Breaking Barriers and Forging Paths: Examining the Entry of Women in the Field of Medicine

Anisha Sen
Assistant Professor, Department of Sociology, P.R Thakur Govt College, West Bengal 743287

Abstract

This research explores the process of constructing professional identity among women professionals. It also examines the experience of women physicians concerning the interplay between career and lifestyle choices and tries to discover how women's experiences have evolved with growing times. It also looks at the nature of the gendering of the medical profession. This chapter adopts a feminist approach towards conceptual advances in the study of women professionals and applies it to research on women physicians with multiple roles. In past research, social values about appropriate roles for women have emphasised negative outcomes, vagueness about the roles conflict, and the assumption that the work role is the most problematic for women. The effects of social context, including interpersonal relationships, have also been ignored. Research using new approaches has shown that there are benefits to combining roles, which role conflict is most common between work and parental roles, and that social support from the spouse is crucial. The importance of the work environment is also stressed. Thus, according to Frierson, the internalisation of professional norms and ethics in the professional identity allows different professions to regulate themselves effectively, assuring that they do not abuse the autonomy they are granted.

Keywords: Gender, Women Medical Professional, Witchcraft, Midwives, Doctors, Breaking Barriers, Women's Rights.

Introduction

The medical industry is not unfamiliar to women. Throughout history, they have worked as doctors, nurses, physical therapists, and pharmacists. Despite going by many titles such as herbalists, healers, and even witches, their role remained the same: tending to the sick and injured. Women looked for or grew plants that could be used medicinally in prehistoric African settlements, medieval European castles, and colonial towns in North America. Women have assisted one another in bearing and caring for newborns since antiquity; this practice is known as midwifery, or the women who assist in giving birth to a child are also referred to as "Daima." Usually, an older woman who has given birth to her own children, this midwife had some basic knowledge of herbal medicine. But women in ancient India knew very little about anatomy, or the physical composition of humans. The rate of maternal deaths was extremely high as a result. However, by the time of the Roman Empire (27 BC), people had more faith in midwives. It is reported that Julius Caesar was delivered by a midwife who cut open his mother's tummy to release him. Caesar's mother was saved by the midwife, whose name is now linked to the Caesarean section, a popular delivery technique. However, there are many myths associated with this conception. Knowledge of medicine and science advanced along with the midwife's abilities. Most medieval European communities acknowledged nurse-midwives by the 1200s. A trajectory enveloped the social realm gradually. We find 37 female surgeons in England who were granted licenses by a

Parliamentary Act in London (Morgan, 1967). While many of these women focused on childbirth and the unique requirements of women, these women could practice a wide range of medical specialties. In actuality, they were the pioneer gynaecologists—physicians who specialize in the health and illnesses of women. A number of the most well-known of these early midwives were Italians. In AD 1100, Tortola was a practicing physician and an instructor at a medical school in Salerno, close to Naples. The University of Bologna awarded the Italian doctor Dorothea Bocchi her medical degree in 1930. But the midwife's destiny soon took a turn for three reasons. The expansion of universities across Europe was the first. Although knowledge was being shared, only men were allowed to the universities. As a result, only men received official training in the medical sciences. The expansion of communities and the governmental structures that governed them was the second factor. These governments enjoyed obtaining licenses and levies as means of collecting revenue. A license was required to formally allow someone to practice a trade. The female midwives quickly lost their positions since the male-run city administrations only issued licenses to male doctors. The Catholic Church's influence was the third factor.

Women had almost been excluded from Europe's established medical profession by the 1600s. They discovered various methods to hone their abilities and skills, as usual. Many went on to specialize in herbal remedies, and others wrote books and pamphlets sharing their scientific expertise. The 1960s and 1970s saw a resurgence of midwives as more women began to voice their disapproval of the impersonal, male-dominated medical aspect of birthing. When going through labor, these women wanted other caring women to be close by. Midwifery is a subspecialty of nursing nowadays. Women were not allowed to enrol in medical schools in the United States or the majority of European nations until the middle of the 1800s. The medical field was viewed as too graphic and indecent for women to practice. Elizabeth Blackwell, an Englishwoman, was of the opinion that she didn't have to, and in 1849 she became the first female graduate of a US institution with a medical degree. The following year, the Female Medical College of Pennsylvania was established in Philadelphia, Pennsylvania, by the Quakers, a religious sect.

Women's rights were equally violated in England. Florence Nightingale, an English nurse, transformed the nursing field in 1854. Nightingale was a woman from the upper middle class who visited the Crimean Peninsula. She was soon invited to take charge of the army hospital. Women demonstrated during the Civil War that they could fill positions created by men enlisting in the military. Upon its opening in 1862, the New England Hospital for Women and Children employed solely female employees. The hospital's professional nursing program, the first of its kind in the US, saw Linda Richards become its first graduate in 1872. The first female graduate of an American university with a D.D.S. degree was Lucy Hobbs in 1866. Clara Barton travelled to Europe following the war and studied at a Swiss humanitarian organization. After his return, Barton established the American Red Cross, a comparable organization, in 1881.

In addition to starting a clinic that would eventually become the New York Dispensary for Poor Women and Children, Elizabeth Blackwell obtained her medical degree in 1849 (Baker, 1994). Being the first female graduate of an American university with a medical degree, Blackwell is recognized as a trailblazer in the history of American medicine. All male doctors advised young Blackwell against going after her dream of becoming a doctor. Additionally, European women were demonstrating that they could withstand the pressures of working in medicine. Elizabeth Garrett Anderson became the first British female physician of the modern era in 1870 while attending medical school in Paris, France. The first birth control clinic in Amsterdam was established in 1882 by Aletta Jacobs, the first female physician in Holland (Europeana, n.d.).

Young women from higher social classes quickly began to view nursing as an honourable career. Frances Elisabeth Croswell, an American nurse, was appointed as the first executive secretary of the Association of Tuberculosis Clinic in New York City in 1910. She became a public health movement advocate as a result of

this event. The first study on occupational health disorders was published in 1911 and concerned lead poisoning among manufacturing workers. The study was conducted by American physician Alice Hamilton. Even so, the male-dominated fields of medicine and politics continued to reject women. American female physicians established their own all-female medical army in 1917 following their exclusion from the military. This force treated the ill and injured during World War I (1914–1918) with expertise.

Entry of Women in the Field of Medicine

Professionally speaking, women physicians came of age during a period of profound change in the way medical education was organized and care was provided. The practice of medicine evolved into a science during the latter part of the nineteenth century as a result of significant advancements brought about by bacteriological discoveries and technical advancements. Between 1850 and 1880, the preindustrial smallness, in-person interactions, and apprenticeship system were replaced by the chaotic conditions brought about by urbanization and the rise of a profession. Because it gave women access to a usually reputable clientele, this served to maintain social snobbery. Female physicians were undoubtedly scarce in Boston throughout the colonial era (Glenn, 2018). Just two out of the 76 physicians in the seventeenth-century town and environs were female, according to the only survey available. There were no female physicians on the list prior to that, in 1835. Women during the colonial era are said to have achieved maximum success as midwives rather than as physicians. A positive re-evaluation of midwifery's function in medicine has resulted from the recent resurgence of interest in the field. The conventional view, which saw the dissolution of midwives as an important scientific accomplishment, has faced a great deal of criticism.It appears that something worthwhile was lost in the shift to a more "scientific" approach to birthing, as seen by the fact that many women now seek out midwives' services for their personalized care and emotional support.

But one must keep in mind that, despite the value of its services, midwifery eventually lost prominence in the medical community. It was considered that a woman who had given birth and had seen other women give birth could also deliver a child, although doctors were expected to have some training (typically through apprenticeship). In fact, according to a doctor who conducted a thorough investigation on how women ended up becoming midwives, most of them were initially "caught"—as they put it—with labouring women. Because they were deemed qualified after successfully giving birth, they almost accidentally became well-known in the field right away.However, the dominance of women in midwifery was challenged and ultimately overthrown by medical advancements in the eighteenth century, which amounted to an obstetrical revolution. Women found it more and more difficult to compete with doctors who believed their devices, such as forceps, could reduce normal labor and help patients during difficult births, and who also had scientific knowledge of anatomy (Walsh, 1977).

It is widely recognized that women are underrepresented in the higher professions of law and medicine, at least in terms of numbers. These occupations have a history of male dominance and female exclusion. The victories were won against fierce and often hysterical opposition from men.It appears that women are able to perform the exact same tasks as males and can now enter higher professions. However, a thorough examination shows that segregation is still in place in this region just like it is in every other one we have looked at.

Numerous significant studies have demonstrated the critical role that women had as healers in pre-industrial civilizations, starting with the groundbreaking Victorian book Women in English Life (1896) by Georgiana Hill and continuing through the work of Clark (1982) and Ehrenreich and English (1979). Women from all socioeconomic classes provided nursing care, treated the sick, and applied healing methods throughout

medieval and Tudor Britain. Along with learning various herbal treatments, women also learnt healing practices, which they then taught to their daughters.

The line separating nursing from healing, or caring from curing, was much less obvious in the pre-industrial era than it is now. However, there is a distinct and expanding difference between the commercialized academic field of medicine, which is founded on research, training, theory, and reasoning, and the empirical, or practical, form of medicine that is based on experience and folk wisdom, and which is what the women mentioned above were practicing. Although there are documented cases of women physicians with university education from the early Middle Ages, male physicians predominated in the theoretical branch. But the academic study of medicine, which dates back to its Greek foundations, had been organized and developed by men, and their push to exclude women and set themselves apart from unskilled practitioners intensified from fifteenthcentury.

Bishops were required to offer licenses to practitioners in order for the Medical Act of 1512 to seek to put this matter under church authority (Davenport, McDonald, and Moss Gibbons, 2012). Despite the fact that a female surgeon was licensed in 1568, women's participation in the field was openly criticized, with particular attention paid to the healing efforts of Smith's weavers and women. The establishment of the churches as arbiters also contributed to the association of women's healing practices with witchcraft and sorcery (Leeson and Gray, 1978, p. 21). The papacy-sponsored Malleus Maleficarum of 1948 (Broedel, 2018) established a connection between female medicine and witchcraft, stating that a woman who attempts to cure without proper training is a witch and should be put to death (cited Oakley, 1972).

Two fronts were used in the assault on female healers. Although many women may have been discouraged from the practice by church attacks and witchcraft executions, male organizations persisted in advocating for the restriction of women's access. In the medical community, doctors continued to be the nobility. During the seventeenth century, two professional groups comprised of men, the apothecaries and barber-surgeons, developed their own identities and formed guilds that excluded women.In an effort to strengthen academic professional control, several Medical Acts were passed. But the changes didn't completely remove women from the profession. To begin with, there were not enough medical men to meet the demand, and the cost of their services was prohibitive (Faulkner & Arnold, 1985). The now-familiar dichotomy between curing and caring initially emerged within the field of academic male medical practice. Nurses provided additional services to doctors, particularly in hospitals, or helped them. Traditionally, women have been assigned to nursing roles as specialized tasks. The most esteemed nursing specialty was midwifery, and women's knowledge and experience created a near-total monopoly in the birthing industry.

They were engaged in a variety of medical, social, and even legal activities, as noted by (Weisner;1986) (administering medicine, supporting the community in times of epidemic, and so on). There was one occupation for women that allowed them to leave the house and enter the public eye. The gradual erosion of women's medical knowledge and expertise began in the eighteenth century and continued into the twentieth. Smell (1985) discovered instances of women in the eighteenth century working as apprentices to surgeons or practicing as independent surgeons and apothecaries. The practice of wearing petticoats was briefly discontinued in the nineteenth century.

The rise of hospitals and the expansion of male-only university education resulted in a clear separation of the roles that women played in medicine throughout the first half of the 20th century, with the roles of curing now firmly in the hands of men. Although they might use conventional therapeutic techniques at home, their sole official public position was as nurses. According to Novarra (1980), one of the six essential responsibilities of women is "tending the sick."Nonetheless, once the feminine connection to healing was fulfilled in the early nineteenth century, the standing of nurses appeared to have declined. According to The Lancet, "man as a

doctor is naturally assisted by women as nurses." It is a conceit that goes against nature for women to become doctors (cited Versluysen, 1980).The start of World War II and the ongoing barring of female physicians from the military reserves gave American women physicians' activism and organizational swagger a boost. Just 15% of medical students were female on the eve of World War II. But during the course of the following ten years, the percentage sharply increased to 40%. However, just 20% of practicing physicians were women, according to Elton's (1977) insightful survey on women in medicine. As a result, when it comes to hierarchy, women have not done well in hospitals. In England and Wales in 1974, there were 29,018 hospital doctors; only 4,590 of these were women. Only one-fifth of registrars and one-tenth of consultants were women, compared to one-third of pre-registered house officers (Leeson & Gray, 1978).Only 14% of general practitioners (GPs) were female, while making up 54% of the local medical workforce (Elton, 1977). Such employment is easier to integrate with household duties because it more easily fits into the nine to five schedules. However, it must also be viewed as a component of a system that directs women toward lower-status jobs within the industry that are thought to be more suited for them. These positions include those in geriatrics, child psychology, mental health, radiology, and anaesthesia. Because general practice offers little better, women are consequently concentrated in what the British Medical Journal has called "less demanding" specialties (Leeson & Gray, 1978). Just 18% of general practitioners in 1985 were women.

Many of the female general practitioners in Laurence's (1987) study reported feeling denigrated and dominated by the male senior practitioners in their group practice. Despite women's general success in medical school, she contends that they still face discrimination in a male-dominated professional culture that establishes norms and standards for what constitutes appropriate medical practice (Laurence, 1987). Therefore, women's progress as doctors has been restricted and hasn't done much to eliminate the sexual stereotypes that still permeate the medical field or to topple the sex hierarchies within it. Even now, women still handle the majority of cleaning and caring duties in the health service. The number of employments at the (NHS) has increased dramatically, with the majority being assigned based on gender. Women are employed in caring positions in the minor medical fields, such as radiography, occupational therapy, and physiotherapy, where patient care is crucial. Neale's (1983), Cockburn's (1985), and Beechey and Penkins (1987) accounts of hospital life demonstrate the pervasiveness of six hierarchies and stereotyping. Men occupied the majority of the top scientific positions in the field of medicine; Cockburn's research on radiographers found that while men and women were equally adept at using machinery, women were more adept at dealing with patients. Homan's study of NHS scientists also reveals stereotyping; men perceived women as less dependable and with different talents, despite the fact that the work they produced was ostensibly equal. Homan contends that men spent more time on administration and actual research, while women's daily routine included more clerical tasks and cleaning up after experiments, echoing the previous patriarchal order of men as directors and women as assistants (Homan, 1987). Neale's description of the hospital environment emphasizes how class, gender, and race areintricately linked. Attempts to bar unskilled practitioners were made in the nineteenth century, but in a society this size and with such rapid development, it was harder for the educated elite to monopolize. Echoing his British counterparts, the American Medical Association (AMA) president said in 1871 that a woman physician was a horrible invention (Ehrenreich & English, 1979). Women were not allowed to work in hospitals and made up only 6% of the workforce in 1900. Since then, their share of the workforce has not grown to the same degree as it did in Britain. According to the United States Bureau of the Census (1988), women made up less than 18% of doctors in 1986, even though feminism had been successful in advancing women's rights. In 1960, women made up just 7% of doctors.

According to Lorber's research, American women physicians occupy a position that is very comparable to that of their British counterparts. Women were forced into traditionally feminine specialties (psychiatry, pediatrics, and anesthesiology) and failed to achieve top positions despite a rise in female enrollment in the 1970s. Similar to Britain, women face exclusion from male networks and a lack of support from influential elders and

educators. One major drawback is that in nations where medicine is more commercialized than in Britain, women cannot make the connections needed to enter a lucrative, high-status medical career. Matthaei draws attention to the differences between the nearly all-female professions and the male-dominated medical field.n contrast to the male professions, which monopolize abstract knowledge through strict organization and self-control, female professions have historically established themselves under the thumb of male authority in hierarchical structures. This naturally curtails their authority and instills a culture of subservience and respect for men.

A historian has called this new ethos, known as the "culture of professionalism," the result of the professionalization of the late 19th and early 20th centuries, the combination of medical, individualism, scientific objectivity, rationalism, personal accomplishment, and careerism. As they battled for equal rights in the medical field, women encountered this ethos and, as devoted practitioners, faithfully preserved and disseminated its principles.It was feasible to operate on both sets of principles; women doctors could introduce science into the house and at the same time harmonize society, elevate the moral standard of the profession, and rationalize the family, as evidenced by the works of numerous nineteenth- and twentieth-century doctors.

They had strong public support for their stance during the liberal reform era. Women physicians played a prominent role in this country's reform movement from 1880 to 1930. They were especially skilled at creating initiatives for women and kids that were included into the liberal welfare state. The important global physician vision was marginalized in the decade following World War I as the political climate turned against liberalization.The pattern of extraordinary economic distress that created such a powerful national outcry against working women that women professionals also suffered from popular approval persisted even during the New Deal reform phase. Notwithstanding this, a small number of less noticeable female physicians were present in the 1930s.

Famous New York doctor Augustum K. Gardner wrote a piece on women physicians for Leslie's Illustrated News. In it, he expresses the opinion that women are now strong, intelligent, sophisticated, and considerate. The mid-1800s saw the emergence of female physicians with this perspective. The excitement of the female doctors demonstrated their belief that they are living in the best possible world.They believed that throughout their lifetimes, women's activities had significantly expanded and that women's standing had improved over the nineteenth century.

Neither their English contemporaries nor their nineteenth-century descendants enjoyed the same level of autonomy and independence as American women physicians throughout the Colonial and Revolutionary periods. They discovered that although the majority of women in the colonies worked from home and in the framework of the family economy, they engaged in a wide range of jobs and occasionally displayed a sizable degree of status. The majority of women worked as midwives, practicing medicine. During the latter part of the 1800s, female instructors in medicine started to assess their circumstances and make advancements.Prior to that, female medical professionals in the 19th and early 20th centuries had arduous emotional and professional struggles that their male counterparts were spared (Markell, 1985). The standing of women in the medical field improved as a result of surveys conducted for the first time in 1880 by Rachel Bodley (Bodley, 1868). "Medical Women are now accepted as a fact of civilization," stated Dr. Marion M. Grady in a 1900 report to the Women Medical College of Pennsylvania Alumnae Association (Keller, 1906, p. 36).

Women's Participation in the Field of Medicine in India

Women have been involved in medicine since the nineteenth century in the West, but by the early twentieth century, their role in the field had diminished because medicine was now viewed as a scientific endeavor. In the 1960s, as wider cultural changes were reflecting, they were once more urged to return and give more humanistic and comprehensive care (Hirshbein, 2004). The first female doctor was Dr. Anandibai Joshi of Pune, who graduated in 1886. However, she had to go abroad to finish her degree due to an unpleasant personal situation. She received training to serve the Indians at the Women's College in Philadelphia, Pennsylvania (Abidi, 1988). Another female student at the Great Medical College in Bombay was Dr. Moti Bai Kapadia, who enrolled in 1884 and completed the LRCP test in 1887 (Kapoor, 1975). The first indigenous woman physician to get training alongside male physicians was Moti Bai. Women's education in the cities was still in its infancy at the time. As a result, society severely criticized and discouraged women who wanted to pursue careers in medicine for having such repulsive attitudes. A case in point was Dr. Rajkumari. She earned her MD from Brussels and LRCP and MRCP degrees from London during a period when it was challenging for women to apply to medical schools.Advertisements for government scholarships implied that women were not required to apply due to the social and professional context (Valladares, 1969). But there were women with natural boldness, like Dr. JeurshaJhjirad. She put in a lot of work and studied overseas for her degree. Women now hold more senior positions in medical colleges as a result of these efforts. The first woman to be appointed as the interim head of Travancore State's medical department was Mary Lukose.

Over the past few decades, there has been a significant growth in the number of women working in the medical field. It has only been slightly more than a century in India for women to be recognized as fully qualified professionals on par with male physicians. Significant advancements in the direction of gender parity in medicine were made in the second part of the 20th century. Since the country's independence, laws guaranteeing women's equal employment opportunities have encouraged more women to pursue careers in medicine. In India, becoming a doctor is regarded as an extremely desirable career. It is regarded as honorable and well-paying. In the pre-independence era, the pioneers and missionaries believed that Indian women doctors were desperately needed to satisfy the requirements of women in zenanas due to a special circumstance resulting from women's seclusion and segregation, coupled with high mortality rates among them (Nair, 1990).Lady Dufferin, the Vicereine, established a fund in 1885 to support women's access to medical education and career progression. It resulted in the funding and founding of the Lady Hardinge Medical College, India's first all-female medical school, in 1916 (Kumar, 2009). Even Nevertheless, women's general education levels meant that they would always remain underrepresented in the medical field.

Conclusion

The arrival of the British in India was matched by the acceptance of the medical field for Indian women. They came to see that the women in this traditional society lacked access to healthcare and no skills. At that time, the ruling classes (men) controlled the medical field, and the only professionals in this field were male, trained physicians. Women doctors were needed in order to normalize women in the medical field. Due to the lack of female doctors in India in the middle of the 19th century, women who were leaders in this field in the West and those who were refused the ability to practice in their home countries traveled to India to give Indian women the much-needed medical care. As a result, favorable conditions were established for Indian women to pursue careers in medicine (Minocha, 1996). Unbelievably, the status of Indian women in the medical field changed during the last two decades of the eighteenth century. Two significant factors contributed to the change's beginning: (a) women's growing awareness of their situation and place in society, particularly with regard to their role in the public and private spheres, as a result of the expanding modern education system, science, technology, spreading culture, and other factors; and (b) the process of neutralization, which refers to the effects of outside/alien culture and other developments, had a significant impact (Dabla, 2007).This had a significant effect on Indian women who, thanks to the influence of the West, were able to leave the home and start earning like men. Women from higher socioeconomic classes benefited from this early on and took full advantage of the opportunity to adapt, while women from lower socioeconomic classes did not. Along with expanded responsibilities for women in society, modernization, education, and scientific and technological

advancements brought about a shift in societal values and beliefs and a new social order. Women began to pursue higher education and expressed interest in careers (Bhadra, 2011).

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