They bear surgical operations much better than white people; and what would be the cause of insupportable pain to a white man, a negro would almost disregard.

—Dr. Charles White

Negroes, on the other hand it is well known, are negligent of themselves, especially when, from the nature of the case, the treatment has to be long continued.

—Henry F. and Robert Campbell, founders of Jackson Street Hospital and Surgical Infirmary for Negroes in Augusta, Georgia

I n v o k i n g t h e m e m o r y o f D r . J a m e s M a r i o n S i m s ’ s s l a v e p a t i e n t s and the advancement of modern American gynecology at Sims’s November 1883 funeral, leading obstetrician Dr. William Waring Johnston stated in his eulogy, “Who can tell how many more years the progress of the art might have been delayed, if the humble negro servitors had not brought their willing sufferings and patient endurance” to assist Dr. Sims’s research. Contrary to Johnston’s assertion, however, these sick black women, representing both Sims’s slave patients and his nurses, were experimented and operated on because their masters permitted them to be, not because of their autonomy. Informed consent did not exist for slave patients. They could bring neither their “sufferings” nor “patient endurance” to the “Father of Gynecology” as free
agents. Dr. Johnston praised Sims’s enslaved gynecological patients because the late doctor was being lauded as not only a pioneering medical doctor in the field of women’s medicine but also as the sort of slave master whom black women would obey willingly. In Johnston’s pronouncement about gynecology’s advancement, black women’s bodies were normalized, even if for a brief moment, because they were made so by a white man, even before their surgeries. As a son of the South, Johnston could invoke and easily remember docile slave servants happy and willing to give their bodies over for medical research.

This chapter refines the concept of “medical superbodies,” which is not a nineteenth-century term but one that describes the myriad ways in which white society and medical men thought of, wrote about, and treated black women in bondage. White medical men tended to write and speak about enslaved black women’s bodies, their fecundity, their alleged hypersexuality, and their physical strength, which was supposedly superior to that of white women. At the same time, white doctors rarely attributed qualities that were seen as natural to white women to black women. These men did not map traits such as beauty, humility, patience, and meekness onto black women in slavery. As medical superbodies, sick black women were expected to still perform the duties fit for slaves such as intense agricultural labor and domestic work even while pregnant, infirm, or recovering from illness. It is ironic that black women could be thought of in this white supremacist culture as both physically inferior and superior. The term “medical superbodies” helps clarify how these unintentional gynecological contributions of these women fit into past dialectics surrounding issues of biology, race, normalcy, and medicine. Novelist Toni Morrison, writing about oppression, gender, and black womanhood, opined that to understand these concepts, they must be “situated in the miasma of black life.” Slavery produced miasmas that polluted all within its reach, including doctors who brought their racial prejudices into examination rooms. It was out of this already putrid environment that the black medical superbody was birthed and came to represent a being that was treated as something between human and lower primate in sickness and in health.

As early as the 1700s, European scientists were deeply involved in the work of trying to define race and rank human beings according to wide-ranging factors that took into account climate, hue, and a host of other reasons. “During the eighteenth century,” as medical humanities scholar Andrew Curran has argued, “the concept of blackness was increasingly dissected, handled, measured, weighed, and used as a demonstrable wedge between human categories.” French scientist Georges Cuvier’s “explicit instructions on how to procure human skeletons” paints a picture of how racial bigotry infused the work of leading European researchers of the period. Theorist Anne Fausto-
Sterling states that Cuvier informed travelers who visited distant and “exotic” lands to “nab bodies whenever they observed a battle involving ‘savages.’”

Scientists began to integrate women into their work as they examined and categorized “savage races” that they believed to be inferior. In a glaring example of racial chauvinism, early naturalist Johann Blumenbach presented his ideas about why African babies possessed broad noses and full lips, which he considered unsightly. Blumenbach believed that black mothers’ carelessness while breastfeeding and performing agricultural labor caused babies faces to be smashed and consequently, their features were flattened. By the nineteenth century, anthropologists, doctors, and scientists’ research about women had morphed into both race science and American gynecology.

As a field, gynecology seemed well suited to perform acts of “racecraft,” a term that scholars Barbara and Karen Fields coined as “shorthand” for the process that “transforms racism, something an aggressor does, into race, something the target is.” Medical men could then conduct an “ultimately vain search for traits with which to demarcate human groups” through their observations and research. They could disseminate their biology-based findings and theories in their medical writings. In a not-so-surprising twist, the normal/abnormal binary that doctors relied on to create newer ideas about racial superiority and inferiority often inverted the era’s reigning medical paradigm. Black people and their blackness, seen as a debilitating medical condition, could also serve as a marker for how to make white people better when they fell ill. The medical writings of these physicians laid bare “the role of race as a metalanguage, a theoretical device linking race, class, and gender,” and brought attention to its “powerful, all-encompassing effect of the construction and representation of other social and power relations, namely, gender, class, and sexuality.”

As doctors, scientists, legislators, and intellectuals reified ideas about racial difference, antebellum-era gynecology provided another platform where abstractions about black people and blackness could become concrete and gain more legitimacy. The antebellum thinkers were simply continuing the work left for them by their intellectual forefathers. Eighteenth-century anthropologists and anatomists formed these types of ideologies because they believed that “African women’s alleged extraordinary ease in parturition seemed to indicate pelvises more capacious than European women’s . . . (this was also assumed to be true of apes and other quadrupeds).” In 1828 a white plantation overseer in South Carolina felt comfortable and confident enough to borrow medical language and share his observations in a slave management journal about pregnant slave women’s deliveries although he was not a medical doctor. He wrote that bondwomen’s child-birthing sessions were “reduced one half”
in comparison to white women. It seemed that white men’s ideas about black women’s reproduction proved foundational for accepting broader and more damaging ideas about black people generally. If black women recovered from childbirth more quickly, experienced surgeries without pain, and had oversized genitalia, perhaps America was right to keep the entire “race” enslaved. It is no wonder that the famed antebellum-era physician Samuel Cartwright was asked by his medical colleagues in Louisiana to author an article that would provide scientific evidence about the “Diseases and Peculiarities of the Negro Race.” For all the articles published, scientific and medical theories introduced, and laws adopted that affirmed the biological differences between black and white people, the results from medical experimentation should have been the biggest obstacle to racist claims—but they were not.

Gynecological experimentation relied on the sick bodies of women of color and poor women who were considered not quite white to heal white women. Experimentation should have brought into question the very premise of biological differences between black and white people. Doctors should have broken with the shibboleths of racial science because they were examining, treating, and ultimately curing black and white women using identical surgeries. Their work confirmed that it would have been fruitless to employ wholly different surgical techniques on bodies that needed to be not only repaired but also kept alive after these procedures. The magnitude of their deeply held racist ideologies, however, was enough to obscure the findings of these medical men that black and white bodies were anatomically the same.

The following case about Dr. Sims’s first enslaved fistula patient elucidates this point in greater detail. In May 1845, eighteen-year-old Lucy of Macon County, Alabama, had recently given birth, during which she experienced deep vaginal ripping. After two months had passed, the severity of her injury prompted her owner, Tom Zimmerman, to send her to Dr. Sims, who lived some miles away, for treatment. After Sims diagnosed Lucy as incurable, he stated that she was “very much disappointed.” She stayed at Sims’s slave farm a few days before returning to her owner, where she remained until Sims persuaded her owner that he could repair her obstetrical fistula through experimental medical intervention. During Lucy’s initial stay over, Sims examined two other enslaved patients suffering from vesico-vaginal fistulae, Anarcha and Betsy, and became convinced that he could also repair their fistulae. Lucy, Anarcha, and Betsy had no clue that their owners would eventually lease them to Sims for five years. Slavery was an institution predicated on migration and control, but one imagines that these young women did not know that their surgeries would be public events for local white townsfolk, that their bodies would
be operated on experimentally. They certainly could not have known that over a century later, they would emerge as potent medical symbols of slavery’s role in American gynecology’s development.

Dr. Sims contacted “about a dozen doctors . . . to witness the series of [fistulae] experiments” he would undertake for five years. Naked, Lucy climbed onto the operation table, got on her knees while two white male medical assistants restrained her. Sims would name this posture “the Sims Position.” The illustration of Sims working on one of his experimental fistula patients (fig. 5.1) reveals much about race, respectability, and gynecology. Sims never denied his work on enslaved women, but in an image published about his pioneering work, he is pictured with a white woman nurse and a fully clad white woman patient who is even allowed to keep on her shoes. The illustration, drawn some years after his experimentation ended and meant to recapture that historical moment, whitewashes his use of the Alabama slaves as experimental subjects and nurses. In the image, Sims seems to be guiding his nurse to use the speculum on the white patient. He has his right hand on the patient’s thigh to gently keep her vagina open enough for the nurse to maneuver and the medical staff to observe the procedure. His left hand rests on the upper corner of the patient’s right buttock. He and the patient appear passive while the white nurse does the indelicate work of inserting the speculum and touching the patient’s genitals. This imagined scene portrays white fistula patients as docile, gentle, and soft. It is a fiction that visually effaced the bodies and real experiences of women who had to absorb pain so much that Sims would write of Lucy as someone “bore the operation with great heroism and bravery.”13 In his autobiography, Sims noted that Lucy’s bladder had become inflamed postsurgery and her “agony was extreme.”14 Yet medical men like Sims and years later his eulogizer, Dr. Johnston, chose to obfuscate her pain and highlight Lucy’s medical role as “a humble negro servitor.”

Although Dr. Charles White, whose remark on black and white people’s differing sensitivity to pain opens this chapter, believed that black people could tolerate surgery with disregard to pain, Dr. Sims’s description of Lucy’s “agony,” a degree of suffering that exceeds pain, reveals the falsity of White’s belief. Sims held fast to the practice of restraining surgical patients because he knew so many of them would physically resist being cut by his surgeon’s blade, even black women who were allegedly impervious to surgical pain. The hypocrisy of medical and scientific racism allowed doctors to write about black women’s supposed bravery and silence in the face of life-threatening and painful operations while also describing how they were restrained physically. The reality is that medical men, based on their experiences with black patients, did not believe that black people did not experience any pain. Instead, they believed
Figure 5.1. Dr. James Marion Sims and nurse repairing a vesico-vaginal fistula patient.

From Henry Savage, The Surgery, Surgical Pathology, and Surgical Anatomy of the Female Pelvic Organs, in a Series of Coloured Plates Taken from Nature (London: John Churchill & Sons, 1862).
black people experienced pain that was not as severe as white people’s pain. In their writings, nonetheless, they nullified black people’s sufferings as a part of the human experience.

Lucy and the other enslaved patients she lived with came to embody either the proper function or the dysfunction of women’s reproductive health in doctors’ medical writings. Historian Jennifer Morgan has called black women slaves “laboring women” because of the physical and reproductive work they performed across the entire landscape of slavery. The psychological stressors such as fear, depression, and feelings of isolation that laboring women faced as sick slaves, particularly fistula patients who were sometimes forced to live away from other slaves because of their stench, must have impacted them negatively. Added to this collection of psychological symptoms, “laboring women” who were considered medical superbodies came to represent more than the physical and reproductive labor they performed, especially as American gynecological medicine developed alongside racism. For these women, as representative black bodies, the meaning assigned to them held as much meaning as the humiliation, brutality, and violence inflicted on them as white doctors sought knowledge on their bodies. In the case of Lucy and her slave cohorts, Sims trained them to work as his surgical nurses while still serving as subjects of his experimental surgeries after the white community stopped supporting his research. The universe of antebellum-er a slavery and gynecological medicine was capacious and malleable enough to provide a space for a slave-owning surgeon to medically train his slave experimental patients so that they, who were deemed intellectually inferior beings because of their race and sex, could help him pioneer a surgical path for healing.

There was a voluminous outpouring of medical texts on the so-called differences between blacks, whites, Celts, and the English, who were thought of as “true” whites. By the mid-1850s, some researchers had concluded that certain “degraded” persons were little more than advanced animals. In his 1852 edition of Comparative Physiognomy; or, Resemblances between Men and Animals, early scientist James W. Redfield likened “Negroes to elephants and fish.” Redfield also believed that “the noisy Irish immigrant in America . . . was more like ‘a scavenger-dog of the city.’” Scientists and laypersons alike projected a simianized image on people of African descent and the Irish. By the first half of the nineteenth century, scientists had linked certain human beings to apes for well over a century. In the antebellum era, the corresponding images of blacks and Celts as closely related to apes began to materialize in diverse ways that worked in tandem with the racism of the age. In White over Black, historian of racial attitudes and slavery Winthrop Jordan documents these early beliefs. Jordan discusses the early attitudes
among various Europeans who believed black women to be the sexual partners of apes. He notes, “The notion had scientific value: it forged a crucial link in the Chain of Being and helped explain the Negro’s and the ape’s prognathism. . . . The sexual union of apes and Negroes was always conceived as involving *female Negroes* and *male apes!* Apes had intercourse with Negro *women.*”

The nineteenth century was a period in American medicine when doctors were bent on discovering the secrets of the “female animal” in order to both tame and remedy her peculiarities. Antebellum medical convention declared women to be the more delicate sex because of their “finer” and “more irritable” nervous systems. By 1868, some gynecologists had begun to “cure” elite white women of nervousness or “neurasthenia,” a condition that allegedly weakened one’s nerves, and they did so through clitoridectomies, the removal of their clitorises. This surgery was a manifestation of the chilling belief that nerves and uteri ruled women’s behavior. For upper-class white women, who were already burdened with the notion of their biological fragility, white male doctors felt obligated to cure them of any ill that might aggravate their sensitive natures. Clearly, this surgery would not have been performed on black women, enslaved or free, for the same reasons because white doctors perceived black women as not having pathologies related to sensitivity. As historians of medicine Carroll Smith-Rosenberg and Charles Rosenberg articulate in their article “The Female Animal,” nineteenth-century medicine definitively declared that substantive emotional differences existed between white men and women.

Even leading American gynecologist Charles Meigs proclaimed, “Women possess a peculiar trait—it is modesty. . . . The attribute of modesty . . . binds her to the domestic altar.”

Modesty was neither a trait nor a trope that enslaved and poor Irish immigrant women could claim and rely on in their interactions with white male physicians. As such, white medical men claimed that these women were unabashedly explicit in succumbing to their so-called naturally carnal natures, a racist belief that nineteenth-century medical research advanced. Moreover, the Western world seemed to be utterly intrigued with the supposed unbridled sexuality of the poor. The Irish-born were included within these beliefs. The conviction that these women’s bodies were somehow “super” in their abilities to transcend pain shaped early gynecologists’ behavior toward them on operating tables and in examination rooms.

The scientific and medical beliefs that doctors held about Irish women were nearly indistinguishable to those they held about African women. Historian of gender and science Londa Schiebinger notes in her work on women’s roles in the creation of science that pioneering German scientist Johann Blumenbach promoted theories about racial difference in various groups of women.
writes, “Blumenbach...argued further that breast size is not a uniform racial characteristic.” As a testament to his relatively liberal attitudes about race, he further asserted, that not “all Europeans have small comely breasts” (he mentioned the large breasts of Irish women). By the nineteenth century, the idea of racially marked women such as the Irish and those of African descent was reflected in the specific ways that doctors wrote about them. For example, Dr. Thomas Gallaher of Pennsylvania described his patient “Mrs. F.” as a “hearty, robust, and healthy Irish woman” in an 1851 medical journal article about her ruptured uterus. Typically, doctors did not highlight the racial characteristics of patients they considered normal or like themselves.

Although the institutions of women’s medicine such as journals and professional organizations outlined how doctors were to treat patients, when race entered the picture, some doctors abandoned the guidelines that they were to follow, as the case of Sims’s patient Mary Smith illustrates. The “Code of Ethics” adopted by the AMA dictated that doctors were not to abandon patients: “A physician ought not to abandon a patient because the case is deemed incurable.” In James Marion Sims’s treatment of his Irish-born patient Mary Smith, Thomas Addis Emmet, his assistant, explicitly stated that Sims abandoned Smith after he botched her final surgery. Article II of the Code of Ethics also highlights the rights of patients. It states, “Patients should prefer a physician whose habits of life are regular,” and in cases of the dismissal of a doctor, the patient should utilize “justice and common courtesy” and provide reasons why the dismissal occurred. The limitations of class, however, precluded poor Irish immigrant women, who were treated in police stations, almshouses, jails, and charity hospitals, from being fully able to rely on all the protections granted by the AMA. The status of the medical superbody was applied to women like Mary Smith, whose reproductive bodies failed the doctors that were expected to heal them.

The status of medical superbody was also ascribed to southern white women who violated the racial norms of the slave-holding region. John Archer, the nineteenth-century Maryland physician and surgeon mentioned in chapter 1, made the erroneous race-based claim that black and white women who willfully engaged in consensual sexual relations with men of the opposite race would produce black and mulatto twin children depending on the mother’s race. He is credited as citing the country’s first documented case of heteropaternal superfecundation, the condition in which two different males impregnate a woman and thereby father fraternal twins. In his article, Archer was clear in his message that both the women and the men in these cases acted outside the parameters of normalcy. His article “Facts Illustrating a Disease Peculiar to the Female Children of Negro Slaves: and Observations, Showing that a White Woman by Intercourse with a White Man and a Negro, May Conceive Twins,
One of Which Shall be White, and the Other a Mulatto; and that, Vice Versa, a Black Woman by Intercourse with a Negro and a White Man, May Conceive Twins, One of Which Shall be a Negro and the Other a Mulatto” highlight two exceptional medical cases that illustrate the multifaceted nature of American racial ideologies. Most telling, the black woman profiled in his article was the only mother capable of birthing a black baby despite being impregnated by a white man. Unlike the white mother of twins, Archer’s slave patient seemed unable to produce a white child—although in reality black slave women often birthed white-skinned babies for white men during slavery’s long presence in America.

Even more surprisingly, in the same article Archer cited a second example of a black-white union that seemed to prove his claims. He stated, “A white man cohabited with a negro woman after her husband, and the negro woman brought a black child and a mulatto at birth.” For Archer, the black female superbbody became an “outlawed body.” Archer explicitly stated in his journal article that he presented these cases to serve a rather high-minded purpose: he wanted their dissemination to provide an accurate “account” of the “propagation of the human species.” Yet Archer chose to focus on miscegenation between black and white people. As an extremely elite Marylander—he was the first person to receive a medical degree in the United States—John Archer was fully aware that sexual relations between black and white people were considered not only taboo but also illegal. His medical case narratives also served as warnings about the dire consequences that existed for black and white people who crossed racial lines sexually. Subsequently, Archer’s obstetric patients symbolized superbodies, ones that could birth “marked” babies whose hues represented the stain of either the white or the black female parent who had transgressed sexually.

Applying the concept of the black medical superbbody allows for a more nuanced way to examine and understand bonded women’s bodies, for every reproductive, gynecologic, and sexual act experienced by them had multiple meanings. For example, the testimony of Hilliard Yellerday, a former slave, reveals the belief that there was little, if any, distinction between slave girls and adult slave women regarding sexual behavior. For slave girls and women, age, childhood, and adulthood were subjective and often arbitrary concepts based on the whims of slave owners or lawmakers. “A slave girl,” Yellerday said, “was expected to have children as soon as she became a woman. Some of them had children at the age of twelve and thirteen years old. Negro men six feet tall went to some of these children.”

Like their more mature female slave cohorts, older teenaged girls who lived under bondage were also expected to produce children at accelerated rates like
“experienced” breeders once they were partnered with slave men. Not only were some enslaved pubescent girls forced to engage in sexual relationships with men, but black women and girls were also required to bear many children like other chattel (cattle, hogs, and chickens) on slave farms and plantations. Nineteenth-century whites embraced the axiom that black women gave birth frequently and easily. While some formerly enslaved persons recalled their mothers bearing as many as twenty children, a few also described the severe and unrealistic notions that masters held about black women’s labor and recovery time. Formerly enslaved Ophelia Whitley remembered that in rare instances, her master would force parturient women to “go ter de house an’ find a baby an’ be back at wuck de next day.” Yet the concerns about their enslaved women breeding that some slaveholders and doctors grappled with seem to contradict common beliefs about black women’s sexuality. Black hypersexuality and lasciviousness should have overwhelmed slave owners, not worries about black women’s inability to reproduce fast enough.

Some enslaved women also held views that they could physically and mentally endure more physical pain than white women because of the condition of their enslavement. They were forced to do more work, swallow insults, and deal with absences from their loved ones, despair, and treatments for sicknesses overseen by white men. Leah Garrett remembered the audaciousness of a bondwoman who struck back at her white mistress for mistreatment and then ran away to live alone in a cave for years. As Leah recalled, the slave woman’s husband formulated an escape plan, and the couple “lived in dis cave seven years.” To further embolden claims of the slave woman’s resiliency and physical prowess, Leah commented that the woman had three children during her time in the cave. She stated, “Nobody was wid her when dese chillun was born but her husband. He waited on her wid each chile.” During childbirth, black mothers were supposedly unable to experience the “pain which attended women of the better classes.” While some enslaved women like Leah Garrett expounded on the strength of black women’s bodies, slaves also noted black women’s sensitivities in childbirth and postpartum recovery. The formerly enslaved Cato Carter remembered, “It was consid’ble hard on a woman when she had a frettin’ baby.”

Frances Kemble, the famous English-born mistress of a large plantation in Georgia, kept a journal of the devastations enslaved women experienced when they became pregnant and gave birth. Kemble later chronicled the brutal conditions of slave lying-in hospitals. She wrote in her memoirs about the conditions of parturient enslaved women she observed over the course of one year, 1838–39: “These poor wretches lay prostrate on the earth . . . with no covering but the clothes they had on and some filthy rags of blanket.” She also described
cases of two women who had undergone a “prolonged and terribly hard labor” with only an old black midwife to treat them. The granny midwife served as “the sole matron, midwife, nurse, physician, surgeon, and servant of the infirmary.” The sickness and mortality rates in Kemble’s slave hospital may have been high because of a practice that the enslaved caretaker used on her patients. She affixed “a cloth tight round the throats of the agonized women” and pulled it “till she almost suffocated them,” which she believed aided in their labors.

In extreme medical cases, white physicians explicitly described the sufferings of black women. In an 1835 article in the *American Journal of the Medical Sciences*, Dr. J. W. Heustis, of Mobile, Alabama, presented the case of an unidentified enslaved woman who suffered from a “strangulated umbilical hernia.” Although the physician described his slave patient as being in “extreme pain,” he also wrote that her master described her recovery from surgery as “speedy.” In Heustis’s example, the black female body might experience a serious ailment but could also heal more rapidly than other bodies. As some scholars of medicine and gender have noted, white physicians and slave owners found biblical support for their beliefs about the healing abilities of black women. The most commonly cited explanation concerning childbirth was the one centered on Eve, the first female character in the Christian creation story. She served as a spiritual reminder that God made women unequipped to manage birthing pain as punishment. Black women escaped the harsh pangs of labor because of an early interpretation of the “Hamitic curse” found in the Old Testament that misread Ham’s children as being cursed with blackness. Although women would want painless births, to have an easy childbirth, as black women were assumed to experience, would indicate that they escaped what was natural and biblically ordained for women after Eve’s “fall.” For some southern physicians, the Hamitic curse would demonstrate the accuracy of polygenism. Black women were not Eve’s descendants and thus fell outside the scope of womanliness and pain related to childbirth. Despite polygenism’s infamy in many southern medical circles, many southerners disagreed with the theory because of biblical contradictions. Many physicians, nonetheless, assumed that black women were innately “primordial” in nature.

Guiding the work of early surgeons was a dialectic that showed the sameness of the female anatomy. Despite conflicting racial and gender ideologies, the practice of medicine could specifically elucidate how ludicrous the era’s racist science was, but doctors chose not to do so. As a slave owner, John Peter Mettauer believed in the inherent inferiority of black people, yet as a doctor, he experimented on bondwomen’s bodies in hopes of curing all women of vesicovaginal fistula. Gender historian Sandra Harding offers her critique of this conundrum mired in racism and science, “Sexism, racism and class oppression
construct and maintain each other, and they do this not once and for all, but over and over again in changing historical contexts. Both intentionally and unintentionally, they form mutual assistance bonds.”

Historian Marie Jenkins Schwartz has pointed out that bondwomen “found themselves struggling to control their own bodies.” Their actions were courageous because to assert ownership of oneself as a slave and a woman in antebellum America was contradictory to the law. For black women who were owned, their lives were forever guided by the landscape of American slavery, and for at least five decades, Irish immigrant women were defined by their racialized immigrant status. Despite their shared challenges, no matter how destitute and disempowered Irish-born women were in antebellum nineteenth-century America, enslaved women suffered worse fates because their blackness was inherent, not mapped onto them, and they were owned. As Jenkins Schwartz asserts, “society . . . did not define control of one’s body as a fundamental right of slaves.”

African American anthropologist Zora Neale Hurston criticized the racial myopia of early twentieth-century publishing and offered an explanation for its willful ignorance of the complexities of nonwhite people: “The answer lies in what we may call the American Museum of Unnatural History. This is an intangible built on folk belief. It is assumed that all non-Anglo-Saxons are uncomplicated stereotypes. Everybody knows all about them. They are lay figures mounted in the museum where all may take them in at a glance. They are made of bent wires without insides at all.” Her critique is certainly applicable to analyzing how narrowly early American gynecologists conceived colored bodies in medicine and racial science. By pondering the analytical meaning of Hurston’s metaphor of black bodies as mounted objects, we can recognize the deeply embedded racialized messages that are contained within and on Drana’s naked body (see p. 87). Those men who pioneered gynecology treated enslaved black women like Drana as “mounted objects” devoid of complexity. With the inclusion of similarly disenfranchised Irish women in our historical treatment of their medical lives, we understand more fully that they were not simply objects to be read for study in medical texts and journals but were also complex subjects.

Slavery, the making and remaking of blackness and otherness, and the defining and redefining of medical superbodies possible just as the social world of the nineteenth century could rely on black women held in medical bondage, all the while whitening them in the spaces where medical men could discuss freely how to handle black women’s naked bodies. The presence and corresponding erasure of black women and poor Irish women reveals how the inner workings of the private medical sphere
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were constantly at odds with its public revelations. Thus black women could be praised for their fecundity in southern slavery, while poor Irish immigrant women could be demonized for birthing more children than they could care for in the northern cities where they lived. These women were linked to motherhood because they birthed children, not necessarily because Americans viewed poor Irish immigrant women as good mothers worthy of respect. Antebellum-era America’s rules on race, class, and gendered respectability did not allow these mothers to be lauded like the white medical men who experimented on their bodies. In this respect, gynecology would be no different. Black women and newly arrived immigrant women were always there to serve the interests of white physicians even while their bodies were broken or being mended.

The white medical gaze on black women’s lives and bodies, the shifting scales on the continuum of racial sameness and difference, and white men’s continued use of black women in gynecology were all grounded in ideas about black subjugation and white control. The black women bore the brunt of these ideas and practices all while coping with doctors’ expectations that they would continue as laboring medical superbodies, performing the duties fit for a servant. The renewed interest in these women’s medical lives provides greater insight into the history of slavery and medicine’s development, the value of black and immigrant women to gynecology, and the importance of reassessing the place and value of historical actors in stories of origin.
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