Lying-In to Lying-Alone: The Loss of Women’s Autonomy in the Birthing Room

by

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Preface

As a Science in Society major, I spent my college career at Wesleyan University investigating the establishment and functions of scientific institutions, the production of scientific knowledge, and the application of scientific technologies to show how society, culture, and science are mutually constructing. My courses with that pursued these avenues of inquiry, in conjunction with my studies in the natural sciences provided me with both the technical and social perspectives of science studies. I would go back and forth between discussion based seminars that challenged the meaning and existence of “objectivity,” and examined how the general acceptance of scientific knowledge as fact establishes science as an institution of power and fortifies social perceptions of scientists as experts, and biology lectures that presented the material as incontestable, beyond the realm of question or doubt. The stark disconnect between the courses on my schedule left me considering how the application of science onto living, social bodies could have dire consequences. In other words, I began to recognize the potential danger of medicine if its practices went unquestioned and history unexamined.

On a personal level, women’s sexual and reproductive safety and health have always been exceedingly important to me. During my first year of college, I started a video campaign to combat sexual assaults on college campuses and victim blaming that caught national and international attention. It had always infuriated me that women are so often stripped of autonomy over physical bodies, and yet simultaneously held responsible for what happens to them. The intersection of my academic studies and my personal activism brought me to obstetrics. When and how
did doctors, who were all originally males, become the supervisors and directors of childbirth, which is inherently female, a process men cannot even undergo? How much reproductive autonomy did women maintain, if any, when and since this happened? Was the “safety” and “efficiency” medical care promises worth the loss of autonomy women inevitably experienced when men entered the birthing room?

My mother has recounted to me the day I was born countless times; on that chilly Friday, she started having back pains—she had contractions in her back with my sister too—and decided to take a long walk. She ended up at her doctor’s office who told her to get to the hospital “right away.” She rushed to the maternity floor of NYU Tisch Medical Center, but the obstetrician she’d been seeing throughout her pregnancy was not there—perhaps he was on vacation. A different obstetrician, a male doctor my mother had not met before, attended my birth instead. Unlike her long labor with my sister two years earlier, I was a fast delivery. “You wanted out of there,” my mother always tells me.

That always seems to be the moral of the story, the punchline—I, who relentlessly kicked and pushed on my mother’s belly throughout her pregnancy, was quick to emerge into the world after a simple walk through New York City. But I realized that there was another part of this birth story more noteworthy than the length of my mother’s labor. She saw one doctor, who urgently rushed her to a hospital where she expected to find the doctor who had been monitoring my development for the past nine months, but was instead passed on to yet a different doctor. Her birth was entirely medicalized, controlled entirely by medical personnel, some of whom were complete strangers. My mother has never called attention to or expressed
concern over this, and neither had I until recently. When did medical control of birth become the standard? Did the average parturient woman recognize that her reproductive autonomy had been taken from her, or had it become so normalized that she didn’t consider any other option?

My parents had chosen to keep my gender a surprise. I had previously never considered the power dynamics inherent in this choice, and if I had I probably would have thought that the option to make it was a privilege, perhaps an example of women’s control over their births. But now I realize that this “choice” is a product of doctors’ control over birth, and that the technologies that enable them to know something like the gender of a fetus before it is born creates the illusion of choice. In other words, it is not really the woman’s choice if the circumstances of that choice only arise because of doctors’ access to biomedical technologies that only they can operate. The illusion of choice can even be seen as a tool the medical institution deploys to keep pregnant women satisfied and to distract them from their loss of autonomy. I know this is a cynical view, and I by no means wish to disregard the many miracles of modern medicine in obstetrics and the countless lives that have been saved by obstetric innovations.

But these factors inspired me to conduct a critical analysis of the transformation of childbirth and reproduction in the United States from social events with histories of tradition into medical conditions. In my first chapter, I use the medicalization framework to interpret the history of obstetrics in the United States. Medicalization situates medicine as an institution of power and explains the process through which a social entity, natural human event, or state of being is defined in
medical terms, and cast as a condition requiring medical intervention. I employ it to illustrate the societal and cultural factors that shape the production and application of medical knowledge and technologies, and show why the social ramifications of this are particularly dire for the medicalization of childbirth and reproduction, and how the medicalization of childbirth resulted in the loss of women’s autonomy over their births.

My second chapter is an analysis of mass coercive sterilizations in the United States, focusing on the Madrigal v. Quilligan case of 1975-1968, in which ten, non-English speaking women of Mexican-origin pressed charges against a public hospital in Los Angeles and ten individual obstetricians who performed tubal ligations on them without their informed consent. This case is the most extreme example of the loss of female reproductive autonomy that resulted from the medicalization of childbirth, the formation of obstetrics, and the consequent (bio)medicalization of reproduction. I build on expand my use of the medicalization framework to include biomedicalization, which emphasizes technology’s increasing role in the medicalization process. I also use the intersectionality framework, and theories of eugenics and biopower. Intersectionality explains that social, hierarchical identities are formed under institutions of power and shows that individuals experience these power relations differently. Consequently, individuals have specific needs, demonstrating the dangers of generalizing the needs of an entire group of people, particularly a marginalized group, such as “all women,” without considering the vastly different oppressions and vulnerabilities different women experience in a sexist society based on their intersecting identities. Eugenics is a social-Darwin-inspired
ideology, and eventual social movement, whose aim is to eliminate the “unfit” members of a population, so that the “fit” members will thrive and reproduce. Eugenics functions under biopower, which is the governance of physical bodies and control of populations. It was in conjunction with obstetrics that the American government was able to execute their eugenic policies in the twentieth century. The two institutions of power recognized that the control over birth enables the power to control populations on an individual level, leading into an era of biopower.

These analyses illustrate that women’s loss of reproductive autonomy resulted directly from the medicalization of childbirth; though there were other contributing factors, they could not have stripped women’s reproductive autonomy if childbirth had not been medicalized. I use myriad sources, including feminist accounts of these historical events, doctors’ writings in scientific journals, diaries, and their statements in interviews or speeches; contemporary newspaper articles; affidavits and trial records; and interviews from a documentary.
Chapter One

Gender, Technology, and the Loss of Women’s Autonomy over Childbirth:
The History of Obstetrics

Introduction

Medicine was not yet a reliable practice by the nineteenth century; some of its foundational principles such as the germ theory, which introduced microbes into the medical sphere, did not emerge until the late nineteenth century, and it is generally estimated that in the United States, it was not until 1910 that physician intervention was more likely to help, rather than harm, patients.\(^1\) Nonetheless, medicine was endowed with scientific status, and physicians were seen as experts or at least scientists representatives.\(^2\) Their formal educations, which were exclusive to members of the elite, certainly contributed to these perceptions. Science had always held a secure place at the top of the intellectual hierarchy, and recent technologies that represented modernity and progress, particularly during the Industrial Revolution, instilled a newfound faith in its promise and potential. Public belief in the ability of science to advance society was not unfounded; technological inventions like the steamboat in the early nineteenth century, the telegraph and transnational railroad in the mid-nineteenth century, and the automobile in the late-nineteenth century had transformed society on a local and international level, and transformed the daily lives of the laity.

These developments also progressed the science community itself. This revolution in communication enabled rapid communication of ideas through newly found medical journals, which facilitated collaborative work provided a platform for debates over the validity and proper application of scientific developments. So after a socially, economically, and politically tumultuous few decades, the atmosphere among the white elite in America by the middle of the nineteenth century was optimistic, characterized by a drive for progress and a sense of potential and opportunity. As individuals, scientists were influenced by these cultural sentiments, which was enhanced by public faith in scientific developments to achieve this progress. Peter Conrad notes that social factors like these “rather than being explanatory, set the context in which medicalization occurs.”

Medicalization is a theoretical framework that describes the process through which an entity, such as a state of being, natural process, or a social event, is defined in medical terms and cast as requiring “treatment” through medical intervention. The medicalization framework recognizes medicine as an institution of power and social enterprise and, as is true under any institution of power, its subjects are controlled in different ways based on their social identities, which are defined by the institution itself. This means that medicalization is an uneven process; it can progress, regress,

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3 This would be true for anesthesia (whose emergence and significance will be explored later in this section), which was used in Scotland in an obstetric case just months after having been discovered by a dentist in the United States.
6 Ibid.
manifest extremely or mildly, depending on the social circumstances and the individual or population. Furthermore, Adele Clarke et al. define the process as *stratified*, noting that “even as technoscientific interventions extend their reach into ever more spaces, many people are completely bypassed, others impacted unevenly, and while some protest excessive biomedical intervention into their lives, others lack basic care.” That is to say, the technoscientific developments that make medicalization possible in a given social atmosphere affect populations and individuals differently based on the social order because of medicine’s function as an institution of power and the collective and individual authority of doctors.

Feminist scholars Catherine Kohler Reissman and Elianne Riska studied the gendered aspect of medicalization and found that women and female aspects of life have been disproportionately medicalized. Because the medical community was historically male-dominated, the sexist principles on which medicine was built and the tendency to pathologize female conditions are obvious upon examination. As Clarke et al. point out, the already present gendered power dynamics at play in any physician-patient interaction are notably exacerbated when what has been medicalized is inherently female. The difference between male and female approaches to childbirth is clear from the transition from the art of midwifery, grounded on empathy, tradition, and practical experience to the science of obstetrics.

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7 Ibid.
8 Clarke et al. 61.
10 Clarke et al. 123.
Obstetrics, which would be legitimized as a medical specialty in the twentieth century, did not form in a vacuum, but rather was the product of the medicalization process of childbirth that had been underway for the past century, when men’s participation in birth transitioned from surgeons with crochet hooks who only extracted fetuses presumed dead in compacted labors, to man-midwives with forceps who wanted to deliver normal births. The earliest incidences of medicalization were of behaviors or entities considered “deviant,” such as alcoholism or homosexuality. In many ways, the medicalization of childbirth was no different; physicians originally attended only complicated labors with tools designed specifically for this purpose. But soon after their development, physicians began using them on normal deliveries as well, rendering natural childbirth deviant and problematic in that it required or benefitted from medical intervention. As late as 1920, Joseph B. DeLee, a prominent Chicago doctor, published the following in the American Journal of Obstetrics and Gynecology:

Labor…is a decidedly pathologic process…If a woman falls on a pitchfork, and drives the handle through her perineum, we call that pathologic, abnormal, but if a large baby is driven through the pelvic floor we say that is natural and therefore normal…the cause of the damage—the fall on the pitchfork…is pathogenic—that is, disease-producing, and in the same sense labor is pathogenic—disease-producing, and anything pathogenic is pathologic or abnormal.

DeLee proposed that prophylactic measures should be taken on parturient women, and his main suggestion was the routine use of forceps for deliveries, something that had been shown as early as the late eighteenth century to be unnecessary and harmful.

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11 Ibid.
Yet, his proposal gained widespread acceptance, indicating physicians’ priorities were intervention and control, rather than patient well-being.

The first physicians to train specifically in midwifery with the intention of attending normal births were in London in the mid eighteenth century and called themselves man-midwives; only their gender, formal educations, and access to tools, specifically the forceps, distinguished them from the female midwives who had been the primary attendants of childbirth for millennia. These three points of difference, however, would prove incredibly powerful in the success of obstetrics, and the social impact of this field’s development.

But despite these helpful advantages, doctors first had to convince women to stray from their longstanding traditions and employ them instead, something they finally accomplished by the middle of the nineteenth century. Understanding how doctors overcame the obstacles that impeded their takeover of normal deliveries from midwives and the way the field progressed once they did, demonstrates the ways in which scientific developments and their application and social issues are mutually constructing. Physicians who attended labors worked hard to distinguish themselves from their midwife predecessors. The term “obstetrician” did not emerge until 1828, but was well in use by the middle of the nineteenth century. Wertz and Wertz point out the significance of this: “The renaming of the practice of midwifery symbolized doctors’ new sense of themselves as professional actors. In fact, the movement toward greater dominance over birth’s natural processes cannot be understood unless midwifery is seen in the context of general medical practice.”

The early stages of the medicalization of reproduction involved doctors casting childbirth as an inherently dangerous condition that required medical treatment. Their aggressive campaigning of this idea understandably ignited immense fear in women and concern over their own well-being and that of their child. That is not to say women had no anxieties about childbirth before medicalization—fear of childbirth pain, birth complications, and being rendered physically debilitated had always been present. Doctors, despite having never experienced it themselves, emphasized that the agony of childbirth was unbearable. They promoted the theory that birth was more painful for the modern woman than our predecessors because of the development of the neocortex—the thinking brain—which is sensitive to pain and discomfort, which made the argument seem scientific and credible. Physicians emphasized the inherent dangers of childbirth and its unbearable agony to present them as necessary actors to end this “suffering,” a feature of medicalization.

Women believed physicians had the answers to a safer, less painful birth because of their prestige as formally educated scientists. This increased their power and authority, giving doctors not just control over women’s processes, but the discretionary autonomy to decide which patients deserved which kind of care.

But if childbirth really had become more painful, physicians themselves were contributors. The forceps, though if applied properly were capable of successfully delivering complicated labors, were often used carelessly and caused internal

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14 Ibid.
lacerations to the woman’s birth canal and trauma to the fetal head. But even though the ‘hands of iron’ symbolized fear, pain, and discomfort, women were understandably relieved that in the case of complication, there was a solution.¹⁷

Physicians had been promising women that they could relieve them of labor pain and ensure a safe, efficient birth since their earliest involvement in normal deliveries. With the advent of anesthesia in 1846, painless childbirth was finally possible (though wildly unsafe), and with this medical innovation, doctors had officially established themselves in the childbirth realm. From this point on, the field continued to develop into a science, and eventually “obstetrics” emerged from man-midwifery. Once this happened, medicalization of childbirth was impossible to hinder, and women continued to lose autonomy. But because doctors had inspired such fear in them and flaunted the prestige society endowed them with, women were originally optimistic about this medical attention. As Judith Leavitt points out, “Physicians carried with them the status advantages of their gender and of the popular image of superior education. Furthermore, birthing women perceived that the male presence had already contributed anesthesia and forceps to obstetrics and promised even greater benefits in the future.”¹⁸

In this chapter, I conduct a historical analysis of obstetrics in America, addressing how childbirth went from a social event with only female participants, to a medical condition treated in the maternity wards of hospitals, and the social factors that impeded and fostered this process. I split my analysis into four sections. The first,

¹⁸Ibid., 284.
Childbirth in Seventeenth- and Eighteenth-Century England, describes the birthing process when it was a social event and female ceremony. I situate this analysis in England because this is where man-midwifery originated and most early American doctors trained there. The second section, Midwifery in Seventeenth- and Eighteenth-Century England, outlines the role of the midwife as primary birth attendant, and demonstrates their vast range of knowledge, which is often underestimated in historical analyses. Again, the English context provides insight into the situation in the United States, because the early American midwives were English immigrants and took from their traditions. The third, Sexism, Technology, and Medical Education: Surgery, Forceps, and Man-Midwives, explores the original role of physicians in childbirth, and traces how this changed with new technologies and pervasive gendered cultural attitudes as medicalization progressed. The last chapter, The Social Climate in the United States Post-Hospitalization of Childbirth, analyzes the transition from home births to hospital births and the social and medical factors and consequences of each. These sections come together to illustrate that the medicalization of childbirth resulted in the absolute loss of female autonomy over their childbirths and eventually their reproduction as doctors’ discretionary power and control rose in its place.
Childbirth in Seventeenth- and Eighteenth-Century England

For centuries, childbirth resided in an exclusively female domain. But childbirth encompassed much more than just the event itself; it was a series of traditions and rituals that comprised a women-only ceremony. In seventeenth-century England, as in many other places, pregnancy was not always a woman’s choice, but rather her duty to her husband, her family, and to ensure her social standing as a true woman. Children helped confine women to domestic affairs, perpetuating the conception that their purpose was to serve their husbands, care for his children, and make him a nice home. During childbirth, though, and the month that followed it, women were liberated from these duties; their bodies were their own.

Not even husbands were allowed in the lying-in chamber, the room in a woman’s home where she would give birth. Instead, women would deliver surrounded by their closest female friends, neighbors, and family members. They may not have had pain medication, but they had an everlasting supply of emotional and physical support systems, all female, who could relate to their experience with compassion, empathy, and love, as well as practical experience. Giving birth was a social event, a gathering open only to those most comforting to the parturient women,

20 Ibid., 29.
21 Studies in the twentieth century found that in the presence of other women during birth, parturient women release oxytocin, the hormone that regulates postpartum contractions and enhances initial mother-infant bonds. (Kara Maria Ananda, *The Sacred Nature of Birth: Natural Wisdom for Conscious Birthing* (USA: Conscious Birth Emissary Project, 2012).
all of whom understood the liberatory significance of being able to lock one’s husband out of a room and having him comply. It was empowering, even when it was painful.22

The lying-in period, a month-long recovery period for new mothers, had even more significance for women and social character of childbirth. Throughout this period, women remained in the confines of their lying-in chambers with only their newborns and the females who attended their births. These women were originally named “God-sibs” as they would be present for the baby’s baptism, but eventually became known as “gossips.”23 In a submission to the journal *The Women’s Advocate*, a woman described the importance of this period: “‘...’tis a time of freedom, when women...have a privilege to talk petty treason.”24 Their husbands were still not allowed to see them until the final week of the lying-in period when they would emerge from the chamber, remaining in the house until the end of the month. If they were religious, they may have participated in something called “churching,” a tradition in which new mothers would thank God for their safety during childbirth and their babies would be baptized. Baptisms in the early eighteenth century were postponed until after the lying-in period so mothers could attend this churching ritual.25

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23 Ibid., 25.
25 Ibid., 27.
How was enduring the agony of childbirth and being locked in a room for a month afterward considered liberatory? Gender norms, and even laws, in late seventeenth and early eighteenth century England rendered women as property under marriage, which was “a contract of inequality,” that stated, “the husband owned the wife’s worldly goods, her physical labour and its fruits, and her sexuality.”

At birth, women were their father’s property, and they remained so until they became that of their husbands. If and when to procreate was not their choice, nor was the decision to participate in sexual intercourse in general. While they were confined to the lying-in room, their husbands, also, had to abstain from sex. During the birth and the month following it, there was nothing husbands could do to regain control over their bodies.

One seventeenth century man even wrote a letter to a friend expressing his yearning for “‘a man’s society’” during the lying-in period.

To stall this contract of inequality for a month, particularly an incredibly emotional month, and to instead be surrounded by the support and protection of female loved ones, situated the mother in a “female collectivity” which “inverted the conjugal relation of individual male property...through the ceremony of childbirth women secured a period of rest and recovery, and they kept childbirth under their own collective control.”

Women of all backgrounds participated in the lying-in ritual though, of course, the availability of the lying-in room in the house, and thus

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26 J.H. Baker, An Introduction to English Legal History, 2 ed. (London 1979); Ibid., 29.
29 Ibid., 29-30.
the duration of the recovery, varied according to class.\textsuperscript{30} Not only were these women free from their husbands and domestic duties for however long their recoveries lasted, but they had control over their own bodies, during the birth itself and after. And this control was ensured by the company of other women, who too understood the significance of childbirth. Not only was the birth itself shared between them and the women they trusted, but so was the period after. Before medicalization, childbirth was not simply a women’s issue, or was it only a social issue, but rather a ceremony that empowered a birthing woman and her loved ones to invert their gender obligations under a patriarchal society, and find autonomy over their own bodies and empowerment in the domestic sphere.\textsuperscript{31}

\textit{Midwifery in Seventeenth- and Eighteenth-Century England}

That childbirth was primarily a social event, filled with female ceremonies and rituals, did not mean that there were no participants specially trained to tend to the birth process itself; that role was filled by the midwife. Delivery of the baby was not her only role, though. She was an essential member of social traditions of childbirth prior to medicalization, and the other social actors in the ceremony, the gossips, were essential to her practice. If it were not for the midwife, the gossips could not fulfill their ceremonial role, and if it were not for them, the midwife could

\textsuperscript{30} Ibid., 28.
\textsuperscript{31} Carroll Smith-Rosenberg, "The Female World of Love and Ritual," \textit{Signs} 1, no. 1 (1975).
not perform her deliveries; it was a communal process. However, as the primary
overseers of the birth, midwives were the leaders of the pack. When a woman’s
female company arrived for her birth, the midwives, who were confident and often
had “strong characters,” told them how to prepare and proceed.\textsuperscript{32}

When a woman’s labor was approaching, her husband, in a process known as
“nidgeting,” would summon her female friends, neighbors, family members—the
gossips—and the local midwife to their home. Upon arrival, the women would hurry
into the designated lying-in chamber, leaving the husband outside where he would
remain until her month-long recovery period following her birth was complete.\textsuperscript{33}
Inside, the gossips and midwife made swift, purposeful preparations. Upon blocking
out all the light in the room and ensuring that no outside air could infiltrate, they lit
myriad candles. Later, in the late nineteenth century, darkness during childbirth
would be “scientifically discovered” as a way to prevent eclampsia, but these women
trusted their own experiences to know the technique was effective. In other words,
their techniques were established because “women had worked out what was best for
them.”\textsuperscript{34} Some of the gossips would prepare caudle, a hot wine with spices that was
thought to have pain relieving properties. Other concoctions of natural herbs were set
aside, clean linens were laid down, and various stones thought to have healing and
spiritual properties were placed around the room. Lastly, sharp tools for cutting the

\textsuperscript{32} Wilson, \textit{The Making of Man-Midwifery}, 31.
\textsuperscript{33} Ibid., 25.
\textsuperscript{34} Ibid., 29.
umbilical cord and various other instruments whose purpose might be of use were prepared, alongside alcohol for cleansing purposes.35

The midwife, with the help of one or a few competent gossips, including the ones who would cut the umbilical cord, gave instructions to the expectant mother and together they monitored her progress, while the others tended to her emotional needs, providing humor, light-hearted conversation, encouragement, or comfort in their very presence.36 These women had often given birth themselves, and they were sources of empathy and compassion for the laboring woman. Sometimes, she herself would have been present at one of her gossip’s previous births. It was a system built on mutual support and female solidarity.37 Those present who had not yet given birth themselves gained enormous experienced from partaking in these traditions, preparing themselves for what to expect in their own deliveries and mitigating natural anxieties surrounding first birth.

The midwives were vital to this support system. They were often referred to as “grace-wives” because the fee they charged for their services, though always small, varied per the family’s class. Janet Bogdan describes the work of a midwife as “a calling rather than just a job or source of income,” for midwives rarely turned down a woman’s call even if she was expecting to hear from someone who ensured more pay.38 This remained true of midwives of all time periods and all cultures.39 In her

35 Ibid.
36 Cassidy, Birth, 26.
38 Janet Carlisle Bogdan, "Notes from a Midwife’s Diary," Graduate Woman 74, no. 1 (1980).
39 Cassidy, Birth, 28-9.
diary, an American midwife in nineteenth-century America, Betsey Ingraham, wrote that childbirth was “a journey” she wanted to help “smooth” for women. She considered herself “serving humanity” by “[pitying] the poor ladies and [wishing] them out of their trouble.”

Grace-wives and gossips tended to the woman long after her delivery. Midwives would help fulfill domestic roles while the new mother could not, cooking for her and her family, and cleaning her home, until her lying-in period was complete. In the cases that fees could not be paid, midwives would accept these favors in return as payment. Their participation in these rituals was especially important for they also had the postpartum knowledge needed to ensure the mother and her newborn were recovering properly, ready to intervene whenever was necessary. Furthermore, midwives were known for their self-sufficiency and confidence, something that gained their respect from the women, so much so that they were often called upon to keep women company during their pregnancies, as confidantes for women’s problems, and generally considered “women healers.”

Midwives earned their reverence and maintained their invitations into family homes for extended periods, not to mention their practice which had lasted for millennia, because of the work they did during childbirth, work that would be contested, attacked, and eventually abolished by doctors with the onset and progression of medicalization. A major target of these attacks was their method of

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40 Betsey Ingraham, quoted in Bogdan, *Notes from a Midwife’s Diary*, 20.
training and transferring knowledge, for, unlike medicine, midwifery lacked formal training programs and institutions. Instead, midwives relied on experience, observation, and “by deputy,” apprenticeship traditions typical of England in the seventeenth and early eighteenth centuries. Their methods were passed down through generations and compassion. When midwives are written off solely for not having had formal training, it is implied that their techniques were simply improvisational, and undermines the medical benefits of female company during childbirth. Furthermore, oversimplification disregards the ability of midwives to collaborate on their experiences and create a compilation of methods that could be meticulously passed down from mentor to apprentice.

Although men must have generally accepted the midwife’s role—she clearly persisted throughout centuries—it is clear why, under patriarchy, their control was challenged. Since the use of early obstetric tools for dead deliveries was the only thing keeping men in the realm of childbirth (which will be explored in the next section), and most contemporary records of midwifery were written by men, it is clear why few indicate that midwives knew how to operate them. It also indicates their limited access to them and men’s capital over them. For oftentimes, multiple midwives would be called to a house in the case of a complication before a surgeon would be, something that deeply aggravated some male surgeons who felt potential

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44 Ibid., 31.
46 Ibid., 29.
business was being taken from them and, more upsetting to the doctors, signified the persistence of women’s control over the birth process.\(^{48}\)

As Wilson illustrates, “The popular ceremony of childbirth both reflected and helped to maintain a collective culture of women. That culture conferred on the midwife her authority over the birth; conversely, in exercising her office she confirmed and maintained women’s collective control over this, the pivotal events in their lives.”\(^ {49}\) This is why some men made it their priority to develop these tools, their potential applications, and keep them out of women’s reach. For, because they had formal education on their side, these tools gave them a claim to science and progress, something that would carry them throughout the medicalization process.

Jane Sharp’s *The Midwives Book*, written in London in 1671, provides one of the best sources of evidence for the actual techniques used by midwives. I use it to demonstrate that the capacity and skill of midwifery practice as early as the late seventeenth century were much more sophisticated than is often recorded. That is not to say that every midwife was qualified to be practicing or skilled in these methods. Sharp, whose writing style is punctuated with Old English trends, opens her text with a call to her fellow midwives that proves this point: “To the Midwives of England: Sisters, I have often sate down sad in the Consideration of the many Miseries Women endure in the Hands of unskilful Midwives; many professing the Art (without any skill in Anatomy, which is the Principal part effectually necessary for a Midwife) meerly for Lucre’s sake.”\(^ {50}\) This small passage is noteworthy for a number of reasons.

\(^{48}\) Ibid., 36-7.
\(^{49}\) Ibid., 38.
\(^{50}\) Sharp. *The Midwives Book*, preface.
For one, it confirms that midwives were, in fact, aware that unqualified practitioners all too often partook in their practice, to the detriment women. Secondly, her characterization of midwifery as an art is a clear marker of the pre-medicalization era, for this is at odds with its conception as a science, a status marker that doctors would later use to advocate for their services over midwives’. However, Sharp also stresses that an understanding of anatomy, a scientific field, is a prerequisite to practicing midwifery. Although midwifery would later be dismissed for its ignorant, unscientific, untrustworthy nature, this short passage indicates that midwives understood their practice’s shortcomings, understood that scientific study was necessary for the field’s success, but still qualified it as an art, a natural process rooted in mutual understanding, empathy, and compassion. Her claim that women were joining the field for “Lucres sake”—that is, for profit—demonstrates the limited opportunities available for women to make a living. Her claim, then, is like those that would be made during medicalization—midwifery needed improvement, needed better educational systems. But this did not mean it needed to be co-opted by doctors.

One chapter in the text is entitled “Of the resemblance, or likeness, of Children to Parents,” implying an early attempt to understand genetics, which dominated contemporary obstetrics. Another chapter, “Of the sympathy between the Womb and other parts,” directly opposes the idea of the women’s body, particularly her pregnant body, as a machine, rhetoric which would dominate throughout medicalization. Instead, it emphasizes that comprehensive care encompassed the whole being. Other chapters range from fetal development, to anatomical explanations, to potential sources of infertility. There is also a focus on pre-natal and
post-natal care, all subjects that are often thought of as products, not predecessors, of medicalization, indicating the misrepresentations of midwifery during medicalization and even now.

This text continues to debunk many misconceptions of midwifery perpetuated in historical texts and by medical rhetoric throughout medicalization. Many doctors would go on to criticize midwives for their inability to recognize the importance of a *theoretical* understanding of their practice, for their training was purely *empirical* and they were too stubborn to pursue any other form of education or training.\(^{51}\) Sharp disproves this point, saying that both a “speculative” and “practical” understanding of midwifery is essential for qualified practice. She makes the point that even though only men have access to the speculative side of childbirth, women make do because childbirth is *inherently* the women’s domain:

> Some perhaps may think, that then it is not proper for women to be of this profession, because they cannot attain...knowledge of things as men may, who are bred up in Universities, Schools of learning...where Anatomy Lectures being frequently read, the situation of the parts both of men and women, and other things of great consequence are often made plain to them. But that *Objection* is easily answered...the holy Scriptures hath recorded Midwives to the perpetual honour of the female Sex...it being the natural propriety of women to be seeing into that Art: and though nature be not alone sufficient to the perfection of it, yet farther knowledge may be gain’d by a long and diligent practice, and be communicated to others of our own sex...even in our own Nation, that we need go no farther, the poor Country people where there are none but women to assist, the women are as fruitful, and as safe and well delivered, if not much more fruitful, and better commonly in Childbed than the greatest Ladies of the Land.\(^{52}\)


And despite her point that this theoretical education was inaccessible for many women, which was used against them, she goes on to demonstrate her own anatomical understanding. The following is her explanation of the umbilical cord’s anatomy: “The Navel-string is twisted that it might be the stronger, and that the blood by that delay might be better prepared; had the Vein in the Navel, or the Arteries...been single, the different postures of the child in the womb, or the difference of the womans standing, sitting, or lying, might press a single vessel, and stop the passage of the blood in the Vein...but the twisting hath prevented that.”

Not only does she have this anatomical knowledge, but she knows how to apply it—through her understanding of the structure of the umbilical cord, she knows it is safe to allow women to be in whatever labor position is comfortable for them as individuals. Explicitly regarding labor positions, she makes the following point: “It also furthers her understanding, common to all midwives, that women experience birth very differently, and that having rigid protocols could be dangerous.” She advises her fellow midwives to “Take notice that all women do not keep the same posture in their delivery; some lye in their beds, being very weak, some sit in a stool or chair, or rest upon the side of the bed, held by other women that come to the Labor.” This indicates that the job of the midwife was to help the birthing woman to choose a position comfortable for her, even if inconvenient for the midwife, and to only intervene if she chose a position she knew to be unsafe for the delivery. This

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53 Ibid., 163-4.
54 Ibid., 153-4.
also demonstrates how the purpose of the gossips exceeded emotional support, and that the birth process was a female collective.

As if this is not enough to prove that women indeed had the qualities and skills doctors claimed they lacked, Sharp goes on to present an impressive array of knowledge about birth itself that has clearly been formulated through both practical experience and an understanding of the anatomy. Even though she attributes childbirth pain to Eve’s sin, she explains its mechanisms anatomically: “the womb that hath many nerves and Sinews, by which the body feels, is strait till time of delivery, and then it is stretched, which causeth great pain; and some women have more pain in bearing than others have, because some womens passages are narrower, and they wombs more full of Nerves as Anatomy will show.” She attributes cold temperatures to more painful births because it shuts the womb, and she stresses the import of diet and lifestyle: “for sower and binding things will straiten the Orifice of the Matrix...sweet scents cause hard delivery, because they draw the martix upward; too much hunger or thirst, weariness...will produce the like painful effects.” Her claim that “the postures [of babies] are so many and strange that no woman Midwife, nor man whatsoever hath seen them all” implies the number of births she herself has attended, and the collaborative effort of this comprehensive text.

But one of the most noteworthy parts of this text are those that directly challenge doctors’ original tactic for distinguishing themselves from midwives: their inability to use tools needed for complicated births. Sharp demonstrates that

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55 Ibid., 167-8.
56 Ibid., 133.
57 Ibid., 130-1.
midwives did not use the tools for complicated births because they were denied access to them and their proper instruction. Even so, the original role doctors played in childbirth was to extract babies already presumed to be dead or those needed to be sacrificed to save the mother; the tools to carry out a successful delivery from a complicated labor had not yet been developed. Considering that it was the development and mastery of tools that did enable live deliveries, mainly the forceps, ignited medicalization, Sharp’s section on the use of instrumentals for dead deliveries is particularly striking. First, she provides instruction for detecting the signs that the baby may be dead in the womb, starting “when the Breasts suddenly hang down slack, Nature makes no Milk or provision for them, for there is no reason she should. Secondly, she is cold all the belly over, chiefly the Navel. Thirdly, her water is thick, and hath a stinking substance that falls to the bottom. Fourthly, The Child moves not though you wet your hand in warm water and rub it over the belly which is a true trial, and it will stir if it be alive.”

Sharp provides numbered instructions for extraction performed by midwives. First, she instructs the midwife to sit the woman with her abdomen pointing in the air, to lubricate her hands, and push it into the womb to see if the baby could be extracted by hand, or to determine if tools were necessary. Should they be necessary, Sharp advises bearing in mind the position of the child determined in the last step, to use a crochet, an early obstetric hook, to clamp onto the baby and pull. If that doesn’t work, she advises using a surgical knife to delimb the baby pull it out piecemeal. If that too does not work because the head is in the way and too big to descend the canal, she

58 Ibid., 145.
advises to “put in your hand, holding a sharp incision knife between your fingers, and so cut open the head...you must divide the skull and take it out by pieces with instruments for that purpose.”

Though these techniques appear gory and vulgar, they were even less extreme examples of what was practiced by the surgeons who would be called to these failed births. Unlike many physicians after her, she admonishes the potential danger of these instruments, and encourages their use only in extreme cases, and with most gentle care. Furthermore, she warns against trying to hasten the natural course of birth with these instruments, or any other technology: “I shall desire all Midwives to take heed how they give any thing inwardly to hasten the Birth, unless they are sure the Birth is at hand, many a child hath been lost for this want of knowledge, and the mother put to more pain than she would have been.”

Though childbirth pain continued to play a significant role in medicalization, doctors would stress that childbirth itself, and not their tools, was the source of the pain.

Before medicalization, childbirth rituals were “constructed and maintained by women because it was in the interests of women.” Furthermore, women attended each other’s births out of their own choice; it was both natural and more comfortable. As Wilson concludes, this “authority over birth” that midwives had ran “against the normal distinctions of rank and status.” Unfortunately, this is the exact reason the interest in childbirth increased in male physicians in the late seventeenth century.

59 Ibid., 149.
60 Ibid., 159.
61 Wilson, The Making of Man-Midwifery, 29
62 Ibid., 31.
Surgery

The first doctors to attend childbirths had no intention of replacing female midwives; they were supplemental to her, actors whose only roles were during emergencies. 63 These men were surgeons, sometimes even called “barber surgeons” or “butchers,” for it was their tools, and not their own credibility as doctors, that defined them. 64 The scope of medicine in the late seventeenth century was limited. Bloodletting through leeches was still considered a routine practice for fighting off infection and fever, and the field was still fighting for recognition as a science. Surgery was no exception; unlike today, it was one of the least regarded fields of medicine. 65 Their only claim to their titles as doctors were their tools, which they themselves were the primary developers of well into the nineteenth century.

Calling a surgeon was considered an absolute last resort, by women, midwives, and surgeons alike. 66 The only role of the early surgeons who were called to childbirths was to extract a baby already presumed to be dead or, in some cases, undeliverable—one who needed to be sacrificed to save the mother’s life. 67 Although Sharp’s manual implies that midwives could use the tools to perform these extractions, their access to them was limited, and they often relied on makeshift instruments. Sometimes as many as four midwives would be called before a surgeon

63 Ibid., 47.
64 Cassidy, Birth, 131.
65 Wilson, The Making of Man-Midwifery, 47.
66 Ibid., 49.
67 Ibid., 50.
was summoned. This reflects what men’s participation in childbirth signified to women before medicalization: that their lives were in danger and that their child had already died or would be killed and extracted through gory, excruciating procedures.68

The most common complication encountered was obstruction of the birth canal by the baby’s head, something that, based on the limited scope of instrumentation and surgical procedures, had only one solution: the craniotomy. This was a procedure through which the fetal head was severed, before being pried out with a crotchet hook while the woman lay restrained with her cervix pried open. Sometimes, the doctors would decide to let the fetus “disintegrate” before performing the operation.69 Even the surgeons admitted to the horrors of this procedure. One early surgeon, James Cooke, said the following: “I shall conclude this dreadful operation with that saying of Sennertus...which amounts to this, that women will seldom or never admit of these operations, but rather submit the business to God, and Nature.”70 Fear of birth came to be associated with these instruments and procedures in the instance of complication, not the delivery itself. But this protocol was standard, pervading all class lines—in the case of a believed fetal death, a surgeon would be called to extract it. Sometimes this would happen days later, due to women’s fear, so that by the time the doctor arrived, she too would be close to death.71 Although sexist attitudes of course prevailed, surgeons accepted the scope of their participation in

68 Ibid., 48
69 Cassidy, Birth, 133-4.
71 Wilson, The Making of Man-Midwifery, 50.
childbirth. One seventeenth century surgeon, Percivall Willughby, complained that “midwives will follow their own ways, and will have their own wills,” but nonetheless accepted that they were the rightful primary birth attendants.\(^{72}\)

Occasionally, doctors would attempt cesarean sections at the encouragement of the Church, who argued that one did not have the right to sacrifice a child for the mother because doing so left that child in purgatory, having not been baptized before its death.\(^{73}\) But this technique, though it had been attempted for many years—it is even made reference to in Sharp’s manual—had a very low success rate; the mortality rate was still as high as fifty-six percent in the late nineteenth century.\(^{74}\) Midwives were opposed to this technique—it was their job to tend to the lives of the mother. For surgeons, attempting cesareans provided a training opportunity, and a chance to further demonstrate their mastery of their tools.\(^{75}\) Increased use of instruments, in turn, only increased women’s fears of difficult labors.

This fear worked in both ways. A trend began in the late seventeenth century of calling doctors in advance, or “onset,” so that they could be there immediately in case a complication arose. Still, seventy percent of surgeon calls were emergencies.\(^{76}\) This trend was exclusive to the upper class, as it required a fee, and occurred when the woman delivering had reason to believe her birth might be difficult. That is, although calling the surgeons meant craniotomies and using the crochet, the sources

\(^{72}\) Percival Willughby, *Observations in Midwifery* (London: Shakespeare Printing Press by H.T. Cooke and Son, 1670); .

\(^{73}\) Cassidy, *Birth*, 150.

\(^{74}\) Ibid., 151.

\(^{75}\) Willughby. *Observations in Midwifery*, 22-3.

\(^{76}\) Wilson, *The Making of Man-Midwifery*, 49.
of dread among mothers, these “fears effectively conspired with the material circumstances—the bodily processes of birth, the prevailing arrangements for its management, and the available technology—to produce a self-perpetuating system.”

But even so, there was a ninety-eight percent normal birth rate at this time; doctors who were called in advance, more often than not, waited in a room nearby the lying-in chamber and, upon being informed the birth was progressing normally, left the rest to the midwife.

Willughby’s “paradoxical” perception of midwives perfectly demonstrates the relationship between early surgeons and midwives. While he and his fellow doctors thought of midwives as inferior for their lack of formal training and their gender, and doubted their “technical skills,” there was a deep-rooted respect for their work and their status. The surgeon was called to save the life of the mother by performing a dead delivery, and the midwife had the job of saving both—her domain was the normal delivery, the live birth, which required no surgical intervention. This can be understood as the desire of surgeons to keep access to surgical tools exclusive and to preserve their titles as doctors, whereas normal midwifery could remain a mere “art.” Willughby, then, advocated not for an expanded role of male practitioners in childbirth, but rather had a “Hearty wish that some public good order might be made for the better educating of all, especially the younger midwives.”

77 Ibid., 50.
78 Ibid., 52.
79 Ibid.
80 Willughby. Observations in Midwifery.
Many early surgeons shared his view, but there were some dissenters who wanted to expand their participation in childbirth—they wanted to deliver live births. For this reason, Willughby, and many of his contemporaries, hated men who tried to step into the midwives’ territory, viewing it as a transgression of social boundaries.\(^{81}\) Live births were for midwives, and emergencies were for surgeons. Despite his opposition, the emergence of men who strove to find a bigger role in childbirth would only increase. These men, who called themselves man-midwives, cropped up almost immediately after forceps became accessible to male surgeons. Suddenly, doctors were capable of carrying out live deliveries using tools only they, and not midwives, had access to.\(^{82}\) They were thus able to perform the midwives’ role using technology that reinforced their statuses and titles.

Forceps and the Man-Midwives

When childbirth was still an exclusively female ceremony, all live births were attended by midwives. Doctors, who were invariably male, were only called to deliveries to remove fetuses who were presumed dead or who, because of their orientation obstructing the birth canal, needed to be sacrificed via piecemeal extraction to save the mother. These doctors were characterized by their instruments, for operating was their sole purpose—they were surgeons. These tools were intentionally destructive, like the crochet, which was used to puncture the skull so it

\(^{81}\) Wilson, *The Making of Man-Midwifery*, 52.
\(^{82}\) Ibid., 53.
could be removed bit by bit. Doctors accepted that their participation in childbirth was confined to dead deliveries, and that all “normal” births, where the baby and mother could be expected to live, were the midwives’ domain.  

This changed, however, with the development of an instrument that could be used to save the baby in complicated deliveries: the forceps. They were invented in the 1620s by Peter Chamberlen, who was part of a family of practicing surgeons in London. Along with the instrument, which had curved blades to fit the birth canal, they mastered its application for successful deliveries in complicated labors. But despite this significant discovery, which would have saved the lives of many newborns and prevented emotional devastation and trauma of their mothers, the Chamberlens kept their forceps a family secret so they alone could profit off of its benefits, providing early evidence that, unlike female midwives, doctors’ intentions were not always in the mothers’ best interests. It was not until two generations later 1673 that Hugh Chamberlen made a public statement that even in labors in which the fetal head obstructed the birth canal, which was traditionally reason for a craniotomy, his family had “long practiced a way to deliver women...without any prejudice to them or their infants.” But even then, he did not disclose the method: rather, he “[offered] an apology for not publishing the secret I mention we have to extract children without hooks” because he “cannot esteem it my own to dispose of, nor publish it without injury to [his father and two living brothers].”

83 Ibid.
85 Ibid.
As a late nineteenth century physician noted, “what really seems to have been the cause of transferring the practice of midwifery from women to men, was the invention of the midwifery forceps.” But, as we see from how long the Chamberlens kept their family secret, it was not the invention alone that enabled this transfer of power; only by the 1690s did practitioners across Europe gain access to the instrument. Moreover, even surgeons who did have access to the forceps did not know how to apply safely. This would be a recurring trend throughout medicalization: the development of a technology itself is not sufficient for its success. It must be accompanied by widespread access and detailed instruction for its proper, necessary, and safe application. It was not for another forty years, and after many lives had been sacrificed in the experimental process, that surgeons would begin to grasp this safe usage. Once they did, medicalization would be underway.

This tool and its proper technique, once mastered, was the founding principle of man-midwifery, the first childbirth specialty to be incorporated into the medical curriculum and the first opportunity doctors (men) had to deliver normal births and maintain their distinction from midwives. The first man-midwifery courses, exclusive to men, were taught in London by William Smellie, who had been practicing as a surgeon, performing only dead deliveries, when he heard of the forceps in 1737. At first he was apprehensive, for most physicians still could not

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88 Ibid., 72.
89 Ibid., 74.
90 Ibid., 85.
operate them and did not know the appropriate circumstances for their use.\textsuperscript{91} For instance, he was introduced to the forceps by a surgeon in Paris who instructed him and his pupils to use them “‘at random, and [to] pull with great force,’” a technique that guaranteed serious injury to the mother and fetus.\textsuperscript{92} But by the time he began his lectures in 1740, he was confident in their potential, and sure of his own skill in using them safely.

Smellie was the original member of what I call the \textit{first generation of man-midwives}. He, along with approximately 900 students who took his courses within his first decade of teaching and who would then go on to teach their own man-midwifery programs, had no intentions of replacing midwives. Smellie was a strong believer that the gender of the practitioner was less important than their knowledge and skill.\textsuperscript{93} Their goal was to train male practitioners in the use of forceps to deliver live births in difficult labors, and to keep midwives in control of normal births.\textsuperscript{94} This is not to say that he and the other first generation man-midwives did not criticize and think that female midwives were inferior; but rather than advocate for their abolition, as the succeeding generation would, they proposed programs to formally train them (though it is important to note that these courses actively excluded forceps instruction). Though these proposed programs failed in England, as would be the case with later attempts in the States, most likely due to the high fees of the courses and the fact that midwives were loyal to local groups of women in a tradition of self-help, rather than

\textsuperscript{91} Ibid., 72, 164.
\textsuperscript{92} Alfred McClintock, \textit{Smellie’s Treatise on the Theory and Practice of Midwifery} (London: The New Sydenham Society, 1876).
\textsuperscript{93} Wertz and Wertz. \textit{Lying-In: A History of Childbirth in America}, 44.
\textsuperscript{94} Wilson, \textit{The Making of Man-Midwifery}, 163.
to a culture of formal education, these efforts are significant. As medicalization progressed, these attempts to include midwives in childbirth would cease.

Another characteristic of first-generation man-midwifery was their non-interventionist approach to childbirth. Though their lessons centered on the use of forceps, extra emphasis was placed on the fact that their use was in emergencies only. Originally, this was because they had only been tested in cases of difficult labor. But when Smellie discovered that forceps could be used in normal deliveries to rotate the fetal head as it descended the birth canal, and incorporated this technique into his lectures, he saw a spike of forceps use in his students’ deliveries. Many of these students, however, were highly unskilled—despite Smellie’s meticulous instructions of forceps use, he often demonstrated on a mannequin, and many of his pupils graduated without having witnessed a difficult labor or any labor. By 1748, then, he recognized both the dangers of frequent use of forceps and the consequent fear they caused women in labor, and stressed even more that their use should be a last resort.

In his 1752 publication, “Treatise on the Theory and Practice of Midwifery,” which was the first man-midwifery text, he even instructed practitioners to conceal the forceps from the mother when their use was necessary. He suggested techniques “without their being perceived by the woman herself or any other of the assistants” because “as women are commonly frightened at the very name of an instrument, it is advisable to conceal them as much as possible, until the character of the operator is

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95 Ibid., 164.
96 Ibid.
fully established.”97 This was because male practitioners and their tools still represented to women that the worst had come, and that their own lives and that of their babies were in danger. Although his intentions were arguably good, this practice of concealing actions and tools from the women being performed on would become a recurring trend throughout the medicalization process. Though the reasons for trying to be discreet would change, this represents a major ramification of the medicalization of childbirth: that women did not know what was happening to their own bodies. But, regardless of his intentions, his acknowledgement of women’s views of forceps indicates another characteristic of first-generation man-midwives. Because women had long associated male birth practitioners with gore and emotional trauma, the first man-midwives faced the obstacle of convincing the female population, particularly of the middle and upper class, that they and their tools were safe and could be trusted.98 They did so by championing their skills and tools as the products of science, progress, boasting of their formal educations which were exclusive to men of intelligence, and emphasizing that childbirth was inherently painful, dangerous, and that only medical intervention could mitigate this pain and danger.

And the development of their field did progress as a science; efforts were constantly made to improve the existing techniques and technologies to be more efficient, though this was not always in the women’s best interest. As variations of the forceps continued to develop in the late eighteenth century, such as the long-armed

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forceps which made the job of the practitioner easier, Smellie was sure to admonish their use even more, even calling attention to the imperfections of doctors and their frequent mistakes:

…for daily experience proves that we are still imperfect, and very far from...discovery in arts and sciences; though I hope every gentleman will despise and avoid the character of a selfish secret-monger or a long pair of forceps, may take such firm hold, that with great force and a strong purchase the head will be delivered; but such violence is commonly fatal to the woman, by causing such an inflammation, and perhaps laceration, of the parts, as is attended with mortification. In order to disable young practitioners from running such risks, and to free myself from the temptation of using too great force, I have always used and recommended the forceps so short in the handles, that they cannot be used with such violence as will endanger the woman's life.  

It is important to acknowledge how Smellie was able to glean so much knowledge about the proper use of forceps if he was only called to emergency births which were relatively uncommon at the time. Moreover, if he understood the importance of clinical experience in learning, how did he expect his students to train? Smellie used the high fees he charged for his lectures to start what he called a “lying-in fund.” He used this money to start a training program in which he recruited poor pregnant women to “offer” themselves to be trained on by his students in return for their medical services. The coercion in this system is apparent--he essentially created a human laboratory for experimentation by convincing the women being experimented on that these procedures were medically safe, even beneficial. The

power of these programs to fuel the progress of the field did not go unnoticed; in 1747, the British Lying-in Hospital, an official institution, was established, and three more opened before 1750. As Wilson notes, lying-in hospitals “conferred on childbirth a new medical aura; and they emphasized the subordination of the midwife to the male practitioner. The latter point indeed has force: in each lying-in hospital the consultant men-midwives had power and status, whereas the matron midwife was firmly placed in a servant” role. 101

The system also created the illusion that the participation of these poor women, often referred to as “charity cases,” were voluntary, when in reality, increasing urbanization in London in the eighteenth century rendered many homes in poor areas inadequate for home births. That is, these lying-in experimental programs were their only options. This was the beginning of a trend that continues to fuel medicalization today, particularly in the pharmaceutical sphere. The mastery of medical innovations, whether they be new technologies, theories, or procedures, was accomplished by experimenting relentlessly on poor and minority women, who were left with no other option but to be the guinea pigs. It was only once these techniques were perfected and tested for safety that they would be performed on middle and upper class women. In short, from as early as the eighteenth century, procedures that were developed to benefit certain groups of women were always accomplished through the abuse of others. Furthermore, once these techniques were perfected, the same group they had been experimented on would lose access to them, and be subject

101 Ibid., 153.
to the next round of experiments. Before long, lying-in hospitals had become normal components of man-midwifery training programs.\textsuperscript{102}

Meanwhile in America, no medical schools had even been established yet. Men who wanted to be doctors traveled to Europe, specifically England, to get their medical educations, the cost of which, plus that of travel, made it accessible to only elite members of the community.\textsuperscript{103} This trend was well underway by the time Smellie, and eventually his students, had established their lecture series. Not only that, man-midwifery had found its way to the forefront of medical focus in England, inspiring American students to start similar initiatives upon their return to the States.\textsuperscript{104}

The first to establish man-midwifery lectures in the States was William Shippen Jr., who left his post in Philadelphia for an education in London in 1758. There, he attended the man-midwifery lectures of Colin Mackensie, who had previously been Smellie’s assistant. Coupled with these lectures, he took anatomy classes and demonstrations with William Hunter, one of Smellie’s most distinguished students. At the time, as would be true in America, anatomy and surgery courses were coupled with those of man-midwifery, for the focus of the specialty was still on operations in difficult deliveries. Samuel Bard moved from New York City to London and received the same education as Shippen Jr., which was directly influenced by Smellie’s teachings. They would become two of the most influential actors in the

\textsuperscript{102} Cassidy. Birth, 54-5.
\textsuperscript{103} Wertz and Wertz. Lying-In: A History of Childbirth in America.
establishment of the American medical community which, following England’s lead, had a newfound focus on childbirth.\textsuperscript{105}

Shippen Jr. returned to Philadelphia, which was considered the “scientific capital” of Colonial America, in 1762 and had established a comprehensive private man-midwifery program, America’s first, and a lying-in facility by 1763. Two years later, he played a major role in establishing the Medical School of the College of Pennsylvania, the first in the United States, where he was one of two faculty members and taught man-midwifery as an adjunct to anatomy and surgery. Samuel Bard was right behind him. In 1767, he helped found the King’s College Medical School in New York City, where he taught the theory and practice of medicine until taking over as Chair of Midwifery in 1770.

These medical schools and lying-in facilities, as in England, were for-profit establishments owned by individuals. This meant they were highly unregulated and that each individual faculty member and doctor had an enormous influence on the functioning of the institution. It also meant that the stability of the establishments was at the whim of individual wealth and success.\textsuperscript{106} The American Revolution, which lasted from 1765-1783, impeded medical progress in the United States, partly by halting the functioning of the newly founded medical schools.\textsuperscript{107} The Medical School of the College of Pennsylvania, which did not survive the war, became part of the University of Pennsylvania by the end of the century. King’s College Medical School became part of Columbia College in the 1790s, and was eventually absorbed by the

\textsuperscript{105} Ibid., 124.
\textsuperscript{106} Ibid.
\textsuperscript{107} Ibid.
New York City College of Physicians and Surgeons in 1814. Only two other medical schools opened in the States before the end of the century: Massachusetts Medical College (Harvard) in the 1780s, and Dartmouth Medical College in 1798. It was not until the second decade of the nineteenth century that each school would establish their own midwifery programs separate from those of surgery and anatomy. Even so, midwifery was not a required field to obtain a medical degree, but anyone who had the degree was eligible to practice man-midwifery.

Even so, these four medical schools that opened in the eighteenth century maintained a level of integrity that the nineteenth century American medical schools lacked. In response to the interrupted progress of medicine, and therefore man-midwifery, in the States because of the war, the number of medical schools skyrocketed in the nineteenth century in an attempt to compensate, a trend that would continue for decades. Those men who could afford it, despite antebellum politics, continued to travel to Europe for their medical education, as the quality was superior. But an increasing number of American trained doctors emerged who were enormously unqualified to safely practice. This resulted in two types of man-midwives by the second decade of the nineteenth century: those who trained in Europe or the early American medical establishments that were influenced directly by the original British philosophies of conservative use of instruments in man-midwifery, and unskilled doctors who obtained their degrees from small medical institutions in the States that had hardly any standards for admission and required few qualification for graduation.108 This was possible because these early medical schools

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were still privately owned, and there were no government mandated standards or medical society dictated regulations for practicing doctors.

But even the most qualified man-midwives in the early decades of the nineteenth century had fundamental differences from those who came before them. While the first generation of man-midwives aimed to preserve the role of female midwives in childbirth, advocating for their formal education rather than their abolition, these new man-midwives, while they still believed in a non-interventionist approach to normal births, believed that normal births were rightfully *their* domain.\(^\text{109}\) This was in many ways a result of the lying-in hospitals. Because most births were normal in seventeenth and early eighteenth century America, doctors in training had few opportunities to practice their techniques for complicated labors, for most births were uncomplicated.\(^\text{110}\) Though most early lying-in hospitals employed midwives to tend to the normal births, as more man-midwives emerged, they infiltrated more and more into midwives’ domain. Consequently, the new man-midwives came to believe female midwives had no place in childbirth,\(^\text{111}\) and that their abolition was essential to the development of the field. I call these men second-generation man-midwives.

“The Midwife Problem” and Second-generation Man-Midwifery

Pervasive sexist attitudes that promoted male superiority contributed to the replacement of male physicians over midwives in the first place. Physicians promotion of birth as inherently dangerous contributed to women’s desire to employ

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\(^\text{110}\) Ibid., 33.
them. Second-generation man-midwives, who emerged in the first two decades of the nineteenth century, were not entirely different from their predecessors. Firstly, all believed that there should be a more structured approach to childbirth, something that should be taught through formal education. But whereas first-generation man-midwives tried to establish female midwifery training programs, though to no avail, second-generation man-midwives believed that the continuation of female participation in midwifery posed the greatest impediment to the field’s progress.\textsuperscript{112}

The eradication of women from childbirth had significance beyond the transfer of control from one gender to another. For when childbirth was still the female’s domain, it was a ceremony full of traditions that did not center entirely on the birth process itself. For female midwives, their work was an art of compassion whose success depended on skill but also on a fundamental understanding that childbirth was an emotional, as well as physical, experience for women. To replace them also underestimated the effects of psychological support on labor.

But even Smellie, who wholeheartedly advocated for midwives’ continuing practice of tending to normal births had a widely different approach to the practice. Rather than consider childbirth as a process that involved a woman’s whole being, he “began to consider the whole in a mechanical view...accurately [surveying] the dimensions and form of the pelvis, together with the figure of the child's head and the manner in which it passed along in natural labours; and from the knowledge of these things I not only delivered with greater ease and safety than before, but also had the satisfaction to find, in teaching, that I could convey a more distinct idea of the art in

\textsuperscript{112}Donegan. \textit{Women and Men Midwives}, 154.
this mechanical light than in any other, and particularly give more sure and solid
directions for applying the forceps, even to the conviction of many old practitioners,
when they reflected on body confined in such a manner.”¹¹³ That is, even the earliest
male practitioners rooted their success in reducing the body to a machine, something
that would serve to give future doctors increasing control over this female process
and to diminish the essential mind-body connection of birthing women. In sum, the
second-generation man-midwives’ attempts to eliminate the female practitioner had
enormous significance for the type of personal care women giving birth would receive.

Disturbingly, many doctors chose to specialize in midwifery for reasons far from the idea that their work was “serving humanity.” Rather, man-midwifery was often seen as the gateway through which doctors could establish themselves as capable doctors. Though they recognized that childbirth was a particularly emotional experience for women, they did not try to ensure more compassion in their work. Instead, they capitalized on this sensitivity in the hopes that a job well done with a family would serve to boost their reputations as generally competent doctors.¹¹⁴ One of the most prominent second-generation man-midwives, Walter Channing of Boston, made the following observation in 1820: “Women seldom forget a practitioner who has conducted them tenderly and safely through parturition...It is this which ensures to [doctors] the permanency and security of all their other business.”¹¹⁵

¹¹³ McClintock. Smellie’s Treatise on the Theory and Practice of Midwifery, 252-3.
¹¹⁴ Donegan. Women and Men Midwives, 141.
¹¹⁵ Walter Channing, Remarks on the Employment of Females as Practitioners in Midwifery, by a Physician (Boston: Cummings and Hilliard, 1820).
This indicates that doctors’ priorities lay more with their own profit than with providing emotionally and physically sufficient care to the women they served.

Moreover, the infant and maternal mortality rates during the era of the second-generation man-midwives were astoundingly high. An 1882 report by the Medical Society of the County of New York, a newfound organization, attempted to find the cause of an unusually high incidence of still-births. The conclusions align with the philosophy of the second-generation man-midwives: “‘The mortality among newly-born children would be materially diminished if the practice of midwifery was more restricted to male attendants.’” The proposal to further eliminate, rather than educate, female midwives demonstrates a fundamental change between the first and second-generation midwives. Needless to say, these conclusions were favorably received by the medical community.

Channing’s famous quote from 1820 demonstrates that the attempts to achieve female eradication were well underway even before this report came about: “It was one of the first and happiest fruits of improved medical education in America that…[women] were excluded from practice; and it was only by the united and persevering exertions of some of the most distinguished individuals in our profession has been able to boast, that this was effected.” William Potts Dewees, a midwifery professor in Pennsylvania, agreed, asserting simply that “the well-instructed

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116 The Medical Society of the County of New York, quoted in Donegan. Women and Men Midwives, 130.
117 Channing. Remarks on the Employment of Females as Practitioners in Midwifery, by a Physician.
physician is best calculated to avert danger, and surmount difficulties.”118 Despite these claims, the field was far from as united and equipped to ensure safety these as these and other second-generation man-midwives were willing to acknowledge.

But first- and second-generation man-midwives who had been well trained were united in they recognized that there was a problem of excessive and unsafe instrument intervention in the field. The ever-increasing number of medical schools emerging in the States produced an army of unskilled doctors, most of whom had never witnessed births, and many of whom had never even attended a midwifery course. This resulted in an enormously increased use of instruments in deliveries, which had detrimental consequences for laboring women. In 1824, Dewees wrote, “It is a vulgar prejudice, that great and constant benefit, can be derived from the agency of the [man-midwife]; especially, during the active state of pain; and this feeling is but too often encouraged by the ignorant, and the designing to the injury of the patient, and to the disgrace of the profession.”119 As late as 1843, Dr. John Metcalf observed that the key to man-midwifery was “letting the patient alone” if there were no indications of complications.120 Even in an advertisement promoting the recent invention of a new type of forceps developed by Dr. Henry Bond in 1850, the author expressed hope that the development would not lead to the instrument’s increased use, for “they are employed very many times when they are wholly uncalled for.”121

118 William Potts Dewees, A Compendious System of Midwifery, Chiefly Designed to Facilitate the Inquiries of Those Who May Be Pursuing This Branch of Study (Philadelphia: Carey and Lea, 1824).
119 Ibid.
120 John G. Metcalf, "Statistics in Midwifery," American Journal of the Medical Sciences, no. 6 (1843).
First-generation man-midwives joined the fight of their successors to admonish interventionist approaches to childbirth. As late as 1815, Bard spelled out the dangers an unskilled man-midwife could be capable of:

He will probably fail at first, for want of judgement, to discriminate accurately between one case and another, as well as for want of skill and dexterity in the application of his instruments; and finding himself foiled in the use of the safer lever and forceps, he will become alarmed, confused and apprehensive for his patient’s safety, as well as for his own reputation. And now, deeming a speedy delivery essential to both and...having taken the case into his own hands...he thinks he must not desist before he has accomplished it, he flies to the crotch, as more easy in its application and more certain in its effect--with this he probably succeeds and although the poor infant is sacrificed, yet he persuades himself, perhaps honestly believes, this was necessary.”

Bard proposed that this trend could be attributed to the intense focus on instrument use in even the midwifery courses taught, though inadvertently, by the most skilled, educated professors whose philosophies were non-interventionist, starting with Smellie himself. Smellie’s treatise dedicated forty-eight whole pages to forceps use, and Bard was “apprehensive that many of [Smellie’s] readers may thereby be induced to suppose them equally safe in their hands, as they appear to have been in his--and hence be led to a more frequent use of them than modern practice has found necessary or safe.” A physician scrutinizing American medical schools “was convinced that [they] placed undue emphasis on abnormal cases. The result was that

123 Ibid.
students gained the mistaken impression that such abnormalities were the rule rather than the exception.”  

Furthermore, it remained the case that normal births prevailed, so even with lying-in hospitals, training doctors had little opportunity, if any, to witness any cases in which instruments were actually necessary. And as late as the 1830s, most medical schools in the United States still didn’t require the completion of midwifery courses for a medical degree, but allowed anyone with a degree to practice midwifery. As a result, many doctors agreed that “the young practitioner would embark on his career with less practical knowledge in obstetrics than in any other branch of medicine.”  

Indeed, “doctors tended to resort to mechanical aids in cases where their use was completely unnecessary…indiscriminate ‘meddlesome midwifery’ persisted, despite the repeated warnings of the authorities that such interference was potentially harmful to mothers and infants.”  

As historian Judith Leavitt points out, “Forceps, after all, gave the male physicians a significant advantage over traditional female midwives as they tried to establish themselves in practice.”  

In 1872, an obstetrician would reflect that “the nineteenth century had seen more abuse of patients and a greater resort to unnecessary instrument deliveries than had the two preceding centuries.”  

But the low quality of medical education that prevailed at the time was not the greatest obstacle second-generation man-midwives faced in the effort to establish  

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125 Ibid., 143.  
126 Ibid., 144.  
their services and eliminate their female counterparts. Rather, it was the cultural norms that valued a woman’s “delicacy,” “modesty,” and “virtue” over all else, something male birth practitioners would have to work to overcome until the middle of the nineteenth century. According to these values, the presence of males during childbirth was severely frowned upon, and opponents even posed it as an act of infidelity against the mother’s husband. This offered female midwives their last chance to preserve their middle and upper class clientele, whose business man-midwives actively sought, for at the time, a doctor’s reputation was determined by that of the patients he served. This created “conflicting demands of modesty and safety” for the female population, which was left “vulnerable in [their] understandable wish for a shorter and safer delivery,” “confined to a narrow sphere of home and family” and “expected to cultivate the virtues of ‘true womanhood.’”\(^{129}\)

Doctors were aware of this conflict, and responded with methods to address each issue. To win women over, they put out more aggressive advertisements in publications widely read by women in which they hailed themselves as best equipped to handle birth, for they had a scientific understanding of the process that they had gained through formal education, and stressing that childbirth pain was unbearable. Midwives, they said, were unscientific and unskilled, and thus unsafe. They used the fact that midwives lacked formal education to argue this point, as if they weren’t working to actively exclude midwives from such training and technology. But by asserting that they were the safest option, they implied that childbirth was inherently dangerous. In response to the cultural issues, they put an increasing focus on how to

\(^{129}\) Ibid., 143; Ibid., 149.
preserve a woman’s modesty when attending to her delivery in their lectures. This was to the detriment of the development of sound medical knowledge; for even when new technologies were developed, such as the speculum which enabled doctors to inspect the cervix for dilation progress and general health, the lessons focused on how to use them without looking, rather than how to use them properly. This demonstrates the quite literal blind faith in technology characteristic of the time. Regarding the use of forceps, Potts Dewees asserted, “the operator must become familiar with the introduction of the instruments without the aid of sight.” In other words, the criticism of man-midwifery was not about safety, nor was the solution; rather, both were rooted in socially ingrained sexist values.

Important to note was that as doctors continued to present themselves as the safer option, and to deprive female midwives from their medical innovations. Although male practitioners had not actually mastered safe services as they claimed they did, they had resources that midwives were deprived of. Meanwhile, lying-in hospitals continued to be the human laboratories for childbirth experimentation, to whom cultural values of modesty did not appear to apply.

Although doctors would have to fight to overcome these cultural obstacles, which impeded both their employment as well as the development of their field, until the mid-nineteenth century, they were still able to convince most the middle and upper class urban women to employ their services. Although these women presumably would not have opted for their services had they been aware of the

130 Donegan. Women and Men Midwives, 117.
deficiency of the field, they were sold in the name of safety and progress. According to Leavitt, “Women had good reason to believe that physicians could provide services that midwives could not...men physicians had the extra advantage and prestige associated with formal learning. Even though most American practitioners had not attended medical school and were themselves apprentice-trained, physicians carried with the status advantages of their gender and of the popular image of superior education.” Superior education was inextricably linked to notions of science and progress, and physicians recognized the power of this fact.

Midwifery professor Hugh L. Hodge noted in 1838, the secret to the acceptance of male practitioners by women was to “diffuse in every direction a knowledge of the great value of obstetrics, as a practical science...if females can be induced to believe that their sufferings will be diminished or shortened, and their lives and those of their offspring, be safer in the hands of the profession; there will be no further difficulty in establishing the universal practice of obstetrics. All the prejudices of the most ignorant nervous female, all the innate and acquired feelings of delicacy so characteristic of the sex, will afford no obstacle to the employment of male practitioners.”

This quote provides the first reference to the field as “obstetrics,” rather than midwifery. Though the term obstetrician was established in 1828, first phase of obstetrics did not begin until the 1840s, when male practitioners finally overcame the

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132 Leavitt, "'Science’ Enters the Birthing Room: Obstetrics in America since the Eighteenth Century," 39.
issue of gender norms. Even so, the term “obstetrician” in and of itself is significant, for it foreshadows the increasingly interventionist agenda the field would adopt. Meaning “to stand in the way of,” it clearly has more interventionist undertones than “midwife,” simply meaning “with woman.” Furthermore, it reinforced the separation between the practice of midwifery as an art based on compassion and empathy, and this strengthening scientific approach to birth. Man-midwives took a non-interventionist approach to instrument use in childbirth in an attempt to distinguish themselves from their predecessors who were characterized exclusively by their use of surgical tools. At the same time, they relied on their ability to use these tools to hail themselves as superior to their female counterparts, who were forbidden access to them and instruction on their use. But obstetricians were able to deploy these tools as much as they wanted as the practice advanced, particularly with the first pharmaceutical used to obstetrics: anesthesia.

Medical Innovations and the Formation of Obstetrics: Anesthesia and Hospitals

Anesthesia and the Professional Management of Pain

The advent of anesthesia was revolutionary for the medical community, rendering surgeries that had previously been difficult routine and bearable for patients and enabling the development of complex procedures that had previously been unimaginable, which in turn gave rise to a newfound understanding of the human

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134 Cassidy, Birth, 131.
anatomy. At the time of its discovery in the mid nineteenth century, doctors’ professional success was dependent on patient satisfaction and the emotional and physical comfort anesthesia provided women fortified their faith in scientific developments, and trust in medical practitioners, even before its safety had been proven.

Anesthesia marked the starting point of a new kind of obstetrics with different primary concerns. By the middle of the nineteenth century, doctors had successfully overcome cultural concerns that men’s presence in the birthing room the modesty of middle- and upper-class women who were their target clientele because the social status of a doctor’s patient had a great impact on their reputation and they could afford it.\textsuperscript{135}

But even though anesthesia did not secure safer births—in fact, within a few decades the detrimental effects of chloroform on mothers and fetuses would be scientifically demonstrated—access to it was an immense social privilege that also indicated status. To be freed from the burden of childbirth pain then was celebrated by women as a means of liberation, and those who could afford doctors demanded their administration of chloroform. For the first time, doctors were able to fulfill a part of the promise they had been making to women since the late eighteenth century of a safer, more efficient, and more comfortable birth experience. Whereas they had previously relied solely on rhetorical devices, alluding to science, and their reputations as educated scientists to create this illusion, they now had a tangible medical innovation to use as bait. Although the safety of anesthesia was far from

\textsuperscript{135} Wertz and Wertz, \textit{Lying-In: A History of Childbirth in America}, 49.
verified in the middle of the century, women with the finances to do so were captivated by the newfound potential to eradicate what constituted their greatest fear of childbirth and its most socially weighted component: pain.\textsuperscript{136} For this reason, Leavitt concludes, “The appeal to overturn tradition was strong.”\textsuperscript{137}

The first woman in the United States to be anesthetized during childbirth was Fanny Apple Longfellow. A letter she wrote to her sister-in-law after the 1847 birth of her third child demonstrates women’s general conception of chloroform in the middle of the century: “‘I did it for the good of women everywhere as no woman should have to suffer that much pain …This is certainly the greatest blessing of this age.’”\textsuperscript{138} As the wife of the famous American poet Henry Wadsworth Longfellow, though, Fanny represented a minority of wealthy, white women who had access to such painless birth. To think her use of the drug set the precedent of its use for all women shows the immense distances between classes of women, and the official breakdown of a tradition that had once unified all of them.

But for the middle- and upper-classes, Fanny started a trend. Once women learned of the potential for painless childbirths, their expectations of physicians and

\textsuperscript{136} Many of these women and doctors were aware of the social significance of this power; the cultural weight of childbirth pain dated back millennia. The religious community viewed it as the price women had to pay for Eve’s curse. Western perceptions of childbirth pain were used to reinforce sexist ideals of femininity that encompassed traits like weakness and fragility. Furthermore, the fear of childbirth pain that had consequently been instilled in women fortified domestic power dynamics that utilized childbirth as a means to subordinate women. (Cassidy, \textit{Birth}, 84).

\textsuperscript{137} Leavitt, "‘Science’ Enters the Birthing Room: Obstetrics in America since the Eighteenth Century." 284.

\textsuperscript{138} Fanny Apple Longfellow, quoted in Cassidy, \textit{Birth}, 88.
their power intensified.\textsuperscript{139} As Leavitt notes, women developed a faith “in scientific advances years before science had significant impact on obstetric practices,” because obstetricians symbolized scientific improvements and anesthesia was a tangible fulfillment of this promise.\textsuperscript{140} And not just any promise—the fear and experience of childbirth pain was so ingrained in the female existence, that women were eager to use it regardless of how much remained unknown. Childbirth pain was not only a source of fear for women, but a vehicle of subordination under patriarchy, which only amplified their demand, for it was cast as both an indication of women’s inability to properly tend to the dangers of birth because of their lack of training, and birthing women’s need for male intervention to subside the pain. Furthermore, it supported the claim that pregnancy and childbirth were diseaselike, for under the medical model, the reproductive body is rendered as a machine and “the male body is taken as the norm (the ideology of patriarchy).”\textsuperscript{141}

As Leavitt says, “as the symbol of what science had to offer, anesthesia enhanced the place and role of physicians in birthing rooms across America. Women who could afford physicians and their new panacea demanded the advantages of painlessness.”\textsuperscript{142} Up until the discovery of anesthesia, physicians had relied on folklore remedies for medicinal purposes. Bloodletting, a technique dating back millennia, was one of the most common methods employed by physicians on pregnant women, considered the best method to fend off fevers and even to mitigate

\textsuperscript{139} Leavitt, "'Science’ Enters the Birthing Room: Obstetrics in America since the Eighteenth Century." 293.
\textsuperscript{140} Ibid. 303.
\textsuperscript{141} Rothman. \textit{In Labor}, 37.
\textsuperscript{142} Ibid., 293.
hemorrhaging. Anesthesia was the first scientifically discovered medication, and particularly once its potential was realized, general medical practice and obstetrics abandoned folklore medicine for good and put their energy into the search for more medical developments.\textsuperscript{143} Anesthesia signified a new era of medicine, one dissociated from homeopathic traditions accessible to and understood by all healers; its access was exclusive.\textsuperscript{144} As before, the only things separating the new obstetrics from traditional midwifery was the access to surgical instruments, formal education, and the high status inherently granted to educated males by a patriarchal society. But now, also the ability to eradicate childbirth pain.

Although anesthesia was hailed as the pinnacle of modern medical development at the time, and reinforced an already growing faith in scientific medicine and its potential, doctors still lacked a basic understanding of the female anatomy and the physiology of reproduction, and were particularly unaware of the effects of anesthesia on such a system.\textsuperscript{145} So while it bolstered the status of physicians who administered it as scientists and led women privy to these services to actively pursue them, physicians still relied on unscientific methods to prove and argue for its safety to the public and to each other, using methods reminiscent of the previous era such as charisma and rhetorical devices rather than statistics and empirical

\textsuperscript{143} Caton. \textit{What a Blessing She Had Chloroform}, 39.
\textsuperscript{144} Ibid., 84.
\textsuperscript{145} “They knew little about the normal physiology of the uterus, much less about its response to drugs. They had only the barest insight into placental function, much less about the permeability of the placenta to ether might affect these processes. They knew nothing about the mechanisms that control postpartum hemorrhage, much less about factors that alter the risk of postpartum infection. Most important, they had no experience in research methods, including statistical analysis. Medicine was just emerging from its own dark age.” (Caton. \textit{What a Blessing She Had Chloroform}, 53).
The debate among physicians over the use of obstetric anesthesia was one of the most contentious moments in the field’s early stages, and demonstrates the lack of unification among its practitioners characteristic of the days before official specialization.

James Young Simpson, who was the first to administer anesthesia to a laboring woman in Scotland in 1847, just months after its original discovery by a dentist in Boston, was the leader of the physician advocates of obstetric anesthesia. Though the medical community celebrated the discovery of anesthesia from the start, many were reluctant to endorse its use in obstetrics, and some vehemently opposed it. Neither the early claims in support of its use, nor the opposing views were rooted in scientific evidence at first, and wouldn’t be until the late 1870s. Doctors hailed anesthesia as the symbol of the power of scientific progress, yet the proponents and opponents of its obstetric application used unscientific methods to support their claims.

Simpson’s campaign for chloroform’s obstetric use was straightforward: “The prevention of pain in surgical operations is, in other words, one means of preventing danger and death to those operated on: the saving of human suffering implies the saving of human life. And what holds good in relation to pain in surgery holds good in relation to midwifery.”

There are many noteworthy things about this claim. For one, he had only administered chloroform in obstetric cases six times when he made

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146 Ibid., 51.
this claim.\textsuperscript{148} Furthermore, he equates the pain of a general surgery to that of childbirth pain, demonstrating the ever-growing distance between the social model of childbirth, rooted in empathy and shared experiences, to a medical model that viewed childbirth like any other medical condition. But despite the obvious loopholes in his argument and lack of scientific evidence, especially clear from a modern perspective, there were physicians who supported his views.

Walter Channing, professor of obstetrics at Harvard Medical School in the mid-nineteenth century, was one such proponent. In his 1848 \textit{Treatise on Etherization in Childbirth: Illustrated by five-hundred and eighty-six cases},\textsuperscript{149} he explicitly advocates for its use. Though he introduces his treatise as a demonstration of the safety of obstetric anesthesia, he draws his conclusions based solely on patient satisfaction: “They may be unconscious of what happened during etherization, and are insensible to pain; but the after condition is matter of distinct consciousness, and is always referred to with entire satisfaction.”\textsuperscript{149} Important to note here is that all five-hundred and eighty-six women Channing chose to survey were middle- and upper-class women who he knew to have delivered successfully under anesthesia.

Both Simpson and Channing used unscientific data and rhetoric to support their case, but they appealed directly to the women they were targeting. They emphasized that the use of obstetric anesthesia was both a means to end human suffering, and that its use was consistently met with satisfaction. They relied on these facts as evidence of the drug’s safety, but their claims were true in that anesthesia

\textsuperscript{148} Caton. \textit{What a Blessing She Had Chloroform}, 17.
provided the first opportunity to eradicate childbirth pain. In a time where doctors’ careers still depended so strongly on their individual reputations, determined by their patients’ satisfaction, and because of the cultural significance of childbirth pain, they saw the power they got from women’s satisfaction with anesthesia. These physicians, then, understandably strove to champion the cause for the eradication of childbirth pain. This created a dependence on doctors to tend to births among the middle- and upper-classes, made it fashionable, and erased any desire to return to the days of midwifery.

On the other hand, there were physicians who staunchly opposed the use of obstetric anesthesia. Historians often attribute this opposition to concerns of safety. I don’t deny this assertion—after instances of death from anesthesia on patients undergoing general surgery had been observed, though these fatalities were most likely the result of the surgical practices themselves, it is understandable that physicians would be cautious.\textsuperscript{150} However, a close look at what these physicians expressed indicate that their concerns were not rooted in issues of safety. Some doctors were reluctant because they were unsure of how women would behave under these new circumstances. Wertz and Wertz claim, “Some feared drugs would excite the laboring woman to voluble and unguarded actions that might be mistaken as eroticism, so that the woman would fear the doctor’s control over her behavior.”\textsuperscript{151} The common medical concerns can be ascertained from those of Charles Meigs, the strongest opponent of obstetric chloroform. Like his opponents, without scientific

\textsuperscript{150} Wertz and Wertz. \textit{Lying-In: A History of Childbirth in America}, 117,
\textsuperscript{151} Ibid.
evidence, he asserted, “birth pain was a desirable evidence of the life force that ensures a mother’s love for her offspring, a kind of psychological imprinting.”

Though he also argued that anesthesia had the potential to weaken a woman’s contractions and ability to push—a true side effect of an overdose of the drug—he also had personal reasons for relying on strong, painful contractions: he used them to “help him determine labor’s progress and believed that their inhibition would make him a less effective birth attendant.” Other physicians made seemingly arbitrary claims about what kind of childbirth experience a woman would prefer. William Tyler Smith said, “women will derive truer comfort and a greater measure of safety and freedom from unnecessary suffering from physiology, than from wild therapeutics, which in her hour of trial only offer a choice betwixt poison and pain.”

I therefore agree with Cassidy, who claims, “the debate remained fixed on religion and morality” and had “nothing to do with safety.”

As early as 1850, evidence was emerging for placental transport, as the understanding of membrane permeability was developing. And yet, it was not for another twenty-five years, in 1877, that the transport of chloroform across the placenta would be proven. In 1850 Channing and Simpson had argued about the placental transfer of anesthetics, and John Snow of England had accepted the fact of transfer based on clinical observation. Just twenty-five years later, physician Paul

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152 Ibid.
153 Leavitt, "Science’ Enters the Birthing Room: Obstetrics in America since the Eighteenth Century."
155 Cassidy, Birth, 89.
Zweifel proved placental transfer using statistical, chemical, and empirical scientific methods.\textsuperscript{156}

And yet, the use of obstetric anesthesia became so widespread that, according to a physician in 1895, “the profession has come to regard the use of chloroform in parturition as almost utterly devoid of danger,” so that “chloroform is given in labor recklessly, carelessly, and copiously.”\textsuperscript{157} Even as late as 1904, an article that appeared in the \textit{Wisconsin Medical Journal} noted, “No standard procedures guarded physicians’ drug dosages.”\textsuperscript{158} But despite conflicting medical evidence, doctors continued to administer anesthesia throughout the latter half of the nineteenth century. This was in large part due to the demands of the women who could afford physician attended births, whose approval these physicians still relied on to secure their own careers and the future of their field.\textsuperscript{159} Experiencing this at home, surrounded by loved ones who could negotiate procedures with the attending physician, advocate for the woman in labor, and supervise the procedure certainly must have mitigated some anxieties parturient women had about being administered such a new drug that also rendered them mentally absent.\textsuperscript{160} But I argue that this still left it up to doctor’ discretion and individual preference.\textsuperscript{161}

\textsuperscript{156} Caton. \textit{What a Blessing She Had Chloroform}, 84.
\textsuperscript{159} Consumer demand can also have an influence on the progression of medicalization. (Conrad, \textit{The Medicalization of Society}).
\textsuperscript{160} Leavitt, "'Science’ Enters the Birthing Room: Obstetrics in America since the Eighteenth Century." 293.
\textsuperscript{161} “…the culture’s position on the relative social worth of different social classes influenced doctors’ views about whose health was likely to be endangered, how their
That physicians complied with women’s persistent requests, despite their own potential moral or medical apprehensions about obstetric chloroform, could indicate a victory for the women who demanded it, especially considering the social significance of childbirth pain. And not just that—women feared childbirth not only because it was painful, but because the possibilities of it leaving a woman physically debilitated were so high. A solution to the issue of pain symbolized to them a starting point of medical solutions to these problems. While the forceps represented the possibility of a live delivery even in the case of a complication, they symbolized trauma and discomfort. But anesthesia was the first development that could actually influence their physical experience of birth. These developments in conjunction with one another gave women an unwavering faith in scientific promise. But I argue that women’s demands for anesthesia were themselves a result of medicalization, and that physician compliance was not a victory or symbol of women’s agency. Jacqueline Wolf makes the great argument that with the loss of midwifery, and with that, the generational and experiential transfer and accumulation of birth knowledge, women lost the ability to prepare for what childbirth pain felt endangered health affected the whole society, and what treatments, if any, were suitable.” (Wertz and Wertz. Lying-In: A History of Childbirth in America, 69).

Doctors only complied with wealthy women’s requests. The majority of women in America could not afford doctors and still delivered with midwives, who did not have access to these drugs. But poor women gave birth in hospitals, where they were experimented upon. Although these hospitals have records of high rates of instrumental intervention, there are few indications of anesthetic administration. This is because doctors had personal beliefs about which women experienced childbirth, which was based on class and perceived morals. This demonstrates the stratification of the medicalization of pain and the power of individual doctors’ discretion. (Leavitt. “Science Enters the Birthing Room,” 289. Caton. What a Blessing She Had Chloroform, 121-2).

Ibid., 284.
like. Unlike in the pre-medicalization era, often women’s first experience with birth was their own. Instead, they relied on doctors’ insistence that the agony was unbearable, and trusted them when they claimed they had a way to eradicate it. She concludes, “Consequently, birth came to be shrouded in mystery and women increasingly bowed to physicians on even the most elementary aspects of treatment during labor.”

I also agree with Nancy Theriot’s point that as the number of physician-attended births increased, so did women’s complaints of labor pain, which suggests that the male presence in the birthing room increased levels of anxiety in the parturient woman, and thus increased her discomfort and pain. The loss of autonomy that resulted from the medicalization of childbirth was apparent with each innovation that increased female dependency on doctors, or rather, with each innovation that convinced women they should be dependent on doctors, regardless of the technology benefitted or harmed them.

Home Births Attended by Obstetricians and Expectations

Despite the fashionable trend of physician-attended deliveries, home-births characteristic of the pre-medicalization era remained intact. Of course, it was a modified version of this tradition; midwives had been replaced, along with their non-


interventionist approach to delivery. But women maintained the power to assemble women to support them in the birthing-room during their labor. Historians of the changing traditions of childbirth argue that women maintained control over their births so long as they still took place in their homes [cite them here]. Only when hospital births became normalized in the first few decades of the twentieth-century did doctors stop “compromising” with parturient women and “physician-directed obstetrics finally became master of the birthing room.”166

For instance, Leavitt argues the following: “Doctors, who may have had only minimal practical experience, were invited to attend women in their own homes in the presence of other women, many of whom had had considerable birth experience and developed strong opinions about birth procedures. Within the birthing rooms, these attendants negotiated…Women retained a lot of power in their own homes, and physicians bowed to it or risked damaging their reputations among a whole community of women and losing patients.”167 I challenge the idea that home births were instances of mere negotiation, and that the respective advantages of men and women evened to create an equal power dynamic. The administration of anesthesia is the perfect example of this misconception. Female demand for the drug was itself a ramification of medicalization, as fear of childbirth pain had been instilled in women by doctors advocating their services. I agree with Wolf’s argument that the timing of the administration of anesthesia is evidence of doctors’ control. Rather than administer the drug at the transition phase, the most painful, they administered it at

166 Leavitt, “‘Science’ Enters the Birthing Room: Obstetrics in America since the Eighteenth Century.” 295.
167 Ibid., 294.
the time of birth, which was their own perception of the most painful part, simply due to their reaction to women’s facial expressions in this moment. She says, “Despite their acquiescence to women’s call for pain relief, when it came to the precise timing of the administration of anesthesia physicians invariably invoked their ostensible expertise without consulting the laboring woman, consequently limiting women’s control and judgement during birth.”

So, while Leavitt points out “for those women who chose physicians instead of or in addition to midwives, birth became a less natural process and more an event that could be altered and influenced by a wide selection of interventions…decisions could be made and actions could be taken that would determine what kind of a birth a woman would have and perhaps whether she and her baby lived or died,” these interventions were entirely the doctors’ choice. Yes, women had expectations that precluded normal birth, but these false expectations were the result of medicalization and the disruption of women’s autonomy over their own births. These available inventions were entirely under doctors’ control—no one present at the birth could instruct doctors on their proper use, and with anesthesia, proper use was undetermined even among physicians. As Barbara Katz Rothman so insightfully

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168 Wolf., 371.
169 Ibid., 289.
170 “Doctors had numerous techniques at their command and complete leeway in their use. If physicians used forceps too often, or if they intervened in the birth process too eagerly, it was because they were more persuaded by the faces of women in agony than by the cautions of their elders. Their decisions about intervention were made on the spot and in relative isolation. Even professors at the medical schools and the leading textbooks taught by anecdotal example, making generalizations hard if not impossible to construct. Physicians could convince themselves easily and in conscience that their judgement to intervene in labor was in the best interests of the
says, “one cannot explain power by the development of technology—power is a prerequisite for the opportunity to develop technology and especially to maintain control over that technology.” 171

I concede that there were some instances in which the presence of the parturient women’s friends and family at home births prevented physicians from adhering entirely to their personal agendas. One Oklahoma physician who attended home-births noted the following about attempting to undertake certain embarrassing, unnecessary procedures like shaving pubic hair: “In about three seconds about the doctor has made the first rake with his safety [razor], he will find himself on his back out in the yard with the imprint of a woman’s bare foot emblazoned on his manly chest, the window sash around his neck and a revolting vision of all the stares in the firmament presented to him. Tell him not to try to shave ‘em.” 172 But this imposition only enraged doctors; they realized they could not attain full control over the birthing process in the presence of “meddling friends,” 173 and worked hard to eliminate them, as is evidenced by their urge for women to birth in hospitals, where they were isolated.

Furthermore, having non-medical witnesses also gave physicians inclination to intervene more than they have otherwise. In 1848, Walter Channing noted, “When called to attend a laboring woman, "A doctor must do something. He cannot remain a

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spectator merely, where there are many witnesses, and where interest in what is going on is too deep to allow of his inaction. Let him be collected and calm, and he will probably do little he will afterwards look upon with regret.”  

And patients’ expectations were not the only things that drove them toward intervention; they also had personal investment in “doing something.” As late as 1912, a doctor in Kansas noted “Perhaps the best way to manage normal labor is to let it alone, but you cannot hold down a job and do that.” This shows that doctors’ investments in their own professional successes fueled them to intervene, even if their actions were not in the best interests of their patients. The continued use of obstetric anesthesia, despite emerging evidence of its dangers, exemplifies this.

Therefore, I argue that medicalization of childbirth caused the recession of female autonomy from the start. Certainly, as I demonstrate in the next section, hospital births were the epitome of physicians’ discretionary power, but I to point out that their control over technology, both access and operation, gave them control at home also.

Hospital Births and the Recession of Women’s Autonomy

The medicalization of childbirth was consummated through the normalization of hospital births and the moral values they came to embody, just as doctors had intended. The notion of hospital births as the moral option has only intensified,

\[174\] Channing, "A Treatise on Etherization in Child-Birth."

despite resistance and the natural birth movements. The former president of the
American College of Obstetrics and Gynecology declared in 1992, “‘Home birth is
child abuse in its earliest form.’”

Although women had been losing autonomy in their birth processes since the
beginning of medicalization, doctors assumed an enormous amount of control when
the site of birth became their own. When women delivered in the hospitals, they
were isolated from their friends and family and forced to submit to the control and
discretion of hospital personnel. These doctors and nurses had the advantage of
numbers, status as experts, and the newest technoscientific advances, which increased
medical intervention and separated women more and more from control over and
mind-body connection between their own bodies. Often, women didn’t even know
what was happening to their bodies because of anesthesia and sedatives. As
biomedicalization theory illustrates, technoscientific developments give way to more
sophisticated and complicated ones which only doctors know how to operate, which
exacerbates patients’ loss of autonomy. Furthermore, not having to tote equipment
from house to house enabled doctors to develop myriad elaborate technologies. These
complex technologies and an increasing number of medical personnel who
specialized in obstetrics and obstetric technologies left women entirely subject to
their power and discretion. Hospitals symbolized the coming together of all the
factors that led to medicalization; technology, unequal gender relations, science, and
education.

176 Pamela Warrick, "Midwives to Leave Home: Denied Malpractice Insurance,
Women Who Assist Home Births Face Two Choices: Go Establishment, or Go
Doctors hailed hospitals as the safest place for a woman to give birth, but the hospitals in the early twentieth century, when hospital births became fashionable among the middle- and upper-classes, still lacked regulations, much less standards rooted in scientific understanding. The previous section demonstrates the potentially detrimental consequences of the lack of regulations in the use of surgical tools like the forceps, whose dangerous application also happened at home. But hospitals were also hubs of contagion. Puerperal fever, also known as childbed fever, was the leading cause of maternal mortality from the second half of the nineteenth century till the mid-twentieth century.177 As Wertz and Wertz, puerperal fever is the “classic example of iatrogenic disease--that is, disease caused by medical treatment itself,” and yet the medical community was incredibly slow to respond to the findings that it was spread by the transfer of deadly bacterium, which could be accumulated in autopsies, into the bloodstream, and more significantly with Louis Pasteur’s germ theory in the late nineteenth century. This demonstrates the resistance doctors developed to admit that they provided anything but help to birthing women.178 Rather, they speculated that it was autogenic, a self-infection caused by women’s own fluids, and others blamed women’s morals and behaviors.179

When doctors finally accepted that they were the vectors of the contagion, rigidity and standardization and prophylactic procedures were emphatically introduced into obstetric practice. Whereas doctors had previously refused to wash their hands and wear rubber gloves, they suddenly became obsessed with sterility and

179 Ibid.
cleanliness. Although this was undoubtedly a good development for eventually stopping the spread of the disease, the obsession with sterility and rigid procedures served to dehumanize parturient women, and reinforce the medical model of their bodies as machines. Birth was, more than ever, cast as a medical condition, a sickness, for which active, invasive medical intervention was necessary.\textsuperscript{180}

Joseph B. DeLee’s “prophylactic forceps operation,” which gained widespread acceptance in the 1920s and 1930s, embodies these dehumanizing efforts and their successes in the name of sterility and safety. According to DeLee, birth was pathogenic, that is, disease-producing, and anything pathogenic is pathologic or abnormal.\textsuperscript{181} He went on that “only a small minority of women escape damage during labor,” and furthermore, “so frequent are these bad effects, that I have often wondered whether Nature did not deliberately intend women should be used up in the process of reproduction, in a manner analogous to that of salmon, which dies after spawning?”\textsuperscript{182} DeLee proposed a prophylactic procedure in which physicians would administer scopolamine, a sedative, then perform episiotomies, which involved cutting open the perineum, the area between the vaginal opening and the anus, to expand the birth canal, and then using the forceps to deliver.\textsuperscript{183} These efforts were

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\textsuperscript{180} “…it is clear that doctors’ need to prevent puerperal fever contributed to the dehumanization of birth. Doctors not only had to control more carefully the processes and contexts of birthcare, they also had to bring preventive treatment to each pregnant and parturient woman, however healthy, because each woman was susceptible to infection from the doctor and the medical environment. Doctors had to regard each woman as diseased, because birth provided the occasion and medicine the cause for infection.” (Ibid., 128).
\textsuperscript{181} Rothman. \textit{In Labor}, 59.
\textsuperscript{182} DeLee. 298.
\textsuperscript{183} Ibid.
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ineffective—these proposals emerged in the 1920s, but puerperal fever was not eradicated until the onset of antibiotics in the 1940s. Furthermore, their increased interventions caused more infections.184

As the doctors separated their mind from their bodies, these women too suffered a loss of connection to and control over their bodies, as technologies and protocol took over. Once the women, who had originally been so excited about delivering in hospitals, began to severely suffer the effects of this dehumanization and loss of autonomy, stories of the terrors that went on inside maternity wards emerged. Women had originally chosen physicians because they were “representative scientists,” who seemingly had credibility. Eventually, though, like by the time hospitalized births were normalized, there was no other option.185 A great example is a series of submissions to the Ladies’ Home Journal, sparked by an anonymous letter to the editor written by a registered nurse expressing the horrors she witnessed in her work. As witnesses to these actions, and the women who experienced them, provide the best evidence for what happened within the confined of twentieth-century maternity wards, a few of these submissions are worth exploring.

Here is an excerpt of the original submission from a registered nurse who worked in a maternity ward:

I feel compelled to write you this letter asking you to investigate the tortures that go on in modern delivery rooms…I was and still am shocked at the...

184 “Pasteur had shown that the presence of bacteria alone was not enough to cause infection; a wound had to be present to allow bacteria to enter the bloodstream. Although all puerperal women were ‘wounded women,’ those who had additional trauma from operative interventions were even more susceptible to infection. This was forgotten by many hospitals, which hoped to prevent infection by asepsis alone.” (Wertz, Lying-In: A History of Childbirth in America, 127).
185 Ibid., 39.
manner in which a mother-to-be is rushed into the delivery room and strapped down with cuffs around her arms and legs and steel clamps over her shoulders and chest. At one hospital I know of it is common practice to take the mother right into the delivery room as soon as she is ‘prepared.’ Often, she is strapped in the lithotomy position, with knees pulled far apart, for as long as eight hours. On one occasion, an obstetrician informed the nurses on duty that he was going to dinner and that they should slow things up. The young mother was taken into the delivery room and strapped down hand and foot with her legs tied together.\footnote{Gladys Denny Shultz, "Journal Mothers Report on Cruelty in Maternity Wards," \textit{Ladies' Home Journal} 75, no. 5 (1958), 45.}

This submission was noteworthy for the mere fact that it was rare for any member of the medical community to speak out against it. It is no surprise then that her words gave victims of this violence the courage to share their stories. One woman in Elkhart, Indiana, described giving births in hospitals as “is a horrible nightmare.” She went on, “They give you drugs, whether you want them or not, strap you down like an animal. Many times the doctor feels too much time is being taken up and he either forces the baby with forceps or slows things up.”\footnote{Ibid., 44.} Another woman in Columbus, Ohio recalled the following: “Women are herded like sheep through an obstetrical assembly line, are drugged and strapped on tables while their babies are forceps-delivered…Modern painkillers and methods are used for the convenience of the doctor, not to spare the mother. There is so much that can be done to make childbirth the easy natural thing it should be, but most of the time the mother is terrified, unhappy, and foiled in every attempt to follow her own wishes.”\footnote{Ibid.}
The journal recorded the response of Dr. Herman Bundesen, the president of Chicago’s Board of Health at the time, which demonstrates that doctors prioritized dehumanizing protocols, rather than women’s psychological and physical experiences: “We do not believe that mothers should be strapped to the delivery table, except as is necessary to keep the patient from contaminating the sterile area.” 189 Two women wrote that one of the hardest parts about delivering in hospitals was being separated from loved ones. Being with them would be more effective than any painkiller or sedative and would expose and stop the atrocities that happened in maternity wards, which were allowed to continue because there were no witnesses. 190

The maternity ward culture, however, persisted, creating myriad opportunities for obstetric violence and doctors’ abuse of their power.

**Conclusion**

The role isolation from loved ones played in doctors’ discretionary powers, which were not always used in the patients’ best interest, demonstrates one of the most severe, underestimated, consequences of doctors being the primary birth attendants. Once physicians established their platform and place in the birthing room, and as science became a more reputable field with developments that came to represent modernity and progress, there was no turning back to the days of midwifery, where women had psychological supports with practice and emotional

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189 Ibid.
190 Ibid.
experience and the empowering ceremonies accompanying childbirth. New technologies, power dynamics inherent in physician-patient and male-female interactions, and isolation from loved ones worked hand in hand when births came to the hospital to eradicate whatever female autonomy remained. This loss of autonomy also resulted in a fundamental dissociation between women’s psychological connections to their bodies and its functions, as new technologies and doctors’ use of them not only left women unable to be the primary actors in their births, but also led them to not even understand what was happening to their bodies during birth. The next chapter examines the most extreme example of women’s loss of autonomy and the abuse of medical power: coercive sterilization. This case not only demonstrates women’s loss of autonomy, but also how this history of the medicalization of childbirth resulted in doctors’ control over the entire reproductive process, and consequently the power to decide who can or cannot procreate.
Chapter Two
Eugenics, Biopower, and the Loss of Women’s Autonomy over Reproduction: Coercive Sterilizations

Introduction

The twentieth century saw an influx of biotechnologies, biomedical innovations and insights, and radical, culturally pervasive ideologies. Unlike the previous era when the public relied on scientific promises of progress, by the middle of the twentieth century, science had demonstrated its ability to effect tangible change and alter lives, particularly in the medical sphere. The medical institution of power that had been forming in the nineteenth century was firmly established; physicians were finally saving lives using biomedical innovations, such as the antibiotic movement in the 1940s. In fact, the 1930s-1950s are often referred to as the “golden age” of medicine. As the medicalization framework explains, this expansion of medical power resulted in its increased control over bodies and discretionary power over the application of scientific knowledge and technology. As Barbara Katz Rothman points out, although scientific and medical information is often presented as “fact,” it is essential to remember that all knowledge has social, political, and cultural origins. In the same vein, knowledge has cultural applications. This is essential to keep in mind considering how social movements and ideologies of twentieth-century America ignited an obsession over populations and their makeup, and the realization of obstetrics’ power to control them.

The eugenics movement of the twentieth century influenced the American social structure, and created newfound connections between obstetrics and the government. Coercive sterilization in the United States has been explored by a number of feminist scholars to illuminate the power of the medical institution and its frequent influence of patriarchal norms over their actions [Roberts, 1999; Ordover, 2003; Stern, 2005]. The case of coercive sterilization represents the pinnacle of the loss of female autonomy over their reproductive processes, symbolizing the power of doctors’ discretion, the influence of cultural movements, and the relationship between medicine and the government, and commitment to government initiatives.

Doctors’ implementation of government initiatives to control who had the right to procreate indicates the influence of eugenic thought and biopolitics, as biomedical technologies were used to control the sexuality of targeted populations. Michel Foucault uses the term biopower to describe the kind of power that functions in the context of eugenics. Biopower invests in life, to foster health and survival of favored populations. One pole of biopower targets the individual body by focusing on “its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls.”¹⁹² The second focuses on the strategic regulation of and intervention on entire biological populations to maximize a state of health. The extension of control over the individual body and collective biological processes comprises a powerful “bipolar technology: anatomic and biological, individualizing

and specifying, directed toward the performances of the body, with attention to the processes of life” that represents the “control over life.” These conjoined strategies are deployed according to social norms that generate and justify social hierarchies.

Medicalization started with doctors’ participation and intervention in childbirth itself, but during the twentieth century, doctors took control of the entire reproductive process. This is evidenced by the fact that every stage of reproduction—prevention, conception, abortion, pregnancy, and childbirth itself—serves as a site of medical intervention. As the government and medical establishment came to the realization that control over reproduction meant control over populations, women lost their power over their reproductive processes, but also of the power to choose to create or not create life. As had been true throughout the medicalization process, some women were more susceptible to the loss of reproductive autonomy than others were. Medical institutions and government agencies were functioning under patriarchy, which, in conjunction with systemic, culturally pervasive racism, classism, xenophobia, and homophobia, which was exacerbated by the contemporary social climate, targeted certain women for obstetric abuse.

Contraceptive technologies that emerged during the twentieth century, like the birth control pill, IUDs, and surgical sterilization, gave doctors the power to decide who was “fit” enough to procreate and to actively prevent the “unfit” from doing so. Assisted reproductive technologies, like artificial insemination and in vitro

193 Ibid.
194 “In a society marked by racial hierarchy, these principles inevitably produced policies designed to reduce Black women’s fertility. The judgment of who is fit and who is unfit, of who should reproduce and who should not, incorporated the racist ideologies of the time” (Roberts, Killing the Black Body, 83).
fertilization, represented an opportunity for “infertile” people—including queer couples—to reproduce, but doctors had the discretionary power over who was entitled to offspring, and often discriminated against single women and gay parents.\textsuperscript{195} The necessity of doctors for abortions, whether surgical or medical, gave them the authority to determine how much of women’s bodies count as their own, and to what extent this applies for different groups of women, and to evaluate what constitutes personhood.\textsuperscript{196} Ultrasounds gave doctors surveillance over women’s pregnancies enabling them to screen for “defects” and predict genders and due dates.\textsuperscript{197} Finally, the mastery of cesarean sections, especially when used with electronic fetal monitoring, systems that provided doctors with unreliable data that led to unnecessary surgeries, gave doctors the power to choose the time of delivery, reduce the time of labor, and perform invasive procedures that separate women from the natural functions of their bodies.\textsuperscript{198}

In this chapter, I examine coercive sterilization in the United States in the late 1960s and early 1970s explore the loss of female autonomy that resulted from medicalization. I will analyze the infamous case of Madrigal v. Quilligan in


\textsuperscript{196} Bayla Ostrach and Melissa Cheyney, "Navigating Social and Institutional Obstacles: Low-Income Women Seeking Abortion," \textit{Qualitative Health Research} 24, no. 7 (2014).


\textsuperscript{198} Matthew Withiam-Leitch, James Shelton, and Emily Fleming, "Central Fetal Monitoring: Effect on Perinatal Outcomes and Cesarean Section Rate," \textit{Birth} 33, no. 4 (2006).
California to illuminate how the medicalization of childbirth and history of obstetrics enabled the power of the medical sector to perform such actions. Using accounts of affidavits from the case, direct citations from the trial records, interviews of the victims and doctors in a documentary, government statements, demographic studies, investigative group report findings, contemporary newspaper articles, and secondary historical sources of analysis, I document how the medical community responded to government efforts to implement eugenic policies, and the significance of contraceptives as contemporary obstetric technoscientific developments. I then show how the connections between the government and obstetric field, as two institutions of power, functioned in a particular cultural climate to create conditions conducive to obstetric abuse. I interpret the astonishing rates of coercive sterilizations that happened in the latter half of the twentieth century, primarily of poor women of color and immigrants, and why these events affected women differently. Building on the argument I made in Chapter One, I use biomedicalization to point out the ways in which technoscientific advances can empower some groups while furthering the oppression of others, which is true of sterilization, which white women celebrated as a liberatory development. Furthermore, these technologies which only doctors could control created the illusion of choice for women.
(Neo)Eugenics and the Government in Twentieth-Century America

The rapid proliferation of medical technologies in the latter half of the nineteenth century, including surgical instruments and procedures, biomedical devices and monitors, and pharmaceuticals, established medicine as an institution of power and officially endowed it with the authority attributed to legitimate sciences. Darwin’s radical theory of evolution, published in 1859, placed humans at the top of the natural order. Anthropocentrism intensified as science seemed to be achieving absolute control over nature and the power to manipulate it. Because the theory was introduced into a patriarchal, elitist society functioning under racist values, old efforts by white males to classify types of people as more or less civilized—as superior or inferior—reemerged with the false backing of scientific proof. By 1883, these efforts took form in “eugenics,” a field created by the Brit Francis Galton, Darwin’s cousin, who presented it as a “the science of improving stock…to give to the more suitable races or strains of blood a better chance of prevailing speedily over the less suitable than they otherwise would have had.”199 By the twentieth century, Americans were desperately striving for progress, and science, more than ever, was coming to represent the promise of the technologies that would enable this modernization.

Eugenics, derived from the Greek words for “well born,” gained immediate international attention, providing scientific justification for social efforts to maintain patriarchal, elitist, racist power structures. In America, eugenic propaganda flooded public media, literature, and discourse throughout the early twentieth century, gaining considerable traction among the socially privileged and the government.

Because of its pervasiveness, widespread acceptance, and status as a science, the government prioritized active efforts to implement policies and initiatives with blatant eugenic motives. Dorothy Roberts even uses the phrase “eugenics movement” as synonymous with the government: “The eugenics movement…did not rely on nature to eliminate the unfit. It implemented a more direct means of weeding out undesirable citizens. The movement’s most lasting legacy is its coercive enforcement of negative eugenics, which aimed to prevent socially undesirable people from procreating. Eugenicists advocated compulsory sterilization to improve society by eliminating its ‘socially inadequate’ members.”

By 1935, thirty-two states had implemented compulsory sterilization laws for criminals and patients at state mental institutions.

The atrocities of the genocide committed by Nazis in World War II, contrary to expectation, did not stop the eugenics movement in the States. Rather, a mere shift in focus and rhetoric occurred, whereas the eugenic movement of the first half

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of the century had focused on the inheritance of ‘unfitness’ through genes and was rooted in biological determinism, post-World War II saw the emergence of “neo-eugenics,” which emphasized the heritability of social problems and culture.\(^{202}\) This movement was fueled by the increased number of welfare recipients that emerged during the war and after, as well as government insecurities emerging out of the Civil Rights Movement regarding the stability of their power structure.\(^{203}\) Although neo-eugenic initiatives were less formal than eugenics, it was just as discriminatory. Women of color, particularly poor women, single mothers, and immigrants became the new targets of neo-eugenic initiatives like coercive sterilizations.

The 1960s saw the emergence of the Civil Rights Movement, and an increasing number of immigrants from Latin America. The government responded to these events by creating the illusion of a national crisis due to population growth, a campaign started by Lyndon B. Johnson along with his “War on Poverty” and Immigration Act. Nixon picked up where he left off, emphasizing that population growth was the greatest challenge facing the nation for social reasons, and implementing the first government organization, the Commission on Population Growth and the American Future, whose sole purpose was to study populations and strategize ways to address its rapid growth.\(^{204}\) Reports by this committee found that there was a twenty percent population increase due to immigrants, who were often poor raising concerns among whites of a “Spanish invasion” that would cause


\(^{203}\) Kluchin

exorbitant taxes for the rest of the population to pay, and came to be known as the “Mexican problem.”\textsuperscript{205} An angry letter published in \textit{Denver Post} in 1977 is indicative of the pervasive cultural opinions at the time: “The citizens of this country are deeply concerned about the 13 million illegal aliens allowed to remain in this country, while just as many Americans are unemployed. Also millions of these aliens are collecting government benefits, at the expense of the taxpayers.”\textsuperscript{206}

The eugenics movement had created an unprecedented connection between the medical sector, particularly obstetrics, and the government—two institutions particularly susceptible to social and cultural influences—and demonstrated the power that was attained through the control over bodies. For the coincidence of eugenic thought and sophisticated obstetric advances illuminated more clearly than ever to both doctors and the government alike that the power to control bodies, particularly their reproductive functions, is the power to control populations. The government turned to the medical community to execute their eugenic, population policies, and “compulsory sterilization continued…riding a wave of enthusiasm for science and technology and benefiting from the goodwill most Americans felt toward the medical community as a result of wartime advances in research and public health.”\textsuperscript{207} The connection the government and medicine then enabled the takeover of women’s autonomy and the targeting of certain groups, justified with false scientific backing. “Eugenics gave the birth control movement a national mission and the

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\textsuperscript{206} Ibid., 26.
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authority of a refutable science...Birth control not only promoted women's health and freedom, it was also an essential element of America's quest for racial betterment. The language of eugenics, moreover, gave scientific credence to the movement's claim that birth control was an aspect of public health and improved the national welfare.”

Government dependence on the medical community for population control strengthened the autonomy of obstetricians, and thus the decreased autonomy of women over their bodies and reproductive processes. Government support of this medical power only exacerbated this loss. This made the significance of the power to govern reproduction come to full realization—it granted the power to control populations. The eugenics movement, gave the medical establishment government approval for determining who had the right to create life, and thus lessened obstetric liability for potential violations of constitutional rights. Furthermore, even official guidelines to avoid such intrusions could be, and as will be demonstrated below, often were, sidestepped by physicians, whose authority was ever increasing with governmental support and reliance. While they aimed to control the circumstances in which sterilization was permissible, they did not cover the measure required for a woman to issue her informed consent for the procedure. As Alexandra Minna Stern pointed out, this “substantial influx of resources into birth control services and the absence of standardized consent protocols made the environment ripe for coercion.”

208 Roberts, Killing the Black Body, 72.
209 Alexandra Minna Stern, “Sterilized in the Name of Public Health: Race Immigration, and Reproductive Control in Modern California,” American Journal of
But as if the governmental regulations alone, or lack thereof, were not enough, the direct control the government had over federally funded public hospitals in conjunction with the inevitably biased personal beliefs of individual doctors indicate the likelihood of high incidences of involuntary sterilizations.\textsuperscript{210} Furthermore, the responsibility obstetricians assumed to address the population problem made this circumstances inevitable. With the recent advancements in sterilization techniques and government backing, obstetrics had gained an unprecedented amount of power and women, particularly poor women of color and immigrants who were most vulnerable to government population policy and physician bias, increasingly lost autonomy over their bodies and reproductive processes and capabilities. Because it was the medical institution that actually had this power to directly control reproduction, doctors responded enthusiastically to the government’s call to arms.

The Medical Community’s Response to Eugenics and Family Planning

Physicians were not merely following orders; they, like every member of society, had personal beliefs. The execution of government sanctioned eugenic initiatives, mainly sterilizations, however, would not have been possible without obstetrics. So because, as Gutierrez writes, the “committed and proactive medical community joined an already strong population control lobby of citizen activists,

government officials, and demographers,” the medical institution, already so powerful independently, became nearly invincible. Their enthusiastic response to the government’s programs meant that two enormously powerful institutions were dedicated to the “population problem,” making the targets even more vulnerable and defenseless. As Gutierrez points out, “physicians believed their professional status and resources granted them the authority and responsibility to protect the public welfare by taking deliberate actions to reduce high rates of population growth.”

Even the American Medical Association reinforced this belief; in their 1966 revised population control policy, they announced that “the medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family.” The findings of a 1972 survey of doctors conducted by the Family Planning Digest, then, are not surprising: “The obstetrician-gynecologists were the most punitive of the doctors surveyed” with “ninety-four percent favoring compulsory sterilization or withholding of welfare support for unwed mothers with three children.”

But in addition to the strong consensus of the obstetric community that it was their responsibility as an institution to address concerns of population growth, the beliefs and opinions of individual doctors within this institution contributed enormously to the high incidence of compulsory sterilizations. Most of these beliefs

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212 Ibid., 20.
213 Ibid.
had clear racial overtones, illuminating the high vulnerability of women of color to these procedures. In his presidential address to the American Association of Obstetricians and Gynecologists in 1975, Dr. Edward C Hughes said, “people pollute, and too many people crowded too close together cause many of our social and economic problems. These, in turn, are aggravated by involuntary and irresponsible parenthood. As physicians, we have obligations to our individual patients, but we also have obligations to the society of which we are a part. The welfare mess, as it has been called, cries out for solutions, one of which is fertility control.”

One senior physician was recorded instructing his less experienced coworkers: “I want you to ask every one of these girls if they want their tubes tied. I don’t care how old they are, remember every one you get to get her tubes tied now means less work for some poor son of a bitch next year.”

Obstetricians also responded to these issues by innovating technologies; the birth control pill was approved for contraceptive use by the FDA in 1960, and the IUD went into widespread use in the 1950s. And it is no coincidence that the Pomeroy technique for tubal ligation, which involves removing a piece of the fallopian tubes and is still the most widely used method today, was published in the 1930s. Mastery of the Pomeroy technique for tubal ligation and developments in hysterectomies, as well as attempts to further simplify and modernize the ligation surgery using laparoscopy. These developments, along with notable developments in

anesthesia, such as regional anesthesia administered into the spine and affected only below the waist, and safe general anesthesia, made obstetric surgeries such as caesarean sections and sterilization feasible and easy.

I argue that this loss would none of this would have been possible had reproduction not been medicalized, for it was only because physicians had turned childbirth, and eventually reproduction, into a medical condition that the government called on them, and that they could effectively respond. It was obstetrics’ success, fortification as a unified specialty, and its scientific status, which endowed it with promise and public faith, that guided the government to the realization of nuanced ways to control population and to call on them to implement them. The inextricable ties between the medical community, particularly obstetrics, and the government which were reinforced throughout the eugenics movement demonstrate the significant ramifications of medicalization of reproduction, and its direct contribution to the loss of female autonomy over their bodies. But as if government sanctions of obstetric control were not enough to demonstrate the cooption of female autonomy, obstetricians also maintained discretionary powers which often prevailed over government regulations, examples of which will be demonstrated below. But most importantly, these attempts to “control the impending ‘population bomb,’”[placed] women’s fertility (and thus, their bodies) at the center of national interest.”

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The second-wave feminist movement, which began in the 1960s, had reproductive rights at its forefront. But second-wave feminists did not take an intersectional approach to their politics; their fight was for the rights of white women, and their campaigns failed to acknowledge the variety of experiences different women have under patriarchy. Often, white women were actively racist, not just ignorant of the specific needs of other groups of women but hostile to them, perpetuating harmful eugenic ideologies and practices and participating in oppressive cultural trends like the discrimination against immigrants.219 White feminists in California in the 1970s could be found picketing against the Chicano/a movement, holding up signs that read, “We don’t like your kind around here” and “Go back where you came from.”220 The ramifications for this exclusionary feminism were particularly dire for issues on reproductive rights, especially considering the pervasiveness of eugenic ideology. White women fought hard for the right to abortion and provision of contraceptives on demand. That only the medical community could provide these resources illustrates the dependence women were forced to develop on obstetricians for their reproductive freedom, and the autonomy that was taken away from them. But the factors that influenced individual doctors’ and hospitals’ applications and provisions of these resources demonstrates how this non-

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intersectional feminism contributed to the likelihood of coercive sterilization of women of color.

Middle- and upper-class white women, then, maintained more autonomy than others. Their focus on contraception availability, particularly sterilization, as liberatory ignored the various cultural and logistic values of motherhood of other groups. In the *Boston Female Liberation Newsletter*, a woman wrote that, along with abortion, “’Sterilization is a right that must not be denied to anyone desiring it, whether that person has ten children or none at all.’” As Nelson rightfully concludes, “while her assertion made sense to women who wanted to end their capacity to reproduce, the letter-writer did not acknowledge the complexities of such a demand in a context in which some women were sterilized without their consent.”

At the heart of this nationwide obsession with the American population was the control over women’s bodies and their reproductive capacities, and thus, the loss of female autonomy, specifically for certain groups due to pervasive eugenic ideology. While some bodies were liberated by new obstetric developments, others were subject to their abuse. As scholar Dorothy Roberts says, “The alliance of the eugenics and birth control movements bolstered the contemporaneous struggle for women's emancipation. At a time when white women were largely confined to the domestic realm, eugenics included women as active participants in a crusade of scientific and political importance. Because eugenics concerned the quality of

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offspring, its prescriptions were often directed at women and women’s role in society…it was an exclusive liberation in the service of racist social ends.”

That women of color not only did not even have the support of white women, but faced more harm due to their agenda, made sterilization even more possible, supporting doctors and their discretion. I argue that the loss of autonomy would not have been possible had reproduction not been medicalized. It was obstetrics’ success, fortification as a unified specialty, and its scientific status, which endowed it with promise and public faith, that guided the government to the realization of nuanced ways to control population and to call on them to implement them. The inextricable ties between the medical community, particularly obstetrics, and the government which were reinforced throughout the eugenics movement demonstrate the significant ramifications of medicalization of reproduction, and its direct contribution to the loss of female autonomy over their bodies. But as if government sanctions of obstetric control were not enough to demonstrate the cooption of female autonomy, obstetricians also maintained discretionary powers which often prevailed over government regulations, examples of which will be demonstrated below.

Coercive Sterilizations and Obstetric Violence against Women of Color

The resultant power of two enormously authoritative institutions—the government and medicine—working in conjunction, in addition to such pervasive discriminatory ideologies that these institutions were so adherent to, makes the high

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222 Roberts, *Killing the Black Body*, 76.
incidence of coercive sterilization unsurprising. As one historian points out, “from the earliest days, the implementation of sterilization policy was discretionary. A formal requirement that advice be non-coercive and that consent be voluntary meant little if state officials such as doctors, nurses, welfare officers, and family planners bombarded uneducated people with ‘expert’ arguments in favor of sterilization.”

Racism was indisputably at the heart of eugenics from the outset. However, the eugenics movement and advent of compulsory sterilization laws in the postwar years was centered on genetics, a field gaining substantial recognition in the first two decades of the twentieth century with increasing widespread acceptance of Mendel’s laws, and primarily targeted the “feebleminded”—patients of state institutions with mental illness. After the war, eugenic thought and action in the States remained just as pervasive, though its aims and the rhetoric surrounding it had shifted, and women of color and immigrants, particularly those who were poor and recipients of welfare, became the new targets of these initiatives. The first instance of compulsory sterilization to come to national attention was the sterilization of Carrie Buck, an eighteen-year-old inpatient at a mental hospital in Virginia. Her loss in the 1927 case *Buck v. Bell*, in which she and her family charged her doctor for coercively sterilizing her, symbolized federal approval for the involuntary sterilization and justified it as constitutional.

Though the Buck v. Bell case raised national awareness about the realities of compulsory sterilization, the practice did not receive condemnation. This is

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exemplified by a 1937 *Fortune* Magazine that asked the following: “‘Some people advocate compulsory sterilization of habitual criminals and mental defectives so that they will not have children to inherit their weaknesses. Would you approve of this?’” Sixty-six percent answered affirmatively for mental defectives, sixty-three percent answered affirmatively for criminals, and fewer than one in six directly opposed it.  

But this case happened in a time where compulsory sterilization laws of institutionalized people were in effect. After the war, although these laws began to disappear, new regulations emerged that made non-institutionalized populations of socially vulnerable people, like women of color, immigrants, and welfare recipients, more subject to medical abuse. In Alabama in 1973, two young, teenage African American girls were taken to a hospital by a state nurse. Their mother, who was illiterate, was told her daughters would be receiving federally funded contraceptive pills, and asked her to sign a form. Unable to read what it said, she marked an “X” on the signature line. She was unaware that she was signing a consent form for the sterilization of her daughters. The two girls were separated from their mother, kept in the hospital overnight, where their father attempted to visit them and was turned away, and were finally sent home. It was only then that they learned they had been sterilized. This case was taken to court, but after an initial ruling on the Relf sisters’ behalf, the case was returned to the court and dismissed.  

A decade earlier, in 1961, Fannie Lou Hamer, an African American woman who became an active civil rights leader, recalled her trip to the North Sunflower County Hospital in 1961 where she

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intended to receive an appendectomy. She learned after the procedure that she had been sterilized. She made the following estimation based on her own experiences: “in Sunflower County, the North Sunflower County Hospital, I would say about six out of the ten Negro women that go to the hospital are sterilized with the tubes tied.”

This was such a common practice, they came to be known as the “Mississippi appendectomies.”

Scholars have extensively investigated the coercive sterilizations in twentieth-century America that stripped away the right and ability to procreate from hundreds of thousands of women without their consent, and in many cases, without their knowledge. These historical analyses demonstrate that women of color, particularly those of low socioeconomic status, were predominantly and disproportionately the victims of involuntary sterilizations and that although these procedures were made possible through loose federal and state regulations, doctors’ individual beliefs and personal motives contributed significantly to the high incidence. Scholars also agree that forced sterilizations epitomizes the loss of female autonomy over their bodies.

In the next section, I conduct an analysis of these events using my theoretical frameworks to demonstrate how this loss of autonomy is the direct consequence of medicalization of reproduction or, in other words, that the medicalization of reproduction eradicated female autonomy over reproduction. Analyses often attribute

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227 Roberts, Killing the Black Body, 90.
these events to a newfound government control over women’s reproduction, and an increasing faith of the medical sector and perception of doctors as “experts” by the public and government. I argue that the medicalization of childbirth was the original and most deeply rooted cause, and that although women’s autonomy had been decreasing since the process began, this case exemplifies one of the most extreme examples of the ramifications of medicalization. As the theory indicates, medicalization has major implications beyond mere medical treatment; the government, corporations, and the science as an institution of power are all involved. The case of medicalized reproduction demonstrates a particular attachment between obstetrics and the government because of the power to control populations, a power that increased with obstetric technoscientific advances. I use the framework of biopower to understand this phenomenon. Furthermore, the role of sterilization in the broader birth control and feminist movements indicate how this loss of autonomy, indisputably experienced by all women, is much more extreme, and potentially harmful, to certain groups of women. Moreover, while some technologies can be liberatory for some groups, they can simultaneously be used as tools of subordination for others. Intersectional analysis is thus required to understand these issues. A close look at instances of coercive sterilization, then, could take myriad forms. I choose to focus on the experiences of ten women at a hospital in California which will effectively illustrate the extreme extent to which female autonomy over reproduction was lost as a direct result of medicalization, and the varying degrees to which different groups of women experienced this loss of autonomy.
Family Planning and Sterilization in California

California was the epicenter of the nation’s fixation on population control that inspired compulsory sterilization and policies. The Population Committee’s report found that throughout the 1960’s, twenty percent of the nation’s population growth could be attributed to immigrants, and that eighty percent of these “illegal aliens” were Mexican. \(^{228}\) The study also reported that California had had experienced a rate of population growth double that of the nation. These findings caught national attention immediately, exacerbating perceptions of the “Mexican problem” and “Spanish invasion.” That the report also claimed that “the majority of new foreign residents are from areas which are associated with high fertility and rapid population growth,” making them more susceptible to sterilization abuse.\(^{229}\)

These fears were exacerbated among white Americans in response to a recession between 1970 and 1971 that left many Americans unemployed. As scholar Elena Gutierrez concludes, “if many experts cast overpopulation as an impending national problem, most identified California as the site of its first and worst incarnation.”\(^{230}\) The fact that Los Angeles was of the most politically active cities during the Civil Rights Movement increased government and public fear among the white populations of the stability of their power. In response, “immigration reform was included under the rubric of population policy discussions, as were the fertility

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\(^{229}\) Ibid., 32.

\(^{230}\) Ibid., 29.
rates of particular immigrant groups” in California. This had particularly dire consequences for federally funded, public hospitals, where the rates of sterilization sky-rocketed.

This fear was reflected in sterilization trends even before the neo-eugenic era of the movement. As one of thirty-two states to have implemented compulsory sterilization laws for institutionalized persons and criminals before the war, California alone was responsible for a third of the more than 63,000 forced sterilizations that occurred before the 1960s. A close look at instances of coercive sterilization in California, then, could take myriad forms. I choose to focus on just one case which effectively illustrates to extreme extent to which female autonomy over reproduction was lost because of medicalization, and the different degrees to which different groups of women experienced this loss of autonomy due to their identities and the contemporary social climate.

Public Hospitals and Sterilization: Los Angeles County Medical Center

“They told me, ‘The baby is coming out feet first. You’re both going to die. Choose: you or the baby?’ I said to save the child. The doctor said, ‘No, I’ll save you both.’ Then, before the birth, the doctor called in a young nurse who said, ‘you need to sign’ a form that was in English. ‘You need to sign right away; they’re going to do a C-section.’ I said I couldn’t sign it without my husband there. ‘If you don’t sign, you’ll die.’ Then they grabbed my hand and signed my name. I didn’t know I was

231 Ibid., 32.
sterilized until four years later.” Dolores Madrigal, recalled her experiences forty-two years later in an interview featured in the 2015 documentary, No Más Bebés about Madrigal and nine other Mexican women coercively sterilized at The Los Angeles County Medical School (LACMC) in the late 1960s and early 1970s and eventually pressed charges in a case known as Madrigal v. Quilligan. These were most certainly not the only coerced sterilizations that occurred at LACMC; one former physician at LACMC estimated that twenty to thirty percent of the doctors there used aggressive tactics to force sterilization on women “who either did not understand what was happening to them or had not been given the facts regarding their options” for alternative contraceptives, nor were they provided accurate details of the procedures—most of the women who underwent the surgery thought it was reversible.

LACMC was the largest public hospital in Los Angeles county in the late 1960s and early 1970s, and the top training medical school in the country. It primarily served low-income people of color and non-English speaking immigrants—it was a place one went to only when they could not afford private surface or have sufficient healthcare. This is not surprising considering the trend from the earliest stages of medicalization of using the bodies of poor, typically urban, women for obstetric training and experimentation in lying-in facilities and charitable hospitals. Furthermore, public hospitals were federally funded and therefore had particularly

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close ties to the government. By 1974, the federal government was paying for the sterilizations of 100,000-150,000 low-income women annually.\footnote{Ibid.}

The orientation of new physicians at the LACMC illustrates how integral sterilization was to the hospital’s principles. Each incoming resident was required to watch a screening of a 1965 training film called \textit{Fertility Control and the Physician}, which emphasized that “‘The resolution of the American Medical Association states that an intelligent recognition of the problems that relate to human reproduction including the need for population control, is a matter of responsible medical practice.’”\footnote{\textit{Fertility Control and the Physician}, (1965), quoted in Tajima-Peña, \textit{No Más Bebés}, 2015.} The film shows four doctors, all male, surrounding an unmoving African American patient, focusing exclusively on their tools and the sewing of her internal genitalia. The video serves to dehumanize the patient and emphasize that it is the doctors who have control over her body, for they have the advantage of numbers and mastery of tools.

Dr. Karen Benker, former resident at LACMC who testified on behalf of the plaintiffs, recalled another aspect of initiation into the obstetric community: “students assigned to obstetric rotation would put on their white coats, go on tour with Dr. Quilligan [the chief of obstetrics and gynecology at LACMC] who told them ‘proudly’ that ‘they’d gotten a big grant to see how low they could cut the birth rate of the negro and Mexican population.’ We were floored.”\footnote{Karen Benker, interview by Renee Tajima-Peña, \textit{No Más Bebés}, 2015.} The doctors at the county hospital, then, were not only prejudiced with discriminatory beliefs and ideas of
women of color as opportunities for training, but also less skilled. One former resident at LACMC, Dr. Jerry Neuman, recalled having a one-hour long orientation with junior and senior residents on his first day at the hospital, then being told simply to “go.” But despite their inexperience, they were granted absolute discretionary power, and encouraged to perform surgeries. “Modern medical practice assigns a high priority to surgical experience. This preoccupation with ‘cutting’ encourages hospital personnel to solicit consent for sterilization operations for the purpose of training interns. Generally, the patients selected for this training are poor women.”

One survivor of coercive sterilization at LACMC remembered being situated in the delivery room, isolated from friends and family, and hearing the doctor tell an inexperienced student in training, “she’s ready,” before leaving the room himself.

Although hospital births were normalized for all classes in the twentieth century, the quality of hospital care varied drastically, particularly between public and private hospitals. Women who could afford private hospital care certainly experienced more autonomy than other women who delivered in public facilities, as is demonstrated by this case. One scholar pointed out “the implicit acceptance of a two-tiered medical standard. County hospitals could not be expected to extend the same level of care or respect or even disclosure as facilities serving the middle classes and the affluent. The poor should neither expect nor demand comparable treatment, even in matters of such gravity as surgery.”

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238 Jerry Neuman, interview by Renee Tajima-Peña, No Más Bebés, 2015.
239 Hernandez. “Chicanas and the Issue of Involuntary Sterilization.”
241 Ordover, Race, Queer Anatomy, and the Science of Nationalism, 175.
would go up to a woman in a private hospital while she was in labor and ask if she wanted to get her tubes tied. They would have gotten probably thrown out of the hospital and gotten sued by the patient.”

Considering the medical profession’s dedication to government population initiatives and the role of their own biases, it is not surprising that this hospital, which served so many patients people found responsible for the “Mexican invasion,” targeted Mexican women for sterilization using, as will be illustrated later, aggressive tactics, such as requesting consent while the woman was in labor. “deep-seated personal beliefs regarding overpopulation, coupled with a particular physician’s arbitrary belief as to what an ‘ideal’ number of children for any family should be” and “frustration over the millions of dollars spent to support the nation’s welfare programs, coupled with the conviction that ‘the more tubes you tied…the few kids you have to support on welfare later.”

If it had not been for Dr. Bernard Rosenfeld, a former resident at LACMC who published his own observations and eventually coauthored a report in 1973, it is likely that these events would have remained secret, confined within the walls of the maternity ward. When Rosenfeld began his residency at LACMC, he was shocked by the blatant prejudices his colleagues had against women of color, particularly Mexican immigrants, and they direct ways their beliefs affected their treatment of patients. First, he investigated the unethical tactics he observed obstetricians employ

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242 Bernard Rosenfeld, interview by Tajima-Peña, No Más Bebés, 2015.
to coercively sterilize their patients by reviewing hundreds of medical files of patients with Latina surnames. Rosenfeld noticed a significant trend of tubal ligations that resulted from caesarean sections, which themselves were often medically unnecessary, and that sterilizations were agreed to after an average of four attempts, and the consent forms were almost always signed while the women were in labor.\textsuperscript{245} Furthermore, at LACMC, “the consent form does not tell the patient that deciding against sterilization will not end other benefits and programs such as welfare and child support, and it does not tell the patient that sterilization must be considered permanent. But hospitals can’t comply unless they are aware of the rules. HEW has left policing to the states.”\textsuperscript{246}

Even though tubal ligations, whose technique had been mastered and made efficient by the 1960s and 1970s, were less costly and decreased recovery time, his report found that the rate of hysterectomies at LACMC between 1968 and 1970 increased by 742 percent.\textsuperscript{247} This evidences physicians’ reliance on county hospitals, with poor clientele, as training facilities. He reported that when a student at LACMC had asked a resident why the woman they were tending to was receiving a hysterectomy rather than a tubal ligation, the physician responded, “we like to do a hysterectomy, it’s more of a challenge…you know a well-trained chimpanzee can do a tubal ligation.”\textsuperscript{248}

\textsuperscript{245}Gutierrez, \textit{Fertile Matters: The Politics of Mexican-Origin Women’s Reproduction.}
\textsuperscript{246}“Sterilization by Intimidation.” \textit{Los Angeles Times}, 1974.
\textsuperscript{247}Rosenfeld, Wolfe. “A Health Research Group Study on Surgical Sterilization: Present Abuses and Proposed Regulations.”
\textsuperscript{248}Ibid.
Even so, the rate of tubal ligations at LACMC during the same time period increased by 470 percent, and there was an 150 percent increase in postpartum tubal ligations. That doctors’ primary interest was the training of new doctors who could confidently take over their control over reproduction demonstrates the diminishment of women’s best interest from physicians’ agendas. These surgeries were to benefit and establish the control of physicians, rather than for the women’s best interests, which is demonstrated in a 1974 report by the Hastings Center, one of the original bioethics research institutes: “the training of a surgeon is an initiation into a system which holds cutting sacred and gives little or no credit for ‘abstinence.’ The surgery specialty and subspecialty boards, including the American Board of Surgery, entrench this philosophy by stipulating numbers of operations at which the candidates must assist or perform. The early ‘rewards’ for doing more operations on the poor and disadvantaged in the form of residency certification and specialty board qualification are translated, after training, into financial rewards wherein, the more you cut, the more money you make.” The county hospital, then, provided the perfect opportunity for these trainings and experiments to take place: it was a “fertile climate…where medicine is in high-volume, often impersonal—and practiced on patients who are generally poor, frightened, and uneducated.” Indeed, the maternity ward was always so crowded that women often went into labor in the hallway. Dr.

249 Ibid.
Howard Blanchette, a former resident at LACMC, remembered the maternity ward as a “war-zone.”

The obstetricians and nurses who worked in this war-zone, located on the fifth floor were the generals. Doctors in administrative positions like Dr. Edward Quilligan, the former head of Obstetrics and Gynecology at LACMC, had their offices on different floors of the large complex. When asked in 2015 for his opinion on Quilligan’s involvement, Dr. Blanchette said, “Dr. Q wouldn’t have known what was going on down there. He was upstairs. Residents were responsible for taking care of patients.” But not only did he claim not to know what happened in the maternity ward; he also said he was unaware of federal guidelines concerning consent of sterilizations. To a Los Angeles Times reporter, he said he “did not recall having seen the guidelines” and “after the regulations were read to him, Quilligan replied: ‘well, I would have to agree that, in some areas, we’re probably not following them at the present time.’” Furthermore, he justified what happened in his maternity ward by making reference to government-led family planning initiatives, saying “that tubal ligations…and hysterectomies…had been part of the hospital’s family planning ‘umbrella’ since 1970.”

In conjunction with the pervasive racial and cultural biases of the LACMC doctors, the extreme targeting of Mexican women is evident and not surprising. As

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252 Howard Blanchette, interview by Renee Tajima-Peña, No Más Bebés, 2015.
Gutierrez points out, “the physicians’ attitudes toward the LACMC clientele, and their perceptions of their own role in providing a panacea for overpopulation, were intricately linked”\(^\text{257}\) In his report, Dr. Rosenfeld interviewed many of his colleagues, without them knowing. In one instance, a co-physician told him, “Well, if we’re going to pay for them, we should control them.”\(^\text{258}\) Of Mexicans, one physician told him, “all they do is screw, drink, and drive.” It was no surprise that another doctor admitted, “I picked up a new prejudice when I came here. I didn’t have anything against Mexicans when I got here.”\(^\text{259}\)

The willingness of physicians to so candidly express such culturally biased beliefs indicates that medicine had become such a strong institution of power, its members felt invincible. When Rosenfeld published his report, the California board of medical examiners accused him of receiving money from lawyers, because they couldn’t believe that he had done it out of morals and it was so rare for a doctor to go against his own community. The backlash he received from many doctors, both at LACMC and other institutions, and their vehement denial of any wrongdoing also demonstrates the egos these doctors had developed by being part of the medical institution, and is reminiscent of doctors’ long reluctance to admit they were the vectors of the contagions that caused puerperal fever in the late nineteenth century.

One doctor from Santa Ana wrote a letter to the editor of *Los Angeles Times* claiming that Rosenfeld “categorically is off base in suggesting USC-LAC Medical

\[^\text{259}\] Interview by Renee Tajima-Peña, *No Más Bebés*, 2015.
Center does sterilization operations more or less at the whim of the particular surgeon” because “the resident staff has too much to do to be looking for something superfluous to do. All California physicians….are overly careful that the individual who is being operated for tubal ligation knows what is happening…and that the patient is awake, and not in the influence of narcotics when he or she signs for the particular surgery.”260 And yet, Rosenfeld recorded one physician who recalled having asked a patient, “Do you really think it’s fair for someone else to pay for your kids?”261 One of the few Chicano doctors at LACMC recalled, “it was not uncommon for doctors to use slurs such as ‘bean’ while discussing patients. Some of the doctors there seemed to enjoy the power they had in being able to sterilize another human being. It was almost as if it gave a few of them a real potent psychological boost.”262

The ten Mexican women who pressed charges in 1975 for the involuntary sterilizations they experienced between 1968 and 1974 were primary targets: they were low-income, Mexican immigrants who, although none of them were on welfare, were eligible for public assistance. That none of the women were primarily English speaking, and some spoke no English at all, made them particularly vulnerable to coercion.

In June, 1975 the plaintiffs and their legal team, led by Antonia Hernandez, filed a class-action civil rights suit in the federal district court in Los Angeles against the director of LACMC, Dr. Edward Quilligan; the chief resident, Dr. Roger Freeman; ten individual obstetricians; LACMC; the state of California; and the U.S.

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262 Ibid.
Department of Health, Education, and Welfare. The charge was for violating the constitutional rights under the fourteenth amendment of the plaintiffs upon whom tubal ligations were performed without their informed consent, and in some cases without any consent or to their knowledge. Former resident at LACMC Karen Benker said that on “almost a daily basis,” she witnessed the following: “The doctor would hold a syringe in front of the mother who was in labor pain and ask her if she wanted a pain killer; while the woman was in the throes of a contraction the doctor would say, ‘Do you want the pain killer? Then sign the papers. Do you want the pain to stop? Do you want to have to go through this again? Then sign the papers.’”

The observations of former residents at LACMC and the findings from reports like Rosenberg’s offer important information about the inner workings of the hospital during the late 1960s and early 1970s. The biases of doctors are exposed, as are their commitment to government initiatives and willingness to work around regulations if necessary. But the only real way to know how these tactics were executed, how they expressed their discriminatory beliefs to patients, and how these actions functioned to strip women of their reproductive autonomy is from the accounts of the women themselves. To locate their voices, I use reports by Hernandez based on their affidavits from the case, and their interviews from a 2015 documentary, No Más Bebés.

There are many commonalities between the experiences of the ten women who testified in the Madrigal v. Quilligan case, and it can be presumed that these

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same tactics were used on the hundreds of other women who were coercively sterilized at LACMC. Each woman was delivered by caesarean section, and coerced into signing consent forms while they were in labor. These trends are significant for myriad reasons. As Rosenfeld found in his study, these caesarean sections were not medically necessary, 264 which has some or all of the following implications: that they were performed solely for training purposes by inexperienced doctors; that they were used as a scare tactic to threaten women and convince them that their situations were dire; or that they provided something tangible to convince women they were signing a consent form for.

Georgina Hernandez, who primarily spoke Spanish, was told “her child would be delivered by caesarean section because it would be too dangerous to deliver naturally. She signed a consent form which was written in English for what she believed to be her permission for the caesarean surgery.” 265 Furthermore, for physiological reasons, tubal ligations are easier to perform when doctors are already surgically situated in the woman’s body as they are in caesarean sections.

To ask a woman to make what one Hastings Center Report refers to as “one of, if not the most important of decisions in a lifetime” 266 during labor, arguably the most physically laborious and emotionally process one can undergo, is demonstrative in and of itself of manipulation and coercion. But not only that—these women were

265 Hernandez. “Chicanas and the Issue of Involuntary Sterilization.”
separated from their friends and family, surrounded entirely by a strange team of hospital personnel, under the influence of heavy pain killers and anesthetics, and experiencing extreme fear about their imminent surgeries and the fate of themselves and their children. Consuelo Hermosillo was, “upon the cesarean delivery of her third child…advised by her doctor that sterilization would be necessary, because a fourth pregnancy would most likely be life-threatening.”

Furthermore, “hospital personnel also strategically limited communication between laboring women and their husbands. For example, when a patient adamantly resisted sterilization, the doctor would warn the husband that his wife's health was in danger, hoping that the husband would then pressure his wife to submit to the procedure.”

Maria Hurtado was told she needed a caesarean section, then “was anesthetized with a spinal injection for the delivery of her child. After the delivery of the child, she was given general anesthesia. While under this unconscious state, she was surgically sterilized by a staff doctor without her consent.” As if these conditions were not enough evidence of coercion, these women were also primarily non-English speakers. So even if they had been in a state of complete consciousness and awareness, they would not have understood the forms they were forced to sign, nor would they have understood the terminology doctors used, such as “tying tubes.” Maria Figueroa was told by her physician that the procedure “involved ‘tying,’ not

268 Ibid., 42.
269 Hernandez. “Chicanas and the Issue of Involuntary Sterilization.”
cutting, her ‘tubes.’ She refused the operation, but was solicited again by the same doctor during her stay in the delivery room, and after general anesthesia had been administered to her. As the moment of birth neared, she reluctantly agreed to a tubal ligation.”

But these women were also targeted for their inability to speak English. According to Consuelo Hermosillo, “you speak English, they treat you one way. You don’t speak English, they treat you another way. That’s how I see it.”

Some doctors coerced women by threatening that their lives were in danger, or that their pain would only be subsided if they signed the consent forms. Maria Hurtado remembered telling her doctor, “‘It hurts!’” He responded, ‘What’s wrong? Do you want the pain to go away? Then sign, sign!’” Estela Benavides was experiencing “the fear of death from pregnancy” that had been “falsely instilled” in her by her physician when she unwillingly signed the consent form. Maria Diaz recalled, “I was in great pain. I thought I was going to die… I kept telling them no and the doctors kept telling me it was for my own good.”

But in some cases, doctors themselves instilled fear by being physically aggressive. Guadalupe Acosta, who had been experiencing pain the entire day before her delivery endured physical violence from her physician, who “pushed violently upon her abdomen in order to induce delivery. Delirious with pain, she flailed at the doctor who responded by punching her in the stomach. Her child was later born dead.

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270 Ibid.
272 Maria Hurtado, interview by Renee Tajima-Peña, No Más Bebés, 2015.
274 Maria Diaz, Trial Record, (1975), quoted in Ordover, Race, Queer Anatomy, and the Science of Nationalism.
It was during the performance of the delivery that the attending physician unilaterally decided to sterilize Mrs. Acosta."275

If these women were informed that they would be undergoing sterilization, none were told the procedure was irreversible. More commonly, though, they did not find out they had been sterilized until weeks or months after they had delivered. This is a clear demonstration of women’s loss of autonomy over their bodies and reproductive processes. But it also illuminates the power of technological developments to separate women from their bodily processes—powerful anesthesia and sophisticated surgeries, both of which doctors had absolute control over, prevented women from knowing such an invasive procedure was even happening. This demonstrates how biomedicalization served to eradicate women’s reproductive autonomy.

The women sterilized also recalled things doctors had said to them that directly evidence the way their personal beliefs and susceptibility to cultural trends influenced their medical practices. Hurtado heard her doctor say, “‘Mexican women were having too many kids,” and that they were “‘devising ways to slow down the population growth of Mexicans.”276 Jovita Rivera was told by her physician that she should be sterilized “because her children were a burden on the government.”277 Georgina Hernandez “was approached by her doctor, who first commented that Mexicans are very poor and cannot provide for her large family, and then suggested

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275 Hernandez. “Chicanas and the Issue of Involuntary Sterilization.”
276 Maria Hurtado, interview by Renee Tajima-Peña, No Más Bebés, 2015.
277 Hernandez. “Chicanas and the Issue of Involuntary Sterilization.”
that she be sterilized,”"278 “emphasizing that her Mexican birth and poverty would make the proper care and education of any additional children unlikely.”279 Dr. Benker summarizes why the accumulation of these tactics and circumstances were so harmful: “crowding, screams of pain, bright lights, lack of sleep by patients and staff, and an ‘assembly-line’ approach so that many women were literally terrified of what was happening at the time they signed the consents. Of course, this was especially true of the non-English-speaking mothers who were left with no explanation of what was happening.”280

Judge Jesse Curtis, a Nixon appointee, dismissed Quilligan and Freeman from the case, having decided that the issue was not administrative, but rather one of physician-patient interaction. Despite Benker’s testimonies of Quilligan’s prejudiced agenda—she remembered him saying that poor, non-white women in Los Angeles “were having too many babies,” which was placing a “strain on society,” and that it was “‘socially desirable’ that the women be sterilized”281—he was vindicated by the court because he was not physically present for the instances in question. Though this ruling was based on the premise that the hospital director of a department, particularly one who was highly revered, would not influence the residents who worked under him, showing a lack of recognition of medical specialties as units of power and the advantage of being able to outnumber the laboring woman with medical personnel. It

279 Hernandez. “Chicanas and the Issue of Involuntary Sterilization.”
281 Ibid.
also demonstrates the court’s failure to investigate the finding that in many public hospitals, residents were rewarded for the number of sterilizations they performed. In sum, the court did not penalize the hospital for overriding women’s reproductive autonomy, which served as a government sanction for these actions.

The case then focused on the plaintiff’s charges against the ten physicians. This was an opportunity to critically examine the power of individual doctors to strip women of their reproductive autonomy using their status as “experts” and mastery over technologies, and the dangerous ways in which society and culture influence their execution of this power over women’s bodies. But in June, 1978 the case, which had no jury, was decided by Judge Jesse Curtis in favor of the physicians. His ruling condoned the fact that doctors could have social opinions that might affect their practice.

…there is a big segment of the people in this country, and not only in this country but in the world, who believe that one of the prime causes of our social and economic problems are big families where the parents are not able to socially or economically support them…People in that category are just as entitled to their beliefs as the people who feel as the plaintiffs do here…So, I do not think it is surprising that you might find a doctor who believes that people who are inclined to have big families shouldn't, and particularly for good medical reasons, undertakes to persuade a person not to have a large family.  

Furthermore, while acknowledging how social beliefs could be pervasive on a professional level, he vindicated the physicians for their actions because they were rooted in individual, and not institutional, motives, implying that doctors always act

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in the patients’ best interests, and thus approving of doctors acting per their personal judgement:

There is no doubt that these women have suffered severe emotional and physical stress because of these operations. One can sympathize with their inability to communicate clearly, but one can hardly blame the doctors for relying on these indicia of consent which appeared to be unequivocal on their face and are in constant use in the Medical Center.\footnote{Ibid., 49.}

That Curtis also seems to blame these women for their “inability to communicate clearly,” shows how the medical and legal systems work in conjunction to strip women, particularly socially vulnerable women, of their reproductive autonomy.

\textit{Conclusion}

As soon as the hospitalization of births was normalized among all classes of women, doctors took over the reproductive autonomy that females had maintained throughout the previous stages of the medicalization process. Once doctors had successfully eradicated the factors that led to high maternal mortality rates, such as puerperal fever, and implemented strict, rigid protocols, they gained even more credibility and discretionary power. Whereas White House reports as late as the 1930s had once focused on the issue of maternal mortality rates among physician attended births,\footnote{Committee, "Preliminary Committee Reports of the White House Conference on Child Health and Protection," in \textit{White House Conference on Child Health and Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal Protection} (New York1930); Hugo Ehrenfest, "Fetal, Newborn, and Maternal} the government came to rely on obstetricians to execute their
family planning initiatives once they realized that the medicalization of childbirth gave obstetricians the power to control populations. The eugenics movement, so pervasive in America throughout the twentieth century, gave this dependence and these initiatives scientific backing for their racist, classist overtones. Furthermore, as Roberts points out, “the selective funding of birth control options takes place within a broader context of misdirected government priorities that emphasize free family planning as a solution to poverty rather than the general improvement of community health.”

The already strengthening discretionary power of physicians increased with the government support of eugenic practices, which had particularly dire consequences for the obstetric patients who were the targets of eugenic ideologies. The violence committed against the Mexican women in the Madrigal v. Quilligan case were just a few of thousands of women subject to this obstetric abuse, but they represent the particular vulnerability of these women under a regime of biopower and demonstrate the influence of cultural attitudes on individual doctors and entire hospitals, particularly those under the control of the government, and the population most vulnerable to obstetric and reproductive violence. These women were immigrants in a climate intensely hostile to immigrants of color; they could not communicate with doctors who were already well trained in practicing procedures without the women knowing, either because they didn’t communicate or because of sedatives and anesthesia; they were isolated from their loved ones. This case exemplifies the ramifications of the cooption of birth by the medical profession as

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demonstrated in the previous chapter, but also shows how this power turned into a control over all of reproduction with the development of technology and connections to other institutions of power, such as the government. When comparing these instances of coercive sterilization with white women’s attempts to access sterilization, the need for an intersectional analysis of these events is apparent. These are characteristic trends of medicalization.
Conclusion

A close examination of the history of obstetrics of course tells the story of the field’s formation, but it also demonstrates the social and cultural factors that dictate how such a formation occurs, and the ramifications of it on both an individual and population level. Obstetric practice and knowledge, like that of all medical fields, often go unquestioned and unchallenged; because medicine is a science, it is endowed with a sense of “objectivity,” founded unbiased principles and empirical techniques. As this thesis demonstrates, this notion is a myth, as cultural and social factors strongly influence the production of scientific knowledge and its applications. But this conception puts science almost out of reach of criticism and challenge, even for those operating within it. Rothman succinctly makes this point: “The obstetrical perspective on pregnancy and birth is held to be not just one way of looking at it, but to be the truth, the facts, science… we believe our medicine has the facts. But obstetrical knowledge, like all knowledge, comes from somewhere: it has a social, historical, and political context. Medicine does not exist as “pure,” free of culture or free of ideology. The context in which medical knowledge develops and is used shapes that knowledge.”

Science, then, is an institution of power, and like all institutions of power, functions under the patriarchal norms that govern society. The consequences of this are most extreme in medicine, where the application of the scientific knowledge is human bodies. But because of the social and cultural weight of reproduction and

286 Rothman, In Labor, 33.
childbirth, much less the psychological components, abuse of obstetric power is particularly dire. That women are the only potential targets of obstetric violence exacerbates the risks under our patriarchal system.

But the formation of obstetrics itself demonstrates this power at work, even before the institution had been fully established. Medical takeover of childbirth, which was previously an exclusively female ceremony with social significance as an empowering event for women, occurred at a time when physicians were invariably male, as would be the case for over another century. Charlotte Borst points out that this inherent power dynamic remains intact in obstetrics, even as the field has integrated female practitioners in recent decades: “since [the field] was originally developed as a challenge to female modes of reproductive care, its ideology has historical roots in anti-feminism…the medical styles of relating to maternity patients are predominantly masculine…doctors exercise a social control function over women’s lives that has little to do with the ostensible medical rationale of disease diagnosis and treatment.”

But gender dynamics were not the only factor that led to the medicalization of pregnancy and reproduction. At the heart of this process was technology, which I use to describe any biomedical innovation including surgical instruments, new procedures, pharmaceuticals, and hospitals. The first men to be involved in childbirth, the surgeons, were defined by their tools. As man-midwives began to replace their female counterparts, they would rely on their access to and knowledge of how to use these tools to distinguish themselves. The power inherent in having access to and

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287 Borst. Catching Babies, 45.
control over technology was apparent; it enabled them to convince women that they could ensure safer, more efficient births, as technology came to embody science and notions of progress and efficiency. As midwives had no access to these developments, women increasingly chose physicians to attend them instead.

Technology not only propelled the field forward, but came to represent the way physicians perceived the women they delivered. As Rothman points out, “The primary characteristic of the modern medical model of health and illness in general is that it is based on the ideology of technology, that appropriate to the technological society, with its values of efficiency and rationality, practical organization, systematizing, and controlling.”

Not only did physicians focus on their own technologies as the center of their practice, but also came to treat women’s bodies as technologies, a mechanistic view that dissociated women’s physical and psychological beings and defined them exclusively by their reproductive organs. This eradicated empathy and compassion from the parturient-birth attendant relationship, and led to dehumanizing procedures. Furthermore, it created an environment that was conducive to obstetric violence, and a neglect of the psychological trauma of such violence. As Borst says, “by equating women with their wombs, obstetricians define women as pregnant patients and exclude other social and emotional considerations as irrelevant to childbearing.”

At the heart of the subordination of women through the medicalization of childbirth, and eventually reproduction, is technology, instrumentation, procedure,

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288 Rothman, *Lying-In*, 34.
tools and the right to use tools, the claim of power to use the tools. Furthermore, these tools created more roles within the medical sector, making it even more inaccessible to the non-doctor and non-technician. It is clear then that women began to lose autonomy over birth as soon as doctors developed the forceps, the technology that could be used in normal deliveries, even though these early practitioners did not want to replace the women. They still withheld their tools from them, demonstrating the power of controlling access to and use of tools.

I do not intend to dismiss the myriad miracles that have resulted from the medicalization of pregnancy, and the countless lives that have been saved. But it is important to recognize that every field of knowledge, even “objective” sciences, have a socially influenced history. Every successful procedure and drug that emerges to be used on patients who can afford the technology has been tested and experimented on by people coerced into clinical trials, or used on patients who were unaware altogether of the procedure. Thomas Volscho found in 2010 that the previous decade evidenced the existing disparities between races and incidence of obstetric violence. Furthermore, Henci Goer published a follow-up fifty years after the anonymous submissions about the cruelty in maternity wards emerged in 1958 with the findings that this cruelty was still a feature of many women’s birth experiences in hospitals, and that the type of treatment they received was analogous to domestic abuse. Moreover, in regards to the obstacles to implementing a change of these

trends, he notes, “Most hospital social systems are rigid hierarchies. Because authoritarian social systems allow some individuals unrestrained dominance over others, mistreatment and abuse are likely to follow.”292 This shows that the medical institution of power remains intact, and I follow in the footsteps of Clarke et al. and Conrad in believing that this institution will only strengthen with time. I am hopeful, however, that with increasing exposure of historically unchallenged fields and structures of power, like medicine, through interpretive and critical analyses, we can help ourselves and others to navigate the medical institution more safely.

292 Ibid., 38.
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