵ This kind of agrarian unrest was inextricably linked with indulging in alcohol and thus, temperance was a convenient method of exerting a form of social control while simultaneously upholding middle-class values of sobriety.

¹ Andrew Wear, 'The history of personal hygiene' in Bynum and Porter, *Companion encyclopedia*, ii, p. 1284.

² Porter, *Greatest benefit*, pp 510–511.

³ *Ibid.*

⁴ Hoppen, *Ireland since 1800*, pp 100–101.

⁵ Elizabeth Malcolm, *Ireland sober, Ireland free: drink and temperance in nineteenth century Ireland* (Dublin, 1986) pp 212–213.

As early as 1834, parliament created a 'select committee to inquire into drunkenness' to consider the drinking customs of the working classes throughout the United Kingdom.¹ The inquiry concluded that drunkenness was indeed a growing problem, especially in Ireland.² However, after the Famine, consumption of alcohol, specifically spirits, decreased significantly.³ Whiskey, especially the illegally distilled variety, was cheap – a gallon of poteen sold for as little as two and a half shillings – but this illegal trade was curtailed in the second half of the nineteenth century when the inefficient revenue police were replaced by the Irish constabulary. In fact, spirit consumption per capita was less than in Scotland and the United States.⁴ The *Freeman's Journal* in 1865 contended that 'half the quantity that leaves a Scot pretty steady, would set an Irishman wild, or on his back'.⁵

Why, then, were the pages of the *Dublin Medical Press* filled with articles proclaiming the evils of alcohol? The temperance movement, beginning in the United States in the 1820s, evolved in Britain and Ireland as a Protestant and essentially middle-class phenomenon.⁶ The *Dublin Medical Press* was anxious to draw distinctions between the classes as regards alcohol consumption and to promote itself as expert on who should drink, who should drink publicly, and who should not drink. In 1856, the *Dublin Medical Press* pointed out that 'Wine taken in moderation can never hurt, but on the contrary, is friendly to the constitution'.⁷ In 1879, a Thomas M. Dolan, medical officer of a workhouse, quoted Hippocrates in his article advocating

¹ John F. Quinn, *Father Mathew's crusade: temperance in nineteenth century Ireland and Irish America* (Amherst, MA, 2002) p. 42.

² *Ibid.*

³ For more on this see Malcolm, *Ireland sober*, pp 322–329.

⁴ *Ibid.*, pp 324–325.

⁵ *Freeman's Journal*, 14 Feb. 1865.

⁶ Quinn, *Father Mathew's crusade*, pp 47–48.

⁷ *D.M.P.*, xxxv (1856), p. 199.

the benefits of alcohol as a medicine: 'Wine is a thing wonderfully suited to man, if in health as well as in sickness, it is administered in moderation'.¹ Invariably, temperance appeared to be an additional means of bolstering their status and moral superiority as, once again, medical practitioners defined what was respectable behaviour.

The Victorian ideal held that life should be organised around work and family. There was a clear belief that hard work and 'good' morals would bring their own rewards. It was implicitly by this standard that the morality of the working classes was measured. Their chosen recreations, usually spiced with alcohol, were seen as evidence of disorderliness and licence.² Trevor May, in an English context, points out that throughout the nineteenth century, the view among the middle and upper classes was that pauperism was directly caused by intemperance.³ When discussing pauperism in Dublin, the *Dublin Medical Press* in 1880 commented: 'usually the only joy of life is strong drink bought at the cost of what would make the home habitable'.⁴ In Ireland, where specific categories of deserving and undeserving poor were not as clearly drawn as in Britain, intemperance was a useful yardstick of one's morals. If you were poor that was one thing, but if you were poor and drunk you were immoral.

The *Dublin Medical Press* increasingly defined alcohol consumption as within the responsibility of the medical profession. The dilemma for doctors was how to pontificate on alcohol's dangers for the lower classes and yet legitimise its use among themselves. They were anxious to separate themselves from the polemics of the

¹ *D.M.P.C.*, lxviii (1879), pp 411–412.

² Barret-Ducrocq, *Love in the time of Victoria*, pp 14–15.

³ Trevor May, *The Victorian workhouse* (London, 1997), p. 7.

⁴ *D.M.P.C.*, xxx (1880), p. 501.

temperance movements but still wished to advocate temperance among the working class as a form of social control. Alcohol consumption among their own class was deemed acceptable but among the working classes, whose numbers alone made the middle classes uncomfortable, sobriety was safer option. Alcohol was seen, very often, as a medicine to be administered by medical practitioners. In 1856 the *Dublin Medical Press* printed an extract from a prize essay, 'Physiological errors of teetotalism', by a Dr Carpenter.¹ It begins by emphasising that 'The action of alcohol upon the animal body in health is essentially poisonous', but it appears anxious to point out that in appropriate and knowledgeable hands, alcohol is a different matter: 'use is not the same as abuse in the case of alcohol, of which it may be asserted that quantitative difference produces qualitative difference'.² Thus, in the right hands, alcohol can have positive qualities and Dr Carpenter is clear as to the problems this information may have for non-professionals: 'alcohol is not a poison, but food. To the popular mind it would be equally paradoxical to say iron is food, salt is food, chalk food; the popular idea of food being limited.'³ Consequently, alcohol can be of value if removed from the popular domain and placed under the watchful eye of medical supervision. The *Dublin Medical Press* cautiously concurs with this view and adds that 'We have some hesitation in giving publicity to them, lest by so doing we should contribute to arguments tending towards an encouragement of intemperance'.⁴ The suggestion appears to be that the public are not equipped to deal properly with alcohol and accordingly should avoid it altogether.

¹ *D.M.P.*, xxxv (1856), pp 55–56.

² *Ibid.*, p. 55.

³ *Ibid.*

⁴ *Ibid.*,

Medical practitioners appeared to be in a dilemma as to whether to denounce alcohol unequivocally or promote it for medical purposes on the premise that it be carefully dispensed and regulated by medical practitioners. 'Our conviction is that alcohol is a medicine',¹ said the *Dublin Medical Press* in 1870. Again, the journal appears anxious to draw a distinction between the drinking habits of the middle classes and those of the lower classes. The latter are to be criticised for spending scant earnings on alcohol: 'as the use of alcohol takes away from the amount of money which its habitual consumer, if poor, is able to expend on nutritious food'.² The *Dublin Medical Press* juxtaposes the image of the poor being devastated by alcohol to a picture of the cosy domesticity of middle-class alcohol consumption: 'Doubtless, numerous persons, especially among the well-fed classes, are but slightly injured by the moderate amount of wine and beer they consume, whilst they are rendered gayer, and have more pleasures of a physical kind, from the moderate consumption of alcohol'.³

The expression 'the well-fed classes' implicitly points to the middle and upper classes, suggesting the *Dublin Medical Press* believes that the lower orders should avoid alcohol because they are less able to manage it or – perhaps most importantly – that the working classes are less of a threat without it. It would appear that the *Dublin Medical Press* was anxious to curtail alcohol consumption among the poor because it feared the disorder and lawlessness it might cause.

Morality and alcohol were inextricably linked in the eyes of the medical profession. The *Dublin Medical Press* in 1875 printed a lecture on temperance by a Dr G.M. Humphry to the Cambridge University Temperance Union, which reflected the concern with working-class drinking customs: 'He said there was nothing which

¹ *D.M.P.C.*, ii (1870), p. 6.

² *Ibid.*

³ *Ibid.*

tended to sap the foundations of society, physically, morally and spiritually, so much as intemperance, lying at the root of almost every sin, evil and crime'.¹ The intrinsic moral tone of the lecture is pointed at the lower classes and their propensity to drink. 'It was to be feared that increase of wages too often led to increase of drinking', and the *Dublin Medical Press* emphasises Dr Humphry's key point:

never, under any consideration, should wages be paid in the form of drink; this was a prodigious evil – giving a man a pint of beer for doing a given service. Secondly, never, or scarcely ever, except medicinally, should beer or wines or any spirituous liquors be taken in the intervals between meals.²

Labourers, particularly farming labourers, in nineteenth-century Ireland were often paid in kind.³ It seems probable that labourers would also be paid, at times, in the form of alcohol – a tradition that nineteenth-century medical men disapproved of. The question of temperance as a form of medical social control is again raised.

By 1880, the medical profession's crusade against alcohol consumption in certain quarters had not waned. This time, the journal focused on the potentially devastating consequences of alcohol consumption by women: 'It is well known that when comparatively young women "take to drinking", their course is usually a brief one'⁴ stated the *Dublin Medical Press* in 1880. It referred to a rather grim tale of a young woman 'with strong passions' who formed an attachment to a 'scoundrel' and at the same time indulged in alcohol. From this point on, the story reads as a rather stern, didactic, moral tale on the evils of intemperance.

¹ *D.M.P.C.*, lxx (1875), p. 211.

² *Ibid.*

³ E. R. R. Green, 'Agriculture' in R. Dudley Edwards and T. Desmond Williams (eds), *The Great Famine: studies in Irish history 1845–1852* (Dublin, 1976) pp 92–93.

⁴ *D.M.P.C.*, lxxx (1880), p. 173.

On the death of her mother she becomes her own mistress, and he induces her to cohabit with him. By doing so she forfeits her position in society and alienates her friends. Having got his prey into his clutches, her paramour encourages her to drink. Under this isolation and intemperance combined he succeeds in depriving her of her property.¹

Thus morality is destroyed by alcohol or, more pertinently, morality is measured by intemperance. Perhaps of most significance is the implicit warning that morally weak people are more susceptible to the evils of alcohol. Barret-Ducrocq notes that alcohol consumption in London in the nineteenth century was a class question: 'The gratuitous oaths, the obscene jokes, the abandonment of restraint, the violence ... intemperance and prostitution were indissolubly linked'.² Malcolm refers to the connection between alcohol and agrarian unrest.³ The *Dublin Medical Press* corroborates this view in an Irish context, emphasising the moral nexus between disorderliness of the lower orders and alcohol. The fear that such disorder provoked among the middle classes was inherent in the medical discussions of intemperance.

In 1854 the *Dublin Medical Press* printed the minutes of the Royal Medical and Chirurgical Society of Ireland, where a Doctor Copland stated that 'Drunkenness proved a common, and at present was a very powerful cause, in reference to the production of insanity throughout the general population'.⁴ This link between insanity and alcohol was fearsome: if the doctor, armed with his scientific education, could point to the connection, who might question him? In 1870 the *Dublin Medical Press* repeated this notion, stressing that 'Many cases of idiocy are distinctly traceable to parental intemperance and excess',⁵ and discussed alcohol consumption in terms of

¹ Ibid.

² Barret-Ducrocq, *Love in time of Victoria*, p. 13.

³ Malcolm, *Ireland sober*, pp 212–213.

⁴ *D.M.P.*, xxxi (1854), pp 306–307.

⁵ *D.M.P.C.*, ix (1870), p. 376.

degeneracy of the race. This scare-mongering legitimised medical practitioners' desire to restrict alcohol consumption among the poor.

By 1882, the *Dublin Medical Press* had not wearied of the link between alcohol and insanity. Increasingly, alcohol consumption was seen as the underlying cause for social unrest among the poor:

Intemperance was one of the most fruitful causes of insanity, not only by directly poisoning the brain, and so originating organic disease, but indirectly by establishing and transmitting a tendency to nervous disease.¹

This is expressed in a tone of morality rather than one of medical knowledge on the detrimental effects of alcohol on the system.

4. Bathing

In an age when it was dawning on governments that dirt spread disease, cleanliness took on new importance. The science of bacteriology, instituted by Pasteur (1822–1895), was yet to be accepted by the medical profession, and so dealing with contagion was uncertain and often inconsistent. By mid-century, medical notions in Ireland about the nature of infectious disease were as conflicting as they had been a century before, but the main belief among doctors was that epidemics could have a spontaneous origin.² This meant that disease could be developed by personal dirt and overcrowding alone, and explained the *Dublin Medical Press*'s preoccupation with personal hygiene, which had become not only a prerequisite for social acceptability and public health, but also a symbol of middle-class status and good character. Joseph Robins points out how as early as 1846 legislation enabled the borrowing of money to

¹ *D.M.P.C.*, lxxxiv (1882), p. 52.

² Robins, *Miasma*, pp 212–213.

establish baths and washhouses in Ireland, but little was done about it.¹ By the end of the 1870s the only public baths for the poor of Dublin were in the Mendicity Institution.² The public baths commissioned by the Iveagh Trust in 1890 would not be built until the twentieth century. This lack of facilities did not deter the medical press from making moral observations. Bathing and baths attracted the attention of the medical profession in a century where dirt was associated with moral degeneracy.

In 1860 *The Lancet* began an editorial with the statement that ‘What poor people may rightly do on a Sunday, and what they should not are very disputable questions. We would refrain from being either very lax or very stringent.’³ The impetus behind the article was that public baths were to be closed to the public on Sundays.

Cleanliness, we have been told, is next to godliness ... If all other acts were prohibited from the poor upon Sunday, we should put in a claim for washing. It is certainly not a crime nor idleness, nor should we regard it exactly as an amusement or as a relaxation. It is possible the poor may look upon it as an occasional joke to be clean, and if so, all we say is – pray let them enjoy it’.⁴

This attempt to portray the lower classes as habitually unclean underlines the constructed relationship between physical dirt and moral degeneracy. In any case, bathing was seen as factor in the prevention of disease and thus, the importance of bodily cleansing was emphasised. Robins points out how previous to the mid-nineteenth century, very little merit had been placed on personal hygiene.⁵ Dr E.D. Mapother, medical officer for health in Dublin, became a leading advocate of bodily

¹ *Ibid.*, p. 237.

² *Ibid.*

³ *The Lancet*, ii (1860), p. 42.

⁴ *Ibid.*

⁵ Robins, *Miasma*, pp 236–237.

washing.¹ In his course of lectures on public health, printed in the *Dublin Medical Press*, he promoted the notion of bathing from the point of view of preventing disease.

No single, hygienic observance has perhaps done more to prolong life or preserve health. The ruddy cheek, full pulse, and muscular activity; in a word, the hale old age of many has been justly attributed to the continuous use for years of bathing.²

Mapother was attempting to treat bathing as a preventive action against the spread of disease, thus contributing to the discourse that those who did not bathe regularly were somehow diseased and infectious. The wealthier classes could afford to equip themselves for this new interest in bathing; for example by the early 1860s Turkish baths were opening across Ireland.³ Mapother emphasises the importance of ‘the bath as a social custom’, and professes it to be:

the most perfect means of ablution we possess, and therefore [it] keeps up a cleanly and vigorous condition of the body, and braces the person against the vicissitudes and the liability to catch contagious diseases.⁴

This promotion of the bath as a panacea for infectious disease highlights the fact that medicine had no idea regarding the source of infection. Was medical authority a substitute for medical knowledge?

The Lancet in 1858 referred to ‘the intimate connexion which exists between moral depravity and physical degradation’.⁵ But not all forms of bathing met with the medical men’s approval. Turkish bathing was increasingly becoming popular in the nineteenth century. Bray’s Turkish Baths opened to the public on 2 January 1859 and

¹ *Ibid.*, p. 237.

² *D.M.P.*, x (1864), pp 157–160.

³ For more on this see K. Mary Davies, ‘A lost Victorian treasure – Bray’s Turkish baths’, in *Journal of the Bray Cualann Historical Society*, v (2004), pp 12–18.

⁴ *D.M.P.*, x (1864), pp 157–160.

⁵ *The Lancet*, ii (1858), pp 456–457.

another Turkish bath establishment opened in Lincoln Place, close to Trinity College, in February 1860.¹ However, the *Dublin Medical Press* viewed the growing popularity of this type of bathing with disapproval. An article appeared in 1861 warning of the ‘evil consequences’ of a Turkish bath:

In the majority of cases, for ordinary purposes of cleanliness and vigour, the Turkish bath, in our experience, by no means surpasses, and we question if it equals, in its beneficial effects the ordinary sponge ... but the Turkish bath cannot probably be made full use of to its full extent more than once a week without giving rise to evil consequences – relaxing the whole system, and lowering the tone both of the body and the mind.²

The article is suggesting that the Turkish bath is too sensual for the public. Once again, the *Dublin Medical Press* was acting as the indefatigable guardian of public morality. It purveyed the notion that the newly popular Turkish baths were somehow a danger to the prevailing middle-class ideologies of respectability. To bathe for cleaning purposes was one thing, but the steaming, massage and oils inherent in Turkish baths concocted a picture of licentiousness and depravity for the *Dublin Medical Press*.

Bathing in general seems to cause disquiet in the columns of the *Dublin Medical Press*. The journal appears anxious to point to the worst-case scenarios in order to illustrate the potential for immorality. In 1887 it reported testily on ‘the nuisance which has been allowed to develop, namely, that of indecent bathing’.³ It becomes increasingly clear that the *Dublin Medical Press* saw itself as the moral watchdog of society.

¹ Davies, ‘Lost Victorian treasure’, pp 16–17.

² *D.M.P.*, xlvi (1861), p. 84.

³ *D.M.P.C.*, xcvi (1887), pp 204–205.

It is only right that the public should be protected from the offences against decency which, as far as one could judge, certain members of the lower orders seem to derive some pleasure in committing. In a case in which the acting commissioner prosecuted, a lad stood in a nude state on the shore about twenty yards from one of the steamboat piers, in full view of the crowds of passengers who were arriving and departing by the steamboats. Such conduct is almost inexplicable. It implies a callousness of feeling with regard to decency which is altogether unnatural.¹

Below this tone of moral outrage is the undercurrent of class prejudice. The *Dublin Medical Press* points out that the 'sense of decency' seems to be less important to 'those belonging to the lower orders, than by the members of the more favoured communities'.² This 'sense of decency' referred to the socially constructed, intrinsically middle-class code of behaviour championed by the medical profession. This commentary not only points to the middle-class bias of the *Dublin Medical Press* but also raises the question that if this is indeed a public morality issue, with no reference to medicine whatsoever, and in fact it was being dealt with by the police, why did medical men feel the need to comment? How is this a matter for publication in a medical journal?

5. Exhibitions and shows

Judging from the prodigious coverage in the *Dublin Medical Press*, medical practitioners evinced a deep suspicion of the exhibitions and shows that were increasing in popularity as the century progressed. Matthew Sweet discusses the nineteenth century's burgeoning interest in what he terms 'sensationalism'.³ He refers to the 'mid-Victorian predilection for spectacular thrills'.⁴ The theatre was to take on

¹ *Ibid.*, p. 204.

² *Ibid.*

³ Matthew Sweet, *Inventing the Victorians* (London, 2001) pp 4–5.

⁴ *Ibid.*

a new visual importance, and exhibits and shows inclined more and more towards sensationalism. In 1863 *The Lancet* referred to the public's 'depraved taste for sensation exhibition'.¹ Later the *Dublin Medical Press* expressed its concern that certain exhibitions and shows 'demoralise the public mind by indulging a morbid taste for horrors'.² Clearly, the amusements of the public – particularly the working-class public – were outside the narrow definition of medical middle-class mores. The cries of excitement, the jostling crowds, the air of exhilaration were clearly, according to the *Dublin Medical Press*, asking for trouble.

During the second half of the nineteenth century, exhibitions enjoyed a boom time, promoted by governments as a means of advancing knowledge.³ Paul Greenhalgh emphasises the importance of exhibitions in nineteenth-century Britain⁴ and it seems reasonable to assume, judging from the interest of the *Dublin Medical Press*, that they were as popular in Ireland. Anatomical museums, in particular, enjoyed a fashionable popularity in the nineteenth century.⁵ Ludmilla Jordanova points to the enormous lengths that anatomical museums went to in pursuit of realism, with wax modelling already well established in popular culture for its unusually life-like resemblance to the human skin.⁶ How would the *Dublin Medical Press* respond to this upsurge in the popularity of exhibitions for the advancement of public knowledge – more specifically, medical knowledge? Given the fact that the medical establishment in Ireland was struggling to establish itself as a proficient and expert profession, it is

¹ *The Lancet*, ii (1863), pp 106–107.

² *D.M.P.C.*, xlv (1887), p. 330.

³ Charles Saumarez Smith, 'Museums, artefacts and meanings' in Peter Vergo (ed.) *The New Museology* (London, 1989), pp 8–9.

⁴ Paul Greenhalgh, 'Education, entertainment and politics: lessons from the great international exhibitions' in Vergo, *New Museology*, p. 85.

⁵ Ludmilla Jordanova, 'Objects of knowledge: a historical perspective on museums' in Vergo, *New museology*, pp 35–36.

⁶ *Ibid.*

unlikely that it would have embraced the idea of furthering the scientific knowledge of the public.

In order to maintain an exalted public perception, it was imperative that medical knowledge – such as it was – remained under the auspices of the profession.

Anatomy, according to the *Dublin Medical Press*, was not a subject for public consumption. The journal was appalled by what it termed ‘obscene exhibitions’ – i.e. anatomical museums. In 1854 it professed concern at exhibitions ‘professing to instruct the ignorant and warn the vicious, but prepared in such a manner as to gratify a morbid curiosity, and minister to depraved tastes’.¹ The museum, according to the *Dublin Medical Press*, was a ‘scandal to public morals’.² The implication was that the sole function of these anatomical exhibitions was to provide titillation, rather than medical erudition, for a curious public. Was this a genuine concern for the morals of prospective patients or the need for the medical man to exclude all areas of medicine from the general public, including anatomy? Not unlike the quacks, the exhibitions claimed the right to dabble in an area that the profession deemed the remit of qualified medicine only. Did the medical establishment fear that an increase in public knowledge in medical subjects would highlight deficiencies in its own knowledge? It might also be argued that this was an attempt by the medical profession to distance itself from all things viewed as non-scientific, in order to maintain or indeed elevate its social position.

The *Dublin Medical Press* firmly believed that there were areas of medical knowledge not for public consumption. A reference was made to an anatomy museum that

¹ *D.M.P.*, xxxi (1854), p. 270.

² *Ibid.*

‘contains many objects which ... however interesting to students of comparative anatomy, are still not suited for inspection by the unlettered public’.¹ The article reported with not a little sense of relief that the authorities had given ‘delicate attention displayed in sundry veils cast over too importunate sexual attributes’.² However, it warned that ‘enough remains to excite a curiosity which cannot by any stretch of indulgence be deemed scientific on the part of lay visitors’.³ Nudity was deemed appropriate for learned and rational men of science but not for the ‘lay’ person, whose morals might be corrupted. The nub of the *Dublin Medical Press*’s difficulty with anatomy exhibitions lies in the fear that an association with a lewd exhibition would taint the dignity and respectability of the medical profession. The profession had struggled to raise its reputation in public estimation and the scientific veneer of anatomical exhibitions was a bridge too far, an association too damning, for the *Dublin Medical Press* to remain silent.

By 1855, the *Dublin Medical Press* in an editorial was calling for dramatic action against anatomical museums. ‘There is a serious question of public propriety involved in these anatomical exhibitions which medical men should be ready to answer’,⁴ it declared. It recounts with disapproval how medical subjects – ‘the beauty of a woman’s pelvis, the origin of spermatozoa and other things’ – were openly discussed, and was at pains to point out the inappropriate nature of these exhibitions for the public:

Young ladies do not want to learn things which puzzle Von Baer, Barry or Newport as to the testis or ovary; and a sailor rolling half-tipsy up the

¹ *D.M.P.C.*, civ (1892), p. 621.

² *Ibid.*

³ *Ibid.*

⁴ *D.M.P.*, xiv (1855), p. 36

Haymarket is not likely to be much advanced as a philosopher by ... taking out the India rubber ovaries and uterus of the poor wax lady's pelvis.¹

The intellectual superiority of the medical profession is alluded to by reference to the extremes of ignorance: the young lady who, by reason of propriety, should never indicate even a passing interest in intimate details of the human body; and the 'tipsy sailor', a figure conveying drunken and debauched behaviour, whose attentiveness to anatomy could only be for reasons of sexual gratification. These figures are juxtaposed to the figure of the rational and scientific medical practitioner, presented as a man who, by reason of his professional qualification, is beyond such vulgar titillation.

The disapproval continued, as the *Dublin Medical Press* in 1856 branded the anatomical museums 'a most abominable outrage on public decency'.² The journal pointed out that:

The preparations, models and 'lectures' are got up in such a fashion as to delude foolish young men into the belief that the whole purpose of man's creation is the performance of that animal function which he exercises in common with the vilest of brutes.³

The recurring theme in the reaction of the *Dublin Medical Press* to anatomical museums is one of fear of the innate sexual nature of society. It is as if exposure to the intricacies of the human body, for anybody other than professionals, has the potential to unleash a chaotic sexual energy. This viewpoint had the added effect of bolstering the power of the medical man, presenting him as immune to the temptations and sexual urges that limited the public. The journal reprovably outlines how 'The

¹ *D.M.P.*, xiv (1855), p. 36

² *D.M.P.*, xxxv (1856), p. 251.

³ *Ibid.*

structure of the generative organs of both sexes is elaborately represented in specimens multiplied without end; the functions of these organs are studiously dilated upon'.¹ It can barely conceal its anxiety that the public are learning about reproduction, a knowledge that, prior to this, was the exclusive domain of doctors. The *Dublin Medical Press* did everything in its power to discredit the educational value of these exhibitions and promote the discourse that medical knowledge is not for public consumption.

The concern of the *Dublin Medical Press* for the morality of humankind considered many forms of entertainment, not least the theatre. Between 1800 and 1875, dramatic art increased dramatically in Europe.² Theatre was true popular entertainment, often reflecting scenes from everyday life. Nineteenth-century playwrights such as Anton Chekhov, Henrik Ibsen and George Bernard Shaw ensured that contemporary issues were presented to the populace, as opposed to the simple moral tales of old. Realistic theatre refused to define what was moral and what was not; unsurprisingly, this attracted a great deal of opposition.³ Narratives of heroines who took lovers, who left unhappy marriages; characters that essentially challenged the strict moral code so central to the medical profession were replacing the traditional didactical tales of the past. The *Dublin Medical Press* did not refrain from commenting on the theatre despite the fact that it bore no relation to health issues – once again underlining how doctors viewed their expanding role.

¹ Ibid.

² Edwin Wilson and Alvin Goldfarb, *Theatre: the lively art* (New York, 1991; 4th edition, 2001) pp 305–306.

³ Ibid., p. 320.

The public press was littered with front-page advertisements and articles on theatre performances, reflecting its increasing popularity in society. The *Freeman's Journal* in 1866 referred to 'the highly attractive and fashionable performances' in the Garrison Amateur Theatricals, and advised patrons to attend performances early to avoid large crowds.¹ In 1875 the newspaper refers to the packed pits, stalls and galleries of the Gaiety Theatre,² all pointing to the growing popularity and increasingly affordability of the theatre in society. This did nothing to dissuade the *Dublin Medical Press* from its view that theatres in general were places of immorality, where performances could provoke audiences to acts of impropriety. Bland points to the middle-class view of the theatre: 'the demoralizing effects on audience and performers alike of near-nakedness, and the insidious sexual innuendo imparted in certain songs'.³ The idea that theatres were places of vice is apparent in many of the articles. For example, in 1856 the *Dublin Medical Press* printed an article on early parturition – a medical man had attended the birth of a baby boy whose mother was thirteen years old. The girl's sixteen-year-old sister was also a mother. What surprised the doctor was the fact that:

the girls, leading a retired rural life, have never frequented theatres or public places of excitement, which in towns, &c. are said by some authors to facilitate the development of the generative organs.⁴

The *Dublin Medical Press* in 1876 stated that 'We doubt whether the stage can be said to do much in the way of improving the public taste or the public morals'.⁵ However, it was at pains to point out that 'for the middle and higher classes of

¹ *Freeman's Journal*, 12 Feb. 1886.

² *Freeman's Journal*, 21 Mar. 1875.

³ Lucy Bland, *Banishing the beast: feminism, sex and morality* (London, 1995), pp 106–107.

⁴ *D.M.P.*, xxxv (1856), p. 120.

⁵ *D.M.P.C.*, lxxi (1876), pp 302–303.

society' the theatre, in moderation, might be a suitable recreational activity. The same could not be said for the poorer classes:

For as respects the lower classes, we cannot expect the vice of intemperance to disappear until the habits and manners of that class have undergone a complete change, until they have become more educated, more provident, and more refined.¹

The suggestion here is that the lower classes simply did not have the same control over their sexual urges as the middle classes, and it is this belief that fuels the medical discourse on morality in general. The medical profession, by sheer fact of their education and profession, were in a position to act as guardians to public morality. The lower classes needed to reform their behaviour and adopt a moral code that was acceptable to the medical profession.

In 1888 the *Dublin Medical Press* again outlined the dangers of attending the theatre, especially for females, in an article sensationally entitled 'The stage as a cause of madness'. It alluded to the new dramatic concept of realism in Goethe's *Faust*, which examines how a doctor bargains with the devil for power. Essentially the play focuses on a doctor's shame, and this might explain the *Dublin Medical Press*'s attempt to discredit it.

Whatever effect ... acting may produce upon actors, it is not pleasant to have to record that two ladies have recently lost their reason in America after merely attending performances at a theatre. In one case the vivid realism of 'Faust' created so deep an impression that the lady became raving mad, imagining herself to be Marguerite, and has since been consigned to an asylum.²

¹ Ibid., p. 303.

² *D.M.P.C.*, xcvi (1888), p. 171

Thus, the journal promotes the idea that the theatre is a place where not merely are the morals of the young and impressionable corrupted, but the sanity of females is at risk. Once again, the *Dublin Medical Press* does not denounce modern theatre unequivocally, but rather suggests that it is an unsuitable pastime for certain categories of people: the poor and women. The implicit suggestion is that women are mentally weaker than their male counterparts and so more vulnerable to the ill-effects of the theatre. The *Dublin Medical Press* itself, in this instance, does not hold back on dramatics as it describes the effect of theatre on this woman. The moral tone of this tale is unmistakable.

The evils of the stage caused a young lady to become extremely infatuated with a well known English actor, and being unable to restrain her sentiments, she rose from her seat during the progress of the play, and, before a full house, openly accused him of unfaithfulness to herself. The unfortunate part of the episode is that she is still at large, carrying a pistol and threatening the life of the actor.¹

The *Dublin Medical Press* implies that the stage has the potential to unbalance mentally the already emotive and unreasoned female. Medical men thus can draw no other conclusion but that theatre is dangerous to mental health.

The idea that the theatre represented untold dangers to women was in keeping with the discourse that respectable women should remain indoors² and maintain the middle-class Victorian ideal of family. Perhaps in an age where there was a strong fear of female sexual identity, the theatre, with its clamour and crowds, represented a place of female corruption, and this fear underpinned the medical condemnation of the theatre.

¹ Ibid.

² Elaine Showalter, *Sexual anarchy: gender and culture at the fin de siecle* (New York, 1991), pp 8–10.

The public desire for sensationalism once again attracted the attention of the *Dublin Medical Press* in 1888. It bemoaned the 'morbid public taste' that 'urges the performer to greater and greater recklessness',¹ and criticised the insatiable appetite of the public for trapeze artists and lion-tamers. The medical men refer to 'horror-loving audiences'² and tell how a young woman in Dublin almost lost her life when, during a performance, she placed her head into a lion's mouth. The young woman, says the article, 'fell victim to the popular craving for death-imminence',³ and:

had not the young lady been very quick her skull would have been crushed into pulp and another victim would have been sacrificed to the debased taste of a sensation-loving audience.⁴

Was it the public that the doctors dreaded, and not the entertainers? The journal's fascination with leisure pursuits suggests that among the jostling crowds, the mounting excitement and the pleasure-seeking thrills of the audience lurked a threat to the social order that the medical profession upheld. In any case, it is clear that the *Dublin Medical Press's* preoccupation with non-medical subjects suggests that they interpreted their role as greater than that of healing the sick. They advanced the medical profession as an authority on all aspects of society.

The medical disapproval of prize-fighting is hardly surprising given that the gathering of half-dressed men and shrieking crowds stood in direct opposition to the middle-class code of acceptable behaviour. In 1860 *The Lancet* commented: 'Of course we are all scandalised at the spectacle of two athletes dealing out to each other terrific blows, whose heavy thuds on the naked body are heard over the whole field in the

¹ *D.M.P.C.*, xcvi (1888), p. 171.

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*

presence of a crowd of backers, patrons and partisans'.¹ In 1888 the *Dublin Medical Press* pointed to 'the many demoralising exhibitions of prize-fighters',² directing its concern to the morality of the community: 'That such exhibitions are tolerated is evidence of the deficiency of a healthy moral tone in our popular assemblies'.³ This form of entertainment is not civilised:

For thinking beings to sit down to watch paid bullies rehearse a performance ... and to find these efforts designated as scientific, is to tell that in our boasted nineteenth century civilisation there are thousands who are yet untouched by any humanising influence.⁴

The performances are described as 'disgusting and demoralising'; the spectacle 'contaminates the idea of manhood'.⁵ The inference is that the journal had a difficulty with exposure of the male body that prize-fighting allowed. It was anxious to promote the idea of the enlightened and rational figure of the professional man, far removed from the lurid passion of the fighting ring. The prize-fighters are described in lewd and suggestive language, contrasting with the solemnity and respectability that was representative of a true gentleman. The moral ideal of manhood, according to the *Dublin Medical Press*, comprised 'great thoughts ... self-sacrificing heroism, purity of conduct'. Again, it saw itself and the profession it represented as judicious commentators on the morality of society.

Art and the idea of beauty were also apparently within the ambit of medical comment. In 1888, the *Dublin Medical Press* justified its interest in an art exhibition in Dublin:

¹ *The Lancet*, ii (1860), p. 448.

² *D.M.P.C.*, xcvi (1888), p. 152.

³ *Ibid.*

⁴ *Ibid.*

⁵ *Ibid.*, pp 152–153.

for there is no human interest which medical science can ignore, and least of all can be properly excluded from the consideration of the elements that make for perfection in the form and function of our race.¹

But how was a medical man qualified to comment on art? The *Dublin Medical Press* editorial drew an analogy between the doctor and painter.

The ideals of the doctor and the painter are probably not utterly unlike each other. They must have something in common for disease is ugly, and ugliness is an expression of disease while health is lovely, and loveliness is but the music of the hidden orchestra of life, well-balanced, and exquisitely modulated. There may be profit then, in an exchange of notes between the doctor and the artist, in mutual explanations and criticism, and there can be no impropriety in examining from a medical point of view, the Museum of Beauty that is now being exhibited in Grafton Street.²

The *Dublin Medical Press* was perhaps reflecting what Paul Greenhalgh refers to as the class hierarchy and social standing of nineteenth-century forms of entertainment.³

The article suggests that doctors wanted to promote themselves as experts on the human form, whether through internal or external knowledge; it can be construed on one hand as an attempt to raise the profession in the social stakes and, on the other, as a discourse on medical expertise that diversifies into every aspect of modern life.

Certainly, an earlier article from the *Dublin Medical Press* corroborates this view.

In 1881 the *Dublin Medical Press* commented on art in an editorial entitled 'Beauty medically considered',⁴ which claimed to reflect 'the merits of a shrewd and scientific observer' and pointed out how some artists, because of their lack of 'scientific knowledge', unwittingly displayed 'morbid tendencies or bad health'.⁵ It noted that one artist's conception of female beauty involved 'a wasting disease at an advanced

¹ *D.M.P.C.*, lxxx (1880), p. 298.

² *Ibid.*

³ Greenslaugh, 'Education, entertainment and politics', p. 85.

⁴ *D.M.P.C.*, xxxi (1881), p. 299.

⁵ *Ibid.*

stage, and physical debility and mental exhaustion, that is painful to witness'.¹ The journal is at pains to point out that the medical profession are the true experts on what constitutes female beauty. The artists depict women who are inherently sick, though this remains hidden to the untrained and unscientific eye. The medical man can also detect an undesirable element in a woman's character by observation alone, according to this article. This particular portrait of a woman betrays the fact that 'she labours under mental trouble or malignity, and carries danger in her sidelong glance', and notes 'the repugnance engendered by her hard and vindictive expression'.² The medical man is thus the all-seeing, all-knowing eye and it is this that makes him the appropriate moral commentator of society. The *Dublin Medical Press* seeks to emphasise that it is the practitioner's scientific knowledge that sets him apart from and above the rest of society.

6. Fashion and fashionable life

Medicine's preoccupation with the human form and its desire to control how that form is presented in public suggests a medical sense of ownership. Essentially, the *Dublin Medical Press* evinces a belief that the human body is an intrinsic part of the science of medicine and, consequently, medical intrusion was vindicated. Thus, given its interest in the leisure pursuits of its patients, it is hardly surprising that the garments those patients (particularly the female patients) chose to wear were deemed an auspicious subject for a medical journal. Indeed, how women dressed became a much-discussed point in the *Dublin Medical Press*.

¹ Ibid.

² *D.M.P.C.*, lxxx (1880), p. 298.

The invention of the sewing machine by mid-century and the advent of machine-sewn dresses in England and Ireland from 1860 ensured that flounces, pleating, frills and so on could now be added with ease and abandon.¹ Britain's expanding world trade system (of which Ireland was a part) and the burgeoning clothing and retail markets² ensured that Irish women had more choice, and uniformity of dress became a reality. Mairead Dunleavy's work alludes to the growing prosperity of the middle classes and how this induced women of those classes to reflect the wealth and social status of their fathers and husbands.³ Certainly the great swathes of material, the huge hoops and tiny shoes made the prospect of practical work an impossibility. But it would seem reasonable to assume that clothing became a way in which the nineteenth-century woman could express herself, a diversion for middle-class women from traditional roles of wife and mother. Certainly, the abundance and cheapness of servants allowed them to occupy their time with other matters. Did a woman's interest in fashion suggest to medical practitioners a diminishing of interest in her traditional middle-class roles of wife and mother?

Nancy Bradfield outlines how, after almost eighty years, the crinoline – a dress with a tiny waist and billowing skirts over a hooped foundation – came back into fashion in the mid-nineteenth century.⁴ C. Willett Cunnington points out that in 1859, a Sheffield factory was producing half a million crinolines a week.⁵ It seems reasonable to assume that such popularity was replicated in Ireland. The *Dublin Medical Press*, unsurprisingly, had much to say on women's fashion; its remarks, once more, take a moral and disapproving tone. It pointed out in 1881 that 'The claims of fashion have,

¹ Nancy Bradfield, *Costume in detail 1730–1930*, 6th edition (London, 2005) pp 228–229.

² Comerford, 'Ireland 1850–1870', p. 377.

³ Mairead Dunleavy, *Dress in Ireland* (London, 1989) pp 154–155.

⁴ Bradfield, *Costume in detail*, pp 162–163.

⁵ C. Willett Cunnington, *Fashion and women's attitudes in the nineteenth century* (New York, 2003).

in all times, pressed more heavily on women than on men'.¹ Behind the façade of medical concern, it examined whether female dress was in accordance with the narrow definition of femininity promoted by the profession. The prevailing middle-class ideologies of feminine behaviour stipulated that women be virtuous, passive and complaisant. Dresses that accentuated their sexuality and emphasised and exaggerated feminine curves were in conflict with the sexually impassive ideal.

In 1882, the *Dublin Medical Press* commented on the latest fashion trend – the crinolette, a variation on the crinoline – which exaggerated the contours of a woman's body, giving the appearance of a tiny waist and a generous bottom. The dress would undoubtedly add to a woman's sexual attractiveness:

We venture to refer to the new vagary of fashion styled 'the crinolette' ... The crinolette is simply a ludicrous excrescence which gives women the outline of a Hottentot, and must be highly inconvenient being something of a birdcage stuffed under the dress and fixed in the region of the archaic bustle.²

The potential hazards the *Dublin Medical Press* apportioned to the dress in question showed, perhaps, a deeper interest in promoting itself as experts in most areas of human life, which included commentary on the latest fashion trends. Moreover, the journal again was at pains to establish the medical profession as the moral watchdogs of society, upholders of a set of clearly defined moral principles. The guise of danger to health masks the true reason for medical concern, as the dress:

by exposing the lower half of the body to currents of cold air and chilling it helped to set up various disorders, and to induce general debility, and by spreading out the inflammable materials of clothing in such a way that they were beyond control and almost beyond cognisance, it kept up a constant risk of conflagration whenever an open fire was approached.³

¹ *D.M.P.C.*, xxxi (1881), pp 446–447.

² *D.M.P.C.*, ii (1882), pp 493–494.

³ *Ibid.*, p. 493.

Similarly, in 1881 the *Dublin Medical Press* referred to ‘the horrors of the hideous cage’ and warned that ‘The follies of fashion are the greatest evil modern society has to combat, and its efforts to resist it are at best flimsy and unreal’.¹ The implicit suggestion is that women with their frivolities need to be protected from themselves: ‘It is with no ordinary feelings of disgust and loathing that men, to whom there remains any sense of propriety, regard the prospect of a possible resuscitation of this dead monster’.² The ‘dead monster’ is the crinoline; the passage reflects the strength of feeling of medical men while suggesting that on account of their whimsical natures women are unfit to make certain decisions, and that every aspect of their lives requires the advice and remonstrance of a member of the medical establishment – the ultimate arbiter of reason and good taste.

The tiny waists that the crinoline demanded, accomplished by ‘strait-lacing’, also incurred the wrath of the medical press. The diminution of waists in itself might not have caused medical doctors such concern if such dresses did not accentuate the swell of the hips, drawing attention to the sexual attractiveness of the female. The *Dublin Medical Press* directed much attention (perhaps rightly so) to corsets or ‘tight-lacing’ and the ill-effects that the practice had on women’s health. It is perhaps the extent of the medical profession’s commentary that is somewhat alarming. For example, an editorial in 1846 entitled ‘The morbid effects of tight-lacing’ outlined the physiological dangers of corsets, citing abortion and menstrual irregularities as commonplace among women who were swayed by ‘the infatuation of modern

¹ *D.M.P.C.*, xxxi (1881), p. 496.

² *Ibid.*

fashion'.¹ The article juxtaposed two categories of women: the traditional figure of wife and mother and the figure of the 'city belle', less traditional and recognised by her love of fashion.

For the purpose of corroborating the position I have assumed, let us draw a contrast between the rustic maid and the city belle, the victim of modern fashion in mature life, when the duties of wife and mother devolve upon them. The former is sprightly, active and vivacious – her countenance lively, animated, and expressive of good health – her mind buoyant amidst all the troubles and vexations necessarily attendant upon the duties of a mother and housewife. But the votary of modern fashion how reversed her condition in after life! Her corporeal powers at an early period begin to evince decay – her intellectual faculties to manifest imbecility – her mind becomes irascible, and her temper fretful and peevish. Such women are generally sterile, or at most conceive but a few times.²

The nature of this comparison underlines the medical journal's disapproval (one might say fear) of the 'fashionable' woman. The nostalgic imagery of language surrounding the 'rustic maid' suggests its corroboration of the traditional roles of wife and mother for middle-class women. The *Dublin Medical Press* was intent on upholding the socially defined and accepted definition of femininity as passive and co-operative. To propose that a woman would be rendered sterile and stupid by the clothes she wore suggests that the medical profession sought to control women by associating the way they dressed and behaved with the proper functioning of society:

It is evident the sins of the mother are entailed on her innocent offspring ... it is reasonable to suppose from the morbid condition of the system met with in such women, that even when milk is secreted in sufficient quantity for nourishment, it is of a very deteriorated quality, calculated to ruin the health and undermine the constitution of her child.³

¹ *D.M.P.*, xvi (1846), pp 102–104.

² *Ibid.*

³ *Ibid.*, p. 104.

It is substantially more than mere corsets that are being discussed: it is the modern 'new woman'¹ and the fear and hostility towards an educated, sexually liberated female. Medicine feared that the ambitions of the modern woman would lead to sickness and sterility and ultimately to the disintegration of the middle-class ideal of family.² The 'modern woman' with all her fripperies was ultimately denying her core role in society, that of reproduction. Thus, the 'city belle' who preferred dressing up and socialising was herself the cause of medical anxiety, and not how tightly she laced her corset.

In an editorial in 1882 the *Dublin Medical Press* explored 'the physical evils of inappropriate dress';³ the tone reflects the weight of moral responsibility to the public, especially women.

It is, however, an all but recent development that is being witnessed now in connection with the efforts made by the medical profession to awaken the public to a sense of the self-inflicted evils suffered from absurd compliance with the demands of 'fashion' and that men in highest eminence deem it part of their duty to society to issue warnings against the miserable consequences of sacrifices offered to the shrine of appearance. The physical evils of inappropriate dress are so manifest to the physiologist, the constitutional damage they entail so apparent to the physician, the miseries they create so evident to the social economist, that it is rather a matter of wonder they have so long been permitted to continue unchecked and unreformed.⁴

The stirring and perhaps histrionic language points to the anxiety of the medical profession to ensure that, in every area of life, a medical opinion was not merely advantageous but a necessity. This scaremongering lent an undercurrent of authority to medical practitioners. References to 'physical evils' and 'constitutional damage'

¹ For more on this see Showalter, *Sexual anarchy*, pp 38–48.

² *Ibid.*, p. 39.

³ *D.M.P.C.*, lxxxiv (1882), pp 187–188.

⁴ *Ibid.*

propounded the indispensability of the doctor. The *Dublin Medical Press* drove home this discourse:

The ill-consequences set up by improper dress are most familiar to medical men and medical men necessarily therefore, are those most competent to advocate reform in customs to the injurious effects of which they are daily witnesses.¹

The article echoes again the growing fears of the middle classes that the fashionable or modern woman at the latter end of the nineteenth century posed a threat to the family unit. The journal suggested the best way of preventing the ‘folly of tight-lacing’: ‘Perhaps, by exciting the maternal instinct, more benefit will be derived than by any other means’.² Thus, the best means of ridding women of this fashion trend was to impregnate them. This desire to preoccupy women with their maternal role continued to pervade the medical discourse on women’s fashion.

The dictates of modern fashion were not the only concern of the *Dublin Medical Press*. The journal also looked with alarm at what it categorised as the ‘fashionable life’ and its effects on the morality of the public. Languid afternoons spent in fashionable coffee houses and the lure of society evenings attracted the commentary of the medical journal. In an editorial in 1861, entitled ‘The insalubrities of the atmosphere of coffee houses and its influence on the development of diseases of the cerebrum’, the *Dublin Medical Press* cast a suspicious eye towards the growing popularity of coffee houses. The article warned:

Among a great number of persons who are the usual habitués of coffee houses, one may observe, as a consequence of it, after a certain time, the duration of which cannot be easily fixed, a certain kind of special poisoning.³

¹ *Ibid.*, p. 188.

² *Ibid.*, pp 187–188.

³ *D.M.P.*, xlvi (1861), p. 81.

The symptoms mentioned progress at an alarming rate: they may begin with sleeplessness and impatience but develop to where the eyes are less tolerant of light, taste becomes dull, the person become irritable, 'the fitness for intellectual work gives way', and the 'the memory is found faulty'.¹ Furthermore, 'The general paralysis of insane people begins generally with congestion, and the atmosphere of the coffee-houses conduces in process of time to this phenomenon'.² Alarming information indeed, at a time when coffee houses were fashionable and centres of intellectual gatherings. However, this discourse is almost entirely based on opinion rather than medical realities and consequently, points again to the intrinsic desire of the *Dublin Medical Press* to aggrandise the profession as the custodians of morality.

It appears that the doctors were not fans of fashionable society in general, seeing most of the trappings of fashionable life as hazardous to the health. The *Dublin Medical Press* in 1878 printed an editorial with the sensational headline 'The perils of fashionable life'.³ It expressed concern about the effect of 'late hours' and 'constant excitement' on the human body. Regarding the 'pleasures' of fashionable people, the tone is unmistakably moral: 'It would, perhaps, be an easier task to conquer a country than to put a stop to the frivolities and unhealthy pursuits of those fashionable men and women'.⁴ The weight of disfavour is directed against women, pointing out how in nine cases out of ten the 'fashionable' woman does not come to the notice of her medical practitioner until the harm is done. 'She does not consult him before she incurs the risk, but after she has reaped the penalty of her unnatural and frivolous

¹ Ibid.

² Ibid.

³ *D.M.P.C.*, lxxvii (1878), p. 71.

⁴ Ibid.

mode of life'.¹ The article suggests that the desire to socialise is unnatural because it is outside the set codes of feminine behaviour outlined by the medical profession. The *Dublin Medical Press* was again seeking to prohibit women from being full members of society, and condemning them for not fulfilling their roles of wife and mother. The roles of marriage and reproduction were seen as primary in a woman's life.

7. Birth control

The role of reproduction

Childbirth in the nineteenth century was a risky, if not downright dangerous, business for women. Many lost their lives due to a variety of complications, from haemorrhaging to blood poisoning. Medical practitioners, having battled to play a leading role in childbirth, were often ill-equipped to deal with complications during the birth process. The development of lying-in hospitals, such as the Dublin Lying-in Hospital in 1757, increased the numbers dying of puerperal fever, as doctors attended parturient women with infected hands.

Thus, it seems natural that women would wish to control their fertility. However, to demand birth control was, in essence, to confront accepted Darwinian thinking on women's role of reproduction. If a woman didn't become pregnant, what was she to do? The *Dublin Medical Press* corroborated this view – sentimentalising the maternal role and viewing birth control as an attack on the 'natural' order of things. Doctors were eager to promote themselves as the acknowledged authorities on procreation, further strengthening their role in society. Nineteenth-century medicine had linked

¹ Ibid.

ovulation to menstruation but still clearly had little idea on the menstrual cycle, particularly ovulation of women.¹ In a world where they were, as yet, struggling to establish medicine as a respectable profession, practitioners were unwilling to advocate artificial means of regulating reproduction. Their ignorance of basic biology led to some doctors promoting the 'safe period', believing it to be immediately after menstruation.²

The *Dublin Medical Press* reflected the desire of nineteenth-century established medicine to keep control of contraceptive advice; it was scathing in its criticism of any attempt to encroach on to what it designated as its domain. In particular it attacked quack advertising in the popular press, which it referred to as 'obscene advertising'. Judging from the profusion of these advertisements, it is abundantly clear that there was a demand for information on contraception in nineteenth-century Ireland. In 1850, one advertisement in a popular newspaper offered 'Observations on marriage with plain directions';³ later in the century another claimed to 'quickly correct all irregularities so prevalent with the female sex'.⁴ Though euphemistically worded, the purpose of the advertisements was clear. Quacks or irregular practitioners shrewdly thronged the contraceptive void left for reasons of propriety by the established medical profession. Perhaps some of the medical objection to contraception related to its association with quacks and rubber-goods suppliers; also, being at pains to establish the profession as genteel and reputable, it chose to view

¹ Angus McLaren, *A history of contraception: from antiquity to the present day* (Oxford, 1990), pp 194–195.

² Jeffrey Weeks, *Sex, politics and society: the regulation of sexuality since 1800*, 2nd edition (Harlow, 1989) p. 46.

³ *Dublin Evening Post*, 27 June 1850.

⁴ *Dublin Evening Mail*, 18 Dec. 1885.

contraception on moral grounds. Moreover, quackery in any form was perceived as a challenge to the monopoly and professionalism of medicine.

It is difficult to calculate the percentage of Irish people that controlled their fertility in the nineteenth century. Many people chose to buy contraceptives from lay/quack suppliers rather than consult the medical profession, thus demonstrating that birth control was a form of 'self-help'; doctors would inevitably have opposed this¹ and attacked birth control as mere quackery.² The *Dublin Medical Press* viewed contraception as an unsuitable subject for the respectable profession of medicine.

In 1875 the *Dublin Medical Press* outlined its antipathy towards irregular practitioners advertising contraception:

But the ingenuity of these rascals is great, and finding that no decent being will read their dirty advertisements, or have anything to say to them, they have recourse to a ruse which at the same time obtains insertions of their advertisements in respectable newspapers and brings them into immediate communication with a class of persons whose money they covet.³

The subject of this particular advertisement is a book that contains contraceptive information. The book, with the innocuous title *The complete herbalist*,⁴ is in fact far from innocent according to the *Dublin Medical Press*:

a disgustingly indecent trap for the unwary and the prurient – a *vade mecum* of all the beastly immoralities ... We would not be understood if we refrained from printing a few of the headlines. We are told of the contents of the book that – 'It gives all the marriage customs ... It teaches how to prevent conception' ... We blush for the necessity which obliges us to transfer such obscenity to our columns.⁵

¹ Bland, *Banishing the beast*, p. 201.

² McLaren, *History of contraception*, pp 192–195.

³ *D.M.P.C.*, lxx (1875), p. 166.

⁴ Brown, O. P., *The complete herbalist* (Jersey City, NJ, 1872)

⁵ *Ibid.*

The interpretation of contraceptive information as 'obscene' and immoral by the *Dublin Medical Press* is indicative of its attitude towards birth control in general. To artificially control the number of children in a family was effectively to step outside the narrow view of womanhood. Also, the medical profession believed itself too genteel for the subject of contraception, yet railed at irregular practitioners for daring to encroach on its territory.

There is little doubt that morality lurks behind many of the medical men's arguments. Bland notes that it was widely accepted in the nineteenth century that frequent sexual intercourse would damage a woman's modesty, and 'given women's supposed lack of will power, her sexual desires would thereby become wild and untrammelled'.¹ Thus if contraception prevented a fear of pregnancy, could it also release a female's 'latent, uncontrollable sexuality'?² McLaren points out that medicine felt compelled to reproach women who, in their attempts to control their own fertility, were resisting the scientific expertise of the medical man.³ Nineteenth-century medicine assumed that the decision as to whether or not to control fertility was the male's alone.

In 1877 the *Dublin Medical Press*, in an editorial, presented male sexuality as centrally important and suggested that 'continence' (abstinence) would be injurious to the health of a man:

Continence cannot in some cases be long persevered in without injuring the health ... And if it is difficult to observe in the un-married state, it is still more impracticable in the case of those that are married. For as the natural impulse and temptation to gratify the passions are much stronger in married men than

¹ Bland, *Banishing the beast*, pp 193–194.

² *Ibid.*

³ McLaren, *History of contraception*, pp 118–119.

those who have resolved to say single, so would continence be a far greater tax upon the moral courage as well as upon the health of the individual.¹

Note the reference to 'nature' as the journal again attempts to discredit birth control as unnatural. The promotion of the male sex drive as assertive, charged and, ultimately, impossible to ignore points to the implicit belief that a woman should not attempt to control her fertility by abstinence. 'Nature is too strong to admit any such evasion of her laws. The sexual instinct is too strong to admit of its being burked in the married state.' This essentially middle-class discourse on a dominant male sexuality suggests a tacit acceptance of the sexual impassivity of women. Therefore, any attempt by a woman to curtail her fecundity would be construed by the medical establishment as going against the middle-class, socially constructed code of feminine conduct. In 1870 a letter to the editor, signed simply 'Lux', promoted the idea of the 'safe period', stressing that:

All will agree that it is extremely desirable that the number of a family should bear a sensible relation to the pecuniary means of parents; and the public would gratefully acknowledge any advice that our profession could give it as to realising so desirable an object.²

The *Dublin Medical Press* replied primly that no further letters would be printed 'on this subject', and gave no explanation. Its unwillingness even to attempt to discuss control of fertility illustrates the ambivalence of the profession as to its place in society. In order to be defined as a profession of gentlemen, doctors could not be seen promoting contraceptive advice that had previously been linked with illicit sexual intercourse.

¹ *D.M.P.C.*, lxxiv (1877), p. 511.

² *D.M.P.C.*, ix (1870), p. 15.

The medical profession's unwillingness to confront the need for the public to gain information and treatment in the area of sexual health and its paradoxical fury at quacks filling the void continued throughout the nineteenth century. In 1864 the *Dublin Medical Press* printed an article condemning 'a dirty treatise on "Marriage and Reproduction"'¹. The writer stated:

What of moral tendency that might come of a treatise on the subject is lost in this, from its attempt at discussing in unscientific language, the physiological relations of the sexes; what of social influence is destroyed by the unnecessary detail of anatomical relations.²

The indignation of the journal of the subject of birth control being discussed by non-qualified practitioners is apparent. The tone implies that such practitioners are simply not sufficiently enlightened to comprehend the subject of reproduction. The *Dublin Medical Press* is anxious to espouse medicine as a profession that is made up of scientific 'gentlemen', for whom the discussion of sexual intercourse, prudently referred to here as 'anatomical relations' is somehow unnecessary. The drive to aggrandise the medical profession in the eyes of the public did not include the area of contraception. Nonetheless, the journal is jealously guarding medical interests when unqualified practice attempts to fill the void. The *Dublin Medical Press* insists that neither the medical profession nor the community in general could possibly benefit by the circulation of such a work: its only appeal would be to those with 'the vulgar immoral senses, without the attraction of fine language or scientific diction'.³ Clear lines of distinction were being drawn; the medical rejection of contraception was inextricably tied to the struggle for professional and social status.

¹ *D.M.P.*, iii (1864), p. 573.

² *Ibid.*

³ *Ibid.*

‘The purification of the press’¹ continued with the medical profession threatening to remove patronage or simply ‘name and shame’ publishing houses that endorsed quack publications on reproductive matters – i.e. information on birth control or any material on sexual health. Not only was established medicine in Ireland unwilling to discuss contraception on the grounds of propriety, it would not assent to anyone else doing so. The *Dublin Medical Press* announced in 1865, with not a little pride or condescension:

The letter of the editor of the *Commercial Journal*, which we will append, will be read with pleasure by our subscribers, and while it affords us subject for congratulation to ourselves, is most credible to its writer. The proprietor of that journal, and of the *Dublin Advertising Gazette*, has the honour of having been the first of the public journalists to make the *amende honorable*, and while acknowledging the justness of the censure which we found necessary to convey, has raised at once the moral character of his journal above that of his more prosperous and therefore more culpable brethren in our city.²

The letter from the editor of the ‘honourable’ publication states how he was ‘arrested’ by the ‘very forcible articles in the *Medical Press*’ and agreed not to publish the indecent articles, but adds rather wistfully that ‘such exclusion will entail a very considerable loss of income; this class of advertisements being paid for at a very high rate’.³ The *Dublin Medical Press* therefore appears to have had sufficient influence to affect what some other public newspapers were advertising.

In 1865 the *Dublin Medical Press* continued this theme of censorship with regard to the subject of birth control.

We rejoice to perceive that a portion of the respectable English newspaper press has manifested a desire to purify themselves from the imputation of knowingly aiding and abetting the machinations of these swindlers by refusing

¹ *D.M.P.*, ii (1865), pp 333–334.

² *Ibid.*, p. 333.

³ *Ibid.*

to use their columns to be made the traps for the maintenance of these harpies.¹

Irish newspapers did not warrant such praise, according to the medical profession – ‘We are most anxious to be permitted to add to the roll of honour the names of such Irish journals as are willing to sacrifice that source of income to the requirements of decency and propriety, and the maintenance of dignity’.² The *Dublin Medical Press* felt it was within its remit to print the names of Irish newspapers that advertised the offending publications, and to detail the actual advertisements that appeared in the named publications. They remonstrated against the *Evening Mail* for one – a popular daily newspaper – citing the advertisement for contraception as: ‘Curtis on marriage; with instructions for removing the impediments which destroy the happiness of wedded Life’.³ Interestingly, the *Dublin Medical Press* had no scruples about printing the ‘obscene’ advertisements in its own pages, perhaps because the audience were men of science, as opposed to the ‘unscientific’ readership of the other publications. The journal again promotes itself as the indefatigable guardian of public morality against what it interprets as profane and licentious, revealing the implicit professional fear that qualified medical practice would be overrun by the less image-conscious quacks.

In 1875 the *Dublin Medical Press* explicitly stated the moral necessity of its trying to influence what advertisements appeared in other publications. This article explicitly claims that information on contraception is a threat to the set codes of conduct in society.

¹ *D.M.P.*, ii (1865), p. 235.

² *Ibid.*

³ *Ibid.*

We are of an unhesitating opinion that the editor or proprietor of any newspaper who admits to its columns the advertisement to which we referred, being aware of its character and objects, is guilty of selling the morality of his journal, and insulting the decency of his readers for the sake of miserable gain obtained in the trade in such advertisements. He is a wilful participator in an infamous plot against the morals of the public ... We shall certainly not flinch from publishing the name of any journal ... if we find that the advertisement has been continued after the editor has had knowledge of its nature.¹

The journal accuses the quacks of being party to an ‘infamous plot’, illustrating its conviction that contraception was a threat to social stability and the natural order of things. The *Dublin Medical Press* believed itself too respectable a publication to pronounce on contraception, yet its response to contemporary newspapers that merely advertised contraception was little short of tyrannical.

Neo-Malthusians

The social and economic desirability of contraception was originally a nineteenth-century phenomenon.² Medical practitioners had plenty to say about the morals of the lower classes, and viewed with some dismay their ability to reproduce. Athill refers to early marriages of the Irish peasantry in the 1840s with disapproval:

Early marriages were the rule, and it was quite common for lads of eighteen or twenty to marry, settling down in a cabin built of sods, and living a life little above that of a pig ... This was an era when the morality of the Irish peasant was so conspicuous.³

¹ *D.M.P.C.*, lxx (1875), p. 257.

² In 1798 Reverend Thomas Malthus (1766–1834) published his *Essay on the principles of population*, which for the first time focused attention on the social consequences of fertility. His views radically challenged previous economic thought by dismissing the discourse that greater population led to greater prosperity. Malthus promulgated the radical idea that population placed a strain on resources and, consequently, the lower orders needed to practise restraint in the form of early marriages. Malthus, an aristocratic Anglican minister, never advocated contraception, but ‘neo-Malthusians’ interpreted Malthusian views on ‘moral restraint’ and ‘preventative checks’ as indicative of contraception.

³ Athill, *Recollections*, p. 126.

Athill, not unlike the *Dublin Medical Press*, was more concerned with making observations on the morals of Irish society than with the economic and social difficulties that might result from early marriages. The explosion of publicity surrounding the Neo-Malthusian League in the 1870s served to confirm to the *Dublin Medical Press* that contraception was not a respectable topic, and it responded by loudly condemning the movement and its aims.

The 1878 trial in England of the radical MP and lawyer, Charles Bradlaugh, and Annie Besant, a socialist, made contraception a public issue in England and Ireland. The trial, attracting huge sensationalism and publicity, resulted in Besant and Bradlaugh securing the right to publish a pamphlet on contraception: *Fruits of philosophy* by Dr Charles Knowlton.¹ The pamphlet recommended the withdrawal method and the douche or 'female syringe' of homemade spermicide, applied immediately after intercourse.² The Besant and Bradlaugh trial brought contraception to the attention of millions of people; one publishing company alone sold 185,000 copies of the sixpenny edition of *Fruits of philosophy* and the total number of copies sold during 1878–81 was thought to be in the region of 235,000.³ McLaren points out that Knowlton's once-obscure pamphlet was given huge publicity and as a result it was reprinted in the hundreds and thousands, thus showing that there was a clear demand for such literature.⁴ The furore over the trial evidently made its way across the sea to Ireland, judging by the response of the *Dublin Medical Press*, and it seems likely that copies of the booklet were available in Ireland also.

¹ Fraser Harrison, *The dark angel: aspects of Victorian sexuality* (London, 1977) pp 187–188.

² Bland. *Banishing the beast*, pp 191–192.

³ *Ibid.*

⁴ McLaren, *History of contraception*, pp 182–183.

The debate on the Besant and Bradlaugh trial clearly indicates that it was the working classes, young people and women generally whose minds were assumed to be open to such immoral influences and who therefore needed protection. The nub of the problem was that the pamphlet was cheap and accessible.¹ By 1877 the *Dublin Medical Press* was referring to Bradlaugh as a ‘purveyor of immorality’² and Besant as ‘beneath the consideration of those who have any respect for womankind’.³ This moral tone shows irritation at the publicity the case brought to the subject of contraception.

The question before the jury was whether the book was obscene, or immoral, or both, for the obscenity or immorality of a work are two distinct questions ... But the obscenity or not of a book much depends upon the class of readers for whom it was written. What would not be obscene to a medical man or a student in physiology would undoubtedly be obscene to the youth who read it to gratify a prurient curiosity. What is perfectly unobjectionable when written to instruct a bona fide student becomes unpardonable when written with a view of advocating practices that may seriously corrupt the morals of society.⁴

The fact that the pamphlet was written by a member of its own profession must have been a source of discomfort for the *Dublin Medical Press*, but the discourse that the profession needed to protect the morals of society was not a new one. The journal was implying that doctors, by dint of their profession, were somehow immune to information that it believed was detrimental to the morals of the public. Essentially, it is another attempt to validate medicine as a profession possessing unequalled expertise. The medical profession quickly dismisses the arguments put forward in the publication and promulgates morality, as opposed to birth control, as a solution to poverty:

¹ Bland, *Banishing the beast*, p. 192.

² *D.M.P.C.*, ii (1877), p. 174.

³ *Ibid.*, p. 268.

⁴ *D.M.P.C.*, lxxiv (1877), p. 511.

with regard to our own country and our colonies a long period will elapse before poverty, misery, destitution, and crime can be imputed to over-population to such an extent as to warrant the general adoption of the checks upon population that have been advocated by some writers ... much of the want and misery we see around us is not so much due to over-population, as to intemperance, to the improvident habits of the lower classes, to their waste and extravagance. Encourage temperance, encourage thrift and social economy, promote education, and encourage emigration, and we shall suffer little from the effects of over-population.¹

Thus, the *Dublin Medical Press* dismisses the ideas of Malthus and points to a lack of morality among the lower orders to explain the problems of poverty. It warns that the information in the pamphlet would go so far as 'loosening the bonds of society' and that 'Its wide and indiscriminate publication showed the unmarried of both sexes how they might safely indulge their passions, and ... therefore, it had the effect of corrupting public morals'.²

And so to the crux of the issue, which lies in the inference that contraception would encourage sexual intercourse outside marriage by eliminating the fear of pregnancy. The journal again espoused and legitimated the prevailing middle-class ideology that emphasised the role the family, and more specifically the woman, in reproduction. It also sought to discredit individuals outside the profession who attempted to provide contraceptive information by branding them as scurrilous and depraved – the antithesis of the moral middle-class family. Essentially, fertility-limiting practices were denounced by the *Dublin Medical Press* as injurious to society as a whole.

¹ Ibid., p. 512.

² Ibid.

8. Sexual morality

Medicine and sexuality

McLaren points out that middle-class sexual ideology was beset by conflict – on one hand it exalted the passionless female as the paragon of virtue; on the other it believed marriage to be built on mutual love.¹ The female's role in reproduction was upheld as her primary function in life and yet, conversely, she was expected to be impassive and aloof with regard to her own sexuality. Similarly, the middle classes preached virtue and honour in males, yet upheld and at times promulgated the sexual double standard whereby men were free to partake in sexual intercourse outside marriage. The *Dublin Medical Press* promoted existing nineteenth-century middle class ideologies by speaking vehemently on sexual morality. Once again, it stepped from the confines of medicine and healing and discussed sexuality in strong, moral tones. This view of doctors as the champions of public morality would bolster their rapidly expanding role, thus enhancing their position in society.

Essentially, the medical profession had a vested interest in adopting a suppressive tone when discussing sexual morality. They were at pains to raise themselves from their humble origins and portray the profession as one fit for a gentleman. By endorsing prevailing middle class-ideologies, particularly in connection with the constructed codes of feminine behaviour, medical practitioners were in effect allying themselves with the views of the upper middle classes. Medicine was effectively creating a niche where it could comfortably disapprove of the excesses of the

¹ McLaren, *History of contraception*, p. 193.

aristocracy, while simultaneously railing against the perceived licentiousness of the working classes.

Jeffrey Weeks points to the fact that sexuality became a major issue in nineteenth-century social practice, pointing out that 'It was the age when sex was publicly, indeed ostentatiously denied, only to flourish in the fertile undergrowth'.¹ The pervading discourse promoted by the *Dublin Medical Press* was of unassertive sexuality expounded as respectable while non-passive sexuality was inextricably linked with the lower classes, whose poverty was attributed to their licentiousness and promiscuity.

Walkowitz points to a change in late nineteenth-century sexual practices as meanings became less entrenched in middle-class ideas of reproduction.² The demand for more information on sexual issues was becoming more pronounced, as we have seen in the discussion on contraception. As sexual practices changed, new issues were raised and medicine was faced with a conflict of ideologies – the set code of conduct espoused by the middle classes promoting the role of the family or the evolving discourse of a less stringent definition of sexual conduct. Doctors chose the former, promoting marriage and children as the ideal for the proper functioning of society. In 1852 the *Dublin Medical Press* emphasised its belief that matters of a sexual nature were inappropriate topics for those outside medicine, warning its readers of improper advertising in the local press:

How many parents will respond to this appeal? How many will forbid the perusal by their children of beastly allusions to 'the secret infirmities of

¹ Weeks, *Sex, politics and society*, p. 19.

² Judith R. Walkowitz, *City of dreadful delight: narratives of sexual danger in late-Victorian London* (London, 1992) pp 5–6.

youth'; 'the physiology and functions of marriage'; 'the treatment of spermatorrhoea'; 'generative debility'; 'excessive indulgence' and 'preventive lotions'? How many will throw the newspaper in the fire when a little daughter inquires : 'Pa, what is fluor albus, or falling of the womb, or syphilis or stricture, or urino-genital disease?' all which she finds set forth on the scrap with which she curls her hair.¹

Essentially, the journal translates a moral issue into a medical one. Moreover, the little girl who curls her hair would be expected, in a few years, to make the roles of wife and mother her *raison d'être* and yet, simultaneously, the *Dublin Medical Press* expects her to be unconscious of matters of a sexual nature. The irony lies in the fact that doctors sought to protect females from sexuality yet identified reproduction as their most important goal. This contradiction was to pervade the manner in which nineteenth-century medicine attempted to interpret female sexuality.

Bland comments that late nineteenth-century medicine interpreted male sexuality as base and animal.² The sexual drive, specifically of men, was promoted by medicine as uncontrolled and ignominious, beyond the control of the hapless male, who was at constant risk of becoming enslaved by it. Male sexuality was a force to be treated with caution and wariness. Very often, this view of uncontrolled male sexuality proved convenient to rationalise the sexual double standard that legitimated men using prostitutes. The *Dublin Medical Press* corroborated this view of sexuality in 1872 when it printed an article entitled 'Marriage in the army' by Francis R. Hogg M.D., which expounded the value of marriage as a refuge from the base, male sexual instinct. Dr Hogg stipulates that 'marriage is a fortress strong against criminal and foolish suggestions, strong against despair and strong against death itself.'³ He emphasises that 'The sexual instinct is the greatest curse of the human race',

¹ *D.M.P.*, xxviii (1852), p. 46.

² Bland, *Banishing the beast*, pp 3–5.

³ *D.M.P.C.*, lxvi (1872), p. 432.

corroborating the view of sexuality as wild and untrammelled. The doctor promotes marriage as the legitimate means of protecting men from depravity and espouses medical practitioners as the defenders of morality: 'Seeing on all sides the terrible physical, mental and social havoc wrought by sexual vice we feel that the medical profession should do its utmost to stem the evil'.¹ The male 'sexual instinct' is portrayed as 'chaotic' and 'evil' and requires the sexual security of marriage. Consequently, the *Dublin Medical Press* again promotes the medical profession as the guardians of society, whose professional expertise would uphold the morals of society.

'Sexual excess'

In the nineteenth century, the medical profession generally believed that frequent sexual intercourse or, worse, masturbation was an important and frequent cause of mental disorder.² In 1758 Simon-Andre Tissot published *Tentamen de morbis ex manustrupatione*, translated into English in 1832 with the title *Onanism: The effects of masturbation*.³ Tissot believed that all sexual activity was potentially debilitating, and this debilitation was merely more pronounced in the case of masturbation. His view that the primary basis for debilitation was the loss of seminal fluid was accepted widely by the medical profession in the nineteenth century.⁴ He proposed that the loss of one ounce of seminal fluid was equivalent to the loss of forty ounces of blood. This belief is a relatively new one – not appearing before the eighteenth century.⁵

¹ *The Lancet*, ii (1892), p. 1055.

² E. H. Hare, 'Masturbatory insanity: the history of an idea', in *Journal of Mental Science*, cdliv, no. 108 (1962), p. 234.

³ H. Tristram Englarth, 'The disease of masturbation: values and the concept of disease', in *Bulletin of the History of Medicine*, xlvii (1974), p. 235.

⁴ *Ibid.*

⁵ Hare, 'Masturbatory insanity', p. 2.

What was the reason for the medical profession's concern with 'sexual excess'? It would seem that nineteenth-century medicine looked on sexuality and its various facets as a means of promoting its own defined and accepted codes of sexual behaviour. This new aspect of medical proficiency would add yet another string to the expanding bow of the profession.

A moral issue such as sexual practices was now expressed in terms of a medical problem. Vice or 'sexual excess', according to medical men, was a risk to the unmarried but also threatened the moral well-being and indeed the health of married people. The 'disease' of 'spermatorrhea', invented by nineteenth-century medicine, was an example of what Bayuk-Rosenman describes as the medical pathologising of sexual experience.¹ Defined as the excessive discharge of sperm caused by illicit or excessive sexual activity – particularly masturbation – it was an essentially male, middle-class phenomenon,² presumably because middle-class men had the means to pay for medical help. It also appears to be a method of controlling male sexuality by alluding to the inherent dangers of masturbation, promoting the discourse that sexual over-indulgence was debilitating. The *Dublin Medical Press*, in its moral role, condemns 'sexual excess' and points out the disturbing consequences for those that do not heed its advice.

In 1893 the *Dublin Medical Press* printed an editorial with the intriguing title 'Post-marital amblyopia',³ which describes a rather alarming ailment:

¹ Ellen Bayuk Rosenman, *Unauthorized pleasures: accounts of Victorian erotic experience* (Ithaca, NY, 2003) pp 16–17.

² *Ibid.*

³ *D.M.P.C.*, cvi (1893), p. 130.

This condition, sometimes described as Burns amaurosis, consists in failure of vision of variable intensity consequent on sexual excess. The liability of certain persons to this form of amaurosis has long been recognised, and though of rare occurrence, it deserves to be made widely known on account of the prognostic importance of a correct etiological deduction.¹

There is no mistaking the authoritative scientific register of the editorial, lending an air of expertise to the notion that ‘excessive’ sexual intercourse can lead, ultimately, to blindness. The didactic message is abundantly clear. Ultimately, the *Dublin Medical Press* is keen to ensure that the moral values it expounds will be upheld. The editorial concludes, with little reassurance, that: ‘Though recovery is the rule, it must not be forgotten that ... cases may and do occur in which the disease advances to complete, and permanent blindness’.² The discourse of sexual excess and blindness was certainly not a new one; the language the doctors utilise is undoubtedly scientific (‘prognostic’, ‘etiological’) and the moral message is all too clear: that patients must be made aware of the existence of this admittedly rare, though frightening disease. The addition of the fact that ‘certain persons’ are ‘liable’ to contract this disease caused by sexual excess implicitly suggests that such persons are those that do not conform to the sexual strictures of nineteenth-century medicine.

Sexual excess or masturbation proved a subject of much anxiety for the *Dublin Medical Press*, reflecting the medical concern for the morality of young men.

In 1873 the journal printed an article, taken from a French medical periodical, entitled ‘New symptom pathognomic of masturbation’³. It examines how the practice of masturbation can be detected by clinical examination: ‘Dr Baraduc asserts that he has discovered that there exist constantly special characters, as ulcerations and recent

¹ Ibid.

² Ibid.

³ *D.M.P.C.*, lxviii (1873), pp 101–102.

scars, in cases of nympho-mania or masturbation'.¹ The doctor is suggesting that masturbation can now be detected by a medical exam, placing the medical practitioner in a strong moral position, and allowing him: 'to diagnose with certainty that the patient in whom they appear had been abandoning himself or herself to masturbation'.² The patient consequently has no choice but to submit to medical authority, and acquiesce to the medical definition of moral behaviour.

The article concludes: 'The consequence is that when this vice has once been discovered, it may henceforward be combated and cured. We then see those pale, languishing adolescents completely recover their physical, moral, and intellectual health'.³ Again, the discourse of general debility brought on by 'excessive' intercourse or masturbation is referred to. The belief that children, as middle-class symbols of status, required an intensification of parental and medical authority is also at play here. The sexual innocence of the adolescent must be protected in order to preserve the reputation of the middle-class family. Thus the new method of diagnosis would enable the doctor to have a clearer idea as to the sexual morality of his patients if they were unwilling to give him that information. The invasive nature of this procedure seems lost on the *Dublin Medical Press*, in its quest not only to raise the moral tone of society, but to defend the narrow and socially defined codes of sexual conduct upheld by the middle classes.

In 1886 the *Dublin Medical Press* printed an editorial that linked epilepsy with masturbation. This concept centred on the ideology of masturbation as an illness, developed on the basis of the belief that the practice was debilitating. Englehardt points to the nineteenth-century presupposition of a parallel between what is good for

¹ Ibid.

² Ibid.

³ Ibid., p. 102.

one's soul and what is good for one's health.¹ Essentially, if a patient's sexual practice was defined as depraved, then this had a correlation to their physical well-being. The *Dublin Medical Press* outlined how:

The practice [masturbation] is one common with idiots, even such as have been so afflicted from birth; it is therefore evident that here we have to do with a habit which is at least not the cause but most probably the result of the mental deterioration.²

Thus masturbation brought about fearsome consequences.

In 1873 the *Dublin Medical Press* again drew on an article from a French medical periodical (*Gazette M. de Paris*) to strengthen its arguments on sexual morality. Dr Emil Duval highlights a case of 'spermatorrhoea and impotence in a young man aged twenty one' who 'had been a masturbator'.³ The symptoms of this supposed disease centre on the discourse that semen was somehow a vital fluid and that its loss would cause general debility (see above). 'He was pale, thin, and remarked emissions continually. There was pain in the loins and weakness in the feet, with headache, weakness of intellect, and melancholia, loss of voice, with sleeplessness'.⁴ The patient is clearly debilitated, and thus serves as a warning to those who might be tempted not merely to masturbate, but to indulge in what the medical profession considers to be excessive sexual intercourse for fear of losing any more sperm than absolutely necessary.

The cure for this 'illness' is indicative of the discourse that viewed certain sexual activities as unclean:

¹ Enghardt, 'Disease of masturbation', p. 237.

² *D.M.P.C.*, xciii (1886), pp 351–352.

³ *D.M.P.C.*, lxxviii (1873), p. 173.

⁴ *Ibid.*

He was treated by ablutions of water at 24°C morning and evenings ... short walks and the use of cold water were enjoined. In the short time the temperature of the water was lowered ... Lastly, in place of the evening ablution, a shower bath of twenty minutes' duration was substituted, together with a douche for one minute over the whole back and loins ... Next an entire cold bath was ordered for three minutes after the shower-bath. Continuance in this treatment for three months produced a perfect cure. The nourishment and intellect became excellent, and the pollutions and spermatorrhoea left off.¹

The continuous 'ablutions' and the cold temperature are suggestive of a punishment rather than a cure. It is as if the profession is attempting to purify the patient of his illicit sexual practice. This preoccupation with masturbation and its consequences again reflected the *Dublin Medical Press's* desire to prohibit certain sexual activity that it considered immoral, using the language of science to lend weight to its authority. By pontificating on sexual morality, the *Dublin Medical Press* was bolstering its jurisdiction and power in society.

The *Dublin Medical Press* reflects the medical preoccupation with the leisure pursuits and sexual conduct of the public. Much of this chapter examines the interest evinced by the profession in the human body and as such, the medical sense of ownership over the bodies of the public. Doctors became the champions of emerging ideas of respectability in Ireland in the second half of the nineteenth century. Expounding codes of acceptable behaviour in the changing social climate of Ireland in this period would distract from the fact that medical practitioners, while struggling to define themselves as a prestigious social group, had yet to uncover the source of many infectious diseases. Moreover, this medico-moral discourse would in itself add to the expanding sphere of medical authority.

¹ Ibid.

CHAPTER 4: CONTAGION

After the Medical Charities Act of 1851, the medical profession went from strength to strength in Ireland. Evidence of this is the fact that medical men were effectively raising themselves above and beyond the practice of healing, and evolving into a powerful force of commentary on all aspects of society. Both the physical and moral welfare of society came under the scrutiny of the *Dublin Medical Press*, the key instrument of the medical profession in Ireland.

In the mid-nineteenth century, another piece of social legislation would offer Irish medical men the opportunity to aspire to levels of authority and social control never attained before. The aim of this chapter is to chart the medical discourse, as documented in the *Dublin Medical Press*, that led to the Contagious Diseases Act in 1864. This act sought the regularisation of women suspected of prostitution and their forcible examination and detention by doctors. This section of the study seeks to highlight how the medical profession sought to blame women exclusively for the spread of venereal disease and punish them accordingly. Specifically, I aim to illustrate how the *Dublin Medical Press* applied the prevailing ideology of the double standard of sexual behaviour to its scrutiny of women.¹ The debate surrounding the legislation termed the Contagious Diseases Acts served, as this chapter aims to

¹ The double standard of sexuality promulgated the supposed sexual passivity and complacency of women and the sexual assertiveness of men.

illustrate, the class prejudices, gender bias and intrinsic misogyny of the medical profession.

This chapter will firstly examine the medical discourse surrounding sexuality and specifically explore the hostility of the medical profession towards women, especially those women of the working class who did not conform to the traditional definition of femininity that placed great importance on celibacy in women before marriage and sexual passivity after it.

The chapter will then examine the problem of venereal disease, which was creating serious difficulties for the government as increasing numbers of the armed forces were recorded as suffering from syphilis. This section seeks to illustrate how the medical profession sought a scapegoat for the escalation of venereal disease. It is hardly surprising, given its hostility towards and suspicion of working-class women, that it was this group that the *Dublin Medical Press* chose to blame.

The next section of the chapter will examine how the journal validated its calls for the regularisation of women. The medical profession in Ireland, as documented by the *Dublin Medical Press*, did not seek to outlaw the practice of prostitution but rather sought to control women it suspected of being involved in the sex trade. To do this it needed to justify the existence of prostitutes by emphasising the double standard of sexuality, a theory that promulgated the sexual passivity of women and defined men as inherently possessed of a sexual urge that demanded satisfaction. The *Dublin Medical Press* promoted this discourse as an unavoidable reality that warranted the existence of sexually available women.

The chapter then seeks to point out how the medical profession in the second half of the nineteenth century looked to identify women as the natural source of infection. Not content to validate the existence of prostitutes, the medical profession sought to prove that the biological system of the female was conducive to the spread of venereal disease. This discourse gave credence to the medical belief that women – specifically working-class women – were to blame for the spread of venereal disease as opposed to their male sexual partners. Consequently, the next section of this chapter examines what exactly constituted a prostitute according to the *Dublin Medical Press*. Under its very narrow definition of appropriate and acceptable female sexual conduct, women who simply did not conform were suspected and indeed labelled as prostitutes. The increasingly hostile and basically misogynistic view of women continues as the *Dublin Medical Press* attempts to discredit women generally by promoting the discourse of a corrupt and unscrupulous female persona. The journal goes further to suggest that the traditional belief that women sold sexual favours due to seduction and economic necessity is an untruth, pointing to examples of female duplicity and corruption. The chapter also draws attention to the links the medical profession made between public sanitation and public morality, dirt and moral degeneracy, in a further attempt to stigmatise the working-class woman.

The last section of this chapter focuses on the Contagious Diseases Acts¹ and specifically how the *Dublin Medical Press* reflected the profession's support of this legislation, which stipulated the forcible detention and examination of any woman suspected of being a prostitute. This legislation did not seek to prohibit prostitution in

¹ The Contagious Diseases Acts of 1864, 1866 and 1869, which stipulated the forcible examination and detention of women suspected of having venereal disease. The acts were repealed in 1886.

an effort to curb the spread of syphilis, but rather to regularise it so that sexual intercourse with women could be made safe for men. The army effectively sought disease-free women and the medical profession, as represented in the *Dublin Medical Press*, endorsed and legitimated this view. This section aims to examine the views that women posed a grave threat to the army and that the stringent legislative control of women was the only effective way of protecting the army from venereal disease. This tacit exemption of males from any responsibility for the spread of venereal disease encapsulates the Contagious Diseases Acts and the response of the *Dublin Medical Press*.

1. Sexuality: a class issue

The medical profession in Ireland showed in the *Dublin Medical Press* how it attributed ideal social characteristics such as nurturance, intuitive morality, domesticity and passivity to females. Spongberg points out how the ideal of domestic harmony was the basis of the middle-class male's demand for political power.¹ This notion of domestic tranquillity was deeply rooted in the belief of intrinsic female virtuousness. Middle-class women were viewed as either virgins or wives and mothers – not free and autonomous sexual beings. Luddy concurs with this view, pointing out how women in the nineteenth century were not expected to be sexual beings.² The *Dublin Medical Press* idealises the 'respectable' woman, expounding the necessity of her celibacy before marriage and emphasising the centrality of her reproductive role. It points to the 'softer domestic and maternal instincts and hopes'³

¹ Mary Spongberg, *Feminizing venereal disease: the body of the prostitute in nineteenth century medical discourse* (London, 1997), p. 9.

² Maria Luddy, 'Prostitution and rescue work in nineteenth century Ireland' in Maria Luddy and Cliona Murphy (eds) *Women surviving: studies in Irish women's history in the nineteenth and twentieth century* (Dublin, 1989), p. 69.

³ *D.M.P.C.*, lxii (1869), p. 253.

of this ideal woman and refers to the 'qualities of her delicate nature'.¹ In 1862 the journal stressed how 'modesty' was 'an ornament and distinctive quality of the sex';² ten years later it outlined the ideal characteristics of 'respectable' women: 'Women ... are characterised by warmheartedness, by love, gentleness, timidity, and a bearing which does not appertain to the other sex'.³ These characteristics emulated the prevailing middle-class codes of female conduct associated with social stability and the proper functioning of society. In an editorial entitled 'The doctor's wife', the *Dublin Medical Press* in 1888 espoused the traditional definition of femininity:

The doctor's wife is, or should be, a lady with peculiar attributes of her own. Not garrulous, or talkative, only about subjects as to which she desires information, she generally holds strong views on matters hygienic and ... questions affecting children's diet and general welfare. She is almost always a peremptory domestic manager'⁴

Thus, the consummate woman embodied characteristics that defined her subordinate role in the domestic sphere and emphasised her maternal role. Essentially, medical men, as represented by the *Dublin Medical Press*, championed an ideological system of ideal womanhood, rigid in its support of tradition. But the journal was not concerned with documenting the reputable woman, at least not in any great detail; rather, the *Dublin Medical Press* was deeply preoccupied with the activities, sexual and otherwise, of non-conforming women, and devoted much space to effective means of controlling them.

The working-class woman was the antithesis of the middle-class ideology of accepted feminine behaviour. Her presumed sexual availability flew in the face of a discourse that wished to present women as sexually contained. The *Dublin Medical Press*

¹ *Ibid.*, pp 506–507.

² *D.M.P.*, vi (1862), pp 31–32.

³ *D.M.P.C.*, lxvi (1872), p. 558.

⁴ *D.M.P.C.*, xlv (1888), pp 94–95.

concurred with the view that women were naturally chaste, with an inherent and intuitive morality, and, unlike men, were not hampered by sexual urges. Women that failed to conform to these confines of sexual conduct were viewed as unnatural and irregular. Middle-class thinking – and indeed medical discourse – could not accept the possibility of females as sexual beings, and so women that showed a propensity for sensuality were seen as depraved and pathological.

Walkowitz points out that in trying to uphold the patriarchal family, medical men regarded any movement away from this ideal as pollution, endangering not only the nucleus of the family but society as a whole.¹ It seems reasonable to assume that in Ireland, the lower-class woman was the antithesis of this medical, middle-class ideal of femininity; the medical articles of the time support this view. Fear of sexual disease represented a wider fear of women, and any attempts to control sexual disease were ostensibly attempts to control women.

2. Syphilis

In the century after the Restoration one disease was particularly common, namely syphilis.² Thought to be American in origin, it broke out in 1493 during a war between Spain and France waged in Italy, and spread throughout Europe.³ This disease excited particular revulsion partly because it possessed all the usual stigma of a sexually transmitted disease but also because of its salient features. Syphilis begins with genital sores and progresses to a general rash and eventual ulceration of such areas as the nose, lips and genitals of the patient. These ulcerations can progress to

¹ Judith R. Walkowitz, *Prostitution and Victorian society: women, class and the state* (Cambridge, 1980), p. 44.

² Roy Porter, *Quacks: fakers and charlatans in medicine* (London, 2000), pp 210–211.

³ Porter, *Greatest benefit*, p. 166.

large abscesses that eat into bone and destroy tissue, literally rotting the flesh of the victim. It is now known that syphilis is one of several diseases caused by members of the *Treponema* group of spirochetes – a corkscrew-shaped bacterium. In the second half of the nineteenth century, when scientific advance was minimal, the disease evoked dread and horror among the populace. It was glaringly conspicuous, a manifestation of shameful and illicit sexual behaviour. Moreover, it patently marked out those who failed to conform to the idealised roles set out for the sexes by middle-class ideology. But above all, it was syphilitic women that exhibited the ultimate defiance of these prevailing ideologies, by evincing indisputable signs of their sexual encounters.

The government interest in curbing syphilis led to a growing platform for the *Dublin Medical Press* to voice its morals and in turn, boost its power. The public ignorance, fear and horror of venereal disease were used to full advantage by the doctors as they sought to establish a scapegoat.

Syphilis began to represent to many Irish medical writers a form of just punishment, an agent of retribution for the practice of illicit sexual intercourse. It was discovered that gonorrhoea could infect only the internal organs and thus carriers could go undetected. Medical rationale centred on the assumption that syphilis was spread through promiscuous sexual contact with prostitutes.¹ But, in truth, doctors knew virtually nothing about the disease throughout the nineteenth century.² They knew it was an infectious disease and was usually introduced into the system by ‘impure’ sexual contact, but the duration of the disease and the fact that it could go undetected

¹ Walkowitz, *Prostitution and Victorian society*, 48.

² Ibid.

for years confused and frightened them. Mercury remained the primary treatment, but this was primarily based on the popular humoral theory of the nineteenth century – that drastic remedies were needed to neutralise a dangerous poison.¹ Essentially, doctors knew little of the physical character of syphilis and recognised that mercury affected the side-effects but not the actual disease. Mercurial treatment in itself involved internal and external application, with bathing, sweating and steaming.² The treatment was unpleasant, often very painful and also highly conspicuous. Moreover, untreated syphilitics had lower mortality rates than syphilitics with mercury treatment.³ Doctors knew little (very like the other endemic diseases of the time, such as cholera and typhus) of what actually caused a syphilitic infection. What they were certain of was the circumstances in which the infection arose and they were convinced that this centred on illicit intercourse – in other words, sexual relations with a prostitute. It was now that the established medical profession in Ireland and Britain, armed with its established middle-class moralities, sought to define acceptable codes of sexual behaviour.

In the 1860s Irish doctors began to determine syphilis as a serious health hazard for the general population. The fact that advertisements for syphilis cures appeared in even the most respectable newspapers suggests the prevalence of the disease and the public fear of it. For example, the *Dublin Evening Post* advertised a pamphlet on its front page:

The Silent Friend: A Medical work on the infirmities of the generative system in both sexes; and on the loss of the reproductive powers, with means of

¹ Ibid., pp 52–53.

² Porter, *Quacks*, pp 215–216.

³ Walkowitz, *Prostitution and Victorian society*, p. 48.

restoration. The baneful effects of solitary indulgence, neglected gonorrhoea; stricture, secondary symptoms.¹

The 'secondary symptoms' refers to syphilis and the advertised pamphlet reflects how quack practitioners were exploiting the general fear of the Irish public.

By the mid-nineteenth century, British military medical returns gave cause for alarm. By 1864, one out of three sick cases in the army was venereal in origin.² This alarm was to spread to Ireland. Richard Carmichael, superintendent of the Dublin Lock Hospital by 1814, had subdivided venereal infections into four major classes, each of which he believed had a specific poison, an unusual primary manifestation and a distinct series of constitutional affects.³ In other words, persons carrying the disease might not always have physical manifestations of it. Essentially, doctors became increasingly interested in the idea of personal contamination and while the government concentrated on legislation on the dangers of physical contamination, medical men became increasingly interested in the morality of particular diseases. The government interest in curbing syphilis led to a growing platform for the *Dublin Medical Press* to voice its morals and in turn, boost its power.

The public ignorance, fear and horror of venereal disease was used to full advantage by the doctors as they sought to establish a scapegoat. In the early 1800s, ideas about the nature and the spread of venereal diseases altered radically.⁴ It was discovered that gonorrhoea could infect only the internal organs and thus carriers could go undetected. Medical rationale centred on the assumption that syphilis was spread

¹ *Dublin Evening Post*, 7 Feb. 1850.

² Walkowitz, *Prostitution and Victorian society*, p. 49.

³ Spongberg, *Feminizing venereal disease*, pp 30–31.

⁴ *Ibid.*, pp 5–6.

through promiscuous sexual contact with women.¹ However, the medical profession remained in the dark with regard to the essential characteristics of the disease. In 1864, the *Dublin Medical Press* reflected this anxiety:

We know that syphilis spreads insidiously and in many occult modes, and as it is in the nature of things that those who are attacked with it should, with all their power, endeavour to conceal their illness, it often becomes impossible with certainty to trace its origin.²

The fear of the disease is evident as the article continues: ‘I have heard medical men express great dissatisfaction that such patients should eat and drink at the same table as healthy persons, dance at balls, nay even travel’.³ This emphasis on the contagion suggests that the medical profession was unclear as to how syphilis was spread, and underlines the prevalent medical ignorance regarding venereal disease in general.

The fact that the medical profession, as with typhus and cholera, could find no specific cause or cure for venereal disease⁴ did not deter it. This chapter seeks to show how the upsurge in syphilis and the impending legislation were a catalyst for transfer of power to an already status-conscious profession that, as we have seen earlier, was desperately trying to establish itself as viable and respectable. The Contagious Diseases Acts placed considerable power in the laps of the medical profession.

3. The double standard of sexuality

The medical discourse on the spread of syphilis in nineteenth-century Ireland was deeply rooted in the middle-class division of acceptable sexual behaviour. Bartley

¹ Walkowitz, *Prostitution and Victorian society*, p. 48.

² *D.M.P.*, ii (1864), p. 504.

³ *Ibid.*, pp 504–505.

⁴ Spongberg, *Feminizing venereal disease*, p. 36.

emphasises that monogamy was considered essential in middle-class women but men of all classes enjoyed greater sexual freedom since the emotional, psychological and physical nature of the sexes was thought to be inherently different.¹ Sexual desire in males was viewed as aggressive, overpowering and, ultimately, uncontrollable. Females were seen to have little sexual desire. Doctor William Acton,² an English surgeon and self-professed expert on sexology, held the idea that ‘The majority of women (happily for them) are not very troubled with sexual feelings of any kind’.³ Acton’s work *The functions and disorders of the reproductive organs* (1857) ran into six editions by 1901, pointing to its popularity. His conception of male sexuality and female sexuality tied in with the prevailing ideologies of appropriate sexual behaviour espoused by the medical profession. Acton draws a clear distinction between middle-class and lower-working-class women, describing the latter as ‘loose or, at least, low and vulgar women’ and he believed that ‘modest’ women vindicated ‘female nature from the vile aspersions cast on it by the abandoned conduct and ungoverned lusts of a few of its worst examples’.⁴ This distinction between the idealised middle-class woman, purported to embody an intuitive morality and sexual passivity and the woman of the lower classes who, by her dress, her mannerisms and her behaviour intimated a forbidden sexual excess, was to shape the response of the medical profession to the spread of syphilis. The *Dublin Medical Press* espoused the discourse of a passive and sexually indifferent female that was irreconcilable with and wholly divergent from her lower-class counterpart.

¹ Paula Bartley, *Prostitution: prevention and reform in England 1860–1914* (London, 2000) pp 6–7.

² Dr William Acton (1814–1875), a venereal specialist, worked in St Bartholomew’s Hospital in London and was deeply committed to state intervention with regard to the regularisation of prostitution. He studied in Paris and greatly admired the French system of detention and forced examination of women. He was the son of a provincial clergyman and had an evangelical position on sexuality and prostitution. His work greatly influenced the British and Irish medical establishment.

³ William Acton, *The functions and disorders of the reproductive organs in childhood, youth, adult age and advanced life, considered in their physiological, social and moral relations* (London, 1857), p. 101.

⁴ *Ibid.*, p. 102.

Spongberg points out that ‘The dominant discourse equated masculine social, economic and industrial vigour with sexual vigour – primacy was given to men’s sexual uncontrollability’.¹ Although Spongberg is drawing her conclusions from an English context, we can reasonably assume, particularly when examining the *Dublin Medical Press*, that these dominant middle-class discourses had resonance in Ireland. The journal promoted the view that male sexual impulses could never be completely repressed or harnessed, and so the existence of prostitution in Ireland was a necessary evil.

In 1873 the *Dublin Medical Press* published a letter to the editor in which the author, a Dr Alexander Lane, alludes to the medical view of male sexuality. The doctor depicts the sexual nature of men as so audacious and assertive that most men are unable to restrain it. He urges how, despite later marriages, ‘the sexual appetite still retains its natural force, and daily calls loudly for indulgence’.² The doctor outlines how most young men ‘commit fornication as often as the opportunity for so doing presents itself’. He asserts:

I cannot... look upon the presence in our midst of a class of professional women as altogether an unmixed evil, for I believe that were such a means, deplorable, as the necessity for its existence must ever continue to be, of gratifying their inclinations unattainable by young men ...³

This tacit acceptance of the double standard of sexuality and the view that a certain class of women should be made sexually available for men lay behind much of the medical discourse on prostitution. Moreover, the idea that men had a vigorous and

¹ Spongberg, *Feminizing venereal disease*, p. 10.

² *D.M.P.C.*, xvi (1873), pp 40–41.

³ *Ibid.*

commanding sexual drive legitimised the existence of a group of women who accepted money for sexual intercourse. When, and if, the average middle-class young man resolved to dispense with his virginity he was obliged to look to lower-class women – on no account could he look to a member of his own class. Economically, middle-class men had a considerable investment in the continuation and expansion of prostitution. Women were seen as a necessity for young men who were not, as yet, in a financial position to marry.

The *Dublin Medical Press* in 1855 outlined a case that reflects the existence and acceptance of a double standard of sexuality in the nineteenth century. The cavalier attitude of the medical men suggests they were willing accomplices for errant husbands. It is reported that ‘a young married woman, aged 20’ was admitted to St Vincent’s Hospital in Dublin:

She is much emaciated; her countenance expressive of suffering ... She has been married two years, and has one child, which is aged about a year. Somewhat more than a year ago her husband contracted syphilis.¹

There is no moral outrage from the medical journal or indeed the doctor who treated the woman. There is no outcry, so characteristic of medical men in this period, on the moral decline of society or the dangers of sexual indulgence. In short, no blame is apportioned at all.

In 1864 the *Dublin Medical Press* alluded to the suspicion that women were secret carriers of venereal disease, infecting others without showing any outward signs of syphilis:

¹ *D.M.P.*, xxxiii (1855), p. 257.

it is very common for married women to acquire a constitutional taint, without having had primary or secondary disease, and therefore, without either themselves or their husbands having the slightest suspicion as to what has happened.¹

The implication appears to be that a woman had the potential to be a carrier of venereal disease and, moreover, could infect her male partner without his knowledge. That a married woman could be infected by a source other than her husband appears to be the suggestion. There is an implicit acceptance of male sexual licence.

In 1886 the *Dublin Medical Press* printed a letter to the editor from a Dr William H. Pearse that reflects the medical acceptance of the double standard of sexuality:

I see a good deal of syphilis amongst ... young married women. It is not uncommon for young women to get syphilis immediately on marriage; many women who have been married years get it from their husbands.²

The doctor does not depict these wives as victims or make any recriminations to the husbands. He adds by way of an explanation: 'I have every reason to think that often, such husbands give their wives disease through having gone astray once only'.³ Thus, the male is exonerated from passing on venereal disease because his propensity to have more than one sexual partner is tacitly accepted in the pages of the *Dublin Medical Press*.

Of one patient, 'a very ill woman' who had been married twenty years, it was stated that: 'About seventeen years ago her husband gave her what she calls "the bad disease"'.⁴ In another case, a male patient 'aged 34, applied to me on the 11

¹ *D.M.P.*, ii (1864), p. 297.

² *D.M.P.C.*, xcii (1886), p. 486.

³ *Ibid.*

⁴ *D.M.P.C.*, xciii (1886), p. 265.

September ... in great suffering and distress of mind. He was covered with syphilitic eruptions; his tongue was enormously swollen ... the mouth ... ulcerated throughout.¹ There are no questions as to how he came to be infected; the medical man adds:

A very interesting feature connected with this case, is the fact that this person married while his system was fully impregnated with the syphilitic poison, his wife became pregnant, and as it has been stated that secondary syphilitic disease could and would be communicated to the mother by the foetus in utero, I anxiously looked for any symptoms of the disease. None has appeared, and a fine healthy child has since been born, without (at present) a syphilitic trace.²

Is the doctor suggesting that it is safe for a syphilitic man to impregnate his wife? In the debate of blame that follows, these calm pronouncements regarding the male as carrier are almost incidental. Ultimately, it is not the philandering male who is brought to book for the alarming rise of syphilis in Ireland but rather the female and, more specifically, the lower-class woman.

In 1871, a Rev. Maguire outlined the inherent acceptance of the double standard of sexuality when he offered this testimony to the royal commission set up to examine the Contagious Diseases Acts:

That half our married men and half our youths would be preserved from misfortune if they did not meet these unfortunate women in the streets. They never would dream of sinning, and it is the looseness and freedom of these women who can walk the streets at night that, generally speaking, have trended to the immorality of our youths and advanced men.³

¹ *D.M.P.*, xlvi (1861), p. 232.

² *Ibid.*

³ *Royal commission on the administration and operation of the Contagious Diseases Acts, ii, minutes of evidence* [c. 408-1], H.C. 1871, p. 677.

Maguire voices the view that women are sexually predatory and portrays men as their passive victims. This of course bolstered the discourse that sought to hold women wholly accountable for the spread of syphilis, thus validating the legislation that would stipulate their forceful detention and involuntary medical examination.

In 1873 the *Dublin Medical Press* again alluded to the double standard of sexuality so inbuilt in the Contagious Diseases Acts. They stipulate in an editorial that ‘It can hardly be supposed, with the moral constitution peculiar to men of this class and temperament, that the procreative instinct can be entirely suppressed or be absent’¹. This validation of the uncontrollable nature of male sexuality concurred with the legislation that sought to make a certain class of women sexually available to men. In the same year, the *Dublin Medical Press* alluded to the ‘passion that overwhelmingly exists, that is one of the most potent in our nature’ and pointed to how ‘women naturally take advantage of it to pursue a business or trade which is obviously dangerous, and is, as incontestably proved to be within complete control’.² Again, women from the lower ranks of society are framed as sexual aggressors that seek to entrap and infect their ‘passive’ male partners.

4. Women as the primary source of infection

The nineteenth-century medical ideology that placed the body of the woman as a centre of infection is a recurring theme in the columns of the *Dublin Medical Press*. As the century progressed, medical science promoted the discourse that the female body was naturally predisposed to carry infectious diseases. Walkowitz refers to

¹ *D.M.P.C.*, xvi (1873), pp 253–254.

² *D.M.P.C.*, xvii (1873), pp 188–149.

Foucault's new 'science of public sexuality'¹ – which identified sex as a social issue and rigidly differentiated male from female sexuality. From the 1830s onwards the female body came to be medicalized, not merely as a sexed body but as a diseased body – a space where disease could and did fester.² Acton's 1851 text, *A practical treatise on the diseases of the urinary and generative organs* (in both sexes), indicated the links between femininity and disease.³ The *Dublin Medical Press* discussed what they perceived as the sexual depravity of the lower orders, particularly women, and developed an assumption that this constituted a threat to the moral and, potentially, the political order. Working-class morality and all it entailed reflected, according to the *Dublin Medical Press*, early signs of malfunction in a healthy social body.

As early as 1830, Philippe Ricord, a specialist in venereal disease in Paris and a tutor to William Acton, emphasised the vagina as a pathological site by stressing that it was a mysterious organ, capable of producing secret and dangerous substances.⁴ Acton himself, in his work *Prostitution considered in its moral, social and sanitary aspects in London and other large cities, with proposals for the mitigation and prevention of its attendant evils* (1857) maintained that the vagina was the principal medium through which venereal disease is transmitted. Lucy Bland points out how medical journals continued to preach the necessity of preserving modesty – an essential female trait, for once it was lost, a woman became utterly changed and entered into a state of pathology and vice.⁵ Essentially, the body of a female was seen as sick and diseased and the *Dublin Medical Press* espoused this view. Thus the term 'prostitute' was used to describe not merely women who exchanged sexual intercourse for money, but

¹ Walkowitz, *Prostitution and Victorian society*, pp 4–5.

² Spongberg, *Feminizing venereal disease*, p. 35.

³ *Ibid.*, pp 48–50.

⁴ Spongberg, *Feminizing venereal disease*, pp 39–40.

⁵ Bland, *Banishing the beast*, p. 60.

women who did not conform to the narrow definitions of femininity and sexual behaviour propounded by the middle classes.

Syphilis was no longer a problem involving all of society. Increasingly, the *Dublin Medical Press* was defining venereal disease as a problem involving a particular gender and a specific class. There is no call on the state to intervene to control the women's male paying customers. They are, according to the *Dublin Medical Press*, merely being guided by 'inherited passions' and thus in the eyes of the medical profession are blameless. There was an acceptance and a justification of male sexual impulses and, with syphilis on the increase at an alarming rate, all eyes turned to the lower classes and, in particular, the common prostitute as a figure of blame. An influential work by the French venerealist Alexandre Parent-Duchatelet (*De la prostitution dans la ville de Paris* [1836]) saw women strictly in terms of a public health problem. In fact, Duchatelet was to be dubbed the 'Newton of harlotry'¹ and it was his thinking on the importance of vaginal discharge that would support the belief that the body of the female was naturally susceptible to disease. The fact that Duchatelet's work emphasised that there was no physical difference between the vagina of prostitutes and ordinary women added to the suspicion that any woman had the potential to be amoral.

Medical men were now emphasising vaginal discharge where previously the penis as the site of disease had taken priority among venerealists. The spread of the disease was demanding some form of definitive action, or at the very least a scapegoat. The authority of a medico-scientific discourse on the body of the woman would lend

¹ Walkowitz, *Prostitution and Victorian society*, p. 36.

respectability to this view. Nineteenth-century medical practitioners expanded Acton's thinking that women 'naturally produced' venereal disease through their bodily discharges.¹ While the chancres, sores, etc. on the penis indicated venereal disease, vaginal discharge was a natural part of the female menstrual cycle and not indicative of venereal disease. This did not deter the medical authorities, who came to argue during the 1830s that it was quite possible for all women to carry some taint of venereal disease.² Consequently, the fact that all women could be carriers without exhibiting any outward manifestations of the disease added to the scaremongering and increasing fear and hostility of female sexuality that was outside male middle-class control.

A medical practitioner hinted at the undercurrent of distrust of females in relation to venereal disease in an article in the *Dublin Medical Press* in 1863.

I refer to the occurrence of tertiary symptoms of an unmistakable character in married persons who deny all history of primary or secondary ones. Of course the denial of previous symptoms by the patient herself must never rank as of the slightest value as evidence unless corroborated by other facts, of which the surgeon can himself judge ... the chief reason for believing that cases of the kind alluded to are not unfrequently bona fide is afforded by their common occurrence.³

This article is explicitly pointed at women and suggests both the female ability to conceal the nature of her disease and her propensity to deceive medical attendants. The implicit warning is that women cannot be trusted with regard to infection, and consequently any woman whose sexual practices are outside the definitive codes of feminine conduct is a potential carrier. The belief that women could harbour infection

¹ Spongberg, *Feminizing venereal disease*, p. 52.

² *Ibid.*

³ *D.M.P.*, xlix (1863), p. 503.

but show no physical sign of the disease was repeated again and again in the *Dublin Medical Press*, creating an air of distrust and fear of female sexuality.

The *Dublin Medical Press* printed an address to the Dublin Students' Medico-Chirurgical Society by a Dr C.T. Abbot in 1850 with the title 'Can primary syphilis exist in the female without her knowledge?'.¹ Again, the subject of the surreptitious nature of female venereal disease is aired. Almost immediately, Abbot says the question of female venereal disease is clouded by 'details of their cases from the patients themselves, details most of which are fallacious and designed to mislead us'.² He refers to a case study where the female patient is described in less than favourable terms: 'though passing in a rather respectable position in society, [she] had nevertheless given occasion more than once to have her virtue questioned'. The moral tone is unmistakable and yet, for the most part in the *Dublin Medical Press*, this is absent when discussing male venereal patients. The doctor had treated two men for syphilis, with whom the girl had 'connexion', while she denied having the disease; Abbot emphasises that she did not present with any symptoms despite thorough examination by the doctor. Eventually, the female patient became very ill with an ulcerated sore throat and 'buboes in the groin area' – both certain symptoms of syphilis. Abbot concludes:

I assure you, I was very much relieved to find she had syphilis, in which we may regard both as primary and secondary form, for I had conceived it a very hard case that a girl should continue to infect a whole neighbourhood while she herself continued to all appearances in good health.³

The article intimates a moral message that all women are potentially infected with venereal disease and that outward signs of respectability and health are no guarantees

¹ *D.M.P.*, xxiii (1850), pp 162–163.

² *Ibid.*

³ *Ibid.*

of immunity. The didactic tenor of this address suggests the medical discourse that points not only to the supposed conspiratorial and underhand nature of women, but also to their biological ability to hide the nature of their disease, enabling them to infect countless men.

In 1864, the *Dublin Medical Press* once again alluded to the discourse of women as sites of infection. This article outlines the failure of new medical breakthroughs to stop syphilitic women from producing infected infants: 'The hope was ... soon destroyed, as it was found that, women, in whom all morbid phenomena had disappeared, nevertheless gave birth to syphilitic children'.¹ Thus, the fear that seemingly healthy females could carry traces of the disease eliminated no woman from suspicion. The article concludes rather insidiously: 'In many of these cases it was proved that the father was entirely innocent'.² Thus, females were defined as the ultimate carriers of this disease and no one was safe from the possibility of contagion, not even infants. For the good of all mankind, the medical profession believed, the woman, as opposed to the male, must be regulated and controlled.

To illustrate the point that all women and not merely the conspicuous, commonly attired prostitute on the street were seen as carriers of syphilis, an article in the *Dublin Medical Press* in 1892 states:

To prove from a public health point of view the present conditions of the law is unsatisfactory, I may mention that within the last two months, the following cases have come under my observation:

1. A – Age 22, unmarried, envelope maker, living with her parents.
2. B – Age 18, unmarried, living as a domestic servant.
3. C – Age 18, unmarried, living with her parents.
4. D – Age 20, unmarried, no occupation, living with her brothers and sisters.

¹ *D.M.P.*, vi (1864), p. 478.

² *Ibid.*

5. E – Age 17, unmarried, primary sore, rash, sore throat, suppurating bubo, housekeeping for her brother.¹

The *Dublin Medical Press* appeared anxious to advance the notion that the most innocent working-class woman represented potential sites of disease. It underlines the fact that though the girls are unmarried, they have experienced sexual intercourse – a direct breach of middle-class sexual mores. Consequently, this stigmatising of young, single working-class women legitimated the medical profession, imbued with a sense of morality, to dehumanise and ultimately degrade. Essentially, the medical discourse looked to blame women from the poorer ranks of society for the spread of syphilis, and it is this that underlines the ultimate misogyny of that discourse.

In 1892, an unnamed doctor wrote to the editor of the *Dublin Medical Press* of cases of syphilis in young women that he had encountered. Again, he pointed to the fact that the girls he treated were ‘living as virtuous members of society with respectable people’. The doctor outlines how this:

discloses an alarming and insidious danger to the public health of the city. This feeling was riveted on me when I saw the last named of these girls performing her duties as a housekeeper and selecting meat in a butcher’s shop – she was evidently hard to please for she inspected and handled whatever came within her reach.²

The idea the *Dublin Medical Press* desires to promote is that prostitution is rife, no working-class woman is beyond suspicion and, as carriers of this disease, these women are a threat to the very core of Irish society. The fact that the doctor refers to his patient handling food, suggesting she was ‘infecting’ the food, points to the lack of knowledge of the medical press as to the infectious nature of venereal disease.

¹ *D.M.P.C.*, civ (1892), p. 663.

² *Ibid.*, pp 662–663.

In 1889 The *Dublin Medical Press* printed an editorial titled ‘Sentimentalism versus syphilis’, which stated: ‘of all the scourges that affect mankind it may be doubted whether there is any one more subtle and terrible than syphilis’.¹ Syphilis went beyond class division: ‘The victims of syphilis are to be found in every rank of society, from prince to peasant’. But the finger of blame is again pointed not at the varied classes of men, but at women – specifically women engaged in prostitution, whom the *Dublin Medical Press* identify as the primary source of venereal disease: ‘a diseased prostitute, especially in large cities, becomes a frightful source of danger and infection’.² The woman was, in effect, the source of contagion, her sexual partners blameless by virtue of the tacit acceptance of the double standard of sexual conduct by the medical profession. As the century progressed, the medical discourse on women engaging in prostitution become increasingly degrading until they were ultimately dehumanised as channels to be purified for the good of society.

5. Defining prostitution, defining women

As the debate surrounding the spread of venereal disease grew more intense, prostitution became increasingly utilised as a moral term. The term ‘prostitute’ or ‘fallen woman’ in the medical discourse on venereal disease identified not merely women who exchanged sexual favours for money but any female who fell outside the espoused and socially defined constraints of femininity, i.e. any woman who had sexual experience outside the boundaries of marriage. The traditional portrait of a

¹ *D.M.P.C.*, xcix (1889), p. 234.

² *Ibid.*, pp 234–235.

prostitute as a woman who propositions men on street corners is a limited one and indeed, for this study, wholly misleading.

Dympna McLoughlin asserts that there was a diversity of sexual unions among the lower classes in the nineteenth century, highlighting the existence of 'irregular unions' in the very poorest ranks of society.¹ These unions were not recognised by church or state and were regarded by the middle classes as illicit. Lombe Athill observes that a couple would 'run away together, some evening after dark to a neighbour's house'.² Athill further attests that 'I knew of many of these runaway matches ... in 1846, our housemaid having gone off thus one evening with a lad who worked for my father' and concludes that this was 'the era when the morality of the Irish peasant was so conspicuous'.³ This suggests that the narrow definition of legitimate sexual union upheld by the middle classes had little resonance with those lower down the social scale. Sexual unions among the lower orders lacked the rigidity of the middle-class equivalent, and the narrow definitions that so curtailed middle-class women applied less to working-class females. Thus, the idealised figure of the impassive and nurturing woman that validated conventional ideas of femininity and female sexuality was incomprehensible to the poorer classes. This did little to modify the disapproval of the medical profession, who interpreted this behaviour as a threat to the proper functioning of society.

The *Dublin Medical Press* in 1868, in an editorial, alluded to common law unions among soldiers:

¹ Dympna McLoughlin, 'Women and sexuality in 19th century Ireland', *Irish Journal of Psychology*, xv, nos 2 & 3 (1988), pp 266–275.

² Athill, *Recollections*, pp 126–127.

³ *Ibid.*

It is found that inasmuch as love laughs at locksmiths, so Cupid, as represented by the soldier, sets regulations and orders in matters Hymeneal, at defiance. It accordingly so happens that, besides those whose wives are what is called 'borne on the strength of the regiment', a number varying, according to circumstances are 'married' without leave.¹

This rather cryptic report suggests that soldiers formed sexual unions with women while they served with particular regiments. Could this union be interpreted as prostitution by the scandalised medical profession?

In 1873, a letter to the editor signed 'The reviewer' appeared in the *Dublin Medical Press*. The author refers to soldiers who 'marry without matrimony – which I conclude, is the newly invented delicate term for natural weakness',² and goes on to state that he would have 'no hesitation in branding this woman a prostitute'.³

Essentially, these common law unions were clearly not regarded as such by the people involved in them but were interpreted as such by a class and by a profession because they failed to adhere to the narrow definitions of acceptable sexual behaviour.

In 1871 a Catholic priest, Rev. Maguire, reflected how 'prostitute' was an obscure term, open to the interpretation of anyone.

A woman picked up with a young man lately. She got into my district, and the mother of this young man complained to me that he was living with this woman, who was a notorious bad character; in fact he had some children by her ... and she was sent out, but she went to the neighbouring parish.⁴

The priest states that this man followed his partner to the neighbouring village; his mother then asked the priest if he would be dismissed from the foundry where he worked. The unfortunate woman who was forced to leave her home with her children

¹ *D.M.P.C.*, vi (1868), pp 392–394.

² *D.M.P.C.*, xvii (1873), p. 20.

³ *Ibid.*

⁴ *Royal commission on the administration and operation of the Contagious Diseases Acts, ii, minutes of evidence* [c. 408-1], H.C. 1871, p. 680.

was evidently involved in an 'irregular union' with this man but was seen by society as a 'notorious bad character'.

The sexual union between an upper-class man and a woman of the poorer ranks of society, referred to by McLoughlin as a 'gentleman's miss', existed in nineteenth-century Ireland.¹ The man would provide for this woman and very often the union would result in children. In 1870 the *Dublin Medical Press* published a letter to the editor by a Dr Henry Williams that refers to:

the innate vanity of women who love to be made much of, especially those who may be in a station superior to themselves in society, as in the case of illegitimate children, you often hear the relatives say 'Never mind my dear, the father's a gentleman, that's a comfort' and many girls prefer being the mistresses of rich men than the wives of poor ones'²

This attests to the diversity of sexual relations prevalent among the lower orders.

What is pertinent to this study is how the middle classes and, therefore, the medical profession in Ireland would respond to these unions, particularly at a time when a scapegoat was required to take the blame for the spread of venereal disease. The working-class woman – the very symbol of working-class depravity, embodying sexual availability – seemed an obvious choice.

William Acton, who had studied in Paris under Philippe Ricord (see above) and admired the Parisian system of state regulation of prostitution, classified reasons why women became women into categories such as 'natural desire' and 'natural sinfulness'.³ The emphasis on desire and sin as rationale for entering into prostitution was an attempt to negate the discourse that women were forced into it by poverty.

¹ McLoughlin, 'Women and sexuality'.

² *D.M.P.C.*, ix (1870), p. 387.

³ Fraser Harrison, *The dark angel: aspects of Victorian sexuality* (London, 1977), p. 227.

This discourse also served to uphold the view that all women, by their very nature, had the potential to become prostitutes, essentially suggesting that there was a biological basis in females for sexual excess. Moreover, this portrayal of the prostitute as a woman driven by lust and greed would take from whatever public sympathy she might have had. Medical men of the nineteenth century increasingly developed a discourse that working-class women became involved in the sale of sex due to 'natural' causes of licentiousness, pride, love of dress and laziness rather than the unavailability of adequately paid female employment. The prostitute was to represent the antithesis of middle-class sexual definitions of femininity. She was the epitome of sexual excess and unbridled passion. The *Dublin Medical Press* sought to promote this ideology of the inherent sinful nature of women and by doing so, espoused and legitimated the victimisation of women under the Contagious Diseases Acts.

A journalist from the *Pall Mall Gazette*, who visited the Curragh in 1867, wrote not only an article on the women he found there living in deplorable conditions, but a pamphlet also, entitled *The Wrens of the Curragh*¹ – so called because they lived outdoors in makeshift huts not unlike the little birds that were their namesake. The journalist² decided that, contrary to popular opinion, the women did not live in the furze because they loved vice but because of sheer economic necessity and the fact that those who sought refuge in the workhouse in Naas lived in even worse conditions.³ The possibility that these women had common law relationships with soldiers in the regiment was ignored in the medical drive to dishonour them. To depict

¹ Con Costello, *A most delightful station: the British army on the Curragh of Kildare, Ireland 1855–1922* (Cork, 1996) pp 160–161.

² The journalist in question remained anonymous but his intimate knowledge of the lock hospital in Kildare suggests he may have been one of the governors or staff there. See Costello, *Most delightful station*.

³ *Ibid.*, p. 161.

these females as poor women merely trying to eke out a living would contravene the discourse that women were naturally predisposed to licentiousness. The medical profession in Ireland endorsed the notion that it was the innate selfishness, indeed sinfulness (that was an inherent part of their nature) that compelled women to take up prostitution. This portrayal of women as amoral, wicked beings helped preclude the pity and compassion that might have hindered its drive to dehumanise them.

The idea that the prevalence of venereal disease was dependent on the morality of women is promoted in a *Dublin Medical Press* article in 1854 entitled 'The extraordinary prevalence of the disease [syphilis] in the east, as compared to the West Indies'.¹ Concern was raised regarding the number of British army regiments infected with the disease in the East Indies. 'To account for the differences [the West Indies had a much lower rate of infected regiments] the author enumerates various circumstances in the mode of life of the native females in the two parts of the globe, which may explain the greater freedom from the above disease'.² The rate of infection supposedly had nothing to do with the habits and decisions of the army, but was entirely dependent on the morals and sexual practices of the local women. This commentary goes beyond imperialist racism but strikes a chord at the very heart of the medical discourse of the nineteenth century that sought to exonerate men completely from any responsibility for the spread of venereal disease. This misogynistic discourse that sought to vindicate men and condemn a certain class of women would be the impetus behind the draconian legislation that was to come.

¹ *D.M.P.*, xii (1854), p. 74.

² *Ibid.*

The *Dublin Medical Press* printed a letter from a doctor that wished to remain anonymous¹ in 1870, offering the love of fashion as a reason why women become prostitutes:

There is not, perhaps, in the lengthened catalogue of causes of prostitution, one more general or more powerful than ambition for fine dress. It is one to the influence of which all women are in a considerable degree subjected. The desire to appear more gay than her companions, is a prominent feeling in the breast of every female child; and it is strengthened rather than diminished when she attains the age of maturity. As her acquaintances multiply, and she begins to court and delight in the society of the opposite sex, this desire becomes more and more excited, till the ambition of appearing fine oversteps the means of doing so. Unless the feeling is curbed at its commencement, or the restraint of a powerful and well-regulated mind is called into operation to check its influence when once matured; some extraordinary means must be adopted, in order to satisfy it; and no method holds out a more encouraging prospect of success than a life of prostitution.²

Thus, unless a woman is not restrained ‘by a powerful and well-regulated mind’ – male, presumably – she is in danger of becoming a prostitute to fund her passion for pretty dresses. The absurdity of this commentary underlines what Walkowitz refers to as ‘sex-prejudice’³ and reflects the insipid dislike of women in this medical debate. The medical men seem determined to paint a picture of a debauched, greedy woman, wilfully spreading a disease that threatened the very core of society. Therefore, to devise legislation that would forcibly detain her against her will and subject her to a degrading and painful examination – in short, take from her the rights of everyone else – would, it might be argued, be more palatable.

¹ Many letters to the editor of the *Dublin Medical Press* whose subject matter was ‘delicate’ signed anonymously. We can only assume that their identities were known to the journal.

² *D.M.P.C.*, iv (1870) pp 122 - 123

³ Walkowitz, *Prostitution and Victorian society*, p. 55.

The author of the following passage in 1870 believed the work of a prostitute to be more attractive than the 'honest' callings of other occupations for certain women. He outlines the natural sinfulness of women:

I must therefore ... refer to other not uncommon causes of the loss of female virtue, such as the natural inclination to vice which prevails in some persons of either sex, and pride and indolence, which often cause women to part with their chastity in preference to following laborious, honest callings.¹

Femininity here is described in terms of conceited languor; women 'naturally' are predisposed to prostitution. There is no reference to the fact that employment opportunities for women in the nineteenth century were at an all-time low, that the possibilities for women to earn what this writer refers to as an 'honest' wage was extremely scarce. These economic realities were of little concern to a profession that sought a scapegoat for the spread of venereal disease.

An article in the same year offered a similar point of view as to why women enter prostitution. 'The love of dress is a most powerful influence – which the present fashion seems specially to favour, from its style and from the opportunities afforded of showing off the natural endowments of hair, good figure, good feet, &c.; the facility for imitating and appearing "the lady", offers great and irresistible attractions'.² This misogynistic viewpoint once again seeks to portray the prostitute the antithesis of victim, but rather as the flamboyant whore that cared for no one but herself, that sought to lavish herself with finery while simultaneously infecting hapless men with a disgusting disease.

¹ *D.M.P.C.*, iv (1870) pp 122 - 123

² *Ibid.*

In 1886, a Dr William Pearse wrote to the *Dublin Medical Press* on 'the felt necessity of clothes and appearances by young girls'.¹ He alluded to the female love of dresses and warned of the danger this might pose:

A large proportion of young girls from fourteen to eighteen slip easily into prostitution. Medical men know well at such ages young girls are almost irresponsible; in them, a new world of feeling and emotion is in the process of evolution; the very trust and beauty of their nature is their danger.²

The doctor appears anxious to portray young women as irrational and silly. The implicit suggestion is that women are incapable of making mature and rational decisions and consequently require the protection and moral guidance of men – specifically, medical men. The doctor suggests that promiscuity and vice are an innate part of femininity that must be controlled and regulated.

The misogynistic and stereotypical view of females as money-oriented is repeated in the *Dublin Medical Press*. The alarming fact of this medical discourse is that it refers generally, extending this portrait of greed and amorality to all women. Letters such as the one by Dr Henry Williams referred to above suggest in an ominous manner that men of the upper orders of society are likely victims to the insatiable greed and vice of women, whose sexual immorality is highlighted by their willingness to become the mistresses of wealthy men. Williams continues to lament the frivolous manner in which women choose prostitution and how they spurn 'honourable' occupations to live the apparently indolent life of a street prostitute. The *Dublin Medical Press* claims that women are not forced into their occupation: 'it is horrible to know there are hundreds of young women who prefer to live in riot, and to them affluence, rather than endeavour to gain their living in an honourable manner, in fact, they glory in

¹ *D.M.P.C.*, xcii (1886), p. 486.

² *Ibid.*

their shame'.¹ Ultimately, in order to create a scapegoat, a figure of blame for the alarming spread of syphilis, women were portrayed as avaricious and amoral beings undeserving of sympathy or compassion.

6. Corrupt women

The figure of the male seducer has long been ensconced in discourses on prostitution. The idea that a vulnerable, innocent, young girl could be lured into a sexual trap by an older, worldly man, causing her reputation to be in ruins and little hope of her supporting herself except for prostitution, is played out time and time again in popular fiction. This study seeks to examine how the *Dublin Medical Press* viewed this theory and how, in the climate that sought to blame and punish the prostitute for her role in the spreading of disease, it interpreted the 'seduction theory', readjusting the traditional view of the debauched male preying on the unsuspecting female to suit their misogynistic discourse on venereal disease. Josephine Butler of the Ladies' National Association, which had branches in Ireland, argued that laws were needed to punish the seducer who preyed on young girls.² In fact, many rescue workers like Butler³ claimed that most women had been seduced by the time they were sixteen. The following articles reflect the journal's desire to portray women as the ultimate threat to innocence.

In 1867 the *Dublin Medical Press* reviewed a pamphlet by a Dr Francis Vacher under the title 'Seduction in Edinburgh'. The reader is informed that Vacher has arranged a

¹ *D.M.P.C.*, ii (1870), p. 387.

² A. S. G. Butler, *Portrait of Josephine Butler* (London, 1954) p. 58.

³ Josephine Butler (1828–1906) was born in Northumberland, the daughter of John Grey, a strong advocate of social reform and a campaigner against the slave trade. She worked in charities of particular interest to women. Among the issues on which she campaigned was child prostitution. She is most famous for her ultimately successful campaign for the repeal of the Contagious Diseases Acts.

series of tables from the records of 364 first confinements in Edinburgh Maternity Charitable Hospital. The *Dublin Medical Press* believes that these figures refute the claim that young girls are seduced: 'These tend to throw considerable doubt upon the popular notions respecting this subject, and the author seems to think that students and military men are commonly most unjustly maligned'.¹ The popular view of philanthropy was to depict women as victims of seduction, robbed of their virtue, so prized in middle-class culture, by a man senior in both age and social status. The *Dublin Medical Press* appears to resent the intrusion of philanthropy, viewing morals as within its remit. It points out that 'a very trifling per cent of the seduced have been led astray by men moving in a higher sphere than themselves'.² The journal does not divulge the 'trifling per cent' but the implication is clear: men do not, for the most part, lead women into lives of seduction. The student and the sailor, both recognised customers of the prostitute, are here vindicated of blame. The journal appears determined that the prostitute herself, and not her paying customers, is the author of her moral downfall.

In 1870, the *Dublin Medical Press* sought to distinguish the young girl from the hardened prostitute. An article entitled 'The love that kills'³ tells how a 'poor, deluded woman' is deserted by her seducer and as a consequence is vulnerable and despairing 'because of the duplicity and villainy of the tempter'. The author is anxious to emphasise the distinction between the 'innocent' girl and the depraved prostitute. He underlines the importance of female chastity and suggests that without it, a woman is debauched:

¹ *D.M.P.C.*, v (1867), p. 11.

² *Ibid.*

³ *D.M.P.C.*, ii (1870), p. 167.

We don't refer to the depraved woman whose profession is prostitution ... we confine our remarks to the first fallen, whose innocence in their confidence of some monster in human form, deprives them of the world's good name and deprives them forever of that which is most dear to a woman.¹

The author is idealising the figure of the virginal girl, juxtaposing her innocence with the depravity of the sexually experienced prostitute. Essentially, the *Dublin Medical Press* is expounding the middle-class discourse that sought to place enormous value on female chastity while presenting female sexual experience as depraved and ultimately corrupting: 'When the chaste spirit of a virtuous woman is once tarnished, and her fair fame is defiled, society, in their civilisation, close their eyes upon the degraded one, and shudder at her presence'.² Thus, without her 'chaste spirit', a woman is rejected by society, made a veritable outcast and ultimately dehumanised. Essentially, the article is keen to highlight how a woman can be destroyed by sexual experience. The *Dublin Medical Press* underlines the huge regard for female virginity in the nineteenth century and how, without it, a young girl was little more than a prostitute.

This differentiation of the 'fallen' woman from the seasoned prostitute is in keeping with the rescue work of the time. In a report from a Poor Law inspector of a south Dublin workhouse there is reference to the fact that all young women drafted into the workhouse were kept carefully segregated from women of known bad character and were not permitted to associate with other females that were likely to corrupt them.³ The report also suggests that certain women may have become inmates solely for the purposes 'of seducing girls to leave the workhouse for improper purposes'.⁴

¹ Ibid.

² *D.M.P.C.*, ii (1870), p. 168.

³ Maria Luddy, *Women in Ireland 1800-1918 - a documentary history* (Cork, 1995) p. 62.

⁴ Ibid.

Spongberg notes that the mingling of young girls and older women in Lock hospitals was a constant anxiety for rescue workers.¹ Similarly, according to Maria Luddy, the policies of Magdalen institutions seemed to have excluded the admission of seasoned women, favouring the young.² The depiction of a young, vulnerable girl would win public sympathy, important for philanthropic movements seeking finance in order to help these women. The *Dublin Medical Press* contradicted this image, promoting the discourse that women as opposed to men were in fact the primary seducers.

The *Dublin Medical Press* announced in an editorial in 1870: 'So far as can be ascertained, about eighteen percent of all the common women have become women in consequence of seduction³ ... this can scarcely be considered a very large percentage'.⁴ It is important, once again, that the prostitute is not presented as a figure of sympathy or a victim. She must ultimately be portrayed as an agent in her own downfall or in the downfall of others. The *Dublin Medical Press* therefore appears to be in opposition to the discourse of philanthropists who promoted the idea of seduction as a cause for prostitution.⁵ In the same year, the *Dublin Medical Press* again dismissed the idea that women were forced into prostitution by male seduction, believing it to be fiction: 'the theory is but a theory, and exists with but a few exceptions only in the excited imaginations of old ladies, good natured clergy ... who hastily have recourse to anathematising an imaginary monster'.⁶ Thus, the journal

¹ Spongberg, *Feminizing venereal disease*, p. 131.

² Maria Luddy, *Women and philanthropy in nineteenth century Ireland* (Cambridge, 1995), pp 111–112.

³ The author of the article quotes from *An enquiry into the extent, causes, and consequences of prostitution* by William Tait, house surgeon in the Edinburgh Lock Hospital (second edition, 1842, pp 141–143).

⁴ *D.M.P.C.*, ii (1870), p. 386.

⁵ See Butler, *Portrait of Josephine Butler*, pp 58–59 for a discourse on the causes of prostitution. Josephine Butler was convinced that this was the main reason young girls entered into prostitution in the first place.

⁶ *D.M.P.C.*, ii (1870), pp 340–341.

espoused the nineteenth century ideology that viewed sexual women, who did not conform to set codes of feminine conduct, as depraved and an aberration of true womanhood. This aberration could not be blamed, the journal purported, on anyone but the woman herself.

The author of this article in 1870 (who remains anonymous) enthusiastically promotes the idea that the chief seducers of women into prostitution are women themselves:

The practical fact is, that the chief seducers are women – woman is still the Eve, even of her own sex, it may seem very hard to say so – and may seem very contrary to all her attributes and kindness and solicitude, but such is the fact and can be proved without question in very numerous instances.¹

The author gives examples of women's propensity to corrupt:

I might say in nine cases out of twelve, a girl living at home with her family, or earning her bread honestly, though perhaps hardly, meets with a female companion, perhaps by chance, perhaps in the course of her business or trade; this companion has herself fallen; directly she sets to undermine the happiness of her friend, she instils the poison, shows her that her trade or her business is too hard, that confinement is irksome, and that she may easily escape it. Incredible as it may appear, she often makes the preliminary arrangement for her destruction, and lures her hitherto virtuous companion to a place of preconcerted meeting, or to some concourse where she will be sure to fall; nay more, she will share the spoils of her ruin.²

Not only are females to blame for their own life of debauchery but they are also portrayed as amoral recruiters of the young into a life of prostitution. Nowhere in this discourse can the figure of a man be seen. The *Dublin Medical Press*, as with venereal disease, seeks to exonerate men, depicting them as blameless and innocent bystanders. The fact that men were the women's paying customers seems an unimportant aside to the *Dublin Medical Press*. The writer concludes that it is increasingly common for a

¹ Ibid., p. 340.

² Ibid.

woman to 'sacrifice one of her own sex for her selfish purposes'.¹ Once again, the *Dublin Medical Press* appears anxious to repudiate claims that girls were seduced into prostitution, advocating that girls themselves were the ultimate deviants, luring each other into profligate and debauched lives.

Further case studies are highlighted in this article, all illustrating how women could blame only themselves for their lives of prostitution. One girl of seventeen who was rescued from a life of prostitution by her 'well-to-do' parents, escaped from her bedroom window, wearing nothing but a chemise, so desperate was she to return to 'her associates'.² The significance of this article is that it supersedes the class debate. The article wishes to warn readers that any woman could be, by sheer dint of her nature and the help of depraved members of her own sex, enticed into prostitution. There is an implicit suggestion of the illogical and impulsive nature of women, which needs to be controlled and strictly supervised. The author concludes with the questions: 'What is to be said about married women who leave their husbands or deceive them? What about widows who not infrequently fall? What about mother and daughter?'³ Thus, no woman is above suspicion, beyond deception and lies. No woman is safe from being lured into a life of vice by a member of her own sex and ultimately, there is no relationship with another female, even the very closest, that is safe from the worst forms of betrayal.

One medical man, a Dr Henry W. Williams, reflects the medical desire to move away from the philanthropists' view of seduction as being the primary cause for prostitution.

¹ Ibid.

² Ibid.

³ Ibid.

My experience amongst our fallen sisters leads me to suppose that 25 per cent only are genuine examples of wilful and premeditated seduction, that is, where deliberate and systematic villainy on the part of the male sex has been brought into play. The other seventy five are made up of the women who have of their own free will gone on the town out of sheer liking of the life, and of others the prey of their own sex.¹

He is adamant that women are central to the blame for prostitution, and appears anxious to promote the belief that women are naturally predisposed to sin and immorality:

Yes, I maintain that women as seducers outnumber the men. Girls who have already partaken of forbidden fruit and found it agreeable to body and pocket by appearing in fine clothes, good spirit and health, excite the jealousy of their associates who want to know how they get all these good things; of course they are told, and are persuaded that it is a jolly life, and advised to do likewise by those who have been their school-friends, their fellow servants, their factory-mates, their fellow shop assistants, and they do go and do likewise, and in their turn become the tempter, the betrayer of their own sex, and it is thus that the ranks of prostitution are recruited.²

The writer depicts women as narcissistic and mercenary, propelled into a life of vice because of vanity and greed. He underlines the essential bias against working-class women by reference to popular female occupations of that class. Ultimately, the *Dublin Medical Press* sought to minimise sympathy for the prostitute, portraying her as depraved and corrupt, and hence dehumanised the figure of the prostitute, in order to make the draconian legislation proposed to control her more palatable.

7. Public sanitation, public morality

In the mid-nineteenth century medical science was decades away from discovering the microbiological agents that caused infectious diseases, but by the 1840s many saw

¹ *D.M.P.C.*, ii (1870), p. 387.

² *Ibid.*

a clear connection between dirt and disease.¹ Robins points to the fact that many doctors, even by the late nineteenth century, believed that epidemic diseases could have a spontaneous origin: in other words, that personal dirt and overcrowding were in themselves enough to create an epidemic.² This idea that disease was generated by filth resulted in legislation in the 1860s such as the Nuisances Removal and Diseases Prevention Acts,³ which empowered Poor Law authorities in Ireland to eliminate dirt in a variety of ways. This medical and government discourse on sanitation and public cleansing has clear connections to the discourse on venereal diseases, as medical authorities sought to 'cleanse' prostitutes of contagion. Indeed, Dr Lombe Athill, in the *Dublin Medical Press* in 1880, referred to prostitutes as 'miserably clad, ill-fed, and very dirty', whose illnesses were a direct result of 'their remaining in this state of dirt, neglect and intemperance'.⁴ Depravity and dirt were clearly and inextricably linked. Outward signs of general dishevelment were at odds with middle-class concepts of cleanliness, and so the adage of 'cleanliness next to godliness' had particular resonance when applied to members of the lower classes.

The language used by the *Dublin Medical Press* to describe non-conforming sexual unions and the spread of venereal disease borrows heavily from the public sanitation discourses of the time. Filth became synonymous with depravity; dirt was seen as a manifestation of licentiousness. Medical men involved themselves in a discourse, evident in the pages of the *Dublin Medical Press*, that portrayed women they termed prostitutes as disease-ridden sexual deviants, callously and wantonly spreading venereal disease. The language might be more appropriate for describing polluted

¹ Cassell, *Medical charities*, pp 108–109.

² Robins, *Miasma*, p. 212.

³ Cassell, *Medical charities*, p. 110.

⁴ *D.M.P.C.*, lxxviii (1880), p. 123.

public areas such as canals or public streets. In Ireland it seems that poverty, dirt and immorality were inextricably linked. The sexual availability of women in the poorer ranks of society was seen as a failure of their moral will and as a result, these women were defined as receptacles of a contagious disease that they had neither the ability nor the will to control or contain. This study seeks to highlight the fact that behind the one-way nature of the Contagious Diseases Acts lurked a medical class-based disdain of women in general that was reflected in a desire to regulate and control them. Moreover, the language adopted by the *Dublin Medical Press* suggests that this disdain went further than class differentiation, and intimated a deeper, and certainly more sinister, dislike of all women.

The *Dublin Medical Press* asserted that the conduct and habits of non conforming women made them infectious, in other words, their outward show of uncleanness and their manner, so far removed from middle class prescribed codes of behaviour made them sites of infection. The subliminal message would appear that the medical profession feared that women involved in exchanging sexual favours for money were also morally contagious. This section seeks to examine how the *Dublin Medical Press* depicted women in language that betrayed their intrinsic dislike and fear of females of the lower orders and how they attempted to brand her as a vessel of infection and a threat to the proper functioning of society in general.

For example, a letter to the *Dublin Medical Press* in 1873 outlined the medical view of the moral illegitimacy of prostitution. Women are blamed almost exclusively for the spread of syphilis:

the great social problem of the age; an army of wretched women, who sell their bodies to the first comer for a pittance wherewith to drag out a miserable

existence, and by their uncleanly lives give rise to a certain proportion of the various diseases by which humanity has been and is afflicted.¹

This editorial purports that, without necessary controls, scores of women are being daily infected with catastrophic results. There is no mention of males infecting females – almost as if men were incapable of spreading the disease. The medical and government discourse on sanitation and public cleansing has clear connections to the discourse on venereal diseases, as medical authorities sought to ‘cleanse’ women of contagion.

In his testimony to the Royal Commission set up to examine the operation of the acts, Rev. Maguire, a Catholic priest residing in Cork, continually refers to groups of lower-class women as ‘nests of women’ and details the necessity of keeping these women in one place because: ‘You destroy the hive and the bees get scattered about’.² He later refers to these women as ‘more ordinary scum’.³ It is this inherent misogyny that underlies the Contagious Diseases Acts, which sought to dehumanise women so that the wilful dismissal of their civil liberties could be vindicated.

In 1867 Dr Henry W. Williams, in a letter to the editor of the *Dublin Medical Press*, responded to the call by opponents of the Contagious Diseases Acts for the examination of men as well as women. His sentiments reflect the belief among the medical establishment that ‘The public want protection from certain abandoned women, who, having no remnant of any good feeling left, wilfully and wantonly

¹ *D.M.P.C.*, lxviii (1873), p. 40.

² *Royal commission on the administration and operation of the Contagious Diseases Acts, ii, minutes of evidence* [c. 408-1], H.C. 1871, p. 679.

³ *Ibid.*, p. 681.

spread disease amongst the opposite sex day after day and night after night'.¹ The prostitute is depicted here as the sexual aggressor. It would seem that the doctor is attempting to assert that more sexualised the female, the more virulent is her disease.

8. The Contagious Diseases Acts and the control of women

The French system of mandatory examination of women began in 1810 and the subsequent writings of Alexandre Parent-Duchatelet and Philippe Ricord (see above) lent prestige and professional approval to regularisation of prostitution. Due to their authority many Irish and British doctors began to call for a system of regulation. William Acton's work *Prostitution considered in its moral, social and sanitary aspects*, written in 1857, was instrumental in generating a respectable, intellectual climate that was sympathetic to regulation.² This section of the study seeks to emphasise the fact that medical men, despite their acute criticism of prostitution, never sought to make it illegal. Rather, medicine sought to control and regulate it and as a consequence of this, the profession sought to regularise women in general. The discourse promoted in the *Dublin Medical Press* was that the regulation of women was an imperative duty of the state.

This study seeks to examine the medical desire to control and regulate not merely prostitutes but any woman who did not conform to the set codes of feminine conduct laid down by the middle classes and espoused by the profession itself. Doctors' approval of the Parisian system, despite evidence that it was far from successful, reflected their desire that medicine would be at the helm of any similar legislation in Britain and Ireland. In short, the misogynistic type of legislation that the *Dublin*

¹ *D.M.P.C.*, lviii (1867), p. 43.

² Walkowitz, *Prostitution and Victorian society*, p. 42.

Medical Press advocated, based on the French system of forcible detention and examination of women, suggested that the medical profession recognised an opportunity to increase its jurisdiction and power while simultaneously imposing its order on the sexual conduct of a class of women.

The Lancet in 1857 urged regularisation of prostitution in an editorial entitled 'Prostitution – the need for reform'.¹ The danger of prostitution to society is emphasised:

The typical Pater-familias, living in a grand-house in the park, sees his sons allured into debauchery, dares not walk with his daughters through the street after nightfall, and disturbed from his night slumbers by the drunken screams and oaths of women reeling home with daylight. If he looks out his window, he sees the pavement, his pavement – occupied by the flaunting daughters of sin.²

Working-class women are presented as chaotic and uncontrolled and a scourge to respectable families. The drunken, cursing female depicted here represents the extreme opposite to middle-class accepted ideologies of femininity. Her supposed depravity contradicts the view that women are sexually passive; her relative freedom to roam the streets at night refutes the accepted codes of female conduct that emphasise that a woman's place is in the home; while her sexual availability is a trap, used to ensnare hapless men.

The *Dublin Medical Press* in 1864 outlined in an editorial why the regulation of prostitution by government intervention was a necessity:

But it must be patent to all that where special evils exist, there should the remedy be applied. Our streets are defiled; our mothers, sisters, and wives are

¹ *The Lancet*, ii (1857), pp 478–479.

² *Ibid.*

tainted by the touch of the Cyprians at all hours and in all places. In Dublin, where this glaring vice exists more patently than elsewhere (and we believe the fact is so from the superior virtue of our women), a young man cannot leave the house without having the temptations of women obtruded on his mind's eye on all occasions. Here legislation can interpose by confining these women to their dens, where at least the vice enacted does not meet the public eye. Again, the frightful ravages of syphilis might be greatly mitigated by a system of medical inspection and compulsory confinement to hospitals of the infected, and lest this system might prove a premium on disease, each woman should be forced to maintain herself when under medical care.¹

The prostitute is described as a social pariah who preys on innocent men; as an animal who must be confined to her den, a social shame who must be hidden from view. The *Dublin Medical Press* thus makes its position clear. Women are the principal agents of syphilis and ultimately there exists among them an aggressive, predatory sexuality that must be controlled and confined.

In 1871 Henry Richardson, Registrar of the Court of Probate in Cork, told the commission formed to examine the Contagious Diseases Acts that:

There is one portion of the city of Cork that I pass two or three times a night, and it is with fear and trembling ... Do you know that respectable persons cannot pass backwards and forwards without being solicited?²

Richardson reflects the discomfort of the middle classes at the behaviour of the lower orders who flout the belief that women should not be outside after dark. Rev.

Maguire, the abovementioned Cork-based priest, communicated his outrage at the behaviour of women in Cork:

At all times that we went out we saw a number of these women and especially in the evening and at night, and we saw everywhere a gathering of these women, who by their blasphemy and obscenity made Cork actually a disgrace

¹ *D.M.P.*, ii (1864), pp 93–94.

² *Royal commission on the administration and operation of the Contagious Diseases Acts, ii, minutes of evidence* [c. 408-1], H.C. 1871, p. 671.

... There was scarcely a year in which letters were not in the papers from strangers coming to hotels that could not sleep at night.¹

Essentially, it was the conduct of women from the poorest rank of society that excited commentary from Maguire and Richardson. There is no mention that any men were among this raucous group, but it seems reasonable to assume that the women were not alone. The behaviour of the men is, in this discourse, made somehow irrelevant in face of the middle-class preoccupation with women. This suggests that the call for the regulation of prostitutes constituted a call for the suppression of women in general, and was in essence a manifestation of a much larger question – that of women and civil society.

Not all medical men supported this point of view. Dr Charles Drysdale, liberal thinker and leader of the Malthusian League (see Chapter 3), once a strong supporter of the regularisation of prostitution, changed his mind on seeing how the civil liberties of the prostitute were being affected. He maintained that regularising prostitution (whereby all registered women would have to be subjected to frequent examination) was not the answer to the syphilis epidemic, and he wrote to the *Dublin Medical Press* outlining his misgivings about the Parisian system:

In the first place, it was found that when the police began to regulate prostitution, it at once became secret, as it was not likely that young women, more than young men, would willingly submit to being imprisoned in [a Lock hospital] for many months for the sake of other people's health. Hence the great mass of prostitution in Paris was clandestine so long as the laws against women were so absurdly unfair as compared with those of young men of similar careless habit.²

¹ *Ibid.*, p. 675.

² *D.M.P.C.*, ci (1880), pp 265–266.

The argument that the continental system was far from being a success was pushed aside; it was abundantly clear that the established medical profession did not support Drysdale's view. Drysdale was a lone voice warning that any attempt to regularise prostitution would have the effect of driving the disease underground.

In 1864, the *Dublin Medical Press* defend the medical position by stating that the:

Contagious Diseases Bill is specially framed for the protection of the public service from the scourge of indiscriminate prostitution which pervades every rank and scale of the army, and any doubt of the necessity for some legal interference must disappear before the statistics of the frequency of venereal disease.¹

Ultimately, medicine looked to the French system of regulation, supervised and monitored by the medical establishment as their template. The labelling of women as social menaces served to promote its cause.

Low wages and poor general conditions of service meant that the army disproportionately comprised members of the lower orders. It seems unsurprising, therefore, that women from the same social class would be found in garrison areas like the Curragh in County Kildare. McLoughlin suggests that at least some of these women were in fact the common law wives of the soldiers.² The soldiers themselves were from the lower ranks of society and their relationship with the women that followed them was likely to be of 'irregular unions'. Lieutenant General Sir Richard Airey referred to the soldiers':

phraseology and the epithets they use as to the relations between the sexes, and the exhibitions of indecency, for instance, making water against a wall and

¹ *D.M.P.*, ii (1864), pp 67–68.

² McLoughlin, 'Women and sexuality', pp 266–275.

conversing with a woman at the same time without exhibiting any sign of feeling of indecency'¹

This suggests the difficulty that members of the middle classes (like Airey) had in interpreting relations of the lower orders. The informality and lack of rigidity that defined lower-class relations appalled and shocked those who modelled human interaction in terms of an ideological system that was rigid in its support of middle-class tradition. The virulent spread of syphilis among the ranks of the army required a scapegoat, and if soldiers, being men, were to be exonerated by the medical profession, it was the women of their social class – their sexual partners – that were to be held wholly accountable for the spread of syphilis in nineteenth-century Ireland.

The sexual practices of the soldiers were reflected in the fact that venereal disease was becoming a serious problem in garrison towns. In 1879, Dr. William Thompson, surgeon to the Richmond Hospital in Dublin, in an address to the Surgical Society of Ireland referred to the effect of venereal disease on the armed forces: 'It is well known that the efficiency of the army and navy was gravely compromised'.² The incidence of the disease could not be ignored.

The *Dublin Medical Press* as early as 1846 was voicing growing concern: 'it is seen that nearly one man in every five – or more correctly, 181 per 1000 – is attacked with venereal disease. According to the army classification, one man out of thirty-one is attacked with true syphilis.'³ The journal is eager to point out that the blame for these statistics lies not with the soldiers but with the women they had sexual intercourse

¹ *Royal commission on the administration and operation of the Contagious Diseases Acts, ii, minutes of evidence* [c. 408-1], H.C. 1871, p. 558.

² *D.M.P.C.*, lxxviii (1879), p. 341.

³ *D.M.P.*, iii (1846), p. 33.

with. The article points to the necessity for government intervention to ‘check’ venereal disease: ‘the impossibility of checking venereal diseases, except by police or government regulations ... and women do not (as some have supposed) perish in large numbers from syphilis’.¹ Incredibly, the old adage that women are somehow immune from syphilis is repeated here, implying that women carry the disease without presenting with external symptoms. This misogynistic discourse is in accordance with the prevailing ideology of the body of the woman as being intrinsically diseased.

A letter to the *Dublin Medical Press* in 1852 by a medical officer of a Union workhouse underlines the latent distrust of females:

I have good reason to know that venereal diseases are now existing to an extent barely credible ... Lately while examining recruits for the militia, I found them to be diseased to the extent of twenty-five percent. Surely it is the time that public attention should be called to such a state of things, if we have any regard for the coming generation; and that by some wise regulation, means should be taken to keep the scourge well known.²

The *Dublin Medical Press* replied:

I think the subject of the letter deserves the attentive consideration of those who have the will and power to benefit the condition of our soldiers and sailors. I allude to the propriety of establishing Lock hospitals at our great naval ports, for that unfortunate class of females, who are the means of propagating a disease fearful in its consequences, and without doubt a very powerful cause of sapping the foundations of our nation’s strength ... While human nature remains as it is, all men cannot be arrested in their career of vice.³

The article implies that men are helpless victims of the urges of their own sexuality and consequently women, who are purported to be devoid of sexual urges anyway, should be culpable for the spread of syphilis. In essence, the *Dublin Medical Press* is

¹ Ibid.

² *D.M.P.*, xxviii (1852), p. 399.

³ Ibid.

espousing the use of legislation to allow men to seek sex wherever they liked, with comfort and safety. Increasingly, women were being defined as not merely carriers of the disease but vessels of infection. Much like the language of public sanitation of the time, which advocated the cleaning of the sewers and streets of contamination, the medical men of nineteenth-century Ireland called for the cleansing and purging of infectious women.

The *Dublin Medical Press* reprinted a letter from *The Lancet* outlining the growing panic surrounding the spread of syphilis. The letter, from H.B. Franklyn, First Battalion army surgeon in the Curragh Camp, begins:

Sir – A few words about venereal in the army here, more particularly at present, when the disease is becoming worse and worse. Huddled together, sometimes as many as twenty in a house, in the neighbourhood of the Royal Barracks, Dublin, the women live in filth, communicating the vilest diseases (syphilis, gonorrhoea, and itch) to almost every soldier who shows himself in the neighbourhood ... When a battery of artillery of under 200 men is totally ineffective for more than three weeks in the course of the year, what must be the true state of things!¹

While the women are described in terms that render them as almost less than human, the soldiers are once again alluded to as if they are victims of their own sexuality:

It is thought that as the Horse Artillery is hard worked, the men get out late and run off to the nearest brothel; get, perhaps, the worst form of disease, having no opportunity to select their loves, and this leads frequently to an ultimate breakdown of their systems. At the present time the Curragh Camp is a hot-bed of disease; but at least the women there are cleaner than in Dublin. They have some little regard to cleanliness, and wash like dogs in the ponds on the common.²

By comparing women to animals, the medical profession hoped to make coercive and cruel legislation more palatable and justifiable, both to themselves and to the public.

¹ *D.M.P.*, vi (1864), p. 153.

² *Ibid.*

In 1871, Sir Richard Airey reflected the middle-class horror at the sexual practices of the lower orders: 'Some of the worst women about the barracks go as often as four times a night, night after night, even while they are in a state of disease, with private soldiers for a shilling apiece'.¹ Airey's emphasis on the supposed high sexuality of the women illustrates that it was the sexual conduct of women that preoccupied middle-class men. This inherent misogyny formed the background to the Contagious Diseases Acts of 1864, 1866 and 1869.

The *Dublin Medical Press* as early as 1867 portrayed soldiers as hapless, compliant beings, unable to ward off the sexual attentions of sexualised women. The language shows the medical derision and disgust of women juxtaposed to the apparent purity and innocence of their male customers:

At every military door ... there lie in wait by the score, women of the lowest and filthiest type, who pounce upon the recruits leaving duty, and almost force the unhappy boys to their loathsome embrace, and yet our wise and benevolent statesmen know this, they also know how to stop it, and yet are guilty of the daily ruin of hundreds who get infected with syphilis, and invoke the curses of future generation.²

The youth of the soldiers is offered as further testimony to the corrupting nature of the women. In the language of sanitary reform of the time, the *Dublin Medical Press* depicts the prostitute as a pollutant to the morals of the soldiers:

the soldiers ... are naturally chosen from young and able-bodied males, who are well fed and housed, and to whom marriage is forbidden. What wonder, then, if healthy and high spirited young men in such an environment should recklessly incur the risks attached to illicit intercourse.³

¹ *Royal commission on the administration and operation of the Contagious Diseases Acts, ii, minutes of evidence* [c. 408-1], H.C. 1871, p. 562.

² *D.M.P.C.*, civ (1892), pp 662-663.

³ *Ibid.*

The implicit assertion is that the sexual availability of working-class women is a necessary evil in face of the appetites of the 'healthy and high-spirited' soldiers. This gives further support and justification to the necessity of the forcible examination of women in order that they will be sanitised and clean for the needs of the army.

Lieutenant General Sir Richard Airey, who was quartered in Dublin, reflects how the Contagious Diseases Acts upheld the double standard of sexuality: 'Soldiers generally are very averse to going into hospitals and in fact I have known seven fatal results from men not going into hospital ... they lose 10d a day for what are called hospital stoppages'.¹ Thus, soldiers infected with syphilis had in fact a disincentive to seek medical attention. Similarly, in 1873 the *Dublin Medical Press* reviewed a pamphlet that suggested that soldiers should be also examined periodically. The journal replied: 'This system has been tried with varying results, but has been found demoralising to the soldier, humiliating to the inspecting surgeon, and calculated to inure the soldier to want of self-esteem'.² The Contagious Diseases Acts had little regard for the sensibilities of women and the journal reflects the essential misogyny of the legislation. The review stipulates that 'The woman unimpelled by passion, pursues a trade. She prostitutes her body for the sake of gain, and she uses for this purpose the attractions of dress, & c., to draw customers.'³ The female is thus to blame for the spread of venereal disease because she is allegedly asexual and not dominated by passion, and because she is attractive to men. The absurdity of this thinking reflected the profession's deep suspicion of women, and particularly women of the lower orders.

¹ *Royal commission on the administration and operation of the Contagious Diseases Acts, ii, minutes of evidence* [c. 408-1], H.C. 1871, p. 557.

² *D.M.P.C.*, xvi (1873), pp 355-356.

³ *Ibid.*

The Contagious Diseases Acts of 1864, 1866 and 1869 applied only to certain garrison towns in Britain and Ireland (in Ireland, the Curragh, Cobh [Queenstown] and Cork) but their implications were to be far-reaching. The three acts were introduced to control the spread of venereal disease, but implicitly examined broad social questions such as the sexual behaviour of the lower orders and, specifically, the conduct of women. Certainly the acts reflected a fear of and inherent hostility towards female sexuality in a form that Walkowitz refers to as 'repressive humanitarianism'.¹ This study seeks to emphasise that this legislation superseded repressive humanitarianism, reflecting rather the sex-prejudice and misogyny that had long been part of the medical establishment's discourse on the spread of venereal disease. This study also seeks to show how this legislation provided the medical profession with the means for further bolstering of its power and status. There is no question that the Contagious Diseases Acts allowed established medicine in Ireland to gain considerable clout. The fact that the 1866 act included the term 'medical police' suggests it was increasing the jurisdiction of the medical man. Who was to ensure that the provisions of the acts were carried out – the police or the doctor? As the century progressed, the medical establishment in both Britain and Ireland called for the acts' extension to the civilian population. However, they did not envisage the extent of the active and organised challenge to the power of the medical profession.

In 1864 Sir Clarence Paget, secretary to the admiralty, introduced a bill 'For the prevention of contagious diseases at certain naval and military stations' to parliament. The stated aim of the bill was to enforce a system of regulated prostitution in naval

¹ Walkowitz, *Prostitution and Victorian society*, p. 85.

ports and garrison towns in Britain and Ireland. However, regulation was designed to protect the civilian population along with the armed forces. The act aroused no debate and received the royal assent by July 1864. It provided for the compulsory hospitalisation of any woman who was suspected of being a prostitute with a venereal disease on the evidence of a policeman before a magistrate. Never before had legislation openly supported the double standard of sexuality, tacitly making women from the poorest ranks of society sexually available to men. The act centred on the premise that venereal disease, specifically syphilis, was passed from women to men. Male sexual behaviour was never questioned or scrutinised by the Contagious Diseases Acts. Article 8 of the act stated:

where an information, in the form given in schedule 2, is laid before a Justice of the Peace by a Superintendent or Inspector of Police or Constabulary authorised to act in any place to which this Act applies, or by any duly registered medical practitioner, the Justice may, if he think fit, issue to the woman named a notice in the form given in the Schedule.

A constable shall serve such notice on the woman.

In either of the following cases:

1. If the woman appears herself, or by some other person, at the time and place appointed.
2. If she does not appear, and it is shown that the notice was served, The Justice present may, if he thinks fit, on oath or affirmation substantiating the information, order such woman to be taken to a certified hospital for a medical examination.¹

The 1866 act stipulated that any woman could be periodically examined and detained against her will. The public outcry was strong and would eventually lead to the repeal of the acts, but not before the medical profession put up a formidable resistance to what it viewed as an encroachment on its power. It ensured that this legislation not only would uphold the double standard of sexuality but also would reflect a base and

¹ *D.M.P.*, i (1864), p. 103, A bill for the prevention of contagious diseases at certain naval and military stations (abstract).

ultimately misogynistic dismissal of the humanity of working-class women by denying their civil liberties.

Josephine Butler, the famed philanthropist who vehemently opposed the Contagious Diseases Acts, outlined the repercussions on the lives of working-class women:

‘ladies who ride in their carriages through the streets at night are in little danger of being molested. But what of working women? What of the daughters, sisters, wives of working men, out, it may be on an errand at night?’¹ The underlying class prejudice of the act ensured that any woman deemed ‘suspect’ was liable to be apprehended and subject to a forcible examination. The legislation stipulated that the medical practitioner had the power to authorise the detention of a woman and had the support of the heavy hand of the law should his authority be contested:

Such order shall be sufficient Warrant for a constable to apprehend such woman, and for the authorities of the hospital to cause her to be examined by some medical officer of such hospital to ascertain whether or not she has a contagious disease, and if so, to detain her in hospital for twenty four hours.

Within the twenty four hours the authorities of such hospital shall cause a medical certificate of the existence of such disease to be laid before the justice who made the order, and thereupon the said justice may order the authorities to detain the woman in hospital for medical treatment till discharged. Any woman refusing to submit to examination, or to conform to the rules of the hospital, or quits the hospital without being discharged, shall be liable for a first offence to one month’s and for a subsequent offence two months’ imprisonment.²

Essentially, the Contagious Diseases Acts increased the power of medicine in the nineteenth century. This new-found power and jurisdiction gave new credibility to a profession anxious about overcrowding in its ranks.

¹ Butler, *Portrait of Josephine Butler*, p. 73.

² *D.M.P.*, i (1864), p. 103, A bill for the prevention of contagious diseases at certain naval and military stations (abstract).

In 1866 the second Contagious Diseases Bill was introduced. This was an extension of the first act and again met with little opposition in parliament. Now a magistrate could order a woman to a fortnightly medical inspection for up to a year, and the period that a woman could be detained in a Lock hospital was extended to six months. A clause was added that stressed the need for adequate moral and religious instruction for women detained.

The acts ensured that the medical establishment were not merely healers to the sick, or moral guardians of society, but a forbidding power backed by legislation, with the authority to subject any woman they deemed 'suspicious' to a forced examination. Given the prejudice towards working-class females that the *Dublin Medical Press* had already shown, the fact that it wholeheartedly supported this legislation is hardly surprising. The government, alarmed at the cost of venereal disease in the army and navy of Britain and Ireland, looked to the medical profession to steer through this controversial and ruthless piece of social legislation. The medical profession had reached the pinnacle of its power.

The reasons why women might engage in full-time or casual prostitution were completely trivialised by the *Dublin Medical Press*, while its refusal to accept women who simply did not conform to their narrow definition of femininity suggests the essential misogyny of the medical establishment in Ireland. The ultimate repeal of these acts in 1886 was a testimony to the philanthropic groups that saw the Contagious Diseases Acts of 1864, 1866 and 1869 as not merely as an attack on women but an attack on the civil liberties of humankind.

CHAPTER 5: GYNAECOLOGY

As the nineteenth century progressed, the medical profession's interest in the workings of the female body expanded. Increasingly, it believed that the functions of the female body – both physical and psychological – were inextricably linked to her reproductive system, in a way that had no correlation in men. This viewpoint was not limited to Ireland but was also discussed in Britain and America in the latter half of the nineteenth century. The aim of this chapter is to explore this medical preoccupation with the female body, specifically the uterus. The chapter also seeks to explore the medical definition of the female body as pathological, and how this definition validated conventional ideas of femininity and women's sexuality and ultimately led to an increase in invasive gynaecological surgical procedures on women.

The medical profession in the nineteenth century perpetuated the belief that sex and reproduction were more fundamental to female nature than to the nature of males. Puberty, menstruation, childbirth, the menopause, among other notable fundamentally female milestones, were estimated to influence the female body and mind in ways that had no correlation in men. Ornella Moscucci points out that because of her role in reproduction, woman was regarded as a special case, a deviation from the norm

represented by the male.¹ This chapter seeks to highlight how the *Dublin Medical Press* corroborated this medical hypothesis of femininity.

The medical community used a combination of anthropological studies, medical evidence and evolutionary law to explain women's appropriate role and place in nature. Science in the nineteenth century depicted women as creatures inferior to men.² The medical view of female health emphasised the grave risks associated with reproduction. Puberty, specifically for the female, was viewed as a catastrophic time, menstruation was regarded as pathological and pregnancy was viewed as a disease. Thus, woman was, by definition, a deviation from the standard of health represented by the male and not only were her biological functions defined as diseased, they were also the breeding ground for a medley of psychological disorders. These beliefs, centred on the premise that the female's physical and psychological disorders derived from her reproductive system and that pathology defined the norm of the female body, legitimised and sanctioned the medical authority over women.

Gynaecology became the study not just of the physical ailments of the female, but of the psychological and moral aspects of femininity.³ There was a lot of vagueness and ambiguity between psychological illness and physiological disorders that deeply confused the medical establishment in the nineteenth century. This study aims to highlight how the *Dublin Medical Press* confirmed this confusion in its interpretation of female patients. Essentially, medical men were obliged to find answers to female

¹ Ornella Moscucci, *The science of woman: gynaecology and gender in England 1800–1929* (Cambridge, 1990), p. 2.

² John S. Haller and Robin M. Haller, *The physician and sexuality in Victorian America* (Carbondale, IL, 1974), p. 47.

³ Moscucci, *Science of woman*, p. 103.

complaints but this was somewhat hindered by the fact that no-one had a very clear idea of human physiology.

The themes of this chapter begin with an examination of the nineteenth-century focus on the domestic and reproductive role of the female. The lack of employment opportunities for women in Ireland in this period gave motherhood a new importance as the rising middle-class ideology of the centrality of reproduction began to develop. The chapter then embarks on an exploration of the nineteenth-century medical discourse on the fragile female sex, as documented by the *Dublin Medical Press*. This discourse promulgated the popular evolutionary view that women were incapacitated by a smaller brain and so could not hope to compete with the assumed larger brained man. The *Dublin Medical Press* corroborated the view of the frail female by publishing articles that attested to the difficulties physical exercise posed for the woman. This theme is further explored when the chapter examines the *Dublin Medical Press*'s disapproval of the alcohol consumption of women, asserting that females were somehow more susceptible to the ill-effects of alcohol than men. The chapter also considers how menstruation was seen as the ultimate debilitating factor in the lives of women, a physical proof that a female was even further incapacitated from the normal functions of life.

In terms of female education, the chapter examines the *Dublin Medical Press*'s essentially gender-biased, if not misogynistic, agenda as articles that asserted the ill-effects of study on females began to appear with increasing regularity. The fact that by mid-century, women not only were achieving academically but also were clamouring for university places rendered the prior evolutionary arguments obsolete.

The *Dublin Medical Press* increasingly asserted new difficulties in their biological make-up that made further study a health hazard for women.

As we have seen, the *Dublin Medical Press* was particularly preoccupied with female sexuality, reflecting the conflict between the middle-class understanding of female sexual passivity and the simultaneous assertion that reproduction was central to a woman's role. The medical profession promoted set codes of what it defined as appropriate sexual conduct that placed females in the domestic sphere, idealising their subordinate position there.

Finally, the area of gynaecological surgery is explored, specifically scrutinising the *Dublin Medical Press's* interpretation and analysis of the marked increase in gynaecological surgical procedures on women in the second half of the nineteenth century. Essentially, this chapter hopes to highlight how the *Dublin Medical Press* not only interpreted women as sickly, but sickness was defined as feminine. The ovary, fallopian tubes and most especially the uterus of women became pathological and were promoted by the *Dublin Medical Press* as indicators of the overall malady of women. These biological body parts became synonymous with the flawed female system that necessitated the surgical intervention of medical science.

1. The domestic role

The gradually increasing economic and social importance of the middle class in Ireland began to be felt in the second half of the nineteenth century, and with it, new parameters of respectability. Outward signs of wealth became increasingly important and a woman engaged in heavy agricultural labour was increasingly associated with

the poorer classes. The focus on respectability saw the work of the female increasingly being shifted indoors, with new emphasis on housework. The mark of bourgeois success promoted the notion of the redundant wife, emphasising the importance of her domestic and reproductive role and consequently her roles within the domain of the home. The lack of employment opportunities for women can be tracked in the considerable numbers of Irish females who emigrated at this period,¹ due to the lack of industrialisation and the dwindling textile industries. The *Dublin Medical Press* reflects how medicine championed ideal social characteristics in females of nurturance, domesticity, inherent frailty and ultimately passivity, and linked them to the proper functioning of society.

A Dr Benjamin Ward Richardson in 1880, speaking at the annual meeting of the Sanitary Institute of Great Britain and Ireland, highlighted the new importance for females 'to learn the house and its perfect management'.² He asserted that 'The house is her citadel' and stressed the need to make housework central to the woman's existence: 'a permanent custom or fashion, to neglect which would be considered a moral defect'.³ As wives and daughters gradually retreated from agricultural work, the new focus on the female's role in the home inevitably gave the position of wife and mother new significance. The *Dublin Medical Press* maps an increasing emphasis on the reproductive role of women, idealising marriage and motherhood as the *raison d'être*.

¹ For more see David Fitzpatrick, 'The modernisation of the Irish female' in Patrick O'Flanagan, Paul Ferguson and Kevin Whelan (eds), *Rural Ireland – modernisation and change 1600–1900* (Cork, 1987).

² *D.M.P.C.*, xxix (1880), pp 257–259.

³ *Ibid.*, p. 257.

In the second half of the nineteenth century Ireland had the highest fertility rates in Europe,¹ validating the centrality of reproduction in medical discourse. At the end of the eighteenth century the mortality rate had been dismal – 40 per cent of deaths were of children under five.² Thus, with newly rising liberalism in social and political thinking, the value of children was championed as a worthy cause. The fate of children became a matter of national pride and for the rising middle class the protection of childhood innocence became a symbol of status. As a consequence of this new emphasis on the nurturing role of motherhood, education in mothering skills became an important facet of the nineteenth-century doctor's role.

It is also a fact that motherhood and the idealization of the family was an inherent element of nineteenth-century middle-class ideology, and thus important for the medical man to uphold as an institution. Luddy points out how the idealised roles of wife and mother formed the basis of a flourishing market of prescriptive literature;³ Fitzpatrick asserts that a wife's accomplishment was measured according to the number of successful pregnancies she had.⁴ Adrienne Rich points out that motherhood served the interest of patriarchy, asserting how the nineteenth century saw crucial changes in assumptions about the home, women, and women's relations to productivity.⁵ The home became the pivotal point of the family, with the mother's responsibility increasingly confined to the indoors. Showalter asserts that motherhood and the family formed a formidable bulwark against sexual decadence.⁶ Motherhood

¹ Liam Kennedy and Leslie Clarkson, 'Birth, death and exile: Irish population history 1700–1921' in B. J. Graham and L. J. Proudfoot (eds), *An historical geography of Ireland* (London, 1993), pp 166–167.

² Jacalyn Duffin, *History of medicine: a scandalously short introduction* (London, 2000), pp 312–313.

³ Maria Luddy, *Women in Ireland 1800–1918: a documentary history* (Cork, 1995), pp 3–4.

⁴ Fitzpatrick, 'Modernisation of Irish female', pp 170–171.

⁵ Adrienne Rich, *Of woman born: motherhood as experience and institution* (London, 1977), pp 48–49.

⁶ Showalter, *Sexual anarchy*, p. 3.

was a convenient method of ensuring that women, particularly middle-class women, stayed within the limits of the socially defined and accepted definition of femininity.

Medical men by the nineteenth century believed they had a large advisory role in the domain of motherhood, once more adding to the remit of the profession and further bolstering their status in society. Murphy-Lawless states that this new medical role strengthened the discourse that women are victims of their uncontrollable reproductive systems.¹ By placing such pre-eminence on their roles of reproduction, the medical establishment presented women as inherently frail, weakened by the demands of their supposed primary role of propagation.

The following article shows that medical men saw it as their responsibility and not the mother's to choose a wet nurse. The *Dublin Medical Press* printed a lecture entitled 'Clinical lecture on nursing' in 1863, by a Dr Trousseau, who states: 'The physician should ... be able to select a woman fit for the task'.² The attitude of the author perhaps reflects the dehumanising attitude of the medical profession towards women. Moreover, the doctor's analogous references to cows imply the medical opinion regarding reproduction and women:

A handsome face and good teeth are of secondary importance; but a good nurse should be young and have already reared one child at least ... a cow at third calving will yield a more copious supply of milk; and a woman will also probably prove a better nurse if she has already suckled one or two infants.³

The doctors further recommend that:

¹ Jo Murphy-Lawless, *Reading birth and death: a history of obstetric thinking* (Cork, 1998), pp 22–23.

² *D.M.P.*, xlix (1863), pp 529–530.

³ *Ibid.*, p. 529.

It is highly desirable that a wet-nurse should be preserved as much as possible from all causes of physical or mental excitement calculated to effect the lacteal secretion in its amount or quality. Thus, to a hired nurse sexual intercourse should be entirely prohibited, and allowed but with much caution to a mother who suckles her own child.¹

Though it might be argued that this patent disregard of a human being is indicative of attitudes to servants in general, the lecture points to the new medical advisory role.

Here, the doctor has not only the knowledge to choose a wet-nurse; he also has the authority to pronounce on the habits of a breastfeeding woman. The lecture views a woman first in terms of her reproductive role and secondly as a human being.

In 1855 the *Dublin Medical Press* printed an article by a Dr Winn discussing 'puerperal mania'. The article describes this disorder as 'that maniacal excitement which supervenes during the first months after delivery, and appears to be the result of extreme irritability of the brain associated with great nervous exhaustion.'² The ambiguity of this particular ailment does not deter the doctor from proceeding with his description of the alarming symptoms of this particular 'disease':

The earliest indications are restlessness, an anxious expression of countenance, peevishness, slight incoherence, and extreme talkativeness ... As the disease advances, all the symptoms become aggravated, and the patient's mind is occupied with various delusions. She often expresses hatred towards her husband and child and frequently utters oaths and obscene language. A tendency to suicide is very common, and the persistence of extreme restlessness is often one of the most inveterate symptoms.³

The article implies that women not only are constrained by their reproductive system, but are helpless victims to it. It suggests that the female role of reproduction intensifies illogical and irrational behaviour in women. Though puerperal fever itself

¹ *Ibid.*, p. 530.

² *D.M.P.*, xxxiii (1855), pp 326–328.

³ *Ibid.*, p. 326.

was a serious and life-threatening illness often caused by the infected hands of doctors, here 'puerperal mania' is presented as an example of the irrational female mind that is inextricably tied to her reproductive system. The fact that the features of the 'disease' are vague and indeterminate emphasises the lack of medical knowledge on obstetrics and the inclination of doctors to interpret women by their sexual functions.

The author further recommends that, should these 'symptoms' persist, the patient be removed to an asylum. It is noteworthy that the power of the doctor is emphasised. The medical man has the authority to decide whether a patient should be sent to an asylum or not. What is also significant is the parity between mental ill-health and the female's reproductive role. Indeed, in this article, the lines are definitely blurred. The doctor then presents a case study to illustrate just how favourable these asylums are in the treatment of these unfortunate women.

About two years since, I was requested to see ... a baker's wife, aged 37 ... who had been attacked with mania five weeks after delivery of her seventh child. I found her in a great state of excitement, talking incessantly and her mind filled with phantasms. Her chief delusion consisted in the belief that she was suffering from poison which had been administered to her before my arrival. Her tongue was white; the countenance animated and cheerful, and the body not in the least degree emaciated. Her watchfulness was incessant. Perfect quietude, a full dose of morphia, with as much seclusion as her circumstances would permit, were prescribed. This course was followed during several days, but without avail; neither sleep nor tranquillity were to be obtained ... I advised her immediate removal to an asylum, which was done a week after the commencement of her attack. In three months she was restored to her family perfectly well. Since then she has been confined with another child without any recurrence of the mania.¹

¹ Ibid.

Thus, the irrationality of the female as a direct result of her reproductive capacity could only be 'cured' by the medical man's intervention. This intervention was to separate the woman from her family and her young infant.

In 1854, the *Dublin Medical Press* printed the discussions of the Royal Medical and Chirurgical Society in Dublin on the use of chloroform during labour. The article alludes to the fact that medical men believed chloroform would interfere with the 'natural' and necessary female pain during childbirth. 'It was not wonderful that women doomed to bring forth their offspring in pain and sorrow should seek to escape from the troubles of our race by means of this treacherous gift of science'.¹ While it is important to interpret this denouncement of the use of chloroform during birth as a reservation regarding a new medical breakthrough, the discussion implies a belief that discomfort and pain are an integral part of womanhood:

'In sorrow shalt thou bring forth children' was an established law of nature – an ordinance of the Almighty as stated in the bible, and it was in vain to attempt to abrogate that law. There could be no doubt that it was a most unnatural practice to destroy the consciousness of women during labour, the pains and sorrows of which exerted a most powerful and salutary influence upon their religious and moral character, and upon all their future relations in life.²

The emphasis on 'nature' bolsters the discourse that pain and childbirth are the natural role for women. The implication is that the pain of labour is somehow a retribution for sexual intercourse and, thus, labour itself is a form of control on the sexual nature of women.

¹ *D.M.P.*, xxxi (1854), pp 19–22

² *Ibid.*, p. 22.

2. The weaker sex

Ehrenreich and English point to the nineteenth-century medical theory of female weakness, which asserted that the female body contained a set quantity of energy that was directed variously from one organ to another – meaning that one organ or ability could be developed only at the expense of another.¹ The *Dublin Medical Press* was anxious to emphasise that the reproductive organs, in particular, were in conflict with the other organs for that fixed supply of vital energy. Thus, any activity taken up by the female would divert energy from her sexual organs. Medical science in the nineteenth century asserted that the female's place in nature rested ultimately on her biology. Women's presumed greater susceptibility to T.B. was seen as evidence of the inherent defectiveness of the female body.² Essentially, the female body was seen as an aberration of the male norm and, thus, pathological. This section of the chapter aims at examining this medical discourse on the inherent weakness of women in the pages of the *Dublin Medical Press*, and considers how it provided a convenient basis for the subordination of Irish women.

Nineteenth-century medical science suggested that female inferiority was clearly evident in almost every analysis of the brain and its functions.³ A Darwinian⁴ sexual science offered 'expert' evidence on the evolutionary differences between the sexes – women were essentially defined as nurturers, their domestic prowess making home

¹ Barbara Ehrenreich and Deirdre English, 'The "sick" women of the upper classes' in John Ehrenreich (ed.), *The cultural crisis of modern medicine* (New York, 1978), pp 130–131.

² *Ibid.*, p. 127.

³ *Ibid.*, pp 50–51.

⁴ See Charles Darwin, *The descent of man* (London, 1871). In this book, twenty years after the publication of *The origin of the species*, Darwin emphasised the centrality of the domestic and, specifically, the reproductive role of women. The book was to create a furore over its theories of evolution and 'sexual selection'.

life most suitable.¹ Men, on the other hand, had evolved aggressive, ambitious traits that made them perfect candidates for public life. The success of the better-endowed males in the competition for wives had gradually caused the male to vary and differ from the female; in this way, Darwin argued, he had become her superior in terms of strength and mental powers.² Darwinian thinking, so popular in the nineteenth century, proved a convenient soap box for medical men to promulgate their discourse on the inherent weakness of the female sex. Moreover, to reject Darwinism was essentially to reject rational science. There was an important link between gynaecology and anthropology. Moscucci shows how the medical establishment utilised images of physical delicacy and psychological instability, equating women to children, and defined women as irresponsible creatures in need of protection and male supervision.³ Medical men jumped, as it were, on the evolution bandwagon, claiming that women had smaller brains and thus were unable to participate in life as fully as their male counterparts. The discourse surrounding the size of the brain became a medium through which doctors underlined female inferiority.⁴ Nineteenth-century medicine promulgated the notion that the sexual functions were dominant in the woman and in order to analyse females, medical men needed to focus on the inextricable link between the female reproductive organs and their minds.

The following articles from the *Dublin Medical Press* highlight the concerted effort by the medical profession in Ireland to set women apart as essentially irrational beings, helpless in the face of the domineering influence that was their gender.

¹ Showalter, *Sexual anarchy*, pp 87–89.

² Darwin, *Descent of man*, pp 270–271.

³ Moscucci, *Science of woman*, pp 31–32.

⁴ See Haller and Haller, *Physician and sexuality*, pp 50–52.

3. The smaller brain

Burstyn points out how the medical profession promulgated the notion that the sexes were physiologically different and were designed to perform different tasks.¹ The profession required justification for the discourse that defined women as ultimately weaker and less capable than their male counterparts. As early as 1846, Dr Thomas R. Mitchell, Master of the South Eastern Lying-in Hospital and lecturer on midwifery in the Dublin School of Medicine, in a discussion on rupture of the uterus, asserted: 'It has been noticed that in the majority of cases of rupture, that the children have been males, and we know that the heads of such are larger than in the opposite sex'.²

The female brain was smaller and so unsuited to the activities of the male. The Darwinian thinking at the time compared the size of the female brain to that of a child and a negro³ – thus showing nineteenth-century medical science's attempt to place the races and sexes in a 'natural' order of ascendancy. To deny this was, in essence, to fly in the face of modern science and to uphold medieval, irrational beliefs.

The Lancet reported almost fifty years later, in 1892, on the differentiation between the male and the female brain. Although great advances had been made in the meantime with regard to female education, there was still a medical belief in the anthropological differences between men and women:

that the man's brain is not only heavier than the woman's, but that in weight it has a wider range of variation; that the distribution of the brain matter differs in both, the grey substance in the woman's brain is so inferior in density to the

¹ Joan N. Burstyn, 'Education and sex: the medical case against higher education for women in England 1870–1900', *Proceedings of the American Philosophical Society*, cxvii, no. 2, Apr. (1973), p. 83.

² *D.M.P.*, xvi (1846), p. 305.

³ James Moore and Adrian Desmond (eds), *Charles Darwin: the descent of man and selection in relation to sex* (London, 2004), pp xxxii–xxxiii.

same substance in the man's as to mean, in her case, a less highly developed organ; and that, finally, the circulation is more richly supplied in the male to that region of the brain which underlines volitional, cognitive, and ideo-motor activity than it is in the female, in whom, on the other hand, the sensory region is awash with blood.¹

Thus, this editorial supports the belief that men, because of their brain development, are more rational and reasoned in their thinking than women. In fact, it pointedly calls the female brain 'a less highly developed organ'. Again, the authority of 'scientific' language is behind the arguments. The ambiguity and vagueness on which the conclusion is drawn does not deter the medical argument on the cognitive inferiority of women.

In 1878, the *Dublin Medical Press* corroborated *The Lancet's* assertion on the illogical nature of women. The editorial commented that 'females ... by nature [are] excitable and more subject to sensational impressions'.² The medical discourse pointed to the existence of a frail, inferior, and ultimately inadequate brain. How then did females hope to compete at any level in the male world?

4. Physical exercise

As discussed earlier, the figure of the nineteenth-century middle-class Irish woman was stealthily retreating indoors in what Hoppen refers to as the 'male farmer hegemony'.³ This new emphasis on domesticity gave the role of motherhood increased prominence. This discourse led to female activity outside the domestic setting being frowned upon. The *Dublin Medical Press* appeared anxious to uphold

¹ *The Lancet*, i (1892), pp 1037–1038.

² *D.M.P.C.*, lxxvii 1878, p. 49.

³ Hoppen, *Ireland since 1800*, p. 108.

the discourse that females were intrinsically frail and unsuited for activities that their male counterparts took for granted.

In 1878, in an editorial entitled 'Swimming for girls', the *Dublin Medical Press* commented on a newspaper article encouraging girls to take up swimming:

In a morning paper, Mr John Macgregor says, 'hundreds of girls are learning to swim, but many hundreds more would gladly learn if teachers could be had'. With regard to the great saving of human life that would result in our daughters learning to swim, as well as our sons, it is not within the province of a medical journalist to say much on the subject. But there is one aspect of the question on which he is entitled to give an opinion, and that is, the effect such a practice would have upon the health of a woman, particularly at that period of life when the human frame has not completed its full development.¹

There is no mention of the adverse effect that swimming might have on young boys.

The article, while offering no rationale or explanation, suggests that swimming would somehow interfere with or disrupt the reproductive development of young girls.

Moreover, the idea that swimming might be harmful to young females is conveniently shrouded in ambiguity and serves to highlight, once again, the emphasis placed on the innate weakness of women. This validated the medical discourse that there was no place for women in society outside the home.

The growing popularisation of cycling did not escape the disapproval of the medical profession. Haller and Haller, in an American context, point out that the reason that many medical men were reluctant to approve of the female cyclist stemmed from their belief that women who took to cycling would find themselves outside the protective influence of the home circle and, in their weakness, might be tempted to be negligent

¹ *D.M.P.C.*, lxxvii (1878), p. 28.

in personal modesty.¹ 'Women have, we believe, never taken very kindly to cycling, and perhaps it is because the pastime makes too exacting and continuous demands upon their powers of endurance'² asserted the *Dublin Medical Press* in 1893. In an editorial, the journal quotes from a Dr B. W. Richardson, 'an advocate of cycling', who recommends, 'that girls should not begin to ride regularly until they have reached their seventeenth year, and not then unless they are strong and well formed'.³ Thus, according to the journal, when females had passed through the fraught and fragile period of puberty and their reproductive potential was assured, only then could cycling be taken up as a pastime. Once again, the reproductive role of the woman is prioritised above all else. Furthermore, the pubescent female is presented as a frail being whose activities require careful monitoring by the omnipresent medical profession.

In 1864 the *Dublin Medical Press* was concerned over working-class women involved in manual labour. (This is interesting as the journal, reflecting medical thinking, usually reserved its remonstrations on everyday activities for middle-class women – the many women in Ireland employed in hard, physical labour were rarely mentioned).

the labour of women in the fields adds to the labourer's income – enables him to pay rent, buy shoes, and to feed the children better ... But at what cost? ... chastity is unknown, artificial abortion common ... and with both married and single [women] the toil in the heat of the midday sun induces premature births and of course, weakly children.⁴

¹ Haller and Haller, *Physician and sexuality*, p. 184.

² *D.M.P.C.*, cvi (1893), p. 522.

³ *Ibid.*

⁴ *D.M.P.*, xxiii (1864), p. 282.

Ireland was renowned for women of the lower orders carrying out such labours such as stone-breaking and carrying heavy bags of potatoes.¹ It would seem, once more, that it is the reproductive role of women that is a cause for concern for the *Dublin Medical Press*, and the implication is that the habits of these women might interfere with the role of motherhood. This reflects the medical discourse that identified only one function for women in society which, according to the *Dublin Medical Press*, should be protected above all else. The fact that these working-class women are outdoors, unsupervised, doing man's work suggests that the question is also a moral one. Moreover, the freedom of these women in both their work and their sexual behaviour is threatening what the medical profession purports to be their most important role – that of a mother. It is also indicative of how the lives of middle-class women were perhaps more easily curtailed and controlled, and more amenable to the narrow definitions of femininity espoused by the medical profession.

In 1880, a Dr Graily Hewitt reported in the *Dublin Medical Press* on a case of a twenty-year-old female patient that serves as yet another didactic tale on the inherent feebleness of women. The doctor tells us the patient 'was always very active but not accustomed to take food in fair quantity'.² He outlines the symptoms of 'severe and constant sickness ... Menstruation has entirely ceased for ten months. There is very extensive emaciation.'³ The patient is 'constantly sick, pulse feeble. Commencing bed sore over sacrum', thus indicating that the young woman had been ill in bed for some time. The cause of this acute debilitation, according to Dr Hewitt, was displacement of the uterus. The article reveals that:

¹ For more see Fitzpatrick, 'Modernisation of Irish female'.

² *D.M.P.C.*, xxix (1880), p. 454.

³ *Ibid.*

just before the sickness began the patient jumped from a height and felt sick after it. Probably the uterus was displaced by this leap. A friend of the patient took the same leap and was also made sick but laid up for it and recovered whereas the patient did not.¹

The didactic message is clear: females are helpless victims of their reproductive organs. The patient, clearly starving herself for whatever reason, was given a diagnosis for her 'illness' that conveniently tied in with the medical discourse that believed women were defined by their reproductive role and consequently needed to rest often. Moreover, the message of the article is that after any strenuous activity the female should be 'laid up' or, in other words, made an invalid.

The *Dublin Medical Press* printed an article in 1888 entitled 'A series of cases of anteflexion and anteversion observed in single women', in which Dr Hewitt cites a series of patients with difficulties associated with the uterus, caused by seemingly innocuous, everyday tasks.

- Miss _____, aged 24. Has been 'ill' (incapacitated probably) four years. It came on after a long walk up a hill; 'felt most miserable, as if something had given way internally'. Has been treated for some time ... Uterus is now anteflexed.
- Miss _____, aged 19. Had much walking. Appetite always bad. Uterus completely anteverted.
- Miss _____, aged 32. Ten years ago lifted two watering cans and ran with them full. She felt ill, and that something had given way. Has had headaches for some years ... The uterus is anteflexed and very low down.
- Miss _____, aged 20. One year and a half ago menstruation arrested by bathing in sea ... Very 'hysterical' ... Uterus very low down.
- Miss _____, aged 32. Menstruation checked by getting wet. Has had pain in abdomen twelve years. Walking painful. Uterus anteverted.²

This article is a clear indication of how nineteenth-century medicine pathologised femininity. It emphasises the fragility of women and asserts the medical belief that the reproductive role of a woman is threatened by seemingly harmless tasks. It also

¹ Ibid.

² *D.M.P.C.*, xcvi (1888), pp 341–343.

underlines, perhaps, the implicit desire by medical men to confine middle-class females indoors, where their roles as wives and mothers could be fully realised.

5. Intemperance

The *Dublin Medical Press*'s attitude to alcohol is discussed in Chapter 4, but the specific focus of the journal on the effects of alcohol on women requires a closer analysis. The following articles suggest the differentiation of the genders with regard to the intake of alcohol and, moreover, imply a medical belief that the apparent inherent irrationality of women is exacerbated by alcohol. The pertinent point for this study is that the *Dublin Medical Press* draws a clear distinction between men and women in terms of alcohol use.

Luddy asserts that prescriptive literature on how a woman should behave in society flourished in nineteenth-century Ireland.¹ Specific female traits of passivity, a natural shyness and an inherent meekness were espoused as ideal. Sobriety was an integral part of maintaining these essentially middle-class values. Drunken women would have represented a polarised version of the socially constructed, idealised version of femininity and represented the worst form of excess. It is therefore of little surprise that the *Dublin Medical Press* promoted abstinence from alcohol for doctors' female patients while extolling the values of alcohol for their male patients.

In 1862, the *Dublin Medical Press* printed a paper presented to the British Medical Association 'On the non-alcoholic treatments of disease' by a Dr John Higgenbottom, which refers to 'the great and fearful responsibility in ordering or prescribing by

¹ Luddy, *Women in Ireland*, p. 4.

medical men, alcohol as a medicine, particularly to delicate females'¹ and asserts that in women, the 'effects have been most calamitous in producing confirmed drunkenness'. The implicit message is that women are more susceptible to alcoholism than their male counterparts. The doctor places much emphasis on the social unacceptability of women, particularly middle-class women, drinking alcohol to excess:

On visiting a lady, I perceived she did not articulate her words distinctly, and on enquiry she told me she had been taking brandy and water. I thought it right to inform her that if any neighbour were to see her in the state she was in, it would be said she was intoxicated. She directly said, 'If I thought so, I would never take a drop again so long as I live.'²

The implication is that the idea of a woman drinking to excess was socially unacceptable in that it did not conform to the narrow definition of how a woman should behave. The doctor is anxious to present the woman as naive in the extreme, unaware of the effect the alcohol was having on her. The prescriptive conclusion warns: 'I have known some of the most truthful, beautiful and excellent mothers and wives arrive at such a state of intemperance as to become a burden on their families and outcasts of society; in a lost state, from which there is no recovery'.³ The reference to wives and mothers is indicative of how medicine centralised these roles in the lives of women. The suggestion that beauty and truth, innately feminine traits, would be ruined by alcoholic excess underlies the discourse that women should behave in a certain way. The result of any deviation from this definition of femininity is to be ostracised from society, as the doctor prescribed.

The Lancet, in an editorial in 1871, reported that:

¹ *D.M.P.*, vi (1862), pp 309–311.

² *Ibid.*

³ *Ibid.*

One of the great hindrances to the progress of temperance is the conservatism of women ... They prefer the old-fashioned forms of drink, such as port wine, stout, champagne and brandy. And, with their neurotic constitutions, there is a terrible danger of their getting to like these things. We as medical men, should remember this, and teach them how they can be relieved by less objectionable means.¹

Here, *The Lancet* is effectively pathologising womanhood.

In 1853, a Dr Kirby, ex-professor of the practice of physic in the Royal College of Surgeons in Dublin, gave an account of the effects of alcohol on a certain class of women.

I have been consulted by many females, on account of diseased sensation in one of their breasts, which made them very uneasy, although they were to all appearance in abundant health. Their bosoms were large ... And they complained of a morbid sensibility over the entire breast. They could not bear my touch, while they handled it carelessly and roughly themselves.²

The suffering of these women was, according to Dr Kirby, a direct result of consuming alcohol. He is careful to underline that the females in question are not from the lower orders; rather they:

belonged to a class who enjoy all the luxuries of life ... They call for wine on many occasions ... In the cases I have seen I have always been able to trace their disease, or their deranged sensation in their bosom, to an overweening indulgence in vinous fluids, believing in their curative virtues. When they found themselves improved from its sparing use, matters amended considerably, and when it was given up altogether every unpleasant feeling disappeared, and every apprehension it so constantly produced vanished for ever.³

The message is clear: alcohol has a damaging effect on women, this article suggesting that it even causes derangement. The rather bizarre reference to the breasts of these

¹ *The Lancet*, ii (1871), p. 648.

² *D.M.P.*, xxix (1853), pp 17–18.

³ *Ibid.*, p. 18.

women ensures that this is seen as a distinctly female problem and that similar consumption of 'vinous fluid' would not have the same impact on men.

In 1873 the *Dublin Medical Press* printed an article by a Dr John Harley that alludes to the 'demoralising tendency'¹ of alcohol on women. The doctor is particularly critical of medical men who prescribe alcohol as a medicine for female ailments. He asserts that this practice has 'wide spread evils resulting from it'. This doctor's assertions suggest a medical anxiety as to the effects of alcohol on the morality of women and girls. Alcohol consumption, even for medicinal purposes (so espoused by doctors for their male patients) would upset the traditional definitions of female passivity. 'The medical man is equally responsible to the intellectual welfare of his patients'² warned the doctor, intimating that nineteenth-century medicine linked intemperance in women with immorality. Ultimately for the nineteenth-century doctor, alcohol consumption in females suggested a potential loss of moral control that could lead to sexual indiscretions. This posed a threat to the middle-class ideological system of domesticity and consequently threatened the proper functioning of society.

The *Dublin Medical Press* again explored the effect of alcohol consumption on the morality of women in 1862, when it printed a translation of the 'celebrated dissertation' of a Dr O.M.A. Salvatori (the journal does not indicate where the doctor originates from) 'on continued, remittent drunkenness'.³ The journal remarks that Dr Salvatori's dissertation 'is little known in this country from the great scarcity and difficulty of access of the volume in which it originally appeared' and extols its

¹ *D.M.P.C.*, xvii (1873), pp 349–350.

² *Ibid.*

³ *D.M.P.*, vi (1862), pp 268–271.

virtues. The translation immediately discusses a patient: 'a handsome woman about thirty, of sanguine temperament, robust habit of body, fat, snowy skin, fair hair, acute and sharp-witted, delicately brought up in a noble family'.¹ The patient is thus presented as attractive, healthy, possessing ideal female attributes. The doctor explains how she became bored in married life: 'looking back to her former life spent in society and gaiety, she became acquainted with members of her own sex, who were addicted by their cups, and by degrees acquired the habit of drinking spirituous liquors'.² It is when the patient goes outside the domestic arrangement of home and husband that she becomes addicted to alcohol. The implicit suggestion is that it can be harmful for women to socialise together. Initially, the patient felt terrible the next day and resolved never to drink again, but the doctor explains that she was soon living by the saying:

If next morn your head feels the carouse over night
Take another stiff glass and 'twill set you all right'³

The results of alcohol consumption were catastrophic; this woman:

threw aside all modesty and decency ... raving mad, with dishevelled hair, staring eyes ... she who formerly appeared a respectable, amiable and virtuous woman, now dressed in a tattered robe, sometimes addressed her husband in obscene language, sometimes immodestly assailed her domestics.

The ideal social characteristics of femininity are, here, destroyed by alcohol. The mild-mannered, beautiful woman is replaced by a slovenly, raving madwoman. The female reproductive role is also impacted by alcohol; Dr. Salvatori states that the patient suffered from 'menstrual menorrhagia', emphasising how alcohol influences every facet of femininity. The didactic message is clear: the effects of alcohol on

¹ Ibid., p. 268.

² Ibid.

³ Ibid.

women, specifically middle-class women, are far-reaching and destructive. Moreover, the inclusion of the servants suggests the potential for social shame and underlines the unacceptability of drunken women.

6. Menstruation

According to Weeks, medical men of the nineteenth century held a deep belief that biology had incapacitated women and this was sustained by expert (medical, of course) opinion that menstruation was, essentially, a disease – a period of pathology.¹ Consequently, menstruation was defined as debilitating – a convenient disqualification for women to pursue goals outside their traditional roles of wives and mothers. By the 1850s, the ‘ovular theory’ of menstruation provided the main explanation of the biological basis of females.² This theory stipulated that it was the spontaneous release of the egg that caused menstruation, and this coincided with the peak of fertility, and also the peak of sexual desire in a woman. Burstyn asserts that in the nineteenth century, ovulation was thought to take place during menstruation and so especial care had to be taken at this time.³ Thus the ovaries were defined as the determining control centres of sex and reproduction in the female. This emphasis on the ovaries, albeit biologically incorrect, is a definitive factor in why gynaecological surgery was performed; this will be addressed later in the chapter.

Medical men pointed to examples of hysteria, apathy, irrationality and even stupidity that accompanied the menstrual cycle. *The Lancet* asserted in 1870 that ‘the English

¹ Weeks, *Sex, politics and society*, pp 42–43.

² Moscucci, *Science of woman*, p. 34.

³ Burstyn, ‘Education and sex’, p. 85.

law courts have apparently admitted the influence of disordered menstruation in producing moral insanity'¹ – essentially, menstruation caused women to go insane. Oppenheim states that the nineteenth-century medical man knew almost nothing about menstruation, and the menses of women remained a subject of controversy until the 1930s when the hormones that trigger the monthly cycle were fully comprehended.² This lack of knowledge did not deter the medical profession in their defining of menstruation as a kind of sickness that seriously impeded a woman. Haller and Haller, in an American context, assert that in the nineteenth century, the onset of puberty was associated with the female's distinctly separate destiny from her male counterparts and implied a fundamental reappraisal of her educational, social and political development.³ Nineteenth-century medicine also asserted that there was a diversion of blood as well as vital energy during the menstrual period and consequently, concentration on any other activity rendered the woman ill and threatened damage to the reproductive organs. Any exertion of any kind could result in dire results for the female including, in a world that prized women most highly for their powers of reproduction, the worst possible scenario – permanent sterility.

In 1892 the *Dublin Medical Press* published an editorial that is indicative of the propensity of the medical profession to link any debilitation, however obscure, in women to the menstrual cycle. In this case an injury to an eye is only healed when the patient's menstrual cycle is 'regulated':

An interesting case of an unusual neurosis has been recorded in a foreign contemporary. The patient was a teacher, intelligent, unmarried, aged 25, with no neurotic family history ... One day her left eye was injured by a broken

¹ *The Lancet*, i (1870), pp 262–264.

² Janet Oppenheim, *Shattered nerves: doctors, patients and depression in Victorian England* (Oxford, 1991), p. 189.

³ Haller and Haller, *Physician and sexuality*, p. 59.

violin string, and as a result of this it was noticed that reading readily caused annoyance. On examination no lesion of the eye could be detected. There was considerable headache. Soon afterwards it was noticed that on excitement or emotion the left half of the face flushed and became warm, and in the course of two or three seconds the left side of the face became the seat of profuse perspiration; the left ear became purple ... a sense of fullness was also felt in the left nostril ... If the provocation was intense, the left arm up to the elbow joint became red ... The phenomena were aggravated during menstruation. Improvement took place as menstruation was regulated.¹

While the bizarre litany of symptoms might be suggestive of the wholesale lack of knowledge of the medical profession in the nineteenth century, more pertinent to this study is the portrayal of the female body as erratic and unpredictable, a deviance from the established norm (the male body), and highly dependent on its temperamental reproductive system.

Later the same year, the *Dublin Medical Press* again alluded to the vulnerability of women during their period of menstruation:

The ready susceptibility of the nervous system, the comparative absence of exposure to weather and accident, of muscular labour and strain, and the diet, clothing, and habits which civilised life impose upon women – all of these have their full play during the time of ovarian activity, and are much more restricted before and after that middle period of life, in girls under puberty and in women after menopause.²

Consequently, during her menstruating life – a significant portion of her entire life – the female was inherently sick and moreover, incapacitated from engaging in activities that might offer opportunities to improve her life. Thus, according to the *Dublin Medical Press*, the female is hindered from experiencing life in the same manner as her male counterparts. Essentially, it would appear that these apparent restrictions were a convenient mechanism to ensure that women remained in their

¹ *D.M.P.C.*, civ(1892), p. 93.

² *Ibid.*, pp 496–497.

traditional roles of wife and mother in order to maintain the social structures so central to the middle classes and promoted by the medical profession.

The Lancet reported in 1860 on the influences of tropical climates on menstruating women:

Taking India as an example, I explained that even if the menstrual function had been previously regular in young women going out to India, it becomes irregular from travelling and the sea voyage; that, without passing through a period of repose, on arriving in India, and, before the menstrual function had had time to 'right itself', these emigrants ... were launched into the fatigues and gaieties of society, often marrying at too early an age, and even before menstruation had become regular ... I have attended patients who have been crippled for life by remaining in India long after the development of uterine inflammation.¹

The Lancet stresses that menstruation disqualifies women from living in certain areas, her biology dictating her movements:

1. When menstruation has been habitually morbid in a temperate zone, women should not form permanent settlements in the tropics.
2. Those who frequently suffered from uterine inflammation in a temperate region should not take up their abode in tropical countries.²

Essentially, the article promotes the inherent frailty of women and the medical insistence on pathologising femininity. Travel, climate and even the 'fatigues and gaieties of society' all have an adverse effect on the health of the woman. Effectively, menstruation, according to this article, served as an impediment to how a woman chose to live her life.

In 1864 the *Dublin Medical Press* reviewed a publication by a Dr Marrote on the employment of apiol (a tonic whose principal ingredient is parsley) in amenorrhoea

¹ *The Lancet*, i (1860), p. 418.

² *Ibid.*

and dysmenorrhoea.¹ The review emphasises the medically constructed link between the biology of a woman and her nervous system:

But it is chiefly in disorders which are under the influence of the nervous system that apiol is a heroic remedy ... it supplies to the nervous system the energy it has lost. Change of life, of habits, or of climate, often determines amenorrhoea. This is a fact that must not be forgotten, and which is well known to the physicians of boarding schools and religious houses. This menstrual suppression is transitory; it lasts some months and sometimes only gives rise to slight nervous disorders, or a slight oddity of character.²

The article continues by offering a case study of a seventeen-year-old girl who travelled to Paris to complete her education:

From the date of her arrival until the month of March of the following year, her menstruation was completely absent. Nevertheless, no change had been observed in her general health, though I was informed that at times she became duller, more melancholy, and more irritable than usual.³

The young girl, at a crucial time of her life, serves as an example of why women and girls should remain in the domestic sphere; the risk alluded to is sterility. Moreover, the suggestion is that the girl's educational ambitions had a direct impact on her menstrual cycle. The article concludes that the patient returned home to her family, ensuring regulation of her system.

In a critical review of *The question of rest for women during menstruation* by an American female doctor, Mary Putnam Jacobi, the *Dublin Medical Press* appeared anxious to refute the author's claims that women do not require complete rest when they are menstruating. The journal attempts to discredit the doctor by presenting her as unfeminine in her discussion of 'menstruation, copulation, gestation, comparison of

¹ *D.M.P.*, ii (1864), p. 192.

² *Ibid.*

³ *Ibid.*

the sexual organs, and the laws which govern them, scarcely subjects we should like to see as part of the education of our young female population'.¹ Dr Jacobi asserted that, according to the data supplied by her questionnaires, she had no reason to suppose 'menstrual rest' was desirable or necessary for the majority of women. The *Dublin Medical Press* suggested that her methodology was flawed and remarked that with 'the number of authorities and names introduced into the text ... to read all the works quoted would require an additional span to human life'.² Its irritation that a female doctor would choose to dispute the accepted medical discourse on menstruation is made clear by its ill-disguised condescension.

In 1875, the *Dublin Medical Press* printed a review of a work entitled *Sex in education* by a Dr Edward H. Clarke of Harvard College, which supported the medical belief that menstruation totally debilitated women:

Nature, he says, has reserved the catamenial week for the process of ovulation, and for the development and perfecting of the reproductive system ... Both muscular and brain labour must be remitted enough to yield sufficient force for the work.³

The doctor is corroborating the medical view that energy taken up with physical exercise or study would deprive the reproductive organs of crucial vitality. Undeterred by the fact that there was no scientific evidence to support this theory, the medical profession used it as a convenient rationale against the further education of women.

¹ *D.M.P.C.*, lxxv (1877), p. 482.

² *Ibid.*

³ *D.M.P.C.*, xcvi (1887), p. 146.

7. Education

In the mid- to late nineteenth century, the medical opposition to higher education for girls became stronger. The fact that more and more females were achieving academically made the earlier evolutionary/anthropological theory that women had smaller brains and, even when given the same educational opportunities as males, could not hope to achieve on a par with them, seem weak. Medical opponents of female education now required more substantial arguments to support their theory. These centred on descriptions of the gynaecological dangers awaiting the university-educated female. That this debate should be so eagerly pursued by the medical profession was not accidental – the practice of medicine was increasingly being considered by some as a suitable profession for women, especially in areas of gynaecology.¹ This study has examined the reaction of the *Dublin Medical Press* to the advance of female doctors; that the journal's response to the further education of women in general was hostile is unsurprising. By the time Dr Henry Maudsley² wrote his article on the effect of further education of females, his college had begun to grant certificates to female students and by 1884, Oxford and Trinity College allowed women to take final honours examinations – but not the intermediate ones, which were required for qualification.³ In Ireland, a dramatic development with regard to the higher education for girls came in the form of the establishment of the Ladies' Collegiate School (later Victoria College) in Belfast in 1859 and the Queen's Institute

¹ Burstyn, 'Education and sex', pp 80–81.

² Dr Henry Maudsley was professor of medical jurisprudence in the University of London. He published an article in 1874 in the *Fortnightly Review* entitled 'Sex in mind and in education' that prompted a discussion of the physiological effects of higher education on women. This article attracted great interest among the established medical profession in Ireland and England.

³ Burstyn, 'Education and sex', p. 81.

(1861) and Alexandra College (1866), both in Dublin.¹ This gave new possibilities for education for Irish middle-class girls. The Intermediate Education (Ireland) Act of 1878 and the Royal University of Ireland Act of 1879 paved the way for the further education of Irish women. Eibhlin Bhreathnach asserts that these moves for female higher education in Ireland were somewhat premature,² but nonetheless the initiative served to determine that the possibilities were there. Though a minority of Irish women were to avail of these educational opportunities in the second half of the nineteenth century, this was sufficient to unnerve the *Dublin Medical Press*, which saw the advance of women through universities, even at this foundational stage, as a threat to proper functioning of society.

Maria Luddy points to the fact that in Ireland by the 1870s middle-class women were demanding greater educational opportunities;³ in 1879 the Royal University of Ireland Act opened up university examinations to women. As a consequence, the old anthropological arguments revolving on the theory of smaller female brains were to ring hollow, forcing medical opponents to accelerate their theories if the female pursuit of higher education was to be stemmed. Robert Lawson-Tait and John Thorburn took up Maudsley's arguments in their books: *Diseases of the ovaries* (1864) and *Female education from a physiological point of view* (1867), and Dr William Withers Moore made female education the subject of his presidential address to the British Medical Association in 1886.⁴ The *Dublin Medical Press* responded to this new awareness of the need for the further education of women with characteristic

¹ Maria Luddy, *Women and philanthropy in nineteenth century Ireland* (Cambridge, 1995), pp 17–18.

² Eibhlin Bhreathnach, 'Charting new waters: women's experience in higher education 1879–1908' in Mary Cullen (ed.), *Girls don't do honours: Irish women in education in the 19th and 20th centuries* (Dublin, 1987), p. 56.

³ Luddy, *Women in Ireland*, p. 11.

⁴ Burstyn, 'Education and sex', p. 81.

pessimism. The women entering the medical colleges (see Chapter 2) might have made its protest all the more urgent.

The discourse that medical men promulgated in the second half of the nineteenth century centred on the notion that when females reached puberty they required rest and calm and needed to be free from any form of pressure, especially intellectual pressure. As we have seen, medical orthodoxy held that the female body could only accommodate excessive exertion of one organ by draining vital energy needed by others.¹ Thus intellectual effort channelled blood to the brain, rendering the ovaries and uterus weakened and damaged. The price that females would pay for academic success, doctors argued, was far too high, not only for themselves (reproduction being the central role for a woman) but for *humankind* in general.

In 1870 *The Lancet* printed the lectures delivered by Dr Henry Maudsley that were to be so influential to the medical profession. Maudsley was professor of medical jurisprudence in University College London, and adamantly asserted the reasons against the further education of females:

The physical and mental differences between the sexes intimate themselves very early in life, and declare themselves most distinctly at puberty: they are connected with the influence of the organs of generation. The forms and habits of mutilated men approach those of women; and women whose ovaries and uterus remain, from some cause, in a state of complete inaction, approach the forms and habits of men.²

The doctor insists that given the same opportunity as her male counterpart, a woman could not hope to achieve to his level. The implicit suggestion is that if a woman pursues third-level education she runs the risk of emasculating herself. Maudsley's

¹ Oppenheim, *Shattered nerves*, p. 194.

² *The Lancet*, i (1870), p. 475.

theory was that of nature as a 'strict accountant' – a theory that stipulated that when excess energy was required in a female, one part of the body had to take from another.¹ So, for example, at puberty (which medical men regarded as a crisis time) the female required surplus energy to aid the development of her reproductive organs and consequently, if she studied at this crucial time, the reproductive organs were robbed of vital energy. The analogy of a castrated man and an educated woman reflect the medical anxiety that further education would interfere with their traditional roles of wife and mother. The 'inaction' of the uterus, caused by the female pursuing educational goals, would, Maudsley asserts, cause her to sacrifice her femininity. The doctor concludes by emphasising the dire consequences of female education:

While woman preserves her sex, she will necessarily be feebler than man ... Where she has become thoroughly masculine in nature, or hermaphrodite in mind – when, in fact, she has pretty much divested herself of her sex – then she must take his ground, and do his work; but she will have lost her feminine attractions, and probably also her chief feminine functions.²

Ultimately, the lecture is promulgating the discourse that the further education of women will result not only in the loss of femininity but also in the inability to bear children. Maudsley's subtle references to female sexuality and sterility essentially pinpoint the primary roles of wife and mother, so central to the lives of nineteenth-century middle-class women. He corroborates the medical discourse that the further education of women would affect the stability and proper functioning of society.

As well as promoting the discourse of differentiation between the sexes with regard to education, the medical profession sought to highlight the dangers that education posed to the health of women and girls. In an editorial entitled 'Health of female teachers',

¹ Burstyn, 'Education and sex', p. 85.

² Ibid.

The Lancet warned in 1871 that ‘Medical men often see examples of the injurious effect of the profession of teaching, especially on females’.¹ In the second half of the nineteenth century, this was a viable career option for middle-class Irish and English women. Alexandra College, founded by Anne Jellicoe in 1866 and modelled directly on Queen’s College, Harley Street, London, was originally a training college for governesses.² Maria Luddy also notes that teaching was a popular choice for Irish middle-class women in this period³. *The Lancet* emphasised the necessity for:

the proper limitation of the work of the younger teachers, whether direct teaching work or the work of preparing for examinations, which often breaks the health of young girls. If work could be suited to age and strength and could be done as it were in open air, we should not see the pale and the weakness and the actual disease which are too often to be seen in female teachers.⁴

The editorial implies that the course work involved in teacher training has a negative impact on the health of girls. This thinking supports the discourse that education, at a certain level, was simply beyond the capabilities of inherently weak and frail females. The rather bizarre suggestion that women might require the ‘open air’ during their teaching activities implies that medicine believed the profession was inappropriate for girls.

In 1888, the *Dublin Medical Press* focused its attention on the female teacher, outlining how study ultimately interferes with the reproductive role of women:

There is something to be said in favour of the measure which is about to be brought before the School Board to render marriage on the part of female teachers a disqualification for appointment to or continuance in office. The proper place for a married woman is at home, attending to her domestic duties,

¹ *The Lancet*, ii (1871), p. 202.

² Anne V. O’Connor, ‘The revolution in girls’ secondary education in Ireland 1860–1910’ in Cullen, *Girls don’t do honours*, pp 33–34.

³ Luddy, *Women and philanthropy*, pp 8–9.

⁴ *The Lancet*, ii (1871), p. 202.

and the discharge of the physiological function of the woman, apart as well as incidental to childbirth, must suffer from the obligation of having to attend school.¹

The editorial suggests that the physiology of a woman is simply ill-equipped to deal with the strains of further education and the occupation of teaching. The *Dublin Medical Press* appears anxious to imbue the belief that teaching, often the only career opportunity for middle-class women, should disqualify a woman from having children.

The discourse that study affects the health of girls and women was also taken up by the *Dublin Medical Press* in 1880. An editorial entitled ‘Punitive treatment at high schools’ emphasises the innate delicacy of females and the pathological effects of education. The patient in question, ‘in spite of the warnings and solicitations of her parents’,² insisted on going to class during adverse weather conditions.

Her obstinacy in going out of doors when she ought to have remained in her own room was caused ... by an ambitious desire to retain the high position in her class to which she had, with much labour attained.

The tone is unmistakably disapproving: the girl is not to be praised for her determination to succeed as her male counterpart would have been; the journal chooses to focus on her defiance of parental authority. The outcome, unsurprisingly, is a sorry one; the patient, who was incidentally ‘of an intensely nervous temperament’³ (casting doubt on her ability to learn at all) fell gravely ill as a result of her exertions. The article continues:

¹ *D.M.P.C.*, xcvi (1888), p. 175.

² *D.M.P.C.*, xxx (1880), p. 197.

³ *Ibid.*

Competition as an instrument of education must be used with extreme caution with girls. If it becomes a goad to stimulate exhausted, jaded, or overstrained powers, it will work incalculable mischief. Only in moderation, and under strictly equitable arrangements, should its use be permitted in girls' schools.¹

In 1886, the subject of the ill-effects of further education on the health of girls was once again broached by the *Dublin Medical Press*. The editorial acknowledged that 'There can be no doubt that the public mind is preoccupied with the question of the higher education of women'² but was eager to point out the differences between the mental abilities of boys and girls and used the analogy of an untrained athlete to press this point home.

The physical strain incidental to severe and incessant study is one which can only be borne by a limited number of boys and young men, and is injurious or as impossible to the remainder as the performance of athletic feats by an untrained juvenile. If, in spite of contraindications, the effort be persisted in, more or less permanent damage to the organism may, and probably will result. Precisely the same condition of things maintains in the matter of female education, with the exception that the proportion of young women physically able to withstand the demands upon their animal economy is smaller than with men, owing to the great requirements in connection with their reproductive function.³

The familiar adage of the centrality of the female reproductive role is once again propounded and reflects how the medical opposition to the further education of women was deeply imbued with the discourse that linked the brain with the womb. Essentially, this viewpoint emphasised the negative impact further education would have on the already precarious nature of a woman's biology.

¹ Ibid.

² *D.M.P.C.*, xciii (1886), 150–151.

³ Ibid., p. 151.

In 1887 the *Dublin Medical Press* printed an article by the renowned gynaecologist Doctor J. Milner Fothergill,¹ physician to the City Hospital in London, outlining the harm of education for females. The doctor illustrates his point by idealising the figure of the woman confined to the house:

Instead of growing up a healthy domesticated creature, learned in all matters of the household, taught to ride and hawk and hunt, to be, indeed, the companion of the countryman of rustic ways and little culture, she is now is sent to school at tender age; for she is destined to be educated and accomplished!²

The subordinate position of the 'healthy domesticated creature' is romanticised in order to support the figure of the woman in a domestic sphere in her traditional roles of wife and mother. These roles were crucial in maintaining the socially defined and accepted definition of femininity so espoused by the medical profession in the nineteenth century.

It is no matter of fashion or caprice that so many girls at the present day prefer to earn their own living. They are practically sexless. They have no physiological aspirations to gratify, no ambition to become wife and mother. They contrast with the large-limbed women for whom motherhood is the true station in life. Betwixt the well-grown women of heroes of the past, and the small sexless spinster of to-day, there are a myriad blends, combinations and varieties.³

The educated woman is thus presented in a most unflattering way; she is stunted and sexless and beside her 'well-grown' sister, unattractive and cast as an aberration of true womanhood. The results of education in women, according to the doctor, are little short of a catastrophic:

¹ Dr J. Milner Fothergill gained a place in medical history for his work on operations for prolapse of the vagina, the bladder, the rectum and the uterus. See Michael J. O'Dowd and Elliot E. Philipp, *The history of obstetrics and gynaecology* (New York, 1994), p. 413.

² *D.M.P.C.*, xcvi (1887), p. 146.

³ *Ibid.*

physical exercise has been limited in order to enable her education to proceed. The pelvic muscles are imperfectly developed and the uterus lacks the usual support. When the reproductive organs are called into play on marriage they reveal their imperfection. The woman with an infantile uterus and ovaries remains sterile and unimpregnated: because she is not capable of impregnation.¹

This thinking was an important rationale to deter women from pursuing the new educational opportunities now open to them, and effectively replaced the now redundant medical claim that women's brains were too small for further education.

In their search for stronger arguments against the further education of women, medical men looked to the idea of racial disintegration. It was a strong argument, leaning on popular Darwinian thinking of the time, that women who had educational ambitions would 'starve' their reproductive organs and produce (if they produced at all) weakened offspring. Thus, by their concentration on matters intellectual, women ran the risk of giving birth to ailing infants. The discourse that reproductive development was totally antagonistic to mental development served to support medical and intrinsically middle-class ideologies of domesticity.

8. Female sexuality – a medical viewpoint

The publication of Doctor William Acton's *Functions and disorders of the reproductive organs*² was hugely influential and served to justify the medical

¹ Ibid.

² Dr William Acton (1814–1875), an English surgeon, published *The functions and disorders of the reproductive organs in childhood, youth, adult age and advanced life, considered in their physiological social and moral relations* in 1857. By 1901 it had run into its sixth edition. The basic premise of the work was a denial that females had any sexual feeling at all.

profession's view of female sexuality.¹ Acton observed that women had little sexual feeling and remained impassive to the physical side of marriage.

In the nineteenth century, medicine promoted a rigid distinction between reproductivity and sexuality – women were urged to be preoccupied with their reproductive powers but, conversely, to have no sexual feelings.² Such feelings were viewed as unfeminine, even pathological. Middle-class thinking asserted ideal social characteristics of passivity and domesticity in women, defining the archetypal woman as one dedicated to her central roles of wife and mother and altogether devoid of sexual feelings. Women that did not conform to this narrow and rigid definition were seen as diseased. Moreover, medical men hinted that there existed in every woman the propensity for unbridled, irrational sexuality; it was precisely this potential aberration that needed to be monitored, checked and ultimately controlled.

Oppenheim outlines the profound medical confusion regarding female sexuality and the accepted notion that middle-class women did in fact go through life in a state of sexual anaesthesia.³ The discourse surrounding the chaste, asexual wife/mother stood at the very pinnacle of middle-class ideas of respectability, where the female was viewed as the champion of the idealised domestic sphere. The woman was assumed to have inbuilt characteristics such as intuitive morality and nurturance. Thus, bestowing her with sexual passions and desires similar to men would call into question the entire theory of domesticity. Consequently, sexuality in women – specifically middle-class women – was viewed as an aberration, an illness, a pathology.

¹ Haller and Haller, *Physician and sexuality*, p. 97.

² Ehrenreich and English, "'Sick' women of upper classes", pp 133–134.

³ Oppenheim, *Shattered nerves*, p. 201.

Weeks points out that the supposed consequences of masturbation in females were even stronger than for males and tended to be linked with infertility, cancer, T.B., or at least frigidity or nymphomania.¹ Masturbation in females was seen as a form of ‘hypersexuality’,² and hypersexuality could lead to consumption (T.B.) – this was thought to explain the high rates of consumption among prostitutes. Collectively, this pointed at the notion that any deviation from sexual norms, as laid out by the medical profession, led ultimately to disease and that, essentially, disease lay behind female sexual desire.

The following articles reflect an anxiety on the part of nineteenth-century doctors as to how to interpret women as sexual beings. Spongberg points out that the notion that women were innately pure was relatively new – the eighteenth century had epitomised women as sexual temptresses.³ As we have seen, the figure of the chaste woman embodying ideal characteristics such as passivity and modesty was ideally suited to the middle-class family. The work of William Acton served as an opportune rationale for the idealisation of the ‘pure’ woman engaged in the domestic sphere. Acton asserted that ‘The best mothers, wives and managers of households know little or nothing of sexual indulgence’.⁴ Moreover, female purity would distinguish the middle classes from the excesses of the upper and lower orders. In Ireland especially, where the emerging middle classes sought to establish themselves as a separate entity from the Anglo-Irish aristocracy, establishing a distinct moral code was central to their identity. Additionally, Weeks refers to how sex in the nineteenth century acquired a

¹ Weeks, *Sex, politics and society*, p. 51.

² Ehrenreich and English, ‘“Sick” women of upper classes’, p. 133.

³ Spongberg, *Feminizing venereal disease*, p. 9.

⁴ *Ibid.*, p. 57.

peculiar significance in structuring ideology and social and political practices.¹

Middle-class thinking, and consequently medical discourse, placed the family as the basic unity of society and any deviance from this was seen to be catastrophic.

Medical men in the nineteenth century castigated the 'new' woman, in her ambitions for education, as unisexual and unattractive but conversely feared the sexuality of women in general. This study has explored how medicine sought to define prostitutes as pathological to explain their sexual availability, and this was to have a bearing on its interpretation of women in general. Behind medical views on the moral illegitimacy of the occupation of prostitution was the subliminal loathing of female sexuality itself. Lucy Bland points out that medical men held that frequent sexual intercourse would lead to the loss of female modesty.² Women were perceived by the medical establishment as lacking the rationality and pragmatism of their male counterparts, essentially having less self-control than men; it is thus unsurprising that female sexuality was viewed as illogical, suggesting a latent, unrestrained sexuality. Moreover, a woman's sexual desires had the potential to become wild and uncontrolled, thus necessitating male medical intervention.

In 1879 *The Lancet* published an article by a Dr Edward T. Tibbets entitled 'On the hygienic and therapeutic influence of habits and character'.³ The doctor asserts the disparity between the sexual desires of men and women:

Sexual feeling, although of different intensity in different cases, perhaps has a greater influence over the life of an individual than any other single sensation; and this idea is supported by the peculiarity of the natural feminine mind. The

¹ Weeks, *Sex, politics and society*, p. 20.

² Bland, *Banishing the beast*, p. 193.

³ *The Lancet*, , ii (1879), pp 421–423.

woman has less control over her feelings than the man, and as a rule, her actions are more liable to be influenced by them than in the opposite sex.¹

The doctor implicitly suggests that this irrationality in women requires the logical arbitration of medical men.

In 1886 the *Dublin Medical Press* again examined the discourse of the uncontrolled nature of female sexuality. Among a list of new medications, the journal draws its readers' attention to one with a rather interesting title: 'Salix Nigra, A sexual sedative'.² The *Dublin Medical Press* attests to the necessity of a sedative for sexual 'excitement' in women. 'The fluid extract of salix nigra is much lauded as a sedative, being used in ovarian irritation and in some cases of dysmenorrhoea, where there is sexual excitement'.³ The medical persistence of linking the female reproductive role with every other function shows the conflict in praising women for their abilities to reproduce, yet simultaneously defining strict codes of feminine sexual conduct. The extract also reflects the medical bewilderment towards the sexuality of women and the attempts to restrict and limit something the medical establishment could not fully explain.

The Lancet in 1870 printed an article entitled 'On a case of ovarian dropsy'⁴, which explores the relationship between sexual deviancy and the reproductive organs of a woman. The punitive backdrop to the diagnosis is clear: the patient in question was not conforming to sexual criteria that the medical profession had laid down for women in the nineteenth century. The author, Dr R. Peel Ritchie, physician to the

¹ Ibid.

² *D.M.P.C.*, xciii (1886), p. 166.

³ Ibid.

⁴ *The Lancet*, i (1870), pp 262–264.

Royal Hospital for Sick Children, Edinburgh tells us of the case of a woman who, 'although of respectable parentage', became 'dissolute in her habits and for many years led a profligate life'¹ and was placed in a mental asylum. The doctor states that his patient was 'very violent, noisy and obscene, intractable in disposition, and filthy in her language and habits'.² It becomes increasingly clear that the 'insanity' that she was suffering from was that she did not conform to the code of feminine conduct prescribed by the medical profession: 'it was owing to her peculiar mental condition that she had been suffering from ovarian tumour for some time'; again we see the inextricable link between the reproductive organs and the female nervous system. This link perhaps helped doctors explain why certain women, despite coming from respectable backgrounds, failed to conform to the idealised notions of passivity and morality so prized in the middle-class woman. For the doctor, ovarian disease pointed to a diagnosis of 'moral insanity':

The immoral conduct of the woman before she became legally insane is of interest in connexion with the ovarian disease which subsequently became developed. Whilst living her profligate life I hold she may be fairly considered to be morally insane. Her removal to an asylum would have been justifiable, and to have placed her under restraint would have been a kind act to her. Unfortunately it is not easy in all cases to decide between moral insanity and wilful immorality.³

This article is indicative of how the medical establishment in England and Ireland in the nineteenth century juxtaposed the reproductive organs of women with their morality – that a disorder in the former could completely overwhelm a woman, requiring, as this article is anxious to point out, the intervention of rational science in the form of the male medical practitioner. By pathologising femininity, the power of the doctor was intensified. By promoting the idea that the female organs and functions

¹ Ibid.

² Ibid., p. 262.

³ Ibid., p. 263.

could not be studied in isolation, the medical man created a discourse that a female, by the sheer nature of her gender, was sick.

In 1887 the *Dublin Medical Press* printed a lecture by a Dr Routh, consulting physician to the Samaritan's Women's Hospital in London, which reflects the medical anxiety with regard to female sexuality. The title itself shows that medicine viewed the sexuality of women with suspicion:

On the etiology and diagnosis of Nymphomania

(considered specially from a medico-legal point of view) in those cases which lead women to make false charges against their medical attendants'¹

The lecture, misogynistic in the extreme, points at the potential for a 'perversion of sexual instinct' in women, and the doctor proceeds to give examples of women of all ages who are slaves to their wild and uncontrolled sexuality:

One was an old woman aged over 70, the reverse of a lustful woman, and yet the act of defecation invariably produced such sexual excitement she was compelled to masturbate ... The other was a case of a high-born lady, and one thoroughly respectable in every way. The moment a part of the vagina behind the urethra was touched, the most violent excitement was induced. Indeed, she confessed to me that on one occasion a man she positively hated had touched her there, and she could not resist him. A third case was of a lady with a fibroid tumour and adherent left ovary. The same unnatural excitement followed the moment the ovary was touched.²

This indicates the medical suspicion that underneath a chaste façade there lay a dormant but uncontrolled sexuality in women. The women here are depicted as helpless and irrational, slaves to the uncontrollable nature of their deviant sexuality. Moreover, there appear to be no age constraints, insinuating that no woman is to be trusted. Again we see medical men's difficulty in attempting to define or comprehend

¹ *D.M.P.C.*, xcvi (1887), p. 48.

² *Ibid.*, pp 48–50.

properly the fundamental nature of female sexuality. On one hand there was the widely accepted premise, corroborated by William Acton, that women were devoid of sexual feeling; on the other, the implicit suspicion that women were sexual beings. This conflict was deepened by the fear that latent female sexuality was dangerous and a threat to men.

The author presents his audience with a specific type of 'sexual perversion' found in women that represents a threat to men: 'It is often sufficient for them to be in the presence of gentlemen for only five minutes, and they are either head and ears in love with them or else hate them with the most cordial hatred'.¹ It would appear that the doctor is attempting to discredit women in general by depicting them as irrational and impulsive creatures. He attempts to identify this 'type' of woman, who is a liability not only to doctors, but indeed to all men:

These women, for the most part present some very special physical characters. They are generally either very good looking, or, at least, very interesting in their appearance, full of sympathy in their manner, having strong affections, and generally attractive to men because of their effeminate appearance. Sometimes, if you look at them, they turn away their eyes as if overcome by your look, or perhaps to lead you to suppose that they are exceedingly modest.²

The tone of the lecture suggests an intrinsic fear of attractive women, with the doctor attesting to a belief that the modesty of women is in fact a façade. Essentially, the point of the lecture and its inclusion in the *Dublin Medical Press* appears to be as a warning to doctors everywhere on the wiles of women. The misogyny masks an anxiety on the part of the medical profession as to the sexual attractiveness of women

¹ Ibid.

² Ibid.

and the conflict this might cause men. Women are castigated as scheming, prolific liars who are hiding a loathsome and implausible sexual drive:

When under the influence of any intoxicating drugs, such as chloroform or inebriating drink, they very often by their conversation before they go off completely, or the manner in which they conduct themselves upon the bed, betray the exalted state of their sexual feelings, and they will sometimes let out while they are under the influence sudden statements which will lead you to fear that they are anything but what they have appeared to be.¹

The women the doctor refers to are presented as deeply sexual beings who deliberately deceives the hapless male. The implicit message then to suggest that the intuitive modesty and sexual passivity, so prized in middle class women, cannot be assumed or accepted. Medical men are being alerted to the latent, untrammelled sexuality that potentially lies within all women.

Later on in the same year the *Dublin Medical Press* printed the second part of Dr Routh's lecture on the 'sexual perversion of women' known as 'nymphomania'.² He warns that these women 'are indubitably the most decided liars in creation'. The author makes numerous references to particular case studies of women who had made allegations of rape to medical men and who, the doctor emphasises, were sexual perverts all the while. One young girl of sixteen who 'in appearance looked like a girl of twenty five years old' had made an allegation of rape against a medical man; she was 'subsequently found making overtures to some railway porters to masturbate her, and had been in consequence placed in an asylum'.³ Thus, by depicting this young girl as sexually deviant and therefore 'mad', the doctor is vindicating the actions of the accused medical man. This girl was pathological, dominated by her sexuality and so

¹ *D.M.P.C.*, xcvi (1887), pp 48–50.

² *Ibid.*, pp 74–75.

³ *Ibid.*, p. 75.

could not be taken seriously. The doctor appears anxious to illustrate the strength of the sexual passion in women, a marked contrast to the idealised figure of the passionless nurturing woman. Here, female sexuality is being defined as perverse and pathological and the antithesis of the proper conduct of women. We are told that one patient, after being rebuked by a doctor for her sexual forwardness, in desperation cried out: 'Doctor, you do not know the agony which I endure every day from the passions that devour me' ... 'She was dead in three days'.¹ Thus, female sexuality is portrayed as a disease, an illness that dominates and controls the woman and provides medicine with yet another example of the irrationality of women. This same sexual abandonment and alarming behaviour is repeated in a case study that stresses that married women must be dealt with using the same level of caution as with their single sisters:

It was not but the other day that a married lady, also a model of everything that is pure and modest told me that she sometimes suffered from such agony and excitement in the sexual organs, which lasted for not one hour but four and five and six at a time, that if she were not kept back by strong religious feeling she would have run into the streets and got hold of the first man she could find.²

The discourse that women were ruled by their erratic and unpredictable emotions, in this case their sexual instinct, immediately suggests that they require the steady and rational intervention of the male. It also appears to imply that women are base victims of primitive urges while men appear to be the logical and rational thinkers. Moreover, the lecture underlines the notion that female sexuality cannot be trusted: women that outwardly presented as chaste and pure beings were potentially masking a seething, dangerous sexuality from which no man was safe.

¹ *D.M.P.C.*, xciv (1887), pp 75–76.

² *Ibid.*

Conversely in 1892 *The Lancet*, in a review of a publication entitled *Differences in the nervous organisation of men and women* by a Dr Lewis, pointed to the more forceful male sexual nature:

An interesting and suggestive chapter is that in which the sexual instinct in man is compared with that in woman, and the definite conclusion is reached that this instinct is much less strong in the woman than in the man.¹

Intrinsically, it is the conflicting juxtaposition of the docile, acquiescent sexual impassivity and the disorderly, uncontrolled and primitive female sexuality that medicine suspected of lying dormant in every woman.

The shocking claim, even for its time, made in a *Dublin Medical Press* editorial in 1890 suggests that medical men were less than empathetic with the sexuality of women: 'Generally speaking, few medical men of experience believe much in rape in the case of a moderately healthy and vigorous woman'.² This intimates a medical distrust of women, a suggestion that if a rape allegation is made, a woman is simply not telling the truth. Doctors' hazy and often blatantly incorrect assessment of the biology of females contributed to their inability to decipher female sexuality, and rather than articulate their ignorance, the *Dublin Medical Press* sought to define narrowly the proper conduct of women. Those who failed to conform to its definition were labelled and ultimately condemned.

¹ *The Lancet*, i (1892), p. 697.

² *D.M.P.C.*, ci (1890), pp 87–89.

9. Exploring the female body

The new emphasis on the female reproductive role validated the new medical interest in the biological functioning of the woman's body. The female's period of pubescence, her menstrual cycle, her pregnancies and her menopause, all became subjects of unparalleled medical conjecture. The ovaries, fallopian tubes and most especially the uterus attracted an almost obsessional curiosity from the medical profession. The sheer volume of gynaecological articles and correspondence in the *Dublin Medical Press* attests to this.

Oppenheim points out how in medico-scientific texts the image of the female was shifting and fluid.¹ On one hand there was the view, featuring heavily in fiction of the time, of the fragile child-woman, asexual and delicate; conversely there was the suspicion that women were in closer contact with nature and thus with natural desires than their rational male counterparts. Certainly, in the second half of the nineteenth century medical discourse on female disease and illness, specifically mental illness, linked abnormality of behaviour with the reproductive system.² Female psychology operated as a continuation of female reproductivity; the female nature was dictated by her reproductive role alone.

Jeffrey Weeks points out that new gynaecological discoveries in the nineteenth century did nothing to assuage the dominant medical discourse that women were

¹ Oppenheim, *Shattered nerves*, p. 20.

² Pauline M. Prior, 'Mad, not bad: crime, mental disorder and gender in nineteenth century Ireland', paper presented at Medical Sociology Conference of the British Sociological Association (York, 1995), p. 13.

dominated by their reproductive systems.¹ The assumption that women belonged to nature while men were logical and rational was tacit in medical beliefs. By the mid-century gynaecology was presenting itself as an admissible specialism to the study and treatment of female reproductive and sexual physiology.² Oppenheim, from an English perspective, asserts that medical men concealed their lack of expertise by employing obscure terminology.³ This basic lack of knowledge did little to deter the medical preoccupation with gynaecological surgical procedures in the second half of the nineteenth century, as reflected in the *Dublin Medical Press*: there was a dramatic and disturbing increase in such surgery towards the end of the century. Why such an interest in surgical procedures on the reproductive organs of women? Dr Lombe Athill, in his capacity as Master of the Rotunda Hospital in Dublin in 1890, asserted that ‘Laparotomy⁴ is an operation now frequently performed ... The operation in uncomplicated cases is an easy and safe one, consequently the temptation to perform it is great’.⁵ This intimates that medical practitioners were using gynaecology to gain surgical experience and establish themselves as expert in their field. Elaine Showalter refers to the fact that opening up a woman was a useful solution to a wide range of medical problems, and the best way to decipher women was to dissect them.⁶ O’Dowd and Philipp, from an American perspective, assert that gynaecology developed very separately from midwifery in the nineteenth century and the female reproductive tract was subject to ‘much unnecessary ... surgical assault’.⁷ Showalter makes an extreme but interesting analogy when she refers to the fact that Jack the

¹ Weeks, *Sex, politics and society*, pp 42–43.

² Bland, *Banishing the beast*, p. 65.

³ Oppenheim, *Shattered nerves*, p. 7.

⁴ This is the name for the surgical procedure which involves the removal of the uterus, ovaries and fallopian tubes.

⁵ *D.M.P.C.*, xcvi (1890), pp 523–524.

⁶ Showalter, *Sexual anarchy*, p. 131.

⁷ O’Dowd and Philipp, *History of obstetrics*, p. 16.

Ripper butchered and mutilated prostitutes in 1888 – opening the bodies and neatly removing the uterus and viscera – an eerie echo of the nineteenth-century theme of opening and dissecting women.¹ This section of the chapter seeks to explore how the *Dublin Medical Press* sought to ratify and ultimately to justify the numbers of women undergoing gynaecological surgery.

In the nineteenth century gynaecology was seen as the study of the ‘whole woman’ whereby medical men fused the physical, the psychological and the moral aspects of women.² Thus the functions of femininity could not be understood in isolation; all needed to be assessed together. The belief that women were ruled by their reproductive systems was implicit in all medical discourses.³ The sexual organs were seen to be in constant interaction with the rest of the female organism. As we have seen, the nineteenth-century ‘economic’ theory expounded that the body of the woman was a closed system in which organs and mental faculties were in competition for a finite supply of energy, thus the stimulation of one organ invariably led to exhaustion in another part of the body. Thus, major biological events such as pregnancy, lactation, even menstruation could lead to major mental and physical upheaval and turmoil for the female.

The *Dublin Medical Press* printed an article in 1854 that highlighted the medical belief that the reproductive role of a woman influenced all her other bodily functions. It points to a medical condition known as ‘retinitis from undue lactation’⁴ and details how ‘The attention of practitioners is often called to imperfect vision, or what the

¹ Ibid.

² Moscucci, *Science of woman*, p. 103.

³ Weeks, *Sex, politics and society*, p. 45.

⁴ *D.M.P.*, xxxi (1854), p. 253.

patient styles weakness of the eyes, in women giving suck'.¹ The editorial intimates the medical belief that the woman's entire physiology was at risk during major biological events – in this case, lactation.

The Lancet reported in 1871:

General or local disorders may in their course react upon, and induce disorder in the sexual system ... These inter-reactions are exceedingly frequent. Indeed, it may be affirmed that no severe constitutional disorder can long continue in a woman during the predominance of the ovarian function without entailing disturbance in this function. And the converse is also true, that disorder of the sexual organs cannot long continue without entailing constitutional disorder, or injuriously affecting the condition of other organs.²

The female body cannot be separated from her reproductive functions; essentially, this article suggests that the medicine establishment could not determine any female disorder without first examining the sexual organs.

In an article entitled 'On the relation which often exists between cutaneous affections and derangements of the internal generative organs of the female',³ the preoccupation with female physiology continued:

The physiological functions of the organs of generation, as menstruation, pregnancy, the puerperal state, and lactation, as well as the irregularities of these functions, are to be met with among the causes of these diseases of the skin.⁴

The article expands by declaring: 'Another affection which frequently depends on a pathological sexual condition is the falling out of the hair'.⁵ The author continues to

¹ *Ibid.*

² *The Lancet*, ii (1871), pp 569–570.

³ *D.M.P.*, xxxv (1856), pp 181–182.

⁴ *Ibid.*, p. 181.

⁵ *Ibid.*

explain how all these conditions are linked with the intrinsically sick female system: 'and as in women the sexual functions have the greatest influence upon the latter, the relation which exists between the falling of the hair and diseases of the generative organs will no longer appear so singular as at first sight it may have done'.¹ Consequently, the sexual functions of the female would dictate how other maladies were to be treated.

Oppenheim shows how the uterus was still credited with the ominous power to disrupt almost all the workings of the female body.² Doctors believed that the sexual organs continually interacted with the rest of the female body and this in turn caused disorders that were often indeterminate and obscure, without any obvious physical manifestations, such as 'uterine irritation'. Increasingly, as women were becoming more and more to be defined by their reproductive capacity, the medical establishment began to intimate that maintenance of the proper functioning of society depended on medical observation and monitoring. This legitimated the widespread increase of gynaecological surgical procedures in women in Ireland in the second half of the nineteenth century. William Stokes, professor of surgery in the Royal College of Surgeons in Dublin, referred to the 'startlingly great' mortality of women in 1874 from gynaecological operations; in a table of twenty-eight procedures, there were only seven recoveries.³ Mary Poovey points to the medical thinking that ensured that even if a woman did not bear children, her capacity to do so dictated her health.⁴ These

¹ Ibid., p. 182.

² Oppenheim, *Shattered nerves*, p. 189.

³ *D.M.P.C.*, lxxviii (1880), pp 120–122.

⁴ Mary Poovey, 'Scenes of an indelible character: the medical treatment of Victorian women' in Catherine Gallagher and Thomas Lacqueur (eds), *The making of the modern body: sexuality and society in the nineteenth century* (London, 1987), p. 145.

assumptions of the centrality of the female biological functions legitimated and authorised invasive medical treatment of women.

The ovary, by the second half of the nineteenth century, had become the primary organ in the examination and understanding not merely of the female reproductive system but also the entire woman. Ornella Moscucci states that nineteenth century medicine viewed the ovaries as the seat of sexual instinct in a woman.¹ The alleged incidence and gravity of ovarian disease legitimised the view that sex and reproduction dominated the woman's mind. By the 1870s ovariectomy, despite being a very dangerous operation² with high mortality rates, was established as an accepted procedure and was hailed as the triumph of gynaecology.

Until the mid-1800s gynaecological surgery was limited to the removal of polyps, the excision of hypertrophied clitoris and so on, but after that medical men were performing perilous and daring abdominal operations such as ovariectomies and hysterectomies.³ By the end of the century, sexual surgery, such as ovariectomies and hysterectomies, had become an antidote for a variety of female ailments, including psychiatric disorders.⁴ Essentially, this would place women in an increasingly vulnerable position as medical science exposed them to dangerous surgical procedures in a bid to define them and also to raise the prestige of the profession. Poovey points out that nineteenth-century obstetrics and gynaecology lent a prestige to doctors that

¹ Moscucci, *Science of woman*, pp 34–35.

² Dr Thomas Spenser Wells, a famous gynaecologist (who performed the first ever ovariectomy in Great Britain in 1857) had performed 50 ovariectomies by the end of 1862 and lost 33 of those patients. By 1872 he had carried out 500 ovariectomies. See Moscucci, *Science of woman*, pp 149–153 and O'Dowd and Philipp, *History of obstetrics*, pp 405–407.

³ Moscucci, *Science of woman*, p. 108.

⁴ Duffin, *History of medicine*, pp 259–260.

midwives did not possess.¹ This section of the study seeks to underline how the value of female reproductive capacity bolstered the status of medicine, thus authorising the medical preoccupation with the bodies of women.

In the *Dublin Medical Press* in 1886, a Dr J. E. Burton discussed case studies of surgical procedures on the reproductive organs of women. The hazardous nature of the procedures is evident. The first case resulted in the death of the patient. The doctor had this to say – ‘I have unfortunately lost the notes of this case, but she [the patient, who had both ovaries removed] died in about six days of septicaemia’.² Another case documented is one of a young woman aged 26 who suffered from epilepsy. ‘Her mind was getting sluggish, and there appeared a probability of her ending her days in an asylum. Although I do not look at oophorectomy as a cure for epilepsy, I think when the disease points to a menstrual origin oophorectomy is quite indicated.’³ Thus, the interdependence of the reproductive organs and all other functions legitimated surgical intervention. The doctor curiously reports as to the success of the operation, the epileptic fits having vanished on removal of the source of irritation: the ovaries.

In 1890, the *Dublin Medical Press* outlined the importance of gynaecological operations:

That even when unsuccessful, as they are to be in a certain proportion of the cases, the sterility which would be entailed by removal of parts of the reproductive organs is not a valid argument against the practice, seeing that it is eminently undesirable in the interests of society and of humanity at large that individuals with transmissible morbid tendencies should procreate.⁴

¹ Poovey, ‘Scenes of an indelible character’, p. 150.

² *D.M.P.C.*, xciii (1886), pp 321–323.

³ *Ibid.*, p. 321.

⁴ *D.M.P.C.*, ci (1890), p. 392.

This justification for surgery is perhaps indicative of the medical profession's general view of women. The journal emphasises that a woman's ability to have children can be the decision of the surgeon: in the interests of the proper functioning of society, surgical intervention is not only desirable but necessary. The ultimate authority rests with the medical man through the suggestion that the female body belongs to nature and so requires the scrutiny of medicine.

In 1863, the *Dublin Medical Press* printed a report by a leading gynaecologist, Dr Robert Lee, of 567 cases of ovariectomy in a London hospital: 235 patients died 'from the direct effects of the operation'.¹ This is suggestive of the dangers associated with gynaecological surgery where the medical profession had still not fully grasped the notion of antiseptic surroundings. In 1880, William Stokes, professor of surgery in the Royal College of Surgeons, claimed that 'the mortality of the operation has largely diminished since the principles of antisepticism have become more thoroughly understood and recognised',² but concedes that there is an absence of published reports and admits that the mortality rates in Dublin were high in the last report in 1874. None of this appeared to deter the medical profession from performing surgical procedures on women. Increasingly, the *Dublin Medical Press* sought to identify more and more inducements to validate such surgical intervention.

Nineteenth-century medical thinking, in its drive to improve the social status of the profession, was eager to promulgate the idea that mental illness was a disease of the brain as opposed to a spiritual state. Oppenheim shows that practitioners believed that

¹ *D.M.P.*, xcxi (1863), p. 363.

² *D.M.P.C.*, lxxviii (1880), pp 120–121.

the ovaries and uterus bound women in a 'stranglehold of sickness', unlike anything men experienced.¹ The *Dublin Medical Press* increasingly linked all female functions to their reproductive one, and therefore it is unsurprising that mental illness should be inextricably tied to the area of sexuality. This section of the study seeks to explore how the *Dublin Medical Press* became increasingly preoccupied with the sexual functions of women, and identified women who did not conform to the narrow, essentially middle-class constraints of femininity as deviant and mentally depraved. It also seeks to highlight how by the end of the century, in Britain and Ireland, a number of gynaecologists began to advocate the removal of healthy ovaries for the cure of a range of conditions from dysmenorrhoea to insanity. Moscucci asserts that nineteenth-century medical men were promoting the idea of appointing gynaecologists to the staff of insane asylums and recommending routine gynaecological examinations to diagnose mental illness.² Essentially, the medical promotion of the interdependence of the reproductive organs and the female brain legitimated the increase in gynaecological surgery.

The *Dublin Medical Press* in 1890 commented on the link between mental disorders and sexual functions in women. This topic had been raised by a Dr Barnes in his paper at the opening meeting of the British Gynaecological Society, indicating the significance of the discourse that pointed to a connection between sexual deviancy and disordered organs of reproduction in females. The *Dublin Medical Press* pointed out that Dr Barnes's paper called for 'a more systematic examination of the pelvic organs in the case of female lunatics'.³ The journal settles the question of the 'impropriety' of operating on mentally ill women by asserting 'that persons whose

¹ Oppenheim, *Shattered nerves*, pp 187–188.

² Moscucci, *Science of woman*, p. 105.

³ *D.M.P.C.*, ci (1890), p. 321.

mental condition was not such as to enable them to give a valid consent ought to be treated as infants'.¹ Again, the premise of the woman as inherently unstable persists in the journal, further authorising the continual medical monitoring of women. The theory that female insanity could be 'cured' by the treatment of a localised pathology, be that in the ovary, uterus or fallopian tubes of a woman, bolstered the prestige of medicine and espoused the daring abdominal surgery that saw such a marked increase at this time.

In 1890 the *Dublin Medical Press* printed an article in which a Doctor McMordie, surgeon in the Samaritan Hospital for Women in Belfast, outlines the case of a twenty-five-year-old female patient who was placed in an asylum for the insane.

She remained there for three months without any improvement in her mental systems. I was then consulted and with a view to making an examination of the pelvic organs. I found the uterus hypertrophied and retroverted, with erosion of the os uteri and canal of the cervix.²

The patient was suffering from the rather ambiguously termed 'mania' and the author states that: 'So violent was she that it was necessary to keep a nurse constantly with her', and immediately identifies the source of this mental disorder to be the uterus:

She was immediately placed under treatment for the uterine trouble, and as that organ returned to a healthy condition the mental disturbances disappeared, and she was discharged cured on August 1st.³

In this case, the woman's mental instability and violence were supposedly as a direct result of a disorder in her reproductive organs; once this was treated, according to the author, she made a rather miraculous recovery.

¹ Ibid.

² Ibid., p. 469.

³ Ibid.

The author cites another case of remarkable recovery:

where I removed both ovaries, which had diseased, for insanity, and where the woman had become a confirmed masturbator. The operation was so far successful as to cure her of the habit of masturbation, and there was an improvement in the mental disturbance.¹

The fact that the woman masturbated seems the crux of the matter and surgical intervention 'cured' her of this sexual deviance. It would seem that medical control over female physiology and morality was total. The morality that the medical profession had long been promoting now had a medical justification. If a woman did not conform to medical discourses on sexuality and sexual roles, she was not merely branded as mad, but the internal workings of her body could be scrutinised and operated upon.

Thus, this chapter reflects how the *Dublin Medical Press* was determined to prove that women were inferior to men. It did this by drawing on evolutionary arguments that suggested the physical incapacity of females and by placing women very firmly in the home by attributing to them ideal social characteristics and a biological basis for domesticity and reproduction. Essentially, the *Dublin Medical Press* was drawing on the conventional and very conservative ideas of femininity associated with social stability, public order and the proper functioning of society. This view of women bolstered the position of the doctor, her vulnerability not merely validating his intrusion into every aspect of her life, but substantiating and legitimising invasive and unnecessary surgical procedures.

¹ Ibid.

CHAPTER 6: HYSTERIA

Medical discourse in the nineteenth century became increasingly preoccupied with the mysterious and predominantly female illness the medical profession termed 'hysteria'. This was an umbrella term for a multifarious collection of ailments ranging from slight headache to violent 'hysterical' fits. The common denominator was that they were psychological and involved what we might today call incapacitating depression. The *Dublin Medical Press* devoted much of its commentary to the prevalence and genesis of hysteria. In the absence of any research on the topic of hysteria in post-Famine Ireland, the aim of this chapter is firstly to examine what precisely hysteria was, and secondly to attempt to understand its prevalence in Ireland by examining the medical discourse on it as recorded in the *Dublin Medical Press*. This chapter ultimately seeks to uncover the stake of the medical profession in its definition and interpretation of hysteria and how this accentuated its influence and power in the second half of the nineteenth century.

This study seeks to highlight, through the articles of the *Dublin Medical Press*, how femininity and morality became inextricably entrenched in the diagnosis and treatment of hysterical patients. Hysteria in all its abstruseness espoused the prevailing middle-class ideology of women as weak and easily incapacitated. Many of the available secondary sources refer to an American and an English context. This chapter aims to fill in some of the gaps in the understanding of hysteria in Ireland,

highlighting the prejudices, gender-bias and ultimately misogynistic attitudes of the medical profession in Ireland. This study has explored how the *Dublin Medical Press* identified the female body as inherently sick: the medical discourse on hysteria pointed to the female mind as being ultimately unstable.

The term 'hysteria' itself was suitably ambiguous to encompass a wide variety of symptoms, from epileptic-type seizures to ovarian 'irritation'. Hysteria legitimised the nineteenth-century medical view that women were inferior and weakened versions of rational man, undermined by unpredictable and capricious natures. Moreover, by explicating women as essentially debilitated by neurosis, the *Dublin Medical Press* was not merely endorsing the role of medicine within society but validating the expansion of that role as the social and moral commentators in society.

The first section of this chapter examines how the medical profession in the nineteenth century classified and defined hysteria. The respectability of the profession demanded that hysteria evince a clear, organic aetiology and a series of recognised symptoms. The long-held medical preoccupation with the female reproductive system came into play in the profession's discourse on hysteria. This section seeks to explore why the *Dublin Medical Press* reflected the profession's anxiety that hysteria be defined as an organic, complex disease. This chapter will also examine how 'neurasthenia' became the socially acceptable term for hysteria.

The second section of the chapter examines the prevalence of hysteria in Ireland in the second half of the nineteenth century as indicated in the *Dublin Medical Press*. To understand this concept it is important to study the social context of the country at this

period, and this section underlines the significance of the increasingly businesslike marriages of post-Famine Ireland. The lack of employment opportunities for women, and how this led to the increased social importance of motherhood, is also explored. This section seeks to examine how the decreasing economic value of daughters and the new import of the female reproductive role impacted on the frequency of the malady the profession termed 'hysteria'.

The third section of this chapter examines how the medical profession sought to construct a disease, complete with a discernible set of symptoms and an organic foundation, looking to Darwinism for its rationale. The *Dublin Medical Press* reflected the medical determination to define women as intrinsically weak creatures, whose fragile, emotive and ultimately illogical natures rendered them vulnerable to hysteria.

The fourth section of the study examines why, according to the *Dublin Medical Press*, the label of hysteria was frequently acceptable to women in the nineteenth century. This part of the chapter explores how hysteria was often promoted as an illustrious illness that preyed on civilised, intelligent people, and how it was linked with desirability and concepts of female sexual attractiveness.

The fifth section of the chapter investigates the constructed link between hysteria and female sexuality. The *Dublin Medical Press* essentially promoted a narrow definition of appropriate female sexual conduct and used hysteria as a convenient tool for the labelling of non-conforming women. The journal emphasised the sexual passivity of women while simultaneously promoting the female reproductive role. Women that

failed to conform to these roles were viewed as aberrant by the *Dublin Medical Press* and defined as 'hysterical'. The final section of the chapter examines the medical stake in the treatment of hysteria. This treatment assured the dominant role of the practitioner and reiterated the subordinate position of his female patient.

1. The classification of hysteria

Martin Charcot (1825–1893), chief physician of the infamous La Salpetriere Hospital in Paris, was arguably the most influential medical man on the subject of hysteria in pre-Freudian times. Showalter asserts that Charcot imposed a set criterion for the diagnosis of hysteria, thereby creating a conceptual and coherent illness that doctors could work from.¹ The following articles reflect the medical profession's attempts to establish hysteria as a valid disease, with a predictable course that threatened the health and happiness of women. Unsurprisingly, the discourse of the intrinsic biological inferiority upheld by nineteenth-century medicine was used to define women as sick. The reproductive role of women was viewed as the primary cause of hysteria, thus warranting medical intervention. Hysteria therefore was yet another means of bolstering the authority of medicine.

The Lancet in 1857 appeared eager to catalogue hysteria as a complex and grave disease. A Dr Lightfoot wrote:

It is rather to an exalted condition of a healthy physiological action than an inflammation, properly so called that we must trace the disturbance of the spinal system giving rise to convulsions of various kinds – included under one generic term – 'hysterical', and that fearful disorder of the cerebro-spinal system itself, terminating in an aberration of the judgement, perversion of all mental actions, in brief, in madness.²

¹ Elaine Showalter, *Hystories: hysterical epidemics and modern culture* (New York, 1997), pp 30–31.

² *The Lancet*, ii (1857), pp 79–80.

The doctor utilises medical terminology and dramatic language to create a picture of a serious and threatening disease. This fashioning of an illness legitimated the medical interest in it and lent kudos to what otherwise might have been a spurious, if altogether doubtful disease. Hysteria provided the medical profession with much-needed customers and added to the medical man's expertise.

In 1885, a Dr J.S. Bristowe wrote an article in *The Lancet* entitled 'Hysteria and its counterfeit presentments'. The long-winded description of the disorder suggests how little the profession understood it.

Hysteria represents an unstable condition of the nervous functions, arising independently of organic changes in the nervous system; in which at one time one or other part, or several parts of the nervous organism may be temporarily affected in various ways.¹

The vague and ambiguous language shows not a medical desire to understand hysteria but an innate need to rationalise it as a logical and reasonable affliction, necessitating medical intervention. In 1889 a Dr James B. Ball, physician in the West London Hospital, described hysteria as 'that special morbid condition of the nervous system'.² Again, the nebulous language points to the medical attempt to construct an illness using medical parlance and attributing hazy and obscure symptoms. In doing so, the medical establishment was also validating the discourse of female susceptibility to mental disorders.

In 1867 a Dr F. T. Porter, demonstrator of anatomy in the Ledwich School, Dublin, asserted in the *Dublin Medical Press* that hysteria 'is a most unsuitable expression for

¹ *The Lancet*, ii (1885), pp 1069–1072.

² *The Lancet*, i (1889), pp 373–375.

a group of disorders' and pointed to the 'increased development of the nervous centres and a specialised evolution of nervous force'.¹ The desire to attribute a set of clear symptoms to hysteria saw this doctor borrowing from fashionable Darwinian thinking, which pointed to evolution as a causal factor. Darwin held that evolutionary progress of advanced societies could result in nervous exhaustion.² Darwin, and indeed any references to evolution, would lend the medical discourse on hysteria a scientific rationale and thus give it an air of respectability.

As early as 1842 *The Lancet* was aligning the reproductive role of women with hysteria. A Dr Stephenson stated that:

The term hysteria implies a connection between the phenomena of the disease and the uterine functions – voepa, the womb – and, although we cannot limit this state of constitution to the female sex, there can be no doubt that it is infinitely more frequent in women than in men, and that in the former deranged uterine action is almost an invariable antecedent or concomitant.³

In the previous chapter we have seen how for most doctors, the female reproductive functions were the key to comprehending women. Here, the identification of hysteria as a manifestation of a sick womb corroborates the nineteenth-century medical view of the female as biologically inadequate. In 1867 the *Dublin Medical Press* printed an article by a Dr C. Handfield Jones who asserted 'increased reflex excitability as the leading characteristic of hysteria ... the uterus as the chief focus of hysteria'.⁴ Medical practitioners placed such emphasis on the role of reproduction in a woman's life that the assumption that her biology would override her individual will hardly seems surprising. But in the construction of hysteria as a plausible illness, the link to the

¹ *D.M.P.C.*, xvii (1874), pp 242–243.

² Haller and Haller, *Physician and sexuality*, pp 62–63.

³ *The Lancet*, ii (1842–43), p. 490.

⁴ *D.M.P.C.*, iv (1867), pp 213–214.

complex and intricate female reproductive system would add further credence. Moreover, many of the perplexing symptoms of hysteria could be conveniently construed as having a biological basis. Thus, to define hysteria as having an organic origin was a further validation of the inherent weakness of women.

Neurasthenia or chronic fatigue syndrome was, according to Showalter, a more prestigious and attractive form of female nervousness than hysteria.¹ As the end of the century loomed, and Charcot and later Sigmund Freud identified hysteria among the working classes, 'nervous exhaustion' or neurasthenia became the 'respectable' form of hysteria. Moreover, doctors had to be guarded in their descriptions of the mental health of some of their more lucrative patients. Haller and Haller, in an American context corroborate this view by attesting to neurasthenia's social acceptability in the nineteenth century.² The unlimited symptoms and distinction of neurasthenia paved the way for the suggestion that women were predisposed to mental instability. Veith shows that in nineteenth-century American medical discourse, women and girls were expected to be weak and vulnerable – both physically and emotionally – and this image was reflected in their disposition to neurasthenia.³ This chapter seeks to examine hysteria/neurasthenia in an Irish context. This study has already examined how the *Dublin Medical Press* promulgated the notion that education and, indeed, modern living precipitated mental and physical fatigue in females; this chapter examines how hysteria enabled the medical profession in Ireland to advance its authoritative power over its female patients.

¹ Elaine Showalter, *The female malady: women, madness and English culture 1830–1980* (New York, 1985), p. 134.

² Haller and Haller, *Physician and sexuality*, p. 25.

³ Ilza Veith, *Hysteria – the history of a disease* (Chicago, 1965), pp 209–210.

In 1876, the *Dublin Medical Press* printed an article by Dr Robert Lafayette Swan, a lecturer in anatomy at Dr Steevens' Hospital School. The doctor asserts that neurasthenia is 'one of the most troublesome affections'¹ he is called on to treat. He indicates how women, usually of 'excitable temperament', suffer from neurasthenia caused by 'trifling causes of anxiety which daily befall most people'. The doctor advises of the necessity of 'keeping the patient free from all exciting influences'.² The implication is that many women are predisposed to nervous complaints and struggle to confront and cope with situations that 'others' find trivial. The doctor is careful to emphasise that he has 'never met with this condition in men'.³ Consequently this nervous complaint is intrinsically female, corroborating the medical viewpoint that women are simply not as equipped to deal with life as their male counterparts and thus adding credence to the theory that females are more fitted to the domestic sphere under the protection of men: father, brother or husband.

The *Dublin Medical Press* in 1855 detailed a case of neurasthenia under the care of a Dr Hughes. The patient, aged 44 years, was suffering 'under a curious want of memory'⁴ and had 'a morbid inability to associate the idea of the commonest things around her with names'. The doctor details how, for example, the woman couldn't count past the number two and 'struggles in the most painful way' to pronounce the first letter in her name. The article stresses the how the 'intellectual action' is affected by 'emotional influences or states of mind'.⁵ Dr Hughes appears anxious to point to the overpowering influence of this patient's emotions. Her inability to perform the

¹ *D.M.P.C.*, lxxi (1876), p. 155.

² *Ibid.*

³ *Ibid.*, p. 158.

⁴ *D.M.P.*, xxxiii (1855), p. 133.

⁵ *Ibid.*

simplest of tasks is juxtaposed with the clear-thinking, clinical gaze of her male practitioner. Once again, the mental instability of women is established.

2. The prevalence of hysteria

Marriage and family

As discussed earlier, post-Famine Ireland saw the rise of the tenant farmer. As farmers became demographically and economically more significant so did their propensity for 'impartible' inheritance – in other words, keeping a single farm intact with one heir.¹ Thus, the 'stem system' became predominant in Ireland in the latter half of the nineteenth century, whereby the farm was handed over to one newly married inheritor in the lifetime of at least one parent, with allowances made for siblings and retiring parents.² Marriage, for the rising farmer, became a calculated business transaction, a negotiation of land and wealth. Comerford points to the 'unexampled ruthlessness and inflexibility' of the marriage contract in the second half of the nineteenth century.³ Luddy corroborates this view by asserting how new emphasis was placed on the 'match' system, whereby social and economic compatibility were far more important than affection or love.⁴ Consequently marriage was an immovable contract that for some was difficult and for others simply unattainable from an economic point of view. Essentially, marriage in post-Famine Ireland was very often a means of acquiring land and achieving economic certainty. The bride's father had to pay an appropriate dowry to the prospective parents-in-law. Moreover, funds had to be made available to the non-inheriting siblings in terms of

¹ Hoppen, *Ireland since 1800*, pp 106–107.

² Fitzpatrick, 'Modernisation of Irish female', pp 162–163.

³ Comerford, 'Ireland 1850–70', p. 382.

⁴ Luddy, *Women in Ireland*, pp 5–6.

emigrant tickets, apprenticeships, money, etc.¹ Apart from the feelings of isolation that arranged marriages can mean, this new designation of marriage as predominantly a financial agreement certainly meant that marriage was less accessible. The match system would have narrowed down choices significantly. Luddy points to the striking demographic trends in Ireland in the post-Famine period – in 1871, for example, 43 per cent of all women between 15 and 45 were married; by 1911 that had dropped to 36 per cent.² Marriage was no longer a certainty in nineteenth-century Ireland. In a society that placed great importance on marriage and reproduction, this would have an impact on how these single women would define their role and how society would view them. Feelings of anxiety and apprehension among women without land or spouse would not have been surprising given the precariousness of their financial situation.

We have examined how medicine in the nineteenth century expounded the reproductive role of women as central; how then would the *Dublin Medical Press* interpret these single women? Women who did not conform to the rigid social definitions of wife and mother were predictably labelled as pathological and could be expediently designated as ‘hysterical’. Thus, hysteria was a useful term to describe non-conforming women; moreover, by labelling these women as hysterical, medicine could legitimate its intrusion into the privacy of patients’ lives and assert its position as moral guardian to families in general and, more pertinently, to women themselves.

¹ Hoppen, *Ireland since 1800*, p. 107.

² Luddy, *Women and philanthropy*, pp 13–14.

Constricting roles

The traditional occupations open to women, particularly in the textile industry, were gradually declining throughout the century. By the 1830s the woollen industry was in a fatal decline, cotton was fast disappearing and, because of the technical innovations in the spinning of yarn, linen too was diminishing as a domestic industry.¹ This was a blow to the farming family where, in the early part of the century, women's spinning had regularly paid the rent and determined the family's standard of living.² The low level of industrialisation in Ireland meant that factory work was not widely available to women.³ Thus, in the second half of the nineteenth century, Irish women would have found the traditional occupational openings to them contracting. The position and choices that faced women were profoundly changing; the possibilities for them to achieve even a limited form of financial and, indeed, emotional independence from men were restricted. What would be the impact of these limitations on Irish women? Could the only role open to them be one designated by the medical profession, a role that would fit appropriately into the prevailing ideologies of femininity it so espoused? The *Dublin Medical Press* reflects a symbiotic relationship between the hysterical patient and her doctor; she is given an identity by the label of hysteria and he a validation for the expanding role of medicine. For many nineteenth-century Irish, mainly middle-class women, hysteria and sickness in general provided a role. The definitive role of the invalid diverted them perhaps from the reality of their contracting position on the farm, from the unsatisfactory marriage, from the pressures of extended family living in close quarters and, perhaps most of all, from the lack of a cohesive role in society for them.

¹ Hoppen, *Ireland since 1800*, pp 44–45.

² Mary Cullen, 'Breadwinners and providers: women in the household economy 1835–36' in Maria Luddy and Cliona Murphy (eds), *Women surviving: studies in Irish women's history in the nineteenth and twentieth centuries* (Dublin, 1990), pp 98–99.

³ Luddy, *Women in Ireland*.

What had also begun to change was the role of women in rural Ireland. In the post-Famine years, the daughters and wives of farmers gradually withdrew from the process of farming.¹ The rise in prosperity of the farmer led to a social difficulty with the females of the family engaging in manual field-work. Comerford refers to the concept of 'respectability' and the 'conspicuous adherence to a strict code'² and indeed, the rise of the farmer brought shifting levels of acceptable behaviour. The ideal social characteristics of middle-class women ensured their withdrawal from active roles in agriculture. This is in contrast to pre-Famine times that saw Irish females partake in heavy labour on farms that led to mortality among women of working age to be almost as high as male mortality, which was in contrast with contemporary England.³ By the end of the century men were monopolising spadework, turf cutting and most other forms of heavy farm work. Women were increasingly being confined to the indoors, specifically house-keeping. What effect did these changes have on nineteenth-century Irish women? I would argue that the contracting role of the woman in outdoor farm work led to much more emphasis on her remaining roles: those of wife and mother. Ostensibly, the focus on the reproductive role of women gave new status to motherhood and women that failed to conform to this narrow definition of femininity were regarded with suspicion.

If marriage and reproduction were not available or desired by women, their misgivings and angst might have presented the medical establishment with a perplexing problem that required a characterization, namely, the term 'hysteria'. Moreover, women that had experienced marriage and motherhood but were still

¹ Hoppen, *Ireland since 1800*, p. 108.

² Comerford, 'Ireland 1870–1921', pp xliv–xlv.

³ Fitzpatrick, 'Modernisation of Irish female', pp 166–167.

unhappy with their lot could also be characterized as hysterical. For the bored, limited, intrinsically unfulfilled middle-class woman, hysteria provided a mantle of sorts, in which she could express her general dissatisfaction.

After the Famine, the economic value of daughters was low; in view of the dowry required to marry them off and the lack of employment opportunities available to them, exacerbated by a declining textile industry and a diminishing role in rural labour. The release of girls from the workforce essentially increased their possibilities of receiving a basic education. In 1841 less than one-tenth of females aged between fifteen and twenty-four could read and write English in Mayo; at the end of the century basic literacy was practically universal among both sexes, actually being more prevalent among females.¹ Consequently, there was now a literate and articulate generation of Irish women whose roles were fast changing and whose hegemony and choice were diminishing. For many, the rigid constraints of traditional female roles were unsatisfactory or limiting. Certainly, the *Dublin Medical Press* validated conventional ideas of womanhood and associated set codes of feminine behaviour with the proper functioning of society. Non-conforming women were seen in a less than favourable light, and the ambiguity of the malady the profession termed 'hysteria' was a convenient method of classifying those who rejected the traditional path.

¹ Ibid.

3. The construction of a disease

The medical rationale of hysteria

The workings of the female body were a major preoccupation of nineteenth-century medicine and towards the latter half of the century, the perceived intricacies of the female mind began to absorb it in equal measure. This study has examined the medical anxiety, reflected in the pages of the *Dublin Medical Press*, at the advent of the 'New Woman', a term for women who sought to further their education and question the traditional middle-class definitions of femininity. Though this university-educated woman was by no means widespread, particularly in Ireland, where the middle classes were only beginning to emerge as a social and political force, the rumblings of her existence were sufficient to concern the *Dublin Medical Press*, especially when medicine was the chosen career path for many of these women (see Chapter 2). The concept of a neurological condition with an indeterminate number of ever-changing, vague symptoms was a plausible means of describing women who, for one reason or another, did not conform to the set codes of female conduct. However, in an age when medicine was anxious to assert itself as a scientific and, above all, respectable profession, an aetiology of hysteria was necessary. Science was to lend the medical establishment its required rationale.

Nineteenth-century definitions of hysteria have deep rapport with Darwinian thought. In 1871, Darwin in *The descent of man* underlined the intrinsic differences in the mental power of the sexes. Through natural selection, he pointed out, the male had become superior to the female in intellect, energy and courage.¹ Janet Oppenheim points out how medical discourse in the nineteenth century portrayed women as

¹ Moore and Desmond, *Charles Darwin*, p. 640.

essentially ill and their intellect as ultimately weak.¹ Darwinian ideology gave credence to the scientific ideas that there were marked biological sexual differences – women were inherently weaker, physically and mentally, than their male counterparts.² This evolutionary thinking complemented middle-class ideas of femininity and appeared to validate the discourse that women, by mere fact of their biology, were more suited to the indoors, preferably resting. This was particularly true of Irish women, who were gradually retreating from many of the processes of farm labour. Ultimately, Darwin asserted, females were designated to be wives and mothers and consequently, all their energies were to be devoted to these roles. Darwin believed that women were mentally constituted to take care of children and possessed a biological, nurturing nature. In the face of nineteenth-century medical and evolutionary ideology, a woman faced a vacuum if she rejected her traditional roles: she was, in essence, refusing the theories of scientific medicine and rational science. The *Dublin Medical Press* presented doctors as promoters and, indeed, invigilators of order and respectability and viewed any aberration from the traditional roles defined for women as a threat to the social order. Thus ‘hysterical’ was an opportune designation or labelling by the medical profession of women who were outside intrinsically middle-class codes of appropriate behaviour.

Medical practitioners were anxious to discern an organic aetiology of hysteria and consequently attested to the prevalence of symptoms such as high temperatures and seizures in hysterical patients as evidence that a coherent disease existed. In 1885, a Dr Robert Saundby in a letter to the editor of *The Lancet* wrote that:

¹ Fitzpatrick, ‘Modernisation of Irish female’, pp 181–182.

² Showalter, *Female malady*, p. 122.

For the sake of British clinical medicine, I desire to say that the existence of hysterical pyrexia (high temperature) is well known in this country ... I should be prepared to give plenty evidence of its existence, and I consider the occurrence of hyperpyrexia in hysteria by no means uncommon.¹

The ambivalence of the medical profession with regard to hysteria is reflected in its anxiety to establish an organic structure for it. The possibility that hysteria was in fact a ruse on the part of females would damage the perceived professionalism of the medical establishment.

The occurrence of an epileptic-type seizure precipitated by a sudden or deeply felt emotion was regarded as a traditional picture of hysteria. The causes of these hysterical fits or 'convulsive paroxysms' were based on the classical theory of movement of the womb around the body.² Robert Brudenell Carter (1828–1918) was an English doctor whose influential work *On the pathology and treatment of hysteria* (1853) asserted the diagnostic importance of the convulsive paroxysm.³ Indeed, in 1867, in 'Clinical lectures on hysteria', Carter is quoted in the *Dublin Medical Press* as claiming that 'the convulsive paroxysm' is 'the essential characteristic of the disease'.⁴ In general, it was believed that hysterical fits were symptomatic of prolonged celibacy in a woman but ultimately it would seem that they lent a persuasive and coherent medical aetiology to the otherwise ambiguous malady of hysteria. The predominant fear of the profession appears to be that hysteria was mere posturing; a feminine duplicity that could humiliate and embarrass the profession. This anxiety is reflected in the medical establishment's desire to construct a rational classification, complete with cogent, plausible symptoms. Charcot himself viewed

¹ *The Lancet*, i (1885), p. 457.

² Veith, *Hysteria*, pp 170–171.

³ *Ibid.*, pp 200–203.

⁴ *D.M.P.C.*, iv (1867), pp 213–214.

seizures as the central sign of hysterical disorders.¹ Were so-called ‘hysterical paroxysms’ in reality actual epileptic fits? The nineteenth-century doctors, as reflected in the *Dublin Medical Press*, evinced little sympathy for these patients if they were, preferring to believe that the paroxysms were a manifestation of hysteria and thus authenticating the medical discourse on the existence of hysteria.

As early as 1843 *The Lancet* printed a lecture by Dr R.B. Todd² which alludes to the importance of paroxysms in the identification of hysteria:

Hysteria shows itself as an affection disturbing the whole system, and although always present in a degree, it is very apt to break forth at times with all the phenomena of a severe paroxysm. This is the hysterical fit or paroxysm which, while it manifests great variety as regards its symptoms and its severity, yet possesses certain characters which are constant and distinctive. It may be more readily confounded with epilepsy than with anything else.³

The author is eager to establish a definitive and easily recognisable criterion for hysteria. Veith points out that the connection between epilepsy and hysteria can be traced back to the eighteenth century, when practitioners believed that the disease caused dilation of the brain and consequently convulsions.⁴ This rather ill-defined and hazy analogy did little to deter the profession from identifying ‘convulsions’ as an integral part of hysteria. Todd mentions that:

one of the most common [affections], which is generally a precursor of the paroxysm, is that which is known by the name of globus hystericus, a sensation as if a ball were rising in the throat, impending free respiration, and given rise to a feeling of choking. Many hysterical patients are constantly subject to globus, as their principal symptom. It is, indeed, one of the most constant accompaniments of the hysterical state.⁵

¹ Showalter, *Hystories*, p. 33.

² This lecture is from a series of clinical lectures on ‘Cases of diseases of the nervous system’ delivered at King’s College Hospital.

³ *The Lancet*, ii (1842–43), pp 489–493.

⁴ Veith, *Hysteria*.

⁵ *The Lancet*, ii (1842–43), p. 489.

The lecture evinces the medical need to define hysteria as a tenable, 'respectable' illness. The ambiguity and vagueness of the disorder is cloaked in convincing medical terminology, validating the profession's preoccupation with it. In an age where the profession of medicine was increasingly viewed as being overcrowded, hysteria was a convenient concern with a ready supply of middle-class patients. Ultimately, it was in the profession's interest to treat hysteria as a bona fide disease.

In 1873, in the *Dublin Medical Press*, Dr Robert Barnes, an 'obstetric physician', wrote that: 'In single women dysmenorrhoea is the most frequent attendant or exciting cause of hysteria or epilepsy'.¹ The old medical assumption of an inextricable link between the female reproductive system and the brain made the discourse on hysterical convulsions all the more plausible. Essentially, medical interest in the 'convulsive paroxysms' of hysteria promulgated the belief that there was a biological basis of female inadequacy. A problem with menstruation could thus be identified as a causal factor to a neurological disorder.

In 1889 the *Dublin Medical Press* printed an intriguing case study by a Dr Routh, where, after a hysterical fit, the patient 'developed strong erotic symptoms, and had an epileptiform attack, after which she again became aggressively amorous to a lady to whose care she was for two hours assigned'.² This link of a latent untrammelled female sexuality, surfacing only during the chaos of a convulsive fit, reflects the prevailing medical discourse on female sexuality. The female susceptibility to convulsions corroborated the idea of female irrationality, while a wild and latent

¹ *D.M.P.C.*, xvi (1873), p. 462.

² *D.M.P.C.*, xlvii (1889), p. 440.

sexuality placed a woman even closer to the animal kingdom and away from the thinking logic of her male counterparts.

In 1874, a Dr McSwiney, physician to the Jervis Street Hospital, outlined a case of hysterical convulsions in the *Dublin Medical Press*. His patient 'appeared to be unconscious during the paroxysm; but it soon became apparent to those who were around her that she was not wholly unconscious'.¹ The doctor claims that 'There was not, however, the least suspicion that she was "malingering" but rather that her diseased will was incompetent to control her wild contortions and disordered movements'.² Thus, the hysterical convulsions are indicative of the 'disordered' female mind and attest to the notion of essentially weak female self-control. Essentially, the convulsions attributed to hysteria reinforced the medical view that women were illogical, easily overcome by their emotions and lacking the judicious control of their male counterparts.

Emotional women

The *Dublin Medical Press* was careful to suggest that all women were susceptible to irrationality. This perception of female irrationality was the medical basis for hysteria. The following articles point to a general medical mistrust of women and reflect nineteenth-century scientific thinking that represented females as susceptible to illogical fears, and at times a danger to themselves and their children.

¹ *D.M.P.C.*, xvii (1874), pp 132–133.

² *Ibid.*

The belief that the emotions of pregnant women could cause deformity in their unborn children tied in with the medical discourse that depicted women as easily influenced. This discourse on how strong emotions of the mother are dramatised in the body of the child was popular in the nineteenth century.¹ Underlying this theory is the Darwinian acceptance of sexual difference and the belief that women were at the mercy of their impressionable nervous systems. For example, as early as 1843 *The Lancet* printed an article entitled 'Maternal impressions on the foetus'.

A lady who had a strong objection to walk abroad during her pregnancy, owing to her fear of meeting a deformed dwarf, who used to walk on his feet and hands, with club feet, turned up behind him, was prematurely delivered of a child, well formed in every respect, except the feet, which exactly resembled those of the unfortunate cripple who had been the mother's aversion.²

The absurdity of the narrative shows the medical belief that women were dominated by their emotions without recourse to reason and logic. The moral message links females with the irrational and the unexplained, the exact opposite to the enlightened and reasonable men of medicine. Moreover, suggesting that the emotive parturient female was a potential threat to the well-being of the foetus was a validation of the discourse that believed women belonged indoors.

This theme continued in the *Dublin Medical Press* in 1865, in an equally bizarre editorial where the mental impressions of the mother have an adverse effect on the foetus.

Two boys from different parts of Germany were brought [to the doctor] with scarcely any foreskin, looking exactly like circumcised little Jews, but without any cicatrices. Both women narrated with great emotion, how they had seen

¹ For more on this see Peter Melville Logan, *Nerves and narrative: a cultural history of hysteria in nineteenth-century British prose* (Berkeley, CA, 1997), pp 117–118.

² *The Lancet*, ii (1842–43), p. 126.

during their pregnancies little Jews so cruelly treated that they could not forget it.¹

In 1854 in the *Dublin Medical Press*, a Dr Johnson broached the subject of the effects of maternal emotion on the unborn child in an article entitled 'Congenital malformation from mental depression in the mother'.² He outlines how a pregnant woman witnessed a boy being thrown from his horse. The woman was deeply affected by the boy's facial injuries, particularly, the blood that covered his eyes.

The sight made a very strong and painful impression on the lady's mind, which remained impressed on it for some time after the accident. All went well until the end of her pregnancy, and she was safely delivered of a little girl in February 1852, but the baby, when born, had no eyes. The eyelids were quite perfect, but there was no eyeball. There appeared to have been an arrest of development from the time of the accident, so that the eyeball, and probably some other parts remained defective.³

The woman, according to the doctor, was unable to defend herself or her unborn child from the rigours of her emotions. The fact that her husband had been present at the time of the accident and in fact lifted the boy from the ground serves as a convenient analogy: the reasonable, rational male versus the emotive and mentally unstable female. It is precisely this comparison that serves as the rationale behind hysteria.

In 1888, a Doctor Robert Morton of the Royal College of Surgeons in Ireland had a similar article in the *Dublin Medical Press*.

Mrs L., a lady of uncommonly fine physique, and in perfect health, while in her sixth pregnancy lost, two handsome boys from scarlatina, her only sons at the time. The shock was great, and her sorrow excessive and uncontrolled by her reason. Every night she visited the graves of her boys, until the birth of her child drew her mind away from her bereavement. The child when born was well developed, but was a hopeless idiot, had sufficient intelligence to know a

¹ *D.M.P.*, i (1865), p. 587.

² *D.M.P.*, xxxi (1854), p. 118.

³ *Ibid.*

friend from a stranger, but could neither speak nor dress herself as she grew up. This lady had two children after, all with the exception of the case in point healthy in mind and body.¹

Here, according to the doctor, the woman is completely dominated by her emotions and ‘uncontrolled by her reason’. The article intimates that because she was unable to place appropriate checks on her ‘excessive’ emotions, her child was damaged. The implication of this thinking was that women needed to stay indoors, protected from such experience.

4. ‘A craving for sympathy’ – the lure of hysteria

The social distinction of hysteria

The Darwinian belief that the evolution of developed humankind led to increased brainpower,² which in turn led to nervous exhaustion, began to be identified with hysteria. Thus, the discourse that nervous ailments were an inevitable prospect facing all advanced civilised societies lent an air of prestige to sufferers of hysteria.

Increasingly, the existence of nervous debility was attributed to the educated and enlightened social classes. The practical non-existence of hysteria among less advanced societies was a clear indication that this was a disorder of social distinction. Oppenheim asserts that nineteenth-century medicine sold the concept of an illustrious illness that only high-born and cultured individuals were susceptible to.³ The lower orders, devoid of imagination and cultivation, were immune.

Alice James, the sister of the nineteenth-century novelist Henry James and afflicted with supposed hysteria all her life, illustrates this point from an American and English

¹ *D.M.P.C.*, xcvi (1888), pp 585–586.

² Moore and Desmond, *Charles Darwin*, pp 186–188.

³ Oppenheim, *Shattered nerves*, pp 99–100.

context rather well. In her diary she muses on the intellectual differences between herself and her servant:

I looked up at Nurse, who was dressing me, and saw her primitive, rudimentary expression as of no inherited quarrel with her destiny of putting petticoats over my head; the poverty and deadness of it contrasted to the tide of speculation that was coursing through my brain made me exclaim, 'Oh! Nurse, don't you wish you were inside of me!'¹

While it is important to remain sympathetic to the class distinctions of the day, it is clear that Alice, despite her protracted invalidism, believed wholeheartedly in her intellectual superiority to others. It is as if her intellectual propensity has in fact incapacitated her. If Darwin promoted the notion that nervous ailments were an inevitable prospect facing all advanced societies, the medical establishment in the second half of the nineteenth century viewed hysteria with its unlimited symptoms as a malady affecting middle-class, cultured women. Though the medical profession used this argument in an attempt to dissuade females from further education (see Chapter 5), it also served to depict hysteria as a sickness of social distinction. The following articles illustrate the fashioning of an attractive and flattering ailment for women in the second half of the nineteenth century.

In 1850, a Dr Burnett in the *Dublin Medical Press* described a female 'hysterical' patient of his as 'cheerful and clever, and very susceptible of admiration'.² Similarly, in 1885, in a letter to the editor of *The Lancet*, a Dr Fredrick Friend spoke of his patient, referred to him because of suspected hysteria, as being 'very intelligent'.³ In an age where there was a definite contraction of the female role in society, to be

¹ Leon Edel (ed.), *The diary of Alice James* (New York, 1999), p. 48.

² *D.M.P.*, xxiii (1850), p. 24.

³ *The Lancet*, i (1885), p. 828.

labelled with a disorder that suggested intelligence and imagination was not altogether a bad thing.

The *Dublin Medical Press* alluded to the social distinction of hysteria in 1874, when a Dr F. T. Porter of Ledwith School of Anatomy in Dublin attested that hysteria was a result of 'an increased development of the nervous centres and a specialised evolution of nervous force. This so called hysteria is referable to the increased nervous activity.'¹ The reference to fashionable Darwinian ideas promulgated the discourse that hysteria was a disease of the highborn. The lack of 'nervous exhaustion' among primitive races was seen as sufficient evidence that hysteria targeted civilised and intelligent people.

In 1887, the *Dublin Medical Press* published some case studies on hysteria by a Dr Routh, consulting physician for the Samaritan Hospital in London. He described one patient as being: 'a high born lady, one thoroughly respectable in every way'² and has this to say about hysterical women in general: 'They are for the most part agreeable, interesting, if not beautiful'.³ In 1890, an editorial in the *Dublin Medical Press* alluded to hysterical patients as possessing 'shrewd, and indeed, often precocious intellects'.⁴ For a middle-class woman, particularly in Ireland, who had more or less withdrawn from manual farming, whose marriage was probably arranged for economic purposes rather than love, the role of the languishing, nervous invalid was one that she could relate to and identify with. Moreover, with increased emigration from Ireland and stringent economic factors with regard to marriage itself, there

¹ *D.M.P.C.*, xvii (1874), pp 242–243.

² *D.M.P.C.*, xlv (1887), pp 48–50.

³ *Ibid.*

⁴ *D.M.P.C.*, xcvx (1890), p. 122.

existed what Ellen Bayuk Rosenman refers to as the 'female redundancy crisis'.¹ Consequently, invalidism was a limited but distinct role for a minority of women.

Pretty sick

If the medical profession promoted hysteria as an illness confined to a certain class of women, the *Dublin Medical Press* increasingly depicted the image of female sickness as sexually attractive. The literature of the nineteenth century offers many examples of the popular images of immature, childlike and debilitated women.² The most obvious characters would be the child-woman, Nora, in Henrik Ibsen's *A doll's house* (1879) and the long-suffering invalid Beth in Louisa May Alcott's *Little women* (1868). Charcot's famed use of photography to illustrate the various stages of hysteria³ attests to the medical interest in the image of the sick woman. In the context of Ireland, the tuberculosis epidemic in the latter part of the nineteenth century left a lasting impression on the public psyche. Tuberculosis was a disease particularly devastating to young people. Between 1881 and 1890, 45.6 per cent of deaths in the age range 25–35 were from this disease.⁴ Sickness was omnipresent and inextricably linked to people in their sexual prime. The translucent skin, dark eyes, flushed cheeks and frailty of the tubercular patient incorporated many of the ideal characteristics of femininity prevalent in the second half of the nineteenth century. Consequently, it is not difficult to imagine how sickness and desirability became linked.

¹ Ellen Bayuk Rosenman, *Unauthorised pleasures: accounts of Victorian erotic experience* (Ithaca, NY, 2003) p. 146.

² Showalter, *Female malady*, p. 206.

³ In fact, a photographic workshop was installed in the Salpetriere Hospital in Paris. By 1886 a professional photographer with the most advanced technological equipment was employed specifically to photograph hysterical patients. The photographs of women were published in three volumes called *Iconographie photographique de la Salpetriere*. For more see Showalter, *Female malady*.

⁴ Greta Jones, 'The campaign against tuberculosis in Ireland 1899–1914' in Malcolm and Jones, *Medicine, disease and the state*, pp 159–160.

This study has explored how the *Dublin Medical Press* depicted women as inherently weak (see Chapter 5); now it is important to examine how that weakness was characterised as somehow desirable. The weaker and more frail the woman, the stronger and more able seemed her father or husband or, for that matter, her doctor. The ideal social characteristics of femininity that prevailed in the second half of the nineteenth century, such as passivity, frailty and docility, fitted excellently in the role of invalid. The existence of the ill, malleable female who required endless medical intervention not only validated the position of the practitioner, but bolstered the power of the profession. To contribute to the iconography of the sick woman was to corroborate medical thinking that females were essentially weaker and thus less capable than their male counterparts. *The Lancet*, for example, outlines a redeeming feature of hysteria: ‘This girl affords a good example of the hysterical constitution. She has, to a marked degree, the full upper lip so frequently to be noticed in women of this excitable temperament’.¹ The author, a Dr Clives, makes a similar observation on an eighteen-year-old patient:

I felt convinced, from the first moment I saw the girl, that the phenomena were of the hysterical kind, and, I confess, that I was led to form this opinion more from the general aspect of the patient than from any particular symptoms. Her countenance was decidedly indicative of the hysterical temperament; she had the full upper lip well developed.²

The fact that full lips are universally perceived as being sexually attractive suggests that hysterical patients are also physically alluring, this allure expanded because of the subdued role of the patient. The implication here is that if a woman is suffering from hysteria she is, by dint of the illness, attractive.

¹ *The Lancet*, ii (1842–43), p. 491.

² *Ibid.*

In 1872 the *Dublin Medical Press* referred to a hysterical patient: 'A pretty, refined young woman, slightly built, with good teeth, and those beautiful dark eyes so characteristic of neuralgia'.¹ In 1890 the *Dublin Medical Press*, in an editorial, asked: 'Why are scrofulous [diseased] people beautiful?'² The article refers to 'The delicate skin, the drooping eye lashes and beautiful eyes, the abundant hair, and the finely cut features' of the invalid woman. The impassive patient, submissive and frail, conformed perfectly to nineteenth-century ideals of femininity. Moreover, it was in the interest of medicine to construct a discourse that intimated that sickness was feminine as it provided many bored, listless women with a desirable and attainable goal.

Fasting girls

While sickness was promoted generally as a desirable state for girls and women and hysteria was increasingly becoming the malady *de jour*, the *Dublin Medical Press* noted that many hysterical patients were refusing food. Ironically, by the late nineteenth century food had never been as plentiful or diverse in Ireland.³ The refusal of food would ensure the patient was in a constant state of sickness. Her gaunt frailty suggested a submissive pliancy that conformed to the prevailing definitions of femininity. Showalter points out that anorexia nervosa was identified in 1874 by a prominent English doctor, William Witney Gull, but she asserts that fasting behaviours had been observed for centuries.⁴ The *Dublin Medical Press* is littered with cases of women who were actively refusing to eat but were not recognised as anorexic; rather, the journal identifies these women as if they were suffering from an

¹ *D.M.P.C.*, lxvi (1872), p. 41.

² *D.M.P.C.*, xcvi (1890), p. 122.

³ L. A. Clarkson and E. Margaret Crawford, *Feast and famine: a history of food and nutrition in Ireland 1500–1920* (Oxford, 2001), pp 89–90.

⁴ Showalter, *Female malady*, p. 127.

organic disease. It would appear that anorexic girls and women offered the medical establishment opportunities to practise their craft and bolster the position of their profession by providing a steady stream of middle-class patients. Essentially, it was in the interests of medical men to define 'fasting' women as yet another symptom of hysteria, a coherent indicator of an organic disease.

In 1886 the *Dublin Medical Press* in an editorial made reference to Anna Belle Langan, the 'American fasting girl':¹ 'She has an abhorrence for food, and positively refuses to eat a mouthful, even the juice of oranges'. Despite the identification of anorexia by nineteenth-century medicine, the journal gives no title to this patient's disorder but rather defines it as a manifestation of hysteria and thus a cogent disease requiring medical expertise and intervention.

In 1887 the *Dublin Medical Press* pointed to a case of a 'highly neurotic and hysterical' patient who was removed by medical officers to an asylum 'where she died in a week; refusing to eat'.² The patient's death was viewed by the journal as being the result of hysteria, as opposed to starvation. It would appear that by refusing food women were in fact providing medical men with a plausible manifestation of the dubious disorder of hysteria.

Dr Graily Hewitt, an obstetric physician, pointed to a case in 1888 in the *Dublin Medical Press*:

Miss ___ aged 22, always delicate. Has had occasional sickness for three years. For four months sickness always after meals. Has frequent faintings and

¹ *D.M.P.C.*, xiv (1886), p. 482.

² *D.M.P.C.*, xlv (1887), pp 48–50.

hysterical attacks. Is much emaciated and very weak from the enforced starvation.¹

Again, the female patient is described in terms that conform to nineteenth-century definitions of femininity – sick and frail and fainting often. The patient is an ideal manifestation of the sick female so carefully constructed by the medical profession. In another case Dr Hewitt describes ‘Miss __ aged 27. Almost incessant sickness. The greatest difficulty found in administering nourishment.’² The diagnosis is the same. Ultimately, these starving women were conforming to a role – the role of invalid and of sickness – in a time when it was socially acceptable for women to be constantly sick. This thinking was inextricably linked to the prevailing romantic pathos of illness and death. For the medical profession, the desire for physical manifestation of a classified disease would underline that hysteria was not a subjective illness defined by the patient, thus ensuring that the reputation of the profession remained intact.

Malingering

The fact that growing numbers of females were seeking out medical attention for myriad ambiguous ailments suggests that women were creating a role for themselves. If women in Ireland could no longer buoy up the household economy with their spinning, or be a significant contributor to the farm work, perhaps the role of invalid might act as a substitute and a consolation. Showalter suggests that when the hysterical woman became sick, she no longer played the role of self-sacrificing daughter or wife; instead she demanded service and attention from others.³ This section of the chapter seeks to explore how doctors interpreted this malingering in the articles of the *Dublin Medical Press*.

¹ *D.M.P.C.*, xcvi (1888), p. 291.

² *Ibid.*

³ Showalter, *Female malady*, p. 133.

In *The yellow wallpaper*,¹ the hysterical patient's husband clearly delights in the child-like qualities of his wife and treats her accordingly. Malingering is pertinent to this study in that it is indicative of the doctor–patient relationship, the submissive, childish patient pretending to be ill and the parental, disapproving doctor. The medical discourse surrounding hysteria was two-fold. Firstly, as discussed earlier, medicine sought to construct a credible aetiology of a 'disease', a classification of an illness with shifting diagnostic criteria. Secondly, there was a concerted effort to depict women as mentally weak, with childlike traits and utterly dependent on medical intervention. The submissive, docile female patient yielding to the stern, sagacious doctor is a theme that surfaced again and again in the *Dublin Medical Press* in the second half of the nineteenth century.

Darwinian thought alluded to the infantile traits, such as trust, dependence and devotion, that separated females from males and made them fundamentally childlike.² This discourse of female infantile evolution dominated medical discussion of hysteria. Oppenheim writes of the childlike attributes that were so often juxtaposed with the discourse of hysteria, pointing to the Darwinian belief that women were ultimately childlike in their nature, in their uncontrolled emotions and craving for sympathy³. In *The yellow wallpaper*, the patient's doctor–husband exclaims: 'Bless her little heart! She will be as sick as she pleases!'⁴ To consider that a woman was not unlike a child (Ibsen's Nora in *A doll's house*) was pertinent in the parental role of the medical

¹ Charlotte Perkins Gilman, *The yellow wallpaper*, first published in *New England Magazine* in 1892. Gilman, having herself been treated for 'hysteria', wrote an account of a hysterical patient confined in a room by her physician husband.

² Hailer and Haller, *Physician and sexuality*, pp 73–75.

³ Oppenheim, *Shattered nerves*, p. 186.

⁴ Charlotte Perkins Gilman, *The yellow wallpaper and other stories* (Robert Shulman, ed.) (Oxford, 1995), p. 12.

practitioner towards his hysterical patient and his treatment of her. Her childish whims must not be encouraged. The discourse of the child-woman authorised the doctor's dominant role. Moreover, it bolstered the belief that intrinsically women were not to be trusted, that unlike their male counterparts they were predisposed to dishonesty requiring the expert intervention of the medical profession.

Medical distrust of women was a factor in the discourse of hysteria in the *Dublin Medical Press*. In the articles below there is an implicit sense that women were ultimately deceptive, naturally lending themselves to falsehood. The backdrop to this was a deep suspicion of women by medical practitioners – that beneath the frailty and doe-eyed innocence of neurotic females, a seething sexuality bubbled, a propensity to dupe and deceive lingered. The cunning nature of the hysterical female was not, according to the *Dublin Medical Press*, to be underestimated.

The attempts of the *Dublin Medical Press* to discredit female patients promoted the notion of the hegemony of the male doctor from the outset. The doctor played a complex role with a hysterical patient – by adopting an emotionally dominating position he was legitimising the patient's behaviour. In 1870 *The Lancet* alluded to the medical need to classify hysteria: 'The disposition to exaggerate painful sensations, the morbid craving for sympathy, and the tendency to simulate or deceive, are the most characteristic elements of hysteria'¹. The hysteric will always be lying and the doctor will be the pragmatic and astute figure who can help her.

¹ *The Lancet*, i (1870), p. 595.

As early as 1843 *The Lancet* examined the concept of malingering and its relation to organic disease. The journal is anxious to highlight a correlation between the two: 'Mimicry is generally an exaggerated representation of reality, and so the merely hysterical or nervous actions frequently exaggerate the symptoms which more serious disease puts on'.¹ Consequently, hysteria is not merely subjective and depending on the whim of the patient, but rather distinct and coherent and linked to 'more serious disease'. In 1889 *The Lancet* referred to malingering as if it was a specific disease in its own right:

When the word 'mimic' is used, it does not always imply conscious imitation by the patient, nor does it always imply close resemblance to the disease imitated. Sometimes the so-called mimicry is very imperfect; sometimes so complete as to mislead, for a time, the most experienced and careful observer.²

The malingerer requires the expertise of the medical profession, and this promotion of the doctor as the indefatigable custodian of truth and science in turn depicts the female patient as dependent and emotional and, above all, untrustworthy. Where the doctor is 'experienced and careful', his hysterical patient is narcissistic and childlike, thus bolstering the public image of the profession and legitimising its intervention.

In 1867, a Dr Copeland in his lectures on hysteria in women pointed to 'the natural desire of being an object of attention when it is disappointed in its legitimate form, and perverted into craving for pity and commiseration'.³ The doctor is suggesting that malingering or craving attention is an inherent factor in the nature of women. The onset of hysteria merely 'perverts' this natural craving for attention. Essentially, this portrayal of women as intrinsically childlike is in keeping with the Darwinian

¹ *The Lancet*, ii (1842-43), p. 492.

² *The Lancet*, i (1889), p. 973.

³ *D.M.P.C.*, iv (1867), pp 213-214.

discourse that believed women were an underdeveloped version of man and so prone to childlike traits such as emotional outbursts, dependency and attention-seeking.¹ Hysteria, promoted by nineteenth-century medicine as inherently female, was a natural progression of such infantile behaviour. Moreover, this also implied that all women were susceptible to hysteria because such emotionality was an intrinsic part of female nature.

In 1873 the *Dublin Medical Press* corroborated this view of the innate nature of women being predisposed to deception and pretence:

In the female may be enumerated all those hysterical affections so peculiar to her sex, producing numberless kinds of deformities impressing the deluded patient with a firm conviction in her own mind that her leg is contracted or paralysed, or that she suffers from spinal affection and is unable to rise from her bed. I remember seeing such a case three years ago in Gorey, Co. Wexford, when a young girl chose to remain in bed, apparently suffering from spinal disease, when all the time it was quite a delusion, as no disease whatever existed.²

In 1867, Dr C. Handfield Jones in his 'Clinical lecture on cases of hysterical disease' underlined the 'ill-regulated, deceitful, perverse mind'³ of the malingerer. The medical discourse that emphasised the innate duplicity of hysterical women was also intimating the need for the parental figure of the medical man who would successfully uncover her pretence, and in doing so evince a cure. Essentially, according to this discourse, the female hysterical figure needed to be monitored by the perceptive eye of the 'parental' doctor.

¹ See Moore and Desmond, *Charles Darwin*, pp 653–655.

² *D.M.P.C.*, lxviii (1873), p. 183.

³ *D.M.P.C.*, iv (1867), pp 213–214.

In 1861, the *Dublin Medical Press*, in an article by a Dr Keyworth of the Richmond Hospital, alluded to the deceptive powers of a hysterical patient that required the stern intervention of the medical man. The patient, a twenty one year old 'well-dressed, good-looking young woman',¹ feigned epileptic fits.

The night-nurse remarked that she never had a fit while she sat near her, but immediately she left to see another patient she went off in a fit, and continued in it till she returned.²

The doctor's remedy was this :

I ordered the nurse in the patients hearing, to place a large sheet of water-proof cloth under her, and to place a pail full of water near the bed, and to let me know if she had any more fits. She got up shortly after I saw her, dressed herself and left the hospital.³

Thus the parental figure of the medical man restores order by a pragmatic and level-headed approach that serves to emphasise the juvenile behaviour of the hysterical woman. The depiction of the hysterical woman undermined by the judicious panacea of medicine serves to bolster the position of medicine and discredit female patients in general.

In 1872 the *Dublin Medical Press* printed an article by a Dr Terrel describing a case of malingering in a female patient 'who lay in bed for twenty five years and taking but little food'.⁴ The doctor is keen to point out that the patient had help in her rather lengthy period of deception: 'She had as nurses two cousins, who appear to have entered into the spirit of fraud and assisted her'.⁵ The female accomplices are

¹ *D.M.P.*, xlvii (1861), p. 292.

² *Ibid.*

³ *Ibid.*

⁴ *D.M.P.C.*, lxv (1872), p. 15.

⁵ *Ibid.*

significant because they exonerate the medical profession from having been duped by a female patient for such a long time – with three cunning and deceptive women, how could the doctor have discovered the malingerer? Similarly, in 1867 the *Dublin Medical Press* printed a lecture, by a Dr C. Handfield Jones, with the title ‘Clinical lecture on cases of so-called hysterical disease’. The doctor is anxious to point out how hysterical patients are predisposed to deception:

In investigating hysteric cases, we should constantly remember that the utmost duplicity and cunning may be displayed, where from mere appearances we should expect nothing but the most rigid truth, in short that the whole energies of the patient’s mind are bent on deception.¹

Thus, the depiction of women as naturally mendacious made the doctor who treated them somewhat heroic, his earnest endeavours to treat them juxtaposed to their irrational and treacherous attempts to misguide him. This discourse ensured that the malingerer of hysterical patients was no threat to the authority of medicine. At best, the malingerer was portrayed by the *Dublin Medical Press* as a wayward child; at worst as a liar, bent on deception. Either way, the reputation of the profession, far from being damaged by this strange, ambiguous, essentially female disorder, was in fact bolstered. Hysteria corroborated the conventional ideas of femininity and validated the extension of the role of the nineteenth-century practitioner.

5. Female sexuality and hysteria

Inherent in nineteenth-century discourse on hysteria lurks the medical anxiety regarding female sexuality. This study has explored the rigid distinction that nineteenth-century medicine drew between reproduction and sexuality. The ideal social characteristics of femininity such as domesticity, nurturance and intuitive

¹ *D.M.P.C.*, lviii (1867), pp 213–214.

morality were at variance with the concept of female sexuality. On one hand, women were being urged to devote themselves to their role in reproduction and on the other, medical opinion told them they had no 'natural' sexual feelings and to be repelled by the sex act itself.¹ William Acton's successful and widely published work: *The functions and disorders of the reproductive organs*² famously remarked: 'The majority of women (happily for them) are not much troubled by sexual feelings of any kind'.³ Sexual feelings were seen as unfeminine, pathological and possibly injurious to reproduction. The idea that 'excessive' sexuality in females resulted in hysteria is a common theme in the articles of the *Dublin Medical Press* and suggests the specifically middle-class anxieties regarding female sexuality. Jeffrey Weeks points out that while the majority of medical practitioners rejected Freudian ideology, many doctors did accept the sexual connections of hysteria and the emotional conflicts behind it.⁴ Thus, the *Dublin Medical Press* reflects how medicine used the term 'hysteria' as a label for women who were, for some reason, not conforming to the set codes of feminine behaviour.

In an Irish context, Comerford has pointed to the increasingly 'mercenary bargaining' that dominated courtship in post-Famine Ireland and also asserts that marriage itself became the 'epitome of calculation'.⁵ Elizabeth Malcolm attests to later marriages in the second half of the nineteenth century and to wives substantially younger than their husbands being the consequence of the system of impartible inheritance.⁶ David

¹ Barbara Ehrenreich and Deirdre English, 'The cult of female invalidism' in John Ehrenreich (ed.), *The cultural crisis of modern medicine* (New York, 1978), p. 123.

² Acton, *Functions and disorders*.

³ *Ibid.*, p. 163.

⁴ Weeks, *Sex, politics and society*, p. 44.

⁵ Comerford, 'Ireland 1850-1870', p. 382.

⁶ Elizabeth Malcolm, 'Marriage in post-famine Ireland' in Malcolm and Jones, *Medicine, disease and the state*, pp 184-185.

Fitzpatrick points to the rigidity and the restrictiveness of marriage in Ireland in this period and underlines that because of mass emigration, marriage was simply not an option for many women.¹ Thus, it would appear reasonable to assume that sexuality – particularly female sexuality – was a subject of unease. Moreover, as Weeks shows how sexual concerns in this period were germane to the respectable middle classes,² it seems likely that the concerns of the *Dublin Medical Press* reflected the anxieties of the rising middle-class farmer in nineteenth-century Ireland. Certainly, the following articles firstly reflect the fact that hysteria and female sexuality were inextricably linked, and secondly suggest a medical preoccupation and perturbation with the sexual conduct of women.

While women that evinced a non-passive sexuality were regarded as hysterical, the medical profession viewed women who were not engaging in sexual intercourse as problematic also. Weeks suggests that hysteria was in fact a symptom of sexual frustration in women, a manifestation of an unfulfilled role.³ Marriage and motherhood were often promulgated as ‘cures’ for hysteria. The contradiction of the sexually impassive woman juxtaposed with the potential of an untrammelled and, according to the medical profession, aberrant female sexuality lay at the foundations of the medical discourse on hysteria. The conflicting emphasis on the reproductive role of woman and promotion of female sexual passivity demonstrates the medical struggle and preoccupation with female sexuality in general. Hysteria, as this section aims to explore, was a conveniently vague malady that served to label non-conforming women.

¹ David Fitzpatrick, ‘Marriage in post-famine Ireland’ in Margaret MacCurtain and Donnacha O Corrain (eds), *Women in Irish society: the historical dimension* (Dublin, 1978), pp 116–117.

² Weeks, *Sex, politics and society*, pp 38–39.

³ *Ibid.*, p. 203.

The following article from the discussions of the Edinburgh Obstetrical Society in 1861, printed in the *Dublin Medical Press*, reiterates this fear of unsatisfied female sexuality. The girl was subject to hysterical attacks and was cured by marriage and subsequent motherhood:

Dr Keiller spoke of a case which he had seen in Dundee, of a girl who was subject to fits of barking, which she could always check by means of antispasmodic. Chloroform had produced only temporary relief, and she was not entirely cured of her disorder until she had married and become pregnant.¹

Thus, the erratic and bizarre behaviour of this female patient is 'cured' by sexual intercourse, implying that female sexuality is acceptable only if it conforms to the set codes of behaviour of the middle classes espoused by the medical profession.

In 1888 the *Dublin Medical Press* printed an editorial entitled 'Another epidemic of hysteria'. The imputation of this somewhat misogynous account is that the remedy for hysteria is sexual intercourse. The article describes an 'outbreak of what may be described as epidemic hysteria ... where a number of women, young and old, have manifested symptoms of hysteria'.² A 'cure' for this female malady is then described:

In years gone by witchcraft would have been formally accused as the origin of the 'evil' spirits and some withered and unpopular hag would have been burned, drowned or strangled in order to remove the enchantment. Less tragic tactics suffice at present to restore order. One of the favourite plans being to quarter a regiment of soldiers in the district, and without pretending to know how or in what manner the cure is brought about, it is generally found that calm is promptly re-established. It is certain that no such epidemics occur in garrison towns or in localities well provided with military escorts.³

¹ *D.M.P.*, xlvi (1861), p. 389.

² *D.M.P.C.*, xlvi (1888), p. 117.

³ *Ibid.*

The insidiously crude, tongue-in-cheek suggestion here is that the panacea for hysteria lies in the sexual satisfaction of females. This surreptitious attempt to discredit female patients also serves to reflect that the *Dublin Medical Press* saw a relationship between female sexuality and hysteria. Moreover, the account implies that hysteria is a manifestation of unrealised female sexuality.

Despite late marriages in Ireland in the second half of the nineteenth century, there were still on average four to five children per family.¹ The reproductive role of women was viewed as central to their existence in a system (impartible inheritance) that enabled parents to have rigid control over their children well into adulthood. The conflict for the rising middle classes in this period, with their emphasis on respectability, was the promotion of reproduction as a primary goal for females and conversely the suppression of a concept of female sexuality. The medical profession, espousing middle-class ideologies, may have championed as ideal the figure of the chaste, asexual middle-class women who, once married, could devote her time to the nurture and care of her children, but the reality of sexualised working-class women was an unavoidable truth. The potential sexual depravity of working-class women was deeply troubling for middle-class men.² Consequently, if the medical profession identified, as this study has explored (see Chapter 4), the existence of an inherent and fundamental female sexuality in the lower classes, there was reason to suspect that these same instincts and desires resided in their respectable middle-class counterparts.

Despite the idealising female social characteristics such as passivity and an intuitive morality, the medical profession had a deep suspicion that under the calm exterior,

¹ Malcolm, 'Marriage in post-famine Ireland', pp 184–185.

² Oppenheim, *Shattered nerves*, p. 201.

women possessed a wild sexuality that once unleashed was uncontrollable.¹

According to the *Dublin Medical Press* in 1863:

The records of medicine give numerous instances of the passage of various foreign bodies into the female bladder, generally during the indulgence of erotic propensities. Pieces of cork, pencils, ivory or bone instruments, such as ear-picks, netting needles, and hair pins, have occasionally been extracted²

This account details the surgical success stories in removing these items from various female patients but one might suspect that the article is also useful as an indication to the medical profession in general of the erotic propensities of the female population.

In 1853, in a review of *On the pathology and treatment of hysteria* by Dr Robert Carter, The *Dublin Medical Press* highlighted a causal factor of hysterical fits or paroxysm: 'Of these [causes of hysterical fits] the writer sets down two, as being specially common – the first being terror, and the second sexual passion'.³ This discourse corroborates the medical profession's belief that the female is generally frail and weak and consequently, unlike her male counterpart, is unable to confront the demands of sexual passion, resulting in a hysterical fit.

Dr Routh's article in the *Dublin Medical Press*, 'On the etiology and diagnosis of nymphomania' in 1887 outlined a case of 'A highly neurotic and hysterical but withal a very engaging young lady'⁴ who was a 'model that was everything pure and holy' until the moment she was seriously affected by 'hysterical mania':

with a strong tendency to suicide she was never left alone. At last the practitioner sat with her. After all the family had gone to rest, she at once

¹ Walkowitz, *Prostitution and Victorian society*, p. 85.

² *D.M.P.*, xlix (1863), p. 242.

³ *D.M.P.*, xxix (1853), p. 375.

⁴ *D.M.P.C.*, xlv (1887), p. 76.

opened her mind to him and urged him to have connection with her, which of course he refused.¹

The doctor's account implies that hysteria has altered the character of this woman in the most dramatic way. Once the paragon of middle-class virtue and morality, she is reduced to a suicidal woman begging her practitioner for sexual intercourse, all as a result of an attack of 'hysterical mania'. The doctor concludes that 'She was a woman clearly of very strong passions which at times had the complete mastery of her'.²

Thus, the medical adage of women belonging to nature and men to culture again surfaces as this case study implicitly warns of the innate sexuality in all women, even the ones you suspect least. It promulgates the notion that hysteria unleashes a dormant and erratic sexuality in women that threatens men, especially medical men.

In 1874 the *Dublin Medical Press* printed a paper delivered to the Dublin Medical Society by Dr S. M. Swiney, physician to Jervis Street Hospital, entitled 'Remarkable case of confirmed hysteria'.³ The paper details a case of a young woman arrested for disorderly conduct; when the police discovered her insensible from 'hysterical fits' they brought her to hospital. The doctor attests that 'A careful examination of the patient's uterine and generative system was made with the result ... much abnormal redness of the os and cervix uteri'.⁴ It is perhaps significant that it is the female patient's sexual organs that are examined on admittance by the doctor. The imputation is that the patient was engaging in sexual activity that did not meet the approval of the doctor. His diagnosis was this:

¹ *Ibid.*, pp 74–75.

² *Ibid.*, p. 76.

³ *D.M.P.C.*, xvii (1874), pp 132–133.

⁴ *Ibid.*

Her story was one of abandonment of herself to a loose life in the streets, and that the physical disturbances, which were excessive, were dependent upon the constant state of mental distress induced by reflecting upon her unfortunate condition.¹

This patient's hysteria erupted through merely thinking of her sexual conduct, suggesting that hysteria is a form of retribution for not conforming to the set codes of feminine conduct advocated by the medical profession. The paper concluded with the medical man deliberating generally on hysteria:

Doctor McSwiney then referred to the obscure nature of hysteria, and entered into some explanations as to the doctrines at present received respecting its etiology. He coincided with the general opinion prevalent among the profession that in most, if not in all the cases of hysteria, there was disorder of the sexual organs.²

Thus, this paper is clearly indicative that medicine drew a correlation between the sexuality of women and hysteria, and used the term 'hysteria' to describe women who failed to comply with prevailing middle-class concepts of sexual behaviour.

Certainly, the infamous Dr Isaac Baker Brown, a member of the Obstetrical Society of London,³ believed in the sexual prodigality of women. Showalter points out that he became convinced that madness in women was caused by masturbation and that the surgical removal of the clitoris could stop a disease that would otherwise progress from hysteria to spinal irritation and alarmingly, to idiocy, mania and death.⁴ While Baker Brown represents the extremity of how medicine linked sexuality with hysteria, he also reveals how dangerously misogynistic this discourse could be, and the deep

¹ Ibid., p. 133.

² Ibid.

³ Dr Isaac Baker Brown, believing that masturbation in females led to madness, advocated surgical removal of the clitoris as a cure. He carried out his work in a private clinic in London between 1856 and 1866, during which he claimed a high success rate. However, he was accused of coercing his patients into the procedure and was expelled from the Obstetrical Society. For more see Ornella Moscucci, *Science of woman*, pp 105–106.

⁴ Showalter, *Female malady*, pp 75–76.

perturbation that female masturbation caused for the medical profession. Dr Thomas Lightfoot in *The Lancet* suggested that hysteria urges some women on 'to indecent practices, which are mere symptoms of the actual disease'.¹ In 1889, Dr Routh in the *Dublin Medical Press* referred to a woman who was 'markedly hysterical. She had been addicted to the habit of masturbation'.² In fact the doctor points to the link between hysterical fits and erotic feelings and warns of the danger of masturbation to female sanity. The same doctor in 1887 reported how an old woman of seventy had such strong feelings of 'sexual excitement' that 'she was compelled to masturbate. It was a source of great mental misery to her and she was ultimately cured by clitoridectomy'.³ Clearly, Baker Brown's procedure with all its horror had advocates among the medical profession in Ireland and Britain.

The *Dublin Medical Press* in 1866 offered a glowing review of a book by the 'senior surgeon' Dr Baker Brown of the title *On the curability of certain forms of insanity, epilepsy, catalepsy and hysteria in females*. The journal describes Baker Brown in glowing terms, emphasising that he 'has long been known as one of the boldest operators in obstetric surgery'.⁴ The journal's review is laced with clinical, 'scientific' language that perhaps is an attempt to sanitise and legitimise an essentially barbaric practice. Moreover, the adoption of scientific language lends the procedure an air of expertise:

Long and frequent observation convinced our author that a large number of afflictions peculiar to females [arise from] loss of nerve power, and that this was produced by peripheral irritation, arising originally in some branches of the pudic nerve, more particularly the incident nerves supplying the clitoris, and sometimes the small branches which supply the vagina, perinaeum, and

¹ *The Lancet*, ii (1857), pp 79–80.

² *D.M.P.C.*, xlvii (1889), p. 440.

³ *D.M.P.C.*, xlv (1887), pp 48–50.

⁴ *D.M.P.*, 55 (1866), pp 401–402.

anus. Closer observation satisfied him that the greater or less severity of the functional afflictions observed depended on the amount and length of irritation, and the consequent amount of nerve power ... This theory of peripheral irritation, as Mr Brown delicately expresses it, means nothing more or less than that many female diseases are either caused or increased in severity by indulgence in solitary vice.¹

The review is careful to point out Baker Brown's theory that masturbation, if it remains untreated, will result in various stages of insanity, concluding in mania or death, thus underlining that the removal of the clitoris is a life-saving procedure. The review emphasises that 'All of these stages are aggravated by the clitoris and on the premise that many females masturbate and thus, the only remedy is removal of the offending clitoris'. Essentially, the sexuality of females is presented as pathological and hysteria is the manifestation of female masturbation. It would appear that the medical profession could use the term 'hysteria' to suit its specific and variable requirements. The *Dublin Medical Press* concluded that 'Mr Brown is to be praised for endeavouring to break down the barrier of false delicacy but too frequently raised by modern practitioners'.² Thus it would appear that the journal viewed the surgical removal of the clitoris as a valid cure for hysteria, intimating, in no uncertain terms that hysteria and sexuality were inherently linked by the profession in the second half of the nineteenth century and that sexuality was seen as pathological and immoral.

6. The doctor's stake/treatment of hysteria

The prevailing ideologies of what Veith terms the 'endearing frailty'³ of women, and the cult of sickness that evolved from these, undoubtedly provided medicine with a ready supply of patients. Ehrenreich and English point out that, as a businessman, the

¹ Ibid., p. 402.

² Ibid., p. 401.

³ Veith, *Hysteria*, p. 212.

doctor had a direct interest in a social role that encouraged women to be sick.¹ This section of the chapter seeks to examine how the *Dublin Medical Press* interpreted the treatment of hysteria as a means of reiterating and strengthening the status of medicine in the public eye. It is this interpretation of their role that encompasses, perhaps more than any other, how the profession in the second half of the nineteenth century tried to widen the scope of its occupation far beyond that of mere healer. The therapy that was expounded for hysteria placed the doctor firmly in a position of dominance over his female patient, and the tone of this treatment was decidedly moral.

The construction of middle-class hysteria bolstered the ongoing campaign to professionalise medicine by providing an elite basis of specialised knowledge on which the doctor could claim an independent basis of authority.² The dubious and obscure nature of hysteria allowed doctors to approach the disorder with a multifarious approach, underlining the mandate of the medical profession. The ambiguous terminology enabled doctors to diagnose indiscriminately. Moreover, in order to 'diagnose' hysteria properly, the practitioner needed to acquire a broad knowledge of the patients' circumstances and personal and family history and this in turn created a new social role for the doctor. Porter, from an English perspective, asserted that the nineteenth century was hysteria's golden age 'because it was then that the moral presence of the doctor became normative as never before in regulating intimate lives'.³ This section of the chapter seeks to explore how the treatment of hysteria sanctioned and legitimated, as never before, the moral role of the medical profession in nineteenth-century Ireland.

¹ Ehrenreich and English, 'Cult of female invalidism', p. 119.

² Logan, *Making the cure*, p. 38.

³ Cited in Showalter, *Hystories*, p. 11.

To understand the importance of social class in the context of hysteria, one need only note that the majority of patients in all mental asylums in Ireland in the nineteenth century were identified as suffering from some form of 'mania' or 'melancholia'.¹ Elizabeth Malcolm asserts that the period 1851–1901 saw admission rates per capita to Irish public asylums increase by nearly 500 per cent. Significantly, Pauline Prior points out that in nineteenth-century Ireland the people most likely to find themselves in an asylum were from the lower classes.² Consequently, in this period, imbued with Victorian values of respectability, it was generally accepted that mental asylums were inappropriate for those with a privileged background, suggesting that those of the middle classes suffering from 'melancholia' needed to explore other options for treatment. If 'mania' or 'melancholia' was an ambiguous term to describe mental disorders among the poorer classes, then 'hysteria' was a socially acceptable term, provided by the medical profession, to categorise patients of the better-off classes. Thus, the umbrella term 'hysteria' was a convenient characterisation of mental disorders that were essentially a nationwide problem. Medicine simply supplied the respectability, so desired by the middle classes, to the stigma of mental illness. Moreover, deeply imbued with a sense of the public perception of the profession, nineteenth-century medical practitioners distanced themselves from the medieval connotations of the mental asylum and believed that the best treatment of middle-class hysterical patients was in the modern ideology of moral treatment or moral medication.

¹ Elizabeth Malcolm, 'The house of striding shadows: the asylum, the family and emigration in post-famine rural Ireland' in Malcolm and Jones, *Medicine, disease and the state*, p. 181.

² Pauline Prior, 'Mad not bad: crime, mental disorder and gender in nineteenth century Ireland', Paper presented at the Medical Sociology Conference of the British Sociological Association (York, 1995) p. 7.

The discourse behind the new concept of 'moral treatment' had its origins in the writings of the fashionable American doctor, Silas Weir Mitchell (1829–1914). He advocated what became known as the 'rest-cure', which specified a period of complete bed rest, on a high-fat diet, without intellectual stimulation of any kind. This moral treatment emphasised that maximum benefit would be derived from the complete isolation of the patient from her family, home and friends. In a British context, Charlotte Perkins Gilman's female hysteric in *The yellow wallpaper* proclaims:

So I take phosphates or phosphites – whichever it is, and tonics, and journeys, and air, and exercise, and am absolutely forbidden to 'work' until I am well again ... Personally, I believe that congenial work, with excitement and change, would do me good.¹

Underlying the Mitchell rest cure was the belief that women were intellectually inferior to men, and that 'hysteria' was the result of the overuse of their minds; Weir Mitchell therefore proposed complete isolation of the patient from family and friends and the prohibition of any mental stimulation such as reading or knitting. Showalter asserts that the removal of the patient from the sympathetic collusion of her family maximised medical influence and enforced a dependency and childlike obedience from the patient.² Moral treatment also took the form of admonishment and chastisement of the patient, all which added to her general degradation. Alice James wrote in her diary: 'I suppose one has a greater sense of intellectual degradation after an interview with a doctor than from any human experience'.³ It would appear that the so-called 'moral' treatment of hysterical patients enforced infantilism of patients and

¹ Gilman, *Yellow wallpaper*, pp 3–4.

² Showalter, *Female malady*, p. 139.

³ Jean Strouse, *Alice James – a biography* (Boston, 1980) p. 47.

propagated the child–woman analogy, forcing complete dependence of the patient on the will of the empowered male doctor.

As early as 1843 *The Lancet* indicated the punitive element of the treatment of hysterical patients. In a series of lectures on hysteria by Dr Todd, physician to the King’s Hospital, a brisk, no-nonsense moralistic approach is advocated. ‘One of the most effectual and simple modes of stopping the paroxysm is by dashing cold water freely in the face ... Flipping the soles of the feet with the end of a wet towel is also a most potent excitant’.¹ The doctor advises ‘providing against disturbance of the nervous system by the avoidance of all unnecessary mental excitement’.² Thus, the moral treatment advocated by the medical establishment had a decidedly punitive aspect, as if the patient was being disciplined for her illness. This punitive element added to the authority of medicine, essentially promoting the medical profession as guardians of morality.

The *Dublin Medical Press* strongly supported the moral treatment of hysterical patients. In 1864, in an editorial, it offered advice to practitioners:

Sometimes a solemn lecture to a patient, of which she is informed of the degrading position in which she is placing herself – one in which she is ruining herself, both mentally and physically, and when there is no hope for the future – would be of the utmost benefit; and where also she might be told that if she promised to make an effort she might make a confidant of her medical advisor, who would not expose her weakness, but assist her in her endeavours in every way.³

The treatment of hysterical women put the doctor in the optimum power position – as the disapproving but congenial parental figure or the strict, authoritative

¹ *The Lancet*, ii (1842–43), p. 573.

² *Ibid.*

³ *D.M.P.*, ii (1864), p. 373.

disciplinarian. There were no impediments to the medical man's total dominance; few questioned it and the patients had little choice but to accept it meekly.

In 1893 the *Dublin Medical Press* printed an article by Dr G. Ernest Herman, obstetric physician to the London Hospital, where isolation of the hysterical patient is championed. The doctor advises: 'The treatment is (1) to take the patient from home; (2) to feed her. The very fact of her being ill from this cause is proof that her home surroundings are not good for her'.¹ The dehumanising of the patient is a key factor in the Weir Mitchell 'rest-cure' therapy. The report emphasises the importance of segregation of the hysteric: 'Taken from home, and separated from injudicious friends, cure is easy'.² This rather insidious hostility is suggestive of the threat that the hysterical female posed to the authority of medicine. By isolating and thus dominating the patient, the doctor could ensure that he was in a position of control.

The Lancet in 1885 printed an article by a Dr Bristowe who expounds the values of the 'rest-cure' treatment for hysterical females. His patient, a nineteen-year-old 'emotional girl' was 'subjected to the Weir Mitchell method of treatment, and at the end of three months left the hospital much improved'.³ Bristowe outlines how his patient 'became bright and cheerful, and useful in the ward, and looked and conducted herself like a sensible girl'.⁴ This report suggests that the perceived successful outcome of the treatment of a hysterical patient was that she should conform to the existing middle-class definition of femininity, explaining perhaps why the

¹ *D.M.P.C.*, xlv (1893), p. 271.

² *Ibid.*

³ *The Lancet*, i (1885), pp 1069–1072.

⁴ *Ibid.*, p. 1070.

demoralising effects of the 'rest-cure' could persuade a patient to discontinue her protest and conform.

In 1864, a Dr Wilkes offered a case study of a hysterical patient in the *Dublin Medical Press*. The patient, Elizabeth P., aged 22 and a dressmaker, had eighteen months before 'lost' her ability for speech during the night. At the same time she became unable to sit up and as a result had remained bedridden ever since. The doctor reports that she communicates her wishes by writing and can make signs readily, and asserts that the patient appears to be quite intelligent, understands what is said, and replies well by writing. She can use her arms and 'passes most of her time in embroidery'.¹ Dr Wilkes is anxious to emphasise the necessity for the moral treatment of this 'typical' case of hysteria but is careful to outline the effects this might have on the professional life of a medical man:

Sometimes a harsh expression or a severe scolding would excite the patient's anger and rouse her dormant will, but the hazard of this method was that a dislike might be taken to the doctor both by the patient and her friends, and he would be dismissed to make room for a kinder, but perhaps a less conscientious man.²

Nonetheless, the doctor outlines the necessity of adopting a stern, even harsh approach to hysterical patients, underlining the need for complete isolation of the patient because of the 'the great advantages of placing her under other influences than those to which she had been accustomed'. The report emphasises the authoritative and intrinsically moral role of the doctor in hysterical cases and stresses that he 'could not speak too strongly in denunciation of the old fashion, the plan of treating hysteria by

¹ *D.M.P.*, ii (1864), p. 272.

² *Ibid.*

physic instead of by moral means, a plan which is known to be useless'.¹ By placing new significance on the 'moral' treatment of female hysterical patients, the *Dublin Medical Press* was effectively bolstering the authority of the profession. The practitioner was now something far loftier than an individual who merely dispensed medicaments for the purpose of healing. This new role in the so-called moral treatment of hysterical patients gave medicine the professional prestige the profession craved.

In 1869 the *Dublin Medical Press* alluded to the use of electric shock treatment with hysterical patients. Advocating this type of painful procedure was in keeping with the punitive element in the treatment of such patients. In an editorial entitled 'Hysterical Aphonia' (where the patient is unable, or unwilling to speak) the journal attests to how one doctor successfully cured a patient of her 'obstinacy'.

Dr Tanner says that he never fails to cure this obstinate nervous disease by means of electro-magnetism. He places the patient in a chair, gives her one handle of the instrument moistened into her hand, and with the other touches the tongue. The patient then screams out so violently, and thus convinces herself and friends that she has not lost her voice.²

Thus the doctor, in his role as moral guardian, has the authority to administer painful treatment in order to punish and discredit the hysteric. This shocking espousal of violent behaviour among doctors reflected the profession's sense of superiority and dominance over its female patients, and its expanding view of its role in society.

¹ *Ibid.*

² *D.M.P.C.*, lxii (1869), p. 521.

In 1875 the *Dublin Medical Press* printed an article by Dr Clinton Wagner that detailed another case of hysterical aphonia; in this case the patient is a twelve-year-old girl:

Her father stated that, six months previously, she had awakened one morning voiceless, although she had retired the night before in good health. She was of very nervous, excitable, timid temperament, which induced me to regard the aphonia of hysterical origin.¹

The fact that the patient was a child did not deter the doctor from prescribing the use of electric currents: 'Application of electric currents to the vocal chords over a two-day period resulted in restoration of 'perfect voice'.² Again the doctor has the licence to administer brutal and vicious treatment. The girl is subordinated to his domineering role as preserver of the moral code. This type of therapy validated the conventional ideas of ideal social characteristics of femininity such as passivity and pliancy while simultaneously promoting the power of the medical profession.

'Hysteria' was a convenient term that substantiated the medical profession's attempts to extend its authority and jurisdiction far beyond the mere healing of the sick.

Hysteria enabled the medical profession to define women as mentally unstable and irrational, thereby validating male medical intervention. The male doctor is presented by the *Dublin Medical Press* as a reasonable and rational figure, in direct contrast to the chaotic, child-like female hysteric. This authenticated the discourse on female inferiority at a time where women were beginning to gain admittance to higher education and professional employment. Moreover, the prescribed punitive treatment of the hysteric bolstered the public perception of medical authority. The link between female sexuality and hysteria corroborated the prevailing medical belief that women

¹ *D.M.P.C.*, lxx (1875), pp 90–91.

² *Ibid.*, p. 91.

were ruled by her reproductive role. Essentially, the subtext of the *Dublin Medical Press*'s discourse on hysteria evinces an inherent misogyny and distrust of women and their sexuality; thus, the so-called treatment of hysteria can often be interpreted as the medical profession's attempt to control women.

CONCLUSION

This study has sought to examine the rising influence and authority of the medical profession through the eyes of a contemporary popular medical journal: the *Dublin Medical Press*. The journal reiterated the view that the role of medical practitioners went far beyond matters of healing the sick. Essentially, the public perception of the medical profession in Ireland, inherently linked with respectability, increased in the second half of the nineteenth century. The *Dublin Medical Press* emphasised from the outset that their primary goal was to uphold the respectability of the profession and so it was this theme that lay behind much of their discourse. The medical establishment was transformed radically in this period. The rising middle classes, increasing emphasis on professionalism and new interest in personal health all aided the growth of the evolving profession. Government intervention in matters of health led to a state health care system that gave medicine a new status and importance in society. This in turn bolstered the confidence of the profession and enabled them to broaden their jurisdiction in society.

The centrality of prestige to the profession of medicine exists to this day. Strict entry requirements and a prolonged period of study ensure that medicine is predominantly open to a select section of society. The medical elite, modern day consultants, continue to be among the most affluent members of our society. The occupation of medicine is to date regarded as a prestigious calling and in modern day towns and

villages, when other professions have ceased to command the deference of old, the doctor maintains an air of authority. The status of the doctor today attests to the steely determination of an embryonic profession in the nineteenth century to construct a reputation that was both prestigious and illustrious in the eyes of the public.

The exclusionary nature of nineteenth century Irish medicine was reflected in the hostility of the *Dublin Medical Press* to bodies outside the profession who attempted to practise medicine. Unqualified practitioners, popular medicine itself and even the discussion of the healing art in contemporary literature was viewed with suspicion by the journal and often defined as threat to the prestige of the profession itself. In order to establish medicine as an occupation of renown and eminence, it was necessary to maintain a policy of exclusion and even disbarment within the practice of medicine. It was precisely this restrictive strategy that would bolster the prestige of the profession. Much attempt was made by the *Dublin Medical Press* to discredit medical personnel other than male doctors. The moves to organise, improve and advance bodies such as nurses, midwives and female doctors was interpreted by the journal as a direct threat to the prestige and authority of the male medical profession.

The anxiety that medical power might somehow be usurped remains evident today. The hierarchical structure of hospital personnel ensures the subordinate position of nurses, attendants, midwives etc. The figure of authority in the hospital is undoubtedly the doctor. The medical establishment often dismisses fringe medicine and 'unqualified' practice but their scorn could be interpreted as a fear that an acceptance of such practices would erode the prestige of established medicine. The competitive medical marketplace of the nineteenth century that saw doctors jealously

guard their private patients has a comparison with the two-tier system of health care firmly established in modern-day Ireland. In her critical work on the modern Irish health care system, Maev-Ann Wren asserts that the basis of the difficulty in the health system is the authority of the medical establishment and in particular, the medical elite, the consultants: 'It [problems in the health care system] has persisted because of the failure of politicians and officials to take on the consultant establishment, to insist on the dismantling of the medical hierarchy'¹. Wren's analysis echoes the debate on the medical charities in 1851, where the medical profession banded together to ensure their power-hold against the central authority of the Poor Law Commission. Rather than a case of history repeating itself, it would seem that the foundations of a formidable Irish medical authority that would promote and guard the interests of the profession were laid in the mid-nineteenth century.

The preoccupation of the *Dublin Medical Press* with the habits and pastimes of the public reflects the widening sphere of medical responsibilities. The journal's promotion of the doctor as the indefatigable guardian of public morality suggests that the medical profession in Ireland saw their remit as one that extended beyond the healing art. In fact, the pages of the *Dublin Medical Press* evince the belief that there was no area of life that was outside the sphere of the medical practitioner. The doctor was defined as an authoritative figure on the moral lives of his patients and thus free to comment and advice on the most intimate functions of humankind.

Such interest by doctors in the moral lives of their patients has not diminished over time. Often the authority of the medical establishment allows doctors to voice

¹ Maev-Ann Wren, *Unhealthy state: anatomy of a sick society* (Dublin, 2003) p. 364.

disapproval or acceptance of the moral choices of the public. There is no public outcry at such interference in non-medical matters, rather medical moralising is deemed appropriate and even necessary and it is this factor that reflects the extent of the established authority of the profession.

The draconian legislation of the Contagious Diseases Acts (1864–1869) served to illustrate the formidable power group the medical profession in Britain and Ireland in the second half of the nineteenth century had become. In a relatively short period of time, the newly professionalised and organised medical establishment were influencing social policy. This is indicative of the burgeoning public perception of the profession of medicine. The Contagious Diseases Acts were much more than an attempt to curb the spread of venereal disease; rather it was a medically endorsed project to control women, specifically working class women. The *Dublin Medical Press* reflected the gender-bias and, at times, the misogynistic nature of the medical profession. This preoccupation with female sexuality, inherent in the Contagious Diseases Acts, was not new to the journal. The *Dublin Medical Press* had evinced a deep interest in emphasising a traditional definition of femininity and was eager to label non-conforming women.

It might be argued that the gender and class bias so upheld by the *Dublin Medical Press* in the second half of the nineteenth century has a legacy in modern medicine where set codes of conduct, rigid in its support of tradition are emphasised and ideal social characteristics upheld. Medical discourses on venereal disease can, at times, reflect a class-bias; medicine itself reflects conventional and traditional middle-class ideologies. Medical intervention in matters of social policy is common –place and

influential. Essentially, the jurisdiction of medicine remains wide in scope and is largely unchallenged.

The nineteenth century medical fascination with the female body is evidenced throughout the *Dublin Medical Press*. The sheer volume of column space dedicated to exploring and pontificating on the biological functioning of women suggests the scope of this interest. The nineteenth century limit of sound scientific knowledge on the subject dampened medical enthusiasm not a whit as increasingly women began to be defined in medical terms by her biology. The female reproductive system was viewed as chaotic, unpredictable and debilitating, corroborating the medically held belief that women were the weaker sex. The uterus and ovaries were given new central roles as the organs that at once controlled how women thought and behaved as well as rendering her unable to carry out certain tasks.

The medical discourse that linked the female brain to her reproductive system has not dissipated. The oppressive nature of female biology is, as yet, purported to provoke unreasonable behaviour and oftentimes, incapacitate women from functioning normally in society. This wholly unreliable and tenuous facet of the functioning of females has no equivalent in the male. Unnecessary surgical intervention and the unwarranted removal of female sexual organs is, unfortunately, not confined to the nineteenth century as recent medical scandals have proved. The easy and largely unchallenged access of the medical profession to the female body has not altered significantly over time and perhaps it is only in the curtailment of this accessibility that will eventually curb these practices.

The cult of illness that developed in nineteenth century Europe and America did not exclude Ireland. The *Dublin Medical Press* reports at length on a variety of vague and mysterious illnesses to beset a section of society. Hysteria appears to be a public reaction to the new emphasis on health and the consequent centrality of the figure of the doctor. Some sections of society viewed incapacitating illness and the ministrations of the all-important doctor as desirous. The medical profession, as reported in the *Dublin Medical Press* authenticated this thinking by creating a series of ambiguous and equivocal symptoms to give an organic aetiology to hysteria.

It might be argued that the legacy of hysteria has echoes in some modern mysterious illnesses with similarly ill-defined and unclear indicators. Modern medicine, not unlike its nineteenth century counterparts, has indeed a stake in supporting and corroborating the vague complaints of potential patients. The allure of the patient role as an escape from modern anxieties and the demands of life does not appear to be a thing of the past. Sickness in the twenty-first century is often defined in feminine terms and in some cases is depicted as being lovely: the hollow-eyed, pale and listless girl continues to be a figure of attraction. But it is the authoritative figure of the medical practitioner that has remained most unchanged. It is the doctor's arbitration that will define, authenticate and prescribe even the most indeterminate illness. It might be argued that it is this power to classify and rationalise sickness that lends such weight to medical authority.

Thus many aspects of nineteenth century medicine are reflected in the practice of medicine in modern day. If anything the influence and authority of medicine has increased, undoubtedly aided by impressive advances in scientific research. However,

it could be argued that medical prerogative has never depended on knowledge and discovery; the lack of such had little impact on the position of the profession in the second half of the nineteenth century. Perhaps their authority can be deciphered by their patients' necessary vulnerability or by the practitioner's access to the most personal and private aspects of those patients' lives. Perhaps the basis of medical influence can be defined by their omnipresence, their all-seeing parental role in so many intimate aspects of human life. But primarily, it is the steps to create a respectable and organised profession that began in earnest in the second half of the nineteenth century, (underlined by the creation of the *Dublin Medical Press*) that was to pave the way to create an exclusive and elitist medical authority, determined to advance its own class interests and champion its own causes. The fact that the authority of medicine remains a formidable force in modern Ireland is perhaps a testimony to the tenaciousness of the medical profession in Ireland in post-Famine Ireland.

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