Introduction: Disapproval, Curiosity, Amusement, Obstinate Hostility?

Women and Surgery, 1860–1918

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

> the Semiramis of surgery, a Fergusson in woman's outward guise, amputating a thigh, or removing a diseased jaw or elbow-joint, aided by assistants of like sex and mind, and surrounded by a host of fair damsels, who regard the proceedings of the operator with that appreciation of the cool head and the ready hand which medical students so well know how to feel! Imagine some fair and amiable damsel, a female Rokitansky, poring with inquisitive eye over a collection of ulcerated Peyer's patches or a piece of softened cerebral substance, or assiduously endeavouring to ascertain, by the aid of the microscope, the presence or absence of fatty degeneration in a piece of heart-tissue, or to determine the nature of a tumour which her associate Semiramis has just removed! Call to mind all things that are done in the ordinary course of hospital duties, or even of general practice in town or country; and imagine, good reader, if you can, a British lady performing them.
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> Women who would practise medicine and surgery must do so wholly; there is no shirking the obligation. If they attempt to do less, they will fail in the duty they undertake; and the male sex will have an unfair advantage over the female, in being able to command a higher exercise of professional skill and knowledge.[1]

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

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

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

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

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

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

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

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

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

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

[4] Anne Digby, *Making a Medical Living* (Oxford: Oxford University Press, 1994).

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

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

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

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

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

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

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

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

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

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

[8] On the varying degrees of procedural adoption, see Michael Worboys, *Spreading Germs* (Cambridge: Cambridge University Press, 2000).

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

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

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

[10] 'Introductory: The Need of Co-operation in Surgical Enterprise', *British Journal of Surgery*, 2.5 (1914), 1–3; 1.

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

[11] Thomas Schlich, 'Surgery, Science and Modernity: Operating Rooms and Laboratories as Spaces of Control', *History of Science*, 45.3 (September 2007), 231–56.

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

[13] Thomas Schlich, *The Origins of Organ Transplantation* (Rochester, NY: University of Rochester Press, 2010), p. 8.

[14] For the classic example of female patient as victim, see Mary Poovey, '"Scenes of an Indelicate Character": The Medical "Treatment" of Victorian Women', *Representations*, 14 (Spring 1986), 137–78. For a response to Poovey, see Morantz-Sanchez, *Conduct Unbecoming*.

[15] Ludmilla Jordanova, *Sexual Visions* (Madison, WI: University of Wisconsin Press, 1989), p. 153.

[16] Lawrence, 'Democratic, divine and heroic', p. 31.

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

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

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

[17] Ann Dally, *Women Under the Knife* (London: Hutchinson Radius, 1991).

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

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

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

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

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

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

[20] I will refer to women doctors by their best-known names throughout, to avoid confusion.
[21] Elizabeth Garrett Anderson to Emily Davies, Bayswater, Wednesday 5 September 1860, HA436/1/1/1: Letters from Elizabeth Garrett Anderson to Emily Davies: June–December 1860, Ipswich Record Office, Suffolk.
[22] Elizabeth Garrett Anderson to Emily Davies, 9 September 1860, 9/10/015, ALC/2905, The Women's Library.

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

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

[23] Elizabeth Garrett Anderson to Emily Davies, Aldeburgh, January 1861, HA436/1/1/2, Ipswich Record Office.
[24] 'Chloe, M.D., On Mr Cowper-Temple's Bill', *Punch*, Saturday 15 July 1876, 24.
[25] Charles Bell Keetley, *The Student's Guide to the Medical Profession* (London: Macmillan, 1878), p. 25.

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

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

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

[26] 'A Special Chapter for Ladies Who Propose to Study Medicine', in ibid., pp. 42–8; p. 47.
[27] S.L.B., 'How the Medicine Woman is Trained', *Sketch*, 15 June 1898, in *Royal Free Hospital Press Cuttings, Volume 3: May 1878–January 1904*, H72/SM/Y/02/003, LMA.
[28] Evidence of Mrs Elizabeth Garrett Anderson, M.D., 5 March 1891, *Select Committee of House of Lords on Metropolitan Hospitals* (1890–1891), 16452–531.