A Subtle Containment:
Women in New Zealand Medicine, 1893–1941

WOMEN entered New Zealand medicine with little fuss and few impediments. Eliza Frikart's registration in 1893 went unnoticed and has since been all but forgotten. Frikart's brief New Zealand career as an advertising doctor peddling abortefacients did little to hinder the path of the better known figures of Margaret Cruikshank and Emily Siedeberg who followed her later in the decade. Yet, having penetrated the profession and soon comprising around 10% of new registrations, women remained at this level until well after the introduction of social security, their numbers rising only temporarily as a result of the Great War. By 1941 women made up 8.6% of all those doctors registered since 1867 but despite their late start were still only 10.3% of that year's registrations.¹ Women were also far less successful in achieving the high incomes medicine offered their male colleagues.² With a few exceptions, the comparatively large number of women in the Health Department remained at its lower levels. In a profession where full-time private practice with an honorary hospital appointment was the confirmation of professional accomplishment, women were more likely to be salaried and part-time. While a few gained positions as visiting consultants these were usually in less fashionable specialities. Surgery, which offered the highest incomes, remained a gentlemen's club. Still, in medicine, compared with other high status, high income professions, women were well represented.³ In 1936 there were 83 women doctors, two women school inspectors, fourteen dentists, four architects and no university professors.⁴

Why were the barriers preventing women from entering the medical pro-

¹ Figures taken from the New Zealand Medical Register, published annually from 1867 in the New Zealand Gazette (NZG).
² In 1938 very few women had annual incomes over £1,000 and the mode income was in the range £364 to £467, half that of male doctors. Statistics of Employment and Income, 1936–1927, Wellington, 1938.
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fession so much more easily overcome than were the more subtle obstructions which frustrated women from competing in the medical economy on an equal footing with their male colleagues? While the New Zealand situation was similar to that of other societies, the relatively small size of the New Zealand profession allows a view of the experience of all women doctors rather than just of those whose strength of character, determination and good fortune allowed them to become successful medical practitioners.  

Women became doctors, as they became teachers, because medicine, like education, was compatible with current stereotypes of women’s role in society. The terms ‘lady doctor’ and ‘medical man’ were more than simple labels: they carried with them much of the sexual ideology of Victorian respectability. ‘Medical man’ was commonly used to denote the medical practitioner as entrepreneur. Whenever the profession as a whole described doctors as actively engaged in the medical economy — developing practices, or pursuing their careers — it tended to make the doctor masculine. ‘Lady doctor’, on the other hand, had very different connotations. The term implied that women doctors remained ‘ladies’, and as such continued to fulfil social roles consistent with late nineteenth-century norms of behaviour acceptable for middle-class women.

Many values attributed to this feminine mystique were also part of the developing professional ethos. Doctors, too, were advancing themselves as compassionate, serving healers, more concerned with preventing suffering than amassing fortunes. In return for being accepted, even in a limited role, women lent medicine the virtues of their sex. Doris Gordon’s professional and political role was, for instance, that of a pragmatic defender of the private practice economy in midwifery, but she was able to present herself as no more than a dedicated woman ‘fired with a compelling ambition to serve as a medical missionary, a decision which later circumstances altered to service for country mothers’. Nonetheless, precisely because feminine virtues contrasted with the masculine economic and scientific characteristics of the ‘medical man’, women doctors, once over the considerable hurdle of getting a medical education, then faced even more challenging obstacles to professional equality within the medical marketplace.

New Zealand women were saved the political battles over entry into medical schools and the right to registration and academic qualifications


6 Obituary, NZMedJ, LV (1956), 326. For a full description of Gordon’s contribution to advancing the professional goals of the medical profession, often against the better interest of women patients, see Philippa Mein Smith, Maternity in Dispute, New Zealand, 1920–1939, Historical Publications Branch, Department of Internal Affairs, Wellington, 1986.
which had occurred elsewhere. The long and bitter campaign for entry into the British profession had been successfully won at the time the Otago Medical School was being established, and in 1885 the University Council affirmed that the medical course was open to both sexes. The entry of Kate Edger and Helen Connorn to the University of New Zealand would have made rejection of a woman’s application for a medical place extremely difficult. The New Zealand Medical Association certainly had no objection in principle to the registration of women practitioners, and had included such a provision in an 1889 draft bill to reform the country’s medical licensing.

While suffering no legal impediment, the first women who dared to test their eligibility did face extensive personal hostility from male students and lecturers alike. The first woman to attempt the course, a Miss Tracy, was apparently hounded out, with staff failing to provide her with practical support. When in 1891 Emily Siedeberg approached the hospital and the university for admission she was accepted by both, and although it appears that she faced active hostility, she stuck it out, aided by a sympathetic Dean. An often repeated tale of her being pelted with human flesh during dissections may reflect the larrikinism typical of the medical student of the period, rather than actual persecution.

In many ways the achievements of the first women to come through the system created restrictions for those who followed. The first women students in medicine, as in other disciplines, developed survival techniques to deal with their critics. In the face of opposition that was often crude, involving ostracism, personal restrictions and verbal abuse, the women nurtured a heightened sense of respectability. They turned ostracism into segregation and poured a scornful dignity over the adolescent antics of the male student body. In this way they gained the support of university staff and at least some of the students. Although they faced the male students in the lecture room, they did so as a group, sitting together, partly for mutual protection, and partly because to sit with the men would be scandalous. Doris Gordon’s account of her first dissection class shows just how ritualized this separation could be. ‘A babel of voices broke loose as students rose from stooping postures and stretched cramped muscles. With boisterous laughter springing from the relief of tension, they rough-housed and buffeted each other as they milled for the wash-basins. But, as if by mutual consent, those

7 Hughes, pp.128–9.
11 The incident was retold by the University’s Janitor and related to Carmalt Jones when preparing the school’s first history. D. W. C. Jones, *Annals of the University of Otago Medical School, 1875–1939*, pp.103–4.
fifty-two men left an alleyway for us women to the end basin. For the next two years that basin was reserved solely for us.\textsuperscript{12} Medical students had cultivated a reputation for ribaldry and a contempt for the conventions associated with sexuality and death. The presence of women forced much of this out of the lecture halls and dissecting rooms. The prospect of lecturing on reproduction, sexual anatomy, or venereal disease horrified many among the university and hospital staffs. For Eleanor Baker this embarrassment could on occasions rebound on to the women themselves. ‘In one class, Public Health and Medical Jurisprudence, the tactless lecturer stopped in the middle of a discourse, blinked owlishly through his round glasses at the two women present, and announced virtuously, “I now come to the part of my lectures that I refuse to give before women. Therefore the women must leave the room or I will leave it.” So covered with blushes and confusion and accompanied by a thunder of hoots, jeers, and stamping the two women hurriedly collected their books and got out.’\textsuperscript{13} Since the topics could include rape and incest, crimes perpetrated by men against women, or the working of the Contagious Diseases Act, the exclusion suggests more than simply male embarrassment. Some attempts were made to segregate classes, particularly clinical classes, but this was only practicable when there was more than a handful of women students. In midwifery, they were even placed at a slight advantage. With St Helens dedicated to the training of midwives, it was difficult for students to get their limited obstetrics experience. ‘Redroofs’, the Salvation Army’s maternity home, allowed only women students to attend deliveries.

At least until after the First World War their social lives were also almost completely separate. They had different common rooms and different leisure pursuits. The ‘Kahanga’, a ‘no rules - dress-as-you-please, fancy or otherwise’ evening, held at the beginning of the year, was an example of such segregated entertainment. Women from all faculties gathered to sing and put on items — although still under the watchful supervision of chaperons.\textsuperscript{14} Long walks around Dunedin by groups of women undergraduates were also a common feature of student life. In contrast the men’s social activities revolved around the specifically male sports of cricket and rugby. Following 1918, there appears to have been a relaxation of segregation ‘as firm as in a Jewish synagogue’.\textsuperscript{15} By the 1930s social interaction had become much less restricted than it had been for the first women medical students. While segregation increased a sense of common identity among the women, it also allowed the perpetuation of socially acceptable sex roles within the apparent equality of the course itself. This would further restrict women doctors’ ability to compete in the medical market after graduation.

\textsuperscript{14} Frances I. Preston, \textit{Lady Doctor, Vintage Model}, Wellington, 1974, pp.15–16. Preston comments that one of these chaperons left when some of the women arrived smoking in fancy dress.
\textsuperscript{15} Gordon, \textit{Backblocks Baby-Doctor}, p.55.
In 1909 and again in 1913, after women had been graduating in New Zealand for over a decade, F. C. Batchelor, the University’s lecturer in midwifery, publicly argued that women in medicine had been a failed experiment. Batchelor’s initial paper was presented before the Society for the Protection of Women and Children, and his argument was part of a general attack on women in the workforce, whether as doctors or typists. His claims infuriated those women already in practice and Agnes Bennett led the counter-attack. While Batchelor’s attempt to find medical reasons against women’s participation in the workforce was a rather facile reaction to changing patterns of women’s work, his comments on women doctors bear further examination. He maintained that while his initial reaction to women as fellow students had been prejudiced and hostile, he had been won over as a teacher. However, he had recently come to realize that women were not shaping up to the demands of professional medicine because while any fool of a man could succeed in practice, the brightest and most intelligent of women were failing to become established as medical practitioners. Batchelor was very mistaken in blaming personal failing for lack of success, but he had touched on the very real problem facing women medical graduates: it was one thing to emerge with a medical degree and quite another to earn a living.

Getting a viable private practice established needed time and capital. While many parents were happy to see their daughters educated, they were often less attracted by the idea of their being enmeshed in the business of running a practice. One woman, for instance, who graduated in 1927, had pestered her father for some years before being allowed to enter the Otago Medical School. His agreement was conditional: after she graduated she was on her own and could expect no further assistance. Another, also a post-war graduate, was sent to medical school at her father’s insistence, and with very little enthusiasm on her part. When her father’s expectations of academic brilliance were not fulfilled she was cut off. She did achieve a house surgeon’s appointment at Palmerston North, where she contracted diphtheria, and was forced to resign. She struggled on through a few locums, the last in Wanaka where she met her future farmer husband, practising only within her family after marriage, although she remained on the medical register and as an octogenarian was still proud of her skill as a healer.

For those women graduating, or arriving in New Zealand between 1893

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16 Society for the Promotion of the Health of Women and Children, Address Delivered by Doctors F. C. Batchelor and Truby King at Annual Meeting of the above Society, held at Burns Hall, Wednesday 19, 1909, Dunedin, 1909, p.6. The suggestion met with a vigorous response from Agnes Bennett, Emily Siedeberg and other women doctors. See Cecil and Celia Manson, Dr Agnes Bennett, London, 1960, pp.62-66,68-69. The hastily-prepared draft of Bennett’s 1913 reply survives in Agnes Bennett Papers, ms. papers 1346, folio 244, Alexander Turnbull Library, Wellington.


18 Interview, Dunedin, 1 October 1982.
and 1914, the employment possibilities were greatly contracted. When Caroline Stenhouse decided to take up medicine, she was advised by an older woman doctor that the difficulties were too immense and she should look elsewhere for a career.\footnote{Interview, Christchurch, 28 September 1982.} Before the establishment of St Helens in 1905, there were no state appointments considered suitable for women, so to work at all women were forced into the uncertain and frustrating world of private practice. Some, like Margaret Cruikshank, were able to make the transition from locum to partner. For the rest it was a matter of putting up a plate and squatting. By 1905 quite a number of women had tried this, mainly in the four main cities. Emily Siedeberg in Dunedin, Alice Woodward in Auckland, and Ella Watson in Wellington had all managed to get established. When she married in 1905, Ella Watson sold her practice to Agnes Bennett. Bennett had spent most of the six years since her graduation in an effort to find a payable practice, often forced by debt to fall back on unpopular salaried work in mental hospitals.\footnote{Some of the correspondence over the sale of the practice and the difficulties other women were having in getting started survives in Agnes Bennett’s papers, ms. papers 1346, folio 261, Alexander Turnbull Library, Wellington.} Appointment to St Helens on a part-time salary of £100 provided some financial security and a base to extend her practice, although a surviving account book indicates she was doing reasonably well from private patients within a few months of her arrival.\footnote{Ibid.}

Women like Siedeberg, Woodward and Bennett were able to establish urban private practices which made them well-known local figures. For many others the task was even more of an uphill struggle. Eleanor Baker whittled away £100 attempting to make a name for herself in Auckland, without success.\footnote{Eleanor Mclaglan, Stethoscope and Saddlebags, Wellington, 1965, pp.80–81.} The problem of making practices transferable, difficult enough for men, was nearly impossible for women. In the 1920s one of the first aims of the Women’s Medical Association was to keep lists of possible practices for sale.\footnote{NZMedJ, XXII (1923), 131.} While women could trade practices amongst themselves, there was little to be gained from purchasing a practice from a man, when the patients were likely to desert on first sight of their new practitioner. The few women’s lodges provided some income.\footnote{See the account of the ‘Farewell to Ada G. Paterson’, Kai Tiaki, V (1912), 95.} In general, meagre practices were more likely to prove unsound than substantial ones, and most women’s practices were meagre indeed. Eleanor Baker purchased a Christchurch practice from Alice Moorhouse, only to find it non-existent, and the St Helens appointment transferred to the vendor’s brother.\footnote{She was employed as assistant medical officer to St Helens before resigning in 1910. Baker does not refer to Moorhouse by name, calling her simply Dr. A. Stethoscope and Saddlebags, pp.90–93. Hester McLean maintained that she would have preferred to have appointed a woman, but that Irvine was the most qualified so Eleanor Baker was only appointed as his assistant. Nursing in New Zealand, History and Reminiscence, Wellington, 1932, p.60.}
abandoned the practice to become an assistant in a backblocks hospital at Te Kopuru. In places such as this there were niches on the edge of the market. Rita Gillies set herself up in Mataura, in a practice previously abandoned by a man as uneconomic.26

As a result of this, women were effectively excluded from the open market for private practices, and more or less restricted to a limited entrepreneurial role. With a private practice remaining the key to professional advancement, women were forced into alternative methods of promoting their careers, either by advancing through salaried positions or by practising within the confines of the stereotype ‘lady doctor’. However much such women shared official views of women’s primary function as wife and mother, they believed quite strongly in sexual equality within medicine.27 In readily assuming professional roles, many women doctors aspired to the same goals as their male colleagues; they were ambitious for financially rewarding practices, for specialist status, for hospital appointments, for honorary positions, and for the ability to research and teach scientific medicine. Agnes Bennett became the first woman to be appointed to an honorary position, when in 1910 she was appointed physician to the Wellington Hospital’s children’s ward.28 For many, advancement followed overseas recognition, as it did for male doctors. Kathleen Mary Todd became a psychiatrist with a Harley St practice, yet she had been unable to gain a house surgeon’s position after graduating in 1923. She passed from locum to locum before going to Vienna and London where she began to specialize in child psychology. After more study in the United States and a Diploma of Psychological Medicine she returned to New Zealand where she worked for the Mental Hospitals Department in Avondale, until moving to London in 1935.29

Although status within the profession was defined by hospital or university appointment and by higher qualifications, all this was meaningless without a successful private practice, especially in surgery, where the best financial rewards were. With the choice hospital appointments honorary until 1941, there was little opportunity for women to compete without proof of entrepreneurial success. However, by the 1920s the level of specialization had increased to the extent that some full-time specialities were being created within the hospital system itself, most notably in anaesthetics and radiotherapy. Because these were often full-time hospital appointments and lowly paid, they were avoided by men, but acceptable to women. Marion Whyte was appointed the first anaesthetist at Dunedin Hospital, eventually leading to an appointment in the speciality at the

27 The women doctors interviewed expressed quite conventional views on the place of women and distanced themselves from feminism, but at the same time they remained strong supporters of women in medicine, the education of girls, and work after marriage.
28 Manson and Manson, p.66.
University of Otago. In a similar manner, poorly paid university research and teaching positions within the University set Muriel Emma Bell on an illustrious career as a nutritional scientist. Even in the higher levels of the profession women were being directed, either by professional pressure, or by their own interest, into areas that corresponded with conventional stereotypes of women's strengths. For Kathleen Todd it was child psychology, for Agnes Bennett, Doris Gordon, and Emily Siedeberg it was obstetrics, and for Muriel Bell nutrition. For others specialization was only possible in areas where it was not so necessary to base one's reputation on private practice, and where full-time hospital appointments were sufficient entry into a speciality (as in radiography), or where specialist skills were not so highly esteemed (as in anaesthetics). As a woman surgeon, Jean Mary Sandel was a rarity. After a brilliant career at Otago, where she won most of the School's awards including the travelling scholarship, she chose to specialize in surgery during the Second World War, becoming the first New Zealand women to acquire the FRCS (England) in 1947.

Because women's private practices remained separate from the rest of the medical economy, many women doctors were forced into the most marginal of medical work, as locums, contract surgeons, back-country doctors, or else they were absorbed into the secure if professional backwater of the school medical service. Even as locums they could well face resistance. In 1923 one doctor asked the Health Department for 'a reliable man who would not let me down. A lady would be unsuitable.' Because of the lower incomes generally available to women they were prepared to accept positions at poor pay in rural areas. According to Violet Rains, miners showed none of the prejudice against women common in the city.

Although the profession as a whole successfully resisted the threat of proletarianization, this pressure was still felt at medicine's edges, and on women most of all.

Such pressure is most clearly illustrated in the interplay of feminine, professional, and bureaucratic roles displayed in the conflict between the


32 She was awarded the Senior Scholarship in Medicine 1936; the Scott Memorial Medal 1936; the Fowler Scholarship 1937; the A. F. J. Mickle prize 1938; the William Ledingham Christie Medal in applied anatomy 1938; the New Zealand Graduates' Clinical Prize 1938. D. W. Carmalt Jones, Appendix V; Obituary, NZMedJ, LXXIV (1975), 359.

33 H. 170/5/1 (38393), New Zealand National Archives (NZNA), Wellington.

34 Interview, Wellington, 5 October 1982.
school medical inspectors, who were mainly women, and their Education Department employers. The school inspection scheme, which had been proposed from at least 1900, came into effect in 1912, under the administrative control of the Education Department. Initially a few men were employed but by 1915, with the demands of the war and relatively low salaries, the four positions were all held by women. In salary and public service grading the medical officers were on a similar level to the school inspectors, but they fitted very uneasily into the departmental hierarchy. In 1915, following a ministerial request, the Department attempted to make the medical officers more accountable to the inspectorate.

The women responded with a vehement defence of their independence. They complained about their salaries, and feared attacks on their professional status, even without being subject to the control of the senior inspectors. Elizabeth Macdonald explained that the ‘salary offered is just sufficient to attract medical men or women (particularly women) who for some private reason prefer this branch of medical work. The private reason may be a real preference for the work, and enthusiasm in the cause of preventive medicine amongst children, as I venture to say it is in my own case. The doctor who takes up Medical School work loses something in professional dignity by accepting work at the salary offered.’ Despite appeals to their dedication, the fact that their positions were feminized was a result of women doctors’ difficulties in competing in the private market, rather than a passion for children’s health. As doctors, their pay was low, ranging from £480 to £500, while public health officers in the Health Department received £525 to £700. However, as women they were by far the highest paid female civil servants. By comparison, Hester McLean was receiving only £400 as Assistant Inspector of Hospitals, and the next highest paid nurses were on only £260. Compared with other male inspectors within the Education Department their salaries were also very high. All of the women were relatively young, and none had more than three years’ government service. In contrast, the men were older and with public service records varying between 11 and 31 years, while their salaries were only slightly higher than the women’s, ranging from £460 to only £575. They too could claim professional qualifications, most had masters degrees and some additional degrees. The women feared their positions within a hostile lay bureaucracy would further detach them from their professional peers. They used their professional status to counter their weak negotiating position as

36 J. A. Hanan to G. Hogben, 9 November 1915; F. K. de Castro to Medical Inspectors of Schools, 6 March 1916, E36/1/2, NZNA Wellington.
37 Ada Paterson to G. Hogben, 10 March 1916, E 36/1/2, NZNA, Wellington.
38 E. H. B. Macdonald to G. Hogben, 10 March 1916, E 36/1/2, NZNA, Wellington.
39 Eleanor Baker had tried unsuccessfully in several places to set herself up in private practice before joining the service. *Stethoscope and Saddlebags*, passim.
women, very conscious of the fact that while they were treated as doctors, they could secure an independence within the bureaucracy, impossible as simply female civil servants. Indirectly, they were also protesting at a sexual division of labour within medicine itself. If women doctors were only allocated lower paid, sexually specific tasks, like the care of children, then their chances of competing within the private market, with its higher incomes and status, were further compromised. The women's campaign was ultimately successful and the school inspection service was transferred to the Health Department, where the inspectors' work could come under direct professional control. Nonetheless, this did not prevent the work of the school medical inspectors from remaining predominantly women's work within the Department.\textsuperscript{41}

The distinction between the 'medical man' and the 'lady doctor' had its parallel in the very different situations of the doctor's wife and the doctor's husband. Marriage could provide many benefits to the work of a male doctor. A well-chosen bride could make social connections of great value to a practice, while a wife's domestic, nursing, and organizational skills were of more tangible benefit. For women, marriage was much more likely to interfere with their professional careers or lead to an abandoning of medicine altogether. Because of better access to child care, and the domestic location of many practices, medical women did have a greater opportunity to continue working after marriage and with small children, than did the vast majority of other middle-class women.\textsuperscript{42} There appears to have been less stigma attached to mothers practising medicine than to mothers in other occupations, at least towards the end of the period.\textsuperscript{43} Nonetheless, a good proportion of those women who remained working doctors throughout their lives stayed single or married very late. Emily Seideberg did not marry until aged 66, and Marion Whyte was even older; Margaret Cruikshank, Agnes Bennett, Kathleen Todd, Jean Sandel, and Ada Paterson all remained single. Late marriage, a feature of the profession, put women at a greater disadvantage than men.\textsuperscript{44}

Whereas the pre-marriage career of the doctor's wife rarely interfered with a doctor's ability to choose where to practise, married women doctors were very often professionally restricted by their husbands' occupations. Those married to farmers were sometimes able to practise without competition, but they were limited to small backblocks practices. Marjorie Wood followed her husband to Hawarden, north of Christchurch, where she

\textsuperscript{41} When Ethel Sands was dismissed in 1922, as a retrenchment measure, she received only nominal support from the BMA Council, which could only comment that 'unfortunately many married men with families found themselves in the same position'. NZMedJ, XXI (1922), 235.

\textsuperscript{42} Heslop et al., p.244.


\textsuperscript{44} Age at marriage was consistently around three years less for women than men in the early decades of the century. See Miriam Gilson Vosburg, \textit{The New Zealand Family and Social Change}, Wellington, 1978, p.32a.
practised from 1923 until 1955, when she joined the School Medical Service in Christchurch. Another woman arrived in New Zealand to visit a friend, decided she had to work, and was appointed a miners’ doctor in Brunner-ton. She married a local farmer and began her married life at Haupiri on an isolated farm, all a great distance from her childhood at Bexhill, a resort town on the south coast of England. Even here she was determined to work: ‘I had no surgery I would see them in the bathroom, kitchen or the dining room, just depending on what was what.’ Although she was isolated, the opening of a nearby sawmill gave her a small band of patients. Her husband was given little opportunity to object. She felt that medicine ‘belonged to me so much . . . it was so much in my family . . . it was just me . . . I wasn’t any good at house-keeping or even gardening, or cooking . . . all those were a trial to me and I used to get headaches . . . but if a patient came to see me as they did, came to the house . . . it was very difficult because when we were first married there was no real access to us . . . [then] the sawmill started and it was easy for me and my headaches used to go’. Yet in this isolated part-time practice, she continued to feel part of a wider profession. She attended meetings of the New Zealand Medical Women’s Association in Christchurch; she underwent short postgraduate courses and in conformity with BMA policy she religiously charged 3s. for each consultation once social security had been introduced.

For many women the ideal partnership was with another doctor, and several married members of their own profession and so continued to practise. Doris Jolly married William Gordon soon after graduating in 1916. Together they practised in Stratford until her death in 1956. This medical partnership gave her a base to develop her extensive political skills in the interest of private practice midwifery and in advancing her own medical ideas, particularly over the use of anaesthetics in obstetrics. Cecily Clarkson practised as a plastic surgeon with her husband, Henry Percy Pickerill. Although Clarkson carried much of the work of the practice her reputation was for her work with children. Hazel and Percy Allison practised in Christchurch. Mabel Hanron practised with her husband, Harry Christie, in Wanganui. Elizabeth Macdonald left the school medical service following her marriage to Robert Bryson. She practised with him in Levin and Wellington until his death in 1934. Doris Berry practised in

46 Interview, Wellington, 6 October 1982.
47 ibid.
48 Pickerill had been Professor of Dentistry at Otago, and had become a plastic surgeon through his work with facial injuries during World War One. Obituary, NZMedJ, LV (1956), 413–14; Death Certificate, 1956; Interview, Cecily Pickerill, Upper Hutt, 6 October 1982.
49 Annual Register, NZG, 1936, p.1006.
Napier with her husband Eric Harold Berry and his brother Allan.\textsuperscript{52}

Marriage to another doctor did not necessarily give all women the will or the opportunity to continue in practice. Catherine Will, who became the first woman house surgeon at Dunedin Hospital in 1911 and then worked for a year at the Pleasant Valley Sanatorium, left medicine in 1913 on her marriage to Arthur Brookfield. She never practised again despite her husband’s early death at the age of 36.\textsuperscript{53} Isabel Roberton and her husband Leslie Averill were both New Zealand-born but British-trained doctors. After her marriage, Roberton was quite content to be the receptionist-nurse while her husband’s practice was becoming established.\textsuperscript{54} Gladys Macalister had a notable undergraduate career and after graduation she studied paediatrics in Britain, demonstrating pathology at Cambridge. On her return to New Zealand with her surgeon husband, Walton Bremner, she practised very little, limiting her work to giving anaesthetics after 1930.\textsuperscript{55}

Faced with an often overwhelming series of barriers preventing equality within the marketplace, it was much easier for girls to follow more socially acceptable career choices. The enthusiasm for becoming a woman doctor, so evident at around the turn of the century, was not so much dissipated as diverted into the rapidly expanding women’s career of nursing. Nursing offered lower possibilities of personal fortune or social recognition, but at least it was not so personally demanding, and nursing education, unlike medical education, did not demand heavy financial backing. It was not so much that a reaction against the advances made by women through educational and franchise reform forced women back into subordinate roles. The woman doctor was only a partial challenge to the domination of medicine by men, based as it was on a conception that women could play only a limited and specialized role within the profession. The revolution which would have allowed women to advance into a position of equality demanded not only a redefinition of the role of women doctor, but a wider readjustment of women’s place within society itself. Few of New Zealand’s early women practitioners were prepared to go so far, nor were they sufficiently secure within the profession seriously to challenge the increasing dominance of male doctors in the delivery of health services for women.

\textit{Waitangi Tribunal, Wellington}

\textsuperscript{52} Obituary, Eric Harold John Berry, NZMedJ, LXXX (1977), 395.
\textsuperscript{54} Interview, Christchurch, 28 September 1982.