

THE EVOLUTION OF THE GYNAECOLOGIST*

BY

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THE Oxford English Dictionary defines gynaecology as "that department of medical science that treats of the functions and diseases peculiar to women" and thus declares that obstetrics is an essential part of the work of the gynaecologist. If this be so, "The Royal College of Gynaecologists" would be a fitting description of our foundation, but the founders had good reason for perpetuating in our polysyllabic and sonorous title a time honoured name and a duality of purpose that is of great historical interest. It is the fortunes of the gynaecologist in this dual role that we are now to consider.

His evolution may be said to have begun in the garden of Eden and although priority may be claimed by the thoracic surgeon, or by the anaesthetist, for we read that Adam was put to sleep, the gynaecologist can afford to be generous for the operation upon Adam was never repeated, whereas the gynaecological activities of Eve have continued to exert a profound effect upon the welfare of mankind ever since. If, therefore, the Aesculapian symbol has a somewhat obscure application to medicine in general, there can be no doubt that the serpent is an emblem of peculiar significance to the gynaecologist.

The earliest phases of his evolution are a matter of speculation, for although the condition of neolithic skulls proves that ancient

man had some knowledge of surgery, there is no such unequivocal evidence of his attainments in gynaecology and we must look to more esoteric sources for information on this stage of his development. We may derive some help from the study of the sex behaviour of modern savages who, according to the best ethnographical opinion, have never come under the influence of civilization and who for this reason must be placed farther back in the evolutionary scale than the earliest civilized communities of which we have any record. Among aborigines of this type, man is lord and master and a firm believer in a system that relieves him of uncongenial occupation while the women do the work and look after the family. Under this system the women are the midwives and also the supervisors of many ceremonies relating to puberty and marriage. Among certain tribes they carry out the operation of circumcision and also the procedure known as fibulation, which involves the removal of not only the clitoris and nymphae but also a portion of the labia majora and the mons veneris—a mutilating procedure which results in a degree of vaginal occlusion so complete as to make coitus impossible until the vagina has been re-opened by the operation of defibulation. The tribal doctors or medicine men play little if any part in these operations, either because they are excluded by a dominant matriarchal tradition or because they consider such work beneath the notice of those who are the friends of the gods and the masters of witchcraft. We

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must not identify the sex behaviour of modern uncivilized man too closely with the customs of his unknown pre-civilized ancestors, but it is reasonable to infer that in prehistoric times midwifery was in the sole charge of women and that the prehistoric physician played no part in either midwifery or gynaecology.

Influence of the Early Civilizations

It is a far cry from neolithic man to the Greek physician but during this long transition the progress of gynaecology can be faintly discerned through the cuneiform inscriptions of the earliest writing and the papyri and the mummified remains of the ancient Egyptians. We learn that the Sumerians in 4,000 B.C. were interested in cattle breeding and thus had the rudiments of genetics, and that the Babylonians 2,000 years later had an organized medical profession with penalties for malpraxis. Medical literature made its appearance and some of it related to gynaecology including the fragmentary Kahun papyrus (850 B.C.), which deals with uterine disorders and one of the Berlin papyri (1,450 B.C.), which consists of incantations for the protection of mothers and babies, whilst the Ebers papyrus of 1,500 B.C. describes a test for pregnancy that adumbrates the principle of Aschheim and Zondek. The conception of health as distinct from disease also took shape with Thoth as the God of Health and the lion-headed Sekhet as the deity of childbirth. It became traditional to associate the lives of great men with the art of healing and the celebrated Imhotep who was the Grand Vizier of Egypt and the architect of the Great Pyramid of Sakkarah, the oldest stone building in the world, was worshipped after death as the God of Healing, although nothing is known of his medical activities during his lifetime. This tendency to identify medicine with the

gods and to confuse the gods with men is beautifully illustrated in Greek mythology in the legends of Apollo and Aesculapius. Apollo, the twin brother of Artemis, is of special interest to the gynaecologist, for at Delphi there may still be seen a monument as old as the pyramids—the Omphalos—a stone placed there to commemorate the separation of the umbilical cord of the young god and to establish for all time the importance of this physiological, if fabulous, event. After Apollo as a prodigious neonate had slain the monster which ravaged Parnassus, he founded the cult for which Delphi became famous, and it was here that Aesculapius is alleged to have practised the art of healing. Unhappily he was all too successful and his career was brought to an end with a thunderbolt after Pluto, the God of the underworld, complained to Zeus that Aesculapius was depriving his dominions of subjects by raising the dead to life. It may be that Aesculapius was not a purely mythical character, for he has been identified with a priest who lived and practised the cult of Apollo at Delphi in 1250 B.C., but whether mythical or mortal he became the God of Health and temples in his honour were built in various parts of Greece and the Ionian islands, including the island of Cos, where Hippocrates was born in 460 B.C.

Influence of the Hippocratic School

It was formerly believed that Hippocrates was a son of a priest-physician of the Aesculapian order, but this view is no longer tenable as it is now known that the cult had not been established at Cos at the time of his birth. It is certain, however, that he visited several of these temples, that he was steeped in their tradition and literature and fully conversant with their methods and practice. After much work and wandering he settled in Thessaly and spent the rest of his life in the vicinity of

Delphi practising medicine and gynaecology in the towns and villages that may still be seen in that neighbourhood. It was here during the first world war that your memorialist may humbly claim to have established a link between the Father of Medicine and this College, when after visiting the oracle at Delphi he performed an operation for excision of the vulva in the village of Suvalla on the foothills of Parnassus, and on another occasion met a Greek physician in consultation over a gynaecological case in the town of Lahriisa, which Hippocrates frequently visited and where he eventually died. This link may be regarded as somewhat tenuous, but at least we may be sure that given the opportunity Hippocrates would have lent his support to the foundation of this College. In his day gynaecology had lost much of its crudity and had become an accepted part of medicine. The range of the subject was considerable and in some ways surprising. For the investigation of sterility attention was paid to the regularity of menstruation, the size of the os uteri and the position of the uterus, and some cases were treated by the insufflation of aromatic fumes conveyed to the uterus through a hollow tube inserted into the cervix. Dilatation of the cervix was carried out by means of wooden or leaden pipes. Astringents were recommended for leucorrhoea and medicated tampons for the treatment of ulcers of the cervix. Accessible tumours and polyp were excised and a type of vaginal hysterectomy occasionally undertaken for prolapse or inversion of the uterus. In addition to his knowledge of gynaecology, the Greek physician had developed an interest in midwifery for, although midwives were still in charge, the Hippocratic system recognized that difficult or preternatural cases came into the province of the physician and should be treated by cephalic version or craniotomy, with Caesarean section as a

last resort for dead or dying patients. The Hippocratic Oath makes a direct reference to the gynaecologist in the following words—"I will not give a pessary to a woman to procure abortion"—and perhaps an indirect one where it says—"I will not cut persons labouring in stone, but will leave this to be done by men who are practitioners of this work". It may be that Hippocrates disapproved of procuring abortion on purely ethical grounds, a view which is in keeping with the moral tone of the rest of the oath, but in conjunction with his reference to lithotripsy the words would seem to imply that such a dangerous operation as procuring abortion should only be performed by those who in the words applied to the lithotritist "are practitioners of this work". It is evident that Hippocrates recognized the importance of technical training and that, although he would not accord to the specialist the full status of the physician, he regarded him as a necessary and acceptable member of the profession. The Greek system whereby physicians were responsible for medicine, most of the surgery and the difficult midwifery, specialists cut for stone and sometimes operated for cataract and other conditions, and women were in sole charge of normal midwifery, persisted right through the ages until the Renaissance of learning in the 16th Century. Among the many universities and schools of medicine which flourished during this period, one is of particular interest to our subject—namely the school at Salerno, which was founded in the 9th century and ranked for 400 years as one of the great universities of Europe. Students could not enter at Salerno until they were 21 years of age and had studied logic for three years. The course lasted five years and was completed by an additional year of post-graduate study under an older practitioner, after which the student was entitled to call him-

self doctor. Associated with this School were "the Ladies of Salerno" whose qualifications remain obscure but who cannot have been fully qualified medical women because the terms of entry obviously preclude the admission of women students—nevertheless they were the recognized teachers of midwifery, and one of them, Trotula by name, is the reputed author of a Text Book on Midwifery written in 1050. Trotula and her colleagues were not of course the first women to become famous as midwives, for Smellie mentions that Cleopatra was an Egyptian teacher of considerable renown and that the writings of Aspasia were known and quoted by Aetius in the fourth or fifth century A.D. It is clear that, whatever the status of these ladies may have been, they must have enjoyed a reputation and a prestige far above that of the untrained women of primitive times. The first teachers of midwifery were in fact women and the training of midwives began long before that of medical students, and there can be little doubt that at the Renaissance the competent midwives were better obstetricians than the untrained and inexperienced physicians. It is therefore not surprising that such women should resent the intrusion of the man-midwife into their traditional field of work.

The rise of the Man-Midwife

This intrusion began with the work of Ambroise Paré, who was born in 1510 and died in 1590. He was a Barber Surgeon and as such not quite acceptable to his academic brethren "of the long robe" and anathema to the physicians who could not forgive the use of the vernacular instead of Latin (of which he had none), but nevertheless he became the greatest medical figure of the Renaissance and the foremost surgeon of his age. His first experience of war surgery made an ineffaceable impression

on his mind. Confronted with the treatment of five desperately wounded men after the battle of Turin in 1537, he was asked by an old sergeant of the regiment whether he could cure them. When Paré said "no", the sergeant quietly and, as Paré himself records, "with no ill will" cut the throats of all five as the quickest and least painful method of treatment. This deplorable if humane action gave an impetus to a life work which touched every branch of medicine, and when Paré substituted podalic version for craniotomy and the use of traction hooks, Smellie claims that he was the first to improve upon the treatment of the ancients. Paré's work was followed up by other Frenchmen, including Mauriceau and Gregoire, who founded the French School which did so much to promote the advancement of midwifery and the training of the man-midwife during the 17th century. This innovation naturally aroused the ire of the women midwives, and these doughty matriarchs entered with zest into a fray that was candid, personal and often libellous. The cause of the men received welcome if unexpected support from the French Court when, in 1663, Louis XIV called in Dr. Clement for the confinement of Louise de la Vallière—apparently because he wished to conceal the condition of this lady and he was not sure that the court midwife could keep a secret. It was not however the work of the French School, great as it was, and certainly not the appointment of a Royal Accoucheur, that finally settled the controversy, but rather the introduction of an instrument which afforded a rapid and comparatively safe method of delivery for normal as well as abnormal cases—namely the Forceps invented by Peter Chamberlen at the beginning of the 17th century, but retained as a family secret for upwards of 100 years. During this time the Chamberlens were exploiting the instrument for their own

benefit, and with great success for three generations enjoyed the patronage of Royalty, but they made no effort to further the interests of their professional brethren, and indeed one member of the family, Peter the Younger, actually espoused the opposite side, for he was accused of "actively and impudently advocating the cause of the midwives". But however much we may deplore this extraordinary conduct, which undoubtedly delayed the development of midwifery in this country, it can hardly be denied that the unique position of the Chamberlens in society and at Court, their large practice and unquestioned skill, and even their suppression of the family secret, must have aroused considerable interest in midwifery and speculation as to its future, long before the details of the forceps were published by Chapman in 1733.

This resurgence of interest had been already manifested by the establishment of a Chair of Midwifery at Edinburgh in the year 1726. This was the first chair to be founded in Europe, but it is significant to note that it was endowed by the City Fathers and provided for the instruction of midwives only: at its inception it did not rank as a University Chair, and it was not until 30 years later that medical students were admitted to its classes. The year 1756 is therefore an important year in the evolutionary calendar, for it marks the appearance of the man-midwife or Physician Accoucheur as a Professor of midwifery and the beginning of the organized teaching of medical students.

The Rise of the Teacher and the Special Hospital

Smellie, that great man of Lanark, settled in London six years after the publication of the forceps and in the course of the next 20 years established a reputation which has exercised a lasting and potent

effect upon the development of midwifery. During his residence in London he gave organized courses of instruction to no less than 900 students and, having no hospital beds, his practical work was conducted at the bedside of his patients in their own homes. In this way he established an "Out Door District" where the poor received the same attention as the rich and the doctor and the midwife met on common ground, and this must be regarded as one of his greatest achievements. Smellie represented a new type, altogether different from the fashionable physician or surgeon with a flair for obstetrics, for he and his contemporaries and successors—Douglas, William Hunter, Fielding Ould and others—were professional obstetricians and students as well as teachers of their subject. But, although Smellie himself had no access to beds, such beds were in fact available to some obstetricians at that time, for Sir Richard Manningham had instituted Lying-in-Wards in 1739, the very year Smellie came to London, and his example was soon followed by others. In Dublin Dr. Moss founded the Rotunda in 1745. In London the Middlesex began to admit maternity patients in 1747, and the London Maternity Hospital was established three years later. The first of the provincial hospitals, St. Mary's at Manchester, was founded in 1790 by Charles White, F.R.S., who, together with his son Thomas and his friends Edward and Richard Hall, resigned their posts at the Manchester Royal Infirmary in consequence of a difference of opinion with the board of management. Charles White, who was the author of a treatise on the Management of Pregnant and Lying-in-Women and the forerunner of Wendell Holmes and Semmelweis in the attack on puerperal sepsis, had been Surgeon at the Royal Infirmary for 38 years and was in fact one of its founders, and one is tempted to suggest

that the difference of opinion may have concerned the admission of the man-midwife to the staff of that institution. Whatever the reason may have been, he and his colleagues took a private house in Old Bridge Street, Manchester, and there established the Manchester Lying-in-Hospital and Charity. The work was carried out chiefly on the district, but accommodation was also provided for the reception of In-Patients, as the records show that in the year 1793-94, 749 women were delivered in their own homes and 203 women were delivered in hospital, whilst 70 were treated for "disease" as Out Patients and so formed the nucleus of a Gynaecological Department. St. Mary's had a flourishing Ladies Auxiliary Society which did much to promote harmony between the doctors and the midwives. In 1816 fifteen midwives were attached to the hospital and the report for the year that states: "Mr. Wood continues to give instructions to practising midwives and female pupils". In addition to these special maternity hospitals many smaller institutions, known variously as Ladies' Charities, Lying-in-Dispensaries, and the like, were set up throughout the country and staffed by the local practitioners.

At the outset most of these dispensaries were concerned with midwifery only, but many like St. Mary's evinced an early interest in the treatment of the diseases of women, and later on as gynaecology developed they were ready to provide in-patient accommodation for such cases under the same roof or in a separate gynaecological or women's hospital. Staff appointments to such institutions were of little interest to the general physicians and surgeons of that time who were apt to regard the obstetrician with pity if no longer with contempt, and his work with its long vigils and night watches as the most arduous and least interesting part of

medicine: but an appointment to the staff of a general hospital in London or the provinces was a very different matter and in many instances attempts to make such appointments aroused a great deal of opposition.

The Physician Accoucheur and the General Hospital

Some of this opposition was not unreasonable for beds were few, skilled obstetricians were rare, and in many general hospitals sepsis was rampant, but nevertheless, as soon as the need for instruction in midwifery was recognized, the teaching hospitals were morally bound to provide facilities for teaching although they were not disposed to attach much clinical importance to such lectureships. Amongst the earliest of these appointments was that made at Guy's in 1789, when John Haighton (1755-1823) was made Lecturer in Physiology and Midwifery and Physician Accoucheur to Guy's and St. Thomas's (which at that time were next door to each other). Haighton is described as a skilful surgeon, and a good lecturer, but he was an irritable and argumentative man and although he obtained an M.D. degree he retained his original title and was never appointed to a full physiciancy. He had the use of some beds for there are records of his operations, but it was not until 1830 that William Blundell, his nephew and successor, obtained a ward of his own. Blundell, like his uncle, was a general surgeon, but he was also an enterprising gynaecologist and removed the uterus for cancer on at least three occasions.

The progress of the Physician Accoucheur is taken a stage further by the sequence of events at St. Bartholomew's Hospital. Here the first Lecturer in Midwifery was Andrew Thynne in 1812. He had no beds. The Lecturer in Midwifery taught gynaecology as well, but only in a

very restricted sense, and in 1861 Charles West resigned because he was dissatisfied with the conditions of service. His successor Greenhalgh was styled Physician Accoucheur in addition to Lecturer, but like Matthews Duncan who came next he was allowed to perform vaginal operations only. Matthews Duncan died in 1890 and Champneys who followed him was restricted in the same way. Champneys retired in 1912, and his successor Griffiths was the first to be allowed to perform abdominal operations, but in fairness to the hospital it must be pointed out that Griffiths was the first holder of this appointment to take the F.R.C.S. The Physician Accoucheur thus gained admission to the general hospitals as a teacher, but was not at first accorded the status of a full member of the staff. As a gynaecologist he was permitted to teach the subject and to perform vaginal operations, but as soon as ovariectomy and other abdomino-pelvic procedures became practicable he found himself opposed by the general surgeons, and we must now go back and consider the *fons et origo* of the situation which then developed.

The Origin of Abdominal Surgery

In the early part of the 19th century surgery as we know it to-day did not exist. There was indeed little to choose, in its rationale and result, between the terrible act of the French serjeant at Turin and many of the operations that were performed by the surgeons of the pre-anaesthetic era. Picture Syme, for example, carrying out an excision of the lower jaw, so distorted by sarcoma as to enlarge the patient's mouth to a circumference of 15 inches, and imagine the feelings of the young man who sat up in a chair and submitted to this procedure for half an hour without any form of narcosis. Nevertheless it was this pre-anaesthetic era of crude, oblativ and often brutal treatment—for the after results

rarely justified the appalling sufferings inflicted upon the patient—that saw the birth of abdominal surgery when Ephraim McDowell performed the first successful ovariectomy. Houston of Glasgow had tackled an enormous cyst over 100 years previously (in 1701) but, although he opened the abdomen, for otherwise he would hardly have dressed the wound, as he says, “with a large napkin dipped in warm French brandy”, he merely tapped the tumour and made no attempt to deal with the pedicle, and McDowell is justly entitled to the honour of priority. He was born in 1771 in America of Scottish parentage and, like a good Scott, studied for a year in Edinburgh, where he came under the influence of Bell, a bold and resourceful operator and the leading surgeon of that time (1793). McDowell returned to his native country with an enthusiasm for surgery and a determination to pursue that branch of medicine. He settled in the West, and there at the small village of Danville in Kentucky in the year 1809 he performed the operation which was to immortalize him and his patient Mrs. Crawford. To face the ordeal this heroic woman travelled 60 miles on horseback with the tumour wedged so tightly against the pommel of her saddle that the abdominal wall was found to be extravasated with blood when the incision was made the following day. During the operation McDowell's house was surrounded by an angry mob accusing him of butchering a woman, but happily the remarkable recovery of the patient—who was up and about in four days and lived to the age of 78—relieved McDowell of any further accusations of this sort, and subsequently he did 13 similar operations of which eight were successful. The publication of McDowell's initial success led to further attempts by different surgeons in America and Europe, but relatively few women

were willing to submit to an abdominal operation prior to the advent of anaesthesia and the heavy mortality amongst those who did was not calculated to encourage other patients, or for that matter, other surgeons. The world was waiting for Simpson and Lister, or rather for the symbiosis of their work, because although anaesthesia must always rank as a supreme discovery, its introduction had little immediate effect upon operative results except paradoxically to increase the death rate. Previously great speed and dexterity had been demanded of the surgeon or he got no patients, and one may marvel at Liston amputating through the thigh in thirty seconds and yet understand the need for such celerity. By eliminating pain and shock, anaesthesia inevitably increased the number of operations but also the number of slow and less skilful operators, with a corresponding increase in the mortality from post-operative sepsis, until the work of Pasteur and Lister solved the problem of infection. In 1877 for example, a date before Lister's work had come to fruition, the mortality rate for ovariectomy in London, according to figures supplied by Mr. McKim McCullagh, was as follows:

	Cases	Mortality per cent
Three large general hospitals	61	60.65
Guy's Hospital	82	52.43
Soho Hospital	71	38.16
Samaritan Hospital	281	23.84

These figures reveal the relative safety of the special as compared with the general hospitals of that time and also the remarkable influence of Sir Spencer Wells at the Samaritan. But, in spite of the inevitable sepsis, the introduction of anaesthesia gave an impetus to the development of surgery, and gynaecology proceeded to advance along two separate and slightly divergent

lines—with Simpson and Marion Sims leading in vaginal surgery and Spencer Wells and Lawson Tait in the van of abdominal work.

The Influence of Simpson and Sims

As a gynaecologist Simpson belonged to the old school and he is remembered chiefly by the sound which bears his name. This instrument resembles the forceps in its capacity for misuse and, in the wrong hands, is admittedly dangerous, but it was the first instrument of precision to be used for the investigation of uterine disease and it remains to-day an indispensable aid to the most advanced gynaecologist. But if the sound is indispensable its use is conditioned by visible access to the cervix uteri, and this type of approach was first made possible by the invention of the duckbill speculum by Marion Sims. This instrument, totally different in principle from its name-sake, the speculum matricis of the ancients, placed in the hands of the operator a new method of approach to the vaginal walls and the uterus, and opened the way for operations which had hitherto been impossible. Simpson and Sims between them made a unique contribution to the development of those vaginal operations which are euphemistically termed minor but which include such difficult procedures as vaginal hysterectomy and the radical repair of vaginal prolapse. Many other names have been associated with these developments, but none is more widely known in this country than that of Fothergill, in association with the Manchester operation. The matter of credit has been much debated, but the situation was pithily summed up by a Liverpool student in a Final Examination at which Sir William Fletcher Shaw was present on behalf of the General Medical Council. The candidate, who was quite unaware of the identity of the gentleman sitting at the side of the examiner, when asked to describe

the Manchester operation replied—"this procedure was begun by Professor Donald, modified by Professor Fothergill and perfected by Sir William Fletcher Shaw".

The influence of Spencer Wells, Lawson Tait and the Ovariologists

Whilst these vaginal operations were being worked out, Spencer Wells and Lawson Tait were following up the pioneer work of Ephraim McDowell and his successors. Lizars of Edinburgh was the first to perform a successful ovariectomy in Scotland, but his success was limited to one operation performed in 1825, and Claye of Manchester, who has clear priority in England, made a much greater contribution to the problem. Born near Stockport in 1801, after studying in Manchester and Edinburgh, he settled in practice (in 1823) at Ashton-under-Lyne where, like Ephraim McDowell, he combined a good deal of surgery with his other work. In 1839, he removed an ovarian tumour weighing 36 pounds, the operation taking, it is said, only ten minutes, and by 1848, i.e. before Wells had done his first case, he had 33 to his credit and, by 1865, no less than 113 cases of whom 77 recovered. This was a great achievement but nevertheless it is to Spencer Wells (1818-97) and to Lawson Tait that we owe most for the development of abdominal gynaecology.

Spencer Wells was born in 1818, and after joining the Navy as a surgeon spent six years in Malta. By training and by inclination he was a general surgeon, and he admitted afterwards that, when he was appointed to the Samaritan Hospital in 1846, gynaecology "was a subject of which I knew less of than of any other special division of our profession." A year earlier he had agreed with Dr. Waters of Chester, whom he met in Paris, that ovariectomy was an unjustifiable operation, but he went to the Crimea in 1854 as an army surgeon and here he revised his

opinion after studying the reaction of the peritoneum to gunshot wounds of the abdomen. Three years later he carried out his first ovariectomy, but the operation was a complete failure and Wells was again inclined to the belief that tapping and incision were alone justifiable and the more so because at this time only one successful case had been reported in London (by Hawkin of St. George's Hospital in 1846). On reflection, however, Wells decided to persevere with his mission and, being an honest as well as a fearless man, he determined to record all his results regardless of the consequences to himself or his reputation. This pledge he scrupulously kept and at the time of his retirement from the Samaritan Hospital, in the year 1877, he had reported 408 cases with 99 deaths—a mortality of 24 per cent.

Lawson Tait

Tait came later than Wells but went further. Born in 1845, he left Edinburgh in 1867, with a determination that he would never deliberately open the abdomen. He said "the results I have seen in Edinburgh were truly awful, some thirty cases and not a recovery". After acting as house surgeon in Yorkshire, he settled in Birmingham, giving as his reasons for the choice of this city that he was the first pupil of Simpson to go there and that Birmingham was about the centre of England and therefore most easily accessible to patients who might desire to see him from all parts of the country. Like Spencer Wells he was a general surgeon rather than a specialist, for although he founded the Birmingham Hospital for Women as a special hospital, he did not restrict himself to gynaecology and in the course of his career carried out 4,000 abdominal sections including the first successful cholecystectomy in this country, and the first operations for cystic ovary, pyosalpinx and hydrosalpinx. He was a fine operator and, although he did not

accept Lister's work on antiseptics or conscientiously apply his principles, he got better results than his great rival Spencer Wells, who believed in both, but it must be remembered that Spencer Wells did a great deal of his work before the principles of antiseptics were established, and that he got far better results than his own contemporaries. Tait held that, if organisms existed at all, they could only live on dead matter, and in the belief that organisms could not survive in a healthy wound, he took infinite care to keep his wounds healthy. He had been greatly influenced by the work of Syme, who unlike most of his colleagues, observed the most scrupulous cleanliness, and Tait developed these principles to such an extent that he finally evolved a method that was practically identical with the modern aseptic technique. He was a man of great originality of mind and above all an individualist, always ready and willing to maintain his own views and to sustain his own reputation against all comers—and particularly against Sir Spencer Wells, with whom he was frequently in conflict. He was certainly the most original and possibly the best abdominal surgeon of his day and as such he made a fundamental contribution to gynaecology, for which his capacity may be judged by the fact that he actually performed a series of 136 consecutive ovariectomies without a single death. But if he made a great contribution to gynaecology, his contribution to the fortunes of the gynaecologist was somewhat different. His earliest operations on the cystic ovary led to the accusation that he was "spaying" his patients—a view that Wells did little to refute when he remarked "I never see such cases, perhaps they all go to Birmingham", and his reputation was not enhanced by his support of Dr. Imlack, the Liverpool surgeon, who was prosecuted for performing an operation for appendage disease. Imlack received little if any support from his colleagues

with the exception of Lawson Tait, and indeed it was darkly hinted that Spencer Wells had himself supplied the funds for the prosecution. The medical evidence given in this case tended to bring gynaecology into disrepute with the general public, and it had an unfortunate effect upon the profession by suggesting that Tait was as unorthodox as Imlack, that specialists were potentially dangerous, and that the new gynaecology might best be left in the hands of the general surgeon. With this latter view, curiously enough, Tait was in agreement for he was never an obstetrician and had very little sympathy with the physician accoucheur. In 1884, two years before the Imlack case, Tait had assisted to found the British Gynaecological Society for the benefit of those who were eager to advance the study of the diseases of women, as opposed to the members of the Obstetrical Society who were supposedly interested in purely obstetrical problems. In his book, written in 1889, Tait animadverts as follows—"The old-fashioned mechanical school, the teaching of the speculum, the sound, the caustic stick and the pessary has been practically killed . . . the day has gone by when the treatment of pelvic and abdominal diseases . . . is to be regarded as a mere appendix to the work of the accoucheur . . . Gynaecology and Obstetrics are now happily severed, and this division of labour has resulted in enormous advances for both".

*The Gynaecological Surgeon or the
Obstetrician and Gynaecologist*

This disruptive idea was short lived, but it was responsible for the establishment of separate Chairs in Obstetrics and Gynaecology in some places, and for sharp differences of opinion and practice in others. In Vienna for example, there was, and possibly is, the Schauta or the Vaginal School and the Wertheim or Abdominal

School—each almost wholly committed to the one technique and almost wholly indifferent to the other. These family differences were good ammunition for the surgeons in their attempt to restrict the activities of the physician accoucheur and to repel the invasion of the gynaecologist into the field of abdominal surgery. Fortunately the attempt to separate gynaecology from obstetrics was doomed to failure, for all the modern advances in medicine and surgery had shown the biological unity of the two subjects, whilst the meetings of the various Obstetrical and Gynaecological Societies, with their transactions and their journals, afforded abundant proof of the common interests of the obstetricians and the gynaecologists. Nevertheless long after this internecine warfare had been settled, the cold war between the general surgeons and the gynaecologists lingered on in those parts of the country outside the influence of teaching centres where trained specialists were not easily available and the general surgeons had come to regard gynaecology as an interesting and remunerative part of their own work. In such places the gynaecologist, like his predecessor the physician accoucheur, gained admission to the general hospital as a teacher, but not always without a struggle, of which one may perhaps be permitted to quote one example. In Newcastle, the late Professor Rankin Lyle, when Assistant Master at the Rotunda, was appointed Lecturer in Midwifery at the Medical School. The appointment carried beds at the Maternity Hospital but none for the teaching of gynaecology, and Rankin Lyle was refused admission to the Staff of the Royal Victoria Infirmary when he applied for access to that institution. He thereupon bought a house at the very gate of the Infirmary, equipped it as a Women's Hospital with an Out Patient Department, Wards and Theatre, and there taught his

students. This spirited riposte was too much for the surgeons and Rankin Lyle was given an appointment and teaching beds at the Infirmary, having fought, as Professor Farquhar Murray tells us, as a complete stranger for a proper status for the gynaecologist—and all honour to him for his courage and altruism.

Foundation of a College

The special societies in London, Edinburgh and elsewhere did much to fuse the two elements of their branch of medicine and to promote the welfare of the obstetrician and gynaecologist, but they did not, and indeed could not, constitute a central authority to which all might look for guidance and control. Their fellows and members owed allegiance to one or other of the Royal Colleges, and in some cases to both, but neither college had a comprehensive knowledge of obstetrics and gynaecology nor a special interest in the obstetrician or gynaecologist.

In the course of the 50 years which preceded the foundation of our College only four obstetricians—Dr. Galabin 1898, Sir John Williams 1900, Sir Henry Champneys 1902, and Dr. Herbert Spencer 1918, were elected to the Council of the Royal College of Physicians, whilst in the Royal College of Surgeons during the same period, if we exclude Sir William Ferguson, Sir Spencer Wells and Sir John Bland Sutton, who were Presidents and general surgeons, only one gynaecologist was elected to the Council, namely, Mr. Victor Bonney in 1926. The situation became the more pressing with the trend of events—the progressive work of the Ministry of Health, the Central Midwives Board and the Municipal Hospital System with its unlimited number of beds—developments which made for disunity in the control of midwifery, and thereby made the need for an independent and authoritative body yet more urgent.

The call for action was answered at a meeting of the Gynaecological Visiting Society—a society of teachers which owed its inception to the imagination and enthusiasm of the late Professor Blair Bell, who resembled Lawson Tait in the fertility of his thought, his boundless energy, and in his burning interest in gynaecology. He shared too his love of polemics and his passionate aspiration towards priority of purpose and achievement, and like Tait he was the outstanding gynaecologist of his generation. It was at one of these gatherings that Sir William, then Professor Fletcher Shaw, first brought forward the project that eventuated in the foundation of a College that was British from birth and has since become Royal by gracious permission and by illustrious fellowship. By this unique foundation—for our College was the first of its kind—Obstetrics and Gynaecology were presented to the world not as a dual specialty, but as the interwoven and indivisible elements of a basic branch of medicine, and its Fellows and Members were called upon to emulate the status and the responsibilities of the physicians and surgeons. This bold claim was a challenge to all those who founded the College and it remains a challenge to us to-day—and especially to the younger men who are called upon to take up the gage. We have received help and encouragement from all parts of the world, and none has been more gratifying than the advice and co-operation of the older Colleges, who have given us a royal welcome and fully acknowledged our position as a junior member of the family. It remains for us to show that this Cinderella of ours is worthy of her older sisters.

Mutation and the Future

And here we must leave the evolution of the gynaecologist to the care of the College and to the discipline of the future and its fortunes, bearing in mind that ours is no

longer an age of gradual transition along the lines laid down by Lamarck and Darwin, but one in which sudden and incalculable changes take place by a process as mysterious and uncontrollable as the mutations described by de Vries and the geneticists. Chemotherapy for example has revolutionised the outlook in puerperal sepsis and the sulphonamides and penicillin have rendered operative delivery so safe that most of the vaginal methods of dealing with difficult cases are now obsolete. By this dramatic stroke obstetrics has been reduced to the simple formula of vaginal delivery with episiotomy and low forceps for normal cases and Caesarean section for all the rest, a formula strangely reminiscent of the Greek system in which the natural cases belonged to the midwife and the preternatural to the physician. But mutation is not always sudden and spectacular, and none has been more interesting and far reaching in its benefits to mankind than the emancipation of women, a long and arduous movement, the consummation of which by a curious if unrelated coincidence marked the prelude to a global war which has waged ever since. We recognize to-day how happily this surrender of the ancient rights of man has affected the destiny of this College, as we reflect that twenty long centuries intervened between the birth of Hippocrates and the appearance of the first woman doctor, and only twenty short years between the foundation of this College and the election of the first woman President.

The ultimate effects of these and other changes are unpredictable, for no man can tell how the lives and work of the fellows and members of this College may be affected by the social strife of a world in which atomic energy may at any moment be unloosed. But as we cannot foretell the future we must face it with courage and resolution, or, better still, in the spirit of Osler's words, "Banish the future, live for

the hour and its appointed task". And it is with the firm hope and belief that we shall do our duty and strive to emulate the spirit of those young men whose supreme sacrifice for their country we commemorate to-day that we recall in honour and in lasting gratitude the name of William Meredith Fletcher Shaw.

APPENDIX

It is my duty to acknowledge the help received from the Fellows and Members of the College in the preparation of this lecture—and to offer them my sincere thanks for answering questions about the hospitals to which they are attached, and thus placing at my disposal much information of historical interest which would otherwise have been unobtainable.

For the sake of simplicity this information has been tabulated under the various types of hospital which have been directly concerned with the evolution of the gynaecologist, and maternity hospitals have been excluded because they have always been conceded to the specialist and have thus escaped most of the problems and controversies which have beset his path. Moreover, the hospitals cited are dealt with from the evolutionary point of view only and no attempt has been made to indicate their present position or importance—and necessarily the list is incomplete. In effect the data here presented are a sketch of the historical background but not a complete picture of the development of the gynaecologist and his work.

The hospital facilities now available to the obstetrician and gynaecologist are in fact much greater than might appear from any summary of the past and, in order to prevent misunderstanding on this point, the situation at Glasgow has been included at the end of this appendix as a typical example of the modern resources of a great city and teaching centre.

GENERAL HOSPITALS IN LONDON

THE MIDDLESEX HOSPITAL

1747—Physician Accoucheur appointed with use of beds.

1912—Title changed to Gynaecological Surgeon. F.R.C.S.(Eng.) made an essential for Staff appointment.

1948—M.R.C.O.G. required as an additional qualification.

Mr. Frederick W. Roques

GUY'S HOSPITAL

1789—John Haighton appointed Lecturer in Physiology and Midwifery to Guy's and St. Thomas's with title of Obstetric Physician.

1831—Obstetric ward opened under care of William Blundell, nephew and successor of John Haighton.

Mr. G. F. Gibberd

ST. THOMAS'S

1789—John Haighton appointed Lecturer in Physiology and Midwifery to St. Thomas's and and Guy's Hospital.

1887—Dr. Gervis resigned and the Governors had some difficulty in filling the appointment—possibly because the ovariectomies were done by the surgeons only. The Medical Board were obliged to look for a distinguished obstetrician outside London and finally they recommended Dr. Cullingworth of Manchester, explaining that "The two or three London men whom we first approached having given the question very ample consideration, for various but sufficient reasons, declined to come forward"! Cullingworth, who was Physician to St. Mary's, Manchester, and Professor of Obstetrics and Gynaecology to Owen's College, got the appointment—and from this time onwards the Obstetric Physician was allowed to perform all gynaecological operations.

Mr. James Wyatt

ST. BARTHOLOMEW'S HOSPITAL

1812—Andrew Thynne appointed Lecturer in Midwifery; but the original appointment carried no beds.

1861—Charles West, who was Lecturer in Gynaecology as well as Midwifery and had a ward of 13 beds, resigned because he was dissatisfied with the conditions of service.

1862—Greenhalgh, West's successor, was styled Physician Accoucheur as well as Lecturer.

1890—Champneys succeeded Matthews Duncan who died in 1890, but he, like his predecessor, was restricted to the vaginal field of surgical work.

1912—Champneys retired, and Griffiths was appointed—the first holder to be allowed to perform abdominal operations and the first to hold F.R.C.S. Diploma. Apparently the Physician Accoucheurs were required to be members or fellows of the Royal College of Physicians.

1946—Title of Physician Accoucheur changed to Obstetrical and Gynaecological Surgeon.

Mr. Wilfred Shaw

[It is clear from the course of events at Bart's that the Obstetricians were rated as Physicians (or perhaps Assistant Physicians) until well into the present century, and no doubt this assessment was fairly general throughout the country. Moreover, there were few special hospitals that required a higher surgical diploma as a condition of appointment to their staff—and most of the earlier specialists in obstetrics and gynaecology were content with an M.D. degree. There was in fact a good deal to be said for those general surgeons who held that the new gynaecology was a part of general surgery, and this attitude had a very stimulating and salutary effect upon the work and the training of the obstetrician.]

UNIVERSITY COLLEGE HOSPITAL

1829—Dr. Daniel Davis appointed first Professor of Midwifery in University College, London, and Obstetric Physician to the North London Hospital (Now U.C.H.). He was Physician to Queen Charlotte's Hospital and Accoucheur to the Duchess of Kent at a time when the public confidence in obstetrics had been rudely shaken by the tragic events surrounding the confinement of Princess Charlotte (daughter of Prince Regent and second in line of succession to the Throne). Sir Richard Croft, an eminent physician but not a practical obstetrician, had been the Royal Accoucheur. His antenatal care consisted of severely restricting the diet of the patient, and frequent bleedings and forbidding all food during labour, which unhappily was protracted for 50 hours and resulted in the birth of a stillborn infant and the death of the mother soon afterwards.

The tragedy was deepened by the death of the obstetrician, who committed suicide a few months later.

In 1819—two years after the death of Princess Charlotte—the confinement of the Duchess of

Kent was a matter of national importance because the child if it survived was destined to succeed to the throne. The Duchess was safely delivered by Dr. Daniel Davis of a female child who in due course became Queen Victoria, and there can be no doubt that this happy result did much to restore the confidence of the public in the obstetrician, and to promote the advancement of obstetrics.

Mr. Clifford White

Miss Josephine Barnes

ST. GEORGE'S HOSPITAL

1853—Dr. Lee, who was already the Lecturer in Midwifery to the School, appointed Obstetric Physician to the Hospital—and to hold office only so long as he shall continue Lecturer in Midwifery.

1898—The Obstetric Physician and Assistant Obstetric Physician should be required to be either Fellow of the R.C.S. of England or Graduate in Surgery of the University of London.

Mr. C. M. Gwilt

[It should be noted that the first successful ovariectomy in London was performed by Dr. Hawkin of St. George's. Evidently the General Surgeon did most of the abdominal gynaecology until 1898, when the Obstetric Physician was required to be a surgeon.]

THE LONDON HOSPITAL

1854—Dr. Ramsbottom was appointed first Obstetric Physician on 11th January, 1854. He had no fixed beds, but it was decided to "set aside as many beds as may be needful in certain allotted portions of medical and surgical wards, as the case may be, until increased hospital accommodation shall admit of a separate ward for obstetric patients." Originally the title was Obstetric Physician and applicants were required to be members of the Royal College of Physicians. It was not until Dr. (now Sir) Eardly Holland was appointed to the staff that the title was changed Honorary Gynaecological Surgeon.

1861—Dr. Ramsbottom had "obstetric beds" but apparently no ward of his own.

1876—Dr. G. G. Herman appointed Obstetric

Physician and a ward of 7 beds for gynaecology and abnormal obstetric cases allocated to him.

Sir Eardley Holland
Mr. R. C. Percival

ROYAL NORTHERN HOSPITAL

- 1857—Physician Accoucheur appointed.
1858—Title changed to Obstetric Physician—Physicians shall possess a degree obtained by examination at a British University or be members of the Royal College of Physicians.
1931—Title again changed to Gynaecological and Obstetrical Surgeons—Surgeons shall be F.R.C.S.

Mr. Lane Roberts

WESTMINSTER HOSPITAL

- 1861—Dr. Frederick Bird was the first Obstetric Physician to be appointed to the Hospital—the appointment “being subject to all the laws and regulations of the hospital relating to Physicians and Surgeons” . . . “he shall have the treatment of such patients as the Physicians and Surgeons may from time to time refer to him” . . . and presumably at first he had no ward of his own.

Mr. Arthur Bell

CHARING CROSS HOSPITAL

- 1868—Dr. Edward Parson was the first Physician Accoucheur.
1877—Title changed to Obstetric Physician when Dr. T. Watt Black was appointed to the staff, and it has remained the same ever since.

Dr. Arthur Gray

WEST LONDON HOSPITAL

- 1868—Dr. (later Sir) William Priestly appointed “Consultant Physician Accoucheur” but, as patients in advanced pregnancy were not admitted, he was in effect physician for the diseases of women and children. Six cots were installed for his patients—suggesting that Priestly had a special interest in pediatrics.
1871—Dr. Willshire appointed Physician for Diseases of Women; Priestly retaining his original position and title.
1887—Record in the minutes to the effect that the Surgeons were not to operate upon the patients in hospital in charge of the Physician for Diseases of Women.
1924—Physician altered to Surgeon.

Mr. Arnold Walker

GENERAL HOSPITALS OUTSIDE LONDON

EDINBURGH: ROYAL INFIRMARY

- 1850—Sir James Simpson, Professor of Midwifery and Diseases of Women and Children, appointed to the Staff.

Prof. R. W. Johnstone

LIVERPOOL: ROYAL INFIRMARY

- 1863—A Gynaecological Ward was endowed by Mr. Thornton at the Royal Infirmary but no appointment was made until 10 years later when 1873—Professor Wallace joined the Staff.

A.R.L.

LEEDS: GENERAL INFIRMARY

- 1885—Obstetric Physician appointed to Staff.

Professor Andrew Claye

GLASGOW: WESTERN INFIRMARY

- 1885—Appointment of Physician for Diseases of Women with use of beds and apparently no restriction was imposed upon the work of the gynaecologist.

Professor R. A. Lennie

BRISTOL: (a) ROYAL INFIRMARY

(b) GENERAL HOSPITAL

- 1887—Appointments (with use of beds) made (a) at the Royal Infirmary with the title of Obstetrician (1887); (b) at the General Hospital with the title of Physician Accoucheur. Both hospitals took in obstetrical as well as gynaecological cases.

- 1910—Up to this year the specialist was not allowed to perform abdominal operations, but after this date, and in spite of opposition by the surgeons, the gynaecologists took the matter into their own hands.

- 1939—After the amalgamation of the two hospitals as the Bristol Royal Hospital, no further obstetrical cases were taken in.

- 1950—The present title is Obstetrician and Gynaecologist. The prefix “Honorary” has been dropped as a result of the New Health Service.

Professor Drew Smythe

GLASGOW: VICTORIA INFIRMARY

- 1890—Physician for Diseases of Women appointed with the use of 8 beds. No restrictions were imposed although in the view of some surgeons “no gynaecologist should open the abdomen.”

Professor R. A. Lennie

ABERDEEN: ROYAL INFIRMARY

1898—Professor Wm. Stephenson appointed as "Surgeon to the newly-opened ward for women." Some doubts were expressed by the surgeons as to the possible "economic repercussions" of this appointment.

Professor Dougal Baird

CARDIFF: ROYAL INFIRMARY

1898—Dr. John Williams appointed Honorary Gynaecologist to the Royal Infirmary with use of beds.

The Honorary Gynaecologist was required to limit his activities to his own subject. He was not allowed to engage in general practice or do general surgery. F.R.C.S. and M.R.C.O.G. now an essential qualification for the appointment.

Professor Gilbert Strachan

DUNDEE: ROYAL INFIRMARY

1899—Professor Kynock and Dr. R. C. Buist appointed gynaecologists and obstetricians.

Mr. A. Chisholm

NEWCASTLE: ROYAL VICTORIA INFIRMARY

1906—Dr. Rankin Lyle appointed Gynaecologist to the Infirmary on 6th December, 1906, with the use of beds.

Professor Farquhar Murray

DERBY: ROYAL INFIRMARY.

1907—First gynaecological appointment 15th July, 1907.

Mr. N. L. Edwards

CAMBRIDGE: ADDENBROOKE'S HOSPITAL

1920—First appointment of Hon. Surgeon Gynaecological Department made in 1920. Previously a small amount of gynaecology was done by a general surgeon.

Mr. J. R. C. Canney

NORTHAMPTON: GENERAL HOSPITAL

1935—Appointment of the first Obstetric Surgeon to the General Hospital—"Candidate must hold the Fellowship of the Royal College of Surgeons of England or Edinburgh, and the successful candidate will have charge of the obstetrical and gynaecological patients and must confine himself to his own specialty."

1946—Appointment of Consultant Obstetrician and Gynaecologist—applicant must be Fellow or

Member of the R.C.O.G. or Fellow of the R.C.S. of England or Edinburgh.

Mr. R. W. Watson

SPECIAL GYNAECOLOGICAL HOSPITALS

The case for the Special Hospital was admirably put by Dr. Protheroe Smith, the Founder of the Hospital for Women, Soho, London, when he addressed the Provisional Committee on 1st September, 1842. His address has been made available by the kindness of Mr. Leonard Phillips.

Dr. Protheroe Smith's Address to the Provisional Committee of the Hospital for Diseases of Women.

1st September, 1842.

GENTLEMEN—Having long deplored the want of suitable accommodation for treating patients labouring under the diseases peculiar to females, and having maturely considered the subject, I have lately determined, with God's blessing, to endeavour to supply the desideratum, by proposing that a hospital should be founded for the Diseases of Women. The knowledge of the great extent of female suffering in this Metropolis, and of the limited means which at present obtain for acquiring professional information on this interesting department of practice, have induced me to suggest this measure.

I have for some years enjoyed the privilege of being associated with Dr. Rigby, the Lecturer on Midwifery and the Diseases of Women, etc., at St. Bartholomew's Hospital, to whose friendship and co-operation in the investigation of the diseases of females I am indebted for much valuable information. But although I gratefully acknowledge the advantages which I have thus had of examining and classifying these peculiar and much neglected maladies, and though I regard with pleasure the opportunity which has been thus afforded of ministering to their wants, I am equally reminded that these benefits, valuable alike to the medical practitioner and his patients, have been much curtailed for lack of hospital accommodation.

The question may arise, whether it would not be more desirable to appropriate a few wards in the large hospitals which already exist, to meet the exigencies of the case, or whether attendance could not be afforded to the suffering female poor at their own homes. In answer to such inquiries,

I would first observe, that there are but two hospitals in this great city, which have severally set apart a ward for this object. Other hospitals, as is well known, find accommodation at present inadequate to their extensive demands, and there appears no reason to expect that they will be able to adopt such a plan, however they might approve its expediency. In consequence of the delicacy of treatment to which the women of this country have always been accustomed, it is quite impracticable, without outraging English modesty, for the physician or surgeons to give requisite attention to such cases as may promiscuously occur in the wards of our general hospitals, where he is usually accompanied on his rounds by a large number of pupils. In the next place, the possibility of carrying out the objects of the proposed charity, by attending the poor at their own habitations, the experience of past years sufficiently disproves.

As a high degree of nervous sensibility is a frequent attendant on female disorders, it is generally necessary to keep the patient free from all excitement; and the great majority of these complaints require confinement to the horizontal posture as essential to their successful treatment; but we are constantly driven to the painful necessity of watching the slow but fatal progress of disease, which might have been arrested in its commencement, had the patient enjoyed the quiet, repose, and other advantages of a hospital.

Such cases abound in the dark and crowded alleys of London, where the sufferer is often found to be a mother, upon whose constant exertions the cleanliness and comfort of the family depend. Whilst the one close room she occupies in common with her family—her careworn aspect—the filthy and squalid appearance of her children—the impure atmosphere in which such misery is necessarily bred—prove that no remedies can be effectually applied whilst so many causes are operating to counteract them; and this is an instance of innumerable cases which daily fall under the observation of professional men.

A very important benefit will also be conferred on society by the accomplishment of this proposal, namely, the opportunity thereby afforded to the profession, of extending their knowledge in this branch of practice, which, I trust, may induce my medical brethren generally to unite with me in carrying out this great undertaking. In urging you

to advance the objects which I here advocate by your personal interest and active co-operation, I feel assured that the appeal will be responded to by all who are interested in Woman, and sympathize in her sufferings. Confidently hoping that our warmest expectations will speedily be realized, that the liberality of the public will be excited in so good a cause, and that England, famed alike for its charities and its high standard of female character, will no longer lie under the reproach of neglecting to provide an asylum for its suffering women

I have the honour to be,

Gentlemen,

Your obedient, humble servant,

PROTHEROE SMITH

HOSPITALS FOR WOMEN IN LONDON

SOHO SQUARE

1842—The first Special Hospital in the world to be established exclusively for the treatment of diseases peculiar to women.

Founded in 1842 by Dr. Protheroe Smith, who was at first the only surgeon.

A Consulting Physician and a Physician completed the original Staff.

1887—Royal Charter granted.

1895—Detailed clinical reports published for the first time. F.R.C.S. required (and by implication the M.R.C.O.G.).

Mr. Leonard Phillips

SAMARITAN HOSPITAL

1847—Founded by Dr. William Hones for reasons similar to those given in Dr. Protheroe Smith's address. Provision was also made for a few maternity cases and sick children. Staff consisted of operating surgeons, including Sir William Fergusson and Sir Spencer Wells and also physicians who were allowed to do vaginal operations only—a distinction that was not eliminated until 1902.

1851—There were 8 in-patient beds and one for the matron.

1855—Maternity cases no longer admitted.

1867—The first medical report was published.

1875—Number of beds now 75.

1889—Children no longer admitted.

1907—F.R.C.S. Eng. a condition of appointment.

Sir Frederick Treves opening the new theatre

said—"At the London Hospital (where Treves was on the Staff) every surgeon was asking what the Samaritan was doing, so great was its renown."

1911—In or about 1911 the first Wertheim operation to be performed in Britain was carried out by Cuthbert Lockyer at the Samaritan.

1934—Lord Moynihan opened a new wing and declared: "there was not a woman in this or any other civilized country who did not owe a debt to the work which had been done at the Samaritan, where lay one of the great shrines of surgery."

Mr. McKim McCullagh

CHELSEA HOSPITAL FOR WOMEN

1871—Dr. James H. Aveling was the original Founder of the Chelsea Hospital for Women. Opened in April 1871 with 8 beds by H.R.H. the Duchess of Albany.

1883—New hospital opened with 63 beds. "One distinguishing feature of the new institution is that it will be the first building specially and entirely designed as a Hospital for Women in London."

1948—The Hospital in conjunction with Queen Charlotte's designated under the National Health Service Act (1946) as Post-Graduate Teaching Group under a Board of Governors. This teaching group was amalgamated with the Obstetrical and Gynaecological Department of the Post-Graduate Medical School to form the Institute of Obstetrics and Gynaecology (University of London).

1950—A salient feature of the work of this hospital has always been the teaching of Post-Graduates. In 1948 the total number of Post-Graduates was 248, derived from 17 different nationalities.

SPECIAL HOSPITALS FOR WOMEN OUTSIDE LONDON

DUBLIN: ROTUNDA HOSPITAL, 1745
and

MANCHESTER: ST. MARY'S, 1790

Both these hospitals were originally lying-in institutions, but almost from the outset (the precise date is uncertain) they made provision for the treatment of those sequelae of child-bearing which at that time formed the chief part of the "diseases peculiar to women." Out of these

early clinics there grew up by a gradual and almost imperceptible process. The gynaecological work of the Rotunda and St. Mary's Hospital and many other gynaecological hospitals have developed in the same way. We are not concerned here with the origin and subsequent history of those hospitals, of which many are justly famous, which have always been exclusively engaged in maternity work.

Dr. John Bride

LIVERPOOL: WOMEN'S HOSPITAL

1841—Dispensary for the treatment of uterine diseases established in connexion with the Lying-in-Hospital.

1855—A special ward was added for the treatment of diseases peculiar to women.

1862—New joint hospital built for lying-in women and the better accommodation of special cases (diseases of women).

1881—The Committee resigned owing to the avowed intention (of one section) to abandon the treatment of the special diseases of women.

1882—Movement started for the "protection of the special wards", but the Committee refused to allow the "new movement" to purchase the hospital in Myrtle Street. This building was sold to the Cancer and Skin Hospital, and the original Lying-in Hospital abandoned its "special wards" and assumed the title of Liverpool Maternity Hospital.

1883—The "special wards and Dispensary", under the direction of the new Committee, transferred to 107 Shaw Street, which was opened in July with 30 beds as the Hospital for Women.

1932—The Hospital for women amalgamated with the Samaritan Hospital and a new building was opened with 100 beds—as the Liverpool Women's Hospital.

LEEDS: HOSPITAL FOR WOMEN

1853—Hospital established for women and children.

1897—Special Maternity Department added with 16 beds. Gynaecological wing continuing with 50 beds.

1909—Children's Surgical Department transferred to Leeds General Infirmary.

1912—Children's Medical Department transferred to Leeds General Infirmary.

1920—Maternity work transferred to Maternity Hospital.

1933—Gynaecological work of the General Infirmary handed over to the Hospital for Women.

F.R.C.S. and M.R.C.O.G. now essential qualifications for Staff.

Mr. Bryan Jeaffreson

BIRMINGHAM: MIDLAND HOSPITAL FOR WOMEN

1871—Founded by Lawson Tait and Ross Jordan—with an in-patient and out-patient department, and 8 beds. Exclusively gynaecological from its inception.

1872—Clinical Report first published.

F.R.C.S. and M.R.C.O.G. now an essential qualification for Staff.

NOTTINGHAM: HOSPITAL FOR WOMEN

1875—Castle Gate Hospital for Women (15 beds); and Samaritan Hospital for Women (10 beds) amalgamated in 1924 as Nottingham Hospital for Women.

1929—New joint hospital opened with 60 beds.

1939—New maternity block opened with 40 beds for abnormal obstetric cases. Originally staffed by general practitioners, the hospital now demands the M.R.C.O.G. as an essential qualification for membership of the Staff.

Dr. M. Glen Bott

GLASGOW: ROYAL SAMARITAN HOSPITAL

1886—Exclusively gynaecological from its foundation in 1886.

1928—Clinical report first published.

N.B.—The Glasgow Lying-in Hospital and Dispensary was founded in 1834 and its work has always been exclusively obstetrical except for one period of 15 months in 1908–09, when gynaecological cases were admitted (see Glasgow General Hospitals).

Dr. John Hewitt

EDINBURGH

A small hospital was founded by the late Dr. Haultain at the beginning of the century. Under the New Heath Service it continues as an exclusively gynaecological unit with 30 beds, and is the only special hospital for the diseases of women in Edinburgh. The old Simpson Memorial Hospital—now the Simpson Memorial

Pavilion of 150 beds in the grounds of the Royal Infirmary—has always been an exclusively obstetrical hospital.

The bulk of the gynaecological work of Edinburgh and the surrounding parts of Scotland is carried out in the wards or the Royal Infirmary, where there are three units of 35 beds each. In addition there are both obstetrical and gynaecological beds in the Eastern General Hospital, the Western General Hospital and a few at Leith.

Dr. Ernest Fahmy

GENERAL HOSPITALS FOR WOMEN STAFFED BY WOMEN ONLY

The establishment of the Elizabeth Garrett Anderson Hospital, the first hospital to be staffed by women only, is of great historical interest in so far as it commemorates the name of the first woman doctor, and records one of the first attempts to assert the professional equality of women. These special hospitals—of which only 2 out of many are cited—subverted a useful purpose in an age that opened the medical register but closed the hospital staff to women graduates—but their usefulness has a limited range in a world that recognizes equal rights for both sexes and it is unlikely that any new hospitals of this type will be set up.

LONDON: ELIZABETH GARRETT ANDERSON
HOSPITAL

1866—St. Mary's Dispensary established in Seymour Street.

1872—10 beds provided over the out-patient department.

1875—Hospital removed to Marylebone and renamed New Hospital for Women—a general hospital for women and children though mainly gynaecological.

1899—Removed to Euston Road—42 beds.

1929—New wing opened—Hospital now 100 beds.

Dr. Beatrice E. Turner

EDINBURGH: ELSIE INGLIS MEMORIAL HOSPITAL

1878—Edinburgh Hospital Dispensary for Women and Children opened.

1886—6 beds provided to form a cottage hospital in Grove Street.

1903—The Cottage Hospital transferred to Bruntsfield Lodge, with 20 beds.

1903—The "Hospice" opened with 8 beds as another small general hospital staffed by women.

1910—Bruntsfield Lodge and the Hospice combined—the hospice becoming an exclusively Maternity Department with 10 to 14 beds—and Bruntsfield continuing as a general hospital.

MUNICIPAL HOSPITALS

In regard to the development of Obstetrics and Gynaecology, the Municipal Authorities came late into the field, because it was not until the Local Government Act of 1929 was passed that the Local Health Authorities and the Medical Officers of Health obtained effective control of the general hospitals working under the old Poor Law System. Nevertheless, it must be recorded with gratitude that many Health Authorities, and above all the London County Council, provided valuable facilities for gynaecological work at a time when such facilities did not exist, or were not made available in many voluntary hospitals—and there can be no doubt that prior to the advent of the National Health Service the municipal hospitals in many parts of the country were making a notable contribution to the practice and teaching of obstetrics and gynaecology, and towards the training and welfare of the gynaecologist.

THE LONDON COUNTY COUNCIL

In 1930, the London County Council took over the hospitals of the Metropolitan Asylum Board and of the 25 Metropolitan Boards of Guardians, and under the aegis of the new governing body these hospitals developed into the largest and most progressive group of municipal hospitals in the world. These developments included three of major interest to the gynaecologist.

1. Under the old regime the maternity work of the public hospitals was carried out by whole time resident medical officers with the help of a part time visiting consultant from the staff of a voluntary or teaching hospital, but the latter was "on call" only, and technically the treatment of the patients was the responsibility of the Medical Superintendent. In 1936, the London County Council, after discussion with the British College of Obstetricians and Gynaecologists, modified the terms of medical appointment by transferring full clinical responsibility from the Medical Superintendent to the

Visiting Consultant—and effected other changes which brought their units into line with the requirements of the College in regard to preparation for the Membership Examination. As a result of these arrangements the status of the Junior (resident) as well as the Senior (Visiting) appointment was greatly enhanced—and the field of training for the young obstetrician and gynaecologist was correspondingly enlarged. The first appointments of this type were made at St. James's Hospital, Balham, and at Dulwich Hospital.

2. Following upon the publication of the Post-graduate Medical Education Committee's Report in 1930, the London County Council played an essential part in the negotiations which ensued between the Government, the University and the Hospital Service of London, and which culminated in 1934, in the establishment of the British Post-graduate School at the London County Council Hammersmith Hospital—with Professor James Young of Edinburgh in charge of the Obstetrical and Gynaecological Department.

Facilities for advanced post-graduate teaching and research had hitherto been almost non-existent in this country, and the provision of a hospital and financial assistance for this purpose was a major contribution towards the solution of a difficult and important problem.

3. A final development was the federation for the purpose of post-graduate teaching, in 1948, of Professor Young's Unit at Hammersmith with Queen Charlotte's Hospital and the Chelsea Hospital for Women as the Institute of Obstetrics and Gynaecology with a Board of Management in affiliation with the British Post-Graduate Medical Federation. The Institute with its fusion of the best elements from the old voluntary and municipal systems has an important and responsible role to play in post-graduate medical education and it is assured of the sympathy and support of every gynaecologist.

MUNICIPAL HOSPITALS OUTSIDE LONDON DUNDEE

1924—Dr. R. C. Buist was appointed Visiting Obstetrician and Gynaecologist by the Dundee Parish Council to the Eastern Hospital—now Maryfield Hospital.

Dr. W. L. Burgess, M.O.H.

BIRMINGHAM

1922—The post of Resident Obstetrician created at Dudley Road Hospital—modified 2 years later as Resident Obstetrician and Gynaecologist.

Mr. R. P. S. Kelman, F.R.C.S.

CAMBRIDGE

1927—The Borough Council obtained the services of a Consultant for Puerperal Pyrexia cases in 1927 and for cases of difficult labour 2 years later—but without providing beds as these were available at the voluntary hospitals (Addenbrooke's).

Dr. Cyril Eastwood, M.O.H.

LEEDS

1928—A Consultant Obstetrician and Gynaecologist was appointed to the Staff of St. James Hospital by the Leeds Board of Guardians. The Consultant was not originally in full clinical control of beds but paid regular visits to the hospital. At such times he was asked to give an opinion on certain cases submitted to him.

Dr. I. G. Davies, M.O.H.

LIVERPOOL

1921—Visiting Obstetrician with clinical control of beds appointed by the select vestry to their Brownlow Hill Hospital.

Gynaecology remained in the hands of the visiting surgeon.

1927—Visiting Obstetrician and Gynaecologist in full clinical charge of obstetric and gynaecological wards appointed to Walton Hospital.

MANCHESTER

1929—Before Crumpsall Infirmary and Withington Hospital were transferred to the City Authority, each hospital had a part time Visiting Obstetrician and Gynaecologist—with beds at their disposal and clinical independence of action.

Dr. C. Metcalf Brown, M.O.H.

GLASGOW

1929—Prior to the Local Government Act, in Glasgow as in London and elsewhere, public assistance institutions had maternity and gynaecological beds with a visiting consultant in clinical charge. As soon as the City took over these hospitals, a new maternity department was created at the largest Municipal Hospital

(Stobhill) and thereafter rapid developments took place and many new consultant appointments were made to the various maternity units established by the Corporation; from the outset these consultant obstetricians were given full clinical control of their beds.

Dr. Stuart Laidlaw, M.O.H.

DERBY

1931—Consultant Obstetrician and Gynaecologist first appointed with control of beds in March 1931.

Dr. V. N. Leyshon, M.O.H.

CARDIFF

1932—The Professor of Midwifery in the Welsh National School of Medicine was appointed Consultant Gynaecologist and Obstetrician to the City Lodge Hospital.

Dr. J. C. Greenwood Wilson, M.O.H.

EDINBURGH

1932—When the Local Government (Scotland) Act 1929 became operative, arrangements were made between the Corporation of Edinburgh and the University whereby the Corporation was enabled to have the expert advice of the professorial staff of the University for work in the hospitals. The professors of Medicine, Surgery, Midwifery and Child Life were appointed to act as Directors of the Municipal Units for their respective subjects with full clinical control of the beds placed at their disposal. These appointments became operative on 22nd November, 1932.

Dr. H. P. Tate, F.R.C.P.

OXFORD

1937—Prior to the 1929 Act, the Oxford Council did not appoint a Specialist in Obstetrics and Gynaecology, but relied upon the expert and gratuitous advice of the local consultants. In 1937, however, the City, in association with the Oxford County Council, provided the equipment for a "Flying Squad" based on the voluntary Maternity Hospital and made arrangements to pay the consultants for services to their own cases.

Dr. Mary Fisher, D.C.H.

BRISTOL

1939—After a new maternity building had been erected at Southmead by the Local Health

Authority the voluntary hospitals in Bristol decided to give up internal and external midwifery work and to leave this to the Local Authority. A comprehensive scheme was then drawn up by the Corporation and the University, and Southmead became the teaching hospital.

The Professor of Obstetrics at the University took charge of the Obstetric Department, and the Medical Superintendent of the Hospital was recognized as a Specialist in Midwifery and a member of the team. Under this system the Professor was responsible for teaching, the Medical Superintendent for administration, and the clinicians in charge of the three units, which together composed the Obstetric Department of 160 beds, had full clinical responsibility for their own cases.

Dr. R. H. Parry, M.O.H.

SUNDERLAND

1938—A Consultant Obstetrician to the Sunderland County Borough, with beds at the Municipal Hospital, was appointed in 1938, the M.R.C.O.G. being a necessary condition of appointment. Prior to the New Health Act, the Royal Infirmary had no Gynaecological Department although the title of Honorary Associate Assistant Obstetrician was conferred upon the Municipal Consultant in order to enable him to perform major obstetrical operations in its private wards: he was not allowed, however, to do gynaecological work in the hospital.

Mr. F. J. Burke

NEWCASTLE ON TYNE

1938—A full-time Maternity Child Welfare Officer under the old conditions was appointed in 1920. In 1938 a new appointment was created of Obstetric Surgeon with charge of a 30-bedded Maternity Unit at the General Municipal Hospital and supervision of the City's obstetric and midwives' services. This appointment was modified in 1943 with the title of Obstetrician and Gynaecologist to the City's Hospitals.

Dr. W. S. Walton, M.O.H.

HULL

1938—Under the old regime, the City took over in 1915 a Maternity Hospital supervised by voluntary auspices and appointed a part-time lady

medical officer (who was in general practice in the town) to look after the cases. In 1929 this lady became part-time Consultant Obstetrician. The first appointment under the new regime was made in 1938 when a member of the British College of Obstetricians and Gynaecologists became part-time Consultant Obstetrician and Gynaecologist to the Corporation Hospitals.

Dr. N. Gabbi, M.O.H.

NOTTINGHAM

1940—An Obstetrician and Gynaecological Surgeon was appointed by the City Council—with a department in the City Hospital.

There has never been a Gynaecological Department at the General Hospital (former Voluntary Hospital) although the anomalous title of Associate Gynaecological Surgeon was created to allow the City Obstetrician and Gynaecologist to come in for consultation—without, however, giving him the control of beds or any routine out-patient or in-patient duties.

Mr. Harold Malkin

Dr. William Dodd, M.O.H.

HOSPITAL FACILITIES FOR THE TREATMENT OF OBSTETRICAL AND GYNAECOLOGICAL CASES NOW AVAILABLE (1950) IN THE CITY OF GLASGOW

1. There are three general hospitals which were formerly voluntary hospitals in which there is a Gynaecological Department but no Obstetrical Department. These are known as the Royal Infirmary, Castle Street, Glasgow, C.4, the Western Infirmary, Dumbarton Road, Glasgow, W.1., the Victoria Infirmary, Langside, Glasgow, S.2.
2. There are Three general hospitals which were formerly municipal hospitals in each of which there is both an Obstetrical and Gynaecological Department. They are known as Stobhill Hospital, Govan, Glasgow, S.W.1; the Eastern District Hospital, Duke Street, Glasgow, E.1; the Western District Hospital, Bairdsbrae, Glasgow, C.4.
3. There is a small general hospital, formerly a voluntary institution, staffed entirely by women doctors and dealing exclusively with female

patients, and having both obstetrical and gynaecological beds.

It is known as Redlands Hospital for Women, Lancaster Crescent, Glasgow, W.2.

4. There is Lennox Castle Institution, formerly a municipal hospital situated about 12 miles from the centre of the city and built initially to accommodate mentally defective children, but now containing both an obstetrical and gynaecological unit.

5. Robroyston Hospital, Millerston, Glasgow, formerly a municipal tuberculosis hospital with two pavillions set apart for cases of puerperal sepsis. These septic wards being no longer required have been converted into a maternity unit.

6. There are two special Hospitals, the Royal Maternity Hospital and the Royal Samaritan Hospital.

Dr. John Hewitt