“THE SACRED DOMAIN”: WOMEN AND THE TRANSFORMATION OF GYNECOLOGY AND OBSTETRICS IN THE UNITED STATES, 1870-1920

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DISSERTATION ABSTRACT

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This dissertation contends that women – as intellectuals, educators, physicians, activists, consumers, and patients – shaped the dramatic transformation that took place in the medical specialties of gynecology and obstetrics in the late-nineteenth- and early-twentieth-century United States. These two specialties were particularly contentious because they were inextricably linked with social, cultural, and political ideas about gender, race, class, sexuality, reproduction, and motherhood. In the resulting climate of chaos and controversy, women themselves played the key roles in resolving medical debates about their bodies. Furthermore, their work had a much broader significance: as women altered medical approaches to female bodies, they influenced a larger discourse about the meaning of normal femininity and the nature of American womanhood.

This project is not an institutional history of gynecology and obstetrics but, instead, serves as a social and intellectual history of these specialties. It features women as primary actors and emphasizes significant connections between medical perceptions of women's bodies and social constructions of women's lives. By examining several key issues in these specialties – medical constructions of menstruation, controversies over women's medical education, the contested evolution of surgical gynecology, and the

development of prenatal care and obstetric anesthesia – it demonstrates that the physical body served as a battleground for the ideological construction of women in society. As women worked from inside and outside the medical community to define what it meant to have a healthy, normal female body, they also constructed larger visions of what it meant, fundamentally, to be a healthy, normal American woman.

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CHAPTER I

INTRODUCTION

This dissertation contends that American women shaped the development of gynecology and obstetrics during the Gilded Age and Progressive Era. As intellectuals, educators, reformers, activists, physicians, and patients, women directed a dramatic transformation in both of these medical specialties, working with and against men to define and redefine the evolving parameters of healthy, normal American womanhood. Late-nineteenth- and early-twentieth-century medicine was characterized by conflict and controversy, with "regular," allopathic physicians campaigning constantly amongst themselves and against a variety of sectarian practitioners.[1] Gynecology and obstetrics became especially contentious, entangled, as they were, with social and political ideas about gender, race, class, sexuality, and reproduction. Indeed, gynecologists and obstetricians frequently disagreed on even the most fundamental principles of their chosen specialties.

I argue that in that chaotic atmosphere, women themselves played crucial roles in resolving medical debates about how their sexual and reproductive organs would be viewed, depicted, and treated. Moreover, I suggest that their work had a broader significance outside the medical profession. As women altered medical approaches to female bodies, they also shaped a larger discourse about the meaning of normal

[1] For the best overview of this chaotic period, which originated much earlier in the nineteenth century, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 93-144. Starr's depiction of nineteenth-century medicine, especially, is marked by "sharp contrasts," "bitter feuds," and "schisms, conspiracies, and coups." This pattern continued well into the Progressive Era, even as the "regulars" triumphed definitively over the sectarians and consolidated their authority over the medical profession.

femininity and the nature of American womanhood. My project purposefully places women at the center of a dramatic transformation in gynecology and obstetrics and, at the same time, connects that transformation to broader ideological changes about gender and American life.

Between 1870 and 1920, fueled in part by continual advances in medical science and technology, gynecology and obstetrics transformed from fledgling enterprises to powerful specialties. In 1884, the eminent gynecologist Thomas Addis Emmet was already remarking, in the introduction to his *The Principles and Practice of Gynaecology*, that updating the widely read textbook had "necessitated almost as much labor as rewriting the volume."[2] Eighteen years later, Dr. Emilius Clark Dudley made a nearly identical claim on behalf of the subsequent generation of gynecologists. Creating the 1902 edition of his textbook, Dudley claimed, had required him to produce more than a dozen new chapters from scratch.[3] Similarly, when the obstetrician Egbert Henry Grandin reissued *A Textbook on Practical Obstetrics* in 1909, he noted that it constituted "practically a new book, such have been the vital changes in practice and technique."[4] Throughout these decades, gynecologists and obstetricians all over the United States echoed these sentiments in medical journals and at professional meetings, celebrating the

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[2] Thomas Addis Emmet, *The Principles and Practice of Gynaecology*, third edition (Philadelphia: Henry C. Lea's Son and Company, 1884), vii.

[3] Emilius Clark Dudley, *The Principles and Practice of Gynecology: For Students and Practitioners,* third edition (Philadelphia: Lea Brothers and Company, 1902), 8. In order to do justice to recent developments, Dudley was obliged to create completely new sections on the topics of "Endocervicitis, Endometritis, Chronic Metritus, Pelvic Cellulitis, Peritonitis, Salpingitis, The Treatment of Pelvic Inflammations, Uterine Myoma, Uterine Carcinoma, Hystero-Myomectomy, Hysterectomy, Ovarian and Parovarian Cysts, Ovariotomy, Tubal Pregnancy, Ureteral Fistulae, and Malpositions of the Uterus." For similar comments see also Alexander J. C. Skene, *Medical Gynecology: A Treatise on the Diseases of Women from the Standpoint of the Physician* (New York: D. Appleton and Company, 1895).

[4] Egbert Henry Grandin, *A Text-Book on Practical Obstetrics*, fourth edition (Philadelphia: F. A. Davis Company, 1909), iii.

fact that their specialties were advancing at what, by all accounts, seemed like an incredible speed.[5] Medical historians, furthermore, have since confirmed their perceptions, demonstrating unequivocally that the Gilded Age and Progressive Era were genuinely transformative for both specialties.[6] They have also identified several key causes of that dramatic transformation, including the development of antisepsis and anesthesia, the innovations of pioneering male surgeons, and the consolidation of medical authority in the hands of "regular" physicians.[7] Unfortunately, though, they have not recognized the extent to which women themselves shaped the branches of American medical science that specialized in caring for female bodies – an omission that this dissertation sets out to correct.

My project is not, however, an institutional history of gynecology and obstetrics. Instead, I have conceived it as a social and intellectual history of these specialties, which features women as primary actors and emphasizes significant connections between

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[5] See, for example, J. Riddle Goffe, "The Woman's Hospital in the State of New York. Founded in 1855. An Historical Sketch," *The American Journal of Obstetrics and Diseases of Women and Children,* Vol. LXXVII, No. 4 (April 1918), 538; "Obstetrical Advances of the Last Half Century," *The Medical News* Vol. LXXVI (1900), 942; Reuben Peterson, "The Indications for Abdominal Cesarean Section," *Physician and Surgeon: A Medical Journal* Vol. XXXV (1879), 109.

[6] See Sara Dubow, *Ourselves Unborn: A History of the Fetus in Modern America* (New York: Oxford University Press, 2011), 10-11; Judith Walzer Leavitt, "The Growth of Medical Authority: Technology and Morals in Turn-of-the-Century Obstetrics," *Women and Health in America: Historical Readings*, second edition, edited by Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1999), 636-658; Lawrence D. Longo, "Obstetrics and Gynecology," *The Education of American Physicians: Historical Essays*, edited by Ronald L. Numbers (Berkeley: The University of California Press, 1980), 215-225; Deborah Kuhn McGregor, *From Midwives to Medicine: The Birth of American Gynecology* (New Brunswick: Rutgers University Press, 1998); Regina Morantz-Sanchez, *Conduct Unbecoming a Woman: Medicine on Trial in Turn-of-the-Century Brooklyn* (New York: Oxford University Press, 1999), 96-113; Judith M. Roy, "Surgical Gynecology," *Women, Health, and Medicine in America: A Historical Handbook*, edited by Rima D. Apple (New York: Garland Publishing, 1990), 173-195.

[7] See, for example, Longo, "Obstetrics and Gynecology," 215-216; Martin S. Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985); Charles E. Rosenberg, "The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America," *Perspectives in Biology and Medicine,* Vol. 20 (1977), 485-506; Starr, *Social Transformation of American Medicine,* 110-112, 156-156.

medical perceptions of women's bodies and social constructions of women's lives. I therefore place the history of gynecology and obstetrics in the larger context of the history of women and gender in the late-nineteenth- and early-twentieth-century United States. During these decades, American women became increasingly visible in the public sphere. They earned college degrees, pursued professional goals, campaigned for woman suffrage, and agitated for a number of causes, including many that overlapped to varying degrees with the theory and practice of gynecology and obstetrics: social hygiene, marriage reform, birth control, and sex education.[8] In addition, the women's medical movement enjoyed what the physician and medical Steven J. Peitzman has termed "a golden age" during the Gilded Age and Progressive Era, when steadily increasing numbers of women enrolled in medical schools, opened profitable practices, published case studies, and joined professional associations.[9] I suggest that all of these phenomena – the tremendous changes in gynecology and obstetrics, the growing presence of women in public and political spaces, and the expanding opportunities for women in medicine – were intimately connected to one another and related to the materiality of female bodies. The physical body has been a central battleground for the ideological construction of women in society. I argue, then, that as women worked from inside and outside the medical community to define what it meant to have a healthy, normal female body, they

[8] These changes have been documented extensively by non-medical historians. See, for example, Steven M. Buechler, *Women's Movements in the United States: Woman Suffrage, Equal Rights, and Beyond* (New Brunswick: Rutgers University Press, 1987); Nancy Cott, *The Grounding of Modern Feminism* (New Haven: Yale University Press, 1987); William Leach, *True Love and Perfect Union: The Feminist Reform of Sex and Society* (New York: Basic Books, 1980); Rosalind Rosenberg, *Beyond Separate Spheres: Intellectual Roots of Modern Feminism* (New Haven: Yale University Press, 1982); Christina Simmons, *Making Marriage Modern: Women's Sexuality from the Progressive Era to World War II* (New York: Oxford University Press, 2009); Barbara Miller Solomon, *In the Company of Educated Women: A History of Higher Education in America* (New Haven: Yale University Press, 1985).

[9] Steven J. Peitzman, *A New and Untried Course: Woman's Medical College and Medical College of Pennsylvania, 1850-1998* (New Brunswick: Rutgers University Press, 2000), 56.

also constructed larger visions of what it meant, fundamentally, to be a healthy, normal American woman.

Early Origins: The Birth of Gynecology and Obstetrics as Medical Specialties

Gynecology and obstetrics emerged, during the middle decades of the nineteenth century, as two of the first modern medical specialties. Specialization was an important component of the professionalization of American medicine and the consolidation of medical authority under the leadership of "regular" practitioners.[10] Although the majority of mid-nineteenth-century doctors identified themselves as general practitioners, and although new specialties tended to lack concrete or universal standards, specialization did enable some of the most skilled and ambitious professionals to define their expertise more narrowly, taking advantage of advancing medical knowledge and technology to maximize their incomes and minimize their competition.[11] Both the first obstetricians and the first gynecologists, for example, employed new medical instruments like the Sims speculum, new surgical tools like silver sutures, and new anesthetics like ether and chloroform to eliminate much of their competition from midwives and "irregulars" and claim their places as the foremost authorities on women's sexual and reproductive

[10] For a brief overview of the history of sectarian medicine and the eventual triumph of "regular," allopathic physicians over "irregular" practitioners like Eclectics and homeopaths, see Norman Gevitz, *Other Healers: Unorthodox Medicine in America* (Baltimore: Johns Hopkins University Press, 1988); Starr, *Social Transformation of American Medicine*, 93-102.

[11] On the origins and evolution of specialization, see James H. Cassedy, *Medicine in America: A Short History* (Baltimore: Johns Hopkins University Press, 1991), 31; William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore: Johns Hopkins University Press, 1985), 207-216; Starr, *Social Transformation*, 76-77. On the fluidity of nineteenth- and early-twentieth-century medical specialties, including an examination of their lack of standardized sets of criteria for specialization, see Roy, "Surgical Gynecology," 180-181; Rosemary Stevens, "The Changing Idea of a Medical Specialty," *Transactions and Studies of the College of Physicians of Philadelphia* 5 (1980), 159-177.

anatomy and physiology. Increasingly, specialists – obstetricians and gynecologists, but also ophthalmologists, otologists, otolaryngologists, and neurologists – became the most influential members of the regular medical community.[12] Until the decades following the Civil War, that community remained almost exclusively male, and even the few "regular" female doctors were typically prevented from joining relevant specialist associations; consequently, men became the first distinguished gynecologists and obstetricians to practice in the United States.[13] Nevertheless, as we will see, women always exerted some influence on these specialties.

Obstetrics, the branch of medicine concerned with pregnancy and childbirth, was the first major medical specialty, coalescing around the 1830s and predating gynecology by at least twenty years.[14] Though midwives continued delivering the majority of American babies – and indeed, continued delivering virtually all babies in many rural areas and immigrant neighborhoods – "regular" male physicians had nevertheless established a thriving new obstetrical specialty by the 1830s.[15] In their attempt to usurp

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[12] Cassedy, *Medicine in America,* 31; Rothstein, *American Physicians,* 213.

[13] The few women practicing medicine before the Civil War generally fared better with irregular sects. Only a handful, beginning with Elizabeth Blackwell in 1849, earned regular medical degrees and practiced regular medicine. See Cassedy, *Medicine in America*, 30; Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 31-32.

[14] It is difficult to pinpoint the exact historical moment at which obstetrics became a bona fide modern medical specialty. "Male midwives" were practicing in Boston as early as the 1770s, and by 1800, it was fashionable for certain elite urban women to employ them. However, the *American Journal of Obstetrics*, which was the first specialty medical journal in the United States, did not debut until 1868, and the American Association of Obstetricians and Gynecologists was not founded until 1888. I suggest the 1830s not arbitrarily but because, by that time, obstetricians recognized themselves as such and perceived their specialty as thriving. See Judy Barrett Litoff, *American Midwives: 1860 to the Present* (Westport, CT: Greenview Press, 1978), 8-20.

[15] Cassedy, *Medicine in America*, 31. Much of the literature on the history of midwifery in America, though extensive, is rather dated; for some of the best work, see Jane B. Donegan, *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America* (Westport, Connecticut: Greenview Press, 1978); Litoff, *American Midwives.* See also Laurel Thatcher Ulrich's wonderful study of one Revolutionary-era Maine midwife, Laurel Thatcher Ulrich, *A Midwife's Tale: The Life of Martha Ballard,*

midwives as the chief experts on childbirth, these specialists, who called themselves "male midwives" before switching to the term "obstetrician," sought to redefine pregnancy, labor, and delivery not as natural life events but as pathological conditions and processes that required the supervision and intervention of medical professionals. As the sociologist William Ray Arney has noted, obstetricians recognized that this reconceptualization was political and rhetorical; they knew that their success hinged not so much on new technological advancements or purported scientific authority but rather on their powers of persuasion.[16] They admitted these facts openly. In 1838, for example, Dr. Hugh L. Hodge lectured medical students at the University of Pennsylvania that "if females can be induced to believe that their sufferings will be diminished, or shortened, and their lives and those of their offspring, be safer in the hands of the profession; there will be no difficulty in establishing the universal practice of obstetrics."[17] Hodge appeared concerned not only with devising legitimate ways to reduce suffering and decrease maternal and infant mortality but also with finding the best ways to convince women that these kinds of improvements were actually possible – a dubious position in the 1830s.

During those first decades of specialization, obstetricians' medical interventions in childbirth were at least as likely to harm parturient women and unborn babies as they

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Based on Her Diary, 1785-1812 (New York: Vintage Books, 1990). For a more recent account of midwifery and the later transition to obstetrics, albeit one focused exclusively on the state of Wisconsin, see Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920* (Cambridge: Harvard University Press, 1995).

[16] William Ray Arney, *Power and the Profession of Obstetrics* (Chicago: The University of Chicago Press, 1982), 42-43.

[17] Hugh L. Hodge, *Introductory Lecture to the Course on Obstetrics and the Diseases of Women and Children, Delivered in the University of Pennsylvania, November 7, 1838* (Philadelphia: J. G. Auner, 1838), 11.

were to help them. The most common interventions were the use of forceps to pull babies through the birth canal by force, the use of ergot to stimulate uterine contractions, and the use of drugs to relax or anesthetize laboring women. In her groundbreaking monograph on the history of American childbirth, the medical historian Judith Walzer Leavitt suggests perceptively that these techniques proved life-saving in many cases but disastrous, even lethal, in others.[18] Forceps, the instruments most closely associated with mid-nineteenth-century obstetricians, exemplify this principle. In prolonged and difficult labors, the so-called "hands of iron" could sometimes shorten the time women spent in agonizing pain; further, in emergency situations, the judicious application of forceps could save the lives of mothers and infants. On the other hand, when used unnecessarily or incorrectly, forceps introduced serious risks, including severe perineal lacerations in mothers and head injuries or even death in babies.[19] Other obstetrical interventions, including the use of ergot, chloroform, and ether, also offered new life-saving potential while simultaneously introducing new hazards to the process of childbirth.[20]

In general, then, the primary difference between obstetricians and midwives in terms of their management of childbirth was that midwives viewed interventions as too dangerous (and were often not trained or able to offer them, in any case), while obstetricians insisted that the benefits of their drugs and instruments outweighed the risks. During most deliveries, midwives tended to watch and wait; obstetricians felt

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[18] According to Leavitt, "if . . . as was statistically more probable, labor was proceeding normally and physicians intervened anyway, their actions introduced dangers not otherwise present." See Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986), 47.

[19] Leavitt, *Brought to Bed*, 44-47. See also Tina Cassidy, *Birth: The Surprising History of How We Are Born* (New York: Grove Press, 2006), 169.

[20] Leavitt, *Brought to Bed*, 43.

compelled to take decisive action, often as a way of demonstrating their supposedly superior knowledge and skill. As Walter Channing, a professor of obstetrics at Harvard Medical School, famously explained, a physician "must do something. He cannot remain a spectator merely."[21] Many nineteenth-century obstetricians followed that imperative, which was constructed on the foundation of the early American history of "heroic medicine." Heroic doctors sought to produce visible, unquestionable, and often violent results, frequently through treatments like bloodletting and purging, thereby justifying their professional existence and assuring patients and their loved ones that they were taking decisive action against illness and disease.[22] As obstetricians followed that tradition, they participated in the process of redefining childbirth as a medicalized event that necessitated constant action and intervention by the physician for the benefit of mothers and infants. They also participated in the evolution of a medical science that was constructed as a masculine project, which functioned to make nineteenth-century medical women oxymoronic. This construction of medicine created a number of challenges and opportunities for women, who, as I will discuss in this dissertation, were navigating their identities as active participants and patients in gynecology and obstetrics.

Nevertheless, I want to note that the success of these specialties always hinged on the desires and decisions of women themselves. By the 1860s, in the context of a developing medical market, obstetricians had persuaded many urban white women of the middle and upper classes that the interventions of medical specialists were desirable

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[21] Walter Channing, *A Treatise on Etherization in Childbirth, Illustrated by Five-Hundred and Eighty-One Cases* (Boston: William D. Ticknor, 1848), 229. See Cassidy, *Birth,* 138; Leavitt, *Brought to Bed,* 43.

[22] See Cassedy, *Medicine in America*, 25, 33; Volney Steele, *Bleed, Blister, and Purge: A History of Medicine on the American Frontier*, third edition (Missoula, MT: Mountain Press Publishing Company, 2005), 48-49.

during childbirth. The fact that these women chose specialists as their caretakers cemented obstetricians' professional futures and secured their status as experts.[23] For this particular group of female patients, at least, the woman-dominated "social childbirth" of early American disappeared, replaced by a more medicalized childbirth characterized by the use of drugs and instruments – a trend that would continue as medical knowledge and technology advanced, reaching new heights in the early twentieth century.[24] Three key factors contributed to this shift. First, privileged women sometimes chose physicians over midwives because they believed that physicians' formal training, as contrasted to the informal training and practical experience that qualified midwives to supervise childbirth, made specialists better equipped to handle potential crises during labor and delivery.[25] Second, many women, terrified of the ordeal of childbirth, desperately wanted pain relief, and, beginning in the 1840s, some obstetricians offered them that comfort in the form of ether or chloroform.[26] Third, many obstetricians campaigned actively against midwives, working deliberately to convince women that only medical specialists could competently supervise a process as potentially dangerous as childbirth.[27] Taken together, these three

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[23] Leavitt, *Brought to Bed,* 49.

[24] On "social childbirth," see Leavitt, *Brought to Bed*, 13-35; and, especially, Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: Schocken Books, 1979), 1-26.

[25] In general, this logic was flawed – or, at least, it only held up in certain cases. Many physicians had very little formal training in the early nineteenth century, and what training they did have did not typically focus on "diseases of women." Nevertheless, many leading obstetricians did get solid training, especially if they went overseas to study with leaders in Great Britain. See Leavitt, *Brought to Bed*, 39.

[26] See Cassidy, *Birth*, 84-85; Leavitt, *Brought to Bed*, 116-125; Litoff, *American Midwives*, 19. Ether and chloroform were, however, used quite inconsistently, and some physicians did not use them at all.

[27] The campaign against midwives was not, however, quite as vicious or unilateral as some feminist historians have supposed, especially in the nineteenth century. Some nineteenth-century obstetricians argued that midwives were actually perfectly well-suited to "normal" deliveries; others argued that training for midwives needed to be increased; others argued that midwives were dangerous "quacks" who needed to be eliminated entirely. See Litoff, *American Midwives*, 19-24. Charlotte Borst has demonstrated that in Wisconsin, obstetricians did not overtake midwives forcibly with any kind of successful campaign; rather,

factors – all of which depended fundamentally on the beliefs and desires of female patients – ensured that in American cities, white women of means increasingly chose to give birth under the care of obstetricians.

Gynecology, the branch of medicine devoted to the care of female sexual and reproductive organs, followed closely behind obstetrics, becoming a viable medical specialty over the course of the 1850s. It differed from obstetrics in that it was strongly connected, from its inception, to developments in surgery, which progressed tremendously following the introduction of anesthesia. The earliest gynecologists were all surgeons who attempted, with varying degrees of success, to resolve sexual and reproductive disorders with scalpels.[28] Like obstetricians, though, gynecologists explicitly sought to persuade women that this new specialty could improve their lives, that certain previously-accepted aspects of women's bodily experiences, including sexual disorders, reproductive ailments, and "accidents of childbirth" like vaginal tears, cervical lacerations, and incontinence, could now be alleviated with the tools and expertise of medical professionals.

In some situations, for certain women, gynecologists could and did genuinely deliver on this promise. For example, the celebrated "father of modern gynecology," the Alabama physician James Marion Sims, acquired his professional fame in 1849 when he developed a reliable surgical cure for a dreaded condition known as the vesico-vaginal fistula. This injury, a hole in the tissue between the bladder and vagina, was fairly common in the mid-nineteenth century. It resulted most frequently from a prolonged,

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pregnant women came to value "the model of disinterested, professionalized science" offered by obstetricians. See Borst, *Catching Babies*, 11.

[28] See Cassedy, *Medicine in America,* 31.

difficult childbirth, when the fetal head put continuous pressure on the delicate tissue for too long; additionally, obstetrical interventions like forceps could sometimes tear the hole by force. Women with vesico-vaginal fistulae became permanently incontinent, and the constant flow of urine through the vagina caused redness, itching, irritation, infection, and pain, as well as extreme embarrassment; by all accounts, they suffered tremendously for the remainder of their days.[29] Sims's innovation meant that American women with access to specialists could now seek a cure for the condition and go on leading normal lives.[30]

As with obstetrics, though, the positive results that gynecology offered some women were balanced by significant risks and abuses. Even Sims, who was "universally beloved and venerated" by the time of his death in 1883, became an incredibly controversial figure by the late twentieth century.[31] The biggest source of controversy is

[29] On the vesico-vaginal fistula (and the related recto-vaginal fistula), see Edward Shorter, *A History of Women's Bodies* (New York: Basic Books, 1982), 268-269. For Sims's published piece on treating the vesico-vaginal fistula, see J. Marion Sims, "On the Treatment of Vesico-Vaginal Fistula," *American Journal of the Medical Sciences* 23 (January 1852), 59-87. Women with rickets, which resulted from malnutrition and was therefore more common among poor and slave women, were particularly susceptible to the vesico-vaginal fistula because they tended to have deformed pelvic bones, which made childbirth long and difficult.

[30] In addition to curing the vesico-vaginal fistula, Sims also developed a number of medical and surgical instruments, including the curved vaginal examination tool – the "Sims speculum" – that came to define gynecological examinations. The literature on his life and work is fairly extensive. See especially McGregor, *Midwives to Medicine*, 1-4, 33-75; Deborah Kuhn McGregor, *Sexual Surgery and the Origins of Gynecology: J. Marion Sims, His Hospital, and His Patients* (New York: Garland Press, 1989); Marie Jenkins Schwartz, *Birthing a Slave: Motherhood and Medicine in the Antebellum South* (Cambridge: Harvard University Press, 2006), 237. For a biographical account, albeit a fawning and uncritical one, see Seale Harris, *Woman's Surgeon: The Life Story of J. Marion Sims* (New York: Macmillan Press, 1950). For a fascinating first-hand account, see J. Marion Sims, *The Story of My Life*, reprint edition (New York: Da Capo Press, 1968).

[31] "Obituary," *The Medical News* XLIII (1883), 555. For an overview of the recent controversy over Sims, see Irwin H. Kaiser, "Reappraisals of J. Marion Sims," *American Journal of Obstetrics and Gynecology* 132 (1978), 878-884; Durrenda Ojanuga, "The Medical Ethics of the 'Father of Gynaecology,' Dr. J. Marion Sims," *The Journal of Medical Ethics* 19 (1993), 28-31; J. Patrick O'Leary, "J. Marion Sims: A Defense of the Father of Gynecology," *Southern Medical Journal* 97 (2004), 427-429; Jeffrey S. Sartin, "J. Marion Sims, the Father of Gynecology: Hero or Villain?" *Southern Medical Journal* 97 (2004); L. Lewis

the fact that he finally succeeded in curing the vesico-vaginal fistula by experimenting repeatedly on unanesthetized enslaved women, Anarcha, Betsy, Lucy, and nine others, who he purchased and borrowed specifically for the purpose. These women suffered terribly, even in Sims's version of the story. Describing one particular incident in his autobiography, Sims recorded that "Lucy's agony was extreme."[32] In addition, evidence suggests that Sims treated his Irish patients at the Woman's Hospital of New York City with similar cruelty, failing to use the anesthesia that he always found necessary to employ when he operated on middle-class, native-born women.[33] Aside from these race- and class-based abuses perpetrated by Sims and other gynecologists, it was also the case that many of the gynecological operations that saved women's lives in certain circumstances – the removal of uteruses and ovaries, for example, in cases of reproductive cancer – were also performed unnecessarily in other cases, and with considerable risk.

For better or worse, Sims and the pioneering physicians who soon followed him created a specialty that applied the tools of modern medical science to the most private parts of women's bodies and the most private aspects of women's lives. In 1855, Sims founded the first hospital devoted to gynecology, the Woman's Hospital of New York

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Wall, "Did J. Marion Sims Deliberately Addict His First Fistula Patients to Opium?," *Journal of the History of Medicine and Allied Sciences* 62 (November 2006).

[32] Sims, *My Life*, 238. Sims did give some of the slaves opium, but he did not use chloroform or ether, which were available at the time, and which he used with other patients. As this project will discuss at length, Sims's failure to use anesthetics when he experimented on enslaved women was probably due, at least in part, to the belief, among medical practitioners, that African Americans did not experience pain as acutely as Americans of European descent did. For the best account of Sims's experimentation on Anarcha, Betsy, and Lucy, see McGregor, *Midwives to Medicine*, 33-68.

[33] Seale Harris's biography of Sims reports that when Sims did attempt to operate on middle-class white women without anesthesia, they inevitably made him stop. See Harris, *Woman Surgeon*, 109. Sims's notes in these cases included: "the pain was so terrific that Mrs. H. could not stand it and I was foiled completely," "the patient insisted that it was impossible for her to bear the operation" and "patient, assistant, and surgeon were all worn out."

City. Similar institutions in Philadelphia, Chicago, Brooklyn, and other cities soon followed, and urban, middle-class women showed considerable support and enthusiasm for them.[34] In these hospitals and in physicians' offices, surgical repairs for vesico-vaginal fistulae were soon eclipsed by a variety of increasingly popular pelvic and abdominal surgeries, including the removal of clitorises, ovaries, uteruses, and Fallopian tubes, developed by Sims and gynecologists like Robert Battey, Edmund R. Peaslee, and Thomas Addis Emmet, to treat aspects of women's sexual and reproductive lives that they perceived as unhealthy or abnormal. By the time of the Civil War, gynecology, like obstetrics, was a thriving medical specialty, and gynecologists had secured their status as experts on women's sexual and reproductive anatomy and physiology.

The potential dangers and abuses associated with the emergence of obstetrics and gynecology makes it tempting to characterize the rise of these specialties as a movement of misogynistic men working against helpless women. Women like Anarcha, Betsy, and Lucy were clearly victimized, subjected to painful and experimental surgeries because their race, gender, and slave status left them vulnerable to such assaults and incapable of effectively resisting. At the same time, it is imperative to remember that in order for obstetrics and gynecology to succeed, specialists required paying patients who sought their care by choice. More privileged women had to accept and support these specialties; they had to seek the care of specialists and cooperate with their treatment. Even during these earliest years, when gynecology and obstetrics were practiced almost exclusively by men, women therefore played critical roles in their development. Most obviously, as

[34] In 1856, the Woman's Hospital of New York City received government support and became the Woman's Hospital of the State of New York. See Mary Putnam Jacobi, "Woman in Medicine," *Woman's Work in America*, edited by Annie Nathan Meyer (New York: Henry Holt, 1891), 169; McGregor, *Midwives to Medicine*, 69-74.

consumers, women chose to seek the care and guidance of obstetricians and gynecologists, as opposed to midwives or other kinds of healers; and, indeed, they did so in numbers large enough to justify and support the existence of specialists devoted to treating women's bodies. In the months preceding childbirth, some pregnant women selected obstetricians because they found specific treatments and services, including the administration of ergot to stimulate contractions and the use of chloroform or ether to diminish pain, desirable.[35] Meanwhile, in relation to gynecology, female patients exercised judgment in deciding which symptoms and conditions were sufficiently troubling to require the assistance of a specialist, and they then had to decide whether or not to follow their physicians' instructions and return for future visits. In urban areas, the formation of women's physiological clubs and associations serves as evidence that many women took an active interest in understanding their bodies and made these decisions in as educated a way as possible.[36]

Outside of the consumer role, certain exceptional women also influenced the early development of American gynecology and obstetrics through their work as intellectuals, educators, and activists. In 1855, for example, the educator and reformer Catharine Beecher sounded an alarm over what she perceived as the "terrible decay of female health all over the land" and asserted that the majority of American women were in fact ill.[37]

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[35] See Leavitt, *Brought to Bed*, 116-125; Litoff, *American Midwives*, 18-20.

[36] In Boston, for example, beginning in 1848, women attended organized lectures on topics such as pregnancy, breastfeeding, and the water cure. See the Papers of the Ladies' Physiological Institute of Boston and Vicinity, 1848-1956, Schlesinger Library, Harvard University.

[37] Catharine Beecher, *Letters to the People on Health and Happiness* (New York: Harper and Brothers, 1855), 121. On Beecher's life and work, see Jeanne Boydston, *The Limits of Sisterhood: The Beecher Sisters on Women's Rights and Women's Sphere* (Chapel Hill: University of North Carolina Press, 1993); Kathryn Kish Sklar, *Catharine Beecher: A Study in American Domesticity* (New York: W. W. Norton and Company, 1976); Barbara A. White, *The Beecher Sisters* (New Haven: Yale University Press, 2003).

Beecher did not suggest that women head directly to the offices of male physicians; on the contrary, she actually warned that many male doctors lacked virtue, and she therefore advised that patients proceed with caution when engaging their services.[38] Nevertheless, her characterization of the female population as dangerously, persistently ill complemented and supported the similar arguments made by mid-nineteenth-century physicians, who were attempting to convince American women of the necessity of their professional services. It also encouraged women to perceive various forms of sickness, disease, and disorder within themselves, to identify various physical discomforts as symptomatic of particular illnesses, not as an unavoidable aspect of everyday life. Their bodies became subjects of scrutiny in a new way, and this development, in the end, brought many of them to the offices of specialists.

Women were also instrumental in raising funds and soliciting community support for institutions devoted to treating the diseases of women. The first such hospital, Sims's Woman's Hospital of New York, is a good case study. The Woman's Hospital would almost certainly not have succeeded if not for the sustained effort of a committed group of female reformers and philanthropists. These women, led by Sarah Platt Haines Doremus, founded the Woman's Hospital Association, raised funds to launch the hospital and keep it functioning, and served in important offices on the Board of Managers. Many of them, including Charlotte Gibbs Astor and Margaret Slocum Sage, also left the Woman's Hospital considerable endowments when they died.[39] For Doremus, as for the women like her who supported similar institutions in other major cities, the drive to open hospitals and dispensaries devoted to the diseases of women was part of the larger mid-

[38] Beecher, *Letters to the People*, 160.

[39] See McGregor, *Midwives to Medicine*, 70-71, 88.

nineteenth-century reform impulse, a movement that originated with the Second Great Awakening and ultimately enabled privileged white women to channel their talents and energies toward benevolence, reform, and "municipal housekeeping."[40] Their commitment to these projects was crucial to the success of gynecology and obstetrics. Physicians needed these hospitals, after all, to house large numbers of patients in one location; to practice, perform, and refine their techniques; and to educate and train future generations of specialists.[41]

In addition, by the middle of the nineteenth century, a few women were becoming regular physicians and practicing gynecology and obstetrics themselves. Elizabeth Blackwell, the first "regular" American woman physician, earned her degree from Geneva Medical College in 1849, the same year that Sims cured the vesico-vaginal fistula.[42] The Woman's Medical College of Pennsylvania opened the following year, graduating a handful of women physicians annually, and it was soon followed by New England Female Medical College and Women's Medical College of Chicago.[43] From that point on, then, some women also influenced gynecology and obstetrics from their

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[40] On mid-nineteenth-century benevolence and moral reform, see Lori D. Ginzberg, *Women and the Work of Benevolence: Morality, Politics, and Class in the Nineteenth-Century United States* (New Haven: Yale University Press, 1990); Lori D. Ginzberg, *Women in Antebellum Reform* (Wheeling: Harlan Davidson, 2000); Elizabeth R. Varon, *We Mean to Be Counted: White Women and Politics in Antebellum Virginia* (Chapel Hill: University of North Carolina Press, 1998), especially Chapter 1. On the idea of municipal housekeeping and its connection to American health, see Suellen Hoy, *Chasing Dirt: The American Pursuit of Cleanliness* (New York: Oxford University Press, 1995), 72-75.

[41] On the development of hospitals and their role in the growth and professionalization of American medicine, see Virginia Drachman, *Hospital with a Heart: Women Doctors and the Paradox of Separatism at the New England Hospital, 1862-1966* (Ithaca: Cornell University Press, 1984); Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); Starr, *Social Transformation of American Medicine*, 145-169.

[42] Morantz-Sanchez, *Sympathy and Science*, 47-49.

[43] See Regina Morantz-Sanchez, "The Female Student Has Arrived: The Rise of the Women's Medical Movement," *"Send Us a Lady Physician": Women Doctors in America, 1835-1920*, edited by Ruth J. Abram (New York: W. W. Norton and Company, 1985), 63.

positions as doctors, especially since so many of them decided to specialize in diseases of women. In fact, as this dissertation will demonstrate, women physicians sometimes proved disproportionately powerful, primarily because they purportedly combined traditionally masculine credentials (medical degrees and professional practices based on rational intellect and scientific knowledge) with traditionally feminine characteristics (compassion, sensitivity, and the urge to heal and nurture) and, at the same time, were endowed with a gendered authority that enabled them to speak decisively about female bodies and female lives.[44] Even as women physicians were marginalized in medical circles and denied many of the most visible manifestations of professional power, their opinions on contentious issues related to the theories and practice of gynecology and obstetrics still carried weight. Their voices mattered.

Women, therefore, always had some impact on the theories and practices of gynecology and obstetrics in the United States. They made choices as patients, wrote about female health, raised funds for hospitals and dispensaries, and, by the 1850s, in small numbers, practiced gynecology and obstetrics themselves. Their power, I argue, increased in subsequent years and, by the 1870s, white middle-class women came to wield tremendous influence, both inside and outside the specialties. This influence was variable, rising and falling during specific times and in specific circumstances; even more importantly, with few exceptions, this power belonged only to a relatively privileged group of white, native-born women. Nevertheless, their contributions mattered, and their

[44] Female nurses were, by the middle decades of the nineteenth century, also working in hospitals and dispensaries devoted to the care of women. More research needs to be undertaken on the role of nurses in the development of gynecology and obstetrics, but, though much less powerful than physicians, they would certainly have played some part in determining diagnoses and treatments. On nurses, see Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987); Margarete Sandelowski, *Devices and Desires: Gender, Technology, and American Nursing* (Chapel Hill: University of North Carolina Press, 2000).

dominant role in the development of gynecology and obstetrics would last, at least, through the first decades of the twentieth century.

Historiography and Methods

The earliest histories of gynecology and obstetrics, written between 1945 and 1980, are institutional histories that closely follow the "great doctor" model, highlighting the heroic innovations of early male physicians and examining the development of these specialties in a vacuum.[45] "Great doctor" histories are almost universally uncritical; they do not analyze the social or cultural implications of medical developments. A typical discussion of James Marion Sims, for example, mentions his surgical innovations and his role as a founder of the Woman's Hospital of New York but does not explore his treatment of enslaved and immigrant women.[46] In most of these narratives, women appear only as patients, and even then, they generally appear not as whole individuals but as disembodied collections of reproductive organs: the vaginas that Sims examined and sutured, the ovaries that Battey removed, the uteruses that obstetricians induced to contract. This approach sets up a fictitious wall between how medical professionals perceived women's bodies and how they understood women themselves. It also fails to account for virtually any agency on the part of patients.

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[45] See, for example, Theodore Cianfrani, *A Short History of Gynecology and Obstetrics* (Springfield, Illinois: Charles C. Thomas, 1960); Harvey Graham, *Eternal Eve: The History of Gynecology and Obstetrics* (Garden City, New Jersey: Doubleday, 1951); James V. Ricci, *One Hundred Years of Gynecology* (Philadelphia: The Blakiston Company, 1945); Harold Speert, *Obstetrics and Gynecology in America: A History* (Washington, D.C.: American College of Obstetricians and Gynecologists, 1980). For an example of a similar approach applied specifically to the history of medical societies, see also Houston S. Everett and E. Stewart Taylor, "The History of the American Gynecological Society and the Scientific Contributions of its Fellows," *The Journal of Obstetrics and Gynecology* 126 (December 1976), 908-919.

[46] See Ricci, *One Hundred Years*, 129-132.

More recently, social and intellectual historians have traced the development of these specialties, and their work has been much more critical. Informed by the growth of feminist theory and women's history in the 1970s and 1980s, this scholarship often focuses on the misogyny of male specialists and the victimization of female patients. Historians of gynecology, such as Deborah Kuhn McGregor, tend to characterize male medical authority as tyrannical and argue that the specialty, from its inception, depended upon "the subordination of women and the objectification of their bodies."[47] Historians of obstetrics share these tendencies, decrying the medicalization of pregnancy and childbirth and emphasizing the transition from "social childbirth" to physician-controlled labor and delivery, which they depict as a manifestation of the male desire to wrest control of the birth experience away from female midwives.[48] These more recent assessments have been important in calling attention to the fact that female patients often experienced male medical authority as oppressive; however, I depart from the villain-victim model for three basic reasons. First, the villain-victim model is fundamentally inaccurate, pitting physicians (who are depicted in a rather one-dimensional fashion, as white and male) and patients (who are generally not differentiated in terms of race or class) against each other rather than acknowledging the complex and multi-faceted ways

[47] McGregor, *Midwives to Medicine,* 3.

[48] See, for example, Nancy Schrom Dye, "The Medicalization of Birth," *The American Way of Birth*, edited by Pamela S. Eakins (Philadelphia: Temple University Press, 1986), 33-43; Margot Edwards and Mary Waldorf, *Reclaiming Birth: History and Heroines of American Childbirth Reform* (Trumansburg, NY: The Crossing Press, 1984), 146-153; Barbara Katz Rothman, "The Social Construction of Birth," *The American Way of Birth*, edited by Pamela S. Eakins (Philadelphia: Temple University Press, 1986), 104-106; Scully, "From Natural to Surgical Event," *The American Way of Birth*, edited by Pamela S. Eakins (Philadelphia: Temple University Press, 1986), 47-58. Scholars like G. J. Barker-Benfield and Mary Daly have pushed this line of analysis to extremes, asserting that both gynecologists and obstetricians purposefully deployed sexual surgery and other treatments in order to restrain women's ambitions and control their behavior. See G. J. Barker-Benfield, *The Horrors of the Half-Known Life: Male Attitudes toward Women and Sexuality in Nineteenth-Century America*, second edition (New York: Routledge University Press, 2000); Mary Daly, *Gyn/Ecology: The Metaethics of Radical Feminism* (Boston: Beacon Press, 1990).

that these groups interacted. Second, the model tends to be purposefully provocative, bolstered by the most appalling, not the most representative, evidence.[49] Finally, the tendency to characterize male doctors as villains and female patients as victims reduces the complexities of women's diverse positions into a single passive experience of oppression – a problem that was noted by Regina Morantz-Sanchez as early as 1973 but which continues to plague medical histories of women, especially where gynecology and obstetrics are central topics.[50] As a result, the existing scholarship on gynecology and obstetrics as medical specialties frequently ignores female agency, minimizing women's myriad roles as scientists, teachers, physicians, and activists.[51]

I have consulted and incorporated both "great doctor" narratives and feminist critiques of gynecology and obstetrics, but more frequently, my work builds upon a variety of newer monographs devoted to narrowly-defined aspects of these specialties or to topics closely related to them. For example, social, cultural, and intellectual histories of sexuality, contraception, abortion, pregnancy, and childbirth have been especially useful, and I have drawn on them throughout the dissertation.[52] Similarly, histories of

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[49] The British physician Ann Dally has already noted this particular problem with recent medical histories of gynecology. See Ann Dally, *Women under the Knife* (New York: Routledge, 1992), xvi.

[50] See Regina Morantz-Sanchez, "The Perils of Feminist History," *The Journal of Interdisciplinary History* IV (1973), 649-660.

[51] There are three recent important exceptions to this rule, all centered around individual women physicians whose extraordinary lives and careers complicated the villain-victim model. See Carla Bittel, *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth-Century America* (Chapel Hill: University of North Carolina Press, 2009); Morantz-Sanchez, *Conducting Unbecoming*; Arleen Marcia Tuchman, *Science Has No Sex: The Life of Marie Zakrzewska, M.D.* (Chapel Hill: The University of North Carolina Press, 2006).

[52] On sexuality, see, for example, Julian B. Carter, *The Heart of Whiteness: Normal Sexuality and Race in America, 1880-1940* (Durham: Duke University Press, 2007); John D'Emilio and Estelle B. Freedman, *Intimate Matters: A History of Sexuality in America* (New York: Harper and Row, 1988); Thomas Lacqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge: Harvard University Press, 1990). On contraception, see, for example, Linda Gordon, *The Moral Property of Women: A History of Birth Control Politics in America* (Urbana: University of Illinois Press, 2002); Andrea Tone, *Devices and*

feminism and women's activism have informed my work and offered models of scholarship centered on female agency.[53] Finally, for the sections of this dissertation centered on the work of medical women, the rich historiography on women physicians in the United States has been a tremendous resource. My own work builds on many aspects of that literature, but with a different emphasis; in general, I highlight the ways that women became active agents in shaping American medicine, while the existing scholarship often underscores the discrimination they faced.[54] My first task, then, in writing this dissertation, has been to examine territory already covered by many historians, but to offer a different perspective, shifting the focus to reveal the presence of

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Desires: A History of Contraceptives in America (New York: Farrar, Strauss, and Giroux, 2002). On abortion, see James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* (New York: Oxford University Press, 1978); Leslie J. Reagan, *Dangerous Pregnancies: Mothers, Disabilities, and Abortion in Modern America* (Berkeley: University of California Press, 2010); Leslie J. Reagan, *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973* (Berkeley: University of California Press, 1996). On pregnancy, see Barbara Duden, *Disembodying Women: Perspectives on Pregnancy and the Unborn* (Cambridge: Harvard University Press, 1993); Reagan, *Dangerous Pregnancies*. On childbirth, see Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986); Richard W. and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (Baltimore: Johns Hopkins University Press, 1989); Jacqueline H. Wolf, *Deliver Me from Pain: Anesthesia and Birth in America* (Baltimore: Johns Hopkins University Press, 2009).

[53] I have relied particularly heavily on Cott, *Grounding of Modern Feminism*; Ginzberg, *Women and the Work of Benevolence*; Leach, *True Love and Perfect Union*; Robyn Muncy, *Creating a Female Dominion in American Reform* (New York: Oxford University Press, 1991).

[54] This literature is vast, but the best general history of women doctors in the United States, by far, is still Morantz-Sanchez, *Sympathy and Science*. See also Ruth J. Abram, editor, *Send Us a Lady Physician: Women Doctors in America, 1835-1920* (New York: W. W. Norton and Company, 1985); Bittel, *Mary Putnam Jacobi*; Drachman, *Hospital with a Heart*; Gloria Moldow, *Women Doctors in Gilded Age Washington: Race, Gender, and Professionalization* (Chicago: University of Illinois Press, 1987); Morantz-Sanchez, *Conduct Unbecoming*; Elizabeth Silverthorne and Geneva Fulghum, *Women Pioneers in Texas Medicine* (College Station, TX: Texas A&M University Press, 1997); Ellen Singer More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995* (Cambridge: Harvard University Press, 1999); Peitzman, *New and Untried Course*; Nancy Theriot, "Women's Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science," *Signs* 19 (1993), 1-31; Tuchman, *Science Has No Sex*; Mary Roth Walsh, *Doctors Wanted: No Women Need Apply: Sexual Barriers in the Medical Profession, 1835-1975* (New Haven: Yale University Press, 1977); Susan Wells, *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine* (Madison: University of Wisconsin Press, 2001).

women as active, conscious agents of change in the history of gynecology and obstetrics during the Gilded Age and Progressive Era.

Once we accept that women actively shaped the evolution of gynecology and obstetrics during the late nineteenth and early twentieth centuries, new historical questions present themselves. Which women exerted the most influence? Why were gynecology and obstetrics so important to them? How did they want to define the roles of the gynecologist and obstetrician? How did they define healthy American womanhood? To what extent did they succeed? How did race and class influence their ideas? How did their contributions reflect their approaches to gender, sexuality, marriage, motherhood, and feminism? How did their work set the stage for the development of twentieth-century gynecology and obstetrics? What, in short, was their legacy?

In answering these questions, I argue that the women involved in the evolution of these specialties were consciously engaged in a much larger kind of work – the definition and redefinition of normal, healthy American womanhood – that both responded to and created strong connections between medical approaches to female bodies and philosophical approaches to female roles in society. In conceptualizing that argument and applying it to specific conflicts inside and outside the profession, I have relied upon the more theoretical work of other scholars. I have paid particular attention to two related kinds of scholarship: work that addresses the role of the medical community in constructing "normal" women's bodies and work that emphasizes the ways physicians, patients, and intellectuals worked with and against one another to define American "normality" and "health." In the first category, for example, the cultural critic Terri

Kapsalis contends in *Public Privates: Performing Gynecology from Both Ends of the Speculum* that "gynecology is not simply the study of women's bodies – gynecology *makes* female bodies. Thus the critical examination of gynecology is simultaneously a consideration of what it means to be female."[55] From the perspective of a historian, Regina Morantz-Sanchez has already applied this basic idea to the history of gynecology, noting that late-nineteenth- and early-twentieth-century gynecologists were indeed engaged in the work of "constructing the female body." Morantz-Sanchez devotes a chapter of her excellent book to a discussion of how one woman doctor "responded" to the gynecological construction of the female body, an approach that, while highlighting the power of physicians in defining the healthy body, still implies that men were generally the ones doing the constructing.[56] I agree with Morantz-Sanchez's basic argument but view women as even more central to the story, suggesting simply that women were actively involved in that process from the start, and that their work had tremendous power.

In the second category, I have drawn on the work of scholars like David G. Schuster, whose history of neurasthenia reminds us that American physicians, as a group, were not enormously powerful and that conceptualizations of sickness, health, normality, and abnormality were, therefore, not constructed by doctors alone. According to Schuster, nineteenth-century American medicine was "too much disorganized, and too much lacked the authority" to define neurasthenia on its own; instead, "the story of

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[55] Terri Kapsalis, *Public Privates: Performing Gynecology from Both Ends of the Speculum* (Durham: Duke University Press, 1997), 6. Kapsalis, who is focused more on twentieth-century gynecology, makes very different arguments than I make, emphasizing male power, the male gaze, and the male specialist role in defining the proper performance of femininity and female sexuality.

[56] Morantz-Sanchez, *Conduct Unbecoming*, 114-137.

neurasthenia is one of reciprocity, wherein the medical profession, patients, and popular culture all interacted to help shape the disease in the imagination of one another."[57] My work, which addresses the same chronological period and many of the same themes, builds on Schuster's, arguing that medical and popular constructions of female bodies and healthy American womanhood developed from this same reciprocal process. Similarly, as Jennifer Terry has argued in her study of science and homosexuality, I demonstrate that reciprocal medical and popular definitions of abnormality and unhealthy femininity served to emphasize, by implication, those characteristics that were especially important for normal, healthy women to have.[58] I suggest that once we broaden our focus to view the story of gynecology and obstetrics in this more complex, multidimensional way, then the crucial importance of women in shaping those specialties becomes especially clear.

Sources

In order to demonstrate the influence of medical and lay women on the development of gynecology and obstetrics, and in order to describe the character and consequences of their work, I have drawn upon a variety of published and archival primary sources. Published sources include medical textbooks (especially the

[57] David G. Schuster, *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1869-1920* (New Brunswick: Rutgers University Press, 2011), 1-2.

[58] Terry notes that "by conceiving of homosexuality as transgressive, experts (though seldom with this express purpose) have deployed it to conceptualize and delimit, by contradistinction, a range of acceptable habits, activities, gestures, relationships, identities, and desires in a manner that affects all of us in countless monumenal and minute ways." Jennifer Terry, *An American Obsession: Science, Medicine, and Homosexuality in Modern Society* (Chicago: University of Chicago Press, 1999), 1. In making that argument, Terry builds on the work of Foucault. See Michel Foucault, *The History of Sexuality: An Introduction: Volume I* (New York: Vintage Books, 1990).

gynecology and obstetrics texts assigned in late-nineteenth- and early-twentieth-century American medical colleges); medical journals (especially the *American Journal of Obstetrics and Diseases of Women and Children* and the *Women's Medical Journal*); printed transactions of state and national medical societies; popular advice literature on health, hygiene, sex, pregnancy, and childbirth; political and persuasive literature written by feminists, educators, and reformers; newspaper articles about hospitals, physicians, medical schools, and women's health; and the published memoirs and autobiographies of individual women.

I also used a variety of unpublished primary sources, relying most heavily on Drexel University's Archives and Special Collections on Women in Medicine, Harvard University's Countway Library of Medicine and Schlesinger Library, Smith College's Women's History Archives, and Tulane University's Rudolph Matas Library of the Health Sciences. Most of these sources fall into one of three key categories. First, I collected materials related to female medical students, including school records, student publications, senior theses, alumnae association records, and students' diaries and photographs. The richest collections in this category were related to the Women's Medical College of Pennsylvania and the University of Michigan. Second, I used materials related to hospitals and clinics influenced by women, such as medical and surgical records, administrative records and reports, and institutional histories. In this category, the best sources I found were related to the New England Hospital for Women and Children in Boston, the Pacific Dispensary for Women and Children in San Francisco, and several women's hospitals and clinics in Philadelphia. Third, I incorporated the personal papers of various female students, educators, physicians,

reformers, and activists, all of whom somehow influenced the development of gynecology or obstetrics as medical specialties. Some of these collections, including those related to respected physicians like Mary Putnam Jacobi and prominent reformers like Elizabeth Lowell Putnam, have been examined already by historians asking different but related sets of questions about women's lives in late-nineteenth- and early-twentieth-century America; others have been almost completely ignored by scholars, and especially by historians of medicine, but nevertheless offer important insights about the construction of healthy womanhood during this time.

Taken together, these published and archival sources offer a relatively complete picture of the ways that women shaped American gynecology and obstetrics during the Gilded Age and Progressive Era.

Organization

Rather than providing a brief overview of all the ways that women shaped and contributed to the development of gynecology and obstetrics in the United States, I have instead chosen to focus on four particularly transformative changes in which women played leading roles: the changing understanding of menstruation, the development of medical education for women, the evolution of surgical gynecology, and the campaigns for prenatal care and obstetric anesthesia. Each case demonstrates that women played the key roles in shaping the evolution of these specialties. Since late-nineteenth- and early-twentieth-century gynecology and obstetrics were characterized by so much conflict and controversy, each chapter focuses on one particular debate (or set of debates) that became

crucial to the transformation of one or both specialties. The project is therefore organized thematically, but I have also arranged the chapters in such a way that they proceed in a loosely chronological order, with some unavoidable overlap. Chapter II begins in the 1870s with the publication of Edward H. Clarke's *Sex in Education*; Chapter V concludes in the 1910s with the rise of comprehensive prenatal care and the campaign for a type of obstetric anesthesia known as twilight sleep.

Chapter II argues that women themselves were ultimately responsible for disproving the belief, fairly popular inside and outside the medical community, that higher education and professional careers harmed women's bodies and endangered their fertility. This idea, first made famous by the Harvard professor Edward H. Clarke and then repeated by respected gynecologists like Thomas Addis Emmet, rested on current medical science (including the principles of reflex irritation and finite energy) and played on social and scientific anxieties about the declining health of Americans and the potential for race suicide. It was, therefore, widely accepted; however, many women immediately recognized that, as a theory, it depended upon a construction of the female body that emphasized weakness and vulnerability and a construction of healthy womanhood that centered almost exclusively on marriage and motherhood. Female intellectuals, educators, reformers, and physicians published cultural criticism, statistical studies, and medical treatises rejecting Clarke's work and presenting alternative views about women's bodies and women's roles in American life. Their ultimate success had several major consequences, but two were particularly important. First, these women ensured that during the late nineteenth century, gynecology constructed the female body in the very particular ways that they viewed as correct. Their specific collective view of

healthy American femininity came to be recognized as normal. Second, because this particular vision of healthy womanhood prevailed, they secured places for themselves in the academic and professional worlds, fueling the feminist project of expanding women's roles outside of the domestic and maternal realm.

One more specific consequence of the successful refutation of Edward H. Clarke was the evolution of the "golden age" of the women's medical movement. Chapter III examines the expanding opportunities for women in American medicine through the lens of popular and professional debates about medical education for women, arguing that as these conflicts unfolded, they altered prevailing definitions of healthy American womanhood. The decision to attend medical school made women, in many senses, "abnormal," but for female medical students, that choice was only the beginning. Once they matriculated, they faced a number of interrelated debates, shaped by the intersection of rhetoric about gender, race, and class, about the nature of normal femininity and the boundaries of acceptable behavior for women physicians. What kinds of medicine should women practice? How should they train? Should they attend single-sex or co-educational programs? How should they dress? What should their professional personas look like? As female medical students negotiated these debates, they consciously shaped their gender performances and pushed for a broader definition of healthy femininity, one that allowed for medical study and medical practice that looked very much like men's. Healthy, middle-class American women, they argued, could attend college, earn money, study anatomy, treat diseases, and even perform surgery. This shift in the understanding of which characteristics defined female health and normality was quite significant for the

development of gynecology and obstetrics – medical specialties that ultimately sought to restore and maintain a state of healthy womanhood.

Chapter IV follows the evolution of medical constructions of healthy American womanhood through the increasingly antagonistic debates between radical and conservative specialists that took place during the last decades of the nineteenth century. These disputes were especially heated in gynecology because they involved the possibility of performing invasive operations on female reproductive organs, often with sterility as a possible consequence. Conservative physicians, including women like Elizabeth Blackwell, Mary S. Briggs, Josephine Peavey, and Mary Spink, believed that gynecological surgeries like hysterectomies and oophorectomies were immoral; they argued that motherhood was a woman's primary purpose and that her reproductive organs were therefore sacred. Radical physicians like Mary Putnam Jacobi, Mary Amanda Dixon Jones, and Rosalie Slaughter Morton, on the other hand, believed that surgery was frequently necessary and that motherhood was not fundamentally central to every healthy woman's life. These debates, which women were ultimately responsible for resolving, highlighted the intimate connections between medical approaches to the female body and philosophical positions about appropriate roles for "normal" women in American life. I argue that the fact that surgical gynecologists like Jacobi and Dixon Jones prevailed ensured that certain surgical procedures – hysterectomy, oophorectomy, and salpingectomy – came to define the practice of gynecology well into the twentieth century, while other procedures – most notably clitoridectomy – fell by the wayside. The dominance of surgical gynecology in the Gilded Age and Progressive Era, which historians have frequently exaggerated and blamed entirely on men, was thus a

consequence more of female agency than of the misogynistic inclinations of male physicians.

Chapter V examines two controversial developments, both initiated and promulgated by women, that changed the practice of obstetrics dramatically during the 1900s and 1910s. First, female reformers, intellectuals, and physicians worked to make comprehensive prenatal care a key component of early-twentieth-century obstetrical practice, particularly for middle-class white women, who paid for their prenatal visits and were charged with carefully following the advice of obstetricians and obstetrical nurses. Second, these women actively campaigned for a specific kind of obstetric anesthesia called twilight sleep, a technique that induced amnesia and allowed laboring women to enter a semi-conscious state and wake the following day with absolutely no recollection of labor or delivery. Both changes featured the cooperation of medical and lay women, and both contributed to the revolutionary shift in the experience of childbirth in the United States that took place in the early twentieth century. In the late nineteenth century, most women received little or no prenatal care and, though at this point they were often attended by obstetricians, they typically delivered their babies at home. By 1920, in contrast, many women – and most middle-class urban white women – received routine, comprehensive prenatal care and delivered their babies in hospitals with the aid of obstetric anesthesia. I suggest that this transformation occurred not because misogynist male physicians campaigned aggressively against midwives and home births but, instead, because female patients, reformers, and activists worked with physicians of both sexes to demand and popularize standardized prenatal care, obstetric anesthesia, and hospital births.

Taken together, these four chapters are representative of some of the major ways that women influenced the evolution of gynecology and obstetrics in the late-nineteenth- and early-twentieth-century United States. They construct a very different narrative from the one that appears in much of the existing scholarship on these medical specialties. They tell a story that features women as the most important actors in the development of the branches of medicine that defined and treated their bodies and, at the same time, set and revised standards for appropriate female behavior in American society. Women, I argue, created and sustained the dramatic transformation that took place in gynecology and obstetrics, and in doing so, they changed both medical and popular perceptions of healthy American womanhood. Chapter VI, the conclusion, reviews this process and suggests some ways that it continued to influence subsequent generations, ultimately exploring the legacy that these women left for twentieth-century gynecology and obstetrics.

CHAPTER II

"A FAIR CHANCE": MENSTRUATION, EDUCATION, AND THE PHYSICAL CAPABILITIES OF LATE-NINETEENTH-CENTURY AMERICAN WOMEN

In 1873, a Harvard Medical School professor named Edward H. Clarke published *Sex in Education*, which contended that the pursuit of scholarly and professional goals inflicted serious, irreparable damage on the bodies of young American women.[59] The book, ironically subtitled *A Fair Chance for Girls*, maintained that during and after adolescence, female bodies required all of their available vital energy for the establishment of a healthy, regular menstrual cycle. When young women devoted themselves to traditionally masculine pursuits and studied "as young men did," this essential energy moved, catastrophically, away from their reproductive systems and toward their brains, triggering a number of menstrual, gynecological, and nervous ailments, including "leucorrhoea, amenorrhoea, dysmenorrhoea, chronic and acute ovaritis, prolapsus uteri, hysteria, neuralgia, and the like."[60] Women who continued their studies over longer periods of time, perhaps earning advanced degrees or acquiring professional credentials, risked forfeiting their fertility completely. Clarke wrote that such ambitious young women frequently "graduated from school or college excellent scholars, but with undeveloped ovaries. Later they married, and were sterile."[61] Though he reassured his readers periodically that he did not view women as inferior, only

[59] Clarke published a great deal on this and other topics pertaining to female health. See the Collected Papers of Edward H. Clarke, 1820-1877, Countway Library of Medicine, Harvard University.

[60] Edward H. Clarke, *Sex in Education,* or *A Fair Chance for Girls*, reprint edition (New York: Arno Press, 1972), 23.

[61] Clarke, *Sex in Education*, 39.

different, Clarke's perspective on female anatomy and physiology rendered healthy femininity incompatible with rigorous academic work and careers in fields like law and medicine. Elite American women, he argued, were dangerously ill, and higher education made them that way.

Sex in Education resonated strongly with many Americans. Even outside of the medical community, American writers and reformers were already remarking frequently on the declining health of elite and middle-class white women. Educators and reformers like Catharine Beecher had begun suggesting that most "civilized" women were ill as early as the 1850s.[62] Beecher, in fact, had preceded Clarke by almost twenty years in condemning methods of modern schooling for exacerbating the poor health of the middle classes. Americans, she argued, "have provided schools for educating the minds of their children; but instead of providing teachers to train the bodies of their offspring, most of them have not only entirely neglected it, but have done almost everything they could do to train their children to become feeble, sickly, and ugly."[63] Beecher was influential, and references to her work were still appearing in popular health manuals when *Sex in Education* was published; many readers, therefore, would have been predisposed to accept Clarke's premises at face value.[64] Further, *Sex in Education* carried a particularly strong appeal for those Americans who worried about the consequences of shifting late-nineteenth-century gender roles, especially those who connected the relaxation of the

[62] For the most extensive analysis of declining female health, including Beecher's very flawed attempt at statistical proof of her assertions, see Catharine Beecher, *Letters to the People on Health and Happiness* (New York: Harper and Brothers, 1855). See also Catharine Beecher, "The American People Starved and Poisoned," *Harper's New Monthly Magazine* XXXII (1866), 771; Catharine Beecher, *Physiology and Calisthenics for Schools and Families* (New York: Harper and Brothers, 1856), 164.

[63] Beecher, *Health and Happiness*, 8.

[64] See, for example, Edward Bliss Foote, *Plain Home Talk about the Human System* (New York: Wells and Coffin, 1870).

"separate spheres" ideology – a sharply gendered view of society that was also espoused by Catharine Beecher – with the threat of race suicide, the idea that the white "American" race was dwindling and being overtaken by people of color and immigrants from eastern and southern Europe . Clarke's book quickly became a bestseller, and Clarke's characterization of the female body soon appeared in major medical journals and widely-used gynecology textbooks, where it would remain throughout the 1870s.

This chapter demonstrates that women physicians, intellectuals, and reformers played crucial roles in the process of discrediting Clarke's depiction of the female body. Their gendered experiences made them uniquely qualified to dispute the purported dangers of higher education for women; after all, as they frequently pointed out, they had endured the rigors of academic and professional work themselves, and they had done so without suffering from menstrual disorders, harming their reproductive organs, or sacrificing their fertility. Their presence in the ranks of highly regarded specialists, scientists, and professors seemed to indicate that, at the very least, the risks outlined by Clarke did not apply universally. The ambitious surgical gynecologist Mary Amanda Dixon Jones, for example, earned an advanced degree, opened a medical practice, published groundbreaking research, and devised new surgical techniques; meanwhile, she married a lawyer and mothered three healthy children.[65] Her very existence as a respected surgeon, therefore, challenged Clarke's arguments about the physical limitations of the female body, and her insistence that her own reproductive organs remained unharmed after decades of study and work would have been difficult to contradict. Because *Sex in Education* rested on several established medical theories,

[65] Regina Morantz-Sanchez, *Conduct Unbecoming a Woman: Medicine on Trial in Turn-of-the-Century Brooklyn* (New York: Oxford University Press, 1999), 30.

however, the process of discrediting Clarke's perspective required more than the personal testimonials of extraordinary individuals. It required serious scientific, intellectual, and persuasive work, much of which was undertaken by women. Their work altered medical – and popular – perceptions of the female body, changing the fundamental principles upon which the development of gynecology and obstetrics rested and clearing a path for "healthy" and "normal" women in academic and professional life.

Transforming the specialties of gynecology and obstetrics was, at its core, an academic process. Between 1870 and 1920, women published innovative research, contested established theories, and promoted new perspectives on the character of healthy American womanhood. Furthermore, they educated, supported, and supervised subsequent generations of female doctors, academics, and reformers. As they did so, they worked to define and redefine the fundamental nature of healthy femininity, asking whether or not women were innately delicate, inherently diseased, and suffering from the "pathology of femininity" – an approach that equated womanhood itself with abnormality and disorder.[66] These issues, they recognized, related directly to questions concerning the changing role of women in American society. Were women's expanding educational opportunities ruining their health? Were women biologically designed for domesticity, or would their bodies permit them to comfortably pursue roles in the public sphere? What would happen to the American family if women's health and happiness came to be determined not by reproduction and maternity but by other factors, including factors outside the domestic realm? As women sought to answer these questions – rather than

[66] On the pathology of femininity, see Ornella Moscucci, *The Science of Woman: Gynecology and Gender in England, 1800-1929* (Cambridge: Cambridge University Press, 1990), 102. Moscucci's work addresses gynecology in England, but the idea that femininity itself was a state of sickness and disease was definitely employed in the United States as well.

simply complying with the answers offered to them by men like Clarke – they were engaged in the work of constructing the female body and redefining healthy American womanhood.[67]

The "golden age" for women in medicine, which provided comparatively abundant opportunities for women during the Gilded Age and Progressive Era, enabled many female physicians and scientists to investigate questions about women's bodies in hospitals and at universities. Increasingly, it also permitted them to report their findings at major professional conferences and, perhaps to a lesser extent, in the pages of respected medical journals. Alumnae and professional organizations, such as the Alumnae Association of the Woman's Medical College of Pennsylvania and the New England Women's Medical Society, which began meeting in the 1870s, and publications like the *Woman's Medical Journal*, which debuted in 1893, enhanced these opportunities by providing supportive intellectual spaces reserved exclusively for the work of medical women.[68] Using all of the resources available to them, women like Dr. Mary Putnam Jacobi and Dr. Charlotte Brown worked to challenge existing medical perceptions of the

[67] As I noted in the introduction, Regina Morantz-Sanchez devotes a chapter to this process of constructing the female body through gynecology in her book on Dixon Jones. She implies, however, that men were the ones doing the constructing and that women occasionally "responded" to those constructions. I suggest that women were key actors in the process itself. See Morantz-Sanchez, *Conduct Unbecoming*, 114-137.

[68] Drexel's Legacy Center holds extensive archival records for the WMCP Alumnae Association. See Alumnae Association Transactions, Archives and Special Collections on the History of Women in Medicine and Homeopathy, Drexel College of Medicine. On the New England Women's Medical Society, see the Medicine Collection, Box 7, Folder 77, the Sophia Smith Collection, Smith College. The NEWMS was the first such society for regular women physicians, but other similar organizations soon appeared in various locations; it was followed by the Rochester Practitioner's Society in New York in 1887, the Portland Women's Medical Society in Oregon in 1891, the Physicians' League of Buffalo in New York in 1892, and the Women's Medical Club of San Francisco in California in 1893. See Kimberly Jensen, "First Portland Women's Medical Society, 1891-92," *Kimberly Jensen's Blog,* July 2, 2010; Cora Bagley Marrett, "Nineteenth Century Associations of Medical Women: The Beginning of a Movement," *Journal of the American Medical Women's Association* Vol. 32, No. 12 (December 1977), 469-74; Cora Bagley Marrett, "On the Evolution of Women's Medical Societies," *Bulletin of the History of Medicine* Vol. 53, No. 3 (Fall 1979), 434-48.

female body. They were assisted by many women outside of the medical profession – especially social reformers and supporters of higher education for women – who envisioned a new sort of healthy American womanhood that focused less on domesticity and motherhood and more on education and public service. Both inside and outside of the medical community, this work began with the rejection of Edward H. Clarke's view of the female body, as exemplified by *Sex in Education*.

To a certain extent, this chapter revisits material that historians of women, gender, medicine, and education have already examined, but it extends the analysis by emphasizing the ways that women themselves influenced nineteenth-century medical debates about menstruation and healthy womanhood. Regina Morantz-Sanchez has argued persuasively that men like Clarke shifted contentious discourse about the nature of womankind "from the spiritual to the somatic," and she notes briefly that women physicians, in conjunction with feminists and reformers, worked to counter Clarke using the modern language of science and medicine.[69] Sue Zschoche echoes these sentiments, suggesting that Clarke's bestselling book became so popular and controversial not because of his conclusions about the dangers of coeducation but because of his premise that the intense late-nineteenth-century debates about "woman's sphere" could be answered definitively by biology.[70] More recently, Lara Freidenfelds has emphasized the

[69] Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985). See also Morantz-Sanchez, *Conduct Unbecoming*, 121-123. See also Adele E. Clarke, "Women's Health: Life-Cycle Issues," *Women, Health, and Medicine in America*, edited by Rima D. Apple (New York: Garland Publishing, 1990), 20-23; Cynthia Eagle Russett, *Sexual Science: The Victorian Construction of Womanhood* (Cambridge: Harvard University Press, 1989), 112-125.

[70] Sue Zschoche, "Dr. Clarke Revisited: Science, True Womanhood, and Female Collegiate Education," *History of Education Quarterly* Vol. 29, No. 4 (Winter 1989), 545-569. For other accounts of the Clarke controversy from the perspective of the history of education, see Rosalind Rosenberg, *Beyond Separate Spheres: Intellectual Roots of Modern Feminism* (New Haven: Yale University Press, 1982), 1-27; Barbara

fact that *Sex in Education* and the controversy surrounding it served as a jumping-off point for the first "extended, published discussion of menstruation in the medical and popular press," a discourse that took place in the context of ongoing debates about education and the "new woman."[71] In addition, Carla Bittel has delved into the career of one particular woman physician, Mary Putnam Jacobi, who worked tirelessly to discredit Clarke, not only because *Sex in Education* threatened women's educational and professional opportunities but also because she found his study lacking in scientific rigor. Bittel demonstrates that Jacobi took the power of modern medical discourse back from Clarke, supporting her own claims scientifically while arguing that his were tainted by his prejudices.[72]

My own research corroborates much of this existing scholarship. Working from the perspective of the history of gynecology (and, to a lesser extent, the history of obstetrics), though, my goal is to suggest that *Sex in Education* mattered in an even larger sense and, especially, that women's central role in discrediting it made them the key players in the late-nineteenth-century medical construction of the female body.

Miller Solomon, *In the Company of Educated Women: A History of Women and Higher Education in America* (New Haven: Yale University Press, 1985), 57-58. For another take connecting Clarke to American ideas about the relationship between science and culture, see David G. Schuster, *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1869-1920* (New Brunswick: Rutgers University Press, 2011), 115-117. Arleen Tuchman offers a slightly different perspective on one aspect of Clarke's work, noting that Clarke supported the physician Marie E. Zakrzewska and worked with the female doctors at the New England Hospital for Women and Children even as he argued against women's fitness for medical study and practice. She suggests that Clarke may have viewed Zakrzewska as an "exception to her sex" or that his ideas about women doctors may have changed gradually over time. See Arleen Marcia Tuchman, *Science Has No Sex: The Life of Marie Zakrzewska, M.D.* (Chapel Hill: The University of North Carolina Press, 2006), 173-175.

[71] Lara Freidenfelds, *The Modern Period: Menstruation in Twentieth-Century America* (Baltimore: Johns Hopkins University Press, 2009), 74-76. See also Joan Jacobs Brumberg, "'Something Happens to Girls': Menarche and the Emergence of the Modern American Hygienic Imperative," *Journal of the History of Sexuality* 4 (1993), 100-102.

[72] Carla Bittel, *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth-Century America* (Chapel Hill: The University of North Carolina Press, 2009), 124-125.

Importantly, I do not wish to exaggerate Clarke's personal importance or influence, as he was never a leading figure among gynecologists. Nevertheless, his view of the female body became a representative construction of womanhood that mobilized both supporters and detractors, launching a debate about healthy American femininity that was much bigger than *Sex in Education.* The controversy surrounding Clarke's perspective became a symbolic battleground, a contentious intellectual space where medical professionals and lay people fought to determine who would define the fundamental nature of American womanhood and who, therefore, would shape the development of the branches of medicine that specialized in female bodies. I argue that a specific group of women – largely physicians and feminists, working together – won that battle and that, as a result, their specific collective view of healthy femininity came to be recognized as correct and normal.[73] As I noted in the introduction, modern American gynecology originated in the 1850s, when it was conceived and practiced mostly by men. By the 1870s, however, women physicians and female reformers were working together to shape the specialty. Their work determined the path that gynecology would take, and their definition of healthy femininity left a lasting legacy.

[73] A note on terms: the words "feminism" and "feminist" can be historically confusing and difficult to define precisely. For the purposes of this dissertation, I have used Nancy F. Cott's thoughtful definition and applied the word "feminist" to people who opposed sex hierarchy; understood that women's condition was, at least to some extent, socially constructed; and had a "group consciousness" wherein they understood themselves to members of a significant social group. See Nancy F. Cott, *The Grounding of Modern Feminism* (New Haven: Yale University Press, 1997), 3-5. Following this definition, I have avoided applying the term "feminist" to people who worked on behalf of women's condition but who did not meet one or more of Cott's criteria.

Edward H. Clarke and Late-Nineteenth-Century Social Anxieties

Sex in Education embodied many of the social anxieties endemic to the United States in the 1870s. First and most obviously, it appeared at a historical moment characterized by changing ideologies about American womanhood. As the educated, community-minded "new woman" of the Gilded Age and Progressive Era replaced the pious, pure, submissive, and domestic "true woman" of the mid-nineteenth century, Americans pondered the meanings of masculinity and femininity and the value of separate spheres for men and women.[74] Higher education for women quickly became one of the most visible manifestations of this change.[75] Eleven thousand American women attended colleges and seminaries in 1870, and this number increased dramatically over the next three decades; by 1900, there were 85,000.[76] Some female college students attended single-sex colleges, including Vassar, which opened just eight years before

[74] On the "new woman," a contentious ideal just beginning to take hold when Clarke published *Sex in Education*, see Ruth Birgitta Anderson Bordin, *Alice Freeman Palmer: The Evolution of a New Woman* (Ann Arbor: University of Michigan Press, 1993); Helen Lefkowitz Horowitz, "'Nous Autres': Reading, Passion, and the Creation of M. Carey Thomas," *Journal of American History* 79 (June 1992), 68-95; Martha H. Patterson, *Beyond the Gibson Girl: Reimagining the American New Woman, 1895-1915* (Urbana: University of Illinois Press, 2005); Sheila M. Rothman, *Woman's Proper Place: A History of Changing Ideals and Practices, 1870 to the Present* (New York: Basic Books, 1980), especially chapters 1-3; Nancy Woloch, "The Rise of the New Woman, 1860-1920," *Women and the American Experience: A Concise History* (New York: McGraw Hill, 2002), 180-211. On the "true woman" ideal, see Nancy Cott, *The Bonds of Womanhood: 'Woman's Sphere' in New England, 1780-1835* (New Haven: Yale University Press, 1977); Kathryn Kish Sklar, *Catherine Beecher: A Study in American Domesticity* (New Haven: Yale University Press, 1973); Barbara Welter, "The Cult of True Womanhood, 1820-1860," *American Quarterly* Vol. 18, No. 5 (Summer 1966), 151-174; Woloch, "Promoting Woman's Sphere, 1800-1860," *Women and the American Experience: A Concise History* (New York: McGraw Hill, 2002), 71-108.

[75] The experience of higher education as representative of the "new woman" figure has been examined in depth by a number of historians. See, for example, Lynn D. Gordon, *Gender and Higher Education in the Progressive Era* (New Haven: Yale University Press, 1990); Helen Lefkowitz Horowitz, *Alma Mater: Design and Experience in the Women's Colleges from their Nineteenth-Century Beginnings to the 1930s* (Amherst: University of Massachusetts Press, 1984); Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991), 4-5; Solomon, *Educated Women*.

[76] Nancy Woloch, *Early American Women: A Documentary History, 1600-1900* (New York: McGraw-Hill, 2002), 312.

Clarke first published *Sex in Education*.[77] Many other young women, especially in the west, attended co-educational colleges; by the time *Sex in Education* debuted, the public universities of Iowa, Wisconsin, Kansas, Indiana, Minnesota, Missouri, Michigan, and California all admitted women as well as men.[78] Though these female college students represented an elite minority of American women, they became a dramatic symbol of potential change, visibly transgressing the boundaries of the true woman's domestic sphere by pursuing college degrees.[79]

For those Americans who found this shift alarming, *Sex in Education* proffered evidence that higher education for women was a terrible idea, at least in its current form. Higher education as practiced in the United States, Clarke contended, made women deathly ill. American girls and women compared unfavorably to their European counterparts: Clarke reported that whenever he traveled abroad, he was "always surprised by the red blood that fills and colors the faces of ladies and peasant girls, reminding one of the canvas of Rubens and Murillo." Upon returning to the United States, he was "always equally surprised . . . by crowds of pale, bloodless female faces, that suggest consumption, scrofula, anemia, and neuralgia."[80] Unsurprisingly, Clarke singled out "our New-England girls and women" as the very sickest; New England, after all, was home to

[77] By 1888, Smith, Wellesley, Bryn Mawr, and Mount Holyoke were also available to women seeking a college education in a single-sex environment.

[78] Woloch, *Early American Women*, 312. A few private colleges and universities also went coeducational during the mid- and late-nineteenth century, including Oberlin, Antioch, Swarthmore, Boston University, Stanford, and the University of Chicago.

[79] Nancy Woloch offers some illuminating statistics: in 1870, of all college-age Americans, male and female, only one percent attended college, and even by 1900, the number was only four percent. Woloch, *Early American Women*, 313.

[80] Clarke, *Sex in Education*, 21-22.

many of the first seminaries and colleges for women.[81] The young women of Boston were, in Clarke's view, suffering particularly dangerous symptoms as a result of the emphasis placed on education there. *Sex in Education* offered an illustrative anecdote: "'I never saw before so many pretty girls together,' said Lady Amberley to [Clarke], after a visit to the public schools of Boston; and then added, 'They all looked sick.'"[82] Higher education, which in its current form encouraged women to "ignore [their] own organization" and attend to their studies just as their male counterparts did, threatened the health of American women.[83] As moral, spiritual, social, and political arguments against the movement of women outside of the domestic sphere faced an assault from feminists, reformers, and educators, this newer medical argument proved both convenient and significant.[84]

Sex in Education also embodied a second, related anxiety prevalent in late-nineteenth-century America: the growing fear of race suicide. White women were indeed having fewer babies; over the course of the nineteenth century, the birth rate fell to 3.56 children per woman in 1900. Birth rates among African American women also fell, though not until the 1880s, but immigrant women – especially the eastern- and southern-European women who native-born Americans often stigmatized as dirty, unintelligent, and immoral – continued to have larger families.[85] Increasingly, native-born white

[81] Clarke, *Sex in Education*, 31.

[82] Clarke, *Sex in Education*, 21.

[83] Clarke, *Sex in Education*, 18.

[84] Morantz-Sanchez has also noted that during this transitional time, "the social need to muster indisputable justification for keeping women in the home became particularly urgent, and historians have rightly seen a connection between social needs and doctors' medical theories." Morantz-Sanchez, *Sympathy and Science*, 206.

Americans worried that these disparities would compromise their race and lead to the downfall of their society as they knew it. When *Sex in Education* debuted, the rhetoric surrounding race suicide was still in its infancy (it would reach its height in the early-twentieth-century eugenics movement), but nevertheless, the book spoke explicitly to these fears, referring repeatedly to "the hope of the race" and "interest of the race."[86] Many Americans already believed that the new opportunities for higher education would encourage elite white women to delay or forsake marriage and motherhood – as indeed, it seems it often did.[87] Now many also believed that even when those women did decide to reproduce, they might find themselves infertile, or, being so ill themselves, they might produce unhealthy offspring.[88]

Clarke's characterization of women and their bodies was clearly racialized, embodying many of the same basic principles that instigated fears of race suicide. He

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[85] Linda Gordon, *The Moral Property of Women: A History of Birth Control Politics in America* (Chicago: University of Illinois Press, 2007), 86-105; Woloch, *Women and the American Experience* ,182. For more on the beginnings of this trend, see also Susan E. Klepp, *Revolutionary Conceptions: Women, Fertility, and Family Limitation in America, 1760-1820* (Chapel Hill: The University of North Carolina Press, 2009); Jan Lewis and Kenneth A. Lockridge, "'Sally Has Been Sick': Pregnancy and Family Limitation among Virginian Gentry Women, 1780-1830," *Journal of Social History* Vol. 22 (1989), 5-19.

[86] Clarke, *Sex in Education*, 18, 33, 180. On eugenics, see Wendy Klein, *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley: University of California Press, 2001); Alexandra Minna Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (Berkeley: University of California Press, 1995).

[87] See Woloch, "Rise of the New Woman," 184. Woloch notes that the availability of higher education, along with increasing professional opportunities and "supportive relationships with women outside the family," gave middle-class women alternatives to the traditional path of marriage and motherhood, and, increasingly, some of them chose those paths.

[88] Morantz-Sanchez, *Sympathy and Science*, 56. Charles E. Rosenberg has also noted that this rhetoric about the health of the race was linked explicitly to the health of the nation, suggesting that in the late nineteenth and early twentieth centuries, "a preoccupation with the idea of race was characteristic of European and American minds" and that in the United States, a patriotic sense of the nation's greatness was frequently linked to its perceived Anglo-Saxon roots. See Charles E. Rosenberg, *No Other Gods: On Science and American Social Thought*, revised and expanded edition (Baltimore: Johns Hopkins University Press, 1997), 95.

offered, for example, the following anecdote regarding his encounters with "Oriental" women:

> When travelling in the East, some years ago, it was my fortune to be summoned as a physician into a harem. With curious and not unwilling step I obeyed the summons. While examining the patient, nearly a dozen Syrian girls – a grave Turk's wifely crowd, his matrimonial bouquet and armful of connubial bliss – pressed around the divan with eyes and ears intent to see and hear a Western Hakim's medical examination. As I looked upon their well-developed forms, their brown skins, rich with the blood and sun of the East, and their unintelligent, sensuous faces, I thought that if it were possible to marry the Oriental care of woman's organization to the Western liberty and culture of her brain, there would be a new birth and loftier type of womanly grace and force.[89]

Clarke's exoticized description of Eastern women, his emphasis on their physical beauty and sexual value, and his direct equation of intelligence with Westernness reflected widespread nineteenth-century perceptions of race and gender. White, urban, upper- and middle-class men and women appeared in popular and medical literature as sick, fragile, and nervous; these vulnerabilities were the purported consequences of their increasing levels of "civilization."[90] Elite white women, especially, came to be characterized by doctors as persistently ill – hysterical, neurasthenic, nervous, and delicate – and, as Laura Briggs has perceptively demonstrated, medical journals like the *Journal of Obstetrics* repeatedly contrasted the nervous, "overcivilized" white woman with the "savage" woman of color.[91] I revisit this discourse in Chapter V as it pertains to the experience of childbirth and the use of obstetric anesthesia, but for now, I simply want to note that

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[89] Clarke, *Sex in Education*, 29-30.

[90] See Freidenfelds, *Modern Period,* 75-76; Margarete Sandelowski, *Pain, Pleasure, and American Childbirth: From the Twilight Sleep to the Read Method, 1914-1960* (Westport, CT: Greenwood Press, 1984); Schuster, *Neurasthenic Nation*, 1; Carroll Smith-Rosenberg and Charles Rosenberg, "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America," *Journal of American History* 60 (1973), 332-56.

[91] Laura Briggs, "The Race of Hysteria: 'Overcivilization and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology," *American Quarterly* Vol. 52, No. 2 (June 2000), 246-273.

nineteenth-century medical depictions of women were racialized and classed in such a way that intelligence and civilization (constructed as white) went hand and hand with illness and fragility, even as they were also constructed as "normal." This perceived truth left genteel white women especially vulnerable to the hazards *Sex in Education* enumerated and paved the way for alarmist claims about the imminent risk of race suicide.

Edward H. Clarke and Late-Nineteenth-Century Medical Science

Clarke's work therefore spoke to social anxieties about race and gender, but its acceptance among many physicians and scientists rested on the ways that it also exemplified two established ideas about the body upon which nineteenth-century medical professionals relied. First, *Sex in Education* rested upon the popular theory of reflex irritation. According to this principle, since all organs were connected by systems of nerves, disturbances in one organ could produce symptoms in another.[92] For centuries, doctors had attributed all kinds of ailments in women's bodies to vaguely defined imbalances in their reproductive organs. As reflex theory gained acceptance among nineteenth-century physicians, it granted scientific validity to those longstanding notions and provided a rationale for operating on body parts that did not seem problematic in and of themselves.

Over the course of the nineteenth century, the specific focus shifted from the uterus to the ovaries to the Fallopian tubes, but proponents of reflex theory consistently

[92] On reflex theory, see Morantz-Sanchez, *Conduct Unbecoming*, 116-117; Morantz-Sanchez, *Sympathy and Science*, 221; Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: Free Press, 1992), 40-94.

emphasized the connection between the brain and the reproductive system.[93] Thus, in the *American Journal of Obstetrics and Diseases of Women and Children*, Dr. A. T. Hobbs could confidently suggest that ovarian lesions caused insanity, reporting that he frequently found it necessary to remove the reproductive organs of insane women. He attributed this link between diseases of the ovaries and diseases of the brain to the principle of reflex irritation, which he viewed as completely unassailable.[94] In the same journal, Dr. Graily Hewitt asserted that "distortion of the uterus" could induce epileptic seizures, explicitly characterizing these attacks as "the result of reflex irritation."[95] Although some physicians did dispute the idea of reflex irritation, arguing that advancements in pathology would ultimately disprove the theory, Clarke's belief that mental activity and reproductive function were directly connected nevertheless enjoyed considerable scientific support.[96]

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[93] Morantz-Sanchez, *Conduct Unbecoming*, 116. See also Nancy Theriot, "Diagnosing Unnatural Motherhood: Nineteenth-Century Physicians and 'Puerperal Insanity,' *American Studies* Vol. 30, No. 2 (Fall 1989), 69-88; Ann Douglas Wood, "The Fashionable Diseases: Women's Complaints and Their Treatment in Nineteenth-Century America," *The Journal of Interdisciplinary History* IV, No. 1 (summer 1973), 28.

[94] A. T. Hobbs, "The Relation of Ovarian Disease to Insanity, and Its Treatment," *The American Journal of Obstetrics and Diseases of Women and Children* 43, No. 8 (April 1901), 484-491. The eminent gynecologist Horatio Robinson Storer corresponded with other physicians about the relation between gynecological diseases and insanity. See Box 3, Horatio Robinson Storer Papers, Countway Medical Library, Harvard Medical School.

[95] Graily Hewitt, "The Exciting Cause of Attacks of Hysteria and Hystero-Epilepsy," *The American Journal of Obstetrics and Diseases of Women and Children* 14, No. 4 (October 1881), 925-926. For some additional examples, see also W. E. B. Davis, "The Graver Nerve Disturbances Due to Organic Changes in the Genital Organs," *The American Journal of Obstetrics and Diseases of Women and Children* 38, No. 5 (November 1898), 761-762; B. Sherwood Dunn, "The Relation of Diseases of the Female Generative Organs to Nervous and Mental Affections," *The American Journal of Obstetrics and Diseases of Women and Children* 38, No. 5 (November 1898), 760-761.

[96] For an example of an article opposing reflex theory, see Edwin Walker, "Reflex Irritation as a Cause of Disease," *The Journal of the American Medical Association* 24, No. 5 (February 1895), 165-166.

Second, *Sex in Education* depended upon the medical understanding of the human body as a closed system that possessed limited energy.[97] According to this theory, the body could not accomplish multiple physically demanding tasks at the same time, at least not successfully and not without exhausting energy reserves. Thomas Addis Emmet, a New York physician and partner of J. Marion Sims, who became one of the most renowned gynecologists in the United States, frequently emphasized the finite nature of vital energy.[98] He warned that a failure to respect the body's limitations could have dire consequences; for instance, he understood the presence of ovarian disease to indicate that "nature's laws have been put at defiance, and that the nervous system has been overtaxed."[99] By incorporating the arguments made in *Sex in Education* into his medical publications, Emmet became one of Clarke's most influential supporters and ensured that Clarke's theories found a receptive professional audience.

The theories of reflex irritation and limited energy applied, at least hypothetically, to male bodies as well as female ones, but because specialists perceived women's nervous systems as overly sensitive, they found women more susceptible than men to the kinds of dangers delineated by Clarke.[100] Moreover, because many physicians thought puberty was more debilitating for girls than for boys, arguments against higher education during adolescence applied to young women alone. Clarke reminded his readers of the

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[97] See Morantz-Sanchez, *Conduct Unbecoming*, 117.

[98] On Emmet's life and work, especially with regard to his involvement in the development of women's hospitals, see his memoir, Thomas Addis Emmet, *Reminiscences of the Founders of the Women's Hospital Association* (New York: Stuyvesant Press, 1893). See also Deborah Kuhn McGregor, *From Midwives to Medicine: The Birth of American Gynecology* (New Brunswick: Rutgers University Press, 1998), 64, 69, 125-130, 141-143, 169, 171-174, 203-204, 206-208.

[99] Specific examples of this kind of overtaxation included "[t]he young girl who has had her brain developed out of season" and "the woman disappointed or crossed in love." See Thomas Addis Emmet, *The Principles and Practice of Gynaecology*, first edition (Philadelphia: Henry C. Lea, 1879), 752.

[100] Morantz-Sanchez, *Conduct Unbecoming*, 117.

crucial timing of female puberty, noting that the development of the menstrual cycle took place "during the few years of a girl's educational life. No such extraordinary task, calling for such rapid expenditure of force . . . is imposed upon the male physique at the same epoch."[101] Emmet echoed this argument, suggesting that at puberty, the biologically-determined paths for boys and girls diverged. "With the female," he explained, "the transition to womanhood is rapid; her organs of generation become the chief power in the complex organic system. . . . Her nervous system is fully taxed in securing this harmony of action, and in preserving it afterwards."[102] Pubescent women, in other words, faced a draining physiological transformation during which their bodies come to be controlled primarily by their reproductive organs for the purpose of childbearing, and, in fact, this process was seen as the defining change from girl to woman.[103] Young men faced no equivalent crises.

Most of the evidence offered in *Sex in Education* came in the form of case studies, and every single one featured the principles of reflex irritation and limited energy. "Miss B," for example, was an accomplished actress suffering from a "slow suicide of frequent hemorrhages." Clarke diagnosed this bleeding as the consequence of misdirected vital energy: "A gifted and healthy girl, obliged to get her education and earn her bread at the same time, labored upon the two tasks zealously, perhaps over-much, and did this at the epoch when the female organization is busy with the development of its reproductive

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[101] Clarke, *Sex in Education*, 38.

[102] Emmet, *Principles and Practice*, 18-19.

[103] Dr. Alfred Auvard stated this principle starkly in his obstetrics textbook, asserting that "woman's life is divided into three great periods: one, praegenital; another, genital; the third, post-genital. The first extends from birth to the first menstruation; the second, from puberty to the menopause; and the last, from the menopause to the close of life. Only the genital period interests the obstetrician, for it is that portion of a woman's life that is consecrated to procreation." See Alfred Auvard, *A System of Obstetrics*, translated by Curtis M. Beebe (New York: J. B. Flint and Company, 1892), 17.

apparatus."[104] Likewise, "Miss F" was a gifted student, but according to Clarke, the demands of her education induced hysteria, insomnia, headaches, neuralgia, and dysmenorrhoea. He noted disapprovingly that "Miss F" pursued her studies all month long, "just as much during each catamenial week as at other times. . . . There were constant demands of force for the labor of education, and periodical demands of force for the periodical function. The regimen she followed did not permit all these demands to be satisfied, and the failure fell on the nervous system."[105] Clarke offered seven such case studies from his own practice, along with various cited cases from other physicians, and all featured these same key principles.

Discrediting the "Gloomy Little Specter, Edward H. Clarke"

Sex in Education was, therefore, bolstered both by popular concerns about gender and race and by current medical theories about the human body, but, unsurprisingly, its fame and impact alarmed many educated American women. The poet, reformer, and suffragist Julia Ward Howe was one of the first to respond to Clarke in print. Howe was at the height of her influence in the mid-1870s, having moved from the abolitionist movement to the women's suffrage movement, where she edited Lucy Stone's *Woman's Journal*.[106] In 1874, the year after Clarke published *Sex in Education*, she compiled the responses of thirteen prominent American women and published them all together in one

[104] Clarke, *Sex in Education*, 73-75.

[105] Clarke, *Sex in Education*, 101.

[106] On Howe's life and work, see Deborah Pickman Clifford, *Mine Eyes Have Seen the Glory: A Biography of Julia Ward Howe* (Boston: Little, Brown, 1979); Gary Williams, *Hungry Heart: The Literary Emergence of Julia Ward Howe* (Amherst: University of Massachusetts Press, 1999). Also see her memoir, Julia Ward Howe, *Reminiscences, 1819-1899* (New York: Houghton, Mifflin, and Company, 1900).

book, *Sex and Education: A Reply to Dr. E. H. Clarke's 'Sex in Education.'* The collection aimed to refute Clarke's claims, not so much from a rigorous scientific standpoint but from a rhetorical position that highlighted the potential damage the authors believed Clarke's work could inflict upon women. In her introduction, Howe argued perceptively that Clarke's book appeared "to have found a fair chance *at* the girls, rather than a chance *for* them."[107] On behalf of all the authors featured in her collection, Howe challenged social and medical authorities to recognize the underlying causes of female sickness, which had nothing to do with education: "To those most eminent in physics and in sociology, we would say: 'Take the social mixture of to-day, with its antecedents and concomitants. Analyze it fairly and thoroughly; and then tell us if the over-education of women is its most poisonous ingredient."[108] Other pressing issues, Howe insisted, constituted much graver threats to American women than this supposed "over-education" did.

Caroline H. Dall, a prominent reformer and Transcendentalist, contributed to Howe's *Sex and Education*. Like Howe, Dall had been active in the abolitionist movement and then became focused on women's suffrage after the Civil War; her published works, including *Woman's Right to Labor*, *Woman's Rights Under the Law*, and *The College, the Market, and the Court*, carried a pronounced feminist tone.[109]

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[107] Julia Ward Howe, "Introduction," *Sex and Education: A Reply to Dr. E. H. Clarke's "Sex in Education,"* edited by Julia Ward Howe, reprint edition (New York: Arno Press, 1972), 6. The emphases are Howe's.

[108] Howe, "Introduction," 8.

[109] Caroline H. Dall, *Woman's Right to Labor; Or, Low Wages and Hard Work* (Boston: Walker, Wise, and Company, 1860); Caroline H. Dall, *Woman's Rights under the Law* (Boston: Walker, Wise, and Company, 1861); Caroline H. Dall, *The College, the Market, and the Court; Or, Woman's Relation to Education, Labor, and Law*, memorial edition (Concord, NH: The Rumford Press, 1914). See the Caroline Wells Healey Dall Papers, 1811-1917, Massachusetts Historical Society, Boston, MA. On Dall's life and work,

Indignant that *Sex in Education* had reached such a broad audience, Dall lamented: "Every woman who takes up her pen to reject its conclusions knows very well that it will penetrate hundreds of households where her protest cannot follow; and Dr. Clarke must be patient with the number and weight of our remonstrances, since he knows very well that upon the major part of the community our words will fall with no authority. . . . This book will fall into the hands of the young, and that I deplore."[110] Dall, a founder of the American Social Science Association, also attacked Clarke's case-study approach from that perspective, reminding her readers that "his examples have no statistical value; for nothing is told us of their proportion to the whole number of students of the other sex under the same precise conditions, or to the failures in the same number of girls educated tenderly at home."[111] Like Howe, she suggested that for those young women who did truly suffer from the diseases about which Clarke warned them, the causes could be traced to other factors:

> In all books that concern the education of women, one very important fact is continually overlooked. . . . Women, and even young girls at school, take their studies *in addition* to their home-cares. If boys are preparing for college, they do not have to take care of the baby, make the beds, or help to serve the meals. A

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see also Helen R. Deese, *Daughter of Boston: The Extraordinary Diary of a Nineteenth-Century Woman, Caroline Healey Dall* (Boston: Beacon Press, 2006); Tiffany K. Wayne, *Woman Thinking: Feminism and Transcendentalism in Nineteenth-Century America* (Lanham, MD: Lexington Books, 2007). On the connection between the abolitionist movement and the origins of "first wave" feminism, see Ellen Carol Dubois, *Feminism and Suffrage: The Emergence of an Independent Women's Movement in America, 1848-1869* (Ithaca: Cornell University Press, 1978).

[110] Caroline H. Dall, "V.," *Sex and Education: A Reply to Dr. E. H. Clarke's "Sex in Education,"* edited by Julia Ward Howe, reprint edition (New York: Arno Press, 1972), 89.

[111] Dall, "V.," 90. Another contributor to Howe's volume, the feminist author and dress reformer Elizabeth Stuart Phelps, also attacked the case-study basis of Clarke's study, pointing out that for every doctor's case study supporting Clarke's side of the debate, there were women whose experiences contradicted it: "Thousands of women will not believe what [Clarke] tells them, *simply because they know better*. Their own unlearned experience stands to them in refutation of his learned statements. . . . They can pile up for him illustration on illustration. Statistics they have none; but no statistics has he. They and the Doctor are met on fair fight." See Elizabeth Stuart Phelps, "VII," *Sex and Education: A Reply to Dr. E. H. Clarke's "Sex in Education,"* edited by Julia Ward Howe, reprint edition (New York: Arno Press, 1972), 129-130.

> great many girls at the High Schools do all this. Then, if a man who is a student marries, he is carefully protected from all annoyance. His study is sacred, his wife does the marketing. If his baby cries, he sleeps in the spare room. . . . So far women have written in the nursery or the dining-room, often with one foot on the cradle. They must provide for their households, and nurse their sick, before they can follow any artistic or intellectual bent. . . . When it is once fairly acknowledged that women properly have a vocation, they may be protected in it as a man is. At present there is no propriety in making comparisons of results in regard to the two sexes.[112]

Thus, Dall turned Clarke's argument on its head, suggesting from a feminist perspective that education was not the culprit; instead, unfair gendered discrepancies were to blame for much of the ill health that existed in the female population.

Predictably, those associated with women's colleges and coeducational universities reacted strongly against *Sex in Education*. Martha Carey Thomas, who would serve as president of Bryn Mawr College from 1894 to 1922, remembered feeling "haunted," in her early career, "by the clanging chains of that gloomy little specter, Edward H. Clarke."[113] Several university professors and administrators contributed to Howe's 1874 collection, and they rejected Clarke's depictions of female students as pale, weak, and sickly. They maintained, in fact, that college women were "at least as healthy as the men," if not healthier. In a typical testimonial, an Oberlin professor stated that "a breaking down in health does not appear to be more frequent with women than with men. We have not observed a more frequent interruption of study on this account, not do our statistics show a greater draft upon the vital forces in the case of those who have completed the full college course."[114] Representatives from Vassar, Antioch, Michigan,

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[112] Dall, "V.," 94-95.

[113] M. Carey Thomas, "Present Tendencies in Women's College and University Education," *Educational Review* 25 (1908), 58. See also Morantz-Sanchez, *Sympathy and Science*, 55.

[114] "Testimony from Colleges," *Sex and Education: A Reply to Dr. E. H. Clarke's "Sex in Education,"* edited by Julia Ward Howe, reprint edition (New York: Arno Press, 1972), 202.

and Lombard agreed.[115] Because their personal experiences so clearly conflicted with Clarke's contentions, feminists found it particularly unfair that *Sex in Education* threatened to undermine their efforts to expand educational and professional opportunities for women.

The contributors to Howe's *Sex and Education*, it should be noted, did not reject the fundamental idea that young men and young women were inherently different; they did not, furthermore, advance any radical claims to complete equality. Moreover, they did not attack the physiological principles reflex irritation and limited energy upon which Clarke's work rested. Rather, collectively, they made three basic arguments, all suggested by the preceding examples. First, they contended that Clarke's case studies lacked statistical validity. *Sex in Education*, they asserted, was not a work of medical or social-scientific legitimacy but rather a "polemic" penned by a man who thought women were "tending ever more and more towards a monstrous type, sterile and sexless" and that higher education ought to remain a masculine undertaking.[116] Second, they argued that young women were harmed more seriously by social inequalities and persistent double standards than they were by educational or professional endeavors in and of themselves. Aside from the unequal domestic duties Dall pointed out, there were also unequal expectations for male and female appearance and behavior. Howe charged parents to support their daughters in acquiring an education while discouraging other unhealthful habits, including "the unintelligent dominion of Fashion" and "the lavish waste of time, talent, sensibility, and money." "Take courage," she advised them, "and

[115] "Testimony from Colleges," 191-195, 196-199, 199-201, 201-202.

[116] Julia Ward Howe, "I.," *Sex and Education: A Reply to Dr. E. H. Clarke's "Sex in Education,"* edited by Julia Ward Howe, reprint edition (New York: Arno Press, 1972), 14-15.

come to a loftier stand. Educate the future wives with the future husbands."[117] Finally, and perhaps most importantly, the contributors to Howe's volume argued that male physicians could not claim final authority over women's bodies or lives, that women themselves knew better what was healthy for them. In fact, Dall believed that Clarke's work made "the need of educated women physicians . . . painfully apparent" because "no amount of professional skill can avail in place of that sympathetic intuition of causes which should spring from identical physical constitution."[118] Intuitive feminine knowledge and sensitivity, these early American feminists suggested, was just as legitimate as scientific training, if not more so – hence the need for women physicians, who, at least in theory, could embody the best of both worlds and bring their distinctively feminine traits to the practice of medicine.

Rejecting the Pathology of Femininity

When *Sex in Education* appeared in print, professional women physicians had existed in the United States for only about twenty-five years. Elizabeth Blackwell, the first woman to earn an American medical degree, had graduated from Geneva Medical College in 1849; the school admitted her on a one-time basis and then, following the conferral of her degree, officially barred all future women from attending.[119] In the

[117] Howe, "I.," 10-11.

[118] Dall, "V.," 89-90.

[119] See Morantz-Sanchez, *Sympathy and Science*, 47-49. The faculty of Geneva Medical College, apparently, never intended to permit Blackwell to enter; however, they sought support from the students in that decision, and those students, who found the possibility of a female medical student uproariously funny, voted to let her in. The faculty remedied this "mistake" with an official policy after Blackwell's graduation. There is not much recent scholarship on Blackwell's life and work. For older biographical

1850s, the Female Medical College of Pennsylvania and the New England Female Medical College, in Philadelphia and Boston, respectively, began to provide women opportunities to earn medical degrees. Consequently, by 1873, when Clarke published his book, there were several hundred degree-holding female doctors in the United States. They remained a rarity, but with more and more medical colleges opening their doors to women, including prestigious co-educational ones like the University of Michigan, in 1870, many women doctors began to think of themselves not as individual curiosities but as the representative beginnings of a growing movement. And they were correct to do so: in the next three decades, their numbers would continue to swell, reaching seven thousand by the turn of the twentieth century.[120]

As Dall hinted, many pioneering women doctors, including Blackwell, ultimately justified their presence in the medical community by claiming that their uniquely feminine virtues would make them effective healers and benefit the profession as a whole. Blackwell believed in a doctrine of feminine difference that marked women as maternal, caring, and compassionate; she argued that "the purpose of the women's medical movement is for occupying positions which men can not fully occupy and exercising an influence which men can not wield at all."[121] The "lady doctors" she envisioned would practice medicine quite differently than their male counterparts did,

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accounts, see Nancy Ann Sahli, *Elizabeth Blackwell, M.D. (1821-1910): A Biography* (New York: Arno Press, 1982); Dorothy Clarke Wilson, *Lone Woman: The Story of Elizabeth Blackwell, the First Woman Doctor* (Boston: Little, Brown, 1970). For the best analysis of Blackwell's writing, see Regina Morantz-Sanchez, "Feminist Theory and Historical Practice: Rereading Elizabeth Blackwell," *History and Theory* Vol. 31, No. 4 (December 1992), 51-69.

[120] Morantz-Sanchez, *Sympathy and Science*, 49.

[121] Quoted in the prefatory pages, Ruth J. Abram, *Send Us a Lady Physician: Women Doctors in America, 1835-1920* (New York: W. W. Norton and Company, 1985).

bringing a quintessentially feminine morality to the care of the sick.[122] Blackwell's maternalist arguments were similar to those advanced by suffragists and other reformers, who often contended that women would bring their special qualities to the American political sphere.[123] In general, gendered Victorian assumptions about male and female qualities made maternalist arguments quite effective: women would provide much-needed "uplift" to a profession still characterized, in the middle decades of the nineteenth century, by conflict, chaos, and a purportedly "masculine" emphasis on personal rivalries and cutthroat competition.[124] The earliest successes of American women in entering the medical community can therefore be traced back to these kinds of maternalist arguments, which resonated with people inside and outside the profession.

For many medical women, though, as well as for their supporters, the arguments about the female body put forth by Edward H. Clarke constituted a more pressing emergency. If, as Clarke insisted, women's bodies could not physically withstand the sort of higher education and professional work that were required to earn medical degrees and open successful practices, then all of this rhetoric about what feminine practitioners could do for the profession was moot. Biology would trump morality, sociology, and

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[122] See Morantz-Sanchez, *Sympathy and Science*, 184-202; Sahli, *Elizabeth Blackwell*.

[123] Molly Ladd-Taylor has noted that historians have overgeneralized in their use of the term "maternalism," invoking it to describe "practically any woman activist who used the language of motherhood to justify her political activities." She argues that the term should be used in a narrower sense, applied only when women believed in a uniquely feminine compassion, suggested that motherhood was a "service to the state," promoted maternal unity across race and class, and thought men belonged in the public sphere, supporting their wives, who would ideally remain in the domestic sphere. Blackwell, I suggest, definitely fit the first three qualifications. The fourth is more complicated, but since she seemed to believe that most women would have to choose *between* marriage and careers, and since she indicated that most would choose the former, she probably fit that category as well. For the purposes of this project, I refer to Blackwell – and those championing her ideology – as maternalist. See Molly Ladd-Taylor, "Toward Defining Maternalism in U.S. History," *Journal of Women's History* 5, No. 2 (fall 1993), 110.

[124] See Ruth J. Abram, "Introduction," *Send Us a Lady Physician: Women Doctors in America, 1835-1920* (New York: W. W. Norton and Company, 1985), 15.

politics every time. The need to prove that women *could* study and practice medicine, from a physical, bodily standpoint, therefore came, in the 1870s, to take precedence over the secondary need to prove that they *should* be allowed to do so. Just as Dall hoped, women physicians began working immediately to refute the claims about feminine weakness that were popularized by Clarke's *Sex in Education* and repeated in medical journals and gynecology textbooks.

Chief among these was the formidable Dr. Mary Putnam Jacobi. Jacobi, born in 1842 to the publisher George Palmer Putnam and his wife, Victorine, devoted herself to science from an early age. She graduated from the New York College of Pharmacy in 1863; she then earned her medical degree at the Female Medical College of Pennsylvania in 1864 before traveling abroad to earn another M.D. from the Parisian Ecole de Medecine in 1871. In 1873, she returned to the United States, where she successfully combined a thriving medical career with marriage (her husband was the distinguished "father of pediatrics," Abraham Jacobi) and motherhood. She published prolifically, climbed rapidly through the ranks of her chosen field, and was, by the time of her death, almost indisputably "the leading woman physician of the United States."[125] Her first taste of professional respect and fame came in the mid-1870s as a direct consequence of her refutation of Edward H. Clarke's *Sex in Education*.

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[125] "A Woman of Greatness," obituary, Box 1, Folder 2, the Mary Putnam Jacobi Papers, Schlesinger Library, Harvard University. The best and most comprehensive work on Jacobi, by far, is Carla Bittel's recent biographical study. See Bittel, *Mary Putnam Jacobi*. As we will see in Chapter IV, Regina Morantz-Sanchez has provided an illuminating contrast between Jacobi as a woman of science and Elizabeth Blackwell as a sympathetic "lady doctor." See Morantz-Sanchez, *Sympathy and Science*, 184-202. See also Thomas Neville Bonner, *To the Ends of the Earth: Women's Search for Education in Medicine* (Cambridge: Harvard University Press, 1992); Regina Morantz-Sanchez, "The Female Student Has Arrived: The Rise of the Women's Medical Movement," *"Send Us a Lady Physician: Women Doctors in America, 1835-1920,* edited by Ruth J. Abram (New York: W. W. Norton and Company, 1985), 65-66; Tuchman, *Science Has No Sex*, 94-95, 154, 228, 239, 240, 244; Susan Wells, *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine* (Madison: University of Wisconsin Press, 2001), 146-192.

In 1874, Jacobi published "Mental Action and Physical Health" in *The Education of American Girls*, a collection edited by the feminist Anna C. Brackett. Much like Howe's *Sex and Education*, Brackett's volume aimed to challenge Clarke's perceptions about the female body, highlighting the importance of education to the development of healthy American womanhood.[126] Jacobi's piece combined social and scientific arguments. She contended first that men like Clarke consistently manipulated scientific "truths" to support their political or religious convictions. Whatever the current medical wisdom entailed, it always seemed, conveniently, to work to subordinate women: "Formerly, [women] were denied the privileges of an intellectual education, on the ground that their natures were too exclusively animal to require it. To-day, the same education is still withheld, but on the new plea that their animal nature is too imperfectly developed to enable them to avail themselves of it."[127] She then proceeded to dismantle each of Clarke's major medical premises, suggesting that while menstrual disorders and discomforts certainly existed, they did not result from study or lack of rest. Moreover, she suggested that Clarke and other physicians were mistaken about the physiological processes of ovulation and menstruation; she offered new theories on these processes, which suggested that nothing about them made the female body unfit for prolonged education.[128] Significantly, she did not openly disagree that gendered experiences of puberty and adolescence dictated that separate education for boys and girls was

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[126] Two other similar volumes devoted to disputing Edward H. Clarke appeared in 1874. In addition to Howe and Brackett, see Eliza Bisbee Duffey, *No Sex in Education; Or, An Equal Chance for Both Girls and Boys* (Syracuse: J. M. Stoddart and Company, 1874); George F. Comfort and Anna Manning Comfort, *Woman's Education and Woman's Health; Chiefly in Reply to "Sex in Education"* (Syracuse: T. W. Durston and Company,1874).

[127] Mary Putnam Jacobi, "Mental Action and Physical Health," *The Education of American Girls*, edited by Anna C. Brackett (New York: G. P. Putnam's Sons, 1874), 259.

[128] See Bittel, *Mary Putnam Jacobi*, 133.

preferable to integrated coeducation; she simply argued that this separation was only required during puberty itself and that it had nothing to do with any oversensitivity to intellectual stimulation on the part of the female body.[129]

Jacobi developed these arguments even further in her most famous scientific study, *The Question of Rest for Women during Menstruation*, which she prepared in response to Harvard University's 1876 Boylston Prize topical medical essay prompt: "Do women require mental and bodily rest during menstruation; and to what extent?" Her study first attacked Clarke's *Sex in Education* for its reliance on case studies and its exclusion of statistics and experimental data, then sought to prove scientifically that he was wrong. She interviewed 268 women of various backgrounds about their experiences with menstruation, charted their answers, and analyzed the evidence statistically, concluding that "*there is nothing in the nature of menstruation to imply the necessity, or even the desirability, of rest, for women whose nutrition is really normal*."[130] She submitted her work to the Boylston Prize Committee anonymously, in "a masculine handwriting," but too much has likely been made of this fact: as Carla Bittel has pointed out, several members of the Committee would likely have recognized Jacobi's work, as it looked very much like her earlier "Mental Action and Physical Health," which had been circulating among prominent members of the medical community. In any case, the Committee awarded Jacobi the prize – she was the first woman to win it – and *The Question of Rest for Women during Menstruation* was cited by leading gynecologists for decades. For example, in his 1887 textbook, *A System of Gynecology*, Dr. Matthew

[129] Jacobi, "Mental Action," 305-306. See also Bittel, *Mary Putnam Jacobi*, 123-126.

[130] Mary Putnam Jacobi, *The Question of Rest for Women during Menstruation* (New York: G. P. Putnam's Sons, 1877), 227. The emphasis is Jacobi's.

Darbyshire Mann stated that Jacobi's work was "the most rational" examination of menstruation that he had encountered.[131] In 1920, more than forty years after *The Question of Rest* appeared in print, Dr. William Graves deferred to Jacobi's expertise and asserted that her study "constituted a most valuable contribution to the physiology of the pelvic organs." He also noted that her results were almost certainly accurate, as they had been replicated by other scientists.[132]

Indeed, in the decades after Jacobi published her groundbreaking study, other women physicians replicated and expanded on most of her findings, in a variety of contexts. One such physician was the respected gynecologist Charlotte Blake Brown, the cofounder of San Francisco's Pacific Dispensary for Women and Children, who graduated from Jacobi's alma mater, the Female Medical College of Pennsylvania, in 1874, at the height of the controversy surrounding *Sex in Education*.[133] Like Jacobi, Brown demonstrated scientifically that young women could remain healthy as they pursued their educational and professional goals, as long as they attended to their body's requirements for rest, nutrition, and exercise. Brown differed from the contributors to Howe's *Sex and Education* and Brackett's *The Education of American Girls* in one striking way, though: she did not challenge the premise that American schools were populated with sick, hysterical women. Instead, she affirmed "the great number of invalids among women" and specifically conceded that most of her new patients were "schoolgirls." In "The Health of Our Girls," which the *Woman's Medical Journal*

[131] Matthew Darbyshire Mann, *A System of Gynecology, Volume I* (Philadelphia: Lea Brothers, 1887), 437.

[132] William Graves, *Gynecology* (Philadelphia: W. B. Saunders Company, 1920), 120.

[133] Deceased Alumnae File for Charlotte Blake Brown, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine. Brown founded the dispensary with another woman physician, Martha E. Bucknell; it later became part of the Children's Hospital of San Francisco. See also Morantz-Sanchez, *Sympathy and Science*, 93-94.

published in 1896, she described these young women as persistently ill: "languid, easily tired, irritable, with backache, irregular menses, anemic and sallow, capricious appetites, dyspeptic, constipated. Examination of the cases shows, in general, a small uterus with endometritis, more or less profuse catarrh, frequently stricture of the internal os, and sometimes displacements."[134] Originally suspecting that puberty and intellectual work were combining, as Clarke had argued, to create so much sickness, Brown studied hundreds of girls in San Francisco schools. Her results, unlike Clarke's, indicated that the physiological processes of puberty were not to blame for their medical problems, and neither were the rigors of full-time study. Rather, Brown contended that the major causes of illness in teenage girls were insufficient sleep, nutrition, and exercise. Accordingly, she advised female students to go to bed by 9:30, consume healthy meals, and take up some kind of "out-of-door sport," such as bicycling.[135]

Two months later, the *Woman's Medical Journal* published a second article by Brown, which argued that attention to the proper physical and mental development of adolescent girls could eliminate most reproductive ailments. "The Physical Development of Girls" contradicted Clarke's fundamental perspective regarding women's bodies, arguing that female adolescence was not inherently arduous and that female nerves were not overly sensitive. Beginning from the premise of relative equality between men's and women's bodies, Brown identified social, cultural, and environmental causes of female illness:

> If you were to take an eminently practical boy and school him into the superficial, sentimental, emotional, and dependent habits of the average girl with the ordinary

[134] Charlotte B. Brown, "The Health of Our Girls," *The Woman's Medical Journal* 5, No. 7 (July 1896), 180.

[135] Brown, "Health of Our Girls," 181-182.

> attendants of a corset, tight and high-heeled shoes and indoor training and insufficient clothing and let him live on de-oxygenated air with no other hope except to get married and not allow him to purchase even as much as a railway ticket for himself, never have a pocket in his clothes, spend hours daily curling his hair and preparing to spend a frivolous evening, etc., he would develop into a veritable hysterical nonentity.[136]

This assessment of the causes of disease in women closely resembled those suggested by reformers like Julia Ward Howe and Caroline Dall. Though Brown did not dispute Clarke's characterization of women as perpetually sick, she did not hold gendered physical traits responsible. Clarke, it should be noted, had also pointed to the injurious nature of some women's apparel, admitting that sickness in young women could sometimes be traced to "artificial deformities strapped to the spine, or piled on the head" as well as to "corsets and skirts."[137] The key difference between them in terms of clothing was that Brown saw women's shoes and corsets as a chief cause of illness while Clarke understood them only as aggravating factors that taxed women's inherently fragile bodies.

On the issue of women's oppression and dependence, though, Brown's contentions were utterly incompatible with Clarke's arguments. "The Physical Development of Girls" explicitly connected women's limited independence with their hysterical symptoms: women became ill, at least in part, because they were forbidden to live independently and relegated instead to a few years of "frivolous evenings" followed by marriage and motherhood. On this point, Brown, Howe, and Dall all agreed. Brown simply offered a specifically medical perspective to complement previous moral, social, and political arguments. In fact, "The Physical Development of Girls" can be understood

[136] Charlotte B. Brown, "The Physical Development of Girls," *The Woman's Medical Journal* 5, No. 9 (September 1896), 228.

[137] Clarke, *Sex in Education*, 23.

to represent a variation on reflex theory, suggesting that a woman's psychological sense of uselessness – a mental and emotional problem – could produce disease in her reproductive organs.

As a result of this perspective, Brown looked specifically to physicians to solve the problems facing women. Modern specialists, she argued, had the opportunity "to mold the coming woman in such a manner as to make the 'new woman' the finest type of mental, nerve, and physical perfection the world ever saw."[138] By deploying the ideal of the late-nineteenth-century "new woman," Brown accomplished three related tasks. First, she connected the social and political progress of feminists – women like Howe, Dall, and Brackett – with the evolution of medical specialties devoted to the health of women. Like many women gynecologists, Brown maintained that as women moved beyond the domestic sphere, medical approaches to women's bodies also needed to change.[139] Second, she affirmed growing authority of medical professionals in creating the turn-of-the-century "new woman," suggesting that physicians – not, for example, political activists or religious leaders – were ultimately responsible for determining what was in the best interest of women.[140] Finally, she promoted preventive rather than curative medicine. The "new woman," as envisioned by Brown, did not seek medical

[138] Brown, "Physical Development of Girls," 227.

[139] In addition to the extensive literature on the "new woman" in general, for an examination of the connection between feminist reform and medical views of women's bodies, see William Leach, *True Love and Perfect Union: The Feminist Reform of Sex and Society* (New York: Basic Books, 1980), 64-80, 318-322.

[140] The medical historian Paul Starr has analyzed the expansion of medical authority in depth, pointing to the fact that it has rested upon both "legitimacy and dependence" and arguing that "the rise of the medical profession depended on the growth of its authority." Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 9-21, 79-144.

care for sickness; rather, she avoided sickness and reached for "physical perfection" by adhering to the preventive guidelines set forth by enlightened medical specialists.

In highlighting the importance of prevention, Brown reinforced the relationship between female practitioners and preventive care and public health – a connection that existed from the time of the very first women physicians in the United States. Judith Walzer Leavitt has demonstrated that though most American medical colleges failed to emphasize public health, women's medical schools almost always made it a strong component of core curricula.[141] In a close study of preventive medicine at the Female Medical College of Pennsylvania, Bonnie Bluestein argues that throughout the nineteenth century, it was "almost axiomatic" that personal and public hygiene were the provinces of women.[142] Brown felt compelled, in "The Physical Development of Girls," to defend her womanly focus on prevention – amusingly, she even suggested that it might seem counter to the financial interests of a gynecologist to "endeavor to diminish the great source of supply of cases."[143] Nevertheless, her decision to prioritize preventive medicine reflected her commitment to the understanding of female fragility as a consequence of avoidable factors, which could be changed, rather than as an inherent physical state.

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[141] Judith Walzer Leavitt, "Public Health and Preventive Medicine," *The Education of American Physicians: Historical Essays*, edited by Ronald L. Numbers (Berkeley: University of California Press, 1980), 251.

[142] Bonnie Ellen Blustein, *Educating for Health and Prevention: A History of the Department of Community and Preventive Medicine at the (Woman's) Medical College of Pennsylvania* (Canton: Science History Publications, 1993), 115. Other historians have concurred. See Morantz-Sanchez, *Sympathy and Science*, 215-216; Steven J. Peitzman, *A New and Untried Course: Woman's Medical College and Medical College of Pennsylvania, 1850-1998* (New Brunswick: Rutgers University Press, 2000), 81.

[143] Brown, "Physical Development of Girls," 228.

Brown's work reflected a feminist ideology about equal male and female abilities, but she also used traditional Victorian ideas about femininity to support her contentions. In "The Physical Development of Girls," she explained that she was attracted to preventive medicine because of her compassionate impulses. She "so often pitied the honest industrious young man who has married an equally honest but physically undeveloped young girl who at once lapsed into invalidism when the duties of housekeeper, homemaker, wifehood, and motherhood were assumed."[144] The central purpose of this article was to argue that women were physically capable of doing the same intellectual and professional work that men did, and by pointing to external factors – tight corsets, limited independence, a sense of uselessness – Brown allied herself with feminists seeking to reject the doctrine of feminine difference. At the same time, her statement in defense of preventive medicine seemed more sympathetic to the husbands of invalid wives than to the invalid wives themselves; Brown "pitied" the men who were burdened with ill spouses. Furthermore, in explaining why such preventive care was necessary, she invoked the traditional duties of housekeeping and motherhood rather than academic work or professional ambition. Somehow, this rather conservative approach served to defend her contentions about the medical construction of a "new woman." As I explain in Chapter III, the development of medical education for women embodied many of the same contradictions and conflicts.

Working together, even if they disagreed on specific issues, women physicians like Jacobi and Brown and feminist reformers like Howe and Dall succeeded in discrediting Edward H. Clarke's *Sex in Education*. Historians have correctly noted that Clarke's influence was short-lived within the medical community, already dissipating by

[144] Brown, "Physical Development of Girls," 228.

the end of the 1870s and disappearing entirely in the 1880s (though echoes of it continued to appear in popular culture and in the form of "old wives tales" about menstruation).[145] From a social perspective, the fall of Clarke's perspective on femininity can be traced to a variety of factors: growing numbers of healthy, educated women who, simply by their continued existence, countered his arguments; persuasive arguments by educators and reformers like Howe and Dall; and the seemingly unstoppable rise of the "new woman" ideal. From a medical perspective, the fall of Clarke's construction of the female body can be traced directly to the work of women physicians, especially Mary Putnam Jacobi – in essence, medical professionals stopped citing Clarke and started citing her instead.[146] Jacobi's understanding of ovulation and menstruation, developed in opposition to Clarke's, became the widely accepted scientific "truth" in the medical community and remained a key principle of American gynecology well into the twentieth century.[147] All of these factors, both social and scientific, originated with the conscious, thoughtful actions of women themselves – female students, writers, educators, reformers, and physicians.

Though I emphasize, with historical hindsight, that women were responsible for discrediting Edward H. Clarke and rejecting the "pathology of femininity," I do not want to overlook the fact that at the time, medical professionals and average Americans

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[145] See Solomon, *Educated Women,* 57; Zschoche, "Dr. Clarke Revisited," 547-548.

[146] See Bittel, *Mary Putnam Jacobi*, 133.

[147] See, for example, Henry Pickering Bowditch, "The Question of Rest," *The Nation* Vol. 13 (September 1877); John Goodman, "The Cyclical Theory of Menstruation," *American Journal of Obstetrics and Diseases of Women and Children* Vol. 11 (1878), 673-694; George J. Engelmann, "The American Girl of To-Day: The Influence of Modern Education on Functional Development," *Transactions of the American Gynecological Society* 25 (1900), 8-45; Paul F. Munde, "Report on the Progress of Gynecology during the Year 1875," *American Journal of Obstetrics and Gynecology* Vol. 9 (1876), 127-73. Engelmann, it should be noted, disagreed with Jacobi's conclusions about the safety of higher education for women; nevertheless, he adopted her physiological theories about ovulation and menstruation.

frequently neglected to see or comment upon the crucial importance of women in shaping the medical construction of healthy womanhood. Women physicians, especially, did not always receive appropriate credit for their work. As Carla Bittel's biographical study explains, Mary Putnam Jacobi believed – with good reason – that her gender sometimes made it more difficult for her to secure the respect of the medical community. Part of her theory of menstruation, for example, involved the concept of a "nutritional wave" – during each menstrual period, the female body drew on a "reserve of nourishment," which "increased its functional capacity."[148] This way of conceptualizing menstruation highlighted the strength and adaptability, as opposed to the weakness and fragility, of the female body. As physicians turned away from Clarke's theory of menstruation, they adopted Jacobi's instead; most notably, William Stephenson published a paper on "nutritional waves" in 1882. Though Stephenson cited Jacobi properly, the concept came, thereafter, to be called "Stephenson's Wave," and so credit was diverted from Jacobi to a male authority.[149] I suggest, however, that medical historians should take care not to conflate name recognition and professional credit with genuine influence. The fact that Jacobi's theory came to be known by a male doctor's name does not negate the fact that she developed and popularized the idea in the first place. Gynecologists adjusted their views on menstruation – and, by extension, on the relative strength and endurance of

[148] See Bittel, 129-130. Jacobi expanded on this concept later. See Mary Putnam Jacobi, "Studies in Endometritis," *American Journal of Obstetrics and Diseases of Women and Children* Vol. 32 (1895), 36-50.

[149] William Stephenson, "On the Menstrual Wave," *American Journal of Obstetrics and Diseases of Women and Children*, Vol. 15 (1882), 287-294. For a few examples of this credit given to Stephenson, see "Intermenstrual Dysmenorrhea," *Medical News* Vol. 76 (April 1900), 657; A. W. Johnstone, "Clinical Importance of the Menstrual Wave," *The American Gynaecological and Obstetrical Journal* Vol. 12 (1896), 62-71; Malcolm Storer, "On Intermenstrual Dysmenorrhea," *The Boston Medical and Surgical Journal* Vol. CXLII, No. 16 (1900), 397-401. See also Bittel, *Mary Putnam Jacobi*, 133-134.

the female body – because of Jacobi, without whom there would have been no "Stephenson's wave."

By the 1880s, then, women inside and outside the medical profession ensured that gynecologists no longer based their construction of the female body on Clarke's perspective. They overturned his notion that healthy femininity was incompatible with higher education and professional ambition; they drew the medical community's attention to external causes of female suffering, ranging from corsets to sexism; and they shaped a developing medical specialty that was just beginning to understand the processes of ovulation and menstruation. Whether they based their claim to authority on a maternalist belief in women's intuitive knowledge of their own kind (as Caroline Dall did) or on a rigorous training that led them to understand the physiological processes of the female body (as Mary Putnam Jacobi did), they did indeed assert that authority, and their particular view of healthy, normal American womanhood came to be the accepted model inside and outside the medical profession.

Perspective and Priorities: The Consequences of Rejecting Edward H. Clarke

Importantly, though these influential women challenged some specific Victorian constructions of normal American femininity, they left many of the fundamental components of nineteenth-century American gender ideology uncontested. They did not, for example, dispute the idea of a racialized spectrum of civilization upon which upper-class Anglo-Saxon Americans occupied the most privileged place: Julia Ward Howe referred, in her published argument against Clarke, to "the savages of Africa," and Anna

C. Brackett defended education as one of the processes that, over time, moved humans from a "savage" natural state to one of civilization and refinement.[150] Nor did they deny that this privileged place came with its specific physical characteristics and medical risks: Howe referred to "every characteristic of the New England race, thin, nervous, wiry, alert, intense," while Brackett stated that well-bred American girls were "more nervous, more sensitive, [and] more rapidly developed in thinking power."[151] From a medical standpoint, Jacobi saw fit to include in her contribution to Brackett's volume a table delineating the cranial capacities of various races, a piece of scientific racism that she employed to prove that differences between men and women were "more marked in proportion to the civilization of the race."[152] These reformers took issue with Clarke's claims that American women were the sickest in the world and that higher education made them that way, but they did not suggest any revolutionary shift in perceptions of refinement and gentility.

Perhaps most significantly, the women who successfully discredited Clarke in the 1870s did not explicitly contradict the doctrine of feminine difference or the supreme importance of fertility and motherhood, at least not at this point.[153] On the contrary, their arguments against *Sex in Education* actually rested on many of the same fundamental principles that Blackwell's maternalist arguments for women's entrance into the medical profession did: gendered distinctions between the sexes that endowed women with

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[150] Howe, "I.," 22; Anna C. Brackett, "Education of American Girls," *The Education of American Girls*, edited by Anna C. Brackett (New York: G. P. Putnam's Sons, 1874), 95-95.

[151] Howe, "I.," 26; Brackett, "Education of American Girls," 14.

[152] Jacobi, "Mental Action and Physical Health," 299.

[153] As we will see in Chapter IV, some of them, including Jacobi, did eventually take this step, arguing that the health and normality of American women ought not to be measured by their reproductivity or maternity.

uniquely feminine traits and the supreme authority on women's needs. Because he was a man, Dall therefore suggested, Clarke could not claim the highest expertise on womankind; his professional credentials could never trump his gender. Howe took this argument even further, characterizing Clarke's book as "an intrusion into the sacred domain of womanly privacy."[154] This stance suggested not only that Clarke could not hold the highest authority on women but also that there was something morally suspect about his attempt to do so.

Moreover, Dall made it clear that the contributors to Howe's volume did not contest many of Clarke's premises but instead questioned his motivations, his methodologies, and, most of all, his conclusions: "I start from the same premises with Dr. Clarke; for I believe the spiritual and intellectual functions of men and women to tend differently to their one end. . . . But I do not believe that any greater difference of capacity, whether physical or psychical, *will be* found between man and woman than *is* found between man and man."[155] Even Jacobi, who, of all the women discussed in this chapter, was probably the least committed to any version of a maternalist ideology, did not, in the 1870s, offer any radical alternative to the maternalist vision of women's unique qualities or distinctive position as mothers – that would come later, as I note in Chapter IV. In "Mental Action and Physical Health" and, more importantly, in her influential *The Question of Rest during Menstruation*, Jacobi simply offered an alternative interpretation of female physiological processes, based on rigorous scientific research, that contradicted Clarke's insistence that women's bodies were debilitated by their menstrual cycles and suggested that higher education and professional ambition

[154] Howe, "Introduction," 7.

[155] Dall, "V.," 87-88.

were not necessarily compatible with healthy femininity. These medical assertions set the stage for her later work.

I suggest that the timing of *Sex in Education* and the explosive debates surrounding it led influential women to postpone a discussion of whether they *should* pursue college degrees or enter fields like medicine and, if so, why and how they should do so, in favor of devoting themselves first to proving simply that they physically *could*. A particular group of women, including feminists committed to women's education and physicians committed to a new understanding of the female body, emerged victorious from this conflict over Clarke's *Sex in Education*. Because they tackled this body-centered issue first, because doing so required them to redefine the physiological nature of the female body, and because gynecology, as a field, developed directly from the prevailing medical construction of that body, these women came to be crucial players in shaping the specialty during the late nineteenth century. Gynecologists (and obstetricians, as well) therefore based their practices on an understanding of healthy American womanhood developed by women themselves – elite white women who rejected Clarke's perspective but shared many of his views about race, class, and civilization.

As we will see in subsequent chapters, once this particular group of women returned to the myriad issues that existed outside the key question of women's physical capabilities – why and how girls should be educated, why and how women should practice medicine, whether the maternalist view of feminine difference should prevail, whether the female reproductive organs were sacred, and whether the height of healthy womanhood was to be found in marriage and motherhood – it became very important that

scientifically-oriented women physicians like Jacobi (and not sentimental, maternalist women physicians like Blackwell) were the key players in constructing the field. Blackwell's answers to these questions looked very different than Jacobi's – a fact that became clear, as we will see in the next chapters, in the late-nineteenth-century debates about medical education for women and about surgical procedures performed on the female reproductive organs. Their distinct voices, along with the voices of many other female physicians and reformers, combined and clashed to produce new discourses about the nature of healthy American womanhood. In the decades following the rejection of Edward H. Clarke, one of the most visible manifestations of this discourse became the conflict over medical education for women.

CHAPTER III

TRAINING "WOMANLY WOMEN": GENDER, CLASS, AND THE DEVELOPMENT OF MEDICAL EDUCATION FOR WOMEN

In the early 1890s, bored with a seemingly unbroken cycle of "home duties, parties, games, and sewing hours," sixteen-year-old Rosalie Slaughter decided that she wanted to study medicine. Her parents were horrified. As members of the elite Virginian aristocracy, they worried that their daughter would willingly "walk alone on the streets at night" and place herself "at the beck and call of rude, uncouth people." Moreover, her father, a lawyer, objected to the idea of women competing with men for wages, insisting that "a gentleman's daughter does not work for money." He implored her to remember her social and familial obligations: "Your field of service is to keep on making us happy, and later to marry a man of your own class. It is essential that society's standards be maintained. . . . Your highest duty is to become a good wife and mother."[156] Although she waited until her father's death to do so, Slaughter ultimately disregarded her parents' objections, left her home in Lynchburg, and entered Mary Putnam Jacobi's alma mater, the Woman's Medical College of Pennsylvania.[157] At WMCP, she found herself

[156] Rosalie Slaughter Morton, *Woman Surgeon: The Life and Work of Rosalie Slaughter Morton* (New York: Frederick A. Stokes Company, 1937), 14-15. For more on Morton, especially her later life, see Regina Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 146-147, 284-285, 287-288, 315; Ellen S. More, "'A Certain Restless Ambition': Women Physicians and World War I," *American Quarterly* Vol. 41, No. 4 (December 1989), 636-660.

[157] This institution changed its name in 1867 from the Female Medical College of Pennsylvania to the Woman's Medical College of Pennsylvania. For an excellent complete institutional history of WMCP, see Steven J. Peitzman, *A New and Untried Course: Woman's Medical College and Medical College of Pennsylvania, 1850-1998* (New Brunswick: Rutgers University Press, 2000). See also Gulielma Fell Alsop, *History of the Woman's Medical College of Pennsylvania* (Philadelphia: J. B. Lippincott Company, 1950).

surrounded by similarly intelligent and adventurous young women, many of whom were also "gentlemen's daughters" who had brazenly defied their parents' expectations and enrolled in one of the only reputable institutions in the United States that offered women full access to medical lectures, scientific laboratories, dissecting rooms, and operating theaters.[158]

In the preceding chapter, I demonstrated that the prominence of the controversy over Clarke's *Sex in Education* led many elite white women, in the 1870s, to prioritize the issue of whether their physical bodies could withstand the rigors of higher education and professional work. As a result, they essentially postponed debates over why and how healthy American women should undertake those goals and how, ultimately, educated and professional women should look and act. Feminists and medical women succeeded in discrediting Clarke and made themselves the key players in the evolving medical construction of the female body – and, by extension, the development of gynecology and obstetrics. Once the primary conflict that united them dissolved, however, their myriad differences rose to the surface once again. At the same time, those who opposed higher education for women, or believed it ought to be limited to specific forms, were forced to abandon the strictly physiological assertions taken directly from gynecologists like Edward H. Clarke and Thomas Addis Emmet in favor of more subjective and multi-faceted arguments about the nature of healthy, normal femininity. In this tumultuous setting, late-nineteenth-century American medical colleges, especially those that

[158] Deceased Alumnae File for Rosalie Slaughter Morton, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine. Slaughter's father died very soon after she announced her plans, and he did not provide for her in his will, as he assumed her future husband would take care of her. This turn of events, she felt, freed her of her obligations to him and allowed her to begin at WMCP during the academic year 1894-1895.

permitted female students to enroll, became highly-scrutinized sites of gender and class conflict.

In the 1870s, women in the United States could attend thirteen regular medical colleges. Of these, four highly-regarded ones were single-sex schools for women: WMCP, the New England Female Medical College, the New York Medical College for Women, and the Women's Medical College of Chicago, which later merged with Northwestern University.[159] Co-educational medical colleges were also available, although only one, at the University of Michigan, was a highly-ranked program.[160] At each of these programs, women encountered intense conflict about why they were studying medicine, what their presence in the medical profession meant, and how they ought to conduct themselves, first as students and then, if they were successful, as physicians. Should women, for example, conform to the sentimental, maternalist model developed by Elizabeth Blackwell, confining themselves to more woman-centered aspects of medicine and practicing their chosen specialties in distinctively feminine ways? If so, which specialties were acceptable, which feminine characteristics should be emphasized, and to what level could women physicians respectably aspire without transgressing the boundaries of suitable female behavior? If not, which alternative paths were possible? Which were appropriate?

This chapter examines the most important debates about medical education for women, demonstrating that as these conflicts unfolded, they altered prevailing gendered and classed definitions of healthy American womanhood. By the late nineteenth century,

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[159] A fifth major woman's medical college, the Woman's Medical College of Baltimore, opened in 1882.

[160] Women earned medical degrees at a number of small, lesser-ranked co-educational programs, generally in western state schools. See Thomas Neville Bonner, *To the Ends of the Earth: Women's Search for Education in Medicine* (Cambridge: Harvard University Press, 1992), 20.

medical schools required some preliminary education, and it cost a significant amount of money to attend.[161] Consequently, most female medical students were "gentlemen's daughters" like Slaughter.[162] Once they committed to the study of medicine, whether they did so in women's schools like WMCP or in co-educational programs like the one at the University of Michigan, they had to make a number of significant decisions about what kinds of medicine to study and how to practice their specialties. They charted paths for themselves in a sea of contentious debates, which were shaped primarily by intersecting and evolving rhetoric about gender, race, and class. As they did so, they defined and redefined the nature of normal femininity and the boundaries of acceptable behavior for women physicians.

Female medical students and women physicians did not all voice identical opinions or act in unison. It is not possible to describe every philosophical position on medical education and healthy womanhood, but I attempt, in this chapter, to portray women's diverging opinions accurately and respectfully. Regardless of these differences, though, my larger point is that although individual medical women disagreed about what constituted normal femininity and about how women physicians should look and act, their presence in the medical community made them all active participants in the

[161] In the late 1880s, for example, the Chicago Woman's Medical College, which later merged with Northwestern University, charged about $100 (about $2400 today) in tuition and fees for one year of coursework – a cost that did not include living expenses. See the Records of the Chicago Woman's Medical College / Northwestern University Woman's Medical School, Box 2, Folder 25, Archives and Special Collections on the History of Women and Homeopathy, Drexel College of Medicine.

[162] Medical historians have noted the fact that most medical students were from privileged families, and female medical students of the time period certainly recognized that fact – especially if they, themselves, did not fit the stereotype. For example, the Oregon physician Esther Pohl Lovejoy, who came from a working-class background and started medical school around the same time as Rosalie Slaughter, noted the middle- and upper-class backgrounds of her classmates. Esther C. P. Lovejoy, "My Medical School, 1890-1894," *Oregon Historical Quarterly,* Vol. 75, No. 1 (March 1974), 27-28. For more on Lovejoy, see Kimberly Jensen, *Oregon's Doctor to the World: Esther Pohl Lovejoy and a Life in Activism* (Seattle: University of Washington Press, 2012.

processes of constructing normal femininity in the context of medical education and medical practice – a process that led ultimately to a new medical understanding of what it meant to be a healthy American woman. As such, it carried tremendous significance for the development of gynecology and obstetrics – medical specialties that aimed to restore or maintain the state of healthy womanhood.

The classic histories of American medical education either neglect women's experiences or omit them entirely. Martin Kaufman's introductory survey of medical education in the United States does not refer to women at all; more comprehensive monographs by Kenneth M. Ludmerer and William G. Rothstein mention them only briefly.[163] Similarly, when Edward Shorter describes the development of scientific medical education, he defines "modern doctors" specifically as "men" who graduated from medical school between 1880 and 1950; he does not incorporate women physicians into his analysis of this period, nor does he ever note that they existed at all, despite the fact that they constituted five percent of American practitioners during that time period.[164] In general, the studies by Thomas Neville Bonner and Steven J. Peitzman, who focus specifically on medical education for women, are much more illuminating. These histories offer useful analyses of gendered opposition to women in medicine; however, they tend to minimize the importance of race and class. Further, because they do not explore the construction or reconstruction of healthy womanhood, they do not directly

[163] Martin Kaufman, "American Medical Education," *The Education of American Physicians: Historical Essays* (Berkeley: University of California Press, 1980); Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985); William G. Rothstein, *American Medical Schools and the Practice of Medicine* (New York: Oxford University Press, 1987).

[164] Edward Shorter, *Bedside Manners: The Troubled History of Doctors and Patients* (New York: Simon and Schuster, 1985), 75.

connect the conflict about medical education for women with the ongoing transformation of gynecology and obstetrics.[165]

The reverse also holds true: historians of gynecology and obstetrics tend to pay little attention to the role of medical education – and women's medical education in particular – in the evolution of medical constructions of the female body. In addition, they deal with gender and, especially, race and class, in somewhat problematic ways. For example, because Deborah Kuhn McGregor's history of gynecology argues that the specialty depended upon "the subordination of women and the objectification of their bodies," she proceeds to draw an artificially sharp gender line between doctors and patients.[166] Physicians, in this kind of scholarship, were male; patients were female. This oversimplification ignores the significant role of women as medical students and professionals. Race and class appear in these monographs almost solely in relationship to patients, so a misleadingly rigid line also separates doctors, characterized simply as white, often with no class identification, and patients, who were treated and sometimes victimized according to their various race and class statuses. I recognize that these generalizations are based, to some extent, on reality; most doctors were, indeed, white and male, and that fact is an important one for the history of gynecology and obstetrics.

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[165] Thomas Neville Bonner, *To the Ends of the Earth: Women's Search for Education in Medicine* (Cambridge: Harvard University Press, 1992); Peitzman, *New and Untried Course*. See also Regina Morantz-Sanchez, "The Female Student Has Arrived: The Rise of the Women's Medical Movement" in *Send Us a Woman Physician: Women Doctors in America, 1835-1920*, edited by Ruth J. Abram (New York: W. W. Norton and Company, 1985), 59-67.

[166] Deborah Kuhn McGregor, *From Midwives to Medicine: The Birth of American Gynecology* (New Brunswick: Rutgers University Press, 1998), 3. See also See Judith Walzer Leavitt, *Brought to Bed: A History of Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986); Deborah Kuhn McGregor, *Sexual Surgery and the Origins of Gynecology: J. Marion Sims, His Hospital, and His Patients* (New York: Garland Press, 1989); Judith M. Roy, "Surgical Gynecology," *Women, Health, and Medicine in America*, edited by Rima Apple (New York: Garland Publishing, 1990); Diana Scully, "From Natural to Surgical Event," *The American Way of Birth*, edited by Pamela S. Eakins (Philadelphia: Temple University Press, 1986).

Nevertheless, I suggest that gender, race, and class rhetoric also mattered when it was applied to the lives and bodies of female medical students and women physicians. I also contend that, as I demonstrated in Chapter II, a particular group of women did claim tremendous influence on these specialties, despite their minority status. These feminists and physicians took on the active, conscious work of defining American femininity and shaping the medical specialties that addressed it.

Rosalie Slaughter's experiences as a student and physician underscore my central point that the conflict over medical education for women and the transformation of gynecology and obstetrics were intimately connected, just as the conflict over Clarke's *Sex in Education* and the evolution of gynecology and obstetrics were. This connection stemmed, in part, from the fact that many female medical students ultimately became gynecologists and obstetricians. Even more importantly, though, it resulted from the new scientific understanding of healthy womanhood that female medical students created, debated, and refined. As Slaughter negotiated intense controversies about women's medical education during her own training, she arrived at strongly-held convictions about women's brains and women's bodies. After she graduated from WMCP in 1897, she quickly became a successful surgical gynecologist, applying her own understanding of healthy womanhood to the bodies of her patients. In addition, she became a dedicated professor of gynecology and surgery and, as a consequence, directly influenced the thinking of subsequent generations of gynecologists.[167] Her responses to the conflict about medical education for women, therefore, continued to resonate long after she completed her training. And she was not alone; she was representative of the role played

[167] Deceased Alumae File for Rosalie Slaughter Morton.

by female medical students and women physicians in the late nineteenth and early twentieth centuries.

Gender, Class, and Opposition to Women in Medicine

By the time Slaughter began her coursework in 1894, most medical professionals had stopped asserting that higher education and professional ambition would harm women's bodies and endanger their fertility. Unlike her pioneering mid-nineteenth-century predecessors, Slaughter would probably not have been warned that her decision to study medicine would result in uterine prolapse, chronic ovaritis, menstrual disorders, hysteria, or sterility. That view, which had been promoted so enthusiastically by men like Clarke and Emmet, had already been discredited by feminists, reformers, and physicians like Mary Putnam Jacobi and Charlotte Blake Brown. Slaughter was certainly aware that women of her race and class were expected to appear delicate – as a teenager, she bemoaned the fact that all of her photographs made her appear "like a fragile gardenia" – but she characterized that expectation as a social standard, not an objective biological reality.[168] She was confident that she was physically and intellectually capable of academic and medical training, and she did not worry about the impact of her studies on her reproductive organs.

Nevertheless, Slaughter did face considerable opposition to the idea of a woman physician, and she would have been acutely aware that many Americans found her desire to study medicine unacceptable. The earliest pioneering women students and physicians had faced the undisguised disgust and contempt of their male counterparts, many of

[168] Morton, *Woman Surgeon*, 14.

whom alternately ignored, insulted, or attacked them. At WMCP, for example, students referred often to the so-called "jeering episode" of 1869, which had, by the time Slaughter attended, become an important, almost legendary, incident in the school's history.[169] In September of that year, Pennsylvania Hospital had made the controversial decision to permit WMCP's students to attend its clinical lectures. When the first thirty of these female medical students arrived at the hospital on November 6, they met hundreds of male students who greeted them, according to the *Philadelphia Bulletin*, with "yells, hisses, 'caterwauling,' mock applause" and "offensive remarks upon personal appearance."[170] Later, when the WMCP students left the hospital, some of the male students went so far as to throw rocks at them. Elizabeth Keller, who became one of WMCP's most distinguished early graduates, recalled that: "We entered in a body amidst jeers and groanings, whistling and stamping of feet, by the men students, who had determined to make it so unpleasant for us that, from choice, we would not care to attend another. On leaving the hospital we were actually stoned by those so-called gentlemen."[171] Anna E. Broomall, who also went on to graduate from WMCP and become one of its most famous and successful alumnae, recalled that the male students treated the WMCP students as freakish spectacles, referring to them as "the She-Doctors."[172] The women of WMCP reacted to the "jeering episode," both in 1869 and in

[169] WMCP student scrapbooks and diaries mention the incident frequently. See for example, the Eliza Wood Armitage scrapbook, the Sarah A. Hibbard Papers, and the Deceased Alumnae File for Anna E. Broomall, all at the Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[170] This quote appears in Peitzman, *New and Untried Course*, 34.

[171] This quote also appears in Peitzman, *Untried Course*, 35.

[172] See the Deceased Alumnae File for Anna E. Broomall. The Archives and Special Collections on Women in Medicine and Homeopathy at Drexel University has also devoted some of its blog to chronicling

the decades that followed, with a mixture of anger, sadness, resignation, and, perhaps most overwhelmingly, determination. Keller, Broomall, and their colleagues wanted to demonstrate incontrovertibly that the male students were the ones in the wrong; they, not the female medical students, were the ones behaving inappropriately, wrongly, abnormally.

The "jeering episode" was not an isolated occurrence. Similar incidents occurred at other medical schools, serving as evidence of the vitriol directed toward women who chose to study medicine. At the University of Michigan, for example, where the anxiety about women in medicine was exacerbated by the co-educational setting, male students blew cigar smoke into the faces of their female classmates.[173] The reaction of these male medical students suggests the level of contempt that the earliest female medical students encountered. Men did not simply object to women entering medical school in an intellectual, rational way; their reactions were visceral and emotional, and they felt angry and offended enough to lash out against the women themselves.[174] By the time Slaughter appeared at WMCP almost thirty years after these early episodes, some of this outrage had certainly dissipated. Nevertheless, she noted that at the time of her matriculation, "it was still the general opinion that women should lead the 'sheltered life,'" protected from

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the evidence for the "jeering episode." See "Go Tomorrow the the Hospital to See the She-Doctors!," *The Legacy Center Archives and Special Collections Blog*, February 23, 2012.

[173] Cora Hawkins, *Buggies, Blizzards, and Babies* (Ames: The Iowa State University Press, 1971), 155. See also Gloria Moldow, *Women Doctors in Gilded-Age Washington: Race, Gender, and Professionalization* (Urbana: University of Illinois Press, 1987), 39.

[174] There were, of course, exceptions – some men advocated for women in the medical profession. As early as the 1870s and 1880s, some of these men were even prominent physicians, such as William Osler and Howard Kelly. In 1872, Dr. Henry Hartshorne gave a speech at WMCP, apologizing to female students "for some of my brethren of the medical profession of Philadelphia. . . . I believe that there is no body of men whose *animus* is more lofty, or whose code is more disinterested and honorable. But they are not infallible in judgment." There were doubtless also many men who simply did not care much one way or the other.

the difficulties and potential horrors of medical work.[175] A generation of successful female medical students had not reversed that philosophy. For many Americans, the words "woman" and "physician" remained incompatible.

Indeed, opposition to the idea of women as physicians did not disappear when Clarke's assessments of the female body faded from popular literature and medical discourse. Part of the reason for this fact, of course, was that, as I explained in Chapter II, the arguments in *Sex in Education* were never the only reasons for opposing women in colleges or women in medicine; rather, they simply became a convenient physiological justification for social and political values. Disproving Clarke did not, therefore, eliminate hostility to the idea of women doctors. Among male physicians, some of this opposition boiled down to the simple desire to eliminate new sources of professional and financial competition.[176] They may have been especially worried that female patients, subject to the same nineteenth-century rhetoric about modesty, vulnerability, and femininity, would prefer female physicians over male ones. Even more problematic, though, was the opposition that rested on ideas about which characteristics constituted normal, healthy femininity and which roles were therefore appropriate for respectable, virtuous American women. These debates would continue well into the twentieth century.

As late as the 1910s, in fact, student publications at WMCP suggested that these questions about the appropriateness of women in medicine were far from resolved. In May of 1910, for instance, WMCP's *Esculapian* printed one student's analysis of the debate regarding the suitability of women to medical study and practice. The author first

[175] Morton, *Woman Surgeon*, 20.

[176] See Morantz-Sanchez, *Sympathy and Science*, 119.

suggested that most women who decided to pursue a career in medicine did so for the simplest, most obvious reason: it appealed to them as individuals, making them happier than quiet lives of traditional marriage and motherhood did. It was not necessarily conceived as a large political choice but, rather, as a simple, individual act of self-fulfillment. Unfortunately, she continued, "the reason given by women for their choice of medicine as a profession, 'I like it,' is met by the assertion that they ought not to like it, or that at least they ought not to be allowed to have what they like."[177] These notions, that either healthy women should not enjoy practicing medicine, or, at least, that they should not be permitted to do what they enjoyed doing, were not inconsistent with some of the earliest opposition to women doctors in the United States.[178] Nevertheless, they did represent a new focus. With Clarke discredited, the parameters of the primary debate about women in medicine had changed. Opponents could no longer argue that women's bodies could not withstand the rigors of medical school and professional practice; now, they could only contend that healthy, normal women should refrain from choosing such a path.

As a result, gendered and classed rhetoric about the nature of normal femininity and healthy womanhood dominated the evolving discourse about whether women should study and practice medicine. The idea of normality was powerful, and Americans associated it with goodness, decency, and civilization. Abnormality carried a negative connotation. Within the American medical community, specifically, normality was

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[177] . E. B., "Women and Medicine," *The Esculapian* 1, No. 3 (May 1910), 5, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[178] The difficulties faced by pioneering medical women have been discussed extensively by historians. See, for example, Bonner, *Ends of the Earth*; Morantz-Sanchez, "The Female Medical Student," 59-67; Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 28-89; Mary Roth Walsh, *Doctors Wanted: No Women Need Apply: Sexual Barriers in the Medical Profession, 1835-1975* (New Haven: Yale University Medical Press, 1977).

becoming a powerful measure of relative sickness or wellness. As medical education and medical care became more standardized, for example, measures of normal height, weight, body temperature, blood pressure, sleep patterns, and sexual behavior became important indicators of a patient's general health.[179] Scholars have noted that although scientific and medical experts who studied norms claimed that they were simply explaining statistical truths, not making moral, social, or political judgments, their norms often carried messages to the public about which qualities and behaviors were right and good – and which, by implication, were wrong and bad.[180] Therefore, when medical professionals argued that normal women did not or should not study medicine, the implied subtext was that women who did so were abnormal. Female medical students were following an immoral, destructive, dangerous, or otherwise negative path, and their actions stood in stark contrast to the behaviors of their more civilized female counterparts, who remained in the domestic sphere.

These contentions only gained potency when combined with the related late-nineteenth-century medical discourse about general health and wellness. Even more obviously than normality, health carried a clearly positive meaning; its opposites, after all, were illness and disease. Historians have perceptively argued that some nineteenth-century American women – especially white, upper- and middle-class women, the

[179] On the thermometer and normal temperature in the late nineteenth century, see Margarete Sandelowski, *Devices and Desires: Gender, Technology, and American Nursing* (Chapel Hill: North Carolina University Press, 2000), 73-78. On blood pressure, see Sandelowski, *Devices and Desires*, 78.

[180] See, for example, Gail Bederman, *Manliness and Civilization: A Cultural History of Gender and Race in the United States, 1880-1917* (Chicago: University of Chicago Press, 1995); Julian B. Carter, *The Heart of Whiteness: Normal Sexuality and Race in America, 1880-1940* (Durham: Duke University Press, 2007), 4-5; John D'Emilio and Estelle B. Freedman, *Intimate Matters: A History of Sexuality in America* (New York: Harper and Row, 1988); Sarah E. Igo, *The Averaged American: Surveys, Citizens, and the Making of a Mass Public* (Cambridge: Harvard University Press, 2007), 11-12.

women about whom Catharine Beecher and other educators and reformers were so concerned – considered certain kinds of diseases fashionable and purposefully tried to appear ill.[181] This seems to have been true, though it remains virtually impossible to pin down just how pervasive that particular trend was. I suggest, however, that even at its height in the middle decades of the nineteenth century, this tendency never completely negated the positive implications of health and wellness; indeed, an important aspect of genteel women's sickness was the quest to restore health, whether through medicine, surgery, or the rest cure – the Victorian attempt to cure nervous conditions like hysteria and neurasthenia with complete physical and intellectual rest, which was developed and popularized by the notable Philadelphia physician Silas Weir Mitchell and later discredited by Mary Putnam Jacobi.[182] In any case, the allure of illness and weakness was definitely disappearing by the turn of the century, when the new woman's rosy cheeks and robust energy began to replace paleness and frailty as attractive physical traits for white, middle-class women. Virtually every woman, by this time, wanted to be both normal and healthy.

For genteel white women, a particular constellation of characteristics typically qualified as normal and healthy. The article in the *Esculapian* correctly noted that opponents of medical education for women frequently suggested that "such study tends to

[181] See, for example, Ann Douglas Wood, "The 'Fashionable' Diseases: Women's Complaints and Their Treatment in Nineteenth-Century America," *The Journal of Interdisciplinary History* 4, No. 1, 25-52.

[182] For Mitchell's discussion of hysteria, neurasthenia, and the rest cure, see S. Weir Mitchell, *Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria*, first edition (Philadelphia: J. B. Lippincott Company, 1877). For more on Mitchell's life and work, see Nancy Cervetti, *S. Weir Mitchell, 1829-1914* (University Park, PA: Pennsylvania State University Press, 2012). On Jacobi's rejection of the rest cure, see Bittel, *Mary Putnam Jacobi*, 135-138.

injure the finer qualities of womanhood."[183] Even in 1910, this reference to "finer qualities" would have evoked the early- and mid-nineteenth-century middle-class model of femininity that historians have termed "the cult of true womanhood." Within the cult of true womanhood, ideal women embodied four fundamental ideals: purity, piety, submissiveness, and domesticity.[184] Though the ideology began to fade in the late nineteenth century, displaced, at least to some extent, by the idea of the more independent "new woman," its conceptualization of appropriate feminine qualities continued to resonate into the twentieth century. Many Americans, both male and female, continued to believe that normal, healthy women belonged in the domestic sphere, where their innocence and moral virtue would permit them to make the American home a peaceful haven from the corrupt and competitive business world, which was perceived as a masculine realm.

All work outside the home therefore violated the cult of true womanhood, but many Americans perceived medical careers as especially problematic. As Regina Morantz-Sanchez has suggested, women doctors transgressed the limits of appropriate feminine behavior much more dramatically than, for example, female teachers did.[185] Bertha Van Hoosen, one of the most respected female surgeons in the United States, recalled in her autobiography that her mother was so upset by her decision to study medicine that her father tried to persuade her to become a teacher instead: "'Your mother cries whenever your studying medicine is mentioned, and I cannot furnish money for you

[183] M. E. B., "Women and Medicine," 5.

[184] Barbara Welter, "The Cult of True Womanhood: 1820-1860," *American Quarterly* 18, No. 5 (Summer 1966), 151-174.

[185] Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 50.

to do something that hurts her so much. Why not teach school, or better still, come home and stay with us.'"[186] Van Hoosen's middle-class parents' reactions to her career decision – they went so far as to refuse to pay for her schooling – clearly indicate that medical school and medical practice were much more disturbing than alternative career choices.

Medical careers were especially troubling for a number of reasons related to students' positions as privileged, white "gentlemen's daughters." Lectures and textbooks acquainted women with the most intimate aspects of human anatomy and physiology, and female medical students learned about sex and reproduction in clinical detail, removed from any romantic or sentimental context. According to opponents of women's medical education, that level of knowledge eroded middle-class feminine purity and innocence. Even more alarmingly, medical training – and, later, medical practice – exposed women to naked bodies in both cadaver and patient form. This exposure supposedly destroyed feminine purity even in a single-sex environment, but it was particularly transgressive in co-educational settings.

When Rosalie Slaughter attended a medical lecture in Germany, she was the only woman present, and the instructor brought out "a naked syphilitic man" for the students to examine. Even Slaughter, who vociferously rejected most gender- and class-based rhetoric against women in the medical profession, felt humiliated in this situation. The professor "seared [her] sense of propriety," and in her memoir, she recalled painfully that "that awful hour realized my father's worst fears for a lady, his daughter, studying medicine."[187] Although she had certainly seen unclothed bodies during her training at

[186] Bertha Van Hoosen, *Petticoat Surgeon* (Chicago: Pellegrini and Cudahy, 1937), 52.

WMCP, these circumstances, in which she viewed male reproductive organs in the presence of male medical students, offended her sensibilities. She recognized that her sense of shame and impropriety was exactly what her parents had feared. They wanted her to retain her "finer qualities," and those qualities often seemed incompatible with medical training. Even when no exposed bodies were present, female medical students sometimes felt similarly offended by "pornographic" discussions of male bodies, especially when lecturers seemed to be deliberately bawdy in their presence. Dorothy Reed Mendenhall remembered feeling horrified and humiliated when a doctor speaking on diseases of the nose and throat told a series of dirty jokes comparing the tissue of the nasal passages with that of the penis. Fifty years after the fact, she wrote that the memory of that event was "branded in [her] mind," surfacing repeatedly "like a decomposing body from the bottom of a pool that is disturbed."[188]

All of the concern about protecting women's "finer qualities" was unquestionably related to the fact that the women who were entering colleges, universities, and medical schools during the late nineteenth and early twentieth centuries were mostly white "gentlemen's daughters" like Slaughter. As the principles of eugenics began to gain traction in the medical community, many doctors and academics became even more firmly convinced that these were the very women who should stay home, marry early, and become mothers.[189] As I noted in Chapter II, higher education therefore seemed

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[187] Morton, *Woman Surgeon*, 62-63.

[188] The Dorothy Reed Mendenhall Papers, Box 1, Folder 12, page 20, Sophia Smith Collection, Smith College.

[189] On eugenics, see Wendy Klein, *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley: University of California Press, 2001); Alexandra Minna Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (Berkeley: University of California Press, 1995). Note that Americans were not using the word "eugenics" in in the 1870s and 1880s,

dangerous because it encouraged these very women to delay or even forsake marriage and motherhood. In an effort to counter that threat, medical professionals fell back on traditional descriptions of normal femininity, rhetoric that had always carried both explicit and implicit references to race and class. Elite white women, despite their supposed tendencies to fragility and nervousness, appeared in medical texts as the embodiment of healthy American womanhood, especially when contrasted with women of color, who were depicted as comparatively uncivilized.[190] Consequently, even though women like Slaughter would not have worried about the physical health of their reproductive organs, they would nevertheless have continued to read that women of their race and class were delicate, sensitive, and emotional, that their natural strengths were domestic, moral, and spiritual, and that, just as their parents often insisted, they belonged at home, fulfilling their traditional duties as wives and mothers.[191] In short, no matter what their bodies could physically withstand, normal, healthy women ought to remain within some version of the nineteenth-century cult of true womanhood.

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but, as Charles E. Rosenberg has explained, "by the end of the 1880s the eugenics movement had come into being in all but name." See Charles E. Rosenberg, *No Other Gods: On Science and American Social Thought*, revised and expanded edition (Baltimore: Johns Hopkins University Press, 1997), 47.

[190] See Laura Briggs, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late-Nineteenth-Century Obstetrics and Gynecology," *American Quarterly* 52, No. 2 (June 2000), 246-273. Briggs demonstrates that the *Journal of Obstetrics* repeatedly contrasted two female characters: the nervous, fragile, "overcivilized" white woman, and the savage woman of color. See also Carter, *Heart of Whiteness*, 42-47; Morantz-Sanchez, *Sympathy and Science,* 223.

[191] For example, see J. Riddle Goffe, "The Physical, Mental, and Social Hygiene of the Growing Girl," *The American Journal of Obstetrics and Diseases of Women and Children* LXIV, No. 2 (August 1911), 210. Goffe's tone throughout the article is primarily scientific, but he also discusses "the beauty, the joy, the responsibilities, and the sacredness of motherhood." On the medical discussion of appropriate roles for women, see, for example, Carroll Smith-Rosenberg, "Bourgeois Discourse and the Progressive Era: An Introduction," *Disorderly Conduct: Visions of Gender in Victorian America* (New York: Alfred A. Knopf, 1985), 178; Carroll Smith-Rosenberg and Charles Rosenberg, "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America," *No Other Gods: On Science and American Social Thought* (Baltimore: Johns Hopkins University Press, 1976), 70.

Ironically, African American women, who appeared in medical and popular literature as the stronger, more robust, less innocent counterparts to white women, still faced almost insurmountable opposition to their entry in medical schools. While opponents of women's medical education claimed white "gentlemen's daughters" were too delicate, sensitive, and refined to practice medicine, and while they maintained that African American women did not normally exhibit the same "finer qualities," they certainly did not extend that logic to conclude that normal African American women should pursue careers in medicine – or in anything else. On the contrary, they tended to characterize African American women as immoral and unintelligent, and most medical schools admitted very few women of color, if they admitted any at all. Rebecca Lee, the first regular African American woman physician, graduated from Boston's New England Female Medical College in 1864, and Rebecca J. Cole, the second, graduated from WMCP in 1867.[192] By 1890, there were 115 African American women physicians practicing in the United States, but the number actually dropped in the following decades: by 1920, there were only 65.[193]

Most of these African American women physicians graduated from medical schools founded to train African American physicians, sometimes alone and sometimes alongside their white counterparts.[194] For example, Howard University, in Washington,

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[192] Black Women Physicians Project, Box 178, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine; Deceased Alumnae File for Rebecca Cole, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine. See also Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995* (Cambridge: Harvard University Press, 1999), 4-5.

[193] Black Women Physicians Project, Box 178, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[194] More, *Restoring the Balance*, 5; Moldow, *Gilded-Age Washington*, 175. For a history of Meharry Medical College, albeit it one that pays very little attention to female students, see James Summerville,

D.C., had opened its medical department in 1868 and aimed to provide a medical education "without regard to race or sex." By 1900, more than one hundred women had enrolled in the program, and 30 of them were African American.[195] Some of these African American women graduated and went on to respectable jobs – Dr. Julia Hall, for example, came back to Howard as an instructor of gynecology – but ultimately, most African American women found it nearly impossible to earn their degrees and support themselves by practicing medicine.[196] As a consequence of racism, African American women clearly faced greater difficulty earning medical degrees, but the overall message of many physicians and academics was that, black or white, women should stay out of the medical profession.[197] Medicine was a masculine realm; normal, healthy women aspired to marriage and motherhood instead.

For women who wanted to study medicine, the disapproval of their families often mattered just as much as – if not more than – the disapproval of distant doctors and academics. Almost all of the women who chose to enter medical school risked embarrassing, disappointing, alienating, or enraging their families. Rosalie Slaughter faced the stern disapproval of her parents, who raised her to remain safely ensconced in the home, occupied only by her duties first as a daughter and then as a wife and mother.[198] Her parents' concerns were not intellectual or academic; they were personal

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Educating Black Doctors: A History of Meharry Medical College (Alabama: The University of Alabama Press, 1983).

[195] See Moldow, *Gilded-Age Washington*, 37.

[196] See Moldow, *Gilded-Age Washington*, 41. Importantly, Hall was never granted the title of "professor."

[197] Moldow notes that "increasing prejudice that drew the color line at Howard drew the line against women doctors as well." See Moldow, *Gilded-Age Washington*, 47. See also Walsh, *Doctors Wanted*, 242-245.

and emotional. Slaughter later recalled that faced with his daughter's desire to study medicine, her father actually cried and, furthermore, attempted to sway her with his personal reaction: "'I would feel that all my efforts as a lawyer, banker, citizen and father were defeated if my daughter prepared herself to go to work. It is unthinkable that you should do so!'"[199] His opposition, then, was deeply emotional and very personal; he objected, in principle, to women working as physicians, but he also internalized his daughter's potential rebellion as an embarrassing breach of social standards and a potential reflection of parental failure.

Similarly, Bethenia Owens-Adair, who entered the University of Michigan in 1878 and later became the first practicing woman physician in Oregon, anticipated some opposition from her friends and family but was nonetheless astonished by the emotional intensity of their reactions: "My family felt that they were disgraced, and even my own child was influenced and encouraged to think that I was doing him an irreparable injury by my course. People sneered and laughed derisively. Most of my friends seemed to consider it their Christian duty to advise against, and endeavor to prevent me taking this 'fatal step.'"[200] In many ways, Owens-Adair came from a background quite different from Slaughter's. She was born in Missouri, in 1840, to parents who "crossed the plains with the first emigrant wagons of 1843." In Oregon, she lived what she described as a "frontier life. . . . Hard, strenuous, often dangerous, but full of free, fresh out-of-door enjoyment."[201] She married an abusive man at fourteen years of age, had a son, and then,

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[198] Morton, *Woman Surgeon*, 1-15.

[199] Morton, *Woman Surgeon*, 15.

[200] B. A. Owens-Adair, *Dr. Owens-Adair: Some of Her Life Experiences* (Portland, OR: Mann and Beach, 1906), 80.

almost unthinkably, divorced. At age eighteen, she started over, educated herself alongside her child, and eventually pursued a career in medicine. Despite these major differences in their early lives, Owens-Adair and Slaughter faced overlapping rhetoric. Just as Slaughter's southern aristocratic family saw itself as an elite example of genteel civility, Owens-Adair's frontier family perceived itself as quintessentially American, the embodiment of "the noblest qualities of the race – courage, resolution, patience, industry, honesty, hope, patriotism, chivalry, cheerfulness, helpful kindness and hearty good will."[202] Neither family supported the idea of one of its daughters becoming a doctor; both believed that such a decision transgressed important values for American women and the American family. Therefore, like Slaughter, Owens-Adair experienced opposition from her family and friends that was both emotionally charged and heavy with moral judgment.

The language that Slaughter and Owens-Adair attributed to their families reveals the significance of both gender and class. Slaughter's parents emphasized their desire for their daughter to meet "society's standards" and marry someone "of [her] own class," and they did not want her to earn wages, go out at night, or interact with "rude, uncouth" members of the lower classes. All her father's "efforts as a lawyer, banker, citizen, and father" were threatened.[203] Owens-Adair's relatives were not simply worried or disappointed; rather, they felt "disgraced."[204] They were further convinced that her decision would taint the reputation of her offspring, perpetuating that disgrace through

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[201] Owens-Adair, *Dr. Owens-Adair*, 5, 41.

[202] Owens-Adair, *Dr. Owens-Adair*, 41.

[203] Morton, *Woman Surgeon*, 3.

[204] Owens-Adair, *Dr. Owens-Adair*, 80.

future generations. In both cases, family objections revolved around perceived standards for both gender and class: both elite southern women and middle-class frontier women who went to medical school transgressed society's rules for femininity and status. They worked for wages outside the home; they learned and spoke about anatomy, sexuality, and reproduction; they encountered bodily fluids, unclothed patients, and dead bodies; and they interacted with the working class and the destitute.

Indeed, even those women who were fortunate enough to secure the enthusiastic support of friends and relatives were acutely aware that they were transgressing generally-accepted boundaries of normal, appropriate feminine behavior. Mary Ryerson Butin, who graduated from the Women's Medical College of Chicago in 1881, was fortunate to have her mother's help and encouragement from her earliest days: "My mother, practical and sensible, was often called to help the neighbors in times of illness and realized the usefulness of a trained and educated woman and early in my life taught me to say when I grew up I was going to be a doctor."[205] Later, when she was in medical school, her mother visited, and Butin "took her to all the classes, clinics, and dissecting rooms. Instead of being shocked and sympathetic, she was enthusiastic over my opportunities and said she would like nothing better than to have had my chance."[206] Despite this unflagging support, Butin realized that she was breaking significant social rules: "When I made my decision known, my schoolmates were aghast. . . . To study and practice medicine was to them a matter of amazement."[207] This experience underscored

[205] Mary Ryerson Butin, *Life Story*, manuscript dated 1930, Elizabeth Bass Collection on Women in Medicine, Rudolph Matas Library of the Health Sciences, Tulane University, 5. Butin began her medical studies at the coeducational Medical Department of Iowa City, then transferred to the Women's Medical College of Chicago.

[206] Butin, *Life Story*, 6.

her sense that she was doing something abnormal. Like other women who chose to leave their families and train for medical careers, Butin did so at a cost. Once she matriculated, it seemed almost impossible for her to conform to the qualities that characterized the normal American woman. If she could not embody those supposedly normal, healthy characteristics, people would judge her as abnormal and unhealthy. For Butin, as for every female medical student, the decision to enroll in a medical college therefore indicated a rejection of at least some aspects of the standard nineteenth-century white middle-class view of healthy femininity.

What Should Women's Medical Education Look Like?

Conflict about women studying medicine did not end when women like Slaughter, Owens-Adair, and Butin matriculated. Once they began their training, they continued to face contradictory ideas about what kinds of medical education and medical practice were most appropriate for them. These debates appeared in medical classrooms, student publications, and, perhaps most visibly, medical journals. In 1902, for example, the *Journal of the American Medical Association* printed an anonymous editorial that argued against equal training for both sexes, suggesting that women would benefit from a modified curriculum structured primarily around gynecology, obstetrics, and pediatrics. Men and women, the author stated, were inherently different and endowed with different sets of innate strengths and weaknesses. Women were "more emotional, more formally unreasoning, more unmechanical, physically weaker, yet stronger in sympathy" than men were. Normal, healthy women – or, as he repeatedly called them, "womanly women" –

[207] Butin, *Life Story,* 5.

ought, therefore, to restrict their areas of specialization and avoid performing major surgery. After all, the author concluded, "the whole question of woman's place in medicine" hinged upon the fact that "when a critical case demands independent action and fearless judgment, man's success depends on his virile courage, which the normal woman has not nor is expected to have."[208] The editorial thus explicitly contended that "womanly women" could not excel in the masculine world of surgery and implicitly suggested that any women who did somehow manage to succeed in that world were not normal – they were not truly feminine.

Immediately after *JAMA* published the anonymous editorial on medical education, it also printed the opposing argument, in the form of an angry letter written by a Chicago doctor named Rosalie M. Ladova.[209] Ladova called for equal, high-quality training for men and women. "What we want," she explained, "is a high standard of preliminary as well as professional training. More surgery, more medicine, more pathology, more bacteriology, etc., more of everything that makes a good doctor." Qualified women who chose to pursue medical degrees were, in Ladova's view, entitled to excellent training in every major field of specialization. They deserved to be evaluated solely on their merits, not relegated to limited or inferior programs on the basis of "misguided" notions about appropriate feminine behavior. "We claim the rights of the individual," she asserted. "There are strong and able – yet normal – women."[210] Ladova believed that many

[208] "Medical Education for Women," *The Journal of the American Medical Association* 38 (May 1902), 1307.

[209] Ladova is probably best remembered for her commitment to dress reform – in 1913, in fact, she was arrested "because she refused to wear a skirt with her bathing suit while swimming at Jackson Park Beach." See "Arrest Skirtless Bather: Chicago Woman Refused to Wear Garment While Swimming," *New York Times*, July 27, 1913.

women physicians could accomplish anything their male counterparts could. They could do challenging laboratory work, treat unclothed patients, dissect dead bodies, and perform invasive surgeries. Even more significantly, she suggested that these abilities did not imply corresponding moral or social deficiencies. Women who could do all of this work were not "unsexed," and they were not abnormal.

This basic conflict about whether men and women should receive identical medical training intersected with an overlapping debate about the benefits and hazards of coeducation. Medical coeducation remained controversial even after Edward H. Clarke's arguments against men and women receiving their educations side by side disappeared from popular and professional literature. This conflict continued, in large part, because both medical professionals and the general public disapproved of situations like the one Rosalie Slaughter experienced while examining the syphilitic male patient in Germany. In particular, the idea that women physicians might learn to examine male bodies and treat male patients – which seemed more likely in a co-educational program than in a single-sex one – offended and alarmed many Americans. It remained taboo to discuss anatomy, physiology, and sexuality with men and women together, and many students and practitioners felt uncomfortable with the idea of men and women examining unclothed bodies (male or female) in mixed-sex groups.

The University of Michigan became the first highly-regarded medical program to admit women in 1870, and the decision was a divisive one. The Detroit *Free Press* complained about the university's decision, contending that coeducation "would tend to

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[210] Rosalie M. Ladova, "Medical Education for Women," *The Journal of the American Medical Association* 39 (June 1902), 1454. For a similar argument, made twelve years earlier, see "Public Demands and the Medical Education of Women," Box 2, Folder 19, Medicine Collection, Sophia Smith Collection, Smith College. According to this piece, "The contest is now no longer for the right of women to practice medicine, but for their right to be properly trained to practice it."

unwoman the woman and unman the man," and most of the medical faculty echoed this popular opinion.[211] Emma Call, one of the program's first female graduates, recalled that "only one of the medical faculty was even moderately in favor of the admission of women."[212] For at least ten years, the President of the University of Michigan, James Angell, referred to the switch to coeducation as an "experiment."[213] The controversy at the University of Michigan was partly based on the same questions about women in medicine that were appearing everywhere, but the tone and vocabulary of the argument certainly suggested that the co-educational nature of the program was also under intense scrutiny.

Practically speaking, there was often little difference, for women, between a single-sex program and a co-educational one. For example, because of faculty resistance at the University of Michigan, which was supposedly a co-educational program, most classes continued to be taught separately; women took classes only with other women. Alternatively, some classes were taught "together," but with women hidden behind a central curtain or dividing wall.[214] Even the opponents of equal medical education recognized that the differences between single-sex programs and co-educational programs were often negligible. The anonymous author of the *JAMA* editorial remarked that "whether in schools solely for women or in coeducational programs, women are at present being taught practical branches of medicine to which they are ill-adapted, and that at the expense of time and energies which might, if better employed, be made to make

[211] Bonner, *Ends of the Earth*, 140.

[212] *Women's Voices: Early Years at the University of Michigan*, edited by Doris E. Attaway and Marjorie Rabe Barritt, Bentley Historical Library, University of Michigan.

[213] Bonner, *Ends of the Earth*, 141.

[214] Bonner, *Ends of the Earth*, 141-142.

women more useful both to themselves and to humanity."[215] The editorial did not devote any space to worrying excessively over the mixing of sexes in the classroom, laboratory, or surgical ward because, in practice, such mixing did not typically occur. Programs might begin to admit men and women, but they would continue to educate the two groups separately, often with male students receiving more attention and better access to the school's resources than female students did.

Gradually, over the last few decades of the nineteenth century, opposition to coeducation evaporated. After the University of Michigan opened its doors to women, its enrollments grew, and by the 1880s, twenty percent of its students were female. In 1881, the program ended its umbrella policy of educating men and women in separate lectures, allowing individual professors to decide whether to repeat their lectures once for men and once for women, separate men and women with a wall or curtain, or simply lecture once to a combined group.[216] Over time, more and more classes were taught together, and by the turn of the century, virtually all of them were.[217] In 1893, the highly-anticipated modern medical school at Johns Hopkins University opened its doors to men and women, and shortly thereafter, medical coeducation officially eclipsed single sex education in the United States: overall, by 1894, 878 female medical students attended coeducational programs, and only 541 attended women's medical colleges.[218]

A number of factors contributed to this shift. First and most importantly, single-sex institutions acquired a reputation for offering less rigorous training, both in terms of

[215] "Medical Education for Women," 1307.

[216] Bonner, *Ends of the Earth*, 141.

[217] Bonner, *Ends of the Earth*, 141-142.

[218] Bonner, *Ends of the Earth*, 138-149; Walsh, *Doctors Wanted*, 240.

the hard sciences and in terms of practical preparation. Medical historians have demonstrated that during the Gilded Age and Progressive Era, medical education in the United States changed dramatically. By the 1880s and 1890s, reputable programs almost universally found it necessary to lengthen their programs, increase their requirements for both entrance and graduation, incorporate more training in laboratory sciences, and provide extensive practical experience.[219] Some of the women's medical colleges certainly did implement these changes. For example, as Steven J. Peitzman has shown, during the 1880s and 1890s, WMCP adopted a mandatory four-year program, increased its clinical training, and prioritized laboratory work.[220] During the same decades, the Chicago Woman's Medical College took similar steps, raising its standards for admittance and graduation and advertising its extensive laboratory and practical training.[221] Other single-sex programs, however, failed to evolve – in 1889, for example, the Woman's Medical College of Atlanta, Georgia was still granting medical degrees after only five months of study and dispensing with dissection entirely – and in the medical community, the consequent stigma began to taint the reputation of single-sex medical instruction in general.[222] The belief in the importance of strong, scientific medical training began, at least in medical circles, to supersede the taboo against mixed-sex groups discussing intimate bodily matters.

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[219] On these shifts in medical education, see Bonner, *Ends of the Earth*, 150-151; Lester S. King, *American Medicine Comes of Age, 1840-1920* (New York: Basic Books, 1985), 83-87; Ludmerer, *Learning to Heal,* 47-101; Peitzman, *Untried Course*, 73; William G. Rothstein, *American Medical Schools and the Practice of Medicine: A History* (New York: Oxford University Press, 1987), 90-116.

[220] Peitzman, *New and Untried Course*, 73-77.

[221] See the Records of the Chicago Woman's Medical College / Northwestern U. Woman's Medical School, 1870-1924, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[222] Bonner, *Ends of the Earth*, 146.

Additional factors contributed to this shift away from single-sex medical education as well. The growing prestige and influence of individual co-educational institutions like Michigan and Johns Hopkins, for example, led many physicians and educators of both sexes to view coeducation as the modern standard. Johns Hopkins, especially, acquired a reputation as the ideal modern medical program, combining state-of-the-art scientific education with increased practical training and residencies.[223] Significantly, too, many of the medical men at Johns Hopkins were some of the strongest male supporters of the women's medical movement; for example, William Osler wrote that "if any woman feels that the medical profession is her vocation, no obstacles should be placed in the way of her obtaining the best possible education, and every facility should be offered, so that, as a practitioner, she should have a fair start in the race."[224] Dorothy Reed Mendenhall, who graduated from Johns Hopkins Medical School in 1900, described Osler as "an unfailing guide" during a frightening time when she felt the strain of being one of a small minority of female students.[225] Finally, the personal preferences of individual American women, who began to attend co-educational institutions in greater numbers, probably played a crucial part in cementing the success of coeducation.

Regardless, for those who believed, as the anonymous author of the 1902 *JAMA* editorial did, that women should follow modified curricula and restrict their specializations, coeducation may have seemed especially alarming because it seemed to

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[223] See Starr, *Transformation of American Medicine*, 113-116.

[224] "On the Opening of the Johns Hopkins Medical School to Women," Medicine Collection, Box 7, Folder 68, Sophia Smith Collection, Smith College. Osler also noted that he had observed completely co-educational programs, co-educational "in the fullest sense of the term," that functioned beautifully in Switzerland.

[225] See typewritten manuscript of the Mendenhall memoirs, Dorothy Reed Mendenhall Papers, Box 1, Folder 12, page 10, Sophia Smith Collection, Smith College.

imply truly equal training for men and women, even if this did not turn out to be true in practice. Indeed, women in favor of equal training, as Rosalie Ladova was, often heralded coeducation as a major step forward for medical women. In 1870, when news of the University of Michigan's decision to admit women to its medical program spread, Eliza Mosher recalled that the women in the laboratory of the New England Hospital for Women and Children "joined hands and danced about the laboratory table."[226] This reaction certainly indicates that some medical women greeted the movement toward co-educational training with a sense of joy and promise. They may even have perceived it as the final, ultimate rejection of Clarke's construction of the female body. Not only could women's bodies withstand the rigors of medical education, but they could do so alongside their male colleagues, in exactly the same programs, with exactly the same expectations.

The issue was not clear-cut, however. Many female medical students and women physicians believed that women actually received better and more thorough training in women's colleges, where they would not have to compete with male students for resources and where they could more frequently learn from female professors and clinicians – these arguments were similar to those made by proponents of single-sex women's colleges. Mary Ryerson Butin argued that "there are some advantages to be had in attending a mixed school of medicine, but in my case I do not see where it could have been a benefit or helped me in private practice. There are facilities to be had and freedom of action in a medical school for women alone which in a mixed school one cannot have or feel free to accept."[227] Among women, the debate about whether single-

[226] Eliza Mosher Papers, Bentley Historical Library, University of Michigan.

sex institutions continued to be necessary in order to offer female medical students sufficient attention and opportunity would continue for decades. The faculty and administration at WMCP believed strongly in the benefits of single-sex instruction and worked to keep the school from going co-educational. In 1915, dean Clara Marshall explained their perspective: "we have no quarrel with co-education or with co-educational schools. On the contrary. . . . But since in the very nature of things women medical students will always constitute a small minority of the whole student body, it is not to be expected that in a co-educational school their particular needs will be fully considered." As proof, she noted that when Cornell University opened its doors, the Woman's Medical College of the New York Infirmary for Women and Children closed, but "in Cornell University Medical School, after fifteen years (with the exception of an appointment to a minor post in 1914) not a single medical woman holds a position on the teaching staff."[228] Staunch advocates of "women's only" medical education would continue to make the same arguments, insisting on the advantages of programs for women only and managing to keep the school a single-sex institution until 1969.

How Should Female Medical Students and Women Physicians Look and Act?

Regardless of the particular setting, though, the individualistic approach to medical education and healthy womanhood exemplified by women like Rosalie Ladova represented a departure from the typical strategies employed by pioneering female

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[227] Butin, *Life Story*, 6.

[228] Clara Marshall, "Our Point of View," WMCP Speeches, Box 1, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

medical students. As medical historians have noted, many early female medical students and women physicians felt compelled to reassure their male colleagues and their potential patients that they had retained their femininity – or, as the article in the *Esculapian* put it, their "finer qualities."[229] Women who wanted to highlight their femininity – and, I argue, their class status as well – frequently spoke softly, dressed fashionably, and adhered to many of the traditional guidelines for normal feminine behavior. They attempted to quietly demonstrate that despite their commitment to medicine, they were "womanly women," that they had no desire to radically alter the Victorian understanding of gender. This approach was especially pronounced in the nineteenth century but continued into the twentieth. In 1909, for example, the WMCP student handbook explicitly advised incoming students to "be womanly first and a medical student afterwards."[230] This advice, coming straight from the medical college itself, prioritized proper gender performance above excellent scholastic and professional performance.

Evidence suggests that female medical students thought quite a bit about the possible tensions between medical study and their public personas as "gentlemen's daughters." Women physicians often remembered and emphasized, even decades later, the ways that their most illustrious professors and supervisors combined medical practice with genteel femininity, with varying degrees of success. In 1925, for example, Dr. Kate Campbell Hurd Mead, who had graduated from WMCP in 1888 and gone on to become a physician and medical historian, recalled two very distinct images of the gynecology professor Hannah T. Croasdale. First, Mead remembered her as "a stylish figure in a

[229] See Morantz-Sanchez, *Sympathy and Science*, 52; Peitzman, *New and Untried Course*, 26-27.

[230] "Student Handbook, 1909," WMC/MCP Medical Students Records, Box 3, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

fashionable gown of silk and velvet and lace, a long gold watch chain hanging from her neck, many diamond rings on her delicate fingers, and the air of a somewhat bored society lady at a mothers' meeting." Second, though, she went on to describe Croasdale "in the old operating theatre, covered with a white apron, ringless, standing by the table where everything was steaming with carbolic lotions, ready for a laparotomy."[231] Mead's tone, in both descriptions, is one of respect and admiration, suggesting that although she recognized the potential conflict between these two images of womanhood, she also supported the idea that they could both be successfully embodied by the same person.

The combination of medical study with conventional femininity was perhaps most effectively embodied by Emeline Horton Cleveland, one of WMCP's earliest and most successful graduates. Cleveland was born in 1829 to a wealthy Connecticut family. She graduated from WMCP in 1855, then traveled abroad to study obstetrics and gynecological surgery in Paris; when she returned, she became Chief Resident at the Woman's Hospital of Philadelphia. Despite her professional achievements, though, in her daily life, Cleveland cultivated an appearance in keeping with customary expectations of genteel femininity – an approach Elizabeth Blackwell would certainly have supported. Her students described her as beautiful, graceful, and "womanly," and Rachel Bodley, who became Dean of WMCP, remembered that she was "every where and always a

[231] Kate Campbell Hurd Mead, "Forty Years of Medical Progress Reminiscences and Comparisons," *75th Anniversary Volume of the Woman's Medical College of Pennsylvania*, 1925, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine. Interestingly, another alumus, the eminent gynecologist and cancer researcher Catharine Macfarlane, recalled that Croasdale was so old-fashioned and ladylike that she allowed her dress and mannerisms to interfere with modern standards of asepsis: "Dr. Hannah T. Croasdale, a Quaker lady and 'tres grande dame,' was head of the Department. . . . A tiny lace bordered handkerchief was tucked in an upper pocket of her operating gown. With this, she would occasionally dab her nose, then proceed with the operation." *Dr. Kitty Mac*, unpublished manuscript, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine. For more on Hurd Meade, see the Kate Campell Hurd Mead Papers, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

womanly woman."[232] In an 1868 commencement speech, Cleveland equated the practice of medicine with the ideals of genteel feminine virtue: "The life of a physician is made up of self-sacrifice and unremitting labor. The relief of human suffering is second only to the promotion of human virtue and is an employment worthy of the highest efforts of the most cultivated and refined." She also emphasized the feminine connection with God: "you have found the study of Anatomy 'a hymn in honor of the Creator,' that Physiology has been to you but the revelation of the glories of a majestic temple, that you have learned to regard disease as an exceptional perversion to the divine order. . . . the study of medicine has but strengthened your womanly feeling, your reverence for the Divine."[233] Cleveland went to medical school, practiced medicine, and performed surgery, but she mitigated these purportedly unfeminine actions by exuding other traits emphasized by the cult of true womanhood. In fact, she went one step further, connecting medical study with the true woman's "reverence for the Divine" and thereby casting medicine itself as a feminine pursuit.

In addition, Cleveland was also a devoted wife and mother, roles that served to reinforce her traditional femininity. Indeed, the fact that her husband, Giles Butler Cleveland, was paralyzed in 1857 may have allowed Cleveland to justify her post-graduate accomplishments; after all, she could argue that if her spouse had been able to fulfill his more traditional role as a breadwinner, she might have chosen not to pursue such a prominent career path.[234] This turn of events – marriage during medical school, a

[232] Peitzman, *New and Untried Course*, 26-27; "Papers Read at the Memorial Hour Commemorative of the Late Emeline H. Cleveland, M.D.," March 12, 1897, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[233] Deceased Alumnae File for Emeline Horton Cleveland, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

husband paralyzed soon after her graduation – meant that she always combined her career with motherhood. At Cleveland's 1889 memorial service, Bodley remembered her first glimpse of Cleveland: "She was descending the stair in the Woman's Hospital, where at the time she was Resident Physician, bearing aloft on her shoulder, her baby boy, less than a year old. Unconscious of the presence of a stranger, they were beaming the brightest smiles each upon the other, and the laughing child and happy mother constituted a fair picture to look upon."[235] Cleveland's motherhood marked her, in many ways, as a "true woman." She had managed to achieve a great deal of success in medical study and medical practice while simultaneously marrying a man and having a child. Her pursuit of a medical career had not destroyed her femininity to such an extent that she could not also perform the duties of a wife and mother.

Although this effort to appear traditionally feminine was perhaps the dominant strategy of late-nineteenth- and early-twentieth-century female medical students, some employed the opposite strategy: they abandoned conventional markers of middle-class femininity entirely and behaved in ways that others perceived as masculine. A 1911 article in the *Iatrian*, another student-run publication at WMCP, illuminated the conflict between these two approaches. The article warned incoming students against becoming "hen medics" – a term used, at least at WMCP, to describe women physicians who "affected a mannishness of not only clothes, but behavior as well."[236] Such mannishness,

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[234] Deceased Alumnae File for Emeline Horton Cleveland.

[235] "Papers Read at the Memorial Hour."

[236] The term "hen medic" was in use elsewhere, most notably at the University of Michigan. At UM, however, the term seems to have been a general term, sometimes used with an insulting tone, used to describe all medical women, and it did not indicate a particular type of appearance or behavior. WMCP is the only place for which I've found evidence of the term "hen medic" being used in this particular way, to distinguish between "types" of female medical students.

the author argued, would alienate male colleagues and intimidate potential patients, who would be dismayed to encounter women physicians who could not be "exactly classified as male or female, gentleman or lady." The *Iatrian* therefore went on to repeat the wisdom traditionally passed along to new female medical students: "Don't forget to have and to wear as pretty clothes when you are a Senior as you do now; don't get 'hen-medicky.'"[237] This advice reflected both ideological and practical concerns about the negative ramifications of abandoning the outward markers of femininity. The fact that the student staff of the *Iatrian* felt the need to publish such a piece, however, indicates that some of the medical students at WMCP were moving away from the traditionally feminine "lady doctor" image championed by Elizabeth Blackwell and toward a more modern conceptualization of a woman physician.[238]

Women like Ladova, who did not fit neatly into either the "lady doctor" or the "hen medic" categories, sought not to revise their own gender performances but to redefine normal, healthy womanhood in a way that prioritized individual talents and preferences.[239] Ladova reminded her readers that "the matter of adaptation of women to major surgery is a matter of individuality, just as it is with men. There are men who faint at the sight of blood and there are women who can do major surgery."[240] According to this perspective, there was nothing inherently unfeminine about the ability to perform

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[237] "Personal Appearance of Hen Medics," *The Iatrian* (October 1911), 11, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[238] See Elizabeth Blackwell, "The Influence of Women in the Profession of Medicine," *Essays in Medical Sociology* (London: Ernest Bell, 1902).

[239] On the performativity of gender, see Judith Butler, *Bodies That Matter: On the Discursive Limits of 'Sex'* (New York: Routledge, 1993); Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990).

[240] Ladova, "Medical Education," 1454.

invasive surgery, just as there was nothing inherently unmasculine about the aversion to blood and gore. Rosalie Slaughter agreed. Though she would not have been perceived as a "hen medic," her outspoken demeanor and surgical specialization would likely have disqualified her from the ranks of "womanly women." She claimed to find performing an appendectomy "no more difficult than swabbing a throat," and she saw no reason why healthy, feminine women could not also excel in the dissecting room and operating theater.[241]

This point of view, I want to emphasize, contradicted many of the arguments that had yielded so much success for the earliest nineteenth-century women physicians: namely, those arguments that highlighted the "special contributions" women would supposedly make to the profession by virtue of their distinctively feminine traits. As I noted in Chapter II, beginning with Elizabeth Blackwell, women physicians justified their presence in the medical community by claiming that they would contribute their uniquely feminine kindness, compassion, morality, spirituality, and sensitivity to the medical community. Moreover, women maintained that they also had a special, innate understanding of the needs of women and children.[242] Blackwell's idealized maternalist "lady doctor" was a conventionally feminine woman, likely white and middle-class, who chose to pursue a medical career because of her natural tendencies toward caring, healing, and nurturing.[243] Just as American suffragists would later argue that women would bring moral and spiritual purity to politics and government, early proponents of

[241] Morton, *Woman Surgeon*, 131.

[242] Morantz-Sanchez, *Sympathy and Science*.

[243] Elizabeth Blackwell, *Pioneer Work in Opening the Medical Profession to Women* (London: Longmans, Green, and Company, 1895); Blackwell, "Influence of Women."

women's access to medical colleges suggested that "lady doctors" might serve as guardians of medical morality, lifting the profession out of competition and corruption and into a higher plane. This theory was reinforced by successful early women physicians; it was certainly reflected, for example, in Emeline Horton Cleveland's equation of medical practice with her "reverence for the Divine." Whatever its limitations, the "lady doctor" model had certainly worked to open doors for some women who wanted to pursue a medical education and open medical practices.

As this gendered logic played out in academic and professional circles, though, it resulted in a hugely exaggerated hypothetical division between male and female practitioners, especially in fields like gynecology and obstetrics. During the late nineteenth century, these fields entered their period of dramatically accelerated growth and change, fueled primarily, as I noted in the introduction, by the explosion in surgery. The most notable specialists, who were mostly, but not exclusively, male, earned their fame by performing increasingly radical operations: ovariotomies, oophorectomies, salpingectomies, hysterectomies, caesarean sections, and pubic symphisiotomies. I will discuss the connection between gynecology and surgery in more detail in Chapter IV, but at this point, I simply want to note that good surgeons were, as the editorial in *JAMA* indicated, distinguished not necessarily by their preparation or precision but by their physical strength and "virile courage," characteristics almost universally perceived as masculine. In contrast, in their roles as guardians of medical morality, women physicians were supposed to be sensitive and sympathetic, and many of them interpreted the qualities of sensitivity and compassion in a way that required them to oppose all of these

surgeries being performed on women's reproductive organs.[244] This stance underscored the division between male and female specialists, heightening the association of surgery with masculinity and sympathy with femininity – at exactly the moment when modern, cutting-edge gynecology came to be associated with the expansion of surgery. Consequently, many female medical students who wanted to highlight their genteel femininity chose to specialize in obstetrics, gynecology, or pediatrics, avoided performing surgery, and continued to practice medicine in a way that was perceived as conventionally feminine.[245] As we will see in Chapter IV, these female practitioners began to seem much less cutting-edge.

Obstetrics, Gynecology, and New Definitions of Healthy Womanhood

Perhaps because they wanted to become leaders in their fields, many female medical students felt pressured or trapped by the presumption that they would conform to conventionally feminine models of medical practice. These women tended to follow the "hen medic" path or to follow Ladova's example, arguing for an increased emphasis on individuality in the definition of healthy femininity. The latter group was certainly eager to challenge the prominent nineteenth-century idea that medical knowledge and medical practice would "unsex" women, but, at the same time, they questioned whether purity and delicacy ought to be the chief hallmarks of healthy womanhood in the first place. In

[244] Sarah Stage has presented this division between male and female approaches to surgery as very clear cut, with male surgeons supporting surgical gynecology and female physicians opposing it. This view has since been amended by Regina Morantz-Sanchez, who has pointed out that some women physicians, like Mary Putnam Jacobi, supported gynecological operations. This topic will be addressed in greater depth in Chapter IV. See Sarah Stage, *Female Complaints* (New York: W. W. Norton and Company, 1979), 78-82; Morantz-Sanchez, *Sympathy and Science,* 221-222; Roy, "Surgical Gynecology," 186.

[245] Morantz-Sanchez, *Sympathy and Science*; Peitzman, *New and Untried Course*.

WMCP's *Esculapian*, a student author rejected that assessment: "Does not a perfect development of womanly character rest upon a basis of strength moral, mental and physical, rather than upon the absence of strength? A cultivated judgment, self-possession, courage and energy are intrinsically good qualities whether present in men or women, whether stamped with the approval of men or not."[246] In other words, healthy women were strong and self-possessed, not fragile and weak. This reasoning represented a clear articulation of a new version of healthy American womanhood.

By the early twentieth century, many student writings suggest that when aspiring women physicians looked for mentors, they looked not to genteel "lady doctors" but to brilliant scientists and – perhaps even more remarkably – skilled surgeons. In 1912, for example, Frances Petty Manship, a student at WMCP, published a piece in the *Iatrian* about watching, with her classmates, as Dr. Ella Everitt and Dr. Marion Potter performed a caesarean section. Manships's descriptions are evocative:

> Bestowed modestly in a corner was Dr. Everitt, swathed like a surgeon to be sure – but remote and detached, looking a good deal as if she had never done a day's work. . . . In a nook on the other side loomed up Dr. Potter, also in official raiment. . . . We had the delicious knowledge that when the other people finished monkeying around, these two demure ones would move together in the center of the scene and *do* things. . . . The anesthesiologist began to give ether. . . . And then Dr. Potter draped herself over the table, ready for her famous strangle hold on the uterine arteries. Dr. Everitt picked up the knife – and the rest writes itself in the minds of all who have seen her operate.[247]

Manship and her classmates respected Everitt and Potter for their emotional detachment, their physical strength, and their surgical skill. They had chosen a supposedly feminine area of expertise – obstetrics and gynecology – but, though they retained a "demure"

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[246] M. E. B., "Women and Medicine," 5.

[247] F. P. M., "Our Evening In," *Iatrian* (June 1912), 7-8, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

appearance, they practiced their specialties as men would. Manship did not attach any stigma to that decision; in fact, she and her classmates responded to it positively. They, too, aspired to *do* things.

By the 1900s and 1910s, female medical students in the process of redefining healthy womanhood could look to a number of role models who performed radical surgeries and maintained that their skill in the operating room did not detract from their femininity. Bertha Van Hoosen, an obstetrician, gynecologist, and professor at the University of Illinois, was perhaps the most famous. When the Austrian physician Karl Pelant visited Chicago, he made a point of going to see Van Hoosen perform a risky caesarean section. His recollection of the operation characterizes Van Hoosen as a surgical hero: "Those present hardly dared to breathe; all eyes were fastened upon that wonderful woman, waging a struggle against nature and death. Seven minutes passed in the deep silence of a grave, when all of a sudden the weak cry of a child was heard. The child was saved!" In the nineteenth century, this kind of heroic portrayal of a surgeon would have been reserved exclusively for men.[248]

Pelant's descriptions of Van Hoosen are also remarkable because they merged her considerable surgical skill with a pronounced femininity. For example, he wrote that "Dr. Van Hoosen operates as if she were embroidering, with great precision. . . . and again you watch that elegant, I might say, womanly, manipulation of the knife."[249] Other female medical students and women physicians made similar statements about surgery

[248] Bertha Van Hoosen Papers, Bentley Historical Library, University of Michigan. See also Bertha Van Hoosen, *Petticoat Surgeon* (Chicago: Pelligrini and Cudahy, 1937).

[249] Bertha Van Hoosen Papers, Bentley Historical Library, University of Michigan. See also Bertha Van Hoosen, *Petticoat Surgeon* (Chicago: Pelligrini and Cudahy, 1937).

and femininity. Rosalie Slaughter found surgery to be "a great satisfaction" and argued that

> surgery is much easier, more instinctive for women; we have a lengthy heritage of sewing, embroidering and knitting behind us, individually learned at an early age. For most men, clumsily manipulating a large needle, surgery is a sweating, nervous task. My concentration and calmness during an operation, on which my colleagues sometimes commented, was due to my mother's training. To quiet an overly active child, she encouraged me to embroider and sew. She taught me to use needles deftly, handle scissors carefully and put everything together neatly.[250]

Slaughter's assessment turned the traditional understanding of gender on its head. When it came to surgery, men were the "nervous" ones; women were cool and capable. Van Hoosen agreed; an article in the Detroit *Free Press* reported her assertion that "woman's greater manual dexterity gives her a potential superiority in surgery. . . . That, of course, means a better technique and more careful work."[251] In addition to reversing standard gender portrayals, these arguments reflected changing standards for surgery itself. Nineteenth-century innovations in anesthesia and antisepsis had altered the practice of surgery completely; within a generation, general impressions of surgeons and surgery caught up to this shift. Precision, neatness, and thoroughness had, by the early twentieth century, eclipsed speed and aggression as the most important qualifications necessary for a surgeon.

Most of the women who became successful surgeons – Slaughter, Cleveland, and Van Hoosen, but also Mary Amanda Dixon Jones, Ella Everitt, Marie Mergler, Marion Craig Potter, Alice Weld-Tallant, and Anita E. Tyng – were "gentlemen's daughters" who had been raised to view themselves as members of the elite classes. Most were

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[250] Morton, *Woman Surgeon*, 131.

[251] "Woman Says Her Sex Gives Best Surgeons," *Detroit Free Press* (Dec. 3, 1922), Bertha Van Hoosen Papers, Bentley Historical Library, University of Michigan.

married, and many, like Cleveland, were also mothers. For female medical students working to redefine healthy femininity, that fact was crucial. Their medical knowledge and surgical skill did not make marriage or motherhood impossible; these two aspects of their lives coexisted in harmony.[252] Therefore, it was possible to argue that these women surgeons were not abnormal or unhealthy. Instead, the standard medical definitions of healthy womanhood were flawed. As I will demonstrate in Chapter IV, feminists and women physicians eventually began to challenge the centrality of marriage and motherhood much more explicitly, arguing for potential health and normality that did not connect to domesticity or reproduction at all. In some ways, though, that next step relied upon the success of this first one, building on the fact that many privileged women had managed to take nontraditional paths, attending medical school and beginning medical careers, while retaining their status as good wives and mothers.

Whether female medical students understood themselves as "womanly women" or "hen medics" or identified more strongly with Ladova's emphasis on true individuality and personal expression, their voices, in conversation, shaped medical discourse about healthy womanhood in the late nineteenth century. Increasingly, over time, female students claimed "the rights of the individual." They demanded access to places that had been characterized as masculine – the scientific laboratory, the dissection room, and the surgical ward – and for the most part, they refused to view themselves as less feminine or of a lower class than their "lady doctor" predecessors. Whether they chose to dress like stylish ladies or like "hen medics," they understood that femininity did not have to be connected directly to the specializations that they chose or to the ways that they practiced

[252] Steven J. Peitzman has commented on this fact as it pertained to Emeline Horton Cleveland. See Peitzman, *New and Untried Course*, 26-28.

those specialties. Their personal experiences then blended with their professional expertise, and so their understandings about themselves became their understandings about female lives and female bodies in general.

By the end of the nineteenth century, these ideas began to appear in the medical literature. Indeed, as female medical students argued for less rigid definitions of normality and more inclusive definitions of healthy womanhood, their ideas were reflected in the scientific and medical literature on women's bodies. Even gynecology and obstetrics textbooks, which were written overwhelmingly by men, began to promote broader definitions of normality in terms of female physiology. For example, in 1872, the eminent gynecologist Lawson Tait prescribed very specific norms for menstruation. Young women who did not begin to menstruate around age fourteen were likely to develop uterine or ovarian disease; women who used fewer than three or more than five sanitary "diapers" a day were "abnormal."[253] In contrast, by 1898, Chauncey D. Palmer reported that the average menstrual flow was between four and five ounces but also argued that "there are great variations within the bounds of health. *Every woman is a law to herself*."[254] This shift might seem minor on the surface, but it was certainly representative of a more individualistic approach to women's health and well being, one that acknowledged a much broader range of "normal" and "healthy."

Similarly, obstetrics textbooks allowed for a much greater variation in "normal" childbirth. Egbert Henry Grandin's 1909 manual advised students that a "normal labor" was one in which "the foetus enters the pelvic inlet and emerges at the pelvic outlet after

[253] Lawson Tait, *Diseases of Women* (New York: William Wood and Company, 1872), 89-90.

[254] Chauncey D. Palmer, "Functional Diseases," *Clinical Gynaecology, Medical and Surgical*, edited by John Marie Keating and Henry Clark Coe (Philadelphia: J. B. Lippincott, 1898), 768.

a fashion in accordance with the normal mechanism of labor" – in other words, any labor that ends with a vaginal birth. The appropriate duration of labor, he further explained, needed to be evaluated "according to the individual case. . . . Under this definition any variety of presentation may be normal."[255] This perspective is striking, especially when compared to obstetrics textbooks from the 1860s and 1870s, which typically tried to make childbirth as much of an "exact science" as possible, assigning rigid guidelines for normal labors and normal deliveries.[256] Grandin would therefore have agreed with Palmer that "every woman is a law to herself."

Thus, the complicated sets of debates about women's medical education that emerged after Edward H. Clarke fell out of favor were inextricably related to ongoing conflict about the fundamental nature of normal femininity and the medical definition of healthy womanhood. Social and scientific debates about whether women should practice medicine, what fields they should specialize in, and how they should behave as professionals all involved serious consideration of gender itself: what was a normal woman, really? What made her feminine? What behaviors disqualified her from the status of a healthy American woman?

Race and class affected all of this discourse, even when it was not invoked explicitly. The normal American was white, and the idealized American woman was middle class; at the same time, these were the same women who were transgressing gendered beliefs about normal and virtuous womanhood in order to attend medical schools, open medical practices, and perform surgery. As the next chapter will examine

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[255] Egbert H. Grandin, *A Text-Book on Practical Obstetrics*, fourth edition (Philadelphia: F. A. Davis Company, 1909), 193.

[256] See, for example, Gunning S. Bedford, *The Principles and Practice of Obstetrics* (New York: William Wood and Company, 1874), 1.

in detail, all of this conflict became especially significant as women physicians exerted more and more influence on the specific specialties of gynecology and obstetrics – the branches of medicine that dealt directly with the female body. The arguments made by Slaughter, Ladova, and others were revolutionary, particularly when they brought their changing definitions of femininity to medical journals, to professional conferences, and to the bedsides of their female patients.

CHAPTER IV

"THERE IS NOT SUCH SPECIAL SANCTITY ABOUT THE OVARY": SURGICAL GYNECOLOGY AND THE CONSTRUCTION OF HEALTHY FEMININITY

In October of 1889, the *Pittsburgh Medical Review* published an article by Dr. Mary Amanda Dixon Jones, who reported that she had cured ten severe cases of "uterine misplacement" by removing her patients' ovaries and Fallopian tubes. Although these patients came to Dixon Jones with a wide variety of symptoms – abdominal pain, pelvic pain, menstrual complaints, severe constipation, epileptic seizures, periodic hallucinations, suicidal thoughts, and mysterious bouts of unconsciousness – Dixon Jones was convinced that all of them were suffering from diseased uterine appendages, which were pushing their uteruses out of place. Radical surgery was the only viable remedy, and so she admitted each patient to the Woman's Hospital of Brooklyn, where she amputated their ovaries and Fallopian tubes. By removing their reproductive organs, Dixon Jones explained, she made many of these miserable patients into "more perfect" women.[257]

Her claim was controversial, especially since Dixon Jones was a woman herself. As Chapters II and III explained, during the middle decades of the nineteenth century, many American women physicians tended to follow Elizabeth Blackwell's idealized

[257] Mary A. Dixon Jones, "Misplacements of the Uterus," *The Pittsburgh Medical Review* 3, No. 10 (October 1889), 301-309. Dixon Jones reported on the same topic at meetings of the Women's Medical College of Pennsylvania Alumnae Association, making the same arguments. See Mary A. Dixon Jones, "Removal of the Uterine Appendages – A Recovery," in "Transactions 1876-1898," folder marked "1885-1886," Alumnae Association Records, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine; Mary A. Dixon Jones, "A Report of Five Laparotomies," in "Transactions 1876-1898," folder marked "1887-1890," Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

model of the genteel, compassionate "lady doctor," who would contribute her uniquely feminine virtue to the profession. Blackwell used standard maternalist rhetoric to argue for a feminine presence in the medical community, insisting that these lady doctors would persistently "repudiate what appears to violate moral law."[258] For Blackwell, surgical interference with female fertility constituted one such violation.[259] By the time Dixon Jones published her cases of uterine misplacement, though, some women physicians were beginning to disagree strongly with Blackwell, both about the role of women as the designated guardians of medical morality and about the legitimacy of operations performed on the female reproductive organs. As they turned away from Blackwell's conception of the ideal woman physician, they embraced surgical gynecology and contributed to its increasing acceptance in the medical community and among the general public.

This shift was significant because surgical gynecology was still such a contested practice, even for male physicians. On one hand, operations like those performed by Dixon Jones were entirely consistent with the foundational principles of gynecology, including an understanding of the female body as innately pathological and a tendency to resort quickly to surgical intervention. After all, James Marion Sims had claimed his place as the celebrated "father of modern gynecology" by pioneering the use of surgery to treat women's sexual and reproductive problems.[260] Another early leader, Dr. Robert

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[258] Elizabeth Blackwell, "The Influence of Women in the Profession of Medicine," *Essays in Medical Sociology* (London: Ernest Bell, 1902), 7.

[259] See Sarah Stage, *Female Complaints* (New York: W. W. Norton and Company, 1979), 79-82.

[260] On Sims, see Deborah Kuhn McGregor, *From Midwives to Medicine: The Birth of American Gynecology* (New Brunswick: Rutgers University Press, 1998); Deborah Kuhn McGregor, *Sexual Surgery and the Origins of Gynecology: J. Marion Sims, His Hospital, and His Patients* (New York: Garland Press, 1989). For a biographical account of his life and work, albeit a fawning and uncritical one, see Seale

Battey, heightened the importance of surgery to the new specialty by introducing the "normal ovariotomy," which involved removing apparently healthy organs as a purported cure for nervous conditions like hysteria.[261] As a medical specialty, then, mid-nineteenth-century gynecological practice evolved directly from the work of men like Sims and Battey and was consequently characterized by the development of increasingly invasive surgical treatments designed to combat the inherently diseased nature of the female body.

On the other hand, gynecologists also endorsed traditional gender ideology, including the emphasis on the importance of female fertility. Over the second half of the nineteenth century, as gynecologists consolidated their authority as experts not only on women's reproductive anatomy and physiology but also on women's lives more generally, they used the language of science and medicine to claim that women were biologically designed for domesticity.[262] Their arguments typically invoked the sanctity of motherhood and the centrality of reproduction and child-rearing in the lives of normal, healthy American women. Gynecology's early connection to surgery notwithstanding, the willful destruction of fertility through the surgical removal of Fallopian tubes, ovaries, and uteruses contradicted such a perspective. If women's bodies were designed

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Harris, *Woman's Surgeon: The Life Story of J. Marion Sims* (New York: Macmillan Press, 1950). For a fascinating first-hand account, see J. Marion Sims, *The Story of My Life*, reprint edition (New York: Da Capo Press, 1968).

[261] This surgery was also known as "Battey's operation," after its inventor. On Battey and normal ovariotomy, see Lawrence Longo, "The Rise and Fall of Battey's Operation: A Fashion in Surgery," *The Bulletin of the History of Medicine* 53 (1979), 244-267; McGregor, *Midwives to Medicine*, 186; Judith M. Roy, "Surgical Gynecology," *Women, Health, and Medicine in America*, edited by Rima Apple (New York: Garland Publishing, 1990).

[262] See Caroll Smith-Rosenberg, "Bourgeois Discourse and the Progressive Era: An Introduction," *Disorderly Conduct: Visions of Gender in Victorian America* (New York: Alfred A. Knopf, 1985), 178; Caroll Smith-Rosenberg and Charles Rosenberg, "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America," *No Other Gods: On Science and American Social Thought* (Baltimore: Johns Hopkins University Press, 1976), 70.

for motherhood, how could the obliteration of reproductive function make them "more perfect" rather than less so?

As Chapter III demonstrated, conflict over the nature of healthy womanhood and the possible incompatibility of femininity and surgery shaped the development of medical education for women during the late nineteenth century. It also affected the practice of medicine outside of medical colleges. Operative gynecology remained somewhat controversial; physicians of both sexes argued that surgeries performed on women's sexual and reproductive organs mutilated the female body and violated the sanctity of female fertility. By the turn of the twentieth century, though, this controversy was largely resolved, both in the professional literature and in the eyes of the general public. While sexual surgeries like the clitoridectomy all but disappeared, major gynecological operations like the oophorectomy and hysterectomy became regular staples of surgical practice throughout the United States.[263] This chapter argues that women physicians, especially surgical gynecologists, played a crucial role in this aspect of the evolution of American gynecology.

Surprisingly little secondary literature exists on the key role that women physicians like Dixon Jones played in creating a gynecology that could claim to make women "more perfect" by operating on – and often removing – their reproductive organs. The scholarship therefore ignores some of the most important ways that women shaped the development of the specialty. Regina Morantz-Sanchez's groundbreaking monograph, *Sympathy and Science*, offers valuable insights regarding the history of women physicians in the United States, but it remains much too broad to adequately

[263] See Deborah Kuhn, *From Midwives to Medicine: The Birth of American Gynecology* (New Brunswick: Rutgers University Press, 1998); Judith M. Roy, "Surgical Gynecology," *Women, Health, and Medicine in America: A Historical Handbook*, edited by Rima D. Apple (New York: Garland Publishing, 1990).

address a subset of specialists.[264] Morantz-Sanchez's excellent second book, *Conduct Unbecoming a Woman*, examines gynecology more closely, focusing specifically on Dixon Jones and her 1890 trial for manslaughter and malpractice. *Conduct Unbecoming a Woman* makes a number of perceptive suggestions about the relationship between surgery and gynecology in the late nineteenth century – and this project certainly builds on some of those ideas – but it does not fully consider Dixon Jones as a member of an influential group of like-minded female medical professionals, nor does it recognize the extent to which these women affected the evolution of the medical specialties that constructed the female body.[265] As active, thoughtful agents who worked deliberately to shape their chosen field, women are still mostly missing from scholarly studies of gynecology.[266] I contend that they were nevertheless central to the story. Women brought their newly constructed definitions of healthy femininity to the practice of gynecology, rejected or accepted specific kinds of surgery, and permanently transformed gynecology as a medical specialty.

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[264] Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985). For another example of an excellent broadly-conceived monograph on women physicians, see Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995* (Cambridge: Harvard University Press, 1999).

[265] Regina Morantz-Sanchez, *Conduct Unbecoming a Woman: Medicine on Trial in Turn-of-the-Century Brooklyn* (New York: Oxford University Press, 1999). For other studies of individual women physicians who practiced or influenced surgical gynecology during this time period, see Carla Bittel, *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth-Century America* (Chapel Hill: The University of North Carolina Press, 2009); Arleen Tuchman, *Science Has No Sex: The Life of Marie E. Zakrzewska, M.D.* (Chapel Hill: The University of North Carolina Press, 2006).

[266] For a few examples of biographical works that do make individual women physicians conscious, thoughtful participants in the transformation of gynecology, see Bittel, *Mary Putnam Jacobi*; Tuchman, *Science Has No Sex.*

Radicals, Conservatives, and Surgical Gynecology

In order to understand the significance of Dixon Jones's case studies – and, on a larger scale, the stark ideological contrast between doctors like Blackwell and doctors like Dixon Jones – it becomes necessary to understand a broader conflict that affected the entire American medical profession during the late nineteenth and early twentieth centuries: the dispute between "radical" and "conservative" physicians.[267] Dividing the medical community into these two neat categories involves a great deal of oversimplification, but put in the most basic terms, radical physicians tended to support surgical intervention while conservative physicians tended to avoid it. In 1895, the *Journal of the American Medical Association* printed an address on "Radicalism and Conservatism" by Dr. Fernand H. Henrotin on its front page, reflecting the centrality of the debate in the medical community. Henrotin defended radicals against the mounting criticism of their more conservative colleagues, reminding his audience that the heroic founding practitioners of modern gynecology were surgeons like Sims and Battey. "It was the work of these very men," Henrotin argued, "that lifted gynecology far toward its present plane, and in fact, it was the radical procedures that later on rendered conservative methods possible."[268] His speech was timely. In the 1890s, the division between radicals and conservatives was becoming increasingly antagonistic; indeed, the opposing sides could not agree even on the basic vocabulary of their argument. Many

[267] Regina Morantz-Sanchez has contrasted Dixon Jones and Blackwell, through the lens of gendered ideas about empathy. She does not, however, situate the conflict in terms of the dispute between conservative and radical gynecologists. See Regina Morantz-Sanchez, "The Gendering of Empathic Expertise: How Women Physicians Became More Empathic Than Men," *The Empathic Practitioner*, edited by Ellen Singer Moore and Maureen A. Milligan (New Brunswick: Rutgers University Press, 1994), 40-58.

[268] F. H. Henrotin, "Radicalism and Conservativism in Gynecologic Societies," *Journal of the American Medical Association* XXIV, No. 4 (January 1895), 108.

radical physicians objected to being called "radical" at all. Dr. E. Arnold Praeger, for example, insisted that even the most innovative surgeon was nevertheless "as conservative as the state of knowledge in his time has permitted him to be, and he has zealously opposed the sacrifice of the most minute portion of skin or the smallest drop of blood which could have been saved."[269] Meanwhile, conservatives rejected the idea that they occupied an extreme point on a continuum. Rather, as the medical historian Martin Pernick has explained, conservative doctors characterized themselves as moderates who carefully weighed risks against benefits.[270]

This dispute was particularly intense within the specialty of gynecology, resulting in the production of competing textbooks and the development of conflicting sets of standards. Dr. Howard Kelly's *Gynecology and Abdominal Surgery*, for example, portrayed gynecology as inseparable from laparotomy; meanwhile, Dr. G. Betton Massey's *Conservative Gynecology and Electro-Therapeutics* continued to argue explicitly against most gynecological surgeries.[271] Arguments frequently erupted at professional meetings as well. In 1894, for instance, the gynecologist Julia Ingram delivered a paper to the members of the Kentucky Medical Society that accused some of her colleagues of resorting too quickly to surgery. According to the published

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[269] E. Arnold Praeger, "Is So-Called Conservativism in Gynecology Conducive to the Best Results to the Patients?," *Transactions of the American Association of Obstetricians and Gynecologists* VIII (Philadelphia: W. M. J. Dornan, 1895), 321.

[270] Martin Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985), 19-31. I have chosen to use these contested terms, "radical" and "conservative," throughout this work, largely for the sake of brevity, with "radical" generally indicating a proponent of surgery and "conservative" generally indicating a proponent of less invasive treatments.

[271] Howard Kelly, *Gynecology and Abdominal Surgery* (Philadelphia: W. B. Saunders Company, 1910); G. Betton Massey, *Conservative Gynecology and Electro-Therapeutics: A Practical Treatise on the Diseases of Women and Their Treatment with Electricity*, third edition (Philadelphia: The F. A. Davis Company, 1898). The term "laparotomy" was coined in the 1870s; it refers to any operation in which the surgeon opens the abdominal cavity.

transactions of the meeting, Ingram argued that "to open the abdomen is a sort of mania with some young surgeons, and they scour the country to hunt up cases that seem to be operable" – a practice that made female patients "victims to the inexperience of young ambition." Predictably, Ingram's contentions provoked heated debate, and in the ensuing discussion, radical physicians defended operative gynecology and emphasized the many lives saved by radical procedures. Dr. Joseph Mathews went so far as to compare gynecological surgeries to emergency appendectomies, stating that in both cases, "the surgeon makes the incision, comes to a solution of the question, and saves [the patient's] life." Mathews made no distinction between an appendix and an ovary, but many of his colleagues disagreed.[272]

In fact, the debate was probably so emphatic among gynecologists precisely because the surgeries in question involved women's reproductive organs. During the nineteenth century, many members of the medical community objected to hysterectomy (the surgical removal of the uterus), salpingectomy (the removal of one or both Fallopian tubes), and oophorectomy (the removal of one or both ovaries, often performed alongside a salpingectomy), especially when the patient in question was of child-bearing age.[273] Even the eminent gynecologist Howard Kelly, who fell definitively into the radical camp, worried that the removal of uteruses, ovaries, and Fallopian tubes would affect the quality of marital relationships, as husbands might find it difficult to genuinely love their infertile

[272] Julia Ingram, "Conservative Gynecology," *Transactions of the Kentucky Medical Society* III (Louisville, John P. Morton and Company, 1894).

[273] These terms were not completely clear-cut in the late nineteenth century. For example, the word "ovariotomy," which came to mean an operation performed *on* an ovary (such as a biopsy or the removal of a tumor), was sometimes used interchangeably with "oophorectomy," which was also sometimes called "ovariectomy."

wives.[274] Blackwell, alarmed by the impact of operative gynecology on female fertility, classified oophorectomy as a form of sexual mutilation.[275] Surgeries performed on uteruses, ovaries, and Fallopian tubes threatened the sanctity of reproduction and motherhood. As Morantz-Sanchez has noted, these kinds of concerns were essentially maternalist: they originated with the premises that women were designed for reproduction, that giving birth and raising children constituted women's primary responsibility to society, and that all women had a moral duty to uphold the sanctity of motherhood.[276]

These maternalist concerns included a significant eugenic component. Using some of the same rhetoric that had motivated supporters of Edward H. Clarke's *Sex in Education*, conservative gynecologists now frequently pointed to the potential eugenic ramifications of the rise of surgical gynecology, arguing that too many hysterectomies, oophorectomies, and salpingectomies performed on white women would result in race suicide.[277] Some physicians explicitly suggested that the need to prevent race suicide ought to take precedence over any individual patient's desire to space her children several years apart or limit her family size in general. The gynecologist Ely Van De Warker

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[274] Howard Kelly, "The Ethical Side of the Operation of Oophorectomy," *The American Journal of Obstetrics and Gynecology* 27 (1893), 208.

[275] Blackwell, "Influence of Women," 90.

[276] Morantz-Sanchez, *Conduct Unbecoming*, 108. For a useful analysis of maternalism in United States history, see Molly Ladd Taylor, "Toward Defining Maternalism in U.S. History," *Journal of Women's History* 5, No. 2 (fall 1993), 110.

[277] The medical concern with race suicide continued well into the twentieth century, even after operations like oophorectomy and hysterectomy were cemented as regular staples of gynecology. For a few examples, see Charles S. Barnes, "The Indications, Dangers and Contraindications of Uterine Curetment," *The American Journal of Obstetrics and Diseases of Women and Children,* Vol. 77 (1918), 940; "Society Transactions," *New York State Journal of Medicine*, Vol. 6 (1906), 345; William F. Whitney, "A Comparative Study of the Death Rates for the State of Massachusetts for the Years 1850, 1875 and 1900," *The Boston Medical and Surgical Journal*, Vol. 150, No. 2 (1904), 536.

went so far as to state plainly that "a woman's ovaries belong to the commonwealth; she is simply their custodian."[278] This perspective emphasized the importance of motherhood and so, in a sense, elevated the significance of women's position in society. At the same time, however, it denied individual women power over their own reproductive lives, and therefore, in another sense, it was an ideology that women physicians like Dixon Jones would likely have found oppressive. Though some conservative physicians were certainly trying to protect women from painful or unnecessary surgeries, the evidence nevertheless indicates that in many cases, they cared more about maintaining traditional race and gender roles in American life than they did about improving the lives of their individual patients.

Proponents of radical gynecology responded to maternalist and eugenic arguments in a number of ways. First, they insisted that the surgeries they performed were genuinely necessary, suggesting that they only removed uteruses, ovaries, or Fallopian tubes when conservative methods would not cure their patients. For example, the influential surgeon Mary Putnam Jacobi accused Blackwell of forgetting, in her rush to condemn operative gynecology as mutilating, that the primary purpose of the medical profession was to make patients well. "When you shudder at mutilation," she wrote to Blackwell in 1888, "it seems to me that you can never have handled a degenerated ovary or a suppurating Fallopian tube – or you would admit that the mutilation had been effected by disease . . . before the surgeon intervened."[279] In other words, disease mutilated patients; surgery did not.

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[278] Ely Van De Warker, "The Fetich of the Ovary," *The American Journal of Obstetrics and Gynecology* 31 (1907), 364. This quote is also discussed in Morantz-Sanchez, *Conduct Unbecoming*, 108, although not in relation to eugenics.

Dr. Anna M. Fullerton made similar arguments, suggesting in an 1898 issue of the *Woman's Medical Journal* that gonorrhea was typically impervious to conservative treatments. It was therefore necessary, she contended, "to subjugate it by very radical measures, viz: by the entire destruction of its defences, the removal of the organs affected."[280] Fullerton, the daughter of Christian missionaries in India, had graduated from the Woman's Medical College of Pennsylvania in 1882; by the time she wrote in support of radical gynecology, she was back at WMCP, this time as an instructor of obstetrics and professor of gynecology.[281] Her perspective on radicalism in these specialties, therefore, influenced a generation of female medical students who would go on to practice gynecology in the early twentieth century – surgical gynecologists like Rosalie Slaughter, whose work I discussed in Chapter III, and Catherine Macfarlane, who became a pioneer in the treatment of gynecological cancers.[282]

In the case of gonorrhea, at least, Fullerton characterized conservative methods not only as insufficient but also as irresponsible. This perspective reflected a second radical response to conservative criticism: the insistence that conservative gynecologists took unacceptable risks by avoiding or delaying surgical intervention when the patient's condition required it. In an 1890 article on abdominal and pelvic surgery, Dr. Joseph

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[279] Bittel, *Mary Putnam Jacobi*, 120; Morantz-Sanchez, *Sympathy and Science*, 195; Sarah Stage, *Female Complaints: Lydia Pinkham and the Business of Women's Medicine* (New York: W. W. Norton, 1979), 82.

[280] Anna M. Fullerton, "Gonorrhea of the Uterus and Its Appendages: A Surgical Survey," *The Woman's Medical Journal* 7, No. 6 (June 1898), 170.

[281] Deceased Alumnae File for Anna M. Fullerton, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[282] Catherine Macfarlane explicitly discussed the influence of Anna M. Fullerton, alongside other prominent WMCP professors like Anna Broomall and Hannah Croasdale, on her education in her unpublished memoir. See *Dr. Kitty Mac*, unpublished manuscript, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University, 21.

Price warned: "Let no man deceive himself into imagining that delay is conservatism. Delay is the fool's paradise, where laggards wait for luck, instead of pluck, to carry them to success."[283] This argument revealed an honest concern that disease would flourish as conservative practitioners shunned laparotomies in favor of poultices, tonics, and electricity; however, it also suggested a defensive posture. Conservatives often accused radicals of taking too many risks and endangering the lives of their patients unnecessarily, so radicals felt compelled to assert that the stubborn avoidance of surgery could also threaten patients' lives.

Surgical gynecologists also addressed conservative criticism with specific reference to maternalism and eugenics. Women who suffered from severe gynecological diseases, they reminded their colleagues, frequently found themselves unable to conceive; in these cases, the decision not to operate did absolutely nothing to protect fertility. Dixon Jones described one such patient, identified only as "Mrs. S," in her study of uterine misplacement. Mrs. S "had been married twenty-six years, and had never had any children. . . . In consequence of disease, she had not only been sterile, but her whole life had been a period of suffering and weakness." Outraged that Mrs. S had previously been denied the appropriate surgical cure, Dixon Jones contended that if the patient's ovaries and Fallopian tubes had been removed fifteen years before, "it would have saved her a life of misery, of invalidism, and of inefficiency." Further, she mocked the flawed conservative logic that had prevented this obvious solution from taking place: "Yet, if they at that time had been removed, we would doubtless have heard the cry, 'Unsexing women!' 'Preventing their bearing children!' 'Enemies to posterity!' etc. We notice,

[283] Joseph Price, "The Past, Present, and Future of Abdominal and Pelvic Surgery," *The Journal of the American Medical Association* 14, No. 1 (January 1890), 109. See also G. Granville Bantock, *A Plea for Early Ovariotomy* (London: H. K. Lewis, 1881), which Price cites in his article.

however, in all her married life of twenty-six years, this woman never bore any children. She was completely *unsexed by disease*."[284] In the case of Mrs. S, Dixon Jones noted, there was no eugenic benefit to the avoidance of surgery.

Moreover, surgical gynecologists suggested that even when women with serious gynecological diseases could theoretically conceive, they remained poor candidates for motherhood. In her article on gonorrhea, Fullerton argued that for patients with venereal diseases, sterility could be the most desirable outcome. Her reasons were twofold. First, she explained that maternalist and eugenic objections to the surgical destruction of reproductive function had to be considered alongside the potential dangers of pregnancy and childbirth. Serious gonorrheal infections, she claimed, posed a considerable risk to pregnant women and to their offspring. Second, Fullerton expressed moral objections to the idea of women afflicted with gonorrhea reproducing. Physicians, she contended, ought to remember that a mother with gonorrhea might "transmit to her offspring a quality of life . . . perhaps more debased in consequence of the diseased condition of the maternal organs."[285] Diseased women, through a combination of heredity and environment, tended, in Fullerton's view, to produce debased children. Importantly, though these arguments certainly aimed to thwart conservative criticism, they did not challenge the tenets of eugenics that conservatives frequently cited. Rather, using the same rhetoric, they simply implied that radical gynecology could serve a eugenic purpose by limiting the reproductive potential of the "unfit" while leaving the fertility of the "fit" untouched.

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[284] Dixon Jones, "Misplacements of the Uterus," 305. The emphases are Dixon Jones's.

[285] Fullerton, "Gonorrhea of the Uterus," 176.

Locating oneself on the spectrum of radicalism and conservatism would undoubtedly have been more difficult for women physicians than for their male counterparts. Many women physicians felt compelled to join Blackwell in advocating for the primacy of motherhood, if only to protect fellow women from surgeons they perceived as overly zealous. Dr. Mary Spink, for example, observed a growing need to shield women's ovaries from the "wholesale onslaught" of operative gynecologists.[286] Similarly, though the gynecologist Mary S. Briggs did not condemn all gynecological operations, she did call for the use of poultices and other conservative treatments as a first course of action. Trying such treatments first, she claimed, would "save scores of operations." Like Blackwell and Spink, Briggs felt obligated, as a woman, to protect the female reproductive organs: "Why," she asked her readers in 1896, "should the uterus be so maltreated?"[287] All three women pointed proudly to the conservative approaches of the first American women physicians, the "lady doctors" who, they believed, understood and upheld the sanctity of motherhood in a way that their male colleagues could not. This approach was very different from the perspective promoted by surgical gynecologists like Fullerton and Dixon Jones.

Religious conviction sometimes propelled some women physicians toward the conservative side of the spectrum. Many maternalist women believed that the female sex enjoyed a particularly intimate connection with God and a stronger understanding of the principles of Christian morality. In an 1895 book, Blackwell happily anticipated "the future influence of Christian women physicians, when with sympathy and reverence guiding intellectual activity they learn to apply the vital principles of their Great Master

[286] Spink is quoted in Morantz-Sanchez, *Conduct Unbecoming*, 108.

[287] Mary S. Briggs, "A Plea for Simplicity," *The Woman's Medical Journal* 5, No. 6 (June 1896), 147.

to every method and practice of the healing art."[288] Religious ideas frequently surfaced when women physicians discussed abortion. Writing about criminal abortion in the *Woman's Medical Journal*, Dr. Josephine Peavey invoked a vision of Christian femininity similar to Blackwell's. She characterized abortion as immoral, horrifying, and "a sad commentary upon the Christian civilization of the age." A number of other physicians expressed moral, medical, and eugenic concerns about abortion, but Peavey also argued explicitly that women specialists had a particular responsibility to educate their "sisters" about the horrors of the practice and encourage them to make more virtuous choices.[289] Her arguments evoked traditional gender ideology, suggesting that although women physicians might step into the professional world, they could nevertheless maintain the feminine relationship with God that was emphasized by the cult of true womanhood.[290] This perspective was echoed by Dr. Marie Formad, who expressed religious and moral outrage over the fact that some physicians willingly provided abortions to women who sought them: "It is difficult to conceive of one so lost to professional honor or so regardless of law as to perform an act of this kind knowing he or she commits a crime in so doing."[291] The issue of abortion, indeed, united many women on the conservative side of the spectrum. These women felt a professional

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[288] Elizabeth Blackwell, *Pioneer Work in Opening the Medical Profession to Women* (London: Longmans, Green, and Company, 1895), 254.

[289] Josephine Peavey, "Criminal Abortion," *The Woman's Medical Journal* 8, No. 6 (June 1899), 209-216.

[290] On the cult of true womanhood, an ideology that emphasized the four feminine ideals of purity, piety, submissiveness, and domesticity, see Nancy F. Cott, *The Bonds of Womanhood: 'Woman's Sphere' in New England, 1780-1835* (New Haven: Yale University Press, 1977); Barbara Welter, "The Cult of True Womanhood, 1820-1860," *American Quarterly* 18, No. 2 (summer 1966), 151-174.

[291] Marie Formad, "Some Notes on Criminal Abortion," senior thesis, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

pressure to speak out against the practice, but they also felt an additional maternalist pressure that was related to their roles as women.[292]

In contrast, radical gynecologists often objected both to the idea that women's reproductive organs carried special sanctity and to the notion that women physicians ought to serve as guardians of medical morality. Women physicians and educators who took this stance risked considerable disapproval, both from members of the medical community and from members of the general public, who sometimes accused them of forsaking their femininity.[293] Regardless, some abandoned Blackwell's "lady doctor" model and argued aggressively for the superiority of surgical gynecology. Dixon Jones, Jacobi, and Fullerton did not take this path alone. Elizabeth Keller, who graduated from WMCP in 1871 and became one of the first successful female surgeons in the United States, served as an early example. In 1875, she began serving as the Resident Physician of the New England Hospital for Women and Children in Boston, where she became known for her surgical skill and innovation:

> It is in the department of surgery where Dr. Keller has exhibited qualities which justly place her in the front rank, not only among women, but among surgeons. . . . Her terms of service have been full of thorough, ingenious and progressive work,

[292] On nineteenth-century medical views of abortion, see James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* (New York: Oxford University Press, 1978). See also Suzanne Poirier, "Women's Reproductive Health," *Women, Health, and Medicine in America: A Historical Handbook*, edited by Rima D. Apple (New York: Garland Publishing, 1990), 232-235; Leslie J. Reagan, "'About to Meet Her Maker': Women, Doctors, Dying Declarations, and the State's Investigation of Abortion, Chicago, 1867-1940," *The Journal of American History* 77 (March 1991), 1240-1264; Leslie J. Reagan, *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973* (Berkeley: University of California Press, 1998); Carroll Smith-Rosenberg, "The Abortion Movement and the AMA, 1850-1880," *Disorderly Conduct: Visions of Gender in Victorian America* (New York: Alfred A. Knopf, 1985), 217-244; Jamie Q. Tallman, *The Notorious Dr. Flippin: Abortion and Consequence in the Early Twentieth Century* (Lubbock, TX: Texas Tech University Press, 2011).

[293] Morantz-Sanchez deals with these risks in detail in her consideration of Dixon Jones, arguing that "in the final analysis, it was not for attending medical school that she was condemned, or for treating women with surgery, or even for running her own hospital. What made Dixon Jones a 'persona non grata' was her failure to live up to the feminine images even she and her lawyer endeavored to project." Morantz-Sanchez, *Conduct Unbecoming*, 210.

> including not only minor surgery, but the reduction of fractures, amputations, and abdominal surgery. . . . As an operator she is cool and deliberate, yet prompt and decided; cautious, but ready; deft-handed and fertile in resource. . . . Knowing the vital importance of correct emergency treatment, she instructs [her internes] in improvising apparatus from material at hand, and many an appliance, made up from the wood-house and attic, has, by its ready utility, enforced essential principles in surgery never to be forgotten.[294]

Even in the nineteenth century, there were perhaps twenty prominent, successful women surgeons who followed paths similar to Keller's, including highly influential physicians like Anna Broomall, Marie Mergler, Anita E. Tyng, and Bertha Van Hoosen.[295] There were dozens more who supported these surgeons in smaller ways, seeking internships with them, enrolling in their classes, employing their techniques, and writing about their work.

In the early decades of the twentieth century, there were many more women who performed and supported surgical gynecology.[296] These women included the leaders in their fields. By 1922, for example, when Catherine Macfarlane successfully applied to replace Ella B. Everitt – the surgeon who had served as such an inspiration for Frances Petty Manship and her classmates – as the Chair of Gynecology as WMCP, she was required to submit an extensive list of operations she had performed during the 1910s.

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[294] This quote is replicated in the Deceased Alumnae File for Elizabeth Keller, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine. It originally came from *The Biography of Ephraim McDowell, M.D., by his Granddaughter Mrs. M. T. Valentine*, first edition (New York: McDowell Publishing Company, 1897).

[295] Bertha Van Hoosen Papers, Bentley Historical Library, University of Michigan; Deceased Alumnae File for Anna Broomall, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine; Rosalie M. Ladova, "Medical Education for Women," *The Journal of the American Medical Association* 39 (June 1902), 1454; Records of the New England Hospital for Women and Children, 1873-1902, Center for the History of Medicine, Countway Library of Medicine; Records of the New England Hospital for Women and Children, Sophia Smith Collection, Smith College; "Transactions of the Rhode Island Medical Society" III (1883-1888), 281-282.Anita E. Tyng, "A Case of Removal of Both Ovaries by Abdominal Section, for the Relief of an Exhausting Menorrhagia and Uterine Fibroid," *The American Journal of the Medical Sciences* 82 (1881), 525-526.

[296] Morantz-Sanchez notes some of these women's contributions. Morantz-Sanchez, *Conduct Unbecoming*, 66.

These included, among other surgeries, 120 salpingo-oophorectomies, 62 hysterectomies, 6 ovariotomies, and 12 myomectomies.[297] Meanwhile, leading female surgeons at Boston's New England Hospital for Women and Children performed these same kinds of surgeries weekly.[298] Women who took this path tended to be among the most ambitious women physicians, leading them to discard the "lady doctor" model in favor of a riskier ideal that might yield greater rewards.[299]

Surgical Gynecology and Healthy Options Outside of Marriage and Motherhood

Because women surgical gynecologists often rejected the idea that women ought to occupy a special, feminine role within the medical profession, they became increasingly concerned about the obstacles that continued to limit women's opportunities for advancement. By the end of the nineteenth century, women physicians numbered around seven thousand and constituted five percent of the total in the United States.[300] Due to a decrease in sectarian, "irregular" practitioners, most of those women were, by this point, regular, licensed physicians.[301] More and more women were joining

[297] Deceased Alumnae File for Catherine Macfarlane, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University.

[298] Records of the NEHWC, Countway; Records of the NEHWC, Smith.

[299] The medical historian Steven J. Peitzman has noted that women gynecologists who refrained from performing the "big" operations, such as ovariotomies and hysterectomies, would have been unlikely to rise to the top of the medical community. See Steven J. Peitzman, *A New and Untried Course: Woman's Medical College and Medical College of Pennsylvania, 1850-1998* (New Brunswick: Rutgers University Press, 2000).

[300] Morantz-Sanchez, *Sympathy and Science*, 232.

[301] On the evolution of sectarian medicine and the eventual consolidation of power with "regular" practitioners, see Mohr, *Abortion in America*; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982). Even as early as the 1880s, most active female practitioners were

professional associations and publishing their case studies in medical journals, and many expressed joy and optimism about the future of women in the profession. In a 1900 issue of the *Woman's Medical Journal*, Dr. Agnes C. Vietor went so far as to claim that "the limitations of sex do not exist." She went on to advise young women about becoming successful surgeons, implying that positions in surgery would definitely be available to them.[302] Despite Vietor's optimism, though, women surgical gynecologists knew that this progress had not come easily, and they realized that serious obstacles still existed; their future was not assured.

Women physicians like Dixon Jones and Jacobi knew that women who wanted to become physicians in the late nineteenth and early twentieth centuries continued to struggle. They had to work harder than men did to gain acceptance into reputable medical colleges; then, if they succeeded in completing their degrees, they struggled to set up profitable medical practices. In addition to the suspicions and prejudices of the public, women physicians also faced the same medical discourse that was the site of debate between radical and conservative gynecologists (and, in a different context, the site of debate about women's medical education, as we saw in Chapter III). Most physicians had stopped arguing that women's bodies could not withstand the rigors of higher education or medical practice, but they continued to maintain that women should not pursue such a path. All of this rhetoric made female surgical gynecologists painfully aware that despite the achievements of pioneering medical women, determined women

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"regulars." In 1881, three women physicians, Emily F. Pope, Emma L. Call, and C. Augusta Pope, surveyed 364 female doctors and reported that "three hundred and forty-one report themselves as practising regular medicine; thirteen, homeopathy; and ten give no answer." See "The Practice of Medicine by Women in the United States," Medicine Collection, Box 2, Folder 22, Sophia Smith Collection, Smith College.

[302] Agnes C. Vietor, "The Making of a Woman Surgeon," *The Woman's Medical Journal* 10, No. 1 (January 1900), 19-22.

physicians could typically attain only a moderate level of success and recognition in the medical profession at large.[303]

Anna M. Fullerton noted in her journal that for a woman physician in the United States, "one source of unhappiness has, in many cases, been the fact that – being a woman – she has had to face the fact that many people still feel that skilled medical advice must be masculine, and she is subjected to the mortification of seeing her own advice set aside for that of some man physician whom she knows to be her inferior professionally."[304] This sense of disadvantage was likely connected, directly, to her defense of radical gynecology; she wanted to reach a higher level of professional advancement by distancing herself from maternalism and associating herself with what she perceived as the scientific future of the field. She did this even though her personal feelings were actually much more conflicted. In her journal, she also wrote that "because of her mother-instinct, and her faculty for looking into details, a woman doctor carries her patient on her heart as well as in her head" – a clear reference to the doctrine of feminine difference. She also felt a distinctive feminine connection with God, suggesting that "since God made mothers – and there must, necessarily – be so much of mothering in the care of the sick, one cannot but think that in the larger type of womanhood which advancing civilization has made possible, God means women both to 'mother' and 'doctor' the race into a healthier and happier state than that in which it now exists."[305] These kinds of sentiments, which pointed to her more complex view of femininity,

[303] Morantz-Sanchez notes that these women could generally achieve a "respectable, though not stellar" place in the profession. Morantz-Sanchez, *Conduct Unbecoming*, 114.

[304] Deceased Alumnae File for Anna M. Fullerton, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[305] Deceased Alumnae File for Anna M. Fullerton, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

appeared only in her personal diary; she did not include them in her published or professional material.

When Jacobi argued against traditional, maternalist ideology in 1891, she was not simply defending radical gynecology; she was also defending her own participation in the medical profession. After all, she noted, even for women who sincerely desired to remain within the cult of true womanhood, the years spent actively mothering children were "preceded by many years, and followed by many years, and for many women, through no fault of their own, never come at all." Therefore, in Jacobi's view, "the seventy years of a lifetime will contain much waste, if adjusted exclusively to the five or six years of even its highest happiness."[306] This perspective was consistent with her defense of operative gynecology. Both views originated with the notion that motherhood was only one part of a healthy woman's life and, in some cases, no part at all. Like Fullerton, Jacobi connected the goal of professional advancement with the need to separate herself from traditional maternalist ideology.

Knowing the history of medical women in the United States, then, ambitious women physicians would certainly have recognized the parallels between Clarke's prioritization of the menstrual cycle and Blackwell's prioritization of feminine morality. They understood that while the specific arguments were different, they both functioned to constrain women. Clarke aimed to keep women out of the profession entirely; Blackwell wanted women to enter the field, but she envisioned physicians who maintained traditional gender performances once they were there. One way to push against such limitations was to disprove their premises scientifically, as we saw Jacobi and Charlotte

[306] Mary Putnam Jacobi, "Women in Medicine," *Woman's Work in America* (New York: Henry Holt and Company, 1891), 196-197.

Brown doing in Chapter II. Another was to counter conservative arguments by relating personal experiences as women. Dixon Jones, for example, responded to Thomas Addis Emmet's assertion that "the ovaries will always be arrested in their growth if the brain is pressed" by scoffing at the idea that women's bodies reacted differently to study than men's bodies did. "I can testify that my efforts at studying never reacted upon the ovaries," she assured readers of the *Woman's Medical Journal*. "I never knew, except for the light of anatomy that I had such organs. *It is not study that makes disease of the ovaries; it is sepsis*."[307] Such personal anecdotes, published both for medical and general audiences, called attention to the prejudices women physicians encountered and, simultaneously, highlighted the logical problems inherent in those prejudices.

Another way to counter conservative constraints was to seek recognition, as physicians, for achievements that would traditionally have been seen as masculine. Abandoning conventional feminine modes of medical practice was sometimes risky, but even Dixon Jones's aggressive, "masculine" behavior, which contributed to her prosecution for malpractice and manslaughter, also earned her high acclaim in certain circles. For example, her contributions to the development of the complete hysterectomy were praised at a Philadelphia meeting of the American Gynecological Society.[308] Jacobi, Fullerton, Keller, Tyng, and Van Hoosen also enjoyed recognition for their work when they transgressed the boundaries of Blackwell's "lady doctor" performance and took on more conventionally masculine roles, publishing cases in which they pursued cures aggressively. Blackwell's vision of feminine medical practice could only take these

[307] Mary A. Dixon Jones, "No. 3: Reminiscences of Travels in Europe in 1886," *The Woman's Medical Journal* 5, No. 1 (January 1896), 13. The emphases are Dixon Jones's.

[308] Dixon Jones, "No. 3," 11.

ambitious women so far; if they wanted to become leaders of their fields, if they wanted to exert real influence on the profession, they needed to find a different model. One possible path – and the one taken by many of the most successful women physicians on the late nineteenth and early twentieth centuries – was to specialize in a field perceived as more feminine (most often gynecology or obstetrics) but to practice those specialties as the most successful male physicians did. Embracing surgery and aligning with the radical gynecologists was one way to do so.

In Chapter II, I concurred with Regina Morantz-Sanchez and other historians that as gynecology developed as a medical specialty, gynecologists used their newfound authority as experts on women to undertake the work of "constructing the female body."[309] They worked to answer questions about the fundamental nature of healthy American womanhood for both the medical community and the general public. Because these questions related directly to the nature of the female body, they fell unequivocally into the domain of doctors – particularly gynecologists. What female gynecologists, specifically, were in a unique position to understand, though, is that these questions about the female body remained inextricably linked to questions about the changing role of women in society. In the previous two chapters, I have demonstrated that many women worked first to disprove the notion that their bodies could not withstand medical study, then to discredit the idea of a distinctive form of female medical education; in so doing, they developed new definitions of healthy, normal American femininity that did not rely on characteristics like sensitivity and fragility. In the late nineteenth and early twentieth centuries, many female surgical gynecologists continued that work by arguing that women's reproductive organs were not sacred, that reproductive capacity was not

[309] Morantz-Sanchez, *Conduct Unbecoming*, 114-137.

necessarily the defining quality of healthy womanhood, and that, therefore, operative gynecology could make some women "more perfect" instead of less so.

Because the conflict over surgical gynecology hinged on the supposed sanctity of the female reproductive organs, many women surgeons challenged the notion that reproductive capacity was the most important aspect of healthy womanhood. They encountered a great deal of resistance. Even after the turn of the century, many doctors, male and female alike, continued to promote traditional, conservative gender roles for women, and their voices pervaded literature aimed at both professional and popular audiences. In 1911, the conservative gynecologist Edith Belle Lowry was still maintaining that motherhood was a woman's primary purpose in life and that sexual activity should lead to reproduction. Lowry's *Herself*, a book written chiefly for newly-married women, insisted that married couples who enjoyed sex without planning to become parents constituted "a menace to society."[310] Women promoting radical gynecology directly challenged these views. Jacobi, for example, acknowledged the beauty and significance of motherhood but argued that the obsession with maternity was dangerous because it could confine women to the traditionally feminine sphere: "A mother occupied with her young child offers a spectacle so beautiful and so touching, that it cannot fail to profoundly impress the social imagination. . . . easy to dread the introduction of other interests lest the woman be unduly diverted from this, which is supreme."[311] Jacobi and others, perhaps still "haunted" by the work of men like Clarke, understood that an exaggerated emphasis on motherhood – even when employed by those

[310] Edith Belle Lowry, *Herself: Talks with Women Concerning Themselves* (Chicago: Forbes and Company, 1911), 103.

[311] Jacobi, "Women in Medicine," 196.

seeking to advance women's opportunities – often meant the restriction of women's participation in the social, political, and professional worlds.

Consequences of Female Support for Surgical Gynecology

Although the existing scholarship on women physicians tends to marginalize women and minimize their influence, female surgical gynecologists participated actively in the medical construction of women's bodies and played influential roles in related debates about appropriate positions for women in society.[312] Many of their male colleagues deferred, at least on some aspects of gynecology, to their expertise, often citing them in gynecology textbooks. Male textbook authors cited Jacobi especially frequently and always depicted her in a positive light. For example, in his treatment of menstruation, Dr. William Graves cited Jacobi's famous *The Question of Rest for Women During Menstruation*, discussing her work respectfully. Graves characterized the prize-winning study as "a most valuable contribution to the physiology of the pelvic organs" and noted that her results had clearly been accurate, as they had been replicated by other scientists.[313] Moreover, because he did not discuss – or even mention – Jacobi's gender, his evaluation of her contributions to the specialty did not appear qualified or condescending. In addition, in the first volume of *A System of Gynecology*, Dr. Matthew

[312] Regina Morantz-Sanchez, for example, though sometimes emphasizing Dixon Jones's contributions, suggests that during the nineteenth century, "gynecology" constructed the female body, and Dixon Jones "responded" to that construction. While I agree with most of Morantz-Sanchez's arguments, I would suggest a shift in emphasis and a greater recognition of the work of Dixon Jones and many other women physicians. I would say, instead, that Dixon Jones, Jacobi, Fullerton, and twenty or so additional women surgeons played a central role in the process of constructing the female body. See Morantz-Sanchez, *Conduct Unbecoming*, 114.

[313] William Graves, *Gynecology* (Philadelphia: W. B. Saunders Company, 1920), 120.

Darbyshire Mann cited Jacobi eleven times, and he made it quite clear that he admired her work; in fact, in a discussion of Jacobi's study of menstruation, he claimed that her assessment of the menstrual cycle was "the most rational" he had encountered.[314] Like Graves, Mann did not discuss Jacobi's gender or hint at any attitude other than professional respect.

The work of other female surgical gynecologists appeared in gynecology textbooks as well. Dr. Edward Emmet Montgomery's *Practical Gynecology* cast Dixon Jones as an authority on ovarian tumors and noted her contributions as a pioneering surgeon: "complete hysterectomy for fibroids was probably first done by Mary Dixon Jones, in 1888."[315] Kelly's *Gynecology and Abdominal Surgery* cited two of Dixon Jones's published cases of uterine myoma, which she had treated with hysterectomies.[316] *Gynecology and Abdominal Surgery* also featured two entire chapters written by women physicians, Fullerton and Elizabeth Hurdon.[317] Their status as contributing authors established them as experts on their specific subspecialties (in Fullerton's case, vulvar and vaginal surgeries; in Hurdon's, pathology of the female reproductive organs) and placed them in the company of leading male gynecologists like Kelly, Henrotin, Brooke M. Anspaugh, Henry Turman Byford, and Alexander Johnston Chalmers Skene. Kelly, a hugely influential gynecologist affiliated with Johns Hopkins Medical School, could

[314] Matthew Darbyshire Mann, *A System of Gynecology*, Vol. I (Philadelphia: Lea Brothers, 1887), 437. Jacobi's work is also cited on pages 49, 410, 435, 602,618, 644, 645, and 662.

[315] Edward Emmet Montgomery, *Practical Gynecology: A Comprehensive Textbook for Students and Physicians* (Philadelphia: P. Blakiston's Son and Company, 1900), 614, 742. See also Henry Turman Byford, *Manual of Gynecology* (Philadelphia: P. Blakiston Company, 1902), 355, 446, 504.

[316] Kelly, *Gynecology and Abdominal Surgery*, 661.

[317] Anna M. Fullerton, "Non-Plastic Operations of the Vulva and Vagina," *Gynecology and Abdominal Surgery* (Philadelphia: W. B. Saunders Company, 1910), 328; Elizabeth Hurdon, "Pathology of the Reproductive Organs," *Gynecology and Abdominal Surgery* (Philadelphia: W. B. Saunders Company, 1910), 79.

certainly have chosen qualified male physicians to write these chapters; alternatively, he could have devoted some space in his introduction to fending off potential criticism about the participation of female gynecologists. The fact that he did neither of these things suggests that placing women in positions of medical authority – especially in gynecology – was not particularly controversial, at least not by the twentieth century.

Male gynecologists also looked to their female colleagues to help them resolve contentious issues. For example, a number of physicians at the 1897 meeting of the American Medical Association sought Fullerton's input on the question of the bicycle for women. The issue involved a great deal of serious debate about sexuality and the body. Concerns that bicycling was unladylike, that women cyclists expended unhealthy levels of energy, that the practice could injure women's bladders, and that women could become sexually stimulated by the saddle of the bicycle prevented many physicians from endorsing its use.[318] Fullerton supported bicycling as a form of healthy exercise for women, and her remarks were instrumental in moving the medical community toward its endorsement.[319] The incident suggests that in some cases, male physicians viewed their female colleagues as authority figures because they were women.

Indeed, the fact that these surgical gynecologists were women may frequently have enhanced their credibility. As medical education for women increased in scope and quality, many women physicians carried a professional, medical expertise equivalent to that of male physicians, but their opinions carried additional weight because they also had

[318] See "Bicycling for Women," *The Woman's Medical Journal* 6, No. 4 (April 1897), 121; Robert Latou Dickinson, "Bicycling for Women from the Standpoint of the Gynecologist," *American Journal of Obstetrics and Gynecology* 31 (October 1894), 25-35; Morantz-Sanchez, *Conduct Unbecoming*, 124.

[319] Anna Fullerton, "Studies in Gynecology from the Service of the Woman's Hospital of Philadelphia," *Journal of the American Medical Association* 29 (December 1897), 1301.

a kind of personal, gendered authority, which their male colleagues sometimes found valuable. Faced with conservative criticism, male surgical gynecologists often found themselves defending the performance of oophorectomies, salpingectomies, and hysterectomies. They struggled to answer Briggs's question about why women's reproductive organs were "so maltreated." In this climate, they often looked to their female colleagues, especially highly respected ones like Dixon Jones, Jacobi, and Fullerton, to defend operative gynecology from a woman's perspective. It seemed less likely, after all, that women physicians would support surgeries that victimized female patients. Women gynecologists had a personal understanding of women's bodies and, consequently, would surely object to unnecessary onslaughts upon those bodies. This perspective was somewhat paradoxical because by associating themselves with radical surgeons in the first place, female surgical gynecologists also rejected Blackwell's notion that women physicians had a special duty to uphold Christian morality and protect women's bodies. Nevertheless, in many cases, their opinions did indeed carry an enhanced authority.

Female surgical gynecologists used this enhanced authority to make a number of arguments, both philosophical and practical. First, they sought to separate healthy femininity from reproductive capacity, contending that the female reproductive organs were not inherently more valuable than other organs. Writing to Blackwell in 1888, Jacobi admitted that gynecological operations were sometimes performed too hastily and that surgeons sometimes made mistakes; however, she went on to reprimand Blackwell for her old-fashioned insistence that female reproductive organs were sacred. "There has been much reprehensible malpractice," Jacobi conceded. "But I do not see that

malpractice which may render a woman incapable of bearing children differs . . . from the malpractice which may result in the loss of a limb or of an eye. There is not such special sanctity about the ovary!"[320] Dixon Jones held similar views. Her rejection of the centrality of motherhood in a healthy woman's life enabled her to argue, in her article on uterine misplacements, that the performance of an oophorectomy or salpingectomy "makes the sick woman a more perfect woman, makes her capable of performing life's duties and meeting life's responsibilities."[321] Her argument differed significantly from more practical contentions about medical necessity and eugenics because they made a philosophical case regarding fundamental gender ideology. The idea that the ovary was not sacred, that removing the reproductive organs could make a woman "more perfect" instead of less so, suggested that reproduction did not form the very core of a healthy woman's existence.

Many female surgical gynecologists, beginning with the ethical premise that there was "not such special sanctity about" the reproductive organs, supported the use of hysterectomies, oophorectomies, salpingectomies, and other operations performed on the reproductive organs. The records of the Alumnae Association of the Woman's Medical Hospital of Pennsylvania, which met annually beginning in 1876, reveal its members' commitment, almost from the organization's inception, to surgical technique and innovation. During the 1880s alone, as membership grew from a few dozen members to around three hundred, the meetings featured reports on ovariotomies by Anita E. Tyng and Charlotte B. Brown; reports on hysterectomies, oophorectomies, and salpingectomies by Dixon Jones; reports on oophorectomies, salpingectomies, and uterine surgeries by

[320] Quoted in Morantz-Sanchez, *Sympathy and Science.*

[321] Dixon Jones, "Misplacements of the Uterus," 305.

Elizabeth Keller; descriptions of the surgical work done by women physicians at the Woman's Hospital of Philadelphia; and a number of more minor surgical procedures performed by other members of the Association. The reports were typically followed by a period of discussion, during which members in attendance tended to express support for these surgical procedures and ask questions about how to perform them most effectively.[322] Leaders of the WMCP Alumnae Association were usually surgeons: Emeline Horton Cleveland served as its first president, and she was followed by leading surgeons like Hannah T. Croasdale, Clara Marshall, Keller, and Jacobi.[323] Even in single-sex meetings, then, away from the pressure to conform to supposedly "masculine" forms of medical practice, many successful WMCP alumnae explicitly supported radical gynecology.

Similarly, the records of the New England Hospital for Women and Children reveal that in Boston, women physicians performed hundreds of radical gynecological surgeries each year, using the same standards of diagnosis and treatment common in hospitals run by men. The NEHWC educated many of the first American women physicians, trained them as surgeons, and was the first institution to provide obstetrical and gynecological care "of women by women," and it was founded in 1862 by a pioneering woman surgeon, the German immigrant Dr. Marie E. Zakrzewska.[324] By the early twentieth century, the women physicians operating there were performing all of the major gynecological surgeries, and they were doing them well: their reports indicated that

[322] See "Transactions 1876-1898," Alumnae Association Records, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[323] For more on the WMCP Alumnae Association, which was one of the first medical societies for women in the United States, see Peitzman, *New and Untried Course*, 61-62.

[324] *The Story of a Woman's Hospital*, typewritten manuscript, Records of the NEHWC, Smith College. On Zakrzewska's life and work, see Tuchman, *Science Has No Sex*.

"no hospital could show a better percentage of recoveries."[325] A careful reading of hundreds of detailed surgical records from the NEHWC in the late nineteenth century reveals no indications that these female surgeons operated less frequently or with more regard for the "sanctity" of the female reproductive organs than radical male gynecologists did.[326] In both Philadelphia and Boston, then – cities that were centers of medical progress, medical education, and, especially, the women's medical movement – many of the most ambitious and successful women physicians performed and supported radical gynecology.

There was one major exception to this support for surgical intervention: women gynecologists did not seem to support clitoridectomy as enthusiastically as their male colleagues did. Although clitoridectomy (the surgical removal of the clitoris) and other clitoral surgeries have not received as much attention as other gynecological surgeries in the scholarship on American medical history, these operations did take place in the United States during the late nineteenth and early twentieth centuries.[327] Clitoridectomy was popularized in Great Britain by the surgeon Isaac Baker Brown, who also introduced the procedure to doctors in the United States. Brown, along with many of his colleagues in both Great Britain and the United States, advocated clitoridectomy as a means of

[325] *Story of a Woman's Hospital*, Records of the NEHWC, Smith College.

[326] Records of the NEHWC, Countway Medical Library.

[327] Clitoral surgery and clitoridectomy are, of course, much older, but prior to the 1860s, in Europe and in the United States, these operations were generally done only to treat tumors and visible manifestations of syphilis. See Ann Dally, *Women under the Knife: A History of Surgery* (New York: Routledge, 1992), 159-160. Sarah W. Rodriguez has identified four separate forms of clitoral surgery performed in the late-nineteenth-century United States: removal of smegma, removal of adhesions, removal of the clitoral hood (also known as circumcision), and clitoridectomy. See Sarah W. Rodriguez, "Rethinking the History of Female Circumcision and Clitoridectomy: American Medicine and Sexuality in the Late Nineteenth Century," *Journal of the History of Medicine and Allied Sciences* 63, No. 3 (July 2008), 323.

stopping female masturbation.[328] Throughout the Gilded Age and Progressive Era, physicians classified female masturbation as a form of sexual deviance, and, as Elizabeth Lunbeck has suggested, doing so allowed them to offer "a medical diagnosis for immorality."[329] In addition, medical professionals connected masturbation to other serious medical conditions, including epilepsy, hysteria, and insanity.[330]

Although most clitoridectomies in the United States were performed by male surgeons – a fact that is not, in itself, particularly surprising, given that approximately ninety-five percent of all physicians were men – there is some evidence that female surgeons performed at least a few clitoridectomies. The 1899 report of the Hospital and Dispensary of the Alumnae of the Woman's Medical College of Pennsylvania, for example, lists one clitoridectomy in its record of gynecological surgeries; the 1905 annual report of the New England Hospital for Women and Children lists one "amputation of clitoris," and six additional listings for "clitoridectomy" appear in other annual reports for the early 1900s.[331] Overall, however, the sources suggest that women physicians did not support or perform clitoridectomies as they did hysterectomies, oophorectomies, and salpingectomies. The medical historian Sarah Rodriguez has compiled a list of relevant published cases, and all seem to have been performed by

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[328] See Dally, *Women under the Knife*, 162-164.

[329] Elizabeth Lunbeck, "'A New Generation of Women': Progressive Psychiatrists and the Hypersexual Female," *Feminist Studies* 13 (1987), 513-543.

[330] See Health Collection, Box 1, Folder 9, Sophia Smith Collection, Smith College, for a sampling of medical literature on clitoridectomy from 1818 through the turn of the century.

[331] Records of the Hospital and Dispensary of the Alumnae of the Woman's Medical College of Pennsylvania, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine; Records of the New England Hospital for Women and Children, Box 4, Folder 1, Sophia Smith Collection, Smith College. For a sense of comparison, note that at the New England Hospital for Women and Children, during these same years, women physicians performed hundreds of oophorectomies, salpingectomies, and hysterectomies.

men.[332] Similar case studies are notably absent from the records even of surgeons like Jacobi, Dixon Jones, Keller, and Tyng, who built extensive publication records over the courses of their medical careers and performed oophorectomies, salpingectomies, and hysterectomies frequently.

More work on the relationship between women physicians and clitoral surgeries needs to be done, but in the meantime, I suggest that the decisions made by female surgical gynecologists to support and perform hysterectomies, oophorectomies, and salpingectomies while generally rejecting or avoiding clitoridectomies were directly related to their evolving vision of healthy American femininity. In the simplest possible terms, within this particular construction of femininity, a healthy, normal American woman did not necessarily require a uterus, but she did require a clitoris. It is possible, then, that even during the Gilded Age and Progressive Era, many women physicians were prioritizing sexual pleasure over reproductive capacity, at least in terms of which kinds of gynecological operations were acceptable. Rodriguez has convincingly demonstrated that, contrary to suggestions made by other historians, physicians understood and respected the importance of the clitoris for female sexual pleasure.[333] Case studies show that male physicians frequently performed clitoridectomies regardless of their fairly accurate knowledge about the physiology of orgasm, usually when, as Rodriguez argues, patients displayed symptoms that were perceived as extreme and untreatable through

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[332] See Rodriguez, "Rethinking the History," 324-325. See also her doctoral dissertation. Sarah Webber, "The 'Unnecessary' Organ: Female Circumcision and Clitoridectomy, 1865-1995" (PhD dissertation, University of Nebraska Medical Center, 2005).

[333] Rodriguez, "Rethinking the History," 323-347. Rodriguez specifically refutes claims made by Rachel Maines that "the role of the clitoris in arousal to orgasm was systematically misunderstood by many physicians, since its function contradicted the androcentric principle that only an erect penis could provide sexual satisfaction to a healthy, normal adult female." For this view, see Rachel Maines, *The Technology of Orgasm: "Hysteria," The Vibrator, and Women's Sexual Satisfaction* (Baltimore: The Johns Hopkins University Press, 1999), 9-10.

other means.[334] The evidence suggests that female surgical gynecologists generally did not. Their notion of healthy womanhood, then, seemed to require a capacity for healthy sexual pleasure – even if this "healthy sexual pleasure" was defined in a heteronormative way and limited to the marital relationship.

Clitoridectomy, though, was the exception that proved the rule, and female surgical gynecologists did indeed support the major gynecological operations. There are several relevant explanations for their firm commitment to the promotion of surgical gynecology, even at the expense of female fertility. Most obviously, they believed in the efficacy of hysterectomy, oophorectomy, and other gynecological surgeries, and they did not see conservative therapies as an equally reliable means to relieve the suffering of their patients. Tonics, poultices, and electrical currents, they argued, would not cure cancer or hysteria. I suggest, however, that their support of surgical gynecology also stemmed from their larger ideological beliefs about the gendered practice of medicine. Many of them recognized how limiting Blackwell's idea of the moral, sentimental "lady doctor" could be, and they saw an alternate identity in the form of the "woman surgeon." Blackwell was pioneering in her quest to become the first regular woman physician in the United States, but her ideas about women in the medical profession did not challenge the dominating "separate spheres" ideology. Dixon Jones, Jacobi, and their like-minded colleagues were not content to expand the "woman's sphere" to include a certain kind of medical practice. They had no desire to establish themselves as compassionate feminine practitioners, compelled to engage in traditional kinds of gender performance. Rather,

[334] Rodriguez, "Rethinking the History," 337-338. According to Rodriguez, "most doctors who performed clitoridectomy on women reserved it for the most extreme cases, those women afflicted with what some physicians labeled nymphomania, a condition where they saw no chance of restoring sexual instinct." On nymphomania, see also Carol Groneman, *Nymphomania: A History* (New York: W. W. Norton, 2000).

they favored the elimination of separate spheres altogether. By indicating, in their medical writing and with their medical decisions, that women's bodies were intended for more than reproduction, they contested traditional gender ideology and secured places for themselves within a profession dominated by men.

Feminist Surgical Gynecology

Many female surgical gynecologists were active in early feminist movements, a fact that adds another dimension to their views about women's bodies and women's roles. During the late nineteenth and early twentieth centuries, many women physicians devoted themselves to the most prominent political cause for women: the campaign for suffrage. Jacobi, unsurprisingly, took a radical stance on "the woman question," dedicating much of her time to the suffrage movement. In April of 1894, the *New York Times* emphasized Jacobi's unwillingness to negotiate with the anti-suffragists: "'I don't believe in eternally compromising,' said Dr. Mary Putnam Jacobi, with considerable asperity. . . . 'If they are not for us, they are against us.'"[335] The next month, the newspaper quoted her again: "I am on the warpath, ladies, and I do not propose to act in a conciliatory manner."[336] Jacobi was not alone in combining radical gynecology with feminist politics. Dr. Mary Thompson, for example, who studied at the New England Female Medical College and the Women's Medical College of Pennsylvania in the 1850s and 1860s and became, according to Howard Kelly, "the first woman surgeon who performed capital operations

[335] "No Compromise with Antis," *New York Times,* April 29, 1894.

[336] "Suffragists on the Warpath," *New York Times*, May 3, 1894.

entirely on her own responsibility," was renowned as a "firm suffragist."[337] In the west, furthermore, Dr. Ella Marble became a vocal leader in the suffrage movement, serving as the president of the Minneapolis City and Minnesota State Suffrage Associations.[338] Dr. Sarah Gertrude Banks, who graduated with the University of Michigan's first co-educational class, was committed to suffrage and corresponded frequently with the National American Woman's Suffrage Association.[339] The passionate commitment of these women to feminist causes, especially combined with the radical, uncompromising style exemplified by physicians like Jacobi and Dixon Jones, was consistent with their approaches to gynecology as a medical specialty. As I have argued in previous chapters, there were clear connections between the ways that women perceived their physical bodies and the ways that they understood their roles in American life. Women physicians – especially those who specialists in gynecology or obstetrics – were in a position to see these connections with a unique clarity.

Writing for the *Iatrian* in 1912, Dr. Ellen C. Potter, a professor of gynecology at WMCP, connected the suffrage movement explicitly to the history of women in medicine. "If any group of women ought to stand solidly for 'Votes for Women,'" she argued, "those of the medical profession should constitute that body." In Potter's view, suffrage represented the extension of the values that early medical women stood for. Pioneering women physicians "stood for the right of women to individual expression and to individual service to the Public in any way open to any human being, which principle

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[337] Howard Kelly, *A Cyclopedia of American Medical Biography: Comprising the Lives of Eminent Deceased Physicians and Surgeons, from 1610 to 1910, Vol. II* (Philadelphia: W. B. Saunders Company, 1912), 443.

[338] "Biographical Series," *The Woman's Medical Journal* 5, No. 3 (March 1896), 69.

[339] Sarah Gertrude Banks Papers, Bentley Historical Library, Ann Arbor, Michigan.

is practically the platform upon which the movement for equal suffrage is based."[340] If women believed themselves capable of studying anatomy, practicing medicine, and performing surgery, then, from Potter's perspective, it followed naturally that they were capable of entering the political world capably and responsibly. Her position on women in medicine and her philosophy on appropriate roles for women in American society were thus inextricably linked.

In the following issue of the *Iatrian*, Dr. Eleanor C. Jones, a graduate of WMCP, agreed with Potter and specifically incorporated the question of suffrage into a larger argument about the need to abandon the concept of separate spheres. She made several interesting points. First, Jones pointed to the exclusivity of the traditional Victorian cult of true womanhood. When anti-suffragists warned that suffrage would take women away from their domestic roles as wives and mothers, Jones contended, they painted a narrow, middle-class view of womanhood and neglected the fact that many women, by necessity, already lived outside of the domestic sphere. "What about the six million working women in the world?" she asked. "These women have their own pressing rights to protect and interests to foster, and the ballot is as necessary to them as it is to men, to enable them to secure their due recognition and rights in the fields of labor." This argument was a perceptive one that evidenced her understanding of the roles of race and class in determining ideologies of American womanhood.

Second, Jones suggested that the separate spheres ideology ignored individual interests and talents, according too much significance to the category of gender: "Then there is the question of following one's talent. Why is the home every woman's sphere

[340] Ellen C. Potter, "Concerning Suffrage," *The Iatrian* 18 (February 1912), 4-5, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

any more than the farm is every man's sphere? . . . Indeed, many women have shown peculiar talent in dealing with political conditions." This contention echoed arguments made by women like Rosalie Ladova, who, as we saw in Chapter III, advocated for equal medical training for men and women based on the presumption that individual traits, talents, and preferences mattered more than gender did. Finally, Jones argued against the notion that, instead of stepping definitively into the political world, women should use their "uniquely feminine" virtues to persuade male leaders to make virtuous decisions: "Why should women attempt to influence indirectly when they might influence directly by means of the ballot? America can never be a real democracy until all of the people whether male or female participate equally in the Government. . . . A man can no more represent a woman at the polls than he can in a millinery shop." All three of these arguments revealed the evolving understanding of gender and healthy womanhood among women physicians of the Progressive Era.[341]

Gender, Power, and Radical Gynecology

Some historians and feminists, as we have seen, interpret the dominance of surgical gynecology during the Gilded Age and Progressive Era as representative of male misogyny in general and abuse of medical authority in particular.[342] Others depict it

[341] Eleanor C. Jones, "A Reply," *The Iatrian* 19 (March 1912), 5-6, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

[342] See, for example, G. J. Barker-Benfield, *The Horrors of the Half-Known Life: Male Attitudes toward Women and Sexuality in Nineteenth-Century America*, second edition (New York: Routledge Press, 2000); Mary Daly, *Gyn/Ecology: The Metaethics of Radical Feminism* (Boston: Beacon Press, 1990); McGregor, *Midwives to Medicine*.

simply as a medical trend initiated, developed, and sustained by male doctors.[343] My position is that women were ultimately responsible both for the widespread acceptance of operative gynecology and for the particular forms that it took: acceptable surgeries performed routinely on ovaries, uteruses, and Fallopian tubes, but not on clitorises. Women, particularly female surgical gynecologists, made those surgeries fundamental elements of American gynecology.

The fact that women played such a major part in the development, acceptance, and standardization of operations like oophorectomies, hysterectomies, and salpingectomies does not negate the negative ramifications of the trend. These surgeries, as I have argued, can certainly be perceived as positive; they saved lives, they reduced suffering, and, in a more philosophical sense, they allowed feminists and doctors to argue against the "special sanctity" of female reproductive organs and the corresponding construction of healthy womanhood that centered on reproductive potential. But even if feminist historians have been mistaken in attributing the rise of surgical gynecology to the power of men, they have not been entirely wrong to criticize it. Some women, especially poor women and women of color, were certainly victimized by doctors who operated on them unnecessarily or operated on them without explaining the pertinent risks and ramifications. For example, the removal of apparently healthy ovaries to cure an enormous array of reproductive and non-reproductive ailments – the surgery often called "Battey's operation" after its inventor, Dr. Robert Battey – was frequently unnecessary; it did not cure nervous or psychological ailments, and it introduced the risks of anesthesia and infection. Further, it was often inflicted on vulnerable populations, including the residents of prisons and asylums, who were likely to be from poor,

[343] See, for example, Roy, "Surgical Gynecology."

immigrant, or African-American backgrounds and who could not effectively object when doctors used them as test subjects for their theories.[344] If women – largely the white, privileged "gentlemen's daughters" who attended medical school and went on to practice medicine in urban areas – were responsible for the widespread acceptance of surgical gynecology, then they also deserve a great deal of the blame for the victimization that did happen at the hands of surgeons.

I am aware that some of the most important voices in this history, the voices of the patients themselves, are missing from this chapter. Despite my best efforts, I have not been able to uncover enough evidence to make assessments about how patients viewed these surgeries, whether or not they mourned the loss of organs they may have perceived as sacred, or whether they felt victimized by their physicians, male or female. Medical records sometimes indicate briefly that a doctor believed a patient was "nervous" or "agitated," but beyond that, sources shed frustratingly little light on the patients themselves. For white women of middle-class backgrounds, I can at least surmise that they sometimes had some agency, some choice in deciding to seek medical care and complying with the recommendations of their physicians and surgeons. Sources show these women returning again and again to their doctors offices and, in some cases, corresponding with these doctors for extended periods of time. Caroline McGee Stewart, for example, wrote regularly to the Philadelphia obstetrician and gynecologist Robert M. Girvin about her condition and her treatment.[345] For the populations with the least power

[344] See Roy, "Surgical Gynecology," 189-190; Andrew Scull and Diane Fabreau, "A Chance to Cut is a Chance to Cure," *Research in Law, Deviance, and Social Control* Vol. 8 (1896), 3-39. For a treatment of Battey's operation dealing with Canada, but which applies to the American context as well, see Wendy Mitchinson, "Gynecological Operations on Insane Women: London, Ontario, 1895-1901," *Journal of Social History* Vol. 15 (1982), 467-484.

[345] McGee letters, Series 1, Robert M. Girvin Letters, College of Physicians of Philadelphia.

and the most vulnerability, though – patients of color, patients located in prisons and asylums – I have been able to find nothing at all.

The history of surgical gynecology in late-nineteenth- and early-twentieth-century America, then, is one shaped primarily by medical women, working with and against medical men. This dynamic shifts in the next chapter, where we will see medical and lay women working together to completely revolutionize early-twentieth-century American obstetrics.

CHAPTER V

"If YOU WOMEN WANT IT YOU WILL HAVE TO FIGHT FOR IT": THE REVOLUTION IN EARLY-TWENTIETH-CENTURY OBSTETRICAL CARE

In 1892, Alice Jones, pregnant with her first child, asked her sister, Dr. Bertha Van Hoosen, to manage her labor and delivery. At the time, prenatal care was in what Van Hoosen described as an "embryonic state," and Jones had not sought any medical advice during her early pregnancy. Even Van Hoosen, an obstetrician, simply advised her sister to eat a nutritious diet, take in fresh air, and get sufficient rest. Like most late-nineteenth-century American women, Jones gave birth at home; indeed, Van Hoosen explained in her autobiography that a hospital birth "never occurred to us. In 1892 the Woman's Hospital in Detroit received only delinquent girls as patients, and home deliveries were the vogue."[346] When Jones's contractions became painful and regular, she went to bed, and Van Hoosen checked on her hourly to assess her progress and listen to the fetal heartbeat. Labor proceeded normally at first, but after thirty hours of labor, an alarmed Van Hoosen could no longer detect the heartbeat, and so she called for chloroform and used the techniques she had learned in medical school and during her internships: "Hastily, but with no difficulty the forceps were adjusted, and gentle traction made. . . . Through the narrow passage, with the aid of instruments, the baby moved, turned, and descended until the birth was checked only by the resistance of the skin at the outlet. The scissors quickly removed that barrier, and birth was allowed to take place."

[346] Bertha Van Hoosen, *Petticoat Surgeon* (Chicago: People's Book Club, 1947), 90.

Though her newborn niece displayed "no signs of life," Van Hoosen successfully resuscitated her, and Jones and her daughter both survived.[347]

In a number of ways, Jones's pregnancy and delivery were typical for a middle-class woman in the late-nineteenth-century United States. The time period was characterized by a transition between what Richard W. and Dorothy C. Wertz have termed "social childbirth" – a ritual-based process dating back to the colonial period and emphasizing the cooperative work of female midwives, friends, and relatives – and the fully medicalized (and typically hospital-based) obstetrical childbirth of the twentieth century.[348] In 1892, when Jones delivered her daughter, most women received little or no prenatal care and gave birth at home; however, unlike their early American predecessors, many were now attended in childbirth by obstetricians, who sometimes employed instruments like the forceps and scissors that Van Hoosen used. Obstetric anesthesia was used sometimes by some doctors but was not standard, and chloroform and ether were the only available options.[349]

Van Hoosen's account of what a typical childbirth under her care usually looked liked seventeen years later, in 1915, stands in stark contrast to her sister's 1892 experience. By 1915, Van Hoosen's patients, like many middle-class patients and some working-class patients, were beginning to receive some routine prenatal care, including specific instructions on diet, exercise, weight gain, and preparation for the baby's

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[347] Van Hoosen, *Petticoat Surgeon*, 94-96.

[348] Richard W. and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New Haven: Yale University Press, 1989), 2. On this transition, see also Nancy Schrom Dye, "The Medicalization of Birth," *The American Way of Birth*, edited by Pamela S. Eakins (Philadelphia: Temple University Press, 1986), 21-22.

[349] See Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986), 116-127; Jacqueline H. Wolf, *Deliver Me from Pain: Anesthesia and Birth in America* (Baltimore: The Johns Hopkins University Press, 2009), 13-43.

arrival.[350] Then, as soon as one of Van Hoosen's patients realized she was in labor, she was admitted to a hospital and given an injection of scopolamine and morphine, inducing a semi-conscious state known as "twilight sleep." Next, the patient received an enema and went to bed, where she was given additional injections of scopolamine every hour or every half hour, depending on the intensity of her contractions. Nurses prepared her vulva with antiseptic solution and wrapped her in a special hospital gown with a continuous sleeve, keeping her hands bound. From that point until the head of the baby became visible in the vaginal canal, the patient was essentially left alone: according to Van Hoosen, she "needs not be touched except to be given every two hours 1/100 gram of scopolamine to maintain the anesthesia." Van Hoosen then delivered the newborn, frequently with the aid of instruments.[351] By the end of the 1910s, this process was generally accepted as the "normal," "healthy" childbirth experience, especially in urban areas.

The preceding three chapters demonstrated that medical women played significant roles in shaping the medical construction of healthy American womanhood during the Gilded Age and Progressive Era. Between 1870 and 1920, gynecologists and obstetricians of both sexes consolidated their authority over women's physical bodies and social roles, and female physicians, scientists, and medical students helped to determine

[350] Wertz, *Lying-In*, 139-141. Prenatal care, as Wertz and Wertz have demonstrated, was also more meaningful by this point because doctors were learning how to catch and treat certain complications of pregnancy, including eclampsia and maternal syphilis, early.

[351] Bertha Van Hoosen, *Scopolamine-Morphine Anaesthesia* (Chicago: The House of Manz, 1915), 40-42. The use of instruments varied across time and place, but during the 1910s, forceps deliveries and episiotomies – the same interventions Van Hoosen had used when she delivered her niece in 1892 – were still quite common, especially in hospitals. In fact, Wertz and Wertz have argued that by the end of that decade, "doctors believed that 'normal' deliveries, those without convulsions, deformed pelves, protracted and difficult labor, the threat of sepsis or of tears in the woman's perineum, were so rare as to be virtually non-existent. The doctors saw every birth as varying from the normal, and thus as potentially pathogenic, or disease-causing. They concluded, therefore, that routine interventions should be made during every labor and delivery in order to prevent trouble." Wertz, *Lying-In*, 141.

how that power would ultimately be exercised. At no point, however, were all women outside of the medical community completely powerless. Instead, in the context of an expanding medical marketplace, female patients made thoughtful choices about the types of care they wanted to receive – a pattern that became increasingly visible in the early decades of the twentieth century, and especially in relation to childbirth. When physicians did not meet patients' expectations, or when medical professionals disagreed about how best to address them, patients and activists campaigned successfully for the medical treatments and childbirth experiences they found desirable.

This chapter examines the evolution of obstetrics. It focuses on two major changes, the first gradual and the second explosive, that took place within that specialty during the early twentieth century: the rise of standardized prenatal care and the campaign for twilight sleep. As insiders and outsiders, women initiated and promulgated both of these changes. The cooperation of lay women proved crucial to the medicalization of maternal bodies, a key component to early-twentieth-century prenatal care and hospital birth; the activism of lay women was instrumental in determining the precise shape that these developments would take. Male specialists did not simply force women to abandon pregnancy and childbirth experiences like Alice Jones's in favor of experiences like those of Van Hoosen's typical 1915 patients. Rather, they interacted with a number of influential women inside and outside of the medical community to produce that shift.

Like the scholarship on gynecology, many existing medical histories of obstetrics tend to emphasize the contributions of men and the increasing control of male

obstetricians over female patients over the first two thirds of the twentieth century.[352] Similarly, feminist critiques of modern obstetrics also focus almost exclusively on male control, highlighting the campaigns of obstetricians (categorized almost universally as male) against midwives (categorized almost universally as female) and the related movement of American childbirth from the home to the hospital, which they characterize as an example of men seizing control of childbirth from women.[353] In contrast, my goal is to illuminate the ways that women themselves shaped major developments that changed the practice of obstetrics in the United States. In doing so, I build on a number of earlier social histories of childbirth and on histories of obstetric anesthesia, but unlike most of this existing scholarship, I foreground female agency, especially in the form of collaborative efforts between medical and lay women.[354] As with gynecology, obstetrics developed from the work of women as active agents.

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[352] See, for example, William Arney, *Power and the Profession of Obstetrics* (Chicago: University of Chicago Press, 1982); Judith Walzer Leavitt, "The Growth of Medical Authority: Technology and Morals in Turn-of-the-Century Obstetrics," *Women and Health in America: Historical Readings*, second edition, edited by Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1999); Cheryl Lemus, "The Maternity Racket: Medicine, Consumerism, and the Modern American Pregnancy, 1876-1960" (Ph.D. diss., Northern Illinois University, 2011); Lawrence D. Longo, "Obstetrics and Gynecology," *The Education of American Physicians: Historical Essays*, edited by Ronald L. Numbers (Berkeley: University of California Press, 1980).

[353] See Dye, "Medicalization of Birth;" Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (New York: Doubleday, 1978); Diana Scully, "From Natural to Surgical Event," *The American Way of Birth*, edited by Pamela S. Eakins (Philadelphia: Temple University Press, 1986).

[354] See, for example, Tina Cassidy, *Birth: The Surprising History of How We Are Born* (New York: Grove Press, 2006); Donald Caton, *What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present* (New Haven: Yale University Press, 1999); Leavitt, *Brought to Bed*; Margarete Sandelowski, *Pain, Pleasure, and American Childbirth: From the Twilight Sleep to the Read Method, 1914-1960* (Westport: Greenwood Press, 1984); Wertz, *Lying-In*; Wolf, *Deliver Me from Pain.*

The Development of Standardized Prenatal Care

Women were a driving force behind the initiation and standardization of prenatal care in the United States. In 1914, the Committee on Prenatal and Obstetrical Care, headed by the reformer Elizabeth Lowell Putnam and organized by the Women's Municipal League of Boston, reported that it had "made the first attempt to determine scientifically what benefit would accrue to mothers and babies if prenatal care were to be given as a matter of routine throughout, as nearly as possible, the full period of pregnancy." Putnam believed this study was a significant one and emphasized the revolutionary nature of this idea, suggesting that the committee's work could change pregnancy and childbirth completely by predicting and preventing complications of pregnancy instead of simply treating them when they arose:

> Pregnant women have been visited time out of mind by their physicians where signs of illness seemed to make such visits necessary, but the investigation here reported was undertaken with a view to determining the possibility of preventing through medical care the very illness which doctors had hitherto only been called in to cure. The work has always been experimental throughout its five years of existence. . . . The committee has felt itself always to be merely the sign post pointing the way to the great help which others would give.[355]

The experiment was a success, according to Putnam, who suggested that the kind of prenatal care investigated by the committee could yield better outcomes for both mothers and babies. In five years, the obstetricians, nurses, and social workers involved with the Committee on Prenatal and Obstetrical Care oversaw more than 1500 pregnancies. Over the course of the study, not a single mother died during pregnancy, less than one percent died during labor and delivery, and less than three percent of the infants died within the

[355] Elizabeth Lowell Putnam, "Report of the Committee on Infant Social Service now changed to The Committee on Prenatal and Obstetrical Care of the Women's Municipal League of Boston," Box 8, Folder 160, Elizabeth Lowell Putnam Papers, Schlesinger Library, Harvard University.

first month of life.[356] As other historians have already noted, these statistics were certainly more favorable than the national averages.[357] The Women's Municipal League of Boston soon expanded its work on prenatal care to include three clinics: the original one, located at Peter Brent Brigham Hospital, and two new ones at the Maverick Dispensary and the Cambridge Neighborhood House.[358]

Putnam was not a doctor or a nurse herself, and she had no scientific or medical training; she was the daughter of a distinguished New England family, the wife of a prosperous Boston lawyer, the mother of five children, and a prominent Progressive-Era reformer.[359] Like that of many female progressive reformers, her work was generally fueled not by a particularly feminist consciousness but by the same maternalist sentiment that motivated early women physicians like Elizabeth Blackwell. She wrote that a woman's central responsibility "must always be at home and her best effort must be given to her home and what makes for the betterment of homes the world over."[360] These sentiments were consistent with the ideology of municipal housekeeping that validated women's activism by connecting domestic work to community work.[361] Her

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[356] Elizabeth Lowell Putnam, "Suggestions on Prenatal Care Founded on a Five Year Experiment," Box 4, Elizabeth Lowell Putnam Papers, Schlesinger Library, Harvard University.

[357] See Richard Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Baltimore: Johns Hopkins University Press, 1990), 239; Robyn L. Rosen, *Reproductive Health, Reproductive Rights: Reformers and the Politics of Maternal Welfare, 1917-1940* (Columbus: The Ohio State University Press, 2003), 11. Neonatal morality rates were 4.3 percent nationally.

[358] Rosen, *Reproductive Rights*, 11.

[359] On Putnam in general, see Rosen, *Reproductive Health,* especially the first chapter, 1-36.

[360] Elizabeth Lowell Putnam, "Woman and the Ballot," *Boston Common* (August 20, 1910), Box 27, Scrapbook 1, 128, Elizabeth Lowell Putnam Papers, Schlesinger Library, Harvard University.

[361] For more on municipal housekeeping, see, for example, Suellen Hoy, *Chasing Dirty: The American Pursuit of Cleanliness* (New York: Oxford University Press, 1995), 72-75.

commitment to prenatal care exemplified the municipal housekeeping perspective and fit the prevailing progressive sentiments of the early twentieth century. As Richard Meckel has noted, during the early 1900s, the progressive focus on infant welfare came to include prenatal and maternal health, as opposed to focusing solely on infant mortality and infant nutrition.[362] Putnam's work epitomized this shift.[363]

Unlike many of her fellow reformers, though, Putnam remained firmly focused on implementing prenatal care for women of the middle class. While other Progressive-Era activists worked to "save" poor mothers and babies – often with a characteristic condescension that stemmed from racial, ethnic, and class biases – Putnam ignored them entirely, concentrating all her efforts on more privileged pregnant women. As a general rule, she disliked charity, and in 1917 she argued further that, regardless of one's stance on the value of benevolence, middle-class women needed the most assistance. She based that claim on the fact that "the rich can afford the best care and to the poor – a very large number of the poor – it is given free in the clinics of the best hospitals."[364] This perspective was either deliberately misleading or simply misguided; as Robyn Rosen has argued, even when poor women did receive free care (and many did not), they were often viewed and treated with contempt.[365] In addition, they frequently received cursory, clumsy, or otherwise inadequate care, as their presence in hospitals and dispensaries

[362] Meckel, *Save the Babies*. As Ruth Rosen has pointed out, Putnam's earliest work in the pure milk movement epitomized Meckel's description of the earlier focus on infant nutrition. See Rosen, *Reproductive Health*, 7.

[363] Robyn Rosen has noted that this shift brought new attention to pregnancy and the pregnant body. See Rosen, *Reproductive Health*, 11.

[364] Elizabeth Lowell Putnam, untitled article draft, Box 3, Elizabeth Lowell Putnam Papers, Schlesinger Library, Harvard University. See also Rosen, *Reproductive Health*, 12.

[365] Rosen, *Reproductive Health*, 12.

served as training opportunities for medical students and experimental opportunities for physicians.[366] Taken together, these facts meant that the care poor women received in hospitals and clinics was not particularly helpful and sometimes even did more harm than good.

Despite her inaccurate assumptions about the care available to poor women, by associating her work on maternal health with the experiences of middle-class women, I suggest that Putnam increased the likelihood that her particular vision of routine prenatal care would come to be seen as part of "normal," healthy American pregnancy and childbirth. Putnam's Committee on Prenatal and Obstetrical Care advocated regular, physician-led prenatal care for healthy women throughout their pregnancies, provided for a cost that Putnam described as "moderate" for middle-class families.[367] This kind of care – very similar to the routine prenatal care that became almost universal by the middle decades of the twentieth century – was different in tone and character from the care provided to poor and desperate women in dispensaries and charity wards. By underscoring the fact that healthy middle-class women would pay modest sums to take a proactive approach to ensuring healthy offspring, Putnam differentiated those patients from the stereotyped masses of uneducated destitute women who wound up in hospitals and clinics because they were forced there out of medical necessity or because they could not pay for anyone else to care for them. The women involved with the Committee's experimental work on prenatal care – and the women involved with subsequent programs

[366] See, for example, Leavitt, *Brought to Bed*, 75.

[367] The women involved in the Committee's experimental study paid between five dollars and ten dollars each for their care, and Putnam proposed that clinics could thereby support themselves. She noted in her report that "the committee is particularly glad to report that the number of patients paying for the services of the nurses is increasing. This is very desirable, for the value of all such work is greatly enhanced if it be self-supporting." See Putnam, "Report of the Committee."

based on Putnam's work – therefore participated in a shift from reactive obstetrics to preventive care, care that pregnant women themselves were depicted as at least partially responsible for obtaining and complying with. This shift moved pregnancy one step closer to the fully-medicalized ideal of the mid-twentieth century.

This medicalized modern pregnancy, then, may have been overseen by mostly male obstetricians, but it was not simply forced on female patients by male authorities. Putnam was female, as were the nurses and social workers who worked with the Women's Municipal League of Boston on the prenatal care project. Moreover, as we have already seen, this concern with maternal and infant health originated with woman-centered Progressive-Era reform movements. In addition, Putnam emphasized the fact that though standards of prenatal care should be developed and overseen by obstetricians ("to be successful," she wrote, prenatal care "must be mostly medical"), much of the day-to-day care of patients could be handled by nurses and other workers, who were mostly female, required only minimal training, and could manage up to one hundred patients at any given time. Most of the care that pregnant women required was, Putnam explained, "not difficult to give."[368] Therefore, though the importance of medical authority cannot be dismissed, it also tells only part of the story. The work of the Women's Municipal League of Boston, I argue, should actually be seen as an example of collaboration between medical experts and lay women, and in this particular case, the lay women were primarily responsible for the distinct shape that the Committee's version of prenatal care would take.

Furthermore, instead of resisting it or meeting it with indifference, many female patients seemed eager to embrace this new form of obstetrical care. In Boston, at least,

[368] Putnam, "Report of the Committee."

women turned out to be willing to pay for routine prenatal care. They were also willing to comply with the Committee's schedule of visits, seeing obstetricians and nurses regularly rather than perhaps once or twice at most before delivery. Their willingness to devote their money and their time to this new form of medical care during pregnancy suggests that physician-directed prenatal care was something that many women found desirable.

Outside of Boston, the enthusiasm with which women besieged the federal U.S. Children's Bureau for information and reassurances about their pregnancies suggests that prenatal care was filling a need that women of the time period perceived as urgent.[369] Women of every race and class and from every geographical region wrote to the Children's Bureau, founded in 1912 and run primarily by women, for information about pregnancy, childbirth, and child-rearing. Their letters reveal tremendous anxiety about their pregnancies and the health of their unborn children, and they also show that early-twentieth-century women consciously sought the advice of medical experts. They received responses that encouraged them to disregard superstitions about pregnancy and follow "the rules of hygienic living, getting plenty of rest, proper food, exercise out-of-doors, and above all, keeping a sane wholesome point of view on life."[370] These responses would likely have reassured many anxious pregnant women by debunking superstitions like maternal marking (the idea that a pregnant woman's experiences, especially shocking and frightening ones, could "imprint" on her unborn child, causing

[369] On the Children's Bureau, see Molly Ladd-Taylor, *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915-1932* (New Brunswick: Rutgers University Press, 1986); Meckel, *Save the Babies*; Leslie J. Reagan, *Dangerous Pregnancies: Mothers, Disabilities, and Abortion in Modern America* (Berkeley: University of California Press, 2010), 7-17.

[370] These "rules" come from a letter from a woman physician, Dr. Viola Anderson, in response to one letter sent to the Children's Bureau. Quoted in Reagan, *Dangerous Pregnancies*, 10.

birth defects and other problems) and giving them some clear basic guidelines to bolster their chances of delivering a healthy baby.[371] Many of them would have consequently moved past their feelings of fear and hopelessness and gained a newfound sense of empowerment, feeling that they could take action to ensure the health of their unborn children.

It was reasonable, from a medical perspective, that these women would seek out prenatal care so enthusiastically around this time. Due primarily to expanding medical knowledge and technology, physicians in the early twentieth century could indeed help many of these women avoid common problems related to pregnancy and childbirth. After 1910, for example, doctors knew how to reduce the likelihood of eclampsia (a condition, also known as "toxemia of pregnancy," which could lead to seizures and death) through rest, nutrition, and drugs; when preventive measures failed, they could diagnose eclampsia earlier with urine tests for albumin. Since eclampsia was thought to occur in approximately one in every five hundred pregnancies, these were important developments.[372] In addition, the new Wassermann test, which detected syphilis antibodies in the blood, enabled physicians to diagnose maternal syphilis; they could then sometimes prevent congenital syphilis in the infant by treating pregnant women with Salvarsan.[373] This advance was also a significant one, as some studies showed that as

[371] The idea of "maternal marking" seems to have been fairly prevalent in the nineteenth and early twentieth centuries. Many women worried that if they saw something gruesome or frightening, or if they saw someone who was visibly disfigured, their unborn child could be injured. See Reagan, *Dangerous Pregnancies*, 8-10.

[372] See C. A. Kirkley, "Eclampsia," *The American Journal of Obstetrics and Diseases of Women and Children* Vol. 52 (1905), 347; "Puerperal Eclampsia," *The Journal of the American Medical Association* Vol. LVIII, No. 11 (1912), 781.

[373] See John Woods Marchildon, *The Wassermann Reaction: Its Technic and Practical Application in the Diagnosis of Syphilis* (St. Louis: C. V. Mosby Company, 1912); Max Nonne, *Syphilis and the Nervous*

many as ten percent of urban pregnant women had syphilis, and the Children's Bureau reported, in 1916, that there had been 73,000 infant deaths from syphilis in that year alone.[374]

The fact that these kinds of diagnostic tools did not exist in the nineteenth century probably accounts, at least to some extent, for the failure of most obstetricians of either sex to attempt to make regular office visits throughout pregnancy a regular part of their business before the early twentieth century. There would have been a significant financial incentive to medicalize pregnancy as early and to the fullest extent possible, but until the 1900s, there were simply very few valuable services that physicians could offer pregnant women. By the turn of the twentieth century, though, physicians began to see pregnancy as a period full of opportunity for medical action. And yet, it remains significant that once these kinds of technologies had been developed, women both inside and outside the medical community – not male specialists – were the ones campaigning most aggressively for standardized prenatal care.

These developments led to a more medicalized construction of pregnancy and childbirth, then, but they also inspired a new model of motherhood that made pregnant women active agents in the pursuit of a normal pregnancy and a healthy baby. Middle-class women chose to seek regular care in the first place, care for which they had to pay; they then kept regular appointments with their obstetricians and nurses, followed increasingly detailed sets of instructions regarding nutrition and weight gain, and

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System, for Practitioners, Neurologists, and Syphilologists (Philadelphia: J. B. Lippincott and Company, 1913), 385. On the development of Salvarsan, an arsenical compound that was developed in Germany in 1909, came into use in the United States by 1911, and ultimately initiated "the modern age of chemotherapeutics," see Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York: Oxford University Press, 1985), 40-41. On congenital syphilis in particular, see Brandt, *No Magic Bullet*, 10-11.

[374] Wertz, *Lying-In*, 140. On syphilis and other sexually transmitted infections, see

submitted to diagnostic tests designed to prevent eclampsia, congenital syphilis, and other potential health problems in themselves or their unborn children. Cheryl Lemus has perceptively suggested that during this period, the image of the "modern pregnant woman" emerged, in the form of a white, middle-class woman who embraced scientific and medical progress, sought to obtain the best prenatal care, and complied with the advice and instructions of medical experts.[375] This new construction of the modern pregnant woman corresponded with the developing ideology of "scientific motherhood," which applied the same values of education, scientific progress, and expert advice to the process of childrearing, particularly among white, middle-class American women.[376] For female patients as well as for doctors, pregnancy therefore became a period of planning, education, and action, rather than a period of waiting and hoping.

For the middle-class women who sought prenatal care during the first decades of the twentieth century, this new role – that of the modern pregnant woman – carried both positive and negative implications. On the positive side, prenatal care did save lives; Putnam's reports and subsequent studies revealed that women who sought prenatal care fared better before and after delivery.[377] Historians of women, gender, and pregnancy, however, have focused almost exclusively on the negative, suggesting that the medicalized modern pregnancy represented an increased authority for physicians (who, as I have argued previously, they typically construct as male) and a corresponding loss of

[375] Lemus, *The Maternity Racket*, 4.

[376] On scientific motherhood, see Rima Apple, *Mothers and Medicine: A Social History of Infant Feeding, 1890-1950* (Madison: University of Wisconsin Press, 1987); Julia Grant, *Raising Baby by the Book: The Education of American Mothers* (New Haven: Yale University Press, 1998).

[377] Twenty-first-century physicians and researchers still view prenatal care as an essential component of a healthy pregnancy for the mother and a healthy infancy for the baby. See S. B. Amini, "Effect of Prenatal Care on Obstetrical Outcome," *Journal of Maternal-Fetal Medicine* Vol. 5, No. 3 (1996), 142-50.

power for women.[378] They have also pointed out that as women assumed this more active ideal, pursuing and paying for proper care and following their doctors' specific guidelines, they also assumed a new perceived level of responsibility for their pregnancies. This perception led to misplaced guilt and shame when women failed to comply fully with physicians' orders or when pregnancies did not culminate in the births of completely normal, healthy babies, and this is a negative consequence of medicalization with which I agree. Female patients indeed felt responsible for the outcomes of their pregnancies and, because of the corresponding ideology of scientific motherhood, for the outcomes of their child-rearing practices in general.[379] The resulting worry, guilt, and frustration, I argue, led them to continue seeking the advice of experts and, when possible, to give these experts almost complete control of the most stressful and frightening aspects of reproduction and motherhood, including the childbirth experience.

The Campaign for "Painless Childbirth"

As Van Hoosen's description of her typical 1915 maternity patients illustrates, the new routine prenatal care of the twentieth century and the new model of modern pregnancy culminated in a hospital birth attended by a physician. Like standardized prenatal care, I contend that hospital birth was not something foisted upon women by

[378] See Lemus, *The Maternity Racket*, 28-30; Meckel, *Save the Babies*; Ann Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (New York: Basil Blackwell, 1984); Wertz, *Lying-In*.

[379] See Apple, *Mothers and Medicine;* Rima Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick: Rutgers University Press, 2006; Lemus, *The Maternity Racket*, 38-40; Jacqueline Wolf, *Don't Kill Your Baby: Public Health and the Decline of Breastfeeding in the 19th and 20th Centuries* (Columbus: Ohio State University Press, 2001), chapters 1 and 2.

male medical experts but rather something that many women actively desired. This fact is exemplified by the twilight sleep movement of the 1910s, which also serves as an excellent representation of the kinds of collaboration taking place between medical and lay women. Twilight sleep, like prenatal care, offered a kind of reassurance to anxious women.

In June of 1914, *McClure's Magazine* published "Painless Childbirth," which joyfully announced that German obstetricians had "abolished that primal sentence of the Scriptures upon womankind: 'in sorrow thou shalt bring forth children.'" The authors, lay women Marguerite Tracy and Constance Leupp, explained that physicians at the Freiburg Frauenklinik had finally perfected a treatment known as "dammerschlaf" or "twilight sleep," which involved injecting laboring women first with a combination of morphine and scopolamine and then, periodically, with scopolamine alone. As a result, patients at the Frauenklinik progressed through labor and delivery in a state of semi-consciousness and woke, the next day, with no memory of giving birth. According to Tracy and Leupp, the procedure was nothing short of miraculous:

> From the standpoint of the mothers, there is but one testimony concerning this Twilight Sleep as given them at Freiburg. When their pains began, they tell you, they went to sleep. Of their part in the events that followed they retain no more memory than a somnambulist might have of the roof he walked upon at night. They woke happy and animated, and well in body and soul; and found, with incredulous delight, their babies, all dressed, lying before them upon a pillow in the arms of a nurse. Those mothers who have once borne children in the Freiburg hospital return, if possible, when childbirth comes upon them again.[380]

Twilight sleep appealed to many American women, who, in 1914, remained almost universally terrified of the inescapable pain and potential death associated with

[380] Marguerite Tracy and Constance Leupp, "Painless Childbirth," *McClure's Magazine* XLIII (June 1914), 38.

childbirth.[381] "Painless Childbirth" received more attention than any piece *McClure's* had previously published, and magazines like *Ladies' World* and *Ladies' Home Journal* rushed to run similar articles.[382]

The popular excitement surrounding twilight sleep intensified as full-length books, such as Hanna Rion Ver Beck's *The Truth about Twilight Sleep*, began appearing.[383] *The Truth about Twilight Sleep* was crafted as a persuasive device, not a scientific contribution, and it was aimed at a popular audience, not a professional one. At the time of its publication in 1915, most American physicians had not yet adopted the techniques developed in Freiburg. Ver Beck implored her readers to recognize the immense relief that the treatment could provide to suffering women, and she exhorted them to take action: "Fight not only for yourselves, but fight for your sister-mothers, your sex, the cradle of the human race."[384] Less than one year after the news of twilight sleep broke in the United States, certain lay women – especially, as Judith Walzer Leavitt has

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[381] Historians have already addressed this pervasive fear of pain and death in childbirth extensively. See, for example, Leavitt, *Brought to Bed*, 13-35; Sandelowski, *Pain, Pleasure, and American Childbirth*, 5-9; Edward Shorter, *A History of Women's Bodies* (New York: Basic Books, 1982), 69-87; Wertz, *Lying-In*, 109-128. Jacqueline H. Wolf also addresses the fear of pain and the characterization of labor and delivery as "terrible torture," though she contrasts these views with depictions of childbirth as a time of "cheerfulness and gayety." See Wolf, *Deliver Me from Pain*, 1-9.

[382] Mary Boyd and Marguerite Tracy, "More about Painless Childbirth," *McClure's Magazine* XLIII (October 1914), 56. Other articles include Van Buren Thorne, "'Twilight Sleep Is Successful in 120 Cases Here," *New York Times Magazine* (August 30, 1914), 8; Marguerite Tracy, "Bringing Babies into the World," *Ladies World* (September 1914), 9-10; Hanna Rion Ver Beck, "The Painless Childbirth: Testimony of American Mothers Who Have Tried 'The Twilight Sleep,'" *Ladies' Home Journal* (September 1914), 9-10.

[383] See Amy H. Hairston, "The Debate over Twilight Sleep: Women Influencing Their Medicine," *The Journal of Women's Health* 5, No. 4 (1996), 489. In addition to Ver Beck's book, see also Marguerite Tracy and Mary Boyd, *Painless Childbirth: A General Survey of All Painless Methods with Special Stress on "Twilight Sleep" and Its Extension to America* (New York: Frederick A. Stokes Company, 1915). Medical monographs on twilight sleep and obstetric anesthesia also flourished during this time. See, for example, American Journal of Clinical Medicine, *Twilight Sleep and How to Induce It* (Chicago: American Journal of Clinical Medicine, 1915); Alfred M. Hellman, *Amnesia and Analgesia in Parturition (Twilight Sleep)* (New York: Paul B. Hoeber, 1915).

[384] Hanna Rion Ver Beck, *The Truth about Twilight Sleep* (New York: McBride, Nast, and Company, 1915), 358.

demonstrated, wealthy white club women – along with a few women physicians like Bertha Van Hoosen and Eliza Taylor Ransom, heeded Ver Beck's call and began to mobilize.[385] Impatient with physicians in the United States, they organized the National Twilight Sleep Association and began campaigning aggressively to make the treatment widely available.[386]

In terms of its stated goal, the NTSA was an unqualified success. Over the course of 1915, twilight sleep became increasingly popular in the United States. It was used regularly in the specialty wards where wealthy women gave birth and, to a somewhat lesser extent, physicians began employing it in some of the charity hospitals where poorer women sometimes delivered their babies.[387] Rachel S. Yarros, a graduate of WMCP who became an obstetrician, gynecologist, and advocate of birth control and sex education, recalled using twilight sleep when caring for some of Chicago's poorest parturient women – which, she said, "relieved the horrors of suffering and made the work a joy."[388] Physicians who had originally objected to twilight sleep on the grounds that it was inadequately tested, potentially lethal, or simply impractical yielded quickly to consumer demand. Elite women were willing to pay for the treatment, and specialists who refused to provide it risked losing valuable business. As patients, consumers, and activists, the

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[385] Ransom, a graduate of Johns Hopkins Medical School, went on to open the first twilight sleep hospital in the United States. See the Eliza Taylor Ransom Papers, Schlesinger Library, Harvar University.

[386] Leavitt, *Brought to Bed,* 131.

[387] Leavitt, *Brought to Bed*, 134.

[388] Rachel S. Yarros, "The Experiences of a Graduate of 1893," *75th Anniversary Volume of the Woman's Medical College of Pennsylvania*, Special Colllections on Women in Medicine and Homeopathy, Drexel University School of Medicine. Yarros, who also spent time interning at the New England Hospital for Women and Children, was a staunchly feminist physician who worked with women inside and outside the medical profession to improve the condition of American women throughout her life. See also the Deceased Alumnae File for Rachel Slobodkinsky Yarros, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University.

women who formed the NTSA exerted tremendous pressure on gynecologists and obstetricians, and their ultimate victory reveals that lay women, especially in connection with medical women, could sometimes compel physicians to change their methods.

Though the campaign for twilight sleep seemed, on the surface, like an attack on male medical authority, the success of the NTSA also furthered the goals of early-twentieth-century physicians. The use of morphine and scopolamine required constant medical supervision, so obstetricians could insist that twilight sleep be dispensed only in institutional settings. Because major goals of the medical community included expanding obstetrics, eliminating midwifery, and delivering babies in hospitals, many physicians perceived the connection between twilight sleep and hospital births as exceedingly advantageous.[389] Moreover, gynecologists and obstetricians appreciated the level of control that twilight sleep afforded them. Van Hoosen noted in her autobiography that twilight sleep relieved her of many annoyances, including the need to provide verbal support to the laboring mother, who, under the influence of morphine and scopolamine, was now present "only physically." In addition, she escaped the aggravation of dealing with the patient's friends and relatives, who were not permitted to remain in the delivery room when narcotics were used.[390] Therefore, physicians benefited from the adoption of twilight sleep in a variety of ways not particularly favorable for patients, whose laboring bodies were now constructed by medical professionals as inert entities rather than as conscious women.

Proponents of twilight sleep initiated a major shift in the management of childbirth in the United States. As they worked to convince physicians to adopt the use

[389] Leavitt, *Brought to Bed,* 134.

[390] Bertha Van Hoosen, *Petticoat Surgeon* (Chicago: Pellegrini and Cudahy, 1947), 283.

of morphine and scopolamine, they succeeded so unequivocally that they generated a new formula for labor and delivery, a formula brought into being by patients and activists but defined and cemented by gynecologists and obstetricians. The new "normal" labor and delivery placed control of childbirth exclusively in the hands of medical specialists and involved no conscious participation on the part of laboring women. Though many of the activists who advocated this form of female passivity during childbirth were feminists, just fifty years later, a new generation of feminists would work to reverse the accomplishments of the NTSA, emphasizing female control, conscious delivery, and natural birth. This striking change suggests that though the NTSA gave many women the resources to fight for the birth experiences they wanted, on balance, the twilight sleep movement may have strengthened medical authority more than it empowered obstetric patients.

Historians who have addressed the twilight sleep movement have, in general, offered oversimplified or insufficient answers to the question of why semi-consciousness in childbirth became a goal for first-wave feminists. Leavitt, who has analyzed the NTSA more extensively than any other scholar, contends that the movement was actually "an attempt to gain control over the birth process." Determined to depict the leaders of the NTSA as proponents of female control of childbirth, Leavitt acknowledges only an "apparent contradiction" – not, evidently, a genuine, problematic one – "in the women's demand to control their births by going to sleep."[391] This understanding of the twilight sleep campaign is, in fact, gravely contradictory, and although Leavitt's analysis of its long-term consequences is insightful and compelling, she ultimately fails to characterize

[391] Judith Walzer Leavitt, "Birthing and Anesthesia: The Debate over Twilight Sleep," *Signs* 6, No. 1 (autumn 1980), 148.

the NTSA's motivations accurately. Richard and Dorothy Wertz and Margarete Sandelowski have offered more nuanced explanations for the phenomenon, pointing, for example, to the relationship between twilight sleep and "female passivity."[392] Their analyses do not, however, fully incorporate factors like class or eugenics, and they do not examine the role of early-twentieth-century relationships between lay women and their physicians.

In 1914 and 1915, I argue, first-wave feminists wanted to give up control of childbirth. Their primary motivation was to make the process less painful and terrifying, but the factors that led them to demand twilight sleep were complex. As the members of the NTSA strategized and campaigned, they participated in the ongoing medical debates about the sanctity of motherhood, the "pathology of femininity," and the connection between their brains and their reproductive organs. They employed eugenic rhetoric and manipulated existing ideologies. Their perceptions of and thoughts about pain, their understanding of themselves as members of a highly sensitive class, and their relationships with individual physicians and with the medical community all contributed to the intensity of the campaign for twilight sleep.

Why Give Up Control of Childbirth?

In the late nineteenth and early twentieth centuries, childbirth in the United States was understood to be painful and dangerous. References to the extreme nature of this suffering appeared in fiction, poetry, and religious texts. For example, John Greenleaf Whittier's frequently anthologized poem, "Maud Muller," suggested that giving birth

[392] Wertz, *Lying-In*, 152.

scarred mothers permanently: "But care, and sorrow, and childbirth pain, / Left their traces on heart and brain."[393] Gynecologists and obstetricians validated this popular perception. The gynecologist Samuel Bricker described delivery as "the keenest agony," and Dr. A. P. Stoner used childbirth as the extreme example against which other kinds of physical pain were measured: in his discussion of appendicitis, he claimed that "the accompanying pains could be compared only with the tortures of childbirth."[394] In *A System of Obstetric Medicine and Surgery*, furthermore, Dr. Robert Barnes stated that labor pains were often severe enough to induce temporary insanity, arguing that when the contractions were at their "most excruciating . . . it is not surprising that a frenzied desire to be released at any cost from her agony should overpower all self control."[395] Perhaps most tellingly, Mary Boyd and Marguerite Tracy reported one male obstetrician's confession that "if he were a woman he would hang himself in the first month of pregnancy."[396] These dramatic depictions of pain and suffering, voiced by medical professionals and lay women alike, pervaded the discourse about childbirth in the early-twentieth-century United States.

Many women were so desperate to avoid or minimize this terrible suffering that they begged their doctors to try new anesthetic techniques, even when those techniques

[393] J. G. Whittier, "Maud Muller," *Our Girls: Poems in Praise of the American Girl* (New York: Moffat, Yard, and Company, 1907).

[394] Samuel Brickner, "On the Physiological Character of the Pain of Parturition," *Gaillard's Medical Journal* LXXII, No. 1 (January 1900), 797; A. P. Stoner, "The Significance of Clinical Symptoms in Determining the Pathological Conditions of Appendicitis," *Medical Record* 66, No. 1 (July 1904), 14.

[395] Robert Barnes, *A System of Obstetric Medicine and Surgery, Theoretical and Clinical* (Philadelphia: Lea Brothers and Company, 1885), 308.

[396] Boyd, "More about Painless Childbirth," 14.

were potentially dangerous.[397] Earlier in the nineteenth century, these women had greeted the increasing use of chloroform and ether enthusiastically.[398] By the late 1800s, some medical professionals had also accepted the utilization of anesthesia during childbirth and incorporated it into obstetrical practice with varying degrees of success and safety – a pattern that foreshadowed the twilight sleep controversy of 1914 and 1915. Other physicians had been much less receptive. They disapproved of chloroform and ether because such drugs were sometimes lethal, because anesthetics violated the biblical curse upon women to suffer in childbirth, and because the pain of labor and delivery were said to inspire maternal love, bonding mother with infant. Consequently, when *McClure's* began publishing articles on the miracle of twilight sleep, the use of anesthesia in childbirth was still rather rare.[399]

Because anesthesia was still employed unevenly, pregnant women continued to dread the pain associated with labor and delivery. For them, twilight sleep constituted a potential miracle, a way to pass from pregnancy to motherhood without suffering unbearable agony. In May of 1914, the *New York Times* published a poem by Ethel H. Wolff that hailed the Freiburg technique as a savior of women everywhere: "Over the dark and cruel stream / that motherhood must cross / A bridge of dreams has flung its / glistening spans . . . In all the corners of the earth pale / women hear; / Their sad eyes shine . . . Oh, Twilight Sleep! White magic of a master mind / Whose sympathy for

[397] See Leavitt, *Brought to Bed*, 116-117.

[398] On the use of chloroform and ether in childbirth, see Wolf, *Deliver Me from Pain*, 13-43.

[399] Wertz, *Lying-In*, 117. For more on the gradual, uneven acceptance of anesthesia in the United States, see Martin Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985).

woman wrought / this priceless boon / To end the suffering of Ages yet to / come."[400] The members of the NTSA employed similarly rapturous descriptions of twilight sleep, exclaiming, for example, that with twilight sleep, "a new era has dawned for woman and through her for the whole human race."[401] These kinds of proclamations were romanticized and exaggerated, but they nevertheless illustrate the desperation that women felt regarding childbirth pain and the excitement with which they regarded potential remedies.

For women during this period, giving birth remained not only physiologically painful but also potentially fatal. In 1917, the Children's Bureau reported that "childbirth caused more deaths among women 15 to 44 years old than any disease except tuberculosis."[402] Two years later, Dr. Henry Schwarz lamented the state of maternal care in the United States at a meeting of the American Association of Obstetricians and Gynecologists, bemoaning the fact that "thousands of women die every year from the effects of confinement, most of these from infection which is absolutely preventable; tens of thousands become invalids from the same cause."[403] According to the medical historian Edward Shorter, maternal death rates began to fall around 1880, but childbirth remained exceptionally dangerous well into the twentieth century. Infection was the most common cause of death, but women also succumbed to hemorrhage, shock,

[400] Ethel H. Wolff, "The Bridge of Dreams," *The New York Times* (May 28, 1914).

[401] Ver Beck, *Truth about Twilight Sleep*, 362.

[402] Grace Meigs, *Maternal Mortality from All Conditions Connected with Childbirth in the United States and Certain Other Countries* (Washington, D.C.: Government Printing Office, 1917), 7.

[403] Henry Schwarz, "Painless Childbirth and the Safe Conduct of Labor," *Transactions of the American Association of Obstetricians and Gynecologists* XXXI (1919), 300.

phlebitis, and various other obstetric and medical complications during or immediately after childbirth.[404]

Twilight sleep proponents contended that, in view of these risks, humane management of childbirth ought to involve unconsciousness or semi-consciousness. In the pages of *McClure's*, Mary Boyd and Marguerite Tracy claimed that "every woman actually confronted with an imminent birth is filled with a living fear of death that few men can grasp" – a perspective very similar to those maternalist sentiments expressed by women like Julia Ward Howe and Elizabeth Blackwell in the nineteenth century in defense of women as the primary authorities on female bodies and female lives. From a more scientific perspective, the physician Inez C. Philbrick, who graduated from WMCP in 1891, argued in 1925 that the extreme fear that women felt as labor and delivery approached affected their bodies physiologically, making childbirth more difficult.[405] All of these women connected that extreme fear of death with the need for twilight sleep, which was the first development in obstetrical pharmacology that offered semi-consciousness throughout the processes of labor and delivery and no memory afterward of either the physical pain or the emotional terror.[406]

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[404] Shorter, *Women's Bodies*, 101-102. Importantly, Shorter also points to the difficulties in interpreting maternal death statistics during this period. Just as the development of antiseptic techniques began to lower the number of infection-related deaths, the number of women who died from infections following abortions began to rise. Those deaths were, according to Shorter, "included in 'maternal mortality,'" so "the overall statistics give the false impression that the death rate of mothers in full-term deliveries was not going down at all."

[405] Inez C. Philbrick, "Fear and Obstetric Efficiency," *75th Anniversary Volume of the Woman's Medical College of Pennsylvania*, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University, 245. Philbrick contended that this physiological reaction to fear mattered much more than any of the "penalties of civilization" other doctors were identifying, and she also blamed obstetricians for employing surgery too quickly and seeing obstetrics as pathological, all of which failed to address the key problem.

[406] Boyd, "More about Painless Childbirth," 69.

Race, Class, and the Need for Obstetric Anesthesia

Medical professionals believed that childbirth was especially painful and dangerous for women of the middle and upper classes. Just as Edward H. Clarke had observed, in the 1870s, that elite women's colleges were filled with sick girls, obstetricians who cared for the wealthy noted that their practices were filled with fragile women. Women of every class, specialists argued, were becoming weaker, but middle- and upper-class women suffered the most. Indeed, medical literature suggests that physicians connected sensitivity to pain directly to a given patient's level of culture and sophistication. In a 1914 book about twilight sleep, Dr. Henry Smith Williams claimed that "civilized women" and "in particular the most delicately organized women" suffered more acutely during childbirth than their less refined counterparts did.[407] Dr. A. Smith reframed the sentiment in pseudo-scientific language: "when we approach civilization the suffering coincident to and the length of time for a labor case is multiplied in proportion to the distance from the primitive and to the nearness of civilization. Therefore, for example, the half civilized Mexican woman is usually in labor for four to six hours and suffers a mild degree of pain."[408] In his book on obstetric anesthesia, Dr. Carl Henry Davis referred to this principle as "the penalty of civilization."[409] The same sentiments

[407] Henry Smith Williams, *Twilight Sleep: A Simple Account of New Discoveries in Painless Childbirth* (New York: Harper and Brothers Publishers, 1914), 40. The historian Laura Briggs has demonstrated that the *Journal of Obstetrics* repeatedly contrasted two female characters: the nervous, "overcivilized" white woman, and the savage woman of color. Briggs, "Race of Hysteria," 249-250.

[408] Smith, *Twilight Sleep in America*, 10.

[409] Carl Henry Davis, *Painless Childbirth: Eutocia and Nitrous Oxid-Oxygen Analgesia* (Chicago: Forbes and Company, 1916), 18. See also W. Hamilton Long, "The Limitations of Nitrous-Oxide-Oxygen in Surgery, and Its Recent Use in Obstetrics," *The Kentucky Medical Journal* XIV (1916), 16. For a contrary

motivated German obstetricians Bernhardt Kronig and Karl Gauss, who developed the innovative twilight sleep method used at the Freiburg Frauenklinik.[410]

Indeed, Kronig believed that twilight sleep was necessary only because "civilized" women simply could not withstand the pain of childbirth without anesthesia. "The modern woman," he stated, "responds to the stimulus of severe pain more rapidly with nervous exhaustion and paralysis of the will. . . . The sensitiveness of those who carry on hard mental work is much greater than that of those who earn a living by manual labor." He blamed this tendency toward "nervous exhaustion" for the increasing use of forceps in difficult deliveries.[411] Forceps deliveries, which, as we have seen, became increasingly common over the second half of the nineteenth century, were in the first decades of the twentieth century somewhat controversial among gynecologists and obstetricians; some specialists defended the practice of delivering babies with forceps while others argued that forceps were dangerous both to mothers and babies. Twilight sleep advocates believed that Kronig's "dammerschalf" could provide a much less damaging option by replacing potentially-damaging instruments like forceps with supposedly "harmless" drugs like morphine and scopolamine.

Although the NTSA perceived itself as a group that worked for the benefit of all women, the organization was undoubtedly motivated by its members' perceptions of

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opinion, see Helen Hughes, "A Consideration of Some Points in Obstetrics," *New York Medical Journal and Philadelphia Medical Journal: A Weekly Review of Medicine* LXXX (1904), 202.

[410] Morantz-Sanchez has also noted that in the late nineteenth and early twentieth centuries, theses written by students at the Woman's Medical College of Pennsylvania reflected the idea that childbirth had become more complicated because of "excessive civilization." Students no longer emphasized "deference to nature" but, instead, recommended some kinds of interference, including the use of drugs. See Morantz-Sanchez, *Sympathy and Science*, 223.

[411] Smith, *Twilight Sleep in America*, 43.

themselves as part of what Kronig called "the better class."[412] The most vocal proponents of twilight sleep were wealthy, cultured, educated white women who believed that their sensibilities were heightened and that they therefore required additional pain relief during childbirth. For example, Ver Beck asserted that "the rather phlegmatic and muscular Scotch women of the working class suffer comparatively little in childbirth, while the more delicately constituted women of the upper classes are prostrated by the ordeal."[413] Although the NTSA crafted rhetoric that emphasized unity for all womankind (hence Ver Beck's "fight for your sister-mothers, your sex, the cradle of the human race"), its members nevertheless perpetuated a class ideology that ignored the needs of non-white and working class women but prescribed elite, delicately-constituted women special help getting through labor and delivery unharmed.

Furthermore, the primary strategy of the NTSA was to direct is rhetoric specifically to other members of that particular class. NTSA activists held their demonstrations at department stores and in upscale theaters, where elite women who had experienced twilight sleep told their stories and displayed their beautiful "painless babies." These meetings were covered by the press. In November of 1914, for example, the *New York Times* reported that "Miss Marguerite Tracy, who made a study of the 'Twilight Sleep' at Freiburg, Germany, addressed a conference of mothers on the subject yesterday afternoon at Gimbel Brothers. . . . Babies who were born at Freiburg were exhibited, and the mothers told of their experiences under the spell of the 'Twilight

[412] Smith, *Twilight Sleep in America*, 43. Leavitt has noted, though perhaps not sufficiently examined, the NTSA's perception of itself as an organization that worked "for their sex, not just their class."

[413] Ver Beck, *Truth about Twilight Sleep*, 8.

Sleep.'"[414] Photographs of these demonstrations depicted fashionably dressed women and similarly outfitted babies and toddlers, and NTSA pamphlets often featured celebrities such as Mrs. John Jacob Astor.[415]

Members of the NTSA also emphasized the need for upper-class women to produce more babies, invoking the same eugenic rhetoric employed by doctors like Edward H. Clarke and by conservative gynecologists. Proponents of twilight sleep maintained that effective anesthetics might encourage elite women to have more children, and many physicians agreed. Smith explained that "the more intelligent members of our population are the ones who, through fear and dread of bearing children, practice race suicide. These are the women who should have large families."[416] Especially when combined with references to a spectrum of civility and refinement, these kinds of remarks suggested a racial component to medical constructions of human suffering. Historically, gynecologists and obstetricians had perceived women of color as less sensitive to pain, and in the 1910s the ideology of both the medical profession and the NTSA still reflected those views.[417] The twilight sleep campaign went even further, though, by explicitly

[414] "Mothers Discuss Twilight Sleep," *The New York Times* (November 18, 1914).

[415] See Wertz, *Lying-In*, 153.

[416] Smith, *Twilight Sleep in America*, 53.

[417]At the birth of modern American gynecology, James Marion Sims had claimed, for example, that the enslaved African-American women he subjected to surgical experimentation felt very little pain compared to white women. His autobiography refers frequently to the fact that when performing any given surgery, he needed to use anesthesia for a white woman but not for an African-American woman. See Sims, *My Life*. Gynecologists repeated these kinds of assertions regularly throughout the Gilded Age and Progressive Era. For selected examples, see Daniel J. Brinton, "The Relations of Race and Culture to Degeneration of the Reproductive Organs in Woman," *Medical News* Vol. 68 (1896), 68-69; David, *Nitrous Oxid-Oxygen Analgesia*, 18; J. Roberson Day, "Cases in Obstetric Practice, with Remarks on the Relation of Homeopathy to Obstetrics," *Homeopathic Journal of Obstetrics, Gynaecology, and Paedology,* Vol. 12 (1890), 325-326.

indicating that easing the pain of childbirth for upper-class white women was not just medically appropriate but also eugenically desirable.

Some women did object to this assumption that twilight sleep constituted an ideal solution to the problem of elite women's extreme suffering in childbirth. Edith Wharton's *Twilight Sleep*, which was published after the success of the NTSA, offered a critical assessment of the results of the movement. The novel featured a pregnant female character, Lita, who "had the blind dread of physical pain common . . . to most of the young women of her set." When Lita went into labor, she did so in "the most luxurious suite" at "the most perfect 'Twilight Sleep' establishment in the country." Her rooms were filled

> with spring flowers, hot-house fruits, new novels and all the latest picture papers – and Lita drifted into motherhood as lightly and unperceivingly as if the wax doll which suddenly appeared in the cradle at her bedside had been brought there in one of the big bunches of hot-house roses that she found every morning on her pillow. 'Of course there ought to be no Pain . . . nothing but Beauty . . . It ought to be one of the loveliest, most poetic things in the world to have a baby,' Mrs. Mansford declared, in that bright efficient voice which made loveliness and poetry sound like the attributes of an advanced industrialism, and babies something to be turned out in series like Fords.[418]

Wharton's Lita, though fictional, was not a particularly exaggerated character. In 1916, Dr. Carl Henry Davis described the modern American woman as a "hot-house product" who was "physically less fit to perpetuate the race."[419] Combined with assertions about the debilitating effects of education and careers on middle-class women's bodies and with physical factors like the corset, these kinds of beliefs encouraged privileged women to

[418] Edith Wharton, *Twilight Sleep*, First Scribner Paperback edition (New York: Simon and Schuster, 1997), 18.

[419] Davis, *Nitrous Oxid-Oxygen Analgesia*, 18.

think of themselves as weak and fragile and to demand anesthesia to help them endure the agony of childbirth.

The corset was indeed a problem for upper- and middle-class women. Charlotte B. Brown had already identified it as a major cause of women's gynecological diseases, as I noted in Chapter II, but as Richard W. and Dorothy C. Wertz have indicated, it was also the reason for many obstetrical complications. Some women whittled their waists to a circumference of fifteen to eighteen inches, even if the practice resulted in frequent fainting. Such tight binding constricted internal organs, reduced oxygen levels, and deformed the ribs, and since some women continued to wear their corsets even during their pregnancies, additional problems arose. Childbirth likely became more painful in a literal, physiological sense.[420] In addition, obstetricians noted that corsets reduced circulation and compressed the abdomen too much; many of them advised pregnant women to put aside their corsets and lamented the fact that their patients, especially those of the fashion-conscious middle class, frequently ignored this advice.[421] Significantly, the consequences of corseting also stimulated ideas about the inherent weakness of upper-class women, further fueling the claims that such women needed obstetric anesthesia. Whether women saw themselves as genuinely fragile or cultivated that impression in an effort to define themselves as upper class, it followed logically that they would willingly forfeit control of childbirth in exchange for the opportunity to "drift into motherhood" like Wharton's Lita.

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[420] Wertz, *Lying-In*, 110.

[421] See, for example, Edward Parker Davis, *A Manual of Practical Obstetrics* (Philadelphia: P. Blakiston, Son, and Company, 1891), 180; Richard Cooper Norris, J. C. Cameron, and Robert Latou Dickinson, *An American Text-Book of Obstetrics: For Practitioners and Students* (Philadelphia: W. B. Saunders, 1895), 205; Reuben Peterson, *Obstetrics*, Volume V (Chicago: The Year Book Company, 1902), 47.

The appeal of delivering a baby "under the spell of twilight sleep" was more complex than the simple, reflexive desire to avoid pain. For women of the upper classes, enduring labor and delivery under the influence of morphine and, especially, scopolamine also meant that they were spared what they viewed as the indignities of childbirth: exposed bodies, intense exertion, bodily fluids. These factors were, of course, still present in twilight sleep deliveries, but women would be blissfully semi-conscious during the process, and then, because of scopolamine's amnesiac properties, they would not remember any of it. This amnesia was heralded as even more important than any actual pain relief the Freiburg method provided. Physicians highlighted the fact that after twilight sleep, women forgot their suffering. In *The Boston Medical and Surgical Journal*, for instance, Dr. John Osborn Polak reiterated the idea that civilization had weakened women and suggested that the real value of scopolamine was that women would forget the agony they consequently endured; perhaps, then, women of the upper classes would prove more willing to embark on future pregnancies, building larger families.[422] Tellingly, a great deal of the medical literature on twilight sleep was devoted to the best way to ensure this amnesia. In some reported cases, women who had twilight sleep babies remembered parts of their labors; physicians called these recollections "isles" or "islands" of memory. Occasionally, when insufficient doses of scopolamine were administered, women remembered the entire episode. As Donald Caton has explained, skillful management of scopolamine doses was crucial to success, as too much scopolomine could poison the laboring women, while too little scopolomine failed to produce amnesia or left "islands of memory." At Freiburg, obstetricians used a memory

[422] John Osborn Polak, "Obstetric Advances, Including Anesthesia, the Use and Abuse of Pituitrin, Extra-Periotoneal Caesarean Section, Pubiotomy, and the Significance of Funnel Pelvis," *The Boston Medical and Surgical Journal* CLXXVI (1917), 85.

test, in which, during labor, they "asked patients simple questions and had them perform simple tasks. Only if they responded correctly did [the doctors] administer more scopolamine."[423] Physicians were obviously concerned, perhaps above all else, with creating complete amnesia in their twilight sleep patients.

Outside of the medical community, women who advocated twilight sleep agreed with physicians about the importance of amnesia but emphasized scopolamine as a means to forget not only pain but also indignity. Ver Beck referred to childbirth as "gross and primitive," and Marguerite Tracy and Mary Boyd called it "an animal agony."[424] These expressions indicated that proponents found labor and delivery not only painful but also offensive to their refined sensibilities. Scopolamine allowed them to "sleep" through the messiness and exertion of the birth process and then forget it entirely. Boyd, one of the first American women to experience twilight sleep, explained gratefully that at Freiburg, she was spared all the indignities of giving birth. The evening that she had her baby was permanently "a night dropped out of [her] life."[425] Female fragility, then, extended beyond an augmented sensitivity to pain; it included an increased sensibility regarding the "primitive," animalistic nature of childbirth in general.

The emphasis on the benefits of amnesia became especially important as the details of twilight sleep became clearer; after all, women who had their babies with morphine and scopolamine, either in Germany or in the United States, continued to suffer in childbirth. As Leavitt has demonstrated, once the initial shot of morphine wore off,

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[423] Donald Caton, *What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present* (New Haven: Yale University Press, 1999), 134.

[424] Ver Beck, *Truth about Twilight Sleep*, 30; Tracy, *Painless Childbirth*, xi.

[425] Tracy, *Painless Childbirth*, 198.

women's bodies experienced the pain of their contractions. Patients cried, screamed, and writhed in agony.[426] In fact, since morphine and scopolomine lowered their inhibitions, women may have voiced their pain even more assertively than they might otherwise have done. Some concerned citizens even filed a lawsuit against a twilight sleep hospital in New York City because its patients screamed too loudly during the night, annoying the neighbors.[427] Such facts underscore the idea that despite calling twilight sleep "painless," it was not analgesia that mattered most. Amnesia was even more important, and women who advocated for or sought out twilight sleep often saw themselves as mentally fragile as well as physically fragile. Forgetting, for them, was a blessing.

For many upper- and middle-class women, it was not only fashionable to be fragile but also fashionable to be ill. The historian Ann Douglas Wood has argued persuasively that nineteenth-century women of the upper classes believed themselves to be in poor health or, alternatively, worked to cultivate that illusion. Further, as Morantz-Sanchez has also noted, women were frequently seen as ill because of their sex, with disease originating in their reproductive organs.[428] This perception continued into the twentieth century, and it was certainly still in evidence during the twilight sleep controversy of 1914 and 1915. When women argued for twilight sleep, they often referred to the fact that painful births led to poor physical and mental health in general. According to Tracy and Boyd, "the psychic traumata of childbirth" were "known to be the chief exciting causes of nervous and mental diseases in women."[429] Ver Beck

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[426] Leavitt, *Brought to Bed*, 128-129.

[427] "Hospital Not a Nuisance," *The New York Times* (June 9, 1917). This incident is also mentioned in Leavitt, *Brought to Bed*, 129.

[428] Wood, "The Fashionable Diseases," 26-27.

reported confidently that "if there is the slightest inclination to neuropathic condition," childbirth would cause "physical and mental injury" and "a long period of exhaustion."[430] On one hand, twilight sleep proponents wanted to improve women's health, an ambition that could conceivably transform the standard medical construction of women as persistently ill; on the other hand, in shaping their rhetoric, they reinforced the common beliefs that women were highly prone to illness and that sexual organs and reproductive functions were often fundamental causes. In that sense, the campaign for "painless childbirth" was not directed at changing medical perceptions of women. Rather, it argued from within an ideology that was already deeply entrenched in both the medical profession and the general public.

Patients, Physicians, and Control of Childbirth

Influenced by this ideology, middle- and upper-class women had already been regularly placing control over their health and well-being into the hands of their physicians. Throughout the nineteenth century and into the twentieth, these women submitted themselves to the care of medical professionals, many of whom subscribed to the ideas about innate feminine weakness and fragility that I have discussed in previous chapters and treated myriad problems as symptoms of gynecological ailments. Depending on the particular patient, physicians might inject various concoctions into the uterus, cauterize the reproductive organs, induce uterine hemorrhage, or perform surgeries like hysterectomies, oophorectomies, or salpingectomies. Alternatively, they

[429] Tracy, *Painless Childbirth*, 34.

[430] Ver Beck, *Truth about Twilight Sleep*, 11.

might prescribe the rest cure.[431] Popularized by S. Weir Mitchell, the rest cure involved complete confinement to a bed. For periods of up to six weeks, patients lay on their backs, consumed a special diet, and refrained from reading, writing, and all other intellectual activity.[432] Whether they endured painful treatments like cautery, underwent surgeries like oophorectomy, or submitted to the restrictions of the rest cure, these women willingly surrended control over their bodies to gynecologists, obstetricians, and other medical professionals. When twilight sleep presented itself as a potential alternative to suffering in childbirth, women were generally disposed to surrender control of their bodies yet again.

Although historians have sometimes characterized the NTSA as acting in opposition to the medical community, its leaders actually liked and respected most physicians – some, as we have seen, were physicians themselves. Their writing did, however, reflect a growing frustration with American obstetricians who refused to provide twilight sleep. For example, at one of the department store exhibitions, Frances X. Carmody related her experiences at Freiburg and called women to action, arguing that "the 'Twilight Sleep' is wonderful, but if you women want it you will have to fight for it, for the mass of doctors are opposed to it."[433] Ver Beck referred sarcastically to "the all-wise physicians" and triumphantly declared that under the auspices of the NTSA, women

[431] See Wood, "Fashionable Diseases," 29-31.

[432] Wood, "Fashionable Diseases," 31-32.

[433] "Mothers Discuss Twilight Sleep." Interestingly, Carmody, one of the most active participants in the twilight sleep movement, died in August of 1915 during a twilight sleep delivery. According to Leavitt, Carmody's husband and physicians insisted that scopolamine was not responsible for her death, but the tragedy still stifled enthusiasm for the movement. Consequently, some physicians and former advocates began to look for "other methods of achieving painless childbirth." Sometimes these methods were also referred to as "twilight sleep," even when scopolamine was not used, and eventually, the phrase "twilight sleep" came to signify the state of sem-consciousness, not the particular cocktail of drugs. See Leavitt, "Birthing and Anesthesia," 163.

were finally voicing their own opinions.[434] Nevertheless, when they could, the same women traveled to Freiburg to submit themselves to the care of the Frauenklinik's "good doctors," who promised to "take care of everything."[435] Moreover, twilight sleep proponents spoke about their German obstetricians – and, later, about the American specialists who provided them with twilight sleep – in admiring, almost worshipful tones. In *Painless Childbirth*, Tracy and Boyd recounted the experiences of several women, all of whom credited "the wonderful care of the doctors" for their amazing childbirths.[436] The NTSA's repudiation of doctors who withheld twilight sleep from their patients was not, therefore, indicative of some greater dissatisfaction with the medical profession in general. On the contrary, the women involved in the NTSA displayed a great deal of affection toward the physicians who gave them what they wanted and a tremendous amount of respect for the obstetricians who pioneered the Freiburg treatment. They had already embraced medical treatment and technology in other aspects of their health, and it was a small step forward to embrace medical treatment and technology in childbirth as well.

Leavitt has attributed the power and confidence of the NTSA to the fact that childbirth was traditionally controlled by women; however, it seems more likely to me that the actions of the NTSA were so effective because twilight sleep was extremely appealing, because it offered relief from many frightening and stressful aspects of the modern pregnancy and childbirth, and because the activists worked from within existing

[434] Ver Beck, *Truth about Twilight Sleep*, 47.

[435] Tracy, "Painless Childbirth," 42; Boyd, "More about Painless Childbirth," 59.

[436] Tracy, *Painless Childbirth*, 190.

medical ideology.[437] Although female patients frequently sought the help of specialists like Mary Putnam Jacobi or Mary Amanda Dixon Jones, they never organized to demand, for instance, access to certain forms of ovariotomies. Twilight sleep, on the other hand, was a treatment women desperately wanted: a comfort, a miracle, a "bridge of dreams." Thus, the fact that activists campaigned so aggressively for it should not be surprising. Furthermore, the success of the NTSA can be also be attributed to the fact that its leaders invoked current medical opinion regarding the principles of eugenics, the authority of physicians, and the nature of women's bodies. Had they attempted to claim, for example, that women felt the same pain regardless of class, that patients had the right to determine the specifics of their childbirth experiences, or that women's bodies were not inherently delicate, they might have failed to recruit supporters among the public and met with more obstinate resistance from obstetricians.

The involvement of women physicians in the NTSA also increased the likelihood of its success. Though only a few members of the NTSA were physicians, the involvement of Eliza Taylor Ransom and Bertha Van Hoosen did help the organization achieve its goals. Employing physicians as speakers meant, first, that the twilight sleep campaign looked more like a movement taking place within the medical profession than a movement taking place against the medical profession. Moreover, the presence of medical authority within the NTSA was a legitimizing and persuasive force, backing the arguments of lay leaders like Tracy, Boyd, Carmody, and Ver Beck with professional assertions about twilight sleep's effectiveness and safety. The fact that the NTSA assigned this vocal role to women physicians underscores some of the problems with the

[437] Leavitt, "Birthing and Anesthesia," 160-162.

historiographical argument that the twilight sleep campaign was really about non-professional, female control of childbirth.

In addition, the twilight sleep campaign illustrates the fluidity of women's positions in the development of obstetrics and gynecology. Female specialists often served in more than one capacity; they practiced medicine, published research, educated students, and became activists. Lay women were able to influence the evolution of the specialties through consumer choices, public demonstrations, and persuasive writing. Nevertheless, with few exceptions, the success of medical activists depended to some extent on a fundamental compatibility with prevailing medical ideology. Because twilight sleep fit nicely with medical constructions of women's bodies, and because physicians stood to achieve certain goals by its implementation, the NTSA and its supporters succeeded quickly and completely in convincing American specialists to use it. As a result of their work – not, I emphasize, the work of misogynistic or power-hungry male obstetricians – childbirth moved from the home to the hospital and from the natural to the medical. For the next fifty years, the standard birth experience involved some form of semi-consciousness and no deliberate participation on the part of the mother, aside from her duty to arrive at the hospital on time.

Like the transformation of gynecology in the Gilded Age and Progressive Era, I argue, the overlapping evolution of obstetrics that reached its height in the early twentieth century resulted directly from the actions of women, especially privileged white reformers, feminists, and physicians. These women transformed childbirth, at least for members of their own race and class, from the experience Alice Jones had in 1892 (characterized by almost no prenatal care and a birth at home) to the experience of Van

Hoosen's 1915 patients (characterized by regular prenatal care followed by birth in a hospital with the aid of drugs like morphine and scopolomine). The fact that this revolution benefited obstetricians, the majority of whom were male, by standardizing routine prenatal care (and its cost) and medicalized hospital birth does not negate the fact that women made it happen. Furthermore, unlike the development of surgical gynecology, this evolution of obstetrics occurred not only because women physicians wanted it to but also because patients desired prenatal care and obstetric anesthesia and therefore worked with medical women to make those newer aspects of obstetrical care available.

In terms of what it meant for the construction of healthy, normal American womanhood, the early-twentieth-century evolution of obstetrics left a more complicated legacy than the developments I addressed in previous chapters did. The availability of meaningful prenatal care encouraged women to see normal pregnancies and healthy infants as goals for which they could actively strive; they became "modern pregnant women" who, through a combination of medical consumerism and healthy decisions, could begin their roles as scientific mothers before their babies were even born. This shift empowered them as agents, especially when their pregnancies proceeded as planned and resulted in the births of healthy children; alternately, it produced guilt and shame when the outcomes of their pregnancy were less than ideal, because they now saw themselves as responsible for delivering healthy babies. At the same time, in ways that seem to contradict that new level of agency and responsibility, the shift subjected them to the expertise of obstetricians. Meanwhile, the availability of twilight sleep enabled women to avoid the memory of childbirth, separating themselves, as healthy, "civilized,"

privileged women, from the pain and indignities of labor and delivery. As women took on the active role of the "modern pregnant woman" and began to see their pregnancies as healthy, then, they also sought to give up control of the final, most frightening part of pregnancy: the childbirth experience. Their desires and decisions had lasting consequences, leaving a legacy of medical intervention in pregnancy and childbirth that continued largely unimpeded until the natural childbirth movement of the 1960s and 1970s.

CHAPTER VI

CONCLUSIONS

By 1920, the thriving specialties of gynecology and obstetrics had claimed scientific authority over women's reproductive and sexual lives, constructing new definitions of normal femininity and healthy womanhood that reflected the evolving positions of women – especially white, middle-class women – in American life. Women's bodies no longer appeared, in most medical literature, as innately weak or incompetent; Edward H. Clarke's notions of women's inability to study and work as men did fell out of vogue, replaced by Mary Putnam Jacobi's scientific understanding of the menstrual cycle, which, she demonstrated, functioned separately from the brain. Nevertheless, as we have seen, competing visions of normality and health led to complex and sometimes paradoxical constructions of both the female body and the female role in society.

I have argued that women themselves, in their myriad roles inside and outside the medical community, shaped the specialties of gynecology and obstetrics and, therefore, the prevailing discourse about American women in general. But women did not speak in unison. Even among the privileged white women with the most power, individuals disagreed. Elizabeth Blackwell, for example, affirmed the sanctity of the female reproductive organs; Mary Putnam Jacobi rejected it. Jacobi ultimately prevailed, and generally, I have demonstrated that women like Jacobi – scientifically-oriented physicians and feminist reformers and activists – won most of these battles, wielded most of the power, and exercised the most influence over their specialties. However, women

like Blackwell – maternalists who argued for a doctrine of feminine distinctiveness – also participated in the process of defining and redefining healthy womanhood.

All of these competing perspectives explain, at least to some extent, the paradoxes present in this project. In general, these women tended to promote a medical construction of the female body that allowed for the expansion of personal choices based not necessarily on traditional gender norms but on individual preferences. But what did these ideas mean, in practice? What, specifically, did these influential women accomplish? They rejected Edward H. Clarke; cemented women's presence in higher education and the medical profession; argued for the possibility of a healthy womanhood that existed outside the realm of marriage, domesticity, and motherhood; and created active roles for pregnant women in ensuring the health of their unborn children. As they did these all of these things, they also popularized surgeries like oophorectomy and hysterectomy; medicalized menstruation, pregnancy, and childbirth; argued that "civilized" women required anesthesia to give birth; and placed control of labor and delivery in the hands of physicians, who were still, at the close of this dissertation, ninety-five percent male. It is a complicated legacy to understand.

The history is further complicated by the fact that these women who shaped the development of gynecology and obstetrics upheld and extended much of the prejudice that male physicians exhibited. Importantly, while female influence on gynecology and obstetrics might have secured the expansion of choices for the elite and middle-class women who could take advantage of them, they also worked to perpetuate many abuses perpetrated against poorer women and women of color, whose reproductive organs were never regarded as sacred and who, for the most part, could not afford to attend college or

approach obstetric care as active, modern consumers. Therefore, as I have argued that women were powerful, I have been acutely aware that what I really mean is that only *some* women were powerful. In the context of gynecology, obstetrics, and the construction of healthy womanhood, poor women, immigrant women, and women of color were likely to be neglected, ignored, or victimized. Unavoidably, that fact means that instead of suggesting that women, as a group, were victimized by male physicians during the development of gynecology and obstetrics, I am contending that women as well as men victimized certain vulnerable groups of women. Gynecology and obstetrics introduced many positive changes into the lives of middle-class American women, but in terms of its more negative consequences, women certainly deserve a fair share of the blame.

Gender, Power, and Twentieth-Century Medicine

On February 22, 1956, the television show "This Is Your Life" featured eighty-year-old Dr. Catharine Macfarlane as its "woman of the evening." One by one, meaningful people from her life – old friends, classmates from the Woman's Medical College of Pennsylvania, patients whose reproductive cancers she had cured – appeared to share the stage with her and reflect on her tremendous contributions to twentieth-century medicine. Macfarlane had practiced medicine for fifty-eight years, specializing in gynecology and obstetrics. She had earned her medical degree at WMCP, then gone abroad, studying obstetrics in Berlin, gynecology in Vienna, and radiology in Stockholm. During the first half of the twentieth century, she had opened a private practice; published

case studies in the *Journal of the American Medical Association,* the *Woman's Medical Journal*, and the *Journal of Obstetrics*; taught gynecology and obstetrics as an instructor and then a professor; served as Chief of Obstetrics and Gynecology at Philadelphia General Hospital; and presided over a long-term study of uterine and cervical cancer, a project that demonstrated the possibility and desirability of early diagnosis, thereby revolutionizing cancer treatment and prevention. She was President of the American Medical Women's Association, Vice President of the International Medical Women's Association, and the first female member of the College of Physicians of Philadelphia. She was, in short, one of the most distinguished medical women in the world.[438]

During the televised tribute to her extraordinary accomplishments, Macfarlane recalled feeling most touched by the final guests: seventeen members of WMCP's Class of 1956, "each one in a freshly starched white coat, each one happy and young and pleased to be there." Full of hope for these young women doctors in training, Macfarlane wrote that "they were the future. They will carry the torch that we older women must lay down."[439] Many of the women physicians of Macfarlane's generation felt a similar sense of optimism and joy about the future generations of medical women, perhaps mixed with envy at the idea of their prospects. For example, Rosalie Slaughter, the "gentleman's daughter" who had faced so much opposition to her academic and professional ambitions, wrote in 1937 that "we have all had to struggle as the first generation following our pioneers. . . . We women who are now fifty are the first generation which has felt the

[438] On Macfarlane's many accomplishments, and on the cancer study specifically, see the Catharine Macfarlane Papers, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel College of Medicine; the Deceased Alumnae File for Catharine Macfarlane, Archives and Special Collections on Women in Medicine, Drexel College of Medicine.

[439] Catharine Macfarlane, *Dr. Kitty Mac*, unpublished memoir, Archives and Special Collections on the History of Women and Homeopathy, Drexel College of Medicine, 153.

click of progress in the making." In writing her autobiography, she "sought to give a picture of this transition period between the pioneer women in medicine and the college girls of today for whom everything is won and done."[440] The women who graduated from medical school in the late nineteenth and early twentieth centuries – and many of the lay women who worked alongside them, advocating for women's education, for prenatal care, or for obstetric anesthesia – understood that women were shaping the paths that gynecology and obstetrics would follow. They expected the "golden age" for women in medicine to continue; they anticipated new constructions of healthy American womanhood, defined and revised by women themselves.

Rather than continuing to increase, it seems, ironically, that women's influence on the specialties of gynecology and obstetrics declined during the middle decades of the twentieth century. The seventeen WMCP students who saluted Catharine Macfarlane on "This Is Your Life" in 1956 would be less likely to play crucial roles in the development of these specialties than Macfarlane, Slaughter, and their classmates had been, and by the 1930s, women physicians themselves recognized and lamented it.[441] There are three related explanations for this phenomenon. First, by the middle of the twentieth century, American medicine no longer suffered from the same chaos and conflict that was so pervasive during the nineteenth century. Sectarians no longer posed a threat to regular medical authority, and gynecologists and obstetricians no longer disagreed so violently about the fundamental aspects of their specialties. More rigorous standards for medical

[440] Rosalie Slaughter Morton, *A Woman Surgeon: The Life and Work of Rosalie Slaughter Morton* (New York: Frederick A. Stokes Company, 1937), vii.

[441] See Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 314-315.

education and medical licensing prevailed, resulting in fewer medical schools, fewer graduates, and a more unified medical profession.[442] Male medical authorities did not, consequently, require the assistance of women to justify modern gynecology and obstetrics, defend reproductive and sexual surgeries, or resolve debates about the nature of normal femininity.

Second, by this time, the medical profession had made tremendous strides in securing the respect of the public. When James Marion Sims, the "father of modern gynecology," announced in the mid-nineteenth century that he planned to become a doctor, his father reacted with disgust, dismissing medicine as an embarrassing job with "no science in it."[443] Much of the public would have agreed with him. Medicine was not, during the Gilded Age and Progressive Era, a particularly venerated profession. This general disregard for the medical community may have permitted women to "sneak through" and wield significant influence on developing specialties, especially those that treated female bodies. By the 1950s, though, Americans admired and celebrated doctors and equated them with the march of scientific progress – a transition illustrated by Catharine Macfarlane's appearance on "This Is Your Life." Physicians eliminated yellow fever, cholera, smallpox, and other diseases; they were better able to treat and prevent tuberculosis, sexually transmitted infections, and puerperal fever.[444] They occupied an

[442] Thomas M. Group and Joan I. Roberts, *Nursing, Physician Control, and the Medical Monopoly: Historical Perspectives on Gendered Inequality in Roles, Rights, and Range of Practice* (Bloomington, IN: Indiana University Press, 2001), 149; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 112.

[443] James Marion Sims, *The Story of My Life*, reprint edition (New York: Da Capo Press, 1968).

[444] James H. Cassedy, *Medicine in America: A Short History* (Baltimore: Johns Hopkins University Press, 1991), 128-129.

elevated position in American society, and one that was now constructed in a traditionally masculine way, under the umbrella of science and technology.

Third, even outside of the medical profession, ideologies of gender and healthy womanhood in the United States were shifting back to something that arguably resembled the "separate spheres" mentality more than they resembled the "New Woman" ideal, especially after World War II. Paradoxically, even as more and more married women entered the workforce – between 1940 and 1960, their numbers tripled – the postwar baby boom and emphasis on domesticity and motherhood meant that many Americans believed the proper place for a white, middle-class woman was in the home, emulating the visions of domestic bliss broadcast on television shows like "Leave It to Beaver" and "The Donna Reed Show."[445] This mid-twentieth-century construction of normal, healthy womanhood underscored supposedly gendered traits. Much like Victorian women, postwar American women were supposed to be distinctly maternal, sensitive, caring, and compassionate; men, in contrast, were supposed to be strong, rational, intelligent, and ambitious. When combined with the emphasis on modern science and technology that imbued mid-twentieth-century medicine with new levels of respect and authority, that postwar gender ideology functioned to separate many women from the profession of medicine.

In many ways, Macfarlane's appearance on "This Is Your Life" illustrated these three changes. Her work in obstetrics, gynecology, and cancer prevention represented the

[445] On numbers of women workers, see William Chafe, *The American Woman* (New York: Oxford University Press, 1972), 218-219; Morantz-Sanchez, *Sympathy and Science*, 352. On postwar domesticity, as idealized on television screens, see Carolyn Herbst Lewis, *Prescription for Heterosexuality: Sexual Citizenship in the Cold War Era* (Chapel Hill: University of North Carolina Press, 2010), 37, 120-121; Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era* (New York: Basic Books, 1990).

triumphs of American medicine, in terms of both professional unity and popular respect. At the same time, her age and gender combined to make her an oddity. The studio audience was amused, for instance, to hear about her early years as a doctor: "I told how I first made my calls on a bicycle, graduated to a horse and buggy, then to an electric car, because I could not crank a Ford."[446] And, at the close of a program dedicated completely to Macfarlane's academic ambition, professional accomplishments, and scientific contributions, the host, Ralph Edwards, presented her with gifts that seemed humorously contradictory: first, a state-of-the-art lamp for her operating room (there were only seven like it in the United States at that point) and, second, a beautiful string of pearls.

For better or worse, medical women like Catharine Macfarlane, Mary Putnam Jacobi, and Mary Amanda Dixon Jones, alongside lay women like Caroline Dall, Marguerite Tracy, and Elizabeth Lowell Putnam transformed gynecology and obstetrics in the United States. Their power and influence declined after 1920, and, ironically, that decline could be traced to their own work, their own values. They helped make medicine a science, not an art; they argued against the special sanctity of women's reproductive organs, against the idea that women were best understood, intuitively, by other women. They made gynecology a surgical specialty; they made childbirth a medical process, moving it from the home to the hospital. And, as a consequence of these shifts, they created medical specialties that would grow in authority, earn accolades for scientific progress, and, ultimately, exclude and ignore them as active agents in the development of American medicine.

[446] Macfarlane, *Dr. Kitty Mac*, 151.

REFERENCES CITED

Manuscripts and Archival Collections

Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, Philadelphia PA

- *75th Anniversary Volume of the Woman's Medical College of Pennsylvania*
- Black Women Physicians Project
- Catharine Macfarlane Papers
- Deceased Alumnae Files from the Woman's Medical College of Pennsylvania
- *Dr. Kitty Mac*, unpublished memoir by Catherine Macfarlane
- Eliza Wood Armitage Scrapbook
- *The Esculapian*
- *The Iatrian*
- Kate Campbell Hurd Mead Papers
- Records of the Chicago Woman's Medical College / Northwestern University
- Records of the Hospital and Dispensary of the Alumnae of WMCP
- Sarah A. Hibbard Papers
- WMCP Alumnae Association Records
- WMCP Senior Theses
- WMCP Speeches
- WMCP/MCP Medical Student Records

Bentley Historical Library, University of Michigan, Ann Arbor, MI

- Bertha Van Hoosen Papers
- Deceased Alumnae Files
- Eliza Mosher Papers
- Sarah Gertrude Banks Papers
- *Women's Voices: Early Years at the University of Michigan*

College of Physicians of Philadelphia, Philadelphia, PA

- Edward A. Schumann Papers
- Robert M. Girvin Letters

Countway Library of Medicine, Harvard Medical School, Boston, MA

- Collected Papers of Edward H. Clarke
- Horatio Robinson Storer Papers
- Records of the New England Hospital for Women and Children, 1873-1902

Massachusetts Historical Society, Boston, MA

- Caroline Healey Dall Papers, 1811-1917

Rudolph Matas Library of the Health Sciences, Tulane University, New Orleans

- Elizabeth Bass Collection on Women in Medicine

Schlesinger Library, Harvard University, Cambridge MA
Papers of the Ladies' Physiological Institute of Boston
Elizabeth Lowell Putnam Papers
Mary Putnam Jacobi Papers
Eliza Taylor Ransom Papers

Sophia Smith Collection, Smith College, Northampton, MA
Dorothy Reed Mendenhall Papers
Health Collection
Medicine Collection
Records of the New England Hospital for Women and Children

Medical Lectures, Articles, and Books

American Journal of Clinical Medicine. *Twilight Sleep and How to Induce It.* Chicago: American Journal of Clinical Medicine, 1915.

Amini, S. B. "Effect of Prenatal Care on Obstetrical Outcome." *Journal of Maternal-Fetal Medicine* 5 (1996): 142-150.

Auvard, Alfred. *A System of Obstetrics.* Translated by Curtis M. Beebe. New York: J. B. Flint and Company, 1892.

Bantock, G. Granville. *A Plea for Early Ovariotomy.* London: H. K. Lewis, 1881.

Barnes, Charles S. "The Indications, Dangers and Contraindications of Uterine Curetment." *The American Journal of Obstetrics and Diseases of Women and Children* 77 (1918): 940.

Barnes, Robert. *A System of Obstetric Medicine and Surgery, Theoretical and Clinical.* Philadelphia: Lea Brothers and Company, 1885.

Bedford, Gunning S. *The Principles and Practices of Obstetrics.* New York: William Wood and Company, 1874.

"Bicycling for Women." *The Woman's Medical Journal* 6 (April 1897).

"Biographical Series." *The Woman's Medical Journal* 5 (March 1896).

Blackwell, Elizabeth. "The Influence of Women in the Profession of Medicine." *Essays in Medical Sociology.* London: Ernest Bell, 1902.

Bowditch, Henry Pickering. "The Question of Rest." *The Nation* 13 (September 1877).

Brickner, Samuel. "On the Physiological Character of the Pain of Parturition." *Gaillard's Medical Journal* LXXII (January 1900).

Briggs, Mary S. "A Plea for Simplicity." *The Woman's Medical Journal* 5 (June 1896).

Brinton, Daniel J. "The Relations of Race and Culture to Degeneration of the Reproductive Organs in Woman." *Medical News* 68 (1896): 68-69.

Brown, Charlotte B. "The Health of Our Girls." *The Woman's Medical Journal* 5 (July 1896).

Brown, Charlotte B. "The Physical Development of Girls." *The Woman's Medical Journal* 5 (September 1896).

Byford, Henry Truman. *Manual of Gynecology.* Philadelphia: P. Blakiston Company, 1902.

Channing, Walter. *A Treatise on Etherization in Childbirth, Illustrated by Five-Hundred and Eighty-One Cases.* Boston: William D. Ticknor, 1848.

Clarke, Edward H. *Sex in Education,* or *A Fair Chance for Girls.* Reprint edition. New York: Arno Press, 1972.

Davis, Carl Henry. *Painless Childbirth: Eutocia and Nitrous Oxid-Oxygen Analgesia.* Chicago: Forbes and Company, 1916.

Davis, Edward Parker. *A Manual of Practical Obstetrics.* Philadelphia: P. Blakiston, Son, and Company, 1891.

Davis, W. E. B. "The Graver Nerve Disturbances Due to Organic Changes in the Genital Organs." *The American Journal of Obstetrics and Diseases of Women and Children* 38 (November 1898): 761-762.

Day, J. Roberson. "Cases in Obstetric Practice, with Remarks on the Relation of Homeopathy to Obstetrics. *Homeopathic Journal of Obstetrics, Gynaecology, And Paedology* 12 (1890).

Dickinson, Robert Latou. "Bicycling for Women from the Standpoint of the Gynecologist." *American Journal of Obstetrics and Gynecology* 31 (October 1894): 25-35.

Dixon Jones, Mary A. "Misplacements of the Uterus." *The Pittsburgh Medical Review* 3 (October 1889): 301-309.

Dixon Jones, Mary A. "No. 3: Reminiscences of Travels in Europe in 1886." *The Woman's Medical Journal* 5 (January 1896).

Dudley, Emilius Clark. *The Principles and Practice of Gynecology: For Students and Practitioners*. Third edition. Philadelphia: Lea Brothers and Company, 1902.

Dunn, B. Sherwood. "The Relation of Diseases of the Female Generative Organs to Nervous and Mental Affections." *The American Journal of Obstetrics and Diseases of Women and Children* 38 (November 1898): 760-761.

Emmet, Thomas Addis. *The Principles and Practice of Gynecology.* First edition. Philadelphia: Henry C. Lea, 1879).

Emmet, Thomas Addis. *The Principles and Practice of Gynecology*. Third edition. Philadelphia: Henry C. Lea's Son and Company, 1884.

Engelmann, George J. "The American Girl of To-Day: The Influence of Modern Education on Functional Development. *Transactions of the American Gynecological Society* 25 (1900): 8-45.

Fullerton, Anna M. "Gonorrhea of the Uterus and Appendages: A Surgical Survey." *The Woman's Medical Journal* 7 (June 1898).

Fullerton, Anna M. "Non-Plastic Operations of the Vulva and Vagina." *Gynecology and Abdominal Surgery*. Edited by Howard Kelly. Philadelphia: W. B. Saunders Company, 1910.

Fullerton, Anna M. "Studies in Gynecology from the Service of the Woman's Hospital of Philadelphia." *Journal of the American Medical Association* 29 (December 1897).

Goffe, J. Riddle. "The Physical, Mental, and Social Hygiene of the Growing Girl." *The American Journal of Obstetrics and Diseases of Women and Children* LXIV (August 1911).

Goffe, J. Riddle. "The Woman's Hospital in the State of New York. Founded in 1855. An Historical Sketch." *The American Journal of Obstetrics and Diseases of Women and Children* LXXVII (April 1918).

Goodman, John. "The Cyclical Theory of Menstruation." *American Journal of Obstetrics and Diseases of Women and Children* 11 (1878): 673-694.

Grandin, Egbert Henry. *A Text-Book on Practical Obstetrics.* Fourth edition. Philadelphia: F. A. Davis Company, 1909.

Graves, William. *Gynecology*. Philadelphia: W. B. Saunders Company, 1920.

Hellman, Alfred M. *Amnesia and Analgesia in Parturition (Twilight Sleep)*. New York: Paul B. Hoeber, 1915.

Henrotin, F. H. "Radicalism and Conservativism in Gynecologic Societies. *Journal of the American Medical Association* XXIV (January 1895).

Hewitt, Graily. "The Exciting Cause of Attacks of Hysteria and Hystero-Epilepsy." *The American Journal of Obstetrics and Diseases of Women and Children* 14 October 1881): 925-926.

Hobbs, A. T. "The Relation of Ovarian Disease to Insanity, and Its Treatment." *The American Journal of Obstetrics and Diseases of Women and Children* 43 (April 1901): 484-491.

Hodge, Hugh L. *Introductory Lecture to the Course on Obstetrics and the Diseases of Women and Children, Delivered in the University of Pennsylvania, November 7, 1838.* Philadelphia: J. G. Auner, 1838.

Hughes, Helen. "A Consideration of Some Points in Obstetrics." *New York Medical Journal and Philadelphia Medical Journal: A Weekly Review of Medicine* LXXX (1904).

Hurdon, Elizabeth. "Pathology of the Reproductive Organs." *Gynecology and Abdominal Surgery.* Edited by Howard Kelly. Philadelphia: W. B. Saunders Company, 1910.

Ingram, Julia. "Conservative Gynecology." *Transactions of the Kentucky Medical Society* III. Louisville: John P. Morton and Company, 1894.

"Intermenstrual Dysmenorrhea." *Medical News* 76 (April 1900): 657.

Jacobi, Mary Putnam. "Mental Action and Physical Health." *The Education of American Girls.* Edited by Anna C. Brackett. New York: G. P. Putnam's Sons, 1874.

Jacobi, Mary Putnam. *The Question of Rest for Women during Menstruation.* New York: G. P. Putnam's Sons, 1877.

Jacobi, Mary Putnam. "Studies in Endometritis." *American Journal of Obstetrics and Diseases of Women and Children* 32 (1895): 36-50.

Johnstone, A. W. "Clinical Importance of the Menstrual Wave." *The American Gynaecological and Obstetrical Journal* 12 (1896): 62-71.

Kelly, Howard. *A Cyclopedia of American Medical Biography: Comprising the Lives of Eminent Deceased Physicians and Surgeons from 1610 to 1910, Vol. II.* Philadelphia: W. B. Saunders Company, 1912.

Kelly, Howard. "The Ethical Side of the Operation of Oophorectomy." *The American Journal of Obstetrics and Gynecology* 27 (1893).

Kelly, Howard. *Gynecology and Abdominal Surgery.* Philadelphia: W. B. Saunders Company, 1910.

Kirkley, C. A. "Eclampsia." *The American Journal of Obstetrics and Diseases of Women and Children* 52 (1905): 347-352.

Ladova, Rosalie M. "Medical Education for Women." *The Journal of the American Medical Association* 39 (June 1902).

Long, W. Hamilton. "The Limitations of Nitrous-Oxide-Oxygen in Surgery, and Its Recent Use in Obstetrics." *The Kentucky Medical Journal* XIV (1916).

Mann, Matthew Darbyshire. *A System of Gynecology, Volume I.* Philadelphia: Lea Brothers, 1887.

Marchildon, John Woods. *The Wassermann Reaction: Its Technic and Practical Application in the Diagnosis of Syphilis.* St. Louis: C. V. Mosby Company, 1912.

Massey, G. Betton. *Conservative Gynecology and Electro-Therapeutics: A Practical Treatise on the Diseases of Women and Their Treatment with Electricity.* Third Edition. Philadelphia: The F. A. Davis Company, 1898.

"Medical Education for Women." *The Journal of the American Medical Association* 38 (May 1902).

Mitchell, S. Weir. *Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria*. First edition. Philadelphia: J. B. Lippincott Company, 1877.

Montgomery, Edward Emmet. *Practical Gynecology: A Comprehensive Textbook for Students and Physicians.* Philadelphia: P. Blakiston's Son and Company, 1900.

Munde, Paul F. "Report on the Progress of Gynecology during the Year 1875." *American Journal of Obstetrics and Gynecology* 9 (1876): 127-173.

Nonne, Max. *Syphilis and the Nervous System, for Practitioners, Neurologists, and Syphilologists.* Philadelphia: J. B. Lippincott and Company, 1913.

Norris, Richard Cooper, and James C. Cameron and Robert Latou Dickinson. *An American Text-Book of Obstetrics: For Practitioners and Students.* Philadelphia: W. B. Saunders, 1895.

"Obituary." *The Medical News* XLIII (1883): 555.

"Obstetrical Advances of the Last Half Century." *The Medical News* LXXVI (1900).

Palmer, Chauncey D. "Functional Diseases." *Clinical Gynaecology, Medical and Surgical.* Edited by John Marie Keating and Henry Clark Coe. Philadelphia: J. B. Lippincott, 1898.

Peavey, Josephine. "Criminal Abortion." *The Woman's Medical Journal* 8 (June 1899): 209-216.

Peterson, Reuben. "The Indications for Abdominal Cesarean Section." *Physician and Surgeon: A Medical Journal* XXXV (1879).

Peterson, Reuben. *Obstetrics.* Volume V. Chicago: The Year Book Publishers, 1902.

Polak, John Osborn. "Obstetric Advances, Including Anesthesia, the Use and Abuse of Pituitrin, Extra-Periotoneal Caesarean Section, Pubiotomy, and the Significance of Funnel Pelvis." *The Boston Medical and Surgical Journal* CLXXVI (1917).

Praeger, E. Arnold. "Is So-Called Conservativism in Gynecology Conducive to the Best Results to the Patients?" *Transactions of the American Association of Obstetricians and Gynecologists* VII. Philadelphia: W. M. J. Dorman, 1895.

Price, Joseph. "The Past, Present, and Future of Abdominal and Pelvic Surgery." *The Journal of the American Medical Association* 14 (January 1890).

"Puerperal Eclampsia." *The Journal of the American Medical Association* LVII (1912): 781-783.

Schwarz, Henry. "Painless Childbirth and the Safe Conduct of Labor." *Transactions of the American Association of Obstetricians and Gynecologists* XXXI (1919).

Sims, J. Marion. "On the Treatment of Vesico-Vaginal Fistula." *American Journal of the Medical Sciences* 23 (January 1852): 59-87.

Skene, Alexander J. C. *Medical Gynecology: A Treatise on the Diseases of Women from the Standpoint of the Physician.* New York: D. Appleton and Company, 1895.

"Society Transactions." *New York State Journal of Medicine* 6 (1906): 345.

Stephenson, William. "On the Menstrual Wave." *American Journal of Obstetrics and Diseases of Women and Children* 15 (1882): 287-294.

Stoner, A. P. "The Significance of Clinical Symptoms in Determining the Pathological Conditions of Appendicitis." *Medical Record* 66 (July 1904).

Storer, Malcolm. "On Intermenstrual Dysmenorrhea." *The Boston Medical and Surgical Journal* CXLII (1900): 397-401.

Tait, Lawson. *Diseases of Women.* New York: William Wood and Company, 1872.

Tyng, Anita E. "A Case of Removal of Both Ovaries by Abdominal Section, for the Relief of an Exhausting Menorrhagia and Uterine Fibroid." *The American Journal of the Medical Sciences* 82 (1881): 525-526.

Van De Warker, Ely. "The Fetich of the Ovary." *The American Journal of Obstetrics and Gynecology* 31 (1907).

Van Hoosen, Bertha. *Scopolamine-Morphine Anaesthesia.* Chicago: The House of Manz, 1915.

Vietor, Agnes C. "The Making of a Woman Surgeon." *The Woman's Medical Journal* 10 (January 1900): 19-22.

Walker, Edwin. "Reflex Irritation as a Cause of Disease." *The Journal of the American Medical Association* 24 (February 1895): 165-166.

Whitney, William F. "A Comparative Study of the Death Rates for the State of Massachusetts for the Years 1850, 1875 and 1900." *The Boston Medical and Surgical Journal* 150 (1904): 536.

Williams, Henry Smith. *Twilight Sleep: A Simple Account of New Discoveries in Painless Childbirth.* New York: Harper and Brothers Publishers, 1914.

Other Primary Sources

"Arrest Skirtless Bather: Chicago Woman Refused to Wear Garment While Swimming." *New York Times*. July 27, 1913.

Beecher, Catharine. "The American People Starved and Poisoned." *Harper's New Monthly Magazine* XXXII (1866): 771.

Beecher, Catharine. *Physiology and Calisthenics for Schools and Families.* New York: Harper and Brothers, 1856.

Beecher, Catharine. *Letters to the People on Health and Happiness.* New York: Harper and Brothers, 1855).

Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women.* London: Longmans, Green, and Company, 1895.

Boyd, Mary and Marguerite Tracy. "More about Painless Childbirth." *McClure's Magazine* XLIII (October 1914).

Boyd, Mary and Marguerite Tracy. *Painless Childbirth: A General Survey of All Painless Methods with Special Stress on 'Twilight Sleep' and Its Extension to America.* New York: Frederick A. Stokes Company, 1915.

Brackett, Anna C. "Education of American Girls." *The Education of American Girls.* Edited by Anna C. Brackett. New York: G. P. Putnam's Sons, 1974.

Dall, Caroline H. "V." *Sex and Education: A Reply to Dr. E. H. Clarke's 'Sex in Education.'* Edited by Julia Ward Howe. Reprint edition. New York: Arno Press, 1972.

Dall, Caroline H. *The College, the Market, and the Court; Or, Woman's Relation to Education, Labor, and Law.* Memorial edition. Concord, NH: Rumford Press, 1914.

Dall, Caroline H. *Woman's Right to Labor; Or, Low Wages and Hard Work.* Boston: Walker, Wise, and Company, 1860.

Dall, Caroline H. *Woman's Rights under the Law.* Boston: Walker, Wise, and Company, 1861.

Emmet, Thomas Addis. *Reminiscences of the Founders of the Women's Hospital Association.* New York: Stuyvesant Press, 1893.

"Hospital Not a Nuisance." *The New York Times.* June 9, 1917.

Howe, Julia Ward. "I." *Sex and Education: A Reply to Dr. E. H. Clarke's 'Sex in Education.'* Edited by Julia Ward Howe. Reprint edition. New York: Arno Press, 1972.

Howe, Julia Ward. "Introduction." *Sex and Education: A Reply to Dr. E. H. Clarke's 'Sex in Education.'* Edited by Julia Ward Howe. Reprint edition. New York: Arno Press, 1972.

Howe, Julia Ward. *Reminiscences, 1819-1899.* New York: Houghton, Mifflin, and Company, 1900.

Jacobi, Mary Putnam. "Woman in Medicine." *Woman's Work in America.* Edited by Annie Nathan Meyer. New York: Henry Holt, 1891.

Lovejoy, Esther C. P. "My Medical School, 1890-1894." *Oregon Historical Quarterly* 75 (March 1974): 7-35.

Lowry, Edith Belle. *Herself: Talks with Women Concerning Themselves.* Chicago: Forbes and Company, 1911.

Meigs, Grace. *Maternal Mortality from All Conditions Connected with Childbirth in the United States and Certain Other Countries.* Washington, D.C.: Government Printing Office, 1917.

Morton, Rosalie Slaughter. *Woman Surgeon: The Life and Work of Rosalie Slaughter Morton.* New York: Frederick A. Stokes Company, 1937.

"Mothers Discuss Twilight Sleep." *New York Times.* November 18, 1914.

"No Compromise with Antis." *New York Times*. April 29, 1894.

Owens-Adair, B. A. *Dr. Owens-Adair: Some of Her Life Experiences.* Portland, OR: Mann and Beach, 1906.

Phelps, Elizabeth Stuart. "VII." *Sex and Education: A Reply to Dr. E. H. Clarke's 'Sex in Education.'* Edited by Julia Ward Howe. Reprint edition. New York: Arno Press, 1972.

Sims, J. Marion. *The Story of My Life.* Reprint edition. New York: Da Capo Press, 1968.

"Suffragists on the Warpath." *New York Times.* May 3, 1894.

"Testimony from Colleges." *Sex and Education: A Reply to Dr. E. H. Clarke's 'Sex in Education.'* Edited by Julia Ward Howe. Reprint edition. New York: Arno Press, 1972.

Thomas, M. Carey. "Present Tendencies in Women's College and University Education." *Educational Review* 25 (1908).

Thorne, Van Buren. "Twilight Sleep Is Successful in 120 Cases Here." *New York Times Magazine.* August 30, 1914.

Tracy, Marguerite. "Bringing Babies into the World." *Ladies World* (September 1914): 9-10.

Tracy, Marguerite and Constance Leupp. "Painless Childbirth." *McClure's Magazine* XLIII (June 1914).

Van Hoosen, Bertha. *Petticoat Surgeon.* Chicago: Pellegrini and Cudahy, 1937.

Ver Beck, Hanna Rion. "The Painless Childbirth: Testimony of American Mothers Who Have Tried 'The Twilight Sleep.'" *Ladies' Home Journal* (September 1914): 9-10.

Ver Beck, Hanna Rion. *The Truth about Twilight Sleep.* New York: McBride, Nast, and Company, 1915.

Wharton, Edith. *Twilight Sleep.* First Scribner Paperback edition. New York: Simon and Schuster, 1997.

Whittier, J. G. "Maud Muller." *Our Girls: Poems in Praise of the American Girl.* New York: Moffat, Yard, and Company, 1907.

Wolff, Ethel H. "The Bridge of Dreams." *The New York Times.* May 28, 1914.

Secondary Sources

Abrams, Ruth J. "Introduction." *Send Us a Lady Physician: Women Doctors in America, 1835-1920.* New York: W. W. Norton and Company, 1985.

Alsop, Gulielma Fell. *History of the Woman's Medical College of Pennsylvania.* Philadelphia: J. B. Lippincott Company, 1950.

Apple, Rima. *Mothers and Medicine: A Social History of Infant Feeding, 1890-1950.* Madison: University of Wisconsin Press, 1988.

Apple, Rima. *Perfect Motherhood: Science and Childrearing in America.* New Brunswick: Rutgers University Press, 2006.

Arney, William Ray. *Power and the Profession of Obstetrics.* Chicago: University of Chicago Press, 1982.

Barker-Benfield, G. J. *The Horrors of the Half-Known Life: Male Attitudes toward Women and Sexuality in Nineteenth-Century America*. Second edition. New York: Routledge Press, 2000.

Bederman, Gail. *Manliness and Civilization: A Cultural History of Gender and Race in the United States, 1880-1917.* Chicago: University of Chicago Press, 1995.

Bittel, Carla. *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth-Century America.* Chapel Hill: University of North Carolina Press, 2009.

Blustein, Bonnie Ellen. *Educating for Health and Prevention: A History of the Department of Community and Preventive Medicine at the (Woman's) Medical College of Pennsylvania.* Canton: Science History Publications, 1993.

Bonner, Thomas Neville. *To the Ends of the Earth: Women's Search for Education in Medicine.* Cambridge: Harvard University Press, 1992.

Bordin, Ruth Birgitta Anderson. *Alice Freeman Palmer: The Evolution of a New Woman.* Ann Arbor: University of Michigan Press, 1993.

Borst, Charlotte. *Catching Babies: The Professionalization of Childbirth, 1870-1920.* Cambridge: Harvard University Press, 1995.

Boydston, Jeanne. *The Limits of Sisterhood: The Beecher Sisters on Women's Rights and Women's Sphere.* Chapel Hill: University of North Carolina Press, 1993.

Brandt, Allan M. *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880.* New York: Oxford University Press, 1985.

Briggs, Laura. "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology." *American Quarterly* 52 (2000): 246-273.

Brumberg, Joan Jacobs. "Something Happens to Girls: Menarche and the Emergence of the Modern American Hygienic Imperative." *Journal of the History of Sexuality* 4 (1993).

Buechler, Steven M. *Women's Movements in the United States: Woman Suffrage, Equal Rights, and Beyond.* New Brunswick: Rutgers University Press, 1987.

Butler, Judith. *Bodies that Matter: On the Discursive Limits of 'Sex.'* New York: Routledge, 1993.

Butler, Judith. *Gender Trouble: Feminism and the Subversion of Identity.* New York: Routledge, 1990.

Carter, Julian B. *The Heart of Whiteness: Normal Sexuality and Race in America, 1880-1940.* Durham: Duke University Press, 2007.

Cassedy, James H. *Medicine in America: A Short History*. Baltimore: The Johns Hopkins University Press, 1991.

Cassidy, Tina. *Birth: The Surprising History of How We Are Born.* New York: Grove Press, 2006.

Caton, Donald. *What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present.* New Haven: Yale University Press, 1999.

Cervetti, Nancy. *S. Weir Mitchell, 1829-1914.* University Park, PA: Pennsylvania State University Press, 2012.

Chafe, William. *The American Woman.* New York: Oxford University Press, 1972.

Cianfrani, Theodore. *A Short History of Gynecology and Obstetrics.* Springfield, IL: Charles C. Thomas, 1960.

Clarke, Adele E. "Women's Health: Life-Cycle Issues." *Women, Health, and Medicine in America.* Edited by Rima D. Apple. New York: Garland Publishing, 1990.

Clifford, Deborah Pickman. *Mine Eyes Have Seen the Glory: A Biography of Julia Ward Howe.* Boston: Little and Brown, 1979.

Cott, Nancy F. *The Bonds of Womanhood: 'Woman's Sphere' in New England, 1780-1835.* New Haven: Yale University Press, 1977.

Cott, Nancy F. *The Grounding of Modern Feminism.* New Haven: Yale University Press, 1987.

Dally, Ann. *Women under the Knife.* New York: Routledge Press, 1992.

Daly, Mary. *Gyn/Ecology: The Metaethics of Radical Feminism.* Boston: Beacon Press, 1990.

Deese, Helen R. *Daughter of Boston: The Extraordinary Diary of a Nineteenth-Century Woman, Caroline Healey Dall.* Boston: Beacon Press, 2006.

D'Emilio, John D. and Estelle B. Freedman. *Intimate Matters: A History of Sexuality in America.* New York: Harper and Row, 1988.

Donegan, Jane B. *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America*. Westport, Connecticut: Greenview Press, 1978.

Drachman, Virginia. *Hospital with a Heart: Women Doctors and the Paradox of Separatism at the New England Hospital, 1862-1966.* Ithaca: Cornell University Press, 1984.

DuBois, Ellen Carol. *Feminism and Suffrage: The Emergence of an Independence Women's Movement in America, 1848-1869.* Ithaca: Cornell University Press, 1978.

Dubow, Sara. *Ourselves Unborn: A History of the Fetus in Modern America*. New York: Oxford University Press, 2011.

Duden, Barbara. *Disembodying Women: Perspectives on Pregnancy and the Unborn*. Cambridge: Harvard University Press, 1993.

Dye, Nancy Schrom. "The Medicalization of Birth." *The American Way of Birth.* Edited by Pamela S. Eakins. Philadelphia: Temple University Press, 1986.

Edwards, Margot and Mary Waldorf. *Reclaiming Birth: History and Heroines of American Childbirth Reform.* Trumansburg, NY: The Crossing Press, 1984).

Ehrenreich, Barbara and Deirdre English. *For Her Own Good: 150 Years of the Experts' Advice to Women.* New York: Doubleday, 1978.

Everett, Houston S. and E. Stewart Taylor. "The History of the American Gynecological Society and the Scientific Contributions of Its Fellows." *The Journal of Obstetrics and Gynecology* 126 (December 1976): 908-918.

Foucault, Michel. *The History of Sexuality: An Introduction: Volume I.* New York: Vintage Books, 1990.

Freidenfelds, Lara. *The Modern Period: Menstruation in Twentieth-Century America.* Baltimore: Johns Hopkins University Press, 2009.

Gevitz, Norman. *Other Healers: Unorthodox Medicine in America.* Baltimore: Johns Hopkins University Press, 1988.

Ginzberg, Lori D. *Women in Antebellum Reform.* Wheeling: Harlan Davidson, 2000.

Ginzberg, Lori D. *Women and the Work of Benevolence: Morality, Politics, and Class in the Nineteenth-Century United States.* New Haven: Yale University Press, 1990.

Gordon, Linda. *The Moral Property of Women: A History of Birth Control Politics in America.* Urbana: University of Illinois Press, 2002.

Gordon, Lynn D. *Gender and Higher Education in the Progressive Era.* New Haven: Yale University Press, 1990.

Graham, Harvey. *Eternal Eve: The History of Gynecology and Obstetrics.* Garden City, NJ: Doubleday, 1951.

Grant, Julia. *Raising Baby by the Book: The Education of American Mothers.* New Haven: Yale University Press, 1998.

Groneman, Carol. *Nymphomania: A History.* New York: W. W. Norton, 2000.

Group, Thomas M and Joan I Roberts. *Nursing, Physician Control, and the Medical Monopoly: Historical Perspectives on Gendered Inequality in Roles, Rights, and Range of Practice.* Bloomington, IN: Indiana University Press, 2001.

Hairston, Amy H. "The Debate over Twilight Sleep: Women Influencing Their Medicine." *The Journal of Women's Health* 5 (1996).

Harris, Seale. *Woman's Surgeon: The Life Story of J. Marion Sims.* New York: Macmillan Press, 1950.

Hawkins, Cora. *Buggies, Blizzards, and Babies.* Ames: The Iowa State University Press, 1971.

Herbst Lewis, Carolyn. *Prescription for Heterosexuality: Sexual Citizenship in the Cold War Era.* Chapel Hill: University of North Carolina Press, 2010.

Horowitz, Helen Lefkowitz. *Alma Mater: Design and Experience in the Women's Colleges from their Nineteenth-Century Beginnings to the 1930s.* Amherst: University of Massachusetts Press, 1984.

Horowitz, Helen Lefkowitz. "'Nous Autres': Reading, Passion, and the Creation of M. Carey Thomas." *Journal of American History* 79 (June 1992): 68-95.

Hoy, Sueellen. *Chasing Dirt: The American Pursuit of Cleanliness.* New York: Oxford University Press, 1995.

Igo, Sarah E. *The Averaged American: Surveys, Citizens, and the Making of a Mass Public.* Cambridge: Harvard University Press, 2007.

Jensen, Kimberly. *Oregon's Doctor to the World: Esther Pohl Lovejoy and a Life in Activism.* Seattle: University of Washington Press, 2012.

Kaiser, Irwin H. "Reappraisals of J. Marion Sims." *American Journal of Obstetrics and Gynecology* 132 (1978): 878-884.

Kapsalis, Terri. *Public Privates: Performing Gynecology from Both Ends of the Speculum.* Durham: Duke University Press, 1997.

Kaufman, Martin. "American Medical Education." *The Education of American Physicians: Historical Essays.* Berkeley: University of California Press, 1980.

King, Lester S. *American Medicine Comes of Age, 1840-1920.* New York: Basic Books, 1985.

Klein, Wendy. *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom.* Berkeley: University of California Press, 2001.

Klepp, Susan E. *Revolutionary Conceptions: Women, Fertility, and Family Limitation in America, 1760-1820.* Chapel Hill: University of North Carolina Press, 2009.

Lacqueur, Thomas. *Making Sex: Body and Gender from the Greeks to Freud.* Cambridge: Harvard University Press, 1990.

Ladd-Taylor, Molly. "Toward Defining Maternalism in U.S. History." *Journal of Women's History* 5 (fall 1993).

Ladd-Taylor, Molly. *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915-1932.* New Brunswick: Rutgers University Press, 1986.

Leach, William. *True Love and Perfect Union: The Feminist Reform of Sex and Society.* New York: Basic Books, 1980.

Leavitt, Judith Walzer. "Birthing and Anesthesia: The Debate over Twilight Sleep." *Signs* 6 (autumn 1980).

Leavitt, Judith Walzer. *Brought to Bed: Childbearing in America, 1750-1950.* New York: Oxford University Press, 1986.

Leavitt, Judith Walzer. "The Growth of Medical Authority: Technology and Morals in Turn-of-the-Century Obstetrics." *Women and Health in America: Historical Readings*. Second Edition. Edited by Judith Walzer Leavitt. Madison: University of Wisconsin Press, 1999.

Leavitt, Judith Walzer. "Public Health and Preventive Medicine." *The Education of American Physicians: Historical Essays.* Edited by Ronald L. Numbers. Berkeley: University of California Press, 1980.

Lemus, Cheryl. "The Maternity Racket: Medicine, Consumerism, and the Modern American Pregnancy, 1876-1960." PhD Dissertation. Northern Illinois University, 2011.

Lewis, Jan and Kenneth A. Lockridge. "'Sally Has Been Sick': Pregnancy and Family Limitation among Virginian Gentry Women, 1780-1830." *Journal of Social History* 22 (1989): 5-19.

Litoff, Judy Barrett. *American Midwives: 1860 to the Present.* Westport, Connecticut: Greenview Press, 1978.

Longo, Lawrence D. "Obstetrics and Gynecology." *The Education of American Physicians: Historical Essays*. Edited by Ronald L. Numbers. Berkeley: University of California Press, 1980).

Longo, Lawrence. "The Rise and Fall of Battey's Operation: A Fashion in Surgery." *The Bulletin of the History of Medicine* 53 (1979): 244-267.

Ludmerer, Kenneth M. *Learning to Heal: The Development of American Medical Education.* New York: Basic Books, 1985.

Lunbeck, Elizabeth. "A New Generation of Women: Progressive Psychiatrists and the Hypersexual Female." *Feminist Studies* 13 (1987): 513-543.

Maines, Rachel. *The Technology of Orgasm: 'Hysteria,' the Vibrator, and Women's Sexual Satisfaction.* Baltimore: Johns Hopkins University Press, 1999.

Marrett, Cora Bagley. "Nineteenth Century Associations of Medical Women: The Beginning of a Movement." *Journal of the American Medical Women's Association* 32 (December 1977): 469-474.

Marrett, Cora Bagley. "On the Evolution of Women's Medical Societies." *Bulletin of the History of Medicine* 53 (Fall 1979): 434-448.

May, Elaine Tyler. *Homeward Bound: American Families in the Cold War Era.* New York: Basic Books, 1990.

McGregor, Deborah Kuhn. *From Midwives to Medicine: The Birth of American Gynecology*. New Brunswick: Rutgers University Press, 1998.

McGregor, Deborah Kuhn. *Sexual Surgery and the Origins of Gynecology: J. Marion Sims, His Hospital, and His Patients.* New York: Garland Press, 1989.

Meckel, Richard. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929.* Baltimore: Johns Hopkins University Press, 1990.

Mitchinson, Wendy. "Gynecological Operations on Insane Women: London, Ontario, 1895-1901." *Journal of Social History* 15 (1982): 467-484.

Mohr, James C. *Abortion in America: The Origins and Evolutions of National Policy.* New York: Oxford University Press, 1978.

Moldow, Gloria. *Women Doctors in Gilded Age Washington: Race, Gender, and Professionalization.* Chicago: University of Illinois Press, 1987.

Morantz-Sanchez, Regina. *Conduct Unbecoming a Woman: Medicine on Trial in Turn-of-the-Century Brooklyn.* New York: Oxford University Press, 1999.

Morantz-Sanchez, Regina. "The Female Medical Student Has Arrived: The Rise of the Women's Medical Movement." *"Send Us a Lady Physician": Women Doctors in America, 1835-1920.* Edited by Ruth J. Abram. New York: W. W. Norton and Company, 1985.

Morantz-Sanchez, Regina. "Feminist Theory and Historical Practice: Rereading Elizabeth Blackwell." *History and Theory* 31 (December 1992): 51-69.

Morantz-Sanchez, Regina. "The Gendering of Empathic Expertise: How Women Physicians Became More Empathic Than Men." *The Empathic Practitioner.* Edited by Ellen Singer Moore and Maureen A. Milligan. New Brunswick: Rutgers University Press, 1994.

Morantz-Sanchez, Regina. "The Perils of Feminist History." *The Journal of Interdisciplinary History* IV (1973): 649-660.

Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine.* New York: Oxford University Press, 1985.

More, Ellen S. "A Certain Restless Ambition: Women Physicians and World War I." *American Quarterly* 41 (December 1989): 636-660.

More, Ellen Singer. *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995.* Cambridge: Harvard University Press, 1999.

Moscucci, Ornella. *The Science of Women: Gynecology and Gender in England, 1880-1929.* Cambridge: Cambridge University Press, 1990.

Muncy, Robyn. *Creating a Female Dominion in American Reform.* New York: Oxford University Press, 1991.

Oakley, Ann. *The Captured Womb: A History of the Medical Care of Pregnant Women.* New York: Basil Blackwell, 1984.

Ojanuga, Durrenda. "The Medical Ethics of the 'Father of Gynaecology,' Dr. J. Marion Sims." *The Journal of Medical Ethics* 19 (1993): 28-31.

O'Leary, J. Patrick. "J. Marion Sims: A Defense of the Father of Gynecology." *Southern Medical Journal* 97 (2004): 427-429.

Patterson, Martha H. *Beyond the Gibson Girl: Reimagining the American New Woman, 1895-1915.* Urbana: University of Illinois, Press.

Peitzman, Steven J. *A New and Untried Course: Woman's Medical College and Medical College of Pennsylvania, 1850-1998.* New Brunswick: Rutgers University Press, 1985.

Pernick, Martin S. *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America*. New York: Columbia University Press, 1985.

Poirier, Suzanne. "Women's Reproductive Health." *Women, Health, and Medicine in America: A Historical Handbook.* Edited by Rima D. Apple. New York: Garland Publishing, 1990.

Reagan, Leslie J. "About to Meet Her Maker: Women, Doctors, Dying Declarations, and the State Investigation of Abortion, Chicago, 1867-1940." *The Journal of American History* 77 (March 1991): 1240-1264.

Reagan, Leslie J. *Dangerous Pregnancies: Mothers, Disabilities, and Abortion in Modern America.* Berkeley: University of California Press, 2010.

Reagan, Leslie J. *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973.* Berkeley: University of California Press, 1996.

Reverby, Susan M. *Ordered to Care: The Dilemma of American Nursing, 1850-1945.* Cambridge: Cambridge University Press, 1987.

Ricci, James V. *One Hundred Years of Gynecology*. Philadelphia: The Blakiston Company, 1945.

Rodriguez, Sarah W. "Rethinking the History of Female Circumcision and Clitoridectomy: American Medicine and Sexuality in the Late Nineteenth Century." *Journal of the History of Medicine and Allied Sciences* 63 (July 2008).

Rosen, Robyn L. *Reproductive Health, Reproductive Rights: Reformers and the Politics of Maternal Welfare, 1917-1940.* Columbus: The Ohio State University Press, 2003.

Rosenberg, Charles E. *The Care of Strangers: The Rise of America's Hospital System.* New York: Basic Books, 1987.

Rosenberg, Charles E. *No Other Gods: On Science and American Social Thought.* Revised and expanded edition. Baltimore: Johns Hopkins University Press, 1997.

Rosenberg, Charles E. "The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America." *Perspectives in Biology and Medicine* 20 (summer 1977): 485-506.

Rosenberg, Rosalind. *Beyond Separate Spheres: Intellectual Roots of Modern Feminism.* New Haven: Yale University Press, 1982.

Rothman, Barbara Katz. "The Social Construction of Birth." *The American Way of Birth.* Edited by Pamela S. Eakins. Philadelphia: Temple University Press, 1986.

Rothman, Sheila M. *Woman's Proper Place: A History of Changing Ideals and Practices, 1870 to the Present.* New York: Basic Books, 1980.

Rothstein, William G. *American Medical Schools and the Practice of Medicine.* New York: Oxford University Press, 1987.

Rothstein, William G. *American Physicians in the Nineteenth Century: From Sects to Science.* Baltimore: Johns Hopkins University Press, 1985.

Roy, Judith M. "Surgical Gynecology." *Women, Health, and Medicine in America: A Historical Handbook*. Edited by Rima D. Apple. New York: Garland Publishing, 1990.

Russett, Cynthia Eagle. *Sexual Science: The Victorian Construction of Womanhood*. Cambridge: Harvard University Press, 1989.

Sahli, Nancy Ann. *Elizabeth Blackwell, M.D. (1821-1910): A Biography*. New York: Arno Press, 1982.

Sandelowski, Margarete. *Devices and Desires: Gender, Technology, and American Nursing.* Chapel Hill: University of North Carolina Press, 2000.

Sandelowski, Margarete. *Pain, Pleasure, and American Childbirth: From Twilight Sleep to the Read Method, 1914-1960.* Westport, CT: Greenwood Press, 1984.

Sartin, Jeffrey S. "J. Marion Sims, the Father of Gynecology: Hero or Villain?" *Southern Medical Journal* 97 (2004).

Schuster, David G. *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1869-1920*. New Brunswick: Rutgers University Press, 2011.

Schwartz, Marie Jenkins. *Birthing a Slave: Motherhood and Medicine in the Antebellum South.* Cambridge: Harvard University Press, 2006.

Scull, Andrew and Diane Fabreau. "A Chance to Cut is a Chance to Cure." *Research in Law, Deviance, and Social Control* 8 (1896): 3-39.

Shorter, Edward. *Bedside Manners: The Troubled History of Doctors and Patients.* New York: Simon and Schuster, 1985.

Shorter, Edward. *A History of Women's Bodies.* New York: Basic Books, 1982.

Shorter, Edward. *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era.* New York: Free Press, 1992.

Silverthorne, Elizabeth and Geneva Fulghum. *Women Pioneers in Texas Medicine*. College Station, TX: Texas A&M University Press, 1997.

Simmons, Christina. *Making Marriage Modern: Women's Sexuality from the Progressive Era to World War II.* New York: Oxford University Press, 2009.

Sklar, Kathryn Kish. *Catharine Beecher: A Study in American Domesticity.* New York: W. W. Norton and Company, 1976.

Smith-Rosenberg, Carroll. *Disorderly Conduct: Visions of Gender in Victorian America.* New York: Alfred A. Knopf, 1985.

Smith-Rosenberg, Carroll and Charles E. Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *Journal of American History* 60 (1973): 332-356.

Solomon, Barbara Miller. *In the Company of Educated Women: A History of Higher Education in America.* New Haven: Yale University Press, 1985.

Speert, Harold. *Obstetrics and Gynecology in America: A History.* Washington, D.C.: American College of Obstetricians and Gynecologists, 1980.

Stage, Sarah. *Female Complaints.* New York: W. W. Norton and Company, 1979.

Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1982.

Steele, Volney. *Bleed, Blister, and Purge: A History of Medicine on the American Frontier.* Third edition. Missoula, MT: Mountain Press Publishing Company, 2005.

Stern, Alexandra Minna. *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America.* Berkeley: University of California Press, 1995.

Stevens, Rosemary. "The Changing Idea of a Medical Specialty." *Transactions and Studies of the College of Physicians of Philadelphia* 5 (1980): 159-177.

Summerville, James. *Educating Black Doctors: A History of Meharry Medical College.* Alabama: University of Alabama Press, 1983.

Tallman, Jamie Q. *The Notorious Dr. Flippin: Abortion and Consequence in the Early Twentieth Century.* Lubbock, TX: Texas Tech University Press, 2011.

Terry, Jennifer. *An American Obsession: Science, Medicine, and Homosexuality in Modern Society.* Chicago: University of Chicago Press, 1999.

Theriot, Nancy. "Diagnosing Unnatural Motherhood: Nineteenth-Century Physicians and 'Puerperal Insanity.'" *American Studies* 30 (Fall 1989): 69-88.

Theriot, Nancy. "Women's Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science." *Signs* 19 (1993): 1-31.

Tone, Andrea. *Devices and Desires: A History of Contraceptives in America.* New York: Farrar, Strauss, and Giroux, 2002.

Tuchman, Arleen Marcia. *Science Has No Sex: The Life of Marie Zakrzewska, M.D.* Chapel Hill: University of North Carolina Press, 2006.

Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812.* New York: Vintage Books, 1990.

Varon, Elizabeth R. *We Mean to Be Counted: White Women and Politics in Antebellum Virginia.* Chapel Hill: University of North Carolina Press, 1998.

Wall, L. Lewis. "Did J. Marion Sims Deliberately Addict His First Fistula Patients to Opium?" *Journal of the History of Medicine and Allied Sciences* 62 (November 2006).

Walsh, Mary Roth. *Doctors Wanted: No Women Need Apply: Sexual Barriers in the Medical Profession, 1835-1975*. New Haven: Yale University Press, 1977.

Wayne, Tiffany K. *Woman Thinking: Feminism and Transcendentalism in Nineteenth-Century America.* Lanham, MD: Lexington Books, 2007.

Webber, Sarah. "The 'Unnecessary' Organ: Female Circumcision and Clitoridectomy, 1865-1995." PhD Dissertation. University of Nebraska Medical Center, 2005.

Wells, Susan. *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine* (Madison: University of Wisconsin Press, 2001).

Welter, Barbara. "The Cult of True Womanhood, 1820-1860." *American Quarterly* 18 (summer 1966): 151-174.

Wertz, Richard W. and Dorothy C. Wertz. *Lying-In: A History of Childbirth in America.* Baltimore: Johns Hopkins University Press, 1989.

White, Barbara A. *The Beecher Sisters*. New Haven: Yale University Press, 2003.

Williams, Gary. *Hungry Heart: The Literary Emergence of Julia Ward Howe.* Amherst: University of Massachusetts Press, 1999.

Wilson, Dorothy Clarke. *Lone Woman: The Story of Elizabeth Blackwell, the First Woman Doctor*. Boston: Little and Brown, 1970.

Wolf, Jacqueline H. *Deliver Me from Pain: Anesthesia and Birth in America.* Baltimore: Johns Hopkins University Press, 2009.

Wolf, Jacqueline H. *Don't Kill Your Baby: Public Health and the Decline of Breastfeeding in the 19th and 20th Centuries.* Columbus: Ohio State University Press, 2001.

Woloch, Nancy. *Early American Women: A Documentary History, 1600-1900.* New York: McGraw Hill, 2002.

Woloch, Nancy. "Promoting Woman's Sphere, 1800-1860," *Women and the American Experience: A Concise History.* New York: McGraw Hill, 2002.

Woloch, Nancy. "The Rise of the New Woman, 1860-1920." *Women and the American Experience: A Concise History.* New York: McGraw Hill, 2002: 180-211.

Wood, Ann Douglas. "The Fashionable Diseases: Women's Complaints and Their Treatment in Nineteenth-Century America." *The Journal of Interdisciplinary History* IV (summer 1973).

Zschoche, Sue. "Dr. Clarke Revisited: Science, True Womanhood, and Female Collegiate Education." *History of Education Quarterly* 29 (Winter 1989): 545-569.