Maternal Bodies
Doyle, Nora

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Maternal Bodies: Redefining Motherhood in Early America.

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Some of the earliest texts that explicitly discussed the maternal body were found in a growing realm of medical literature relating to reproduction and the practice of midwifery. The Western tradition of medicine traces its roots back to ancient Greece, where medical writers such as Hippocrates, Aristotle, and Galen sought to understand human physiology and were much exercised to explain the peculiarities of the female body in relation to the male body, which they perceived as both normative and superior. Medical authorities debated whether women were best defined in terms of their cooler and moister constitutions or in terms of their wombs. By the medieval period many medical writers came to place more emphasis on women’s reproductive capacity as their defining feature, and by the early modern period the notion of “woman” was inextricably tied to the womb and to her generative capacity.

With this vision of the female body as predominantly a reproductive body, it is no surprise that the early modern period saw a growing number of medical texts that focused on what we would now call obstetrics and gynecology, though those medical terms were not in use until the nineteenth century. Thomas Raynalde, for instance, is credited with publishing the first English-language midwifery manual in 1540. This text was designed for the instruction of women and their midwives and went through numerous editions through the mid-seventeenth century. The seventeenth century saw an unprecedented proliferation of medical texts, particularly those aimed at a vernacular audience. Nicholas Culpeper’s *A Directory for Midwives*, for instance, was first published in 1651 for the benefit of women and their midwives and went through numerous editions. His extremely popular midwifery text helped shape a growing discourse about women’s reproductive bodies that also included the writings of female midwives, such as the English midwife Jane Sharp, who first published her *Midwives Book* in 1671.
In England the practice of midwifery remained almost exclusively in the hands of female midwives into the early eighteenth century. Male practitioners were called on only in emergency situations, often to extract a fetus using instruments such as the crochet or forceps. This division of medical labor was reflected in the fact that most early midwifery texts were addressed to women, providing information that female midwives and their patients needed to navigate the perils of childbearing. Midwives received their knowledge primarily through apprenticeship and practice rather than through formal medical education, and writers saw their books as a helpful addition to the midwife’s store of knowledge. The English midwife Sarah Stone, for instance, published a collection of case histories in 1737 that she hoped would help “instruct my Sisters in the Profession; that it may be in their power to deliver all manner of Births.”

Beginning in the mid-eighteenth century, both the practice of midwifery and its literature began to change as male practitioners—known as man-midwives or accoucheurs—increasingly attended the deliveries of elite women. Thus began a process of professionalization in which male practitioners asserted their authority over midwifery by virtue of their formal medical training. Their newfound (and somewhat tenuous) authority was articulated in a wave of new midwifery texts, such as William Smellie’s widely influential *Treatise on the Theory and Practice of Midwifery*, which he published in 1752, followed by an anatomical atlas of the female reproductive body. The professionalization of midwifery also made its way to America, though the process was slightly delayed. British-trained physicians such as William Shippen, who returned to Philadelphia in 1762 and offered the first formal series of lectures on midwifery, carried their training in obstetrics back to the colonies and began to attend elite American women. American practitioners relied on British and European medical texts until the nineteenth century, when prominent American physicians such as Samuel Bard and William Dewees began to publish their own obstetric texts, which borrowed heavily from earlier British and European authors.

This chapter therefore examines a transatlantic body of medical literature, encompassing the British texts and English-language translations that were used by American practitioners in the eighteenth century, as well as the nineteenth-century texts produced by American physicians themselves.

The professionalization of midwifery resulted in changes not only in the practice of midwifery but also in the representation of the maternal body in medical literature. Changes in medical literature reflected the fact that the figure of the man-midwife raised the specter of sexual impropriety in
the birthing chamber. Sarah Stone, writing in the 1730s, warned that the new fashion of calling for a man-midwife meant that “the Modesty of our Sex will be in great danger of being lost.” Another English midwife, Elizabeth Nihell, was even more vociferous in her concerns, and she sought to defend the authority of female midwives in her 1760 treatise by asserting that the presence of the man-midwife sacrificed “modesty and decency.” The private parts of women should be accessed only by their husbands, she argued, and medical necessity did not justify allowing another man access to that which was not rightfully his. The discussion of sexual decency continued into the nineteenth century, with both women and men raising concerns about the moral implications of having men in the lying-in chamber. This meant that would-be accoucheurs were forced to justify their presence at deliveries and to develop ways of legitimizing their practice by demonstrating not only their medical competence but also their respect for decency and sexual propriety. This concern came through with particular clarity in the ways that physicians negotiated the female body and their role as man-midwives in the obstetric texts that they produced in increasing numbers.

Beginning in the mid-eighteenth century, physicians found new ways in their medical writings to mitigate the potential for sexual danger in their encounters—both real and textual—with the maternal body. They did this in several ways. First, unlike earlier medical writers who lingered gleefully on women’s physiological capacity for sexual pleasure, they began to describe women’s sexual organs in ways that evaded any hint of sexual enjoyment. Women’s sexual subjectivity disappeared, thus easing the danger of allowing a male practitioner access to the female body. If women did not experience sexual pleasure, they could not be tempted by the ministrations of a man-midwife. Second, medical writers began to turn away from portraying the whole female body in their anatomical illustrations and focused exclusively on the pelvis and reproductive organs. The body, as illustrated, was literally cut to pieces, turning the woman into a series of disembodied specimens that allowed the physician to escape (textually, at least) the moral dangers of physical intimacy with a woman. Third, in their descriptions of the processes of childbearing, medical writers began to efface the presence and agency of the mother. In doing so they made the womb the focus of their studies and eventually a main character in their medical texts. As the womb became textually more prominent, the mother herself became increasingly invisible, easing fears of sexual intimacy.
The invisibility of the maternal body in medical texts had important class and race dimensions. By the nineteenth century, physicians’ fixation on the uterus as the primary agent in reproduction contributed to an understanding of childbearing as a pathological process for “civilized” women whose bodies were not vigorous or animal enough to perform the work of pregnancy and childbirth alone. The refined woman—understood to be white and economically privileged—became the normative figure in the medical text. She was the frail patient whose body could not handle the power of the uterus and therefore required the labor of the physician to assist her. In contrast, physicians believed that “savage” (nonwhite) and unrefined (lower-class) women could successfully navigate the perils of childbearing. These women’s bodies were robust and could do the work of childbearing without danger. Moreover, physicians did not concern themselves with questions of delicacy and sexual modesty in relation to these women. When they appeared in medical texts their bodies were rendered visible and tangible, and for physicians they represented useful sources of medical knowledge that could be probed with impunity.14

The disappearance of the refined mother in medical texts also had implications for the meaning of motherhood and women’s work. As physicians began to emphasize the primacy of the womb alongside their own agency as practitioners, childbearing came to seem less a result of women’s labor and more the outcome of a tense relationship between the uterus and the man-midwife. In short, over the course of the eighteenth and early nineteenth centuries, the reproductive work of white middle-class and elite women was gradually written out of medical texts. This was directly at odds with women’s own view that motherhood was fundamentally defined by the labor of their bodies. However, medical depictions of the refined maternal body as passive and even invisible anticipated a broader cultural trend that highlighted white middle-class and elite women’s moral and emotional work as mothers while effacing the labor of their bodies. This vision of motherhood evaded the physical messiness and the sexual implications of the female reproductive body, allowing the mother to emerge as an idealized figure symbolizing virtue and order. Because this vision was predicated on the disappearance of the maternal body, however, it was a vision that excluded poor women and women of color, who were perceived as fundamentally embodied.

These aspects of medical literature highlight the fact that medical knowledge speaks not only to physiological realities but also to a host of
assumptions about social roles and relationships. Indeed, the disappearance of the maternal body and the dominance of the uterus in medical literature indicate that these texts can tell us as much about common assumptions regarding gender roles, race and class differences, and sexual ideology as they do about medical knowledge and practice. Medical representations of the female reproductive body reveal that it was perceived as deeply problematic on both a medical and a cultural level. Concerns about sexual propriety meant that eighteenth- and nineteenth-century medical practitioners were never at ease with the mother as a corporeal agent and accordingly turned their attention to plumbing the mysteries of discrete reproductive fragments. Medical writers of course could not simply ignore the whole body and its messiness—they did after all treat living patients—but they could use textual representations to deal with maternal corporeality with greater scientific ease and less embarrassment. Medical practitioners wrote about some of women’s most intimate physical experiences, but they were able to create an authoritative narrative that articulated a new, more passive role for the mother that stood in tension with women’s lived experiences of childbearing.

One of the first significant shifts in medical representations of the maternal body occurred in descriptions of women’s anatomy and the processes of sexual intercourse and conception. Sixteenth- and seventeenth-century medical texts, particularly those aimed at a vernacular audience, did not shy away from references to sexual pleasure. Indeed, they seemed to revel in depictions of human sexuality, drawing on popular earthy metaphors to explain physiological facts, as did Jane Sharp when she explained that “the Yard [penis] is as it were the Plow wherewith the Ground is tilled, and made fit for the production of Fruit.” In their descriptions of reproductive anatomy, intercourse, and conception, they portrayed both women and men as lusty participants in the enjoyments of procreation. At the same time, however, these authors betrayed a certain degree of ambivalence. They offered disclaimers that the information they provided was for medical instruction alone, not for purposes of titillation. Their fears were perhaps not unfounded, for there was indeed a history of medical texts serving as “a kind of ‘ersatz’ for hard-core pornography,” and some readers must certainly have found certain descriptions and illustrations titillating. Yet these concerns did not ultimately prevent these authors from presenting explicit information about female and male sexuality.
When Thomas Raynalde published an English translation of Eucharius Rösslin’s midwifery manual in 1540, he intended to provide readers with a practical guide that included descriptions of female anatomy as well as the process of conception. His text highlighted the importance of sexual pleasure, arguing that if “the God of Nature had not instincted, and inset in the body of man and woman such a vehement and ardent appetite and lust . . . neither man nor woman, would never have been so attentive to the works of Generation and increasment of Posteritie, to the utter decay in short time of all Mankind.” Thus both women and men were driven by sexual desire to procreate, so much so, his text insisted, that even women who foreswore intercourse because of their suffering in childbirth shortly thereafter forgot their pain and returned to the pleasures of the marital bed. Women were therefore sexually lusty, and Raynalde made no attempt to apologize for this characterization. He did express some scruples about translating such information into English for laypeople to read, for he feared those who “shall condemn and utterly reprove the whole matter; some alledging that it is shame, and other some, that it is not meet nor fitting such matters to be treated of so plainly in our Mother and vulgar language, to the dishonor (as they say) of Womanhood, and the derision of their wont secrets.” Yet his fears centered less on the potentially titillating nature of his text than on the risk that male readers might use the information to mock and disparage women and their bodies.

In general, early vernacular medical writers thought that the benefits of a clear explanation of reproduction outweighed possible risks. Raynalde’s popular manual was superseded in 1651 by Nicholas Culpeper’s text, *A Directory for Midwives*, which was reprinted for over a century. Culpeper was unabashed in his representations of reproductive bodies, and he focused his anatomical explanations on men’s bodies as well as women’s, portraying women’s bodies as imperfect variations of male anatomy. In his section on female anatomy he specified without apology that the clitoris “is that which causeth lust in Women, and gives delight in Copulation; for without this a Woman neither desires Copulation, or hath pleasure in it, or conceives by it.” He insisted, moreover, that lust was more often the cause of procreation than the pious desire to fulfill God’s mandate to people the earth. Another text compiled by a group of London practitioners in 1656 presented similarly detailed depictions of men’s and women’s genitals and made frequent references to copulation and sexual pleasure. The clitoris, these authors noted, “is the seat of Venereal pleasure,” and they furthermore invited
the reader to peer (in imagination, presumably) within the female body, “that as soon as ever your sight is entred within the female fissure, there do appear to the view, two certain little holes or pits, wherein is contained a serous humour; which being pressed out in the act of copulation, does not a little add to the pleasure thereof.” The authors of these texts did not explain their choice to include information about intercourse and sexual pleasure in texts ostensibly intended to help women navigate the perils of childbirth, suggesting that they felt no pressure to justify the presence of such inessential material.

It was not only male practitioners who published explicit accounts of copulation and procreation. Two decades after Culpeper published his midwifery guide, the midwife Jane Sharp published a similar text, borrowing heavily from previous authors. The only English-language midwifery manual to be published by a woman before 1700, Sharp’s work offered childbearing women and practitioners a lively and explicit source of information about the female reproductive body and was reprinted in numerous editions. Like Culpeper, Sharp portrayed women’s anatomy as an inferior and “not so compleat” version of men’s, and the first section of her book was devoted entirely to a minute description of the male and female reproductive organs and their functions during intercourse. Sharp mirrored Culpeper in asserting that “we Women have no more cause to be angry, or be ashamed of what Nature hath given us, than men have.” Both Sharp and Culpeper saw shame as an impediment to gaining the knowledge that would aid women in living healthy reproductive lives. Sharp was also quite direct about female sexual pleasure, explaining that the clitoris “will stand and fall as the Yard doth, and makes women lustful and take delight in Copulation, and were it not for this they would have no desire nor delight, nor would they ever conceive.” She referred frequently to both women’s and men’s experience of sexual pleasure throughout her section on anatomy.

Perhaps the text most emblematic of this early modern enthusiasm for sexual matters was *Aristotle’s Masterpiece*, which was first published in London in 1684 as a compilation of other texts. It quickly became the most popular English-language guide to sexuality, conception, pregnancy, and childbirth and went through numerous editions in England and America. *Aristotle’s Masterpiece* began with a frank discussion of anatomy and the mechanics of sexual intercourse, explaining the nature of men’s and women’s sexual organs and their specific roles. The author explained that the penis “is covered with a Preputium or Foreskin . . . and by its moving up and down in the Act of Copulation brings Pleasure to both the Man and
Women’s parts were equally implicated in the giving and receiving of pleasure, for the author emphasized the “neck of the Womb . . . which receives the Man’s Yard like a Sheath; and that it may be dilated with the more Ease and Pleasure in the Act of Coition, it is sinewy and a little spongy.”

In case precise anatomical explanations of pleasure were not sufficiently clear, the author also included verses that testified to the delights of the marital state and implied that women were so driven by sexual desire that they were discontented until they married and became mothers. Sexual desire and motherhood, therefore, were two sides of the same coin.

Aristotle’s Masterpiece proved to be so titillating that it caused trouble in at least one respectable town. In 1744 the celebrated Puritan minister and theologian Jonathan Edwards conducted an investigation into rumors that men in Northampton, Massachusetts, were reading a copy of Aristotle’s Masterpiece and making lewd comments to women. The men caused trouble with their provocative claim to local women that “we Know as much about ye as you and more too.”

As Raynalde had feared two centuries before, precise knowledge of female reproductive anatomy could lead men to mock women. Evidently medical writers were right to consider the risks of putting sexually explicit material into their midwifery texts, yet these risks did not prevent early authors from dwelling on the particularities of reproductive anatomy and the sources and functions of sexual pleasure. The maternal body in these texts was indeed a sexual body. More importantly, these authors often evoked the sexual subjectivity of women rather than portraying their bodies as solely the objects of men’s sexual desire and the sources of men’s sexual satisfaction (though this, too, was an important factor in their representations).

With the professionalization of midwifery in the mid-eighteenth century, a new model of midwifery manual emerged in which discussions of intercourse and sexual pleasure were almost entirely absent. In particular, the professionalization of midwifery prompted the rapid disappearance of women’s sexual subjectivity from obstetric texts. By separating women from sexual pleasure, medical writers could ease fears about the sexual impropriety of having men in the birthing chamber. By erasing women’s sexual desires, they could erase the possibility that childbearing women and their man-midwives might be tempted into illicit relations, thus desexualizing the encounter and allowing men to participate with propriety in the formerly female domain of midwifery.

William Smellie, one of the earliest and most well-known man-midwives in England, was deeply concerned with legitimizing his profession and the publications that emerged from the pens of physicians. His work was
frequently cited by later practitioners in both Britain and America, and his writings reflected deep-seated concerns about sexual propriety. He wrote in his 1752 treatise that the man-midwife “ought to act and speak with the utmost delicacy of decorum, and never violate the trust reposed in him, so as to harbor the least immoral or indecent design, but demean himself in all respects suitable to the dignity of his profession.” He included further practical details about how the practitioner ought to behave, shaping a vision of the man-midwife as scrupulously modest and respectable.

Smellie was one of a handful of medical writers who ushered in a new type of midwifery manual to reflect the newly professionalized field. These texts were written in a highly technical style with an emphasis on internal anatomy (as opposed to external genitalia) and aimed primarily at male practitioners and medical students rather than at female midwives and their patients. Smellie wrote his 1752 treatise in a strictly professional manner, unlike the cheerful, anecdotal, and garrulous style of authors like Raynalde, Culpeper, and Sharp, or the mixture of medical knowledge and bawdy verse in Aristotle’s Masterpiece. He downplayed sexual desire in favor of the objective precision of anatomy. Smellie described the female sex organs and mentioned the clitoris in passing without giving any hint of its role in female sexual pleasure. In his detailed descriptions of the female organs, Smellie gave only two hints of the potential pleasure involved in intercourse, explaining that “the Uterus yields three or four inches to the pressure of the Penis, having a free motion upwards and downwards, so that the reciprocal oscillation which is permitted by this contrivance increases the mutual titillation and pleasure.” He reiterated this idea a few pages later, adding that such movements “produce a general titillation and turgency,” resulting in the ejection of fluids. Embedded as these ideas were in highly technical language, they lacked the same ability to evoke a real sense of sexual pleasure. The result was a medical text seemingly devoid of titillating features. More significantly, in Smellie’s text the sense of female sexual subjectivity faded away, and internal reproductive anatomy came to the fore.

The English physician, Thomas Denman, demonstrated a similar approach to female sexuality in his treatise from the 1780s. “The clitoris is supposed to be the principal seat of pleasure, and to be capable of some degree of erection in the act of coition,” he wrote, suggesting with the word “supposed” that he did not entirely credit the information and that it was not relevant enough for him to pursue the question. Later, he insisted that
“the clitoris is little concerned in the practice of midwifery.” The Scottish practitioner Alexander Hamilton seemed to agree, merely noting in his 1780 treatise where the clitoris was located and the fact that it might differ in size from woman to woman. Women’s external parts were rapidly becoming less relevant to the study of midwifery than internal parts such as the uterus and the pelvis, which could be seen only through the process of dissection that so greatly interested practitioners such as Smellie and Denman.

By the turn of the nineteenth century, medical writers displayed even greater reluctance to discuss or even acknowledge women’s sexual activity and pleasure as part of the reproductive process. In his course of lectures published in 1800, the American physician Valentine Seaman explained that “the peculiar manner in which conception takes place, being a matter more of curiosity than of real utility, we shall omit at present any attempt to investigate.” Samuel Bard, credited with publishing the first American midwifery textbook in 1807, explained that “immediately below the superior angle which unites the labia, rises the clitoris C, a pendulous substance, not quite an inch in length.” He did not include any description of the mechanics of intercourse or the function of the clitoris. His primary nod to human sexuality was to warn against early marriage, before the sex organs in both men and women could be fully matured. The Scottish surgeon John Burns similarly discussed female anatomy in his 1809 midwifery text without recognizing either female or male sexual pleasure. He described the diseases the clitoris was subject to, but did not explain the mechanics of intercourse or the role of the female genitals in generating sexual pleasure. The eminent Philadelphia obstetrician William Dewees was equally uninterested in sexuality, writing of the clitoris that “it is supposed, but without sufficient proof, to contribute to sensual gratification.” Here too the subject was not relevant enough to warrant further investigation. These later medical writers quickly bypassed the issues of intercourse and conception and restricted their representations of the reproductive body to pregnancy and delivery, processes in which the internal reproductive parts might be given a leading role, allowing physicians to avoid the immodest possibilities of sexual temptation.

In addition to the shift away from depictions of female sexuality, the mid-eighteenth century also saw a significant transition in visual representations of the female body in medical texts. The new generation of professional man-midwives became increasingly preoccupied with the study of internal
reproductive anatomy, and they particularly sought to understand the structure of the pelvis and the functions of the uterus by dissecting bodies and creating highly detailed anatomical illustrations. As Charles White proclaimed with pride in the 1770s, “Bringing the art of midwifery to perfection upon scientific and mechanical principles seems to have been reserved for the present generation. We have been but lately able to explore the secret operations of nature.” As their interests turned inward, these medical writers and the artists and engravers they collaborated with shifted the ways in which the female body was represented visually. Whereas earlier visual depictions of the female reproductive body often featured the woman as a whole and animated figure, with anatomical parts such as the uterus displayed in their bodily context, in later texts the figure of the mother was literally cut into pieces. This visual fragmentation of the maternal body resulted in the disappearance of the woman as an animated character in the obstetrical text, allowing the practice of midwifery to be visually articulated as a relationship between the practitioner and impersonal fragments of anatomy. In this way, these anatomical pieces allowed the man-midwife to conduct his explorations of the female body in ways that did not evoke a dangerous intimacy with the childbearing woman. Instead, the intimacy of the physician’s gaze turned to fragments of skeleton and organ.

Vernacular medical writers in the sixteenth and seventeenth centuries had a range of conventions to choose from when it came to visually depicting the female reproductive body. Often, their images combined artistic trends with anatomic precision, based on the relatively new practice of human dissection. Indeed, as Jonathan Sawday has shown, the separation between the arts and the sciences was not well established in Renaissance Europe; the science of dissection shaped creative depictions of the human body, and artistic conventions shaped medical imagery. Artists and medical men all strove to arrive at a clearer understanding of the “interior world of the human frame.” The dissection of human bodies did not become a significant part of medical practice and knowledge until the fourteenth century, when it spread from Italy to other parts of continental Europe. The practice of teaching human anatomy via dissection did not reach England until the late sixteenth century, but it grew swiftly in importance, and the centrality of anatomical study was firmly established there by the eighteenth century. Dissection made the visual representation of the interior body increasingly important, and medical writers across Europe compiled texts that revealed the inner secrets of the human body in both prose and picture.
The male body predominated in these early explorations of human anatomy. For one thing, male bodies were more readily available for dissection because anatomists frequently worked on the bodies of executed criminals, who were more likely to be men. Moreover, the male body was generally understood to be the norm from which the female body deviated; thus understanding the male body took priority. The female body was interesting only in the ways that it differed from the male body. Andreas Vesalius of Brussels, for example, published a groundbreaking anatomical atlas in 1543 that helped set the stage for a massive effort at mapping the human body. Following in the footsteps of Galen, Vesalius emphasized the need for medical men to learn anatomy by seeing it for themselves via the process of dissection. He provided a comprehensive series of precise drawings of the dissected human form, beginning with the skeleton and moving on to the muscles, nervous system, abdominal organs, heart, and brain. His illustrations featured complete skeletons and flayed figures (nearly all male) in lifelike and active poses. It was only in the section on the abdominal organs, including the reproductive organs, that Vesalius highlighted images of the female body, implying that woman was primarily defined by her reproductive parts: vagina, uterus, ovaries. Anatomical illustrations of the female reproductive body were found in other sixteenth- and seventeenth-century medical texts as well, but almost always in the context of revealing the reproductive organs. The female body was not needed to display other parts such as muscles, heart, or brain, being understood solely in terms of its reproductive parts and generative capacity, while the male body expressed the full range of the human form.

Images of the female body generally appeared in two types. The most common image in sixteenth-century texts was the figure of a whole and lifelike woman with the skin and muscles of her abdomen gently peeled back to reveal the inner reproductive organs or a fetus. An anatomical text by the Frenchman Charles Estienne, published shortly after Vesalius’s De humani corporis fabrica, focused on images of male bodies to show the form of the skeleton, muscles, vessels, and other aspects of internal anatomy, but he also included several images illustrating women’s reproductive anatomy. In each of his images the woman appeared as a lifelike figure in various seated or semi-recumbent poses, often gesturing discreetly and with modestly averted gaze toward the part of her anatomy that was on display. With curled hair, small, high breasts, and hairless genitals meant to signify a delicate and pure sexuality, these women represented a widely recognized classical aesthetic of female beauty. At the same time, each figure displayed
a particular aspect of women’s reproductive anatomy, such as the uterus, the position of the fetus in the uterus, or the genitalia.\textsuperscript{54}

This type of image appeared in other works as well, such as Jacob Rueff’s 1554 midwifery manual, which was first published in German and Latin and later published in an English translation. Rueff’s text included an image of a whole and lifelike woman with her abdomen opened to reveal her reproductive organs and a tiny fetus.\textsuperscript{55} As in Estienne’s work, this figure represented a recognizable classical ideal—the figure of the woman might have passed for a copy of a Botticelli Venus if it were not for her dissected abdomen. These images persisted through the seventeenth century, appearing with little variation in works such as Jane Sharp’s late seventeenth-century midwifery manual (see fig. 1.1). The illustration in Sharp’s text offered a vision of the mother as whole, lovely, and sexual (the vagina was suggestively concealed by a flower, drawing attention to the woman’s sexual parts even as it partially concealed them), rather than fragmented and faceless, as she would become in later images.\textsuperscript{56} These lifelike images made the mother a visible character in anatomical texts and midwifery manuals. Moreover, she was depicted as a participant in the act of dissection rather than merely an object of science: many of these lifelike figures pointed or gestured to their anatomy or met the viewer's gaze with an inviting glance as if complicit in their own dissection.

As an alternative to images of the whole and lifelike woman, some sixteenth- and seventeenth-century medical texts also included truncated versions of the female body that hinted at the lifelike presence of the woman but placed more emphasis on the specifics of her anatomy. Thomas Raynalde and Andreas Vesalius published their texts within three years of one another, and both included truncated images of the female body. Both images depicted a headless and limbless body, displaying only the woman’s breasts and her open abdomen with a detailed depiction of her internal parts.\textsuperscript{57} These images were essentially abbreviated versions of the lifelike images that appeared in other publications, but by focusing solely on the torso and the contents of the abdomen they were able to emphasize the anatomical interest of the figure over the woman’s aesthetic appeal or sense of human subjectivity. Although the woman’s head and limbs were cut off in these images, the presence of her high, round breasts and shapely shoulders gestured to the same aesthetic of female beauty found in the more complete images and indicated to the viewer that the anatomized figure represented the body of a once-animate woman. These truncated images also appeared in seventeenth-century texts such as Culpeper’s midwifery
manual and the treatise by the French obstetrician François Mauriceau, whose work was translated into several languages and frequently referenced.58

Alongside the lifelike and truncated images of the female body, a few of these early medical writers also included detailed images of anatomical fragments such as the uterus, ovaries, and vaginal canal, indicative of an increasingly precise vision of the internal body. These illustrations pictured female reproductive anatomy as detached from the woman’s body, but they almost always appeared alongside more complete renditions of the female
body. Rueff’s midwifery text, for instance, included the image of the whole woman discussed above as well as separate magnified images of the uterus and surrounding parts. Similarly, Mauriceau provided images of the truncated female body with the abdomen open to reveal her inner organs, and he also included multiple enlarged illustrations of these organs with carefully labeled sections. These illustrations of specific organs added a further scientific dimension, indicating that the author’s authority as a medical practitioner derived from his precise scrutiny of the internal body via the practice of dissection. Yet virtually all of these authors provided at least some images that presented the female body as more than simply a dissected uterus.

Thus medical writers emerging in the eighteenth century had a range of prior models from which to draw inspiration for their own illustrations. They could choose to depict the female body in a way that paired the study of anatomy with a lifelike figure of a woman, offering not only anatomical knowledge but also an aesthetically appealing (and perhaps titillating) female form. They could also choose to depict a more fragmented female body, either a truncated figure of a woman or precise diagrams of organs that were disconnected from the rest of the body. The new professional midwives of the mid-eighteenth century, then, inherited a well-developed visual vocabulary for depicting the female form, but they ultimately took their anatomical illustrations in new directions.

By the second half of the eighteenth century, prominent British practitioners such as William Smellie, William Hunter, Charles Jenty, and James Hamilton were at the forefront of the new specialty of midwifery and were working to take the study of female reproductive anatomy to new heights of precision. In their anatomical illustrations the figure of the woman disappeared entirely, to be replaced by precise, at times almost photographic, renditions of the pelvis and the reproductive organs. This manner of representing the female body was not restricted to midwifery texts. General anatomies also moved away from representing the whole female body, offering only illustrations of the reproductive organs. Whereas the animated male skeletons and flayed figures that walked and gesticulated across the pages of early atlases like those of Vesalius and Estienne continued to appear in anatomy texts into the nineteenth century, their lively female counterparts largely disappeared. In short, the male body continued to enjoy a range of representations, while the female body was reduced to a pelvis and a collection of reproductive organs. For specialists in midwifery, the new single-minded focus on women’s reproductive parts al-
allowed them to present a more sophisticated visual understanding of the mechanics of conception, pregnancy, and childbirth. Moreover, the practice of dissection and the anatomical illustrations that resulted offered a less fraught way to interact with the female body. Man-midwives could hardly be accused of sexual impropriety when the female body was cut into pieces that bore little resemblance to a living woman.

William Smellie published an anatomical atlas in 1754 that was one of the first to focus exclusively on the female body. Smellie’s text exemplified a single-minded emphasis on the internal body by envisioning the female body as a series of disconnected and neatly presented parts. The first edition of his atlas included thirty-nine plates, but not one of the illustrations so much as gestured to the presence of a complete and lifelike woman. Instead, Smellie first turned his focus to the form and dimensions of the pelvis, which he represented visually in isolation from the rest of the body and without reference to the skeleton as a whole. Smellie and his contemporaries saw knowledge of the shape and dimensions of the pelvis as crucial for understanding the mechanics of childbirth and for identifying potentially problematic deliveries. The other illustrations primarily consisted of depictions of the different positions of the fetus in the uterus and in the process of delivery.\textsuperscript{52} Taken together, these illustrations dissociated childbirth from the body of the mother. For Smellie, childbirth involved the pelvis, the uterus, the fetus, and the man-midwife. These illustrations turned childbirth into a mechanical process facilitated by a man-midwife with precise anatomical knowledge, rather than a social experience involving interactions among a laboring woman, her female companions, and the female midwife. In effect, these illustrations suggested that childbirth had very little to do with the woman herself. She provided the necessary parts, but thereafter did not have a significant or visible role to play in the delivery drama.

William Hunter, another renowned British anatomist and accoucheur, followed Smellie with his own anatomical atlas two decades later. \textit{The Anatomy of the Human Gravid Uterus} included thirty-four nearly life-size illustrations by the artist Jan van Rymsdyk, who had done many of the original images for Smellie’s atlas as well as the illustrations for Charles Jenty’s 1757 dissections of a pregnant cadaver.\textsuperscript{53} Hunter’s atlas was massive in scale, an expensive and beautiful work of both science and art, and it came to dominate the field. Simultaneously beautiful and gruesome, the fragments of female anatomy were photographic in their realism, revealing the texture of flesh and the full shape of the pregnant uterus. One illustration,
for instance, invited the viewer to peer between the severed thighs of a cadaver and see the surface of the pregnant uterus rising high above the woman’s genitals (see fig. 1.2). Hunter’s images emphasized the process of dissection by showing the severed stumps of the legs and the flesh of the abdomen as if just peeled away from the uterus. Although some of Hunter’s illustrations revealed the shape of the cadaver’s buttocks and upper thighs as well as offering close-up images of her genitalia, the fragmented nature...
of these images made it hard to imagine them as part of a living woman, much less one with the potential to elicit male desire or evince desires of her own. By reducing the maternal body to scientifically useful pieces, Hunter simultaneously highlighted his own authority as a preeminent anatomist and man-midwife and presented a desexualized and scientific vision of the female body.

A slightly later anatomical text by James Hamilton, a professor at the University of Edinburgh, followed in the footsteps of Smellie and Hunter and expanded in some respects the disembodied nature of the reproductive parts. Hamilton copied a number of his images directly from both Smellie and Hunter. His goal, as he explained in his preface, was to present anatomical illustrations on a smaller and therefore cheaper scale than Smellie’s or Hunter’s publications so that more students and practitioners could have access to the information. Like his predecessors, he began with the structure of the pelvis so that practitioners could understand the mechanics of delivery, and then he included a number of illustrations of the fetus in various positions in the uterus. Finally, he offered illustrations based on dissections of specific organs, including the uterus and the vagina, as well as a diagram of the vascular system of the reproductive organs. In most respects, these illustrations were not noticeably different in content from those in previous atlases, but Hamilton’s images went a little further by avoiding recognizable external body parts, such as the thighs or the external genitalia, in almost all of his illustrations. Whereas both Smellie and Hunter presented several images in which the viewer was allowed to peer directly between the splayed thighs of the cadaver, only one of Hamilton’s illustrations did this, and it was borrowed from Hunter. Moreover, Hamilton’s illustration of the uterus was entirely dissociated from any reference to the rest of the female body. Whereas Hunter included an image of the uterus taken partially out of the abdomen and hanging between a faint sketch of thighs and vulva, Hamilton’s illustration depicted the uterus suspended alone on a blank page.

The works of these prominent British anatomists were influential at the time they were published and continued to be referenced and copied well into the nineteenth century. Samuel Bard, for instance, published the first American midwifery textbook in 1807 and copied images from Smellie and others. These mid-eighteenth-century British anatomists provided a new visual vocabulary for depicting the female reproductive body as a scientific specimen rather than as a lifelike figure. They presented their interactions with the pelvis, the uterus, and the fetus, not the woman, therefore there...
could be no reason to suspect man-midwives of unwarranted intimacy with their patients. In essence, the illustrations in eighteenth-century anatomical texts replaced the social interactions of childbirth with scientific ones, rendering the question of sexual impropriety less urgent.

As anatomical illustrations shifted emphasis toward the internal female reproductive parts in the mid-eighteenth century, the focus of written medical descriptions also turned inward. Practitioners such as William Smellie and his contemporaries were at first particularly entranced by their growing knowledge of the pelvis, a part that had received little attention in sixteenth- and seventeenth-century manuals. Whereas earlier authors such as Jane Sharp and Nicholas Culpeper had begun their texts with discussions of the sexual organs, mid-eighteenth-century practitioners such as Smellie, John Burton, and Thomas Denman began their treatises with lengthy discussions of the dimensions of the pelvis, followed by generally shorter discussions of the uterus.66 These practitioners saw the pelvis as the foundational structure in childbirth. They pictured childbirth as a mechanical process and the pelvis as the frame that held the machine together. A well-formed pelvis allowed childbirth to proceed smoothly, while a malformed pelvis (often the result of rickets) brought suffering, medical intervention, and the risk of death for the woman and her infant. This focus on the pelvis set the model for subsequent midwifery texts.

At the beginning of the nineteenth century, however, medical writers began to display a growing interest in the nature of the uterus, and it soon became a central character in medical narratives, an organ with a personality and agency of its own. Unlike the pelvis, which was portrayed as a static frame, the uterus gained a startling degree of power as medical writers began to adopt new language and grammatical patterns. The uterus became the grammatical subject of strong verbs—the womb seemed to do a great deal and often appeared imperious or uncontrollable. In their descriptions and in the grammatical structure of their sentences, medical writers began to replace the agency and subjectivity of the mother with that of her womb. In consequence, the labor of the uterus replaced the labor of the mother, making the woman an unnecessary appendage to the process of childbirth.

The idea that the womb was an overbearing and somewhat uncontrollable character in its own right was not new. From antiquity at least through the nineteenth century, the uterus emerged and reemerged in different con-
texts, being of particular interest to medical men and to philosophers busy pondering the nature of woman and man. Hippocrates had theorized that the womb wandered, raging up and down the body in disappointment and anger when it was not pregnant. Later medical writers rejected the idea that the uterus could actually travel throughout the body but continued to view it as the primary feature of interest in female anatomy. In their eyes, the womb was what distinguished woman from man. It made her anatomically different, it allowed her to reproduce, and it shaped her mind and behavior.

Ideas about the uterus were closely linked to broader cultural trends, and therefore changing views of the female body often reflected larger debates about gender, sexuality, power, religion, and even politics. Mary Fissell, for instance, has argued that the shift to Protestantism in sixteenth-century England transformed ideas about the uterus. Previously, vernacular culture in Catholic England tended to link the female reproductive body to notions of divinity through the figure of the Virgin Mary. English women and men saw the womb as a marvelous organ that participated in the divine work of procreation. But in the seventeenth century the womb “went bad,” and English writers emphasized its chaotic properties, including its propensity for producing monsters.

During the period of the Enlightenment, the image of the womb as a fierce and troublesome entity enjoyed even greater attention. The eighteenth century was an era of ideological upheaval in which ideas about the nature of men and women were debated and reconfigured. One of the paradoxes of the Enlightenment was that proclamations of natural human equality went hand in hand with a philosophy of sexual difference that radically divided women and men by highlighting intellectual, moral, and physical difference. Scientific and philosophical debates about woman’s nature took center stage beginning in the mid-eighteenth century. Influential Enlightenment thinkers, inspired by a sentimental vision of nature, recast female identity as being rooted in women’s reproductive organs.

This philosophical preoccupation with the uterus was not yet mirrored in the midwifery literature of the eighteenth century. Although practitioners of midwifery—those who were most interested in the womb—began to offer more precise descriptions of the reproductive organs, few attributed particular power or agency to the uterus. Their writings tended to focus on precise anatomical description, with few subjective evaluations of the character of different organs. William Smellie, for instance, described the size, shape, and components of the uterus at length, but essentially viewed it as
a container like the pelvis, except that the uterus “contracts itself and grows thicker” during labor.\textsuperscript{70} John Burton was more enthusiastic than most of his contemporaries; writing in 1751, he described the womb as the “great Nursery of Mankind . . . which may very justly be said, With Regard to its Substance and Structure, to be as extraordinary a Piece of Mechanism as any in the whole Body.”\textsuperscript{71} Burton expressed a sense of wonder at the functions of the uterus, but did not describe the uterus as particularly powerful or possessing any agency of its own. Charles White noted the ability of the uterus to contract itself, but did not seem to find this ability particularly impressive. Moreover, in his midwifery treatise from 1773, he described natural labor as a combined effort between woman and womb. “After the child is expelled in this gradual manner by the force of the woman’s pains,” he wrote, “the womb by degrees contracts itself.”\textsuperscript{72} Here, the woman (grammatically) possessed the pains needed to expel the fetus, while the womb then worked to return to its usual shape. Each character—the woman and her womb—was an active subject in its own way. Thomas Denman seemed more impressed than either Smellie or White with the ability of the uterus to contract during labor. He explained that “it does not seem reasonable to attribute the extraordinary action of the uterus at the time of labour to its muscular fibres only . . . unless it is presumed, that those of the uterus are stronger than in common muscles.”\textsuperscript{73} Denman posited that there must be something special about the uterus that gave it its physical strength, but it was a question that did not seem significant enough for him to dwell on. For the most part, these eighteenth-century authors gave the uterus (mechanically and grammatically) the power to contract itself, but beyond this it was presented primarily as an object of their anatomical descriptions rather than a subject of its own actions.

In this respect, the uterus was not unlike other organs. Other medical texts in the eighteenth century began to describe with new precision the functions of parts such as the heart, the brain, or the nerves. Medicine became increasingly specialized, with some practitioners focusing on particular diseases, organs, or systems within the body, which was always presumed to be male unless presented in the context of reproduction. The Scottish physician Matthew Baillie, for example, was instrumental in advancing the study of pathology in the late eighteenth century, while the anatomist Charles Bell was renowned for his treatise on the brain and the nervous system, which included detailed illustrations of the anatomy of the brain.\textsuperscript{74} In spite of this greater specialization, these medical writings did not imply that a particular organ or process dominated men. The male
body was a mechanism with a wide range of components, each with its own role in the system, but none of these single-handedly defined men’s subjectivity, behavior, or social roles in the way that the womb defined women.

By the end of the eighteenth century some medical writers began to hint at a growing interest in and a changing perception of the uterus. The Scottish practitioner John Burns signaled a new interest in the womb when he wrote, “I cannot, then, be wrong in maintaining, that the anatomy of the gravid uterus is the very foundation of the art of midwifery.” Writing around the same time as Burns, the English midwife Martha Mears hinted at a more extravagant view of the uterus and its powers. She explained with palpable awe that the uterus “has another property, which appears directly opposed to all reasoning on mechanical principles: it does not grow thinner in proportion to its greater stretch, but retrained its thickness through the whole period, to whatever degree it may be distended. Here our inquiries are for a moment lost in admiration” (my emphasis). Mears drew her readers’ attention to the ability of the uterus to flout mechanical principles (things that are stretched grow thinner). She also highlighted the womb’s physical power, writing that “the human womb is capable of exerting infinitely greater power, for the expulsion of its contents, than that of any other living creature.”

Nineteenth-century medical writers adopted a similar sense of wonderment in their depictions of the uterus, but pushed their descriptions of its powers considerably further. Marie François Xavier Bichat, a French anatomist whose works were translated into English and printed in both Britain and America, described each organ as having an independent life of its own, but then seemed to suggest that the uterus possessed special powers, claiming that “it might be said that the contractile power of the womb has been formed at the expense of the forces of all the other organs.” He explained that other organs in women’s bodies, such as the heart and the stomach, gave weaker responses than men’s organs in experimental situations, suggesting that the womb took more than its fair share of strength from the system as a whole.

Not only was the uterus physically powerful, but medical writers began to give it an impressive degree of agency. Moreover, the early nineteenth century saw the publication of the first American midwifery texts, and these authors seemed to be particularly vociferous in their depictions of the powerful uterus, perhaps as a way of strengthening the importance of the relatively new professional field of midwifery in America. William
Dewees, the first physician in America to offer a full course on the practice of obstetrics, wrote in 1806 that “we cannot fail being struck with the various resources [the uterus] seems to possess, and the wonderful order it pursues, to give the greatest possible chance of perfection to the ovum; to secure it against accident; and finally, to cast it off when it can no longer be useful to it.” Referring with awe to the resources of the womb and making it the grammatical subject of decisive verbs such as “pursue,” “secure,” and “cast off,” Dewees granted the uterus extraordinary agency. Similarly, Valentine Seaman wrote in his lectures to New York midwives in 1800, “At the end of the thirty-ninth week [of pregnancy], the womb, from some unaccountable law of nature, exerts itself to get rid of its contents.” The active subject of his description was the uterus itself, which had the power and initiative to “exert itself.” Furthermore, Seaman’s description of labor focused on the actions of the womb rather than on the laboring mother. He explained that after the birth of the fetus, “the womb, having now got rid of so great a proportion of its contents, generally is free from pain for a little while.” Here the womb, not the woman, was the subject that experienced pain. The American physician Samuel Bard described the process of natural labor as controlled by the womb: “The womb first begins to contract at the fundus, and hence that subsidence of the belly, which denotes the approach of labour, and proves not only that the womb has begun to act, but that it is prepared to act in a favorable manner.” Thus writers such as Dewees, Seaman, and Bard framed their descriptions in such a way that the uterus became the primary agent in childbearing. As the English physician Francis Ramsbotham asserted, “The principal agent in labour is the uterus itself.” As a result the mother began to recede into the background of the medical text just as she had disappeared from anatomical illustrations in the mid-eighteenth century.

Although medical writers seemed to marvel at the powers of the uterus, they also betrayed uneasiness. Dewees, for instance, was frustrated by the seemingly mysterious nature of this organ: “There is no organ in the human body, from whose structure so little can be inferred, as the unimpregnated uterus; in it, when laid open by the knife, we see no manifestation of capacity for distention; on the contrary, we observe nothing but dense unyielding walls . . . in it we have no promise of the immense force which it is destined to exert.” Unlike the pelvis, which at least had a decipherable structure and could be measured with precision, the uterus, as Dewees saw it, was without clear form and structure, secretive, nothing but dense walls that refused to yield to the probing of science. In pregnancy the form and

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function of the uterus might become clearer, but it remained a mysterious entity that seemed to conceal its capacity for “immense force.”

Physicians also began to portray the uterus as potentially antagonistic to the practitioner. The British physician Samuel Merriman described the uterus as working in opposition to the man-midwife. Explaining when and how the accoucheur should attempt to turn a fetus that was presenting incorrectly, he emphasized that nothing should be attempted as long as the uterus was making strong contractions. He believed the danger of attempting to turn the fetus was greater than the danger of the wrong presentation: “Will there be less hazard in the efforts of the operator to push forward his hand in opposition to the powerful resistance of the uterus?” he asked. “Nay, is not the attempt to introduce the hand likely to excite the uterus to still more inordinate action, and consequently to increase rather than to diminish the danger?”83 Here, Merriman portrayed the womb as working against the man-midwife and as being incited to greater resistance. He later reiterated the point that it was fruitless and dangerous for the accoucheur to intervene manually “when the uterus opposes so obstinate a resistance.”84 Depicting the womb as powerful, resistant, and obstinate, Merriman seemed to set up an antagonistic relationship between two principal agents: the man-midwife and the uterus. These depictions framed the process of labor as a series of standoffs between these two figures, with the presence of the laboring woman fading away in the face of these confrontations.

The autonomy and power of the uterus were deemed so great that medical writers began to depict it as an imperious and dangerous character. The American physician Charles Meigs, for instance, was emphatic in describing the tyrannical powers of the womb and surrounding reproductive organs, for he wrote that “they are among the most powerful disturbers of the complacency of the organisms. They constitute an imperium in imperio, whose behests are not to be disobeyed. These organs can disturb the brain—the respiration—the digestion—the circulation—the secretions—the nutrition.”85 Here the reproductive organs took on the persona of an imperious ruler whose willful behavior threatened the delicate balance of the body. According to a story recounted by Meigs, this tyrant could also pose a threat to the physician. One day a physician was obliged to insert his hand into the uterus to extract the placenta, and as he did so the cervix closed with such force on his wrist that he could not remove it. “After various unsuccessful attempts to extricate himself from such an unheard-of difficulty,” Meigs explained, “he sent for a Bleeder, and, after causing a large quantity of blood to be drawn from the lady’s arm, the spasm of the cervix
ceased, upon which he was liberated from an imprisonment of two hours. His wrist was marked, as if a cord had been strongly bound round it; the red traces of which impression were visible, even the next day.” Such descriptions of the female reproductive organs revealed a profound unease on the part of physicians tasked with the management of the female reproductive body.

Thus, beginning in the nineteenth century physicians took the eighteenth-century emphasis on the interior body a step farther by developing a vision of the uterus as powerful, autonomous, imperious, and potentially antagonistic. As a result, the uterus became the primary agent in reproduction, allowing the woman to become largely invisible and inactive. The labor of the mother seemed to be replaced by the actions and subjectivity of her womb, allowing her to become detached, at least rhetorically, from the messy and dangerous processes of childbearing. Male practitioners were needed to study and manage the obstreperous uterus, thus saving women from almost certain reproductive calamity.

This growing focus on the dangerous and disruptive nature of the uterus revealed that nineteenth-century physicians were increasingly invested in an understanding of reproduction as a pathological process. This had not always been the case. The British physician John Aitken asserted in the late eighteenth century that “parturition, proceeding in the way described, is in every respect an action of health.” Some practitioners, like Samuel Bard, continued to view childbearing as a generally natural process. But the trend in the medical profession was to see childbearing as a state of danger and disorder. In his medical notes from 1804 to 1809, for instance, the celebrated Philadelphia physician Benjamin Rush listed pregnancy under the category of pathology. The American Quaker physician Horton Howard noted that “no organ of the female system is perhaps so liable to become diseased, or fail to perform its healthy functions, as the uterus; and hence arise some of the most obstinate and painful maladies to which the sex is liable.” Marcia Nichols has argued that by situating women as the victims of their internal organs, physicians were able to represent themselves as the heroes in their own medical narratives. Women were weak and needed to be rescued from the tyrannical womb. As one American physician effused to his fellow practitioners, “On your own resources alone rests the issue of life or death.”

But when physicians grappled with the dangers posed to women by their reproductive organs, they were not presuming a universal physiological reality. Instead, they created a close link between their understanding of
pathology in childbearing and the concept of civilization. Physicians believed that women whose lifestyles they perceived as primitive did not suffer the same pain and danger in childbirth as “refined” or “civilized” women, nor did lower-class women whose access to the refinements of so-called civilized life were limited. Ultimately, medical writers came to associate purportedly primitive and unrefined women with a robust corporeality, while refined women were represented as generally noncorporeal, their wombs taking over the work of childbearing while they disappeared from the medical text. Ultimately, physicians made it clear that the mother who needed their care throughout the process of childbearing was white and socioeconomically privileged.

The idea that civilization shaped women’s experience of reproduction was not new, nor was it unique to the medical profession. Almost as soon as European travelers came into contact with people in Africa and the Americas, they took note of different practices surrounding pregnancy and childbearing. Observing that African and Native American women often did agricultural work while pregnant and returned to work shortly after childbearing, they concluded that these allegedly savage women suffered little in childbirth. This observation allowed them to differentiate Christian women (those who suffered from the curse of Eve) from African and Native American women, whose bodies could be exploited for productive and reproductive labor because they were deemed so robust.  

The eighteenth-century Scottish explorer Sir Alexander Mackenzie, for instance, observed of the “Chepewyan” Indians of North America that “child-birth is not the object of that tender care and serious attention among the savages as it is among civilized people. At this period no part of their usual occupation is omitted, and this continual and regular exercise must contribute to the welfare of the mother, both in the progress of parturition and in the moment of delivery.” Many European observers saw such women as healthier and closer to nature and assumed that their supposedly primitive ways of life made them more robust and therefore less in need of protection and consideration.

What Mackenzie and other European observers did not consider, of course, was the different cultural contexts in which women in different societies gave birth. In a study of Native American communities in eastern Canada and New England, for instance, Ann Marie Plane has proposed that Indian women may have de-emphasized the pain of childbirth because they were part of a culture that respected women and men for bearing pain and suffering without complaint. Moreover, in many Native American
societies the maternal body was viewed as powerful and life-giving, a site of pride and authority rather than weakness and despair. Such beliefs may have shaped the attitudes with which Indian women anticipated and experienced childbirth. Yet, rather than consider the variety of beliefs and practices surrounding childbirth, observers such as Mackenzie assumed that Indian women experienced childbirth differently because of their purportedly primitive nature. The way women experienced childbearing thus became a measure of their degree of civilization.

Many eighteenth-century medical writers agreed that there was a clear difference between childbearing in European society and in societies that were allegedly closer to the state of nature. But these writers tended to attribute the problems of “refined” women to individual mismanagement rather than viewing reproduction itself as fundamentally pathological. As the Scottish physician William Buchan wrote in 1769, the norms of elite European society kept women indoors and in restrictive clothing, causing their bodies to be weakened by excessive refinement: “The confinement of females, besides hurting their figure and complexion, relaxes their solids, weakens their minds, and disorders all the functions of the body.” He praised the robustness of milkmaids in the English countryside and claimed that “we seldom find a barren woman among the laboring poor, while nothing is more common among the rich and affluent.”

Charles White concurred, describing how smoothly childbirth would go for a “straight healthy young woman, who had never suffered from improper dress, inactivity, or unwholesome diet.” Essentially, these physicians blamed difficult childbearing on lifestyle choices made by refined women with respect to habits such as diet, exercise, and clothing. These lifestyle choices marked them as physically deficient, but also worthy of special consideration.

By the early nineteenth century some physicians began to argue that reproduction had become a fundamentally pathological process, no longer solely a matter of individual behavior. Civilization had changed women’s bodies, and not for the better. In his essay on the treatment of pain in childbirth, William Dewees claimed that “however easy the act of Child-bearing may be among savage tribes and certain individuals in various states of society, we find it among others an operation of great pain and frequent danger.” More particularly, Dewees thought that labor contractions would not be painful were it not for “some change which the muscular fibre has undergone from civilization, refinement, or disease.” Moreover, he insisted that “a number of circumstances must concur that a woman carry her child to the full period of utero-gestation, and then give birth to it with the least
possible trouble and risk.” There were so many conditions necessary for a natural delivery that Dewees deemed problems to be inevitable. By the nineteenth century most of the medical profession agreed that elite women suffered more in childbirth than previously. Refinement had so weakened the bodies of succeeding generations that they could no longer cope with the powerful functions of the uterus.

Although American physicians in the South treated enslaved women when complications arose, and both British and American practitioners often delivered the babies of the urban poor in hospitals, nineteenth-century medical texts nevertheless assumed that the normative patient was an affluent white woman whose weak body required their ministrations. Physicians’ differentiation of civilized and uncivilized women exposed how integral notions of race and class were to their understanding of the reproductive body. Physicians assumed that pain was felt differently by refined women, and refined women were by definition white and socioeconomically privileged. Although physicians expressed a certain admiration for the allegedly natural reproductive powers of “savage,” rural, or working women, they nevertheless envisioned their work as benefiting refined women, who in their view both required and merited greater concern. These white women needed to be rescued from civilized debility. Pain and pathology thus became markers of social worth and privilege.

More importantly, by linking pain and pathology to notions of civilization, medical writers opened the way for the use of nonwhite and nonelite women’s bodies in the development of gynecology and obstetrics. These women were believed to be sturdier and more resistant to suffering; medical men saw them as closer to nature, more like animals and therefore less chaste, so that their bodies could be manipulated by physicians with little impropriety. The American physician Samuel Gregory, for instance, complained that practitioners took greater liberties with lower-class patients, so “there is often too much officiousness and freedom for the physical welfare of the patient, and the moral good of patient, practitioner, and female assistants.” He feared that physicians’ lack of respect for lower-class women’s moral delicacy could compromise practitioners as well as the women in their care. In addition, a great deal of pioneering work in gynecology was done by physicians in the American South because they had ready access to black women’s bodies. And, as with the physicians Gregory complained about, they did not feel many scruples about violating the feminine delicacy of their patients. Many of the surgeries and treatments that became routine in obstetrics and gynecology during the second half of
the nineteenth century were first practiced on enslaved women in the ante-bellum South. Marie Jenkins Schwartz has argued that enslaved women’s bodies were integral to nineteenth-century medical progress because physicians could operate more boldly and even recklessly on black bodies than on white ones. When gynecological problems occurred, slaveholders had a vested interest in taking extreme measures to restore a woman’s reproductive capacity. On the other hand, when a woman’s organs were so debilitated as to render reproduction impossible, her body was devalued and therefore became a suitable subject for medical experimentation. Similarly, Deirdre Cooper Owens has argued that impoverished women in northern American cities, often immigrants, came to hospitals to be delivered and treated and in so doing provided needed subjects for medical training and experimentation in the North.  

One of the most important examples of the use of women’s bodies in medical experimentation was in the work of the American physician James Marion Sims. Sims became renowned for his innovations in gynecological surgery, including the development of a surgical repair for vesicovaginal fistula, a devastating condition that could result from prolonged labors during which the tissue of the vagina was weakened and torn. In his autobiography he recalled his frustration at receiving a number of patients who suffered from this condition, which he deemed utterly incurable. It was not until a chance discovery prompted him to operate repeatedly on several enslaved women that he developed a successful surgical technique. As he later wrote, “I made this proposition to the owners of the negroes: If you will give me Anarcha and Betsey for experiment, I agree to perform no experiment or operation on either of them to endanger their lives, and will not charge a cent for keeping them.” His success depended on repeated experimentation without, as he noted, the benefit of anesthesia. Anarcha endured thirty operations over the course of four years, from 1845 to 1849, when Sims finally achieved a cure.  

Sims’s medical techniques and writings revealed important differences in his handling of black and white female patients. He described two different moments with patients that gave him clues as to how to develop his surgical techniques. One of the first moments that prompted Sims’s quest for a surgical cure involved an examination of a poor but “respectable” white woman with a prolapsed uterus. Placing the patient on her knees, covered from sight by a large sheet, Sims inserted one finger to touch the uterus, then introduced his entire hand in an effort to restore the uterus to its proper
position, discovering that the vagina and uterus could be opened up in a way that would allow for surgical work. This moment of discovery emphasized the act of “touching” the patient, an approved medical technique for examining the internal organs that was extensively described in medical texts beginning in the eighteenth century. The practice of touching allowed physicians to interact with the female body in a way that preserved modesty by touching only the internal parts, allowing the external (and potentially appealing) female body to remain invisible.

Sims’s next discovery occurred in a different way and highlighted sight and the manipulation of the external body. He and two of his students examined an enslaved woman suffering from a vaginal tear. “I got a table about three feet long,” Sims later narrated, “and put a coverlet upon it, and mounted her on the table, on her knees, with her head resting on the palms of her hands. I placed the two students one on each side of the pelvis, and they laid hold of the nates [buttocks], and pulled them open.” This anecdote reveals important differences from the one featuring the “respectable” white woman. First, while the white patient was covered entirely by a sheet, no such courtesy seemed to be afforded the enslaved woman, who was instead “mounted” onto the table in full view of at least three men. The sight of the female body was problematic in ways that appropriate medical touching was not. Touching focused on information that could be gathered from the internal parts of the body, while sight could take in the external body—breasts, hips, buttocks, thighs, and genitals—that might inspire a more prurient interest in the female form. Second, two assistants were present to manipulate the body of the patient by grasping her buttocks, an act that did not qualify as part of proper touching. Thus, by being exposed to the sight and grasping hands of male practitioners, the body of the enslaved woman was subjected to different treatment, both in the moment and in Sims’s textual depictions of the events. Such treatment emphasized her corporeality, while her race and status precluded any claim she might have made to feminine modesty.

The notions of pathology and civilization that were promulgated in nineteenth-century medical texts perpetuated physicians’ drive to master the perceived disorder of the internal female body. The refined woman needed to be rescued from her imperious uterus by the heroism of the man-midwife. But these assumptions about the pathology of childbirth permitted and even encouraged the exploitation of enslaved and impoverished women for the development of medical techniques. Their bodies were
assumed to be stronger and able to handle the pain of childbearing with ease. They were also assumed to be less chaste, so that male physicians could manipulate their bodies without fear of violating feminine modesty. This meant that the bodies of these women could be used to develop medical techniques intended primarily to benefit the refined women perceived by male physicians to be at risk of being overwhelmed by their reproductive organs.

As the womb became the dominant character in medical illustrations and descriptions over the course of the late eighteenth century and into the nineteenth century, the ultimate result was that the labor of the mother in the process of childbearing was written out of midwifery texts. This was particularly striking in descriptions of childbirth. Childbirth was a profoundly embodied experience, and women saw it as a test of their ability to endure pain, fatigue, and fear. But for male practitioners, childbirth was the moment when mother and man-midwife were forced to occupy the same real and textual space in intimate and troubling ways. For the sake of modesty and sexual propriety, physicians had to disguise the female body when it was at its most active, keeping the laboring mother’s flesh covered from sight at all times and effacing the work of her body in the process. In midwifery texts the refined mother did not labor—the physician and the uterus did the work for her. Erasing the mother from the scene of childbirth, both textually and in their encounters with birthing women, helped physicians do their work without the risk of sexual impropriety.

Even in the nineteenth century, when man-midwives had been delivering the babies of elite women for decades, concerns about modesty, female delicacy, and propriety resurfaced regularly. In the mid-eighteenth century the outspoken English midwife Elizabeth Nihell had expressed concern that man-midwives might take advantage of their ready access to women’s “secrets.” She wrote that “a skill in what we call the Touching, is not to be acquired without a frequent habit of recourse to the sexual parts whence the indications are taken,” and she feared that men would become addicted to the practice. Writers in the nineteenth century perpetuated Nihell’s concerns. John Steven presented an entire work to the Society for the Suppression of Vice in which he evaluated the history of man-midwifery and labeled it a profound moral evil, blaming its origins on the “luxury and lewdness” of the French courts. Thomas Ewell, an American physician, was deeply
concerned about the risk of seduction in the lying-in chamber and asserted that his purpose in writing was to “wrest the practice of midwifery from the hands of men, and to transfer it to women, as it was in the beginning, and ever should be.” The American practitioner George Gregory likewise railed against man-midwifery, inquiring, “What is it but a vast system of legalized prostitution?” In general, concerned practitioners and laypeople agreed that male self-restraint could not always be relied upon and that the woman in childbed was uniquely vulnerable. As the American physician Wooster Beach put it, “The great intimacy and confidence which exist between the physician and the patient, gives the most unbounded liberties and temptations to the unprincipled and licentious to alienate their affections from their husbands.” He went on to cite examples of adultery resulting from conquests in the lying-in room, making the link between man-midwifery and sexual misconduct appear indubitable. Such concerns may sound a bit hysterical, but there was occasional anecdotal evidence to suggest that sexual impropriety did sometimes intrude on the sanctity of the birthing chamber. One young southern physician who was attending a young white woman in labor reported that she “imprinted on my lips a voluptuous kiss which shot through my system like electricity.” For many, both physicians and laypeople, the potential intimacy of the physician-patient relationship carried real danger.

Based on what we have seen of medical representations of the reproductive female body prior to the professionalization of midwifery, it is not surprising that the mother was more visible and active in early descriptions of childbirth than in later periods. Thomas Raynalde’s sixteenth-century manual, for instance, described in detail the actions of a woman in labor. He recommended that “it shall be very profitable for her, for the space of an houre to sit still, then (rising again) to go up and down a pair of stairs crying and reaching so loud as she can, so to stir her self.” In his text the laboring woman was loud and active; she kept herself moving and straining to make sure the labor progressed. After she had bestirred herself awhile, he recommended that “also it shall be very good for a time, to retain and keep in her breath, for because through that means, the guts and intrails be thrust together and depressed downward.” The woman’s physical strength and her agency in deciding when to move, when to rest, and when to hold her breath were essential to the progress of the labor. When the final stage of labor began, Raynalde explained that the mother needed a pallet bed: there she could lie with legs splayed and feet pressed against something solid,
shoulders held by two female assistants, breath held and body straining. In this vision of labor the mother was physically strong and fully present, both physically and mentally, in the work of giving birth.116

Writing in the late seventeenth century, the English midwife Jane Sharp offered a similarly active description of labor. She explained that “when the Patient feels her Throws coming she should walk easily in her Chamber, and then again lie down, keep her self warm, rest her self and then stir again, till she feels the Waters coming down and the womb to open.” The woman’s movements were essential to the progress of the labor. Sharp insisted, “Let her not lie long a Bed, yet she may lie sometimes and sleep to strengthen her, and to abate pain, the Child will be the stronger.”117 In Sharp’s vision, the laboring woman’s activities were not only essential for her own safety by promoting a prompt delivery, but they also enhanced the strength and well-being of the child that was about to be born. Moreover, in Sharp’s descriptions the mother was subject to her own authority; she needed to notice the way her body felt and make her own decisions about when to rest and when to move. The functions of the body might be disruptive and messy, but early medical authors did not shy away from describing the mother as active and authoritative, with a body whose labor was at the center of the drama.

With the professionalization of midwifery in the mid-eighteenth century, these descriptions of the active and embodied mother began to fade, though this transition was neither immediate nor complete. In William Smellie’s midwifery treatise from 1752, for instance, the scene of the birthing chamber with the woman walking, crying out, marching up and down stairs, or straining on a pallet bed disappeared in favor of a more minute examination of the internal process of labor. Yet even in Smellie’s text, the woman’s presence and agency did not entirely vanish. In first describing the onset of labor, Smellie explained that the gradual dilation of the cervix created an “uneasy sensation; to alleviate which, the woman squeezes her Uterus, by contracting the abdominal muscles, and at the same time filling the lungs with air.” As a result of the woman’s actions, “the waters and membranes are squeezed against the Os Uteri, which is, of consequence, a little more opened.”118 Thus in Smellie’s depiction the deliberate actions of the woman advanced the process of labor. But soon the woman began to recede from his descriptions. Smellie noted that after contracting her muscles, the laboring woman became fatigued by pain and effort and allowed her muscles to relax for a short time until “the compression of the womb again takes place, and the internal mouth is a little more dilated.”119 This time, the com-
pression of the womb seemingly took place without the deliberate action of the woman—it simply happened.

Other eighteenth-century writers followed this pattern. The Scottish practitioner Alexander Hamilton explained that during labor “the child advances, and by the astonishing expulsive force of the womb, assisted by the midriff and muscles of the belly, is thus ushered into the world.”\textsuperscript{120} The womb performed most of the work, and Hamilton made no mention of the woman’s efforts to contract her muscles or to position her body in such a way as to advance the process. The British practitioner John Aitken likewise described labor as something apart from the woman herself. Yet he also paused in his description to note that “the mother’s cries, during this event, are exceedingly strong, expressive of the racking anguish she suffers.”\textsuperscript{121} Thus in many midwifery texts from the second half of the eighteenth century the mother was not entirely forgotten, though her role in labor became increasingly unclear. Writers repeatedly described labor as a process that happened to the woman, rather than making her actions part of the process.

There were some exceptions to this pattern. Charles White, for instance, did not give the mother much agency in the process of childbirth, but he did make her an animated presence in the lying-in room. He generally recommended to practitioners a noninterventionist approach, placing his faith in the natural process of labor. Accordingly, he explained that he never confined his patients to bed during labor, but allowed them to walk around or lie down as they saw fit. Describing the ideal natural labor, White explained how the mother “would for some time walk about, then sit down to rest, then rise and walk again, till for her own ease, and the safety of the child, she would find it necessary to lie down. During this time the mouth of the womb would be gradually opening.”\textsuperscript{122} Thus in White’s depiction the mother performed little physical work in the process of labor, but she was present and participated in managing herself during the long process. In a similar vein, Thomas Denman explained that the accoucheur should pay attention to the sounds the laboring mother made in order to know where she was in the stages of labor. As he insisted, “The expressions of pain uttered by women in the act of parturition may be considered as complete indications of the state of the process, so that an experienced practitioner is often as fully master of the state of the patient, if he hears her expressions, as by any mode of examination.”\textsuperscript{123} Thus Denman encouraged practitioners to be attentive to the experience of the laboring woman rather than focus solely on the internal mechanisms of labor. This was an approach that the
anti-interventionist physician Samuel Bard would continue to promote in the early nineteenth century, but most nineteenth-century writers would erase even this small role for the mother in their writings.

As the profession of man-midwifery continued to grow and physicians were more regularly called upon to assist even uncomplicated deliveries, medical writers developed increasingly specific recommendations for medical practice that were intended to preserve female delicacy even during the messiness of childbirth. The dilemma of employing male midwives could be mitigated if the female body could be removed, or at least hidden, from the gaze of the male practitioner. By the nineteenth century, some physicians became especially insistent in their discussions of how man-midwives should conduct themselves so as to assist patients with propriety. William Dewees, for instance, taught that all examinations should be done by touch rather than sight, preferably in a darkened room. “The slightest exposure is never necessary,” he cautioned. The practice of touching focused on examining the internal body with the first two fingers of the right hand, allowing the physician to monitor the birth process while still maintaining some sense of separation from the woman herself, who was thoroughly covered. Although physicians were allowed to use the touch to gain information about the progress of labor, Dewees insisted that they “beware of officious and unnecessary touching.” The American practitioner Joseph Warrington’s Obstetric Catechism epitomized concerns about improper practice by delineating in great detail the procedure for a blind examination:

Q: What arrangements should be made in order to conduct the examination most satisfactorily?
A: The room should be darkened, and the patient lightly dressed, and placed in the suitable position . . .

Q: What is the rule for carrying the hand under the coverings?
A: The clothes should be properly raised at their lower edges, by the left hand, and then the right hand with the index finger lubricated, passed cautiously up under the clothes without uncovering the patient.

These medical writers signaled that the sight of the female body was problematic, even during a medical examination. It was the external female body—the shapely limbs, breasts, and soft flesh—that was potentially desirable and titillating, not the internal reproductive parts that anatomists studied with scientific detachment. Thus physicians could examine their laboring patients with propriety as long as they used the utmost caution and
consideration. Moreover, the practice of touching made the agency and subjectivity of the mother unnecessary. The physician did not need to listen to the tone of her cries or to ask her questions to ascertain which stage of labor she was enduring. Instead, he had an approved medical technique that would allow him to gather that information in such a way that he could evade the very presence of the laboring woman and instead consult her cervix and uterus. Thus medical knowledge could become detached from the dubious social context of the birthing room.

The birthing positions that physicians prescribed also mitigated their encounters with the body of the mother during delivery. Most British and American practitioners recommended positioning the laboring mother on her left side with knees drawn up. This was quite different from the position described by Raynalde, with the woman bracing herself with her feet against the foot of a sturdy pallet bed. But this side position saved the physician the discomfort of gazing between the spread thighs of a woman. French physicians, as these writers often noted with a hint of disapproval, generally favored delivery with the woman on her back with thighs spread. The American physician Valentine Seaman recommended that the mother “should be properly supported by some of her female friends, a few of whom are always welcome companions upon such occasions, not only on account of the assistance they afford in enabling her to bear her pains to more advantage, but also as their cheerful conversation supports her spirits, and inspires her with confidence.” The only bodies that could with propriety touch and support the mother in her time of crisis were those of her female attendants. The physician might be allowed carefully to insert his fingers in order to gather information from her internal parts, but the women could use their own bodies to bolster her strength and confidence during labor. As the historian Laurel Thatcher Ulrich has written, “Early American women literally gave birth in the arms or on the laps of their female neighbors,” making the childbirth experience a profoundly embodied one for the laboring woman and her female assistants alike. But the man-midwife needed to keep his distance, restricting his assistance to monitoring and guiding the internal process of childbirth.

Once they had positioned the mother in the most seemly way possible, physicians turned their attention to the uterus and allowed the woman to recede into the background of the birth narrative. As the Scottish practitioner John Burns asserted, “Labour, may be defined to be, the expulsive effort made by the uterus, for the birth of the child.” The effort of the mother was not an essential part of his vision. Similarly, Valentine Seaman described
the stages of labor without mentioning the birthing mother. In the final stage, he wrote, “the membranes being broken, and the waters evacuated, the head now falls down into the cavity of the bason, and by the continuation of the pains, is forced forward.”

Here, delivery proceeded like clockwork; the physician’s role was to monitor the actions of the uterus while the mother played no essential part in the drama. William Dewees similarly explained how delivery occurred without once implying that a woman was also involved, referring to the “body” of the uterus but not to the body of the mother. He explained that “the uterus may be enabled to expel its contents, as we have already said, the fundus and body must contract, while the mouth must relax.”

Here, the uterus functioned autonomously, doing all of the work of labor. The primacy of the uterus became abundantly clear when he explained how exhaustion in the laboring woman would not slow delivery of the child, for as long as the uterus “preserve its powers,” delivery would progress without delay. Even in their unpublished case notes, physicians often cited the powers of the uterus. For example, the American physician Walter Channing noted after a delivery in 1821, “About 2 a.m. the uterus began to act with powerful effect.”

Women’s personal writings reveal that childbirth was a time of intense emotional and physical labor that birthing women shared with their kinswomen and female friends. But because of fears of sexual impropriety, male practitioners could not participate in the complex social context of the lying-in room in the same way that women could. Of course, physicians’ texts do not tell us how they actually behaved in the lying-in chamber. Surely in moments of crisis they did not always manage to keep their patients modestly invisible or maintain a discreet physical distance. Physicians also became part of the social fabric of the lying-in chamber, though in different ways than female companions. But in their writings physicians had to describe their practice in ways that would bolster their medical authority and testify to their moral decency. Thus physicians did their best to conceal the figure of the mother, both in their descriptions of childbirth and in their prescriptions for medical practice in the lying-in room. In consequence, medical writers evaded the presence of the woman and made themselves and the uterus the protagonists in their birth narratives.

The practice of midwifery underwent a profound transformation over the course of the eighteenth century as it became a part of the male medical profession. The new generation of man-midwives that emerged in Britain
and then America in the second half of the eighteenth century was concerned with legitimizing men’s involvement in childbirth. They moved away from the cheerfully bawdy traditions of early vernacular medical writings and developed a new textual realm in which they could imagine applying their medical knowledge to fragments of the female body rather than to complete women. In consequence, women were removed from medical images and narratives of childbearing, and the uterus emerged as the primary agent in reproduction, a powerful character whose dangerous propensities highlighted the need for heroic medical intervention on the part of the man-midwife.

As medical writers made clear, the women they rendered invisible in their texts were assumed to be the “refined” women of the upper classes, those who required and merited the ministrations of a physician. Thus the disappearing mother was white and socioeconomically privileged. As she receded from medical images and writings, she was dissociated from the messiness of childbearing and from the potential moral dangers of embodiment. Without a body, the mother would not find her sexual virtue at risk; without a body, her moral character could not be warped by the pain, fatigue, and fear wrought by pregnancy and childbirth.

By writing the mother out of their texts, medical writers made it possible to envision her as an idealized figure, rising above the taint of the body. At the same time, they separated the mother from the physical work of childbearing, thus making it possible to imagine motherhood as an effortless emanation of maternal tenderness rather than as a process involving grueling physical labor. Medical writers opened the way for an emerging cultural ideal of the mother as an ethereal creature who was defined by her tender emotions and her moral strength. Although this vision of the mother emerged most clearly in the prescriptive and popular print culture of the late eighteenth and early nineteenth centuries, in many respects it was first fostered by medical men grappling with the implications of their new profession in the mid-eighteenth century.