Women, Power, and Reproductive Healthcare:

Highlights from 19th and 20th century Obstetrical and Gynecological Practice
Through a Gendered Lens

Medicine is a field of study and an established profession perceived to be guided primarily by scientific methodology and objective, rational thought. Over the years, sociologists, historians, and other scholars have critiqued these perceptions, examining and illustrating the ways medical practice shapes and is shaped by the political climate, social norms, and power dynamics between oppressed and privileged groups.¹

When seeking to better understand the relationship of the medical field to the shifting construction and enforcement of gender roles, one does not have to look far. The history of obstetrical and gynecological practice provides an intimate look into the ways perceptions of women and their bodies dictate not only medical procedures but also the construction of the very diagnoses these procedures are meant to aid.

The famous phrase “the personal is political,” made popular by Carol Hanisch in 1969, still rings true with women’s access to reproductive healthcare remaining one of the most divisive topics in American politics today.² Through the changes in obstetrical and gynecological practices over the 19th and 20th centuries, this exhibit aims to highlight the ways these practices illustrate pervading societal perceptions of women and their bodies and how these perceptions constrain and/or enhance the choices available to women in regards to reproductive healthcare.
Side-view of the female urogenital system by OHSU medical illustrator Clarice Ashworth Francone, circa 1936-1969
WOMEN, INSANITY, AND THE WOMB: Hysteria and Neurasthenia

Hysteria as a medical diagnosis gained momentum in the late 19th and early 20th centuries, a catch-all for an assortment of exhibited nervous symptoms resulting from overuse of the mind, overwork, and sexual repression. A related ailment, neurasthenia, otherwise known as weakness of the nerves, was believed to result from the stressors of working life. Although men were also diagnosed, white middle and upper-class women were disproportionately diagnosed with the disorders, particularly hysteria.4

One of the leading causes of hysteria, according to physicians of the late 1800s, was overuse of the female mind. It should come as no surprise that an increase in the diagnoses of hysteria occurred at the same time women were increasingly seeking higher education. Hysterical women were prescribed months-long bed rest with no visits from friends and family and absolutely no mentally strenuous activities, such as reading and writing. It was imperative for women to save this energy in order to fulfill their duties as wives and mothers, lest these women succumb to a miserable life of spinsterhood, or worse, utter madness. It was also not uncommon for women exhibiting extreme symptoms of hysteria to be admitted into insane asylums.5

Because female nervous disorders were perceived as directly connected to a woman’s reproductive organs, ovariotomies (removal of the ovaries) and hysterectomies (removal of the uterus) were among the more extreme treatments given. Ovarirotomies became quite popular in the Victorian era, requested by women in large numbers. It is posited that the procedure provided a covert way for women to resist the societal pressure to have or continue having babies.6

Other treatments for hysteria included hypnosis, made most famous by French physician, Jean-Martin Charcot at the Salpetriere hospital.7 Much like a circus, or even modern-day
One of the four stages of a hysterical episode observed by Charcot, 1892.

And with the widespread availability of electricity and electrical appliances in the early 1900s, women diagnosed with hysteria were then able to treat themselves at home. Relieving pent up sexual energy also believed to cause hysteria, electro-massage machines became increasingly popular. Although hysteria has gone out of fashion, the electro-massage machine, otherwise known today as a vibrator, has not.

Hysteria and neurasthenia fell out of popularity in the mid-20th century as the study of the psychosomatic within the fields of psychiatry and psychology became more established. Advances in research on diseases with a mental illness component, such as syphilis, further contributed to the diagnosis’s decline. Although no longer considered valid diagnoses, the symptoms of hysteria and neurasthenia are reflected in a variety of modern-day mental illnesses, including PTSD, chronic fatigue, and personality disorders. And it is not uncommon today to still hear the phrase: “She was hysterical!” when describing a woman displaying intense emotions.
In order to fully understand the development of obstetrical and gynecological practices, it is critical to also examine the influences of race and class. The following illustration was taken from a pharmaceutical art print distributed by the Parke-Davis company in 1961, a copy of which is housed in the HC&A Ephemera Collection.

In the image, a slave woman sits upon a table facing gynecologic surgeon, J. Marion Simms, standing arms crossed, holding an obstetrical retractor. J. Marion Simms was an Alabama surgeon who performed a series of experimental surgeries on black slave women during the years 1845-1849. Although these experiments resulted in the first successful operation on a woman with vesicovaginal fistulas, a channel that develops between the vagina
and bladder, most often caused by complications in childbirth, there is debate on whether or not these women were truly able to give their consent.\textsuperscript{13}

Medical experimentation on people of color was not uncommon practice at the time and continued to occur long after the abolishment of slavery.\textsuperscript{14} Such experiments were considered socially acceptable, reflecting the influence of racism on the history of medical research and practice in the United States.

\section*{Birth Control and Abortion}

Womens’ access to contraceptives as well as abortion services, both central components of reproductive healthcare, continue to be protested, legislated, and restricted to this day. These are not recent issues, however, as women have been employing birth control methods and seeking abortion services for centuries.\textsuperscript{15}

Historically, abortion as a term was used by obstetricians and midwives to denote not only the elected termination of pregnancy but miscarriages as well. Pierre Cazeaux’s \textit{A Theoretical and Practical Treatise on Midwifery}, published in 1863, divides abortion into three categories: spontaneous, accidental, and provoked, with provoked abortions defined the way the procedure is primarily understood in the 21\textsuperscript{st} century. Already bearing a social stigma, Cazeaux notes that provoked abortions were obtained solely through “criminal efforts.”\textsuperscript{16}

The exhibit displays an assortment of pessaries, small ring-shaped devices used both to support the vaginal walls during prolapse as well as a means of contraception. The usage of pessaries as birth control dates as far back as 400 B.C., used to administer early forms of spermicide such as coco butter and quinine as well as serving as a barrier to the cervix, blocking the ability for sperm
to pass through. Popular in the mid-1800s, German gynecologist Friedrich Wilde manufactured rubber contraceptive pessaries for women that served as a precursor to the modern-day cervical cap and intrauterine devices (IUD’s).
Midwives have assisted women in childbirth as long as there has been the written record. It was not until the 17th and 18th century that physicians began playing a more primary role in childbirth. At first, physicians only stepped in during emergency situations, leaving most cases to the midwife. As medical practice advanced and effective means of sanitation developed, however, physicians (mostly male) began systematically excluding midwives (mostly female). Midwifery courses developed by physicians in the 18th century were offered only to the male barber-surgeons of the time, and when assisting midwives during emergencies, frequently refused to pass on their medical knowledge so midwives could handle future complications without the doctor’s aid.

The application of forceps during childbirth
Labor and delivery as we know it today in the United States was largely influenced by Joseph B. DeLee’s “The Prophylactic Forceps Operation,” published in the 1920s by the *American Journal of Obstetrics and Gynecology*. The famous article champions the usage of forceps during routine childbirth as well as the necessity of the episiotomy, cutting of the perineum, in order to reduce tearing. Although still a routine procedure performed during hospital births, episiotomies are a controversial procedure, believed by many to actually facilitate tearing rather than reducing it. Those against the procedure also argue that the risk of perineal tearing is a direct result of delivering supine (on the back) or in the lithotomy position (laying on one’s back with knees bent and legs often in stirrups).
The usage of anesthetics during childbirth also has a complicated and controversial history. Ether and chloroform as an anesthetic was developed in the mid-1800s. Their usage to relieve the pain of childbirth was initially frowned upon, particularly by the church, as it was seen as going against God’s wishes. Pain resulting from childbirth was perceived by the church to be divine punishment for Eve’s sins in the Garden of Eden. As more women began seeking out the practice, including Queen Victoria who was one of the first to receive chloroform in 1853 for the birth of Prince Leopold, the usage of anesthetics for pain relief gradually gained acceptance.\(^{26}\)

Beginning in the 1930s and into the 1950s, through a mixture of morphine and scopolamine, women were brought into what was commonly known as “twilight sleep.” An amnesiac, the scopolamine disabled the woman’s ability to consciously respond to pain and contractions and remember the delivery upon waking. Women under “twilight sleep” were frequently restrained in order to disable their ability to thrash around during the procedure.\(^{27}\)

Women still receive anesthetics for pain relief today, most commonly administered using an epidural anesthetic, allowing the woman to stay conscious throughout the delivery. Due to the numbing effect from the waist down, epidurals still, however, usually require women to deliver supine, in the lithotomy position, or on their sides.\(^{28}\)

In response to the routine medical procedures of the early 20\(^{th}\) century, natural childbirth and midwifery reemerged in the 1970s and 80s. This model of childbirth aims to intervene in the birth as little as possible, pain relief and labor inducing drugs not routinely administered and mothers encouraged to deliver in a position that is most comfortable.\(^{29}\)

Midwives continue to assist in childbirth today at the woman’s home or within a birthing center. Mothers can also elect to have a nurse-midwife aid in childbirth within the hospital, too. The American College of Nurse-Midwives (ACNM) was established in 1955 and continues to oversee certified nurse-midwives (CNMs) and certified midwives (CMs). According to ACNM, over 94.9\% of
CNMs delivered babies within the hospital in 2012.\textsuperscript{30}

As natural childbirth both within and outside the hospital gained in popularity, the United States has also witnessed a significant increase in birth by cesarean section.\textsuperscript{31} The c-section was previously a procedure performed during the 19\textsuperscript{th} and early 20\textsuperscript{th} centuries only in the event of an emergency.\textsuperscript{32} Although the average rate has not increased since 2009, over 32.8\% of babies are delivered via c-section in America.\textsuperscript{33}

Hospital labor and delivery units have also expanded to provide a more active birthing experience for women. For instance, OHSU’s Family Birth Center provides a spacious and cozy setting for women in labor, shifting away from the stereotype of the sterile, non-descript hospital room. The family birth center provides a variety of pain relief alternatives, including “hydrotherapy, water birth, birthing balls and stools, massage, walking, and breathing.” Their website stresses, “Rest assured, you always have a choice about who participates in your care,” encouraging women to include a birth partner or doula if they wish.\textsuperscript{34}

**Birth Home, Inc.**

*Birth Home, Inc. logo* \textsuperscript{35}

Birth Home, Inc. was the first birthing center in Oregon, located on 2006 SE Ankeny St in Portland, Oregon. Established
by a group of midwives, nurses, physicians, and other childbirth educators seeking to provide an alternative to hospital births, the Birth Home opened its doors in 1982.\textsuperscript{36}

Just as the name suggests, the Birth Home provided a cozy, domestic setting for the delivery, with comfortable beds, houseplants, and friendly décor placed throughout the facility. A promotional flyer found within the Birth Home Records now housed at the Historical Collections & Archives, states: “When you enter the Birth Home in labor, it is your home....The Birth Home treats birth as a natural process.” Women were provided a variety of methods for delivery, including a birthing chair, supporting the woman while delivering upright. The home was also active in the reproductive rights movement in Portland.

Additionally, the Birth Home encouraged fathers to actively participate throughout the labor and delivery process, a radical departure from the solitary birthing experience of the 18\textsuperscript{th} and early 19\textsuperscript{th} centuries. Although the center was unable to maintain funding, closing its doors in the late 1980s, the Birth Home
and facilities like it, helped to empower women throughout the birthing experience.  

SYMBOLS OF CHANGE

As illustrated by the examples highlighted here and in the exhibit, obstetrical and gynecological practices have grown exponentially over the past 200 years. Women are no longer locked away in insane asylums as persecution for seeking an education or deciding not to marry. Hospitals are now offering nurse-midwives and water births to their obstetrical services. And through the Affordable Care Act, access to birth control and other family planning and maternity services has become more available.

We must certainly celebrate these many advances and changing societal perceptions. However, we must also remain critical of the ways in which things have not changed. Access to reproductive health care and abortion services in the United States continues to be heavily protested and legislated against.

This is why it is so important to look to history, to examine these artifacts and documents that symbolize not only hard fought social change, but also the persistence of oppressive belief-systems that continue to limit the rights granted to women. This exhibit merely touches the surface of a rich, dynamic history. Hopefully it sparks conversation and inspires viewers to critically examine the past and its persisting influence on our present and future.
Pin donated with the Birth Home, Inc. Records to HC&A 41
By Crystal Rodgers, OHSU HC&A Student Archives Assistant

Crystal has a B.A. in women’s studies with a minor in sociology from Georgia State University and is completing her MLIS with a concentration in archives through the University of Wisconsin-Milwaukee’s distance program. In addition to her work for HC&A, she also works as an archives assistant at the City of Portland Archives and Records Center.

For more information about the exhibit and related materials, contact Max Johnson, Archivist.