

MORE PERFECT WOMEN, MORE PERFECT MEDICINE: WOMEN AND THE
EVOLUTION OF OBSTETRICS AND GYNECOLOGY, 1880-1920

by

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This thesis argues that women were instrumental in creating the period of transformation that took place in American obstetrics and gynecology during the late nineteenth and early twentieth centuries. Historians have emphasized the ways that male physicians victimized female patients, but in the academic, professional, and public worlds, women directly influenced these specialties. As intellectuals and educators, women challenged existing ideas about their presence in academia and shaped evolving medical school curricula. As specialists, they debated the ethics of operative gynecology and participated in the medical construction of the female body. Finally, as activists, they demanded that obstetricians and gynecologists adopt treatments they believed were desirable. In doing so, they took part in larger debates about gender difference, gender equality, and the relationship between women's physical bodies and social roles.

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CHAPTER I

INTRODUCTION

Between 1880 and 1920, the medical specialties of obstetrics and gynecology underwent a period of exhilarating transformation.¹ During the same decades, women in the United States became increasingly involved in the public sphere; they earned college degrees, pursued professional careers, campaigned for women's suffrage, and advocated for causes like social hygiene, sex education, and birth control.² The women's medical movement, specifically, was enjoying what the medical historian Steven J. Peitzman has termed "a golden age," which was characterized by steadily increasing numbers of women enrolling in medical colleges, opening profitable practices, publishing case

¹ See 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), 636-654; 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; 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.

² On the social and political lives of late-nineteenth and early-twentieth-century American women, see Steven M. Buechler, *Women's Movements in the United States: Woman Suffrage, Equal Rights, and Beyond* (New Brunswick: Rutgers University Press, 1990); Nancy F. 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).

studies, and joining professional associations.³ All of these events were intimately connected, but historians have not considered them together. They have traced the advancements in late-nineteenth- and early-twentieth-century obstetrics and gynecology to the innovations of pioneering male physicians, to the development of advanced antiseptic techniques, and to the consolidation of authority in the hands of “regular” physicians; however, they have not generally noticed that women were partly responsible for the evolution of these specialties.⁴ This oversight is unquestionably linked to the persistence of a historiography that casts women as victims of the professionalization of medicine rather than as actors in that process.

Indeed, most existing histories of American obstetrics and gynecology emphasize the misogyny of male physicians and the victimization of female patients. Historians who focus primarily on obstetrics tend to decry the medicalization (which they portray as synonymous with the masculinization) of pregnancy and childbirth. They highlight, especially, the transition away from midwifery, which they depict as a consequence of the male desire to wrest control of labor and delivery from women.⁵ Scholars who focus on gynecology make similar claims. In *From Midwives to Medicine*, for example,

³ 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.

⁴ See, for example, Longo, “Obstetrics and Gynecology,” 215-216; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 110-112, 156-157.

⁵ 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; Diana Scully, “From Natural to Surgical Event,” *The American Way of Birth*, edited by Pamela S. Eakins (Philadelphia: Temple University Press, 1986), 47-58.

Deborah Kuhn McGregor characterizes male medical authority as tyrannical and argues that the specialty of gynecology, from its inception, depended upon “the subordination of women and the objectification of their bodies.”⁶ G. J. Barker-Benfield and Mary Daly take such arguments even further, asserting that both obstetricians and gynecologists purposefully deployed sexual surgeries and other treatments to restrain women’s ambitions and control their behavior.⁷ Such scholarship utilizes the most shocking evidence available. The physicians featured are almost always men, and these men are almost always stunningly misogynistic. They approach women’s bodies with contempt and revulsion, reject their patients’ thoughts and concerns, and wield the speculum and the scalpel as weapons.

These assessments are flawed for two reasons. First, the villain-victim model is fundamentally inaccurate. Although many American women were certainly victimized by reckless, uncaring, or misogynistic specialists, historians have unfairly privileged the most appalling, not necessarily the most representative, evidence. Second, the model reduces the complexities of women’s diverse positions into a single passive experience. As a result, existing scholarship ignores female agency, minimizing women’s roles as intellectuals, educators, physicians, researchers, and activists. Women were not simply victims in this story; they actively shaped the development of obstetrics and gynecology.

⁶ Deborah Kuhn McGregor, *From Midwives to Medicine: The Birth of American Gynecology* (New Brunswick: Rutgers University Press, 1998), 3. See also Deborah Kuhn McGregor, *Sexual Surgery and the Origins of Gynecology: J. Marion Sims, His Hospital, and His Patients* (New York: Garland Press, 1989).

⁷ 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).

By the 1880s and 1890s, women were obtaining medical degrees and pursuing medical careers in larger numbers, and the majority of them specialized in obstetrics or gynecology.⁸ Throughout the late nineteenth and early twentieth centuries, they produced some of the most revolutionary research in their fields. For instance, Dr. Mary Putnam Jacobi's *The Question of Rest for Women during Menstruation*, originally printed in 1877, successfully challenged conventional wisdom regarding women's physical and mental capabilities.⁹ The landmark study earned Harvard University's prestigious Boylston Prize. Because Jacobi taught materia medica at the Woman's Medical College in New York, she also made a direct impact on the next generation of women physicians.¹⁰ Other respected professors, such as Dr. Hannah Croasdale and Dr. Anna Broomall, both at the eminent Woman's Medical College of Pennsylvania, educated and inspired ambitious women specialists as well.¹¹

⁸ Peitzman, *Untried Course*, 64. For statistics compiled in 1881 for the graduates of the Woman's Medical College in Pennsylvania – the largest and most successful women's medical school – see Rachel Litter Bodley, "Valedictory Address to the Twenty-Ninth Graduating Class of the Woman's Medical College of Pennsylvania" (Philadelphia: Grant, Faires, and Rodgers, 1881), 5. Ellen S. More has pointed out that because many specialized professional societies excluded women physicians until the 1930s or later, the specialization of women was frequently "unofficial." This thesis will therefore refer to "specialties" and "specialization" to reflect the kinds of cases women physicians typically took and the kinds of research they conducted, even when no official specialty designation existed. See Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995* (Cambridge: Harvard University Press, 1999), 55.

⁹ Mary Putnam Jacobi, *The Question of Rest for Women during Menstruation* (New York: G. P. Putnam's Sons, 1877).

¹⁰ On Jacobi, see Carla Bittel, "Mary Putnam Jacobi and the Nineteenth-Century Politics of Women's Health Research," *Women Physicians and the Cultures of Medicine*, edited by Ellen S. More (Baltimore: Johns Hopkins University Press, 2009); Carla Jean Bittel, *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth-Century America* (Chapel Hill: University of North Carolina Press, 2009).

¹¹ On Croasdale and Broomall, see Peitzman, *Untried Course*, 82-84.

By 1891, Jacobi estimated that more than two thousand women were already practicing medicine in the United States, and by 1900, there were more than three times that many, with women representing five percent of the total.¹² Because their presence in obstetrics and gynecology was disproportionate and because their gender accorded them some degree of symbolic power, they effected a tremendous impact on those specialties. They delivered babies, performed surgeries, and treated reproductive diseases; further, in considerable numbers, they reported their cases in medical journals and at professional conferences. As they did so, they engaged in medical discourse about the nature of femininity and participated in the medical construction of women's bodies. Through all of these activities, they made valuable contributions to the growth and development of their fields.¹³

In addition, women changed the ways that obstetrics and gynecology were practiced through their roles as activists. The campaign for twilight sleep, which took place in 1914 and 1915, was a striking example. American physicians were initially reluctant to offer their patients twilight sleep, a new form of obstetric anesthesia that had been developed in Germany. Unwilling to wait, upper-class club women like Frances X. Carmody organized the National Twilight Sleep Association and encouraged women to demand the treatment.¹⁴ The NTSA proved extraordinarily successful, indicating that

¹² Mary Putnam Jacobi, "Woman in Medicine," *Woman's Work in America*, edited by Annie Nathan Meyer (New York: Henry Holt and Company, 1891), 197; Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 232. In general, these women physicians were concentrated in major cities, such as Philadelphia, Chicago, Washington, D.C., and New York City.

¹³ For general histories of women physicians in the United States, see Morantz-Sanchez, *Sympathy and Science*; More, *Restoring the Balance*.

although physicians were certainly gaining authority during this period, their patients retained some power. In fact, since twilight sleep was usually administered only in institutional settings, these patients were instrumental in moving childbirth from the home to the hospital – a phenomenon frequently attributed simply to power-seeking male obstetricians.¹⁵

As an immediate consequence of women’s intellectual, scientific, and political influence, obstetrics and gynecology experienced a period of astonishing progress. Between 1880 and 1920, obstetricians and gynecologists frequently remarked that their specialties were evolving at an incredible rate. At the 1916 meeting of the Obstetrical Society of Philadelphia, for example, Dr. George M. Boyd marveled at the progress that had been made “since the days of the rudimentary training us older men received back in the 80’s.”¹⁶ Dr. Frank R. Oastler concurred, claiming, in a 1919 issue of *The American Journal of Obstetrics and Diseases of Women and Children*, that obstetrics was progressing much more quickly than other specialties were. He stressed the role of surgery in this progress, noting that obstetrics was now “a surgical procedure taught

¹⁴ A note on terminology: this thesis will sometimes use designators like “upper-class” or “middle-class,” which are, of course, problematic, and which are not meant to be fully descriptive. In general, the terminology is employed to distinguish elite women from their less privileged counterparts, who often had different sets of concerns and beliefs; it is also used to reflect the way that women perceived themselves. This project will also refer to “white,” “African-American,” and “nonwhite” women, again both as a way to distinguish between groups and to reflect self-perceptions.

¹⁵ On the twilight sleep movement, see Judith Walzer Leavitt, “Birthing and Anesthesia: The Debate over Twilight Sleep,” *Signs* 6, No. 1 (autumn 1980); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986), 128-141; Margarete Sandelowski, *Pain, Pleasure, and American Childbirth: From Twilight Sleep to the Read Method, 1914-1960* (Westport, CT: Greenwood Press, 1984), 3-26; Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven: Yale University Press, 1989), 150-154.

¹⁶ “Transactions of the Obstetrical Society of Philadelphia,” *The American Journal of Obstetrics and Diseases of Women and Children* LXXIX, No. 5 (May 1919), 659.

under the general principle of surgery . . . and enjoying that careful technic given the surgical operation.”¹⁷ These advancements were due, at least in part, to the willingness of women specialists to embrace operations performed on women’s reproductive organs.

The change in gynecology was even more pronounced. In the introduction to his textbook, *Modern Gynecology*, Dr. Charles H. Bushong worried that physicians who had graduated from medical school only ten years before might already be finding themselves unprepared to practice gynecology according to current standards.¹⁸ Dr. Thomas Addis Emmet, one of the most renowned gynecologists in the United States, prefaced his 1884 edition of *The Principles and Practice of Gynaecology* with the observation that the specialty was advancing so quickly the revising a textbook “necessitated almost as much labor as rewriting the volume.”¹⁹ Similarly, in 1902, Dr. Emilius Clark Dudley explained that preparing a third edition of his textbook – also titled *The Principles and Practice of Gynecology* – entailed extensive rewriting. In order to do justice to recent developments, Dudley was obliged to create completely new sections on the topics of “Endocervicitis, Endometritis, Chronic Metritis, Pelvic Cellulitis, Peritonitis, Salpingitis, The Treatment of Pelvic Inflammations, Uterine Myoma, Uterine Carcinoma, Hystero-Myomectomy, Hysterectomy, Ovarian and Parovarian Cysts, Ovariectomy, Tubal Pregnancy, Ureteral

¹⁷ Frank R. Oastler, “Some Recent Developments in Obstetrics,” *The American Journal of Obstetrics and Diseases of Women and Children* LXXIX, No. 5 (May 1919), 659.

¹⁸ Charles H. Bushong, *Modern Gynecology: A Treatise on Diseases of Women Comprising the Results of the Latest Investigations and Treatment in this Branch of Medical Science* (New York: E. B. Treat, 1893), 5.

¹⁹ Thomas Addis Emmet, *The Principles and Practice of Gynaecology*, third edition (Philadelphia: Henry C. Lea’s Son and Company, 1884), vii. For an autobiographical account of Emmet’s work, see Thomas Addis Emmet, *Reminiscences of the Founders of the Women’s Hospital Association* (New York: Stuyvesant Press, 1893).

Fistulae, and Malpositions of the Uterus.”²⁰ Historians have confirmed what these specialists perceived: the period from 1880 to 1920 was transformative for both obstetrics and gynecology.

This project will incorporate women thinkers, physicians, and activists into the story of the transformation in obstetrics and gynecology. The first chapter examines the contributions of academic women, who defended their presence in medical colleges by challenging established theories regarding the hazards of higher education for the female sex. As they secured places for themselves at universities and in professions, these women sought to answer complex questions about their proper roles in public life. Were women physicians different from their male counterparts in any meaningful way? Were they particularly suited to specialties like hygiene, obstetrics, and gynecology? Should they practice those specialties in a distinctively feminine manner? Should medical education for women reflect gender difference?

The second chapter argues that women specialists were powerful figures in the medical construction of women’s bodies. As they defined themselves as “radical” or “conservative” practitioners, women obstetricians and gynecologists took various stances on the ethics of operative gynecology and the nature of the female body. Their choices also reflected ongoing debates about appropriate roles for women in society at large. By asserting, as many women surgical gynecologists did, that women’s reproductive organs were not particularly “sacred” and that operations that rendered women sterile were medically acceptable, they suggested that motherhood was not necessarily central to the

²⁰ Emilius Clark Dudley, *The Principles and Practice of Gynecology: For Students and Practitioners*, third edition (Philadelphia: Lea Brothers and Company, 1902), 8.

life of every woman. These connections between physical bodies and social roles were highlighted by the commitment of women surgical gynecologists to the rejection of the cult of true womanhood.²¹

The third chapter contends that female activists shaped the development of obstetrics and gynecology as well. Medical specialists established their authority during this period, but as the medical marketplace expanded and consumer power increased, patients could sometimes influence the practice of medicine in meaningful ways.²² The 1914-1915 campaign for twilight sleep demonstrated that nonprofessional women could successfully insist on particular forms of treatment, especially if they organized effectively and attracted publicity. Further, the controversy illustrated the ways that middle- and upper-class white women reinforced the medical construction of their bodies. Their 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 their campaign.

²¹ On the cult of true womanhood, which 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.

²² On the changing medical marketplace in the late nineteenth and early twentieth centuries, see Starr, *Social Transformation*, 65-78.

CHAPTER II

“AS BROAD AND GENEROUS A COURSE AS WE CAN GET”: WOMEN,
EDUCATION, AND MEDICAL THOUGHT

In 1873, the Harvard Medical School professor Edward H. Clarke published a bestselling book, *Sex in Education*, which contended that the pursuit of scholarly and professional goals inflicted irrevocable damage on young women’s bodies. *Sex in Education* (ironically subtitled *A Fair Chance for Girls*) maintained that during and after adolescence, the female body needed to devote much of its energy to the establishment of a healthy menstrual cycle. Regular attendance at school and sustained emphasis on academics redirected essential energy from the ovaries to the brain, triggering “leucorrhoea, amenorrhoea, dysmenorrhoea, chronic and acute ovaritis, prolapsus uteri, hysteria, neuralgia,” and a variety of additional psychological, sexual, and reproductive disorders.²³ According to Clarke, girls who persisted in acquiring advanced degrees despite these dangers risked the complete forfeiture of their fertility: “They graduated from school or college excellent scholars, but with undeveloped ovaries. Later they

²³ Edward H. Clarke, *Sex in Education, or A Fair Chance for Girls*, reprint edition (New York: Arno Press, 1972), 23. Hysteria was a particularly problematic diagnosis. For an excellent overview of the gendered and racialized diagnosis and treatment of hysteria, 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.

married, and were sterile.”²⁴ Though Clarke reassured his readers that he did not view women as inferior, only different, his perspective rendered femininity incompatible with academics and, therefore, with careers in fields like medicine.

Women physicians and intellectuals were instrumental in discrediting Clarke’s theories about the female body. Their gendered experiences made them uniquely qualified to dispute the purported dangers of higher education for women; they had, after all, endured the rigors of academia themselves, and they had done so without destroying their reproductive organs or succumbing to hysterical symptoms. Indeed, their very 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. For example, the ambitious surgical gynecologist Mary Amanda Dixon Jones earned an advanced degree, opened a medical practice, devised new surgical techniques, and published groundbreaking research; she also married a lawyer and became the mother of three healthy children.²⁵ Her existence as a respected surgeon challenged the physical limitations of the female body that Clarke so avidly promoted, and her insistence that her own reproductive organs had been unharmed by long hours of study would have been difficult to contradict. Because *Sex in Education* rested on several established medical theories, however, discrediting Clarke’s arguments required more than personal testimonials; it required serious scientific and intellectual work.

Indeed, much of the work involved in transforming the specialties of obstetrics and gynecology was fundamentally academic. During the period from about 1880 to

²⁴ Clarke, *Sex in Education*, 39.

²⁵ Morantz-Sanchez, *Conduct Unbecoming*, 30.

about 1920, women published innovative research, contested established theories, promoted new perspectives, and educated medical students. As they did so, they engaged in the work of, in the medical historian Regina Morantz-Sanchez's words, "constructing the female body."²⁶ This construction involved defining the nature of women's bodies: were women inherently diseased, suffering from "the pathology of femininity?"²⁷ Were they innately delicate? Such questions were directly related to issues concerning the changing role of women in American society. Were women capable of completing college degrees without compromising their physical health? Were they biologically designed for domesticity, or would their bodies allow them to comfortably pursue professional careers in the public sphere? The "golden age" for women in medicine allowed many physicians and scientists to investigate these questions in hospitals and at universities and to report their findings in respected medical journals and at major professional conferences. Publications like *The Woman's Medical Journal*, which debuted in 1893, enhanced these opportunities by providing intellectual space reserved exclusively for the work of medical women. Using all of the resources available to them, women like Mary Putnam Jacobi, Charlotte B. Brown, Hannah Croasdale, and Anna Broomall shaped the path that obstetrics and gynecology would take. Their work began with the scientific rejection of Edward H. Clarke.

Clarke's *Sex in Education* exemplified three established ideas that were central to the nineteenth-century medical profession as a whole and to the specialties of obstetrics

²⁶ Morantz-Sanchez, *Conduct Unbecoming*, 114-137.

²⁷ For more 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.

and gynecology in particular. First, Clarke relied upon the theory of reflex irritation, which held that all organs were connected by systems of nerves and that disturbances in one organ could therefore produce symptoms in another.²⁸ For centuries, doctors had attributed all kinds of ailments to vaguely defined imbalances in the female reproductive organs; as reflex theory gained acceptance among physicians and scientists, it granted scientific validity to those longstanding notions. 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 almost always emphasized the connection between the brain and the reproductive system.²⁹ In *The American Journal of Obstetrics and Diseases of Women and Children*, for example, Dr. A. T. Hobbs argued that ovarian lesions caused insanity. Hobbs reported that he frequently found it necessary to remove the reproductive organs of insane women, and he pointed specifically to the theory of reflex irritation as a probable explanation for the link between diseases of the ovaries and diseases of the brain, which he viewed as unassailable.³⁰ Similarly, in the same medical journal, Dr. Graily Hewitt asserted that “distortion of the uterus” could induce epileptic seizures, and he explicitly characterized such attacks as “the result of reflex irritation.”³¹ Although

²⁸ 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.

²⁹ Morantz-Sanchez, *Conduct Unbecoming*, 116. See also 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.

³⁰ 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.

³¹ 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 physicians did dispute the idea of reflex irritation, suggesting that advancements in pathology would ultimately disprove the theory, Clarke's belief that mental activity and reproductive function were directly connected still enjoyed considerable scientific support.³²

Second, *Sex in Education* depended upon the medical understanding of the human body as a closed system that possessed limited energy.³³ 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, one of the most renowned gynecologists in the United States, frequently emphasized the finite nature of vital energy and warned that a failure to respect the body's limitations could have dire consequences. He understood the presence of ovarian disease, for instance, to indicate that "nature's laws have been put at defiance, and that the nervous system has been overtaxed."³⁴ Every clinical case study presented in *Sex in Education* featured the principle of limited energy. For example, "Miss B" was an accomplished actress, but she suffered from a "slow suicide of frequent hemorrhages," which Clarke diagnosed as the consequence of misdirected vital energy: "A gifted and healthy girl, obliged to get her

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.

³² 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.

³³ See Morantz-Sanchez, *Conduct Unbecoming*, 117.

³⁴ 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.

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 apparatus.”³⁵ Likewise, “Miss F” was a gifted student, but according to Clarke, the demands of her education induced hysteria, insomnia, headaches, neuralgia, and dysmenorrhoea. “Miss F” pursued her studies all month, “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.”³⁶ Such case studies illustrate Clarke’s combination of the theory of reflex irritation and the idea of finite energy to argue that education was hazardous to the reproductive health of female students.

Both the theory of reflex irritation and the theory of limited energy applied, at least hypothetically, to men as well as to women; however, because specialists understood women’s nervous systems to be overly sensitive, they found women more susceptible than men to the dangers delineated by Clarke.³⁷ Moreover, because many physicians thought puberty was more debilitating for girls than for boys, arguments against higher education during adolescence applied to women alone. Clarke reminded his readers 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

³⁵ Clarke, *Sex in Education*, 73-75.

³⁶ Clarke, *Sex in Education*, 101.

³⁷ Morantz-Sanchez, *Conduct Unbecoming*, 117.

of force . . . is imposed upon the male physique at the same epoch.”³⁸ Emmet agreed, suggesting that at puberty, the 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.”³⁹ Young men faced no equivalent crises.

The third major medical idea that *Sex in Education* exemplified was the fear of race suicide, which late-nineteenth- and early-twentieth-century physicians often expressed in medical journals and at professional conferences.⁴⁰ When Clarke discussed the perils facing American college women, his warning carried a powerful subtext: the women in question were white and upper- or middle-class. As the pseudo-science of eugenics became increasingly influential in the medical community, obstetricians and gynecologists worried that this group of women – perceived as “the fit” – would continue to enter universities, pursue careers, and delay motherhood, reducing numbers of white children and threatening the predominance of the race.⁴¹ Obstetricians seemed especially troubled by race suicide, complaining that those women “who should have large

³⁸ Clarke, *Sex in Education*, 38.

³⁹ Emmet, *Principles and Practice*, 18-19.

⁴⁰ Charles E. Rosenberg has noted that in the late nineteenth and early twentieth centuries, “a preoccupation with the idea of race was characteristic of European and American minds.” In the United States, a patriotic sense of the country’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.

⁴¹ 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).

families” were choosing not to do so, either because they were prioritizing their involvement in the public sphere or because they feared the pain of childbirth.⁴² At the same time, birth rates for poor women, immigrant women, and African-American women, who were not demographically represented in nineteenth-century academia, would rise or, at least, remain constant. Eugenicists like Charles B. Davenport predicted that, as a result, the population would “rapidly become darker in pigmentation, smaller in stature, more mercurial, more attached to music and art, more given to crimes of larceny, kidnapping, assault, murder, rape and sex immorality.”⁴³ *Sex in Education* exacerbated these concerns by suggesting that even if those “fit” women finally married, they might find that their years of academic and professional exertions had rendered them permanently sterile.

Clarke’s basic perspective was grounded in scientific theory, and influential specialists like Emmet had already made similar claims, but the popularity and impact of *Sex in Education* alarmed many educated American women. The poet and reformer Julia Ward Howe compiled the responses of thirteen prominent women and published them together in 1874; the book, *Sex and Education: A Reply to Dr. E. H. Clarke’s “Sex in Education,”* aimed to refute Clarke’s claims and to call attention to the potential damage they believed would result from his work. In the introduction, Howe argued perceptively that Clarke’s book appeared “to have found a fair chance *at* the girls, rather than a chance

⁴² A. Smith, *Twilight Sleep in America: The Truth about Painless Childbirth* (New York: The Victor Publishing Company, 1915), 53.

⁴³ See Rosenberg, *No Other Gods*, 95.

for them.”⁴⁴ The author Caroline H. Dall concurred. She bemoaned the impact *Sex in Education* was making in the United States: “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.”⁴⁵ Howe, Dall, and other contributors to *Sex and Education* emphasized how harmful Clarke’s views could prove, especially if the younger generation accepted them.

Predictably, those associated with women’s colleges and coeducational universities were particularly disturbed by *Sex in Education*. For example, Martha Carey Thomas, who served 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.”⁴⁶ Several university professors and administrators contributed to Howe’s *Sex and Education*, and they disagreed strongly with Clarke’s descriptions of female students. Clarke had maintained that schools in the United States were populated by throngs of “pale, bloodless female faces, that suggest consumption, scrofula, anemia, and neuralgia.”⁴⁷ The faculty and staff featured in Howe’s book, in

⁴⁴ 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.

⁴⁵ 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.

⁴⁶ M. Carey Thomas, “Present Tendencies in Women’s College and University Education,” *Educational Review* 25 (1908), 58. Thomas is also quoted in Morantz-Sanchez, *Sympathy and Science*, 55.

contrast, all maintained that college women were “at least as healthy as the men,” if not healthier. In a typical testimonial, one 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, nor do our statistics show a greater draft upon the vital forces in the case of those who have completed the full college course.”⁴⁸ 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.

Women physicians also responded to *Sex in Education* with anger, disgust, and indignation, and some attempted to counter Clarke’s arguments with their own experiences. For instance, in a response to Emmet’s claim that “the ovaries will always be arrested in their growth if the brain is pressed,” Dixon Jones scoffed at the idea that women’s bodies required so much energy to maintain healthy reproductive organs and regular menstrual cycles. She assured readers of *The Woman’s Medical Journal* that the intense study she had undertaken to become a physician had not negatively affected her reproductive health: “my efforts at study never reacted upon the ovaries. 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.*”⁴⁹ The pioneering gynecologist Marie E. Zakrzewska related, with some degree of amusement, that when she met Dr. Henry E. Clark, he treated her

⁴⁷ Clarke, *Sex in Education*, 22.

⁴⁸ “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), 201.

⁴⁹ 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 hers.

politely but explained that he did not believe women were fit to practice medicine. Upon becoming better acquainted with Zakrzewska's skills and credentials, Clark adjusted his position to make room for the possibility that she might be "an exception" to her sex.⁵⁰ Such personal stories, published for both medical and general audiences, called attention to cases in which women successfully pursued college degrees and medical careers without inflicting damage on their reproductive organs.

In addition, women physicians refuted Edward H. Clarke's claims with research of their own. The respected gynecologist Mary Putnam Jacobi was deeply concerned about Clarke's influence, and her famous 1876 study, *The Question of Rest for Women during Menstruation*, was formulated primarily as a response to some of Clarke's claims. It began with a simple question: "Do women require mental and bodily rest during menstruation?" After scrupulous research and statistical analysis, Jacobi concluded 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."⁵¹ The piece won Harvard University's Boylston Prize, and it was cited by leading gynecologists for decades.⁵² For instance, in his 1887 textbook, *A System of Gynecology*, Dr. Matthew Darbyshire Mann stated that Jacobi's work was "the most rational" examination of

⁵⁰ Marie E. Zakrzewska, *A Woman's Quest: The Life of Marie E. Zakrzewska, M. D.*, edited by Agnes C. Viator (New York: D. Appleton and Company, 1924), 254. For a biographical account of Zakrzewska's life and work, see Arleen Marcia Tuchman, *Science Has No Sex: The Life of Marie E. Zakrzewska, M.D.* (Chapel Hill: University of North Carolina Press, 2006).

⁵¹ Jacobi, *Question of Rest*, 227. The emphasis is Jacobi's.

⁵² The Boylston Prize, named after the first American physician to practice inoculation, was awarded every two years to an outstanding medical essay. Jacobi was the first woman to win the award.

menstruation that he had encountered.⁵³ Similarly, in the 1920 textbook *Gynecology*, Dr. William Graves deferred to Jacobi's expertise and asserted that *The Question of Rest for Women during Menstruation* 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.⁵⁴

One such scientist was Charlotte B. Brown, a gynecologist whose work demonstrated that attention to rest, nutrition, and exercise would allow young women to remain healthy as they pursued educational and professional goals.⁵⁵ Brown differed from the contributors to Howe's book in one striking way: 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 admitted that most of her new patients were "schoolgirls." In "The Health of Our Girls," which *The Woman's Medical Journal* 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."⁵⁶ Originally suspecting that puberty and study were combining to create so much sickness, Brown studied hundreds of adolescent girls in San

⁵³ Mann, *System of Gynecology*, 437.

⁵⁴ Graves, *Gynecology*, 120.

⁵⁵ For more on Brown, who was known primarily for founding the San Francisco Children's Hospital, see Morantz-Sanchez, *Sympathy and Science*, 93-94.

⁵⁶ Charlotte B. Brown, "The Health of Our Girls," *The Woman's Medical Journal* 5, No. 7 (July 1896), 180.

Francisco schools, but 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 argued that the major causes of illness in teenaged 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.⁵⁷

Two months later, *The Woman's Medical Journal* published a second article by Brown, which contended that attention to the proper physical and mental development of adolescent girls would 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 this position of relative equality between men's and women's bodies, Brown could identify 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 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.⁵⁸

Brown did not dispute Clarke's characterization of American women as perpetually sick; however, unlike Clarke, she did not hold gendered physical traits responsible. Clarke had

⁵⁷ Brown, "Health of Our Girls," 181-182.

⁵⁸ Charlotte B. Brown, "The Physical Development of Girls," *The Woman's Medical Journal* 5, No. 9 (September 1896), 228.

also pointed to the injurious nature of women's apparel, admitting that sickness in young women could sometimes be attributed to "artificial deformities strapped to the spine, or piled on the head" as well as to "corsets and skirts."⁵⁹ The key difference between them was that Brown saw women's shoes and corsets as a chief cause of illness while Clarke understood them as aggravating factors that taxed women's already fragile bodies.

Brown's contentions about oppression and dependence, however, 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 behave independently and relegated to "frivolous evenings" preceding marriage and motherhood. On this point, Brown and Howe agreed. In *Sex and Education*, Howe implored parents not to "surrender" their daughters, "in the very bloom of their youthful powers, to the unintelligent domain of Fashion." She accused mothers and fathers of subjecting young women "to the extravagant, immodest rules of display" and "to the poison of heated and crowded rooms, late hours, and luxurious suppers," all in the hope that they might someday marry well.⁶⁰ Brown differed from Howe only in the sense that she offered a particularly medical perspective; in fact, "The Physical Development of Girls" represented a kind of variation on reflex theory, suggesting that a woman's psychological sense of uselessness could make her physically ill.

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

⁵⁹ Clarke, *Sex in Education*, 23.

⁶⁰ Howe, "Introduction," 10-11.

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.”⁶¹ 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 with the evolution of medical specialties devoted to the health of women. Like many women surgical gynecologists, Brown maintained that as women moved beyond the domestic sphere, medical approaches to women’s bodies also needed to change.⁶² Second, she affirmed the authority of medical professionals in creating the turn-of-the-century “new woman,” suggesting that physicians – not, for instance, political activists or religious leaders – were ultimately responsible for determining what was in the best interest of women.⁶³ Finally, she promoted preventive rather than curative medicine. The “new woman,” as envisioned by Brown, did not seek medical care for sickness; rather, she avoided sickness and attained “physical perfection” by adhering to the preventive guidelines set forth by enlightened medical specialists.

Both the medical community and the general public perceived preventive care and public health as particularly female spheres of medical practice. The historian Judith Walzer Leavitt has demonstrated that most American medical colleges failed to

⁶¹ Brown, “Physical Development of Girls,” 227.

⁶² On the connection between feminist reform and medical views of women’s bodies, see Leach, *True Love and Perfect Union*, 64-80, 318-322. On the ideal of the “New Woman,” see Martha H. Patterson, *Beyond the Gibson Girl: Reimagining the American New Woman, 1895-1915* (Urbana: University of Illinois Press, 2005); Joshua Zeitz, *Flapper: A Madcap Story of Sex, Style, Celebrity, and the Women Who Made America* (New York: Three Rivers Press, 2006), 7-9.

⁶³ 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.” See Starr, *Social Transformation*, 9-21, 79-144.

emphasize public health, but women's medical schools almost always made it a strong component of core curricula.⁶⁴ In a close study of preventive medicine at the Woman's Medical College of Pennsylvania, Bonnie Blustein has argued that throughout the nineteenth century, it was "almost axiomatic" that personal and public hygiene were the provinces of women.⁶⁵ Other historians have concurred, noting the propensity of early women physicians like Zakrzewska to stress "how to keep well" over how to cure specific ailments.⁶⁶ Brown felt compelled, in "The Physical Development of Girls," to defend her focus on prevention, admitting that it might be perceived as counterproductive for "one who makes a specialty of chronic diseases of women" to "endeavor to diminish the great source of supply of cases."⁶⁷ Her decision to prioritize preventive medicine despite this apparent paradox reflected her commitment to the understanding of female fragility as a consequence of avoidable factors rather than as an inherent natural state.

Brown's devotion to preventive medicine also illustrates significant conflicts regarding appropriate positions for women in the medical community. Many women physicians aligned themselves carefully with Elizabeth Blackwell, the first licensed woman physician in the United States. Blackwell had entered Geneva Medical College in 1847. At that time, medical education was all but completely inaccessible to American

⁶⁴ 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. Leavitt uses the terms "medical police, personal or public hygiene, sanitation, sanitary science, social medicine, preventive medicine, [and] public health" interchangeably, and this thesis will do the same.

⁶⁵ 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.

⁶⁶ See, for example, Morantz-Sanchez, *Sympathy and Science*, 215-216; Peitzman, *Untried Course*, 81.

⁶⁷ Brown, "Physical Development of Girls," 228.

women, and her arguments for opening the profession to women were based on a belief in feminine difference that marked the female sex as uniquely maternal, compassionate, and caring.⁶⁸ “Lady doctors,” in Blackwell’s view, would practice medicine differently than their male counterparts did; they would bring a quintessentially feminine morality to the care of the sick.⁶⁹ These maternalist arguments were similar to those advanced by some suffragists and reformers, who contended that women would bring special qualities to the American political sphere.⁷⁰ As women in medicine entered their golden age, however, more and more women physicians turned away from the idealized “lady doctor” role, which they found limiting, and began to insist that women could successfully pursue medical paths that were traditionally seen as “masculine.” Jacobi and Dixon Jones both fell into this second category.⁷¹ By promoting the supposedly “feminine” sphere of preventive medicine, Brown seemed to locate herself on

⁶⁸ Even Geneva Medical College, in fact, refused to admit any women besides Blackwell. When Sarah R. Adamson applied in 1849, she was rejected; the Dean, James Hadley, explained that “Miss Blackwell’s admission was an experiment, not intended as a precedent.” See Thomas Neville Bonner, *To the Ends of the Earth: Women’s Search for Education in Medicine* (Cambridge: Harvard University Press, 1992), 6.

⁶⁹ For more on Blackwell and the idea that women physicians were fundamentally different from their male peers, see Morantz-Sanchez, *Sympathy and Science*, 184-202. For more on the connection between femininity and morality, 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).

⁷⁰ As Molly Ladd Taylor has noted, historians have overgeneralized in their use of the word “maternalist,” invoking it to describe “practically any woman activist who used the language of motherhood to justify her political activities.” She argues that it should only be used 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 should enter the public sphere to support their wives, who would ideally remain in the domestic sphere. Blackwell definitely fit the first three qualifications, and since she seemed to believe that most women would have to choose *between* marriage and careers, she probably fit the fourth as well. See Molly Ladd Taylor, “Toward Defining Maternalism in U. S. History,” *Journal of Women’s History* 5, No. 2 (fall 1993), 110.

⁷¹ Morantz-Sanchez, in fact, uses Jacobi and Blackwell as contrasting “representative types,” with Jacobi as the rational, scientific surgeon and Blackwell as the sentimental, maternalist “lady doctor.” See Morantz-Sanchez, *Sympathy and Science*, 184-202.

Blackwell's side of the spectrum, but she also rejected established medical theories about the physical embodiment of female difference, suggesting that women could do the same work that men could do, and in the same ways.

Brown's stated reasons for advocating preventive medicine were also quite complex. In "The Physical Development of Girls," she explained that she was attracted to hygiene 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."⁷² 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 – Brown allied herself with the feminists who sought to reject the doctrine of 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, she invoked the traditional female duties of housekeeping and motherhood rather than any kind of academic work or professional ambition. Somehow, this rather conservative approach was supposed to defend the medical construction of a "new woman."

In general, medical education for women embodied the same conflicts. By the 1880s, several strong women's medical colleges had opened in New York, Chicago,

⁷² Brown, "Physical Development of Girls," 228.

Philadelphia, and Baltimore.⁷³ As Peitzman has demonstrated, the Woman's Medical College of Pennsylvania was, during this period, the strongest medical school open to women. Its administration sought to make women physicians competitive with their male counterparts and to eradicate the supposition of female difference.⁷⁴ Ambitious deans like Rachel Litter Bodley and Dr. Clara Marshall wanted to make "Woman's Med" one of the best medical colleges in the United States, not just one of the best women's schools.⁷⁵ Consequently, they adopted a four-year program and added advanced laboratory work around the same time that competitive men's medical schools did.⁷⁶ Nevertheless, its curriculum continued to emphasize medical specialties that were seen as "feminine," such as hygiene, obstetrics, and gynecology, and its most highly regarded faculty members tended to teach those subjects. In part, this concentration was simply an accurate reflection of the demands of female medical students, who tended to specialize in obstetrics or gynecology for a variety of reasons, both practical and philosophical. Still, the administration's decisions regarding the college's curriculum also seemed to tacitly endorse the idea that certain medical specialties were "feminine" while others, such as neurology, psychiatry, and surgery, were not.

Faculty members in those "feminine" specialties, however, tended to teach obstetrics and gynecology in a manner that overtly challenged the "lady doctor" image.

⁷³ Bonner, *Ends of the Earth*, 20.

⁷⁴ Peitzman, *Untried Course*, 56-64.

⁷⁵ On the Woman's Medical College of Pennsylvania under Bodley and Marshall, see Peitzman, *Untried Course*, 56-72.

⁷⁶ Peitzman, *Untried Course*, 74-76.

They promoted, performed, and taught sexual and obstetric surgeries, for example, and they valued many of the same characteristics that male physicians viewed as crucial to professional success. Their students learned to respect and aspire to those same traits. Frances Petty Manship, a student at the Woman's Medical College of Pennsylvania, described observing a Caesarean section performed by Dr. Ella Everitt, her professor of gynecology, with the assistance of another woman physician, Dr. Potter: "Bestowed modestly in a corner was Dr. Everitt, swathed like a surgeon to be sure – but remote and detached. . . . The anaesthetist 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 of us who have seen her operate."⁷⁷ Everitt and Potter were admired, in this student's writing, for their emotional detachment, their physical strength, and their surgical skill. They had chosen supposedly feminine areas of expertise, but they practiced those specialties as men would. Their values and attitudes were especially significant because, as the medical historian Kenneth Ludmerer has noted, faculty members were largely responsible for the quality and character of medical education during the late nineteenth century. Because there were no standardized curricular guidelines set forth by government agencies or professional organizations, individual academics determined what subjects their students would learn, what level of mastery they would require, and how they would put that knowledge into practice.⁷⁸

⁷⁷ F. P. M., "Our Evening In," *Iatruan* (June 1912), 7-8. A much longer excerpt is quoted in Peitzman, *Untried Course*, 142-143. It is also interesting to note that assisting Drs. Everitt and Potter were male interns, which turned the traditional gender hierarchy on its head.

In both their professional writings and their personal memoirs, female medical students and physicians took pride in mastering skills and behaviors that were not traditionally feminine. Dr. Rosalie M. Ladova's letter to the editor of *The Journal of the American Medical Association*, for example, disputed the idea that women's medical education ought to be different from men's. "You wish to exclude major surgery," she argued, "on the ground that women lack the courage and quick judgment necessary for this work. Is this true? Anyone acquainted with the work of medical women knows better." Just as Manship had described the strength and technique of Everitt and Potter, Ladova recounted watching Dr. Marie J. Mergler perform a complicated gynecological surgery with "as much self-possession, courage, and good judgment as could be desired in any surgeon, man or woman." Speaking for both students and practitioners, she declared, "[o]ur cry is, 'More surgery!' We want just as broad and generous a course as we can get."⁷⁹ Mergler's specialty was one of the acceptable women's concentrations, but Ladova's assessment of her most admirable traits – strength, composure, fearlessness – were those traditionally associated with men.

Similarly, when the turn-of-the-century gynecologist Rosalie Slaughter Morton recalled entering the "new world" of medical college, she emphasized the rigorous scientific education she received, stating that "[m]odern medicine, with its microscopic accuracy, allows no loose generalizations."⁸⁰ Morton's understanding of what the highest

⁷⁸ Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985), 43-71. See also Peitzman, *Untried Course*, 73-74.

⁷⁹ Rosalie M. Ladova, "Medical Education for Women," *The Journal of the American Medical Association* 38 (May 1902), 1454.

quality medical education ought to look like featured meticulous study and scientific research; she was apparently much less interested in more general kinds of compassion or caring. Interestingly, though, Morton also appealed to a variation of the doctrine of difference by suggesting that women were, in actuality, particularly suited to surgical work: “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. . . . 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.”⁸¹ Morton’s appeal to the feminine history of needlework and to skills passed from mother to daughter represented a fascinating reframing of the traditional understanding of the medical profession. As a woman and a surgeon, she contested the old contrast between “masculine” surgical practice and “feminine” caring and compassion, charting a path for herself between the two extremes.

The combination of traditionally feminine and traditionally masculine characteristics was modeled by many of the most beloved faculty members at women’s medical colleges. Peitzman has shown that this pattern began in the earliest days medical education for women. During the middle decades of the nineteenth century, the woman physician who best exemplified the integration of masculine and feminine traits was probably the gynecologist Emeline Horton Cleveland, who graduated from the Woman’s

⁸⁰ Rosalie Slaughter Morton, *A Woman Surgeon: The Life and Work of Rosalie Slaughter Morton* (New York: Frederick A. Stokes Company, 1937), 21.

⁸¹ Morton, *Woman Surgeon*, 131.

Medical College of Pennsylvania in 1855.⁸² Cleveland differed from Blackwell's "lady doctor" ideal because she performed gynecological operations, which required both a willingness to sacrifice the female reproductive organs and a predilection for the masculine world of surgery. In her professional and her personal life, however, Cleveland embodied a graceful, traditional femininity; her students recalled that she was unfailingly modest, that she spoke softly and elegantly, and that she never stood when she lectured. Moreover, Cleveland combined her professional career with marriage and motherhood. These traits, in Peitzman's persuasive assessment, made Cleveland more acceptable to professionals of both genders.⁸³

During the period between 1880 and 1920, the pattern continued. Dr. Anna Broomall, for example, was a beloved professor of obstetrics at the Woman's Medical College of Pennsylvania. She was perhaps most well known for initiating a required program of clinical training for graduating seniors. As Morton remembered, "each senior had to attend, deliver, and give after-care to ten obstetrical cases. . . . During this period of education we resided in a house in the poorer section of Philadelphia, equipped by the college as a pre-natal clinic, the first of its kind ever established."⁸⁴ Broomall taught the most advanced European techniques and insisted on rigorous antiseptic practices, and her students considered her a "genius." She was also, however, kind, gentle, and maternal.⁸⁵

⁸² Peitzman, *Untried Course*, 26. At the time of Cleveland's graduation, the college was still known as Female Medical College.

⁸³ Peitzman, *Untried Course*, 26-27.

⁸⁴ Morton, *Woman Surgeon*, 36.

⁸⁵ Peitzman, *Untried Course*, 76, 83.

Similarly, Dr. Hannah Croasdale, a professor of gynecology at the same school, was renowned as a skillful surgeon; however, she was also a wife and a mother, and her students remembered her as feminine and fashionable.⁸⁶ As these respected female faculty members presided over medical education for aspiring women physicians, they embodied some of the significant conflicts regarding their presence in the profession.

The success of prominent female specialists like Jacobi, Brown, Broomall, and Croasdale do suggest remarkable progress for women in the medical community. Clarke's *Sex in Education* was published in 1873, and by the end of the nineteenth century, the intellectual work of medical women had largely discredited his theories. By 1900, due in no small part to the contributions of women like Mary Putnam Jacobi and Charlotte B. Brown, the idea that women were physically unfit to complete college or practice medicine was no longer so widespread. Seven thousand women were practicing medicine in the United States. Due to decreasing numbers of sectarian practitioners, most of those women were regular, licensed physicians, which meant that they were more widely respected.⁸⁷ Many were exceedingly optimistic about the future. For example, in a 1900 issue of *The Woman's Medical Journal*, Dr. Agnes C. Vietor stated forcefully that "the limitations of sex do not exist." She went on to advise young women physicians about careers in surgery, confident that positions would be available to them.⁸⁸

⁸⁶ Peitzman, *Untried Course*, 83-84.

⁸⁷ Morantz-Sanchez, *Sympathy and Science*, 232. On the evolution of sectarian medicine and the eventual consolidation of power with "regular" practitioners, see James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* (New York: Oxford University Press, 1978), 147; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 98-102.

⁸⁸ Agnes C. Vietor, "The Making of a Woman Surgeon," *The Woman's Medical Journal* 10, No. 1 (January 1900), 19-22.

Nevertheless, certain limitations did, in fact, exist.⁸⁹ Although by 1900, women could attend any of a growing number of coeducational schools, many medical colleges remained closed to them.⁹⁰ If they succeeded in earning their degrees, they often struggled to establish profitable practices. Furthermore, even as most physicians stopped arguing that women's bodies *could* not withstand the rigors of medical college or medical practice, both professional and nonprofessional Americans continued to maintain that women, for various reasons, *should* not pursue such a path. Morton's parents, for example, worried that if she became a physician, she would face "constant danger of contagion" and find herself "at the beck and call of rude, uncouth people." Her father disapproved of an upper-class woman earning a living at all, arguing that she should not "go into competition with those who need to support themselves. A gentleman's daughter does not work for money; your field of service is to keep on making us happy, and later to marry a man of your own class. . . . your highest duty is to become a good wife and mother."⁹¹ Morton disregarded these objections, but her parents were certainly not alone. In fact, their feelings were actually reflected in much of the medical literature

⁸⁹ The difficulties women physicians have faced are addressed extensively by historians and sociologists. See, for example, Bonner, *Ends of the Earth*; Judith Lorber, *Women Physicians: Careers, Status, and Power* (New York: Tavistock Publications, 1984); Gloria Moldow, *Women Doctors in Gilded-Age Washington: Race, Gender, and Professionalization* (Chicago: University of Illinois Press, 1987); Morantz-Sanchez, *Conduct Unbecoming*; More, *Restoring the Balance*; Peitzman, *Untried Course*; Rosemary Pringle, *Sex and Medicine: Gender, Power, and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998); Mary Roth Walsh, *Doctors Wanted: No Women Need Apply: Sexual Barriers in the Medical Profession, 1835-1975* (New Haven: Yale University Medical Press, 1977).

⁹⁰ See Bonner, *Ends of the Earth*, 152. According to Bonner, "Of the older, established private schools in Canada and the United States, only McGill, Pennsylvania, Yale, and Columbia remained closed to women until the First World War, and Harvard until 1945." Interestingly, increasing opportunities for coeducation led to what Bonner has termed "the demise of the women's schools." After the 1910s, only the eminent Women's Medical College of Pennsylvania continued to provide a high-quality medical education for women only.

⁹¹ Morton, *Woman Surgeon*, 15.

of the time, which argued that higher education and professional ambition detracted from motherhood, understood by many specialists to be a woman's primary responsibility in life.

Women intellectuals and educators shaped the development of obstetrics and gynecology first by challenging Edward H. Clarke's arguments and justifying their place in the intellectual and professional worlds of medicine. Once there, they shaped women's medical curricula by choosing to specialize in women's health and by emphasizing preventive approaches to medicine, which male and coeducational colleges typically ignored and neglected. They also confronted gendered notions of how women ought to practice medicine. Respected professors like Cleveland, Broomall, and Croasdale, who embodied admirable traits seen as both "masculine" and "feminine," provided models for aspiring students, who would have to face the same kinds of prejudices, weigh the same philosophical concerns, and make the same kinds of decisions. As they navigated these social, philosophical, and practical concerns, aspiring and practicing women physicians, especially those specializing in obstetrics and gynecology, had to make tremendously important decisions about the fundamental nature of the female body and about appropriate positions for women in society.

CHAPTER III

“THERE IS NOT SUCH SPECIAL SANCTITY ABOUT THE OVARY”: SURGICAL GYNECOLOGY AND THE MEDICAL CONSTRUCTION OF WOMEN’S BODIES

In October of 1889, Mary Amanda Dixon Jones published ten of her most recent cases in *The Pittsburgh Medical Review*. Her patients reported a wide variety of symptoms. One twenty-seven-year-old woman, identified only as “Mrs. L,” came to Dixon Jones “emaciated, nervous, and feeble.” By the time Dixon Jones admitted her to the Woman’s Hospital of Brooklyn, “Mrs. L” was also experiencing vivid hallucinations and threatening to commit suicide. Another young woman, “Mrs. O,” suffered from epileptic seizures and periods of unconsciousness, which Dixon Jones attributed to a severe form of hysteria. “Miss X” endured constant pelvic pain, and “Mrs. S” complained of an assortment of vague symptoms that had kept her confined to her bed for decades. Despite their diverse complaints, Dixon Jones diagnosed all four of these women, along with six others described in the article, with the same condition: “misplacement of the uterus.” She proceeded to remove the ovaries and Fallopian tubes of all ten patients, a course of treatment that would necessarily induce menopause and cause sterility, but according to the article, all were restored to health. By removing their

diseased reproductive organs, Dixon Jones argued, she had made her patients “more perfect” women.⁹²

Her claim was controversial. On one hand, the utilization of operations like those performed by Dixon Jones was entirely consistent with foundational principles of gynecology, including both the inclination to view women’s bodies as innately pathological and the tendency to resort quickly to surgical intervention. During the 1850s and 1860s, the celebrated “father of gynecology,” Dr. James Marion Sims, had pioneered the use of surgery to treat the sexual and reproductive ailments of women.⁹³ Dr. Robert Battey, another early leader, had introduced the “normal ovariectomy” – the removal of healthy ovaries as a purported cure for nervous conditions like hysteria – and was, as a result, partly responsible for the subsequent surge in gynecological surgeries.⁹⁴ The specialty had developed from the work of men like Sims and Battey and was, by the late nineteenth century, 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 tended to promote traditional gender ideology, which emphasized the importance of motherhood. Over the second half of the nineteenth century, they consolidated their authority as experts not only on women’s sexual anatomy and reproductive physiology but also on women’s lives more generally.

⁹² Mary A. Dixon Jones, “Misplacements of the Uterus,” *The Pittsburgh Medical Review* 3, No. 10 (October 1889), 301-309.

⁹³ On Sims, see Seale Harris, *Woman’s Surgeon: The Life Story of J. Marion Sims* (New York: Macmillan Press, 1950); McGregor, *Midwives to Medicine*; McGregor, *Sexual Surgery*. See also Sims’s fascinating autobiography: J. Marion Sims, *The Story of My Life*, reprint edition (New York: Da Capo Press, 1968).

⁹⁴ On Battey and “normal” ovariectomy, 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; Roy, “Surgical Gynecology,” 188-189.

In the process, they employed medical and scientific language to argue that women were biologically suited for domesticity. Such arguments typically invoked the sanctity of marriage and motherhood and emphasized the centrality of reproduction and child-rearing in the lives of healthy, “normal” women.⁹⁵ The willful reduction or elimination of a patient’s fertility, which was an unavoidable consequence of many gynecological operations, seemed to contradict such a perspective. If women’s bodies were designed for motherhood, how could the obliteration of reproductive function make them “more perfect” rather than less so?

Dixon Jones’s argument was especially problematic because she was a woman herself. Even at the beginning of the “golden age” for women in medicine, many women physicians still felt quite connected to Elizabeth Blackwell’s “lady doctor” ideal. Blackwell thought of motherhood as sacred; as a result, she opposed most operative gynecology on moral grounds. Further, she argued that because of their inherent virtue and compassion, women physicians had a special duty to “repudiate what appears to violate the moral law,” including any interference with female fertility.⁹⁶ In the 1880s, many women physicians still agreed with Blackwell, but some, like Dixon Jones, perceived her as old-fashioned and rejected the doctrine of difference that she used to

⁹⁵ 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. For a good primary-source 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.”

⁹⁶ Elizabeth Blackwell, “The Influence of Women in the Profession of Medicine,” *Essays in Medical Sociology* (London: Ernest Bell, 1902), 7.

justify the presence of women in the medical profession. In fact, many women specialists promoted surgical gynecology just as enthusiastically as their male colleagues did. These women comprised a small but powerful minority that played a crucial role in determining the path that gynecology would take in the late nineteenth and early twentieth centuries.

The women who played this instrumental role rarely appear in studies that adhere to the model of villainy and victimhood conceived by G. J. Barker-Benfield and others. Of course, the victimization these scholars describe did, in fact, take place. The venerated “father of gynecology,” James Marion Sims, originally gained the respect of the medical community by curing the vesico-vaginal fistula, thereby relieving the suffering of many women; however, he accomplished that particular feat by repeatedly performing risky experimental surgeries on the bodies of unanesthetized slave women.⁹⁷ Moreover, Sims declared himself to be repulsed by the female reproductive organs.⁹⁸ Battey, apparently unconcerned with the proliferation of dangerous gynecological surgeries, advocated the removal of healthy ovaries as a treatment for everything from occasional headaches to sexual frigidity. Obstetricians, who carried out a rather ruthless campaign against “dirty” midwives, tended to perform hazardous Caesarean sections and

⁹⁷ See Marie Jenkins Schwartz, *Birth of a Slave: Motherhood and Medicine in the Antebellum South* (Cambridge: Harvard University Press, 2006), 237. On vesico-vaginal fistula, see Edward Shorter, *A History of Women's Bodies* (New York: Basic Books, 1982), 268-269. On Sims, also see Seale Harris, *Woman's Surgeon: The Life Story of J. Marion Sims* (New York: Macmillan Press, 1950); McGregor, *Midwives to Medicine*; McGregor, *Sexual Surgery*; and, especially, J. Marion Sims, *The Story of My Life*, reprint edition (New York: Da Capo Press, 1968). The autobiography is a particularly rich and fascinating source.

⁹⁸ In his autobiography, Sims confessed that “if there was anything I hated, it was investigating the organs of the female pelvis” – a rather ironic statement for the venerated “father of gynecology” to make. Sims, *My Life*, 231.

symphysiotomies much too quickly, placing the lives of parturient women at risk.⁹⁹

Additionally, many obstetricians and gynecologists were influenced by the principles of eugenics and attempted to discourage or prevent supposedly “unfit” women from reproducing.¹⁰⁰ All of these developments certainly victimized women; nevertheless, the existing model of history does not account for the contributions of women specialists, who participated actively in the growth of surgery and the acceptance of eugenics within the field.

Aside from the monographs that emphasize the villain-victim model, surprisingly little secondary literature exists on the most compelling instance of women’s influence: the development of surgical gynecology. *Sympathy and Science*, Morantz-Sanchez’s groundbreaking study of women physicians in the United States, offers valuable insight but remains too broad to address small groups of specialists adequately; the same is true of Ellen S. More’s *Restoring the Balance*.¹⁰¹ Morantz-Sanchez’s excellent second book, *Conduct Unbecoming a Woman*, deals extensively with Dixon Jones, who was tried for malpractice and manslaughter in 1890, but treats her as an outsider and an aberration rather than as a member of an influential group of like-minded physicians. Other historians have analyzed the work and writing of individual women gynecologists,

⁹⁹ Examples of professional references to “dirty,” “filthy,” “unclean,” or “unhygienic” midwives appear frequently in medical journals. For a few examples, see “The Apotheosis of Dirt,” *Medical Review* 27, No. 13 (April 1893), 242; J. Milton Mabbott, “The Regulation of Midwives in New York,” *The American Journal of Obstetrics and Diseases of Women and Children* 55, No. 4 (April 1907), 516-527; “Shall We Educate Obstetric Nurses for the Poor?,” *The Medical and Surgical Reporter* 75, No. 10 (September 1896), 305-306.

¹⁰⁰ See, for example, Roy, “Surgical Gynecology,” 194.

¹⁰¹ Morantz-Sanchez, *Sympathy and Science*; More, *Restoring the Balance*.

especially early pioneers like Mary Putnam Jacobi and Marie E. Zakrzewska.¹⁰² Older “great doctor” histories can sometimes prove helpful as well, but because they focus on the scientific achievements of individual physicians and omit historical analysis, their value is somewhat limited.¹⁰³

In order to understand why women physicians might turn away from Blackwell’s views and embrace the supposedly masculine world of surgery, it is necessary to understand the key debates taking place in the medical community. Most importantly, during the years between 1880 and 1920, the whole profession was marked by intense conflict between “radical” and “conservative” practitioners. The division was particularly antagonistic within the specialty of gynecology, where physicians could not even agree on the basic vocabulary of their argument. Radicals, generally understood to be those who advocated gynecological surgeries, insisted that they were actually quite conservative by nature. Dr. E. Arnold Praeger, for example, claimed that there was no such thing as a “radical surgeon” because “the true surgeon has always been 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 be saved.”¹⁰⁴ Meanwhile, conservatives, essentially understood as those who opposed the increasing use of surgery, rejected the idea that they occupied an

¹⁰² For example, see Bittel, *Mary Putnam Jacobi*; Nancy Theriot, “Women’s Voices in Nineteenth-Century Medical Discourse,” *Signs* 19 (1993), 1-31; Tuchman, *Science Has No Sex*.

¹⁰³ For an example of this “great doctor” history, albeit a slightly more analytical one, see James V. Ricci, *One Hundred Years of Gynecology* (Philadelphia: The Blakiston Company, 1945).

¹⁰⁴ E. Arnold Praeger, “Is So-Called Conservatism 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.

extreme side of the spectrum. As the historian Martin Pernick has demonstrated, conservatives did not define themselves in opposition to radicals; rather, they conceived of themselves as moderates who carefully weighed risks against benefits.¹⁰⁵

Whatever the terminology, the dispute resonated powerfully with gynecologists, who debated the issue heatedly. The renowned gynecologist Howard Kelly explicitly linked the practice of gynecology with the utilization of laparotomy when he published *Gynecology and Abdominal Surgery*.¹⁰⁶ Other specialists published textbooks promoting nonsurgical therapies. Dr. George Betton Massey, the author of one such textbook, criticized radicals for exposing their patients to unnecessary risks. “The cost in lost functions or lost lives of the surgeon’s mistakes,” he argued, “are all out of proportion.”¹⁰⁷ The same themes surfaced at professional conferences. In his 1894 address to the Chicago Gynecologic society, the surgical proponent Dr. F. H. Henrotin defended radical gynecologists against the mounting criticism of their conservative colleagues. He reminded his audience that “it was the work of these very men that lifted gynecology far toward its present plane, and, in fact, it was the radical procedures that

¹⁰⁵ Martin Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985), 19-31. For the purposes of this project, despite the contested terminology, I continue to use the terms “radical” and “conservative” to mean, respectively, those who embraced surgery as fundamental to gynecology and those who advocated limiting or eradicating gynecological operations.

¹⁰⁶ Howard Kelly, *Gynecology and Abdominal Surgery* (Philadelphia: W. B. Saunders Company, 1910). “Laparotomy,” a term coined in the 1870s, referred to any operation in which the surgeon opened the abdominal cavity.

¹⁰⁷ 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), 9.

later on rendered conservative methods possible.”¹⁰⁸ The same year, at the annual convention of the Kentucky Medical Society, a conservative gynecologist named Julia Ingram delivered a paper accusing some of her colleagues of resorting too quickly to surgery. In the ensuing discussion, some physicians reported witnessing dangerous or nonessential operations forced upon women who might have benefited from less invasive treatments. Radical physicians responded that many lives had been saved by surgical procedures. Dr. Joseph M. Mathews, for example, compared sexual surgeries to appendectomies, contending that in both cases, “the surgeon makes the incision, comes to a solution of the question, and saves [the patient’s] life.”¹⁰⁹ Mathews saw no distinction between an appendix and an ovary, but many of his colleagues disagreed.

In fact, the division between radicals and conservatives was probably so emphatic within the specialty of gynecology because the surgeries in question were being performed on women’s reproductive organs. Like Blackwell, conservative physicians of both sexes expressed moral objections to hysterectomies, ovariectomies, oophorectomies, and salpingectomies, especially when the patients in question were still of child-bearing age.¹¹⁰ Radical physicians were also troubled, in certain circumstances, by the potential ramifications of the surgeries they were promoting. Even Kelly, who viewed the

¹⁰⁸ F. H. Henrotin, “Radicalism and Conservatism in Gynecologic Societies,” *The Journal of the American Medical Association* XXIV, No. 4 (January 1895), 108. The journal printed Henrotin’s speech on its front page, suggesting the significance of the debate.

¹⁰⁹ Julia Ingram, “Conservative Gynecology,” *Transactions of the Kentucky Medical Society* III (Louisville: John P. Morton and Company, 1894), 157-160.

¹¹⁰ During this period, these terms were not always clear-cut. “Hysterectomy” referred to the removal of the uterus. “Ovariectomy” and “oophorectomy” both entailed the removal of ovaries, and some physicians seemed to use the words interchangeably. Others distinguished between them, with “ovariectomy” meaning the removal of diseased ovaries and “oophorectomy” meaning the removal of healthy ovaries (also called “normal ovariectomy” or “Battey’s operation”). “Salpingectomy” was the removal of the Fallopian tubes.

laparotomy as absolutely fundamental to the practice of gynecology, worried that the removal of uterus, ovaries, and Fallopian tubes might negatively affect marital relationships. In an article devoted to the ethical implications of the oophorectomy, he explicitly questioned the capacity of a husband to genuinely love an infertile wife.¹¹¹ Blackwell, who classified oophorectomy as a form of sexual mutilation, was also especially disturbed by the consequence of infertility.¹¹² As Morantz-Sanchez has observed, then, many concerns regarding surgical gynecology were fundamentally maternalist.¹¹³

Maternalist concerns were not limited to philosophy or ethics. Conservative gynecologists also pointed to the practical implications of the proliferation of gynecological surgeries, and their views had a strong eugenic component. Too many sexual surgeries performed on white women, they contended, would result in race suicide. Some physicians even suggested that the need to prevent race suicide ought to take precedence over any given patient's individual desire to space her children several years apart or to limit her family size in general. Dr. Ely Van de Warker went so far as to assert that "a woman's ovaries belong to the commonwealth; she is simply their custodian."¹¹⁴ According to this perspective, every ovariectomy performed on a white woman, especially a white woman of "the better class," robbed the world of desirable

¹¹¹ Howard Kelly, "The Ethical Side of the Operation of Oophorectomy," *The American Journal of Obstetrics and Gynecology* 27 (1893), 208.

¹¹² Blackwell, "Influence of Women," 90.

¹¹³ Morantz-Sanchez, *Conduct Unbecoming*, 108. See also Taylor, "Defining Maternalism," 110-115.

¹¹⁴ Quoted in Morantz-Sanchez, *Conduct Unbecoming*, 108. Van de Warker made this statement in a 1906 issue of *The American Journal of Obstetrics and Gynecology*.

children. Therefore, though some conservative physicians were certainly trying to protect women from painful or unnecessary surgeries, the evidence suggests that in many cases, they cared more about eugenics than they did about their individual patients. In seeking to shield women's ovaries from surgeon's knives, they often implied – or, in Van de Warker's case, clearly stated – that female patients did not deserve to control their own bodies.

Radical gynecologists responded to conservative criticism in a number of ways. First, they frequently insisted that the surgeries they were performing were critical to their patients' recoveries. Jacobi accused Blackwell of forgetting, in her rush to condemn operative gynecology as “mutilating,” that the primary purpose of medicine was to make patients well. “When you shudder at mutilation,” she wrote in an 1888 letter to Blackwell, “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.”¹¹⁵ The surgical gynecologist Anna M. Fullerton made similar arguments in *The Women's Medical Journal*, depicting surgery as a necessary treatment for certain manifestations of venereal disease. As a case in point, she described the resistance of gonorrhoea to conservative treatments: “within the cervical and uterine canals and in the Fallopian tubes, gonococcus finds itself in an impregnable fortress. . . . it is so often necessary to subjugate it by very radical measures, viz: by the entire destruction of its defences, the removal of the organs affected.”¹¹⁶ In addition,

¹¹⁵ Quoted in Morantz-Sanchez, *Sympathy and Science*, 195. Morantz-Sanchez uses Jacobi and Blackwell as contrasting “representative types,” with Jacobi as the rational, scientific surgeon and Blackwell as the sentimental, maternalist “lady doctor.”

radical gynecologists warned that conservative gynecologists took unacceptable risks in refusing to operate when the patient's condition called for it.¹¹⁷ These claims reflected a genuine concern that disease would flourish if practitioners shunned laparotomies in favor of poultices, tonics, massage, or electricity; however, they also reflected a defensive posture. Conservatives frequently accused radicals of taking unacceptable risks, and so radicals wanted to emphasize that the philosophical avoidance of surgery could also prove dangerous.

Surgical gynecologists also directly addressed the eugenic concerns voiced by physicians like Blackwell and Van de Warker. Some believed that, in general, the women who were submitting to gynecological operations were not the women who ought to be producing offspring in the first place. Fullerton suggested that for patients afflicted with venereal disease, sterility was often the most desirable outcome. Her reasons were twofold. First, she pointed out that pregnancy and childbirth could be particularly risky for women with serious venereal infections: "objections to these operations on the grounds that they destroy the child-bearing functions . . . must be weighed against the question of her risk in doing so." Second, Fullerton raised moral objections to the idea of women with venereal diseases reproducing at all: "we should consider the question of the desirability of her transmitting to her offspring a quality of life . . . perhaps morally debased in consequence of the diseased condition of the maternal organs."¹¹⁸ Though

¹¹⁶ Anna M. Fullerton, "Gonorrhoea of the Uterus and Its Appendages: A Surgical Survey," *The Woman's Medical Journal* 7, No. 6 (June 1898), 170.

¹¹⁷ See, for example, 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.

these arguments aimed to thwart conservative criticism, they did not challenge the principles of eugenics that conservatives cited. Rather, using some of the same rhetoric adopted by eugenicists, they implied that surgical gynecology would not result in race suicide because it functioned to limit the reproductive capacities of the physically or morally “unfit” while leaving the fertility of the “fit” untouched.

Women who chose to specialize in gynecology had to navigate this complicated rhetoric and locate themselves on a vaguely defined spectrum of radicalism and conservatism. They probably felt pulled in both directions. Many felt compelled to join Blackwell in advocating for the sanctity of motherhood, either because they agreed that women doctors should bring a special morality to the profession or because they wanted to protect female patients from overly zealous surgeons. Dr. Mary Spink believed women physicians were morally obligated to “object to the wholesale onslaught upon” the ovaries.¹¹⁹ Along the same lines, Dr. Mary S. Briggs expressed concern about the rapidly increasing numbers of gynecological surgeries being performed in the United States. Her 1896 “Plea for Simplicity,” published in *The Woman’s Medical Journal*, did not condemn all sexual surgeries but did promote the use of poultices and other conservative therapies, at least as a first course of action. Trying conservative treatments first, she argued, would “save scores of operations.” Like Blackwell and Spink, Briggs felt a protective impulse toward the reproductive organs of other women: “Why,” she asked her readers, “should the uterus be so maltreated?”¹²⁰ All three women pointed

¹¹⁸ Fullerton, “Gonorrhoea of the Uterus,” 176.

¹¹⁹ Quoted in Morantz-Sanchez, *Conduct Unbecoming*, 108.

proudly to the conservative heritage of women physicians, who, they believed, understood the significance of motherhood in a way that men could not.

Blackwell, Spink, Briggs, and other conservatives also suggested that women physicians had an especially intimate connection with the principles of Christian morality. In *Pioneer Work in Opening the Medical Profession to Women*, Blackwell eagerly 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 to every method and practice of the healing art.”¹²¹ Dr. Josephine Peavey employed a similar vision of Christian femininity in her approach to abortion. Many physicians expressed eugenically-motivated concerns about abortion, but Peavey argued that women specialists had a particular obligation to educate other women about the horrors of abortion and advise them to make more honorable choices: “As women physicians it is our duty to educate our sisters in this direction, and although we may never see them, results must follow, for light always dispels darkness.” She characterized the high number of criminal abortions in the United States as “a sad commentary upon the Christian civilization of the age.”¹²² Such arguments evoked traditional gender ideology, suggesting that even as women physicians transgressed some traditional boundaries imposed by the cult of true womanhood, they continued to maintain their special connection to God.

¹²⁰ Mary S. Briggs, “A Plea for Simplicity,” *The Woman’s Medical Journal* 5, No. 6 (June 1896), 147.

¹²¹ Elizabeth Blackwell, *Pioneer Work in Opening the Medical Profession to Women* (London: Longmans, Green, and Company, 1895), 254.

¹²² Josephine L. Peavey, “Criminal Abortion,” *The Woman’s Medical Journal* 8, No. 6 (June 1899), 209-216.

Despite these inclinations, though, many women gynecologists firmly objected both to the idea that women physicians ought to be guardians of medical morality and to the notion that women's reproductive organs carried special sanctity. Taking this position might have been somewhat risky. Morantz-Sanchez argues that for women like Dixon Jones, taking the radical path – understood as more “masculine” – led to considerable disapproval both from the medical community and from the public at large. Her assessment, however, requires further analysis. After all, Morantz-Sanchez has also convincingly demonstrated that even with exceptional “boldness and sensitivity to effective strategies of self-advancement,” determined women physicians could typically reach only “a respectable, though not stellar place” in the medical community.¹²³ In other words, taking a conservative path – defined as more “feminine” – did not guarantee a woman physician's success or shield her from discrimination. Faced with this turn-of-the-century glass ceiling, Steven J. Peitzman argues persuasively that a woman gynecologist who refrained from performing the “big” operations, such as ovariectomies and salpingectomies, would not have earned the respect of her peers.¹²⁴ Therefore, women physicians probably chose radical paths for both practical and philosophical reasons.

Indeed, many of the most ambitious women practicing medicine between 1880 and 1920 persisted in promoting operative gynecology. Jacobi and Dixon Jones advocated gynecological surgeries throughout their careers.¹²⁵ The surgical gynecologist

¹²³ Morantz-Sanchez, *Conduct Unbecoming*, 114.

¹²⁴ Peitzman, *Untried Course*.

Anita E. Tyng gave addresses and published articles on the clitoridectomies, hysterectomies, and ovariectomies she performed, usually with no reference at all to the need for restraint or the sanctity of motherhood.¹²⁶ Fullerton published a number of articles on surgical gynecology; she also authored Kelly's textbook chapter on vulval and vaginal surgeries.¹²⁷ Like Tyng, she typically omitted any reference to the debate, but when she did address conflicts between radicals and conservatives, she always defended the radical tendency to treat mental illness, venereal disease, and reproductive ailments with surgery, even at the expense of the patient's fertility. Dr. Rosalie Slaughter Morton, who opened a thriving practice in Washington, D.C., at the turn of the century, staunchly defended operative gynecology. In fact, she openly rejoiced in performing surgery, calling it "a great satisfaction." Using the doctrine of difference in a different way, she contended that women were particularly adept surgeons.¹²⁸

Morton's description of surgery also suggests that women gynecologists understood their professional decisions to be directly relevant to debates about

¹²⁵ It should be noted, though, that Jacobi did sometimes refer to the "special capacities of women as a class." She did not wholly repudiate the idea that certain feminine strengths existed; however, she typically discussed feminine qualities in conjunction with arguments about the intellectual equality of men and women. See Jacobi, "Women in Medicine," 177.

¹²⁶ See, for example, 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; "Transactions of the Rhode Island Medical Society" III (1883-1888), 281-282; Anita E. Tyng, "A Case of Clitoridectomy," 25. Clitoridectomies, pioneered by British surgeon Isaac Baker Brown, were never as popular, in the United States, as ovariectomies and oophorectomies were, but they were nonetheless performed. See McGregor, *Midwives to Medicine*, 146; Ricci, *100 Years*, 431-432.

¹²⁷ See, for example, Fullerton, "Gonorrhoea of the Uterus," 171-176; Anna M. Fullerton, "Studies in Gynecology from the Service of the Women's Hospital of Philadelphia," *The Woman's Medical Journal* 7, No. 3 (March 1898), 65-72; Anna M. Fullerton, "Non-Plastic Operations of the Vulva and Vagina," *Gynecology and Abdominal Surgery*, edited by Howard Kelly (Philadelphia: W. B. Saunders Company, 1910), 328-347.

¹²⁸ Morton, *Woman Surgeon*, 131.

appropriate roles for women in society. Just as Jacobi and Brown had justified places for women in the public sphere by redefining the nature of women's bodies, proponents of operative gynecology suggested valuable lives for women outside of the domestic sphere. When radical women gynecologists defended surgeries like hysterectomy and ovariectomy, arguing, as Dixon Jones did, that removing uteruses and ovaries could make women "more perfect," they influenced the way that the specialty collectively constructed the female body. Women were not necessarily defined by their reproductive organs.

The voices involved in the medical construction of women's bodies were diverse, but motherhood was almost always central to the discussion. Many physicians, both male and female, continued to promote traditional gender roles for women, and their voices were especially prevalent in literature aimed at popular audiences. In 1911, for example, the respected gynecologist and bestselling author Edith Belle Lowry was still maintaining that motherhood was a woman's primary responsibility and that reproduction was the only valid reason for sexual activity. Lowry's *Herself*, a book aimed chiefly at newly-married women, stated that married couples were obligated to reproduce; those who enjoyed sex without planning to become parents were cast as "a menace to society."¹²⁹ Radical gynecologists forcefully challenged these views. Jacobi acknowledged the beauty and significance of motherhood; however, she perceived the cultural obsession with maternity as dangerous because it confined women to the traditionally feminine sphere. In an essay on the status of medical women in the United

¹²⁹ Edith Belle Lowry, *Herself: Talks with Women Concerning Themselves* (Chicago: Forbes and Company, 1911), 103.

States, she cautioned against such an exaggerated emphasis on motherhood: “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.”¹³⁰ Jacobi and others understood that a focus on maternity often meant the restriction of women’s participation in the social, political, and professional worlds.

In her study of Dixon Jones’s manslaughter and malpractice trials, Morantz-Sanchez implies that Dixon Jones stood somehow outside of the professional “construction of the female body,” looking in on the men who undertook that work and “responding” to them.¹³¹ On the contrary, Dixon Jones, Jacobi, and dozens of other women 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. Dixon Jones was cited frequently by male surgeons, including Charles A. L. Reed and Thomas Addis Emmet. Tyng’s work on hysterectomies, oophorectomies, and clitoridectomies was often referred to by prominent gynecologists.¹³² In addition, Fullerton was considered one of the most authoritative experts on women’s sexual organs; Kelly even recruited her to write one of his textbook chapters. Specialists of both sexes eagerly sought her opinions at professional meetings. Her remarks at the 1897 meeting of the American Medical Association, for instance, were instrumental in moving the medical community toward the endorsement of

¹³⁰ Jacobi, “Women in Medicine,” 196.

¹³¹ Morantz-Sanchez, *Conduct Unbecoming*, 114.

¹³² Morantz-Sanchez, *Conduct Unbecoming*, 124.

bicycling as a healthy form of exercise for women.¹³³ While medical approval of the bicycle might seem inconsequential to modern readers, the issue actually involved serious debates about the body and about sexuality. Physicians worried that cycling would drain energy levels, cause inflammation, and deform the pelvic organs. Further, they sometimes refused to endorse cycling because they thought the cycle was unladylike or because they thought women might receive sexual stimulation from the saddle of the bicycle.

Because they had such a personal stake in the construction of women's bodies, women surgical gynecologists were often quite passionate in their work. Writing to Blackwell in 1888, Jacobi admitted that sexual surgery was sometimes performed too hastily and that surgeons sometimes made mistakes; nevertheless, she went on to reprimand Blackwell for her insistence that the female reproductive organs were somehow sacred. "There has been much reprehensible malpractice," she 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!"¹³⁴ Dixon Jones held similar views, and because she rejected the centrality of motherhood to a woman's existence, she could argue that the performance of hysterectomy, ovariectomy, or salpingectomy "makes the

¹³³ Morantz-Sanchez, *Conduct Unbecoming*, 124. Bicycling was intensely debated. See, for example, "Bicycling for Women," *The Women's Medical Journal* 6, No. 4 (April 1897), 121; Thomas R. Evans, "Harmful Effects of the Bicycle upon the Girl's Pelvis," *The American Journal of Obstetrics and Diseases of Women and Children* 33, No. 4 (April 1896), 554-556; Francis Smith Nash, "A Plea for the New Woman and the Bicycle," *The American Journal of Obstetrics and Diseases of Women and Children* 33, No. 4 (April 1896), 556-560.

¹³⁴ Quoted in Morantz-Sanchez, *Sympathy and Science*, 195.

sick woman a more perfect woman, makes her capable of performing life's duties and meeting life's responsibilities."¹³⁵ These arguments differed significantly from more practical contentions about medical necessity and eugenics because they explicitly addressed the ideology of gender. 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 might not be at the very core of a woman's being.

The firm commitment of these radical women physicians to the promotion of surgical gynecology had multiple explanations. Most obviously, they believed in the efficacy of the operations they performed, and they did not see conservative therapies as reliable means to relieve the suffering of their patients. Understandably, they viewed tonics, poultices, and electricity as insufficient methods for treating cysts, tumors, or hysteria. More importantly, though, many of these women physicians recognized how limiting Blackwell's moral, sentimental "lady doctor" ideal could be. Blackwell was certainly pioneering in her quest to become the first licensed physician in the United States, but her ideas about women in the medical profession did not challenge the dominating ideology of "separate spheres." 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, and they did not want to be forced to engage in traditional kinds of gender performance. Instead, they seemed to favor the elimination of the sphere ideology. By indicating, in their medical writing and with their professional behavior, that women's

¹³⁵ Dixon Jones, "Misplacements of the Uterus," 305.

bodies were intended for more than reproduction, they contested traditional ideology and secured places for themselves within a male-dominated profession. They also exerted a powerful influence on the way the specialty developed.

The fact that many women surgical gynecologists were active in political movements illustrates the social significance of the medical construction of women's bodies. Unsurprisingly, Jacobi was particularly radical in her political activities, especially in regard to woman's suffrage. In April of 1894, *The New York Times* emphasized Jacobi's unwillingness to negotiate with antisuffragists: "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.'¹³⁶ 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."¹³⁷ Jacobi was not alone in combining radical gynecology with radical politics. Dr. Ella Marble was also a leader in the suffrage movement, serving as president of the Minnesota State and Minneapolis City Suffrage Associations; Rosalie Slaughter Morton belonged to the Collegiate Equal Suffrage League of New York and the Equal Suffrage League of the City of New York.¹³⁸ The surgical gynecologist Mary Thompson was also known as a "firm suffragist."¹³⁹ Their passionate commitment to feminist causes,

¹³⁶ "No Compromise with Antis," *The New York Times*, April 29, 1894.

¹³⁷ "Suffragists on the Warpath," *The New York Times*, May 3, 1894.

¹³⁸ "Biographical Series," *The Woman's Medical Journal* 5, No. 3 (March 1896), 69; John William Leonard, *Woman's Who's Who of America: A Biographical Dictionary of Contemporary Women of the United States and Canada* (New York: The American Commonwealth Company, 1915).

¹³⁹ 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.

especially combined with the radical, uncompromising style exemplified by Jacobi, was consistent with their approach to gynecology as a specialty.

As women physicians combined radical medicine with radical politics, they helped create the period of transformation that characterized gynecology and obstetrics during the late nineteenth and early twentieth centuries. Women participated actively in the medical construction of women's bodies, and they effected a tremendous evolution in their specialties. Even though men outnumbered women in the medical profession, women physicians possessed considerable symbolic power. Morantz-Sanchez has noted that radical male gynecologists frequently looked to women surgeons like Dixon Jones for approval, eager to have female doctors "on their side."¹⁴⁰ Indeed, the existence of ambitious, respected women in the ranks of gynecological surgeons helped radicals deflect the attacks of conservatives who viewed operative gynecology as mutilating or immoral. From the twenty-first century perspective, it is impossible to ignore the fact that women surgical gynecologists enabled and participated in medical trends that harmed other women. Viewed historically, however, the situation is more complex. These specialists opened doors for themselves and for other women by challenging traditional gender ideology, and they were often motivated by the desire to let new scientific knowledge about women's bodies triumph over older and more restrictive gender norms.

¹⁴⁰ Morantz-Sanchez, *Conduct Unbecoming*, 136.

CHAPTER IV

“DELICATELY ORGANIZED WOMEN”: MEDICAL ACTIVISM, MATERNAL BODIES, AND THE CAMPAIGN FOR TWILIGHT SLEEP IN AMERICA

Educators and physicians of both sexes played leading roles in the medical construction of women's bodies, but they did not undertake this work alone. Between 1880 and 1920, obstetricians and gynecologists consolidated their authority over women's physical bodies and women's social positions, but at no point were women outside of the medical community completely powerless. In an expanding medical marketplace, they made choices about the type of care they wanted to receive; further, when physicians did not offer the medical treatments and childbirth experiences that they wanted, they were able to campaign successfully for change. The active cooperation of lay women was crucial to the medicalization of maternal bodies and the institutionalization of childbirth practices, and the activism of lay women was instrumental in determining the precise shape that these developments would take.

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, laywomen 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 parturient women first with a combination of morphine and scopolamine, then, periodically, with scopolamine alone. As a result, patients at the Frauenklinik could progress through labor in a state of semi-consciousness and wake, 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.¹⁴¹

Twilight sleep was extremely appealing to many American women, who, in 1914, were almost universally terrified of the inescapable pain and potential death associated with childbirth.¹⁴² “Painless Childbirth” received more attention than any piece *McClure’s* had published previously, and magazines like *Good Housekeeping* and *Woman’s Home Companion* rushed to run similar articles.¹⁴³

The popular excitement surrounding twilight sleep grew exponentially as full-length books, such as Hanna Rion Ver Beck’s *The Truth about Twilight Sleep*, began

¹⁴¹ Marguerite Tracy and Constance Leupp, “Painless Childbirth,” *McClure’s Magazine* XLIII (June 1914), 38.

¹⁴² Historians have addressed the nearly universal fear of pain and death in childbirth extensively. See, for example, Leavitt, *Brought to Bed*, 13-35; Sandelowski, *American Childbirth*, 5-9; Shorter, *Women’s Bodies*, 69-97; Wertz, *Lying-In*, 109-128.

¹⁴³ Mary Boyd and Marguerite Tracy, “More about Painless Childbirth,” *McClure’s Magazine* XLIII (October 1914), 56.

appearing.¹⁴⁴ *The Truth about Twilight Sleep* was crafted as a persuasive device, not a scientific contribution. At the time of its publication in 1915, 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 grant 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.”¹⁴⁵ Less than one year after the news of twilight sleep broke in the United States, certain women – especially, as the historian Judith Walzer Leavitt has demonstrated, wealthy white women – heeded Ver Beck’s call and began to mobilize. Impatient with physicians in the United States, these women organized the National Twilight Sleep Association and began campaigning aggressively to make the treatment widely available. The founding members of the NTSA included suffragists, authors, reformers, and clubwomen; two notable women physicians, Eliza Taylor Ransom and Bertha Van Hoosen, also took leadership roles.¹⁴⁶

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, utilized both in the specialty wards where wealthy women gave birth and, to a somewhat lesser extent, in the charity hospitals where poorer women sometimes delivered.¹⁴⁷ Physicians who had

¹⁴⁴ 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).

¹⁴⁵ Hanna Rion Ver Beck, *The Truth about Twilight Sleep* (New York: McBride, Nast, and Company, 1915), 358.

¹⁴⁶ Leavitt, *Brought to Bed*, 131.

¹⁴⁷ Leavitt, *Brought to Bed*, 134.

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 women who formed the NTSA exerted tremendous pressure on their obstetricians and gynecologists, and their victory reveals that lay women were sometimes able to compel physicians to change their methods.

Though the campaign for twilight sleep seemed, on the surface, like an attack on 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.¹⁴⁸ Moreover, obstetricians and gynecologists 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

¹⁴⁸ Leavitt, *Brought to Bed*, 134.

room when narcotics were used.¹⁴⁹ Therefore, physicians benefited from the adoption of twilight sleep in various ways, most of which were not particularly favorable for patients, whose laboring bodies were now constructed 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 of morphine and scopolamine, they succeeded so unequivocally that they generated a new formula for labor and delivery, a formula crafted not by patients or activists but by obstetricians and gynecologists. 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. Many of the activists who advocated this form of female passivity during the childbirth process were first-wave feminists; however, just fifty years later, second-wave feminists would work to reverse the accomplishments of the NTSA, emphasizing female control, conscious delivery, and natural birth.¹⁵⁰ This striking change in feminist approaches to childbirth suggests that the twilight sleep movement 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

¹⁴⁹ Bertha Van Hoosen, *Petticoat Surgeon* (Chicago: Pellegrini and Cudahy, 1947), 283.

¹⁵⁰ Hairston, “Debate over Twilight Sleep,” 490. For more on the typical mid-twentieth-century hospital birth and feminist resistance to it, see Margot Edwards and Mary Waldorf, *Reclaiming Birth: History and Heroines of American Childbirth Reform* (Trumansburg, NY: The Crossing Press, 1984), 29-68; Shorter, *Women's Bodies*, 156-176.

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.”¹⁵¹ 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 fails to characterize 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.”¹⁵² 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, 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 ideology. Their perceptions of and thoughts about pain, their

¹⁵¹ Judith Walzer Leavitt, “Birthing and Anesthesia: The Debate over Twilight Sleep,” *Signs* 6, No. 1 (autumn 1980), 148.

¹⁵² Wertz, *Lying-In*, 152.

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.

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, “Maud Muller,” a frequently anthologized poem by John Greenleaf Whittier, suggested that giving birth scarred mothers permanently: “But care, and sorrow, and childbirth pain, / Left their traces on heart and brain.”¹⁵³ Obstetricians and gynecologists validated this perception. In *A System of Obstetric Medicine and Surgery*, 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.”¹⁵⁴ The gynecologist Samuel Brickner 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: discussing violent attacks of appendicitis, he claimed that “the accompanying pains could be compared only with the tortures of childbirth.”¹⁵⁵ Perhaps

¹⁵³ J. G. Whittier, “Maud Muller,” *Our Girls: Poems in Praise of the American Girl* (New York: Moffat, Yard, and Company, 1907).

¹⁵⁴ Robert Barnes, *A System of Obstetric Medicine and Surgery, Theoretical and Clinical* (Philadelphia: Lea Brothers and Company, 1885), 308.

¹⁵⁵ 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.

most tellingly, Mary Boyd and Marguerite Tracy reported one male obstetrician's opinion that "if he were a woman he would hang himself in the first month of pregnancy."¹⁵⁶

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 were potentially dangerous.¹⁵⁷ Earlier in the nineteenth century, such women had greeted the increasing use of chloroform and ether enthusiastically. 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 frequently lethal, because they violated the biblical curse upon females to suffer in childbirth, or because the pain of labor and delivery were thought to inspire maternal love. Consequently, when *McClure's* began publishing articles on the miracle of twilight sleep, the use of anesthesia in childbirth was still somewhat rare.¹⁵⁸

Because anesthesia was still employed unevenly, pregnant women continued to dread the pain associated with labor and delivery. For them, twilight sleep was a potential miracle, a way to pass from pregnancy to motherhood without suffering such unbearable agony. In May of 1914, *The New York Times* published a poem by Ethel H. Wolff that hailed the Freiburg technique as a the savior of women everywhere: "Over the

¹⁵⁶ Boyd, "More about Painless Childbirth," 14.

¹⁵⁷ See Leavitt, *Brought to Bed*, 116-117.

¹⁵⁸ Wertz, *Lying-In*, 117. For more on the gradual, uneven acceptance of anesthesia in the United States, see Pernick, *Calculus of Suffering*.

dark and cruel stream / that motherhood must cross / A bridge of dreams had 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
woman wrought / this priceless boon / To end the suffering of Ages yet to / come.”¹⁵⁹

The members of the NTSA employed similarly rapturous descriptions of twilight sleep, exclaiming, for example, that “[t]hrough Twilight Sleep a new era has dawned for woman and through her for the whole human race.”¹⁶⁰ These kinds of proclamations were romanticized and exaggerated, but they illustrated the desperation women felt toward childbirth and the excitement with which they regarded potential remedies.

For women during this period, giving birth was not just physiologically painful; it was also potentially fatal. Statistics published by the Children’s Bureau in 1917 demonstrated that “childbirth caused more deaths among women 15 to 44 years old than any disease except tuberculosis.”¹⁶¹ In 1919, Dr. Henry Schwarz lamented the “unnecessary and deplorable” pain of childbirth, which, he argued, “constitute but the smallest part of the crimes against the mothers of our great nation. 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.”¹⁶² The historian Edward Shorter has confirmed Schwarz’s perceptions, demonstrating that

¹⁵⁹ Ethel H. Wolff, “The Bridge of Dreams,” *The New York Times* (May 28, 1914).

¹⁶⁰ Ver Beck, *Truth about Twilight Sleep*, 362.

¹⁶¹ 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.

¹⁶² Henry Schwarz, “Painless Childbirth and the Safe Conduct of Labor,” *Transactions of the American Association of Obstetricians and Gynecologists* XXXI (1919), 300.

although maternal death rates did begin to fall around 1880, childbirth remained exceptionally dangerous. Infection was the most significant cause of death, but women also succumbed to hemorrhage, shock, phlebitis, and various other obstetrical and medical complications.¹⁶³ 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 “[e]very woman actually confronted with an imminent birth is filled with a living fear of death that few men can grasp.” They connected that extreme fear with the need for twilight sleep, which was the first development in obstetrical pharmacology that offered complete oblivion throughout labor and delivery and no memory afterward of the pain or terror.¹⁶⁴

When the twilight sleep controversy developed, many medical professionals believed that childbirth was especially painful and especially dangerous for women of the middle and upper classes. Just as Clarke had observed 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

¹⁶³ 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.”

¹⁶⁴ Boyd, “More about Painless Childbirth,” 69.

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.¹⁶⁵ 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."¹⁶⁶ In his book on obstetric anesthesia, Dr. Carl Henry Davis referred to this principle as "the penalty of civilization."¹⁶⁷ The same sentiments motivated German obstetricians Bernhardt Kronig and Karl Gauss, who developed the method used at the Freiburg Frauenklinik.¹⁶⁸

Indeed, Kronig believed twilight sleep was necessary because many "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

¹⁶⁵ 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.

¹⁶⁶ Smith, *Twilight Sleep in America*, 10.

¹⁶⁷ 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 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.

¹⁶⁸ 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.

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.¹⁶⁹ Forceps deliveries were somewhat controversial among obstetricians and gynecologists, with some specialists defending the practice and others arguing that it was dangerous both to mothers and to babies. Twilight sleep advocates believed that Kronig’s “dammerschlaf” was a much less damaging option.

Although Leavitt has suggested that the NTSA worked for the benefit of all women, the organization was undoubtedly motivated by its members’ perceptions of themselves as part of what Kronig called “the better class.”¹⁷⁰ 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. Ver Beck, whose book was read widely by the general public, 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.”¹⁷¹ 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”), but its members nevertheless perpetuated a class ideology that prescribed elite, delicately constituted women special help getting through labor and delivery unharmed.

¹⁶⁹ Smith, *Twilight Sleep in America*, 43.

¹⁷⁰ Leavitt, *Brought to Bed*, 131; Smith, *Twilight Sleep in America*, 43.

¹⁷¹ Ver Beck, *Truth about Twilight Sleep*, 8.

Furthermore, the primary strategy of the NTSA was to direct its rhetoric specifically at other members of that particular class. They 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.” Such meetings were covered by the newspapers. 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 Sleep.’”¹⁷² 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.¹⁷³

In addition, members of the NTSA emphasized the need for upper-class women to produce more babies, invoking the same fears of race suicide employed both by conservative gynecologists and by specialists like Edward H. Clarke. Proponents of twilight sleep maintained that effective anesthetics might encourage such 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.”¹⁷⁴ Especially when combined with references to a spectrum of civility and refinement, these

¹⁷² “Mothers Discuss Twilight Sleep,” *The New York Times* (November 18, 1914).

¹⁷³ See Wertz, *Lying-In*, 153.

¹⁷⁴ Smith, *Twilight Sleep in America*, 53.

kinds of remarks suggested an explicitly racial component to medical constructions of female suffering. Historically, obstetricians and gynecologists 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 such views.¹⁷⁵ The twilight sleep campaign went even further, though, by explicitly 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.¹⁷⁶

¹⁷⁵ 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*.

¹⁷⁶ Edith Wharton, *Twilight Sleep*, First Scribner Paperback edition (New York: Simon and Schuster, 1997), 18.

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."¹⁷⁷ Combined with assertions about the debilitating effects of education and careers on women's bodies and with physical factors like the corset, these kinds of beliefs encouraged women to 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, 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 during their pregnancies, additional problems arose. Childbirth likely became more painful in a literal, physiological sense.¹⁷⁸ Significantly, though, 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.

¹⁷⁷ Davis, *Nitrous Oxid-Oxygen Analgesia*, 18.

¹⁷⁸ Wertz, *Lying-In*, 110.

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 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.¹⁷⁹ Tellingly, a great deal of the medical literature on twilight sleep was devoted to the best way to ensure that 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: “too much was toxic. Too little left ‘islands of memory.’” At Freiburg, obstetricians used a memory test, in which, during labor, they “asked patients simple questions and had them perform simple tasks. Only if they

¹⁷⁹ John Osborn Polak, “Obstetric Advances, Including Anesthesia, the Use and Abuse of Pituitrin, Extra-Peritoneal Caesarean Section, Pubiotomy, and the Significance of Funnel Pelvis,” *The Boston Medical and Surgical Journal* CLXXVI (1917), 85.

responded correctly did [the doctors] administer more scopolamine.”¹⁸⁰ 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.”¹⁸¹ 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.”¹⁸² Female fragility 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,

¹⁸⁰ 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.

¹⁸¹ Ver Beck, *Truth about Twilight Sleep*, 30; Tracy, *Painless Childbirth*, xi.

¹⁸² Tracy, *Painless Childbirth*, 198.

women's bodies experienced the pain of their contractions. Patients cried, screamed, and writhed in agony.¹⁸³ In fact, since drugs 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.¹⁸⁴ 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 seen as ill because of their sex, with disease originating in their reproductive organs.¹⁸⁵ 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

¹⁸³ Leavitt, *Brought to Bed*, 128-129.

¹⁸⁴ "Hospital Not a Nuisance," *The New York Times* (June 9, 1917). This incident is also mentioned in Leavitt, *Brought to Bed*, 129.

¹⁸⁵ Wood, "The Fashionable Diseases," 26-27.

causes of nervous and mental diseases in women.”¹⁸⁶ Ver Beck 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.”¹⁸⁷ 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.

Influenced by this ideology, women had already been regularly placing control over their health and well-being into the hands of physicians. Throughout the nineteenth century and into the twentieth, many women, particularly middle- and upper-class women like those who joined the NTSA, submitted themselves to the care of medical professionals. Depending on the particular patient, physicians might inject various concoctions into the uterus, cauterize the reproductive organs, induce uterine hemorrhage, or perform a hysterectomy, salpingectomy, or ovariectomy; they might, alternatively, prescribe the rest cure.¹⁸⁸ Popularized by Dr. S. Weir Mitchell, the rest cure involved complete confinement to a bed. For periods of up to six weeks, patients lay on

¹⁸⁶ Tracy, *Painless Childbirth*, 34.

¹⁸⁷ Ver Beck, *Truth about Twilight Sleep*, 11.

¹⁸⁸ See Wood, “Fashionable Diseases,” 29-31.

their backs, consumed a special diet, and refrained from reading, writing, and all intellectual activity.¹⁸⁹ Whether they endured painful treatments like cauterization, underwent surgeries like ovariectomy, or submitted to the restrictions of the rest cure, these women willingly surrendered control over their bodies to obstetricians and gynecologists. When twilight sleep presented itself as a potential alternative to suffering in childbirth, women were generally disposed to surrender control of their bodies to their doctors 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, in fact, were physicians themselves. Their writing did reflect 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.”¹⁹⁰ Ver Beck referred sarcastically to “the all-wise physicians” and triumphantly declared that under the auspices of the NTSA, women were finally voicing their own opinions.¹⁹¹ Nevertheless, when they could, the same women traveled to Freiburg to submit themselves to the care of the Frauenklinik’s “good doctors,” who

¹⁸⁹ Wood, “Fashionable Diseases,” 31-32.

¹⁹⁰ “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. See Leavitt, “Birthing and Anesthesia,” 163.

¹⁹¹ Ver Beck, *Truth about Twilight Sleep*, 47.

promised to “take care of everything.”¹⁹² 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.¹⁹³ 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 that the actions of the NTSA were so effective because twilight sleep was extremely appealing and because the activists worked from within existing medical ideology.¹⁹⁴ 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 ovariectomies. Twilight sleep, on the other hand, was a treatment women

¹⁹² Tracy, “Painless Childbirth,” 42; Boyd, “More about Painless Childbirth,” 59.

¹⁹³ Tracy, *Painless Childbirth*, 190.

¹⁹⁴ Leavitt, “Birthing and Anesthesia,” 160-162.

desperately wanted: a comfort, a miracle, a “bridge of dreams.” 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 met with more obstinate resistance.

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 historiographical argument that the twilight sleep campaign was really about nonprofessional, 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 basic 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 succeeded quickly and completely in convincing American specialists to use it. As a result of their work, childbirth moved from the home to the hospital, and 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.

CHAPTER V

CONCLUSION

Through their diverse positions as intellectuals, educators, physicians, and activists, women directly shaped the transformation that took place in obstetrics and gynecology during the late nineteenth and early twentieth centuries. They conducted significant research, taught ambitious students, attended complicated births, performed gynecological surgeries, and campaigned for access to effective treatments. Historians, however, generally ignore these contributions and depict women only as victims in the history of obstetrics and gynecology – a tendency that is neither wholly accurate nor particularly constructive. The villain-victim model overlooks significant female agency and oversimplifies complex medical history, neglecting some of the richest and most fascinating sites of conflict and convergence.

This project has shown that the participation of women in the academic, professional, and political worlds influenced the development of obstetrics and gynecology, and it has highlighted the fundamental conflicts that defined women's work in all three realms. Whether women were shaping medical curricula, performing sexual surgery, or organizing activist groups, they confronted many of the same debates about women's physical bodies and women's social roles. Chief among these conflicts were questions about gender difference and gender equality. Maternalists argued that women

should enter medicine because they would bring a uniquely feminine compassion and morality to the profession; others argued against the idea of feminine distinctiveness and contended that women should enter medicine because they were equally capable and equally deserving. These philosophical differences often affected the ways that women chose to practice obstetrics and gynecology, dictating their adherence to either “conservative” or “radical” principles. If maternalists traced women’s special qualities to their capacity for motherhood, after all, then it followed logically that women’s reproductive organs were somehow “sacred.” Ovariectomies and hysterectomies violated that sanctity, so maternalist thinkers often became conservative physicians. The reverse, of course, also held true: women who rejected the idea of inherent female difference often maintained, as Jacobi did, that there was “not such special sanctity about the ovary” and that motherhood was not the primary purpose of every woman’s life. These women tended to join the ranks of radical operative gynecologists.

A second key conflict in late-nineteenth- and early-twentieth-century obstetrics and gynecology involved the fundamental nature of the physical female body. Academics, physicians, and activists debated whether women were more fragile than men were, and, if so, whether that delicacy was innate or acquired. This discourse also carried significant race and class components, both explicit and implicit. Edward H. Clarke argued that women were inherently susceptible to nervous disorders and reproductive diseases, but he saw these tendencies as particularly problematic for women who pursued higher education -- a group that was disproportionately white and upper- or middle-class. He thereby appealed to professional and public fears of race suicide. Similarly, members

of the NTSA, who were also largely white and upper- or middle-class, maintained that “refined” women suffered more in childbirth than poor women and women of color did. They invoked the same fears of race suicide that Clarke had, suggesting that twilight sleep was both medically necessary and eugenically desirable.

Throughout the period, these conflicts also featured a significant connection between the physical body and the social world. Medical discourse about the nature of women’s bodies was directly related to political discourse about women’s appropriate roles in American society. This relationship was particularly obvious in the debate over Clarke’s *Sex in Education*. When Clarke argued that women’s bodies were innately fragile, he argued, simultaneously, that women should remain largely in the domestic sphere. By attacking either his theoretical premises or his scientific conclusions, opponents like Howe, Dall, Jacobi, and Brown defended the presence of women in the academic and professional worlds. In addition, operative gynecologists perceived a strong link between radical medicine and radical politics, often combining a defense of gynecology surgery with a commitment to women’s suffrage. The members of the NTSA, furthermore, carried out the campaign for twilight sleep in the public sphere while simultaneously reinforcing the traditional gender ideology that exalted motherhood.

Because women possessed considerable power – both “real” and symbolic – their participation in these conflicts frequently influenced the profession’s collective attitudes and decisions. Women physicians were outnumbered in the medical community, and they faced both professional discrimination and public prejudice; nevertheless, male physicians often looked to them to justify or dispute the acceptability of obstetrical and

gynecological treatments. Women activists faced the consolidation of medical authority; however, as consumers and campaigners, they exerted tremendous pressure on obstetricians and gynecologists to provide them with the kinds of care that they wanted. None of these women were exclusively victims. They consciously shaped the development of obstetrics and gynecology.

APPENDIX

GLOSSARY OF MEDICAL TERMS

amenorrhoea	the absence or cessation of menstruation. In primary amenorrhoea, menstruation never takes place; in secondary amenorrhoea, menstruation is established during puberty but then stops.
clitoridectomy	the surgical removal of all or part of the clitoris.
dysmenorrhoea	menstrual cramps caused by contraction of the uterus.
endometritis	inflammation of the uterine lining.
hysterectomy	the surgical removal of the uterus. The cervix is sometimes removed as well.
hysteromyomectomy	the surgical removal of a myoma.
laparotomy	any surgical procedure that involves the opening of the abdominal cavity.
leucorrhoea	vaginal discharge resulting from inflammation.
morphine	an opiate analgesic drug that acts directly on the central nervous system.
myoma	a benign uterine tumor, often called a fibroid.
neuralgia	pain that follows the path of specific nerves.
oophorectomy	the surgical removal of one or both ovaries.
ovariotomy	used to indicate either 1) the surgical removal of one or both ovaries; or 2) a surgical procedure performed on an ovary, as to remove a tumor.

ovaritis	inflammation of the ovaries.
parturition	the physical process of childbirth, involving the delivery of the baby and the placenta.
phlebitis	inflammation of a vein, often associated with blood clots.
prolapsus uteri	a condition in which the uterus slips from its normal position into the vaginal canal.
salpingectomy	the surgical removal of one or both Fallopian tubes.
scopolamine	a tropane alkaloid drug used for a variety of purposes, including as a depressant and as a supplement to analgesics.
symphysiotomy	a surgical procedure in which the cartilage of the symphysis pubis is split to aide a difficult childbirth. Symphysiotomy was sometimes performed as an alternative to Caesarean section.
vesico-vaginal fistula	a hole in the tissue that separates the bladder from the vagina, allowing urine to leak constantly into the vaginal canal. Fistulas result most frequently from prolonged, difficult childbirths.

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