CHAPTER ONE

THE BIRTH OF AMERICAN GYNECOLOGY

[Medicine] is a profession for which I have the utmost contempt. There is no science in it. There is no honor to be achieved in it; no reputation to be made.

—John Sims to his son, James Marion Sims, the "Father of American Gynecology"

AFTER CONGRESS BANNED THE IMPORTATION OF AFRICAN-BORN SLAVES in 1808, American slave owners became even more interested in increasing the number of slave births in the United States. At the same time that the stature of the United States was rising globally, especially as an increasingly profitable slave-based nation, another one of the country's industries, namely, reproductive medicine, was developing and expanding rapidly. It was not long before medical doctors and slave owners began to work closely to protect the reproductive health of black women who were held in bondage. Doctors developed complex relationships with slave owners, slave traders, one another, and finally, the enslaved women they treated for gynecological diseases. Despite the complicated connections between white men and black women as doctors and patients, they sometimes worked collectively in the name of healing, but most often they did so separately. Their end goal was nevertheless the same: to maintain the reproductive health of enslaved women so that they could continue to produce children.

Since the early seventeenth century, colonial Virginian legislators determined that the status of enslaved children would be tied solely to their mothers' station.[1] A century later, bearing many children was a constructed measure of success for enslaved women, with some slave owners going as far as to reward slave mothers of large broods with gifts and, in rare instances, manumission. On Mary Reynolds's plantation, her owner promised to give every bondwoman who birthed twins in a year's time "a outfittin' of clothes for the twins and a double warm blanket."[2] Reynolds also told the story of a slave mother on her plantation who received certain privileges because of the sexual relationship she had with her master. A light-skinned enslaved woman, originally from Baton Rouge, Louisiana, was placed in a house, located some distance from the other slave quarters on the plantation. The woman had been bought as a seamstress, possibly a euphemism for "fancy girl" or sex slave.[3] After a few years, she bore a number of children for the plantation master, Mr. Kilpatrick. Yet he seemed so taken with his concubine that he violated racial etiquette and acknowledged his paternity of their children. According to Mary Reynolds, the

plantation owner purchased the children's clothes, visited them daily, and allowed them to call him "Daddy" publicly. Of course, the archival records do not indicate how Kilpatrick's slave mistress felt as his concubine and the mother of his enslaved brood.

Unlike the fertile women Mary Reynolds mentioned who lived on her plantation, an infertile enslaved woman presented a problem not only for her owner but also for those white residents who lived in a slave society dependent on black women's reproductive labor. Alice Sewell remembered how her enslaved grandmother was "swapped away" because she "didn't bear children." She stated that after her grandmother had lived on the new slave farm, her current owner informed her former master "dat Grandmama was heavy with child." Sewell recalled how "sick" her grandmother's previous owner was over the sale and that Alice's mother never saw her mother again, "till she had all dem thirteen children."[4]

As black women's birthrates increased, white medical doctors began to work in midwifery in greater numbers too. Midwifery was not a medical field that men had previously controlled; it had been the domain of women for centuries. Since the country's colonization and founding, its citizens had believed that maintaining women's health was a job divinely ordained for women. Although there was a long history of male involvement in professional women's health care in Europe, American women—like most women globally—tended to one another when they gave birth. Despite women's predominance within the field, American doctors "masculinized" gynecological medicine by creating institutions and cultivating pedagogical approaches for men who would work exclusively on women's bodies.[5] These early Americans were building on a practice begun by their European predecessors nearly a century earlier. American men's entrance into this exclusively female terrain was regarded by some citizens as not only intrusive but also unnatural. Their outcry gained attention as the criticism entered the pages of colonial newspapers, like the *Virginia Gazette*, which described male midwives as "immoral" in a 1722 opinion piece.[6]

Despite these initial protests, however, white men continued to enter reproductive medicine over the course of the century. As a result, formally trained doctors devoted serious consideration to the complaints, conditions, and diseases of women. As these men became increasingly concerned with formalizing medicine more broadly and legitimizing certain branches of the field such as women's health, they transformed it into modern American gynecology. Most importantly, women's health improved globally as early American gynecologists innovated surgical procedures that aided in successful cesarean births, obstetrical fistulae repair (which stopped incontinence and repaired vaginal tearing after childbirth), and the removal of diseased ovaries via abdominal surgeries.

The partnerships formed by medical doctors and schools, especially those located in the South, with slave owners to treat the reproductive ailments that affected enslaved women gave them even greater access to black women's reproductive bodies and, later in the century in the North, to those of poor Irish immigrant women. Male midwives relied on the bodies of vulnerable populations like the enslaved and the poor to advance their medical research, to create effective surgical procedures to cure women of formerly incurable gynecological conditions, and, to a lesser degree, to provide a pedagogical model for physicians who were interested in understanding what they believed to be the biological differences between black and white women.

In slavery, healthy black people who labored diligently made the system economically valuable. Within the professional women's health-care world, deceased and living black women's bodies were also profitable. Doctors used the diseased reproductive organs of black cadavers to facilitate gynecological research and provide education in the field of gynecology. Career benefits also accrued to these medical men, who achieved their professional goals through the publication of their research in medical journals.

As the number of medical journals increased and they became more accessible, their popularity extended beyond the medical profession. Some lay planters relied on medical advice culled from these journals in the slave-management periodicals to which they subscribed.[7] Health problems proved to be a physical and economic burden to slave-owning southerners, and those who had a stake in maintaining a healthy slave labor force appreciated the availability of professionalized medical advice via the medical journal. Medical librarian Myrl Ebert, whose work provides the genealogy of American medical journals from 1797 to 1850, posits, "The advent of medical societies in America, combined with the need for better communication among native physicians, produced the first truly American medical periodical literature." Medical journals symbolized the growth of modern American medicine because they allowed doctors to

make “demands for definitive ethics in practice, medical legislation for the protection of patient and physician, and the reorganization, expansion, and adjustment of medical education.”[8]

If medical journals had by midcentury become so important culturally and socially, especially concerning matters of racial difference, how did this transformation occur so quickly when America had lagged behind Western Europe medically for nearly two centuries? During the late eighteenth century, American medical journals were limited and consisted typically of “reprints, translations, or imitations of European counterparts.”[9] The *Medical Repository* began publication in 1797 as the first medical journal published in the United States, and in it a number of pioneering articles appeared. Dr. John Stearn wrote on the “use of ergot in childbirth” before American gynecology and obstetrics were even formalized as professionalized branches of medicine.[10] By 1850, American editors had published 249 periodicals about health and medicine, and out of that group, 189 were medical journals specifically. The growth of the American medical journal demonstrated that although Americans continued to rely on their kith and kin to care for them during illness, the status of formally trained medical men grew as they continued to professionalize and document their work through medical periodicals.[11] By the late 1870s, gynecologists’ reputations had certainly improved from the low point indicated by the dismissive remarks made by the father of James Marion Sims at the start of Sims’s career.[12]

In Augusta, Georgia, the brothers Dr. Henry F. and Dr. Robert Campbell served as editors of the Deep South’s first medical journal, *Southern Medical and Surgical Journal*, and they served an exclusively slave population at the Jackson Street Hospital they founded. Enterprising and elite men like the Campbell brothers connected their private medical practices with other institutions such as slave hospitals, regional and national medical societies, and leading medical journals. In the case of the Campbells, slavery, medicine, and medical publishing formed a synergistic partnership in which southern medicine could emerge as regionally distinctive, at least through its representation in medical literature, and especially with regard to gynecology. For instance, Henry Campbell worked on enslaved patients as a gynecological surgeon, published medical case narratives of those operations in the *Southern Medical and Surgical Journal*, helped to found the American Gynecological Society in 1876, and in 1885 served as the president of the American Medical Association (AMA).[13] For pioneering southern doctors like Henry and Robert Campbell, the American medical journal served to legitimize their careers as much as the work they performed in early American gynecology served to authenticate their professional writings.

Antebellum-era doctors wrote articles that were supposed to be value neutral and to be free of bias and prejudiced claims about patients’ race, gender, and class. Much of their writing, however, reflected the scientific racism of the day. Gynecology, specifically, was becoming increasingly scientific because of its growing focus on research and experimentation. Gynecologists’ ideas and practices demonstrated a broader belief that their forays into formal medicine should be trusted precisely because they were now leading a new medical field that was formerly the domain of women, who were considered inherently inferior. These doctors medicalized women’s biological functions and problems that needed “expert” medical intervention. Moreover, their scientific research, which included experimental trials, accorded them the slowly growing respect of other Americans by midcentury.

Particularly by midcentury, physicians’ medical writings offered laypersons and professionals alike foundational texts that modeled how to treat and think about black and white women and their perceived differences based on biology and race. The authors of these texts understood at the time, as historian Bruce Dain has argued, “that a sharp distinction between nineteenth-century biology and eighteenth-century natural history [was] not tenable.”[14] Natural historians had primarily sought to classify and understand plants and animals, and they did so by describing the fertilization processes of plants and the mating of animals, for example, using language that likened them to human courtship rituals. In the nineteenth century, scientists and medical doctors began to not only study humans but also research ways to treat human diseases. The blending of science and medicine that occurred during the nineteenth century opened up space for research and even more rigid racial categorization to occur. Medical journals denoted this merger. Historian of slavery Walter Johnson describes medical journals as a site “where race was daily given shape.”[15]

Racial reification occurred in these journals when questions emerged about whether certain diseases,

features, and behaviors were endemic to women of African descent, for example, steatopygia (enlarged buttocks), elongated labia, low-hanging breasts, and lasciviousness.[16] The discourses on bondwomen and other racialized "inferior" bodies gave rise to the "black" female body serving as "a resource for metaphor," as literary theorist Hortense Spillers put it.[17] The descriptors in the American grammar book on race range from "Hottentot Venus" and "fancy girl" to "humble negro servitor." And one of the most common descriptive terms for enslaved black women was "breeder." In nineteenth-century America, the slave and, later in the century, the poor immigrant woman epitomized the "breeding woman," whose primary value lay in her ability to reproduce. There was little room for women who did not fit into this category. These names were all deeply rooted in America's long fascination with black women as hypersexual beings. Even as medical branches like gynecology and obstetrics grew, black women and those whom blackness was sometimes mapped onto, such as the Irish, were seen as willing and strong servants for white medical men, impervious to physical pain and unafraid of surgeries.

Southern hospitals that treated enslaved women who suffered from gynecological conditions proved to be critical sites where ideas about black and white biological distinctions were given credence. The Medical College of Georgia was one of the early sites of medical teaching about black and white differences. In mid-April 1850 in Augusta, Georgia, Mary, a twenty-eight-year-old married black woman who experienced irregular menstrual cycles and vaginal hemorrhaging, visited Dr. Paul Eve, a professor of surgery at the college, for treatment of her illnesses.[18] Eve was one of the South's leading surgeons and a founder of the AMA.[19] Besides disclosing her medical history and list of symptoms to the doctor (she had experienced problems with excessive vaginal discharge for three years), Mary also expressed concern because she had never conceived. Dr. Eve was not surprised by her symptoms; as he claimed, these kinds of gynecological ailments were common among local black women. He wrote, "The history of diseases among our negro population is generally very imperfect and unsatisfactory, and this is especially true as regards uterine derangements."[20] After diagnosing Mary with cancer, Eve assembled a surgical team, and they excised her cancerous uterus. The doctors claimed it was the first successful full uterine removal operation performed in the United States. Mary's postsurgery recovery was initially successful. As she recuperated, Mary asked the doctors a question that continued to nag her: why had she not yet menstruated after her surgery?

Mary may never have learned that the removal of her womb had rendered her infertile and not very valuable as a slave or perhaps as a wife who was supposed to birth children, for she died on July 22, 1850, three months after her initial visit to Eve. Her surgical team, however, understood fully the nature of her surgery and its likely consequences for an enslaved woman of childbearing age.

After Mary's death, her diseased uterus proved useful and valuable for another leading gynecologist, Dr. Charles Meigs, Dr. Eve's northern colleague. Eve granted Meigs permission to display Mary's preserved womb in his Philadelphia medical museum, so other doctors could observe how cancer ravaged uteri.[21] Even postmortem, some black women seemed unable to escape the gaze and ownership of white men.

Black women, like Mary, were exceptionalized in American society because of their blackness, alleged hypersexuality, and their seeming susceptibility to certain gynecological diseases. In reports of procedures performed on enslaved women, doctors used stark medical terminology that reduced black women's reproductive organs and bodies to mere "physical specimens." Their organs were used as clinical matter that was displayed for observation and dissection so that white women's pathologies and sick bodies could be cured. Although the biomedical research that nineteenth-century doctors conducted sought to locate the alleged biological differences between black and white people, white doctors used black women's bodies in their research because they knew that black women's sexual organs and genitalia were identical to white women's.

To be clear, male doctors viewed all women as inferior because they believed women to be neither as intellectually developed nor as physically strong as men. Medical doctors attributed all "women's complaints" to their "sensitive" natures, controlled by their uteri and nerves. Historian Londa Schiebinger found that for nineteenth-century American physicians, "females in general were considered a sexual subset of their race. . . . The male body remained the touchstone of human anatomy."[22] Black women were

especially exceptionalized. Scientific theories and, later, medical ideas about their bodies, their fecundity, and their supposed abnormal ability to endure pain in childbirth can be traced back several centuries to the writings of European natural historians and male travelers who visited Africa. These ideas seeped into other areas too. White abolitionists throughout the British Atlantic world, who had aligned themselves on the side of black emancipation as early as the late eighteenth century, nonetheless accepted ideas that promoted black women as overtly sexual and much stronger than white women.

The purported differences that marked black women as distinctive took shape in the first exchanges between European men and African women.[23] In an early travel narrative, one author hypothesized about the sameness of West African men and women's bodies. He noted, "One cannot know a man from a woman but by their breasts, which in the most part be very foule and long, hanging down low like the udder of a goate."[24] These early male travelers were not always learned scientists and natural historians; nevertheless they carried their racialized narratives forward as the discipline developed. Natural scientists such as Carolus Linnaeus (Sweden), Johannes Blumenbach (Germany), Henri de Boulainvilliers (France), and Edward Long (England) ranked human beings using rubrics they believed were based in science and thus unbiased, and African people were nearly always ordered at or near the bottom of their scales. Linnaeus's seminal work on the origins of humankind, *Systema Naturae*, published in 1748; de Boulainvilliers's 1767 book on the theory of race and political conquest; and Long's *History of Jamaica*, published in 1774, all contained lengthy treatises on the racial inferiority of people of African descent. These publications represented, in the span of nearly two decades, how scientists' ideas of racial alterity and inferiority evolved from a belief in one's national origin as the sole indicator of racial difference to a conviction that human variation and hybridity were biologically grounded through the nerves, muscles, blood, and even bile of human beings.

Near the end of the eighteenth century, America's growing acceptance of scientific racism, or at the least a sort of proto-scientific racism, against people of African descent was highlighted by the publication of Thomas Jefferson's sole book, *Notes on the State of Virginia*. As a lay scientist, Jefferson established himself as one of America's earliest spokesmen on theories of race and nature, framing his ideas in the language of science. In Query 14 of his book, Jefferson defined the critical distinctions that, in his estimation, separated black people from what he thought of as less savage Indian people and the most highly evolved group, white people. Three of the most salient racial variances he observed among these groups were deeply embedded in western European definitions of beauty, respectable sexuality, and nature. The first difference Jefferson highlighted was the supposed ugliness of darker-complexioned African people when compared to the assumed beauty of lighter-skinned European people. The second mark of distinction concerned black people's temperaments. Jefferson noted that when black people were confronted with fear-inducing situations, "they [were] at least as brave, and more adventuresome" than white folks.[25] Per Jefferson's logic, black people's bravery stemmed from their childlike fearlessness and also their seeming naïveté about the perils of entering dangerous environments. Finally, Jefferson linked black women's perceived hypersexuality to the observable practice and scientific "fact" that African women preferred apes as their romantic and sexual partners rather than African men. Using matter-of-fact language, Jefferson asserted that African women had a "preference of the Oranootan . . . over those of [her] own species."[26] African people's physical traits—darkly hued skin, flat, wide noses, prognathism—were symptomatic of, Jefferson thought, their supposed primitive animalistic natures.

More broadly, this "biologically rooted racism," of which Jefferson was a proponent, further strengthened the anti-African racism of white Americans. Educated white people employed myriad methods to justify their belief in African inferiority and slavery. They wrote and decided court rulings that highlighted the "degraded" natures of black people in cases of rape, white ministers preached a Christian gospel that was proslavery, and men of medicine and science wrote voluminous accounts of the biological failings of black people as a degenerate race. Further, these racist ideologies influenced the burgeoning disciplines of biology and anthropology.[27] Yet, for all the measuring and experimenting this kind of racial formation theorization inspired, it failed as science because of its inconsistent findings.[28] As much as these conversations concerned the measurement of concepts like "nature" and "essence," what they did establish were significant attempts by white intellectuals to construct complex understandings of the seen and unseen biological forces of blackness such as wooly hair, thick lips, and even temperament. Under these

circumstances, it is no wonder that nineteenth-century reproductive medicine emerged as one of the foremost fields in which the failures of race science were revealed. Once doctors examined, excised, and sometimes preserved black women's sexual organs in jars, how could they accurately detect whether a burst ovary or a small cervix belonged to a black woman or a white woman?

Several decades later, American scientific disciplines developed alongside British abolitionism and were translated into discourses on race and, later, the failures of both slavery and emancipation to properly civilize black people. By the mid-nineteenth century, famed abolitionist James Redpath even wrote that enslaved women [were] "gratified by the criminal advances of Saxons."[29] Thus notions of black women's innate inferiority worked in tandem with the tenets of racialized science. Like other branches of science, American reproductive medicine was influenced greatly by biologically rooted racism and was not a value-neutral field, despite how vehemently doctors asserted that the field was an objective one. Enslaved women were perfect medical subjects for gynecological experimentation because doctors deemed them biologically inferior to white women based on their research findings, yet black women supposedly had a high tolerance for pain. Also because of the low status of black women, white doctors felt no obligation to give merit to their thoughts on the matter.

Historian Deborah Kuhn McGregor has written about the tendency of early gynecologists to rely on emerging "scientific" methods to evaluate their patients, such as pelvimetry. This new tool was designed to aid doctors in assessing the size of a woman's pelvis and how easy or difficult the birthing process would be for the patient. Kuhn McGregor states, "Pelvimetry was also a tool of early physical anthropology. . . . The use of pelvimetry was profoundly embedded in perceptions of racial differences and went on to emphasize sexual differences and variation in the experiences of giving birth."[30] Few white Americans questioned the biases of formally trained medical doctors who authored articles that aided in the invention of a racialized metalanguage. Hence, what was thought to exist in the abstract could be made real because white medical doctors could prove through the "scientific" study of black people's "peculiar" diseases and behaviors that they were fit for slavery.

American gynecology's relationship to racial and gender prejudice was based on the precepts of an older Western, mainly Greek-derived *unani* medicine model that was used in cosmopolitan European medical centers for centuries. Historian Deborah Brunton notes, "In unani medicine, all women were believed to have a natural imbalance in their humors that made their constitution colder and wetter than men."[31] With a firm belief that women were literally the weaker sex, American doctors focused their attention on women's health. As a result, their published writings became much more focused on reproductive medicine. These publications signaled that the gynecological landscape had changed and midwifery was accorded less value. Gynecology, as a male-led profession, allowed doctors to determine that women's biological functions like libido, menstruation, and even childbirth were conditions that needed fixing. Since elite women tended to seek out the services of professionally trained doctors in cases of obstetrical emergency, medical men tended to publish more and more articles about abnormal births because those were the ones for which they were engaged.

Gynecology differed from midwifery in that men, not women, were delivering babies. During difficult births they used tools like forceps, and in rare instances, they administered anesthesia to women giving birth, though this practice was usually reserved for the most elite obstetrical patients. The following case highlights this latter point. In the country's earliest case of an American being given anesthesia to reduce delivery pains, Fanny Wadsworth Longfellow, wife of the famed poet Henry Wadsworth Longfellow, received anesthesia administered by a Boston dentist (dentists used pain-numbing medicines more frequently than other doctors).[32] Longfellow's example demonstrates how doctors privileged elite white women's alleged fragility and distress with physical pain.[33]

Medical doctors did not typically use anesthesia because of their well-founded fears that surgical patients could bleed to death in the time between unconsciousness and surgery. Dexterity and speed were much more highly valued than making a patient unconscious. For instance, in the case of James Marion Sims's experimental surgeries on slaves, Sims discussed in his memoir how he relied on speed in the surgical area to save his patients' lives.

More pertinent to men interested in medicine, especially southern men, was whether they could receive a quality medical education at their local medical colleges, if such an institution existed. Many southern

men interested in women's medicine had to move away from home due to the dearth of medical schools in the region. In 1840 there were seven schools scattered throughout the South: the Kentucky School of Medicine, in Louisville (founded in 1817); in Virginia Winchester Medical College, in Winchester (1826), and Randolph Macon College Medical Department, in Prince Edward Court House (1840); in Maryland the Washington University School of Medicine, in Baltimore (1827); the Medical College of the State of South Carolina, in Charleston (1832); and in Georgia Savannah Medical College (1838) and the Southern Botanico-Medical College, in Macon (1839). While many white southern men learned medicine through apprenticeships, some "sons of the South" traveled to leading European metropolitan centers like Edinburgh, London, and Paris for formal training in medicine. Those who remained in the United States tended to seek their medical educations in northern medical colleges. American medical college administrators offered students the following courses, which were typical of the course offerings in European schools: "1) anatomy, physiology, and pathology; 2) material medica, therapeutics, and pharmacy; 3) chemistry; 4) medical jurisprudence; 5) theory, and practice of medicine; 6) principles and practice of surgery; and 7) obstetrics and the diseases of women and children."[34]

Notwithstanding the small number of southern medical schools, the region represented an important site for pioneering innovations and achievements in gynecological medicine. Commenting on this issue, historian Joseph Waring emphasizes how vital black southerners, mainly the enslaved, were in this regard. Their sick bodies provided doctors with "great opportunities for the acquisition of anatomical knowledge."[35] And southern physicians carved out paths that guided their peers in how they treated and thought about their patients based on the patient's race and gender. Prominent medical men such as Ephraim McDowell (the "Father of the Ovariotomy"), John Peter Mettauer (the first American physician to perform a successful plastic surgery), François-Marie Prevost (the "Father of the Cesarean Section"), and James Marion Sims (the "Father of American Gynecology") revolutionized their fields.[36] They legitimized American medicine through their work in obstetrics and gynecology, and the larger Western world's medical researchers and their peers took notice of their work. Thus American slavery and early modern gynecology have intertwined roots that are distinctly southern. As much as white medical men are lauded for serving as the "fathers" of American gynecology, black women, especially those who were enslaved, can arguably be called the "mothers" of this branch of medicine because of the medical roles they played as patients, plantation nurses, and midwives. Their bodies enabled the research that yielded the data for white doctors to write medical articles about gynecological illnesses, pharmacology, treatments, and cures.

Pioneering medical men like Dr. James Marion Sims were heirs to a legacy left by a long line of older southern physicians and scientific researchers who relied on enslaved black bodies to find cures for ailments that afflicted all races. In a lesser-known medical case, President Thomas Jefferson began a smallpox vaccination experiment in 1801 that included both black and white members of his family and a few of his neighbors. Interestingly enough, Jefferson did not want white infants, some of whom were being nursed by vaccinated enslaved women, to possibly become infected with smallpox, especially if the experiment failed. So he ordered that only black babies would suckle from enslaved women.[37] A few years later, cesarean section surgery was pioneered in Louisiana solely on enslaved women by French-born surgeon François-Marie Prevost, who had repatriated to the southern state from Haiti after the Haitian revolution.

The professionalization of American medicine during the early nineteenth century culminated in the establishment of the AMA in 1847, and medical doctors' interest in establishing national reputations for themselves worked alongside their desire to build an institution. The antebellum era saw significant advances in gynecological research as gynecological surgeons first performed abdominal surgeries that removed diseased ovaries, delivered babies via cesarean section, and repaired vesico-vaginal fistulae, a common and non-life-threatening condition that affected many parturient teenaged girls and women.

Unlike ovariotomies and cesarean section surgeries, which required abdominal cutting, surgeries to correct vesico-vaginal or obstetrical fistulae entailed a low risk of death. Women lost little blood during fistula surgeries. During childbirth when vaginal tearing occurred, the woman's bladder (vesico-) became exposed because of the fistula (hole) formed while pushing the child out the birth canal. Once much of the upper vaginal tissue was sloughed away, an opening allowed for a "continuous involuntary discharge of urine into the vaginal vault."[38] Vesico-vaginal fistula patients suffered from incontinence, infections, and

strong odors, and many became depressed. These women were quite often ostracized because of the stench that emanated from the constant stream of urine and sometimes feces that trickled from the fistula.

Because the future of slavery and the South's growing ascendancy as a global economic leader depended on black women's fecundity and the birth of their healthy slave offspring, southern doctors found no shortage of bondwomen to examine and treat for various gynecological ailments. They removed burst ovaries, sutured holes in bladders, delivered stillborn children, and excised tumors. Southern slave communities were so flush with sick bodies that James Marion Sims boasted, "There was never a time that I could not, at any day, have had a subject for operation."[39] Some enslaved women's illnesses were so severe that medical doctors were brought in to replace the plantation nurse who normally treated this group. The following 1811 medical case describes one such case.

During a summer afternoon, a parturient enslaved woman, some seven months along, attempted to climb a fence. She fell and "discharged from the uterus at least two pounds of blood." Her fellow slaves were ordered immediately to carry her into the big house. They struggled to pick her up but could not do so because of her girth and "dragged her into the kitchen . . . The blood marked her passage to the house." She fainted as soon as she reached the entry.[40] Dr. Thomas Wright noted that he was present when the accident happened. He wrote, "Her clothes were cut off immediately, her head supported, her hips raised while she laid on her back on the floor. . . . She was now raised upon some blankets that laid near her, and cloths wet with cold vinegar and water were constantly applied to the abdomen and labia. . . . I now directed ten grains of the Prussiate in milk. . . . The discharge entirely ceased. . . . Uterogestation was carried to its full time and the patient had a good labour."[41] After the entire ordeal, Wright estimated that the woman had lost a total of six pounds of blood.[42] Fortunately, he had saved the life of the hemorrhaging patient and her fetus, but his bedside manner and treatment reveal how negatively he thought of the bondwoman. Wright describes how he had the woman's clothes cut away so that she lay naked in front of other slaves who observed him as he patted her vagina to stem the bleeding. It was obvious that he did not regard her as a member of "the delicate sex."[43]

Wright's subsequent article that appeared in the *Baltimore Medical and Philosophical Lycaeum* would come to serve as a tool of nineteenth-century cultural production about blackness; the point of departure from whiteness expressed in art, intellectualism, and nationalism; and a basis of pedagogy for other early American obstetricians and physicians. A large body could be dragged, dumped on the floor, disrobed, and laid out for observation by a mixed slave community as a point of knowledge production. This disrespect belies the fact that doctors like Thomas Wright needed their black patients, as a means to learn about curing disease, much more than their black patients needed them. In the case just described, medical men would learn two important lessons. First, doctors would be instructed about providing care for parturient patients who experienced intrauterine bleeding. Second, and less explicitly, white medical men would be taught how to treat black women in particular medical spaces. Tellingly, the article included no messages about sympathetic gestures that might cater to enslaved women's needs. As historian Elaine Breslaw argues in her work about health care in early America, "white doctors were free to perform procedures on black women that would have been socially unacceptable to white women, at the minimum violating the standard of modesty."[44]

In the same article, Wright acknowledged how flummoxed he was when presented with the earlier case of a white woman patient he treated in 1809 for severe, protracted uterine bleeding following her pregnancy. The doctor was concerned because the young mother was still bleeding heavily two weeks after she had given birth. Wright noted in his article that she was a "lady of a delicate constitution."[45] Afraid that she was too fragile to be helped, the doctor consulted with local colleagues. He was informed that an old midwife, who had treated obstetrical cases for forty years, used a digestible powder known as "Prussian blue" on her patients with great success.[46] The doctor was ready to test the effectiveness of "Prussian blue" but first had to investigate the character of the midwife. After a male colleague verified the midwife's credentials and character, Wright was satisfied that he could use her concoction to treat his fragile white patient and ironically, later, his "negro" patients.[47] The irony lies in the fact that Wright's experimentation on his white patient taught him how to treat the bondwoman, a reversal of the roles for black and white patients.

Wright was only one of countless white physicians whose medical work symbolized the dynamism of antebellum-era notions of race. As historian Marli Weiner has noted, white southerners' notions of racial and sexual distinctions between black and white people were rooted in an older "argument about superiority and inferiority. . . . Race and sex differences had to be understood in some manner that suited the ideological needs of a slave society."[48] Black people were alleged to be biologically distinct from and inferior to white people. This belief, however, had to be put aside when medical work was performed. Southern white physicians knew all too well that a black woman's vagina and cervix were identical to the vagina and cervix of a white woman. Thus the gynecological operations were the same for black and white patients, even if the bedside manner and medical treatment differed because of racism.

Southern doctors like Thomas Wright and his contemporaries stood at a crossroads where medicine and slavery converged in ways that continued to build on the era's notions of racial and gendered distinctions; paradoxically, their findings actually diverged from current nineteenth-century medical knowledge. Slavery's importance to their research could neither be denied nor ignored; it was at the heart of their practice and scholarship, even if these doctors did not explicitly identify the institution as the linchpin of their intellectual work. The presence of a black enslaved population that included enslaved women complicated conceptions based on black inferiority and women's fragility. How could these doctors explain, through their medical writings, that supposedly inferior black female bodies were being used to glean knowledge that was then applied to the treatment and cure of illness for superior white women? It was a perplexing question that many doctors avoided answering directly, largely remaining silent on the issue. Fortunately their publications, which included medical case narratives that outlined the gynecological illnesses of enslaved women, revealed the inconsistencies centered on race and biology in nineteenth-century medicine.

FIGURE 1.1. Portrait of John Archer.
From the Collections of the University of Pennsylvania Archives.

As they were forging new paths in professional women's medicine, pioneering gynecological surgeons were also involved, sometimes quite heavily, in medical publishing. In 1768, Maryland-born John Archer became the first American granted a medical degree from the College of Philadelphia. Archer achieved some notoriety when he wrote about superfecundation, a rare occurrence in which two or more eggs are fertilized during the same ovulation cycle by sperm introduced through sexual acts with more than one male. Dr. Archer described two cases of superfecundation in his 1810 medical 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." In the article, the doctor detailed two interesting gynecological cases that involved pregnant enslaved women that had nothing to do with superfecundation. The first one concerned a thirty-nine-year-old enslaved obstetrical patient whom he had treated in 1783. The woman had experienced severe pain during her labor. After examining her, Archer observed that her vaginal opening was nearly closed because her labia were fused.[49] He did not

identify the enslaved woman's birthplace, but it is quite plausible that this eighteenth-century parturient slave might have been born in West Africa in either 1743 or 1744, since the trans-Atlantic slave trade was thriving and not yet banned in 1783. If so, the woman could have had her clitoris and some part or all of her labia removed as a part of a rite-of-passage ceremony.

Archer operated on the enslaved woman, who belonged to "Mr. W.M.," with help from an enslaved midwife who had originally handled the obstetrical case.[50] The doctor "immediately introduced a director [guide] between the united labia and os pubis, and with a crooked bistoury, surgical knife with a curved blade." After this procedure, Archer "divided the labia . . . completely" opening the vaginal passage.[51] Archer's medical article documents one of the earliest cases of sexual surgeries performed on women of African descent in colonial British America; this kind of case would not be his last. In a discussion of a second case of fused labia, Dr. Archer describes how he treated a "young negro girl" who belonged to "Mrs. M'A."[52] Archer broke the parturient girl's fused labia with his fingers, and doing so allowed her to have a normal delivery despite the painful method employed.

Compared to Dr. Archer, Ephraim McDowell, a frontier doctor who would become lauded, some decades later, as the "Father of the Ovariotomy," is much better known in the history of medicine. His story exemplifies how challenging life could be for those who were innovators in the field of reproductive medicine. McDowell was born in the colony of Virginia in 1771. His father was a military officer and government official. When Ephraim was still a child, the McDowells relocated to Danville, Kentucky. As a young man, he entered the medical field, serving as an apprentice to a local medical doctor, but his apprenticeship ended abruptly after he was accused of grave robbing. He then left the country to study at the University of Edinburgh, arguably the premier medical school in the Western world.

After his stint in Edinburgh, McDowell returned to Kentucky, where he began treating the local community, which was mainly composed of white people and a smattering of black people. In 1809, Ephraim McDowell performed an ovariotomy on Jane Todd Crawford, a middle-aged white wife and mother. McDowell initially believed that Mrs. Crawford was experiencing a difficult pregnancy. After he discovered that she, in fact, had a tumor, he informed her that he would have to remove it surgically. Danville was a small town, and through the local grapevine word traveled quickly that McDowell planned to cut into the woman's abdomen to perform an ovariotomy. Surgeries were exceedingly rare in the new nation, and in a frontier community like Danville, Kentucky, people believed correctly that abdominal surgery meant certain death for the patient. Some townsmen threatened McDowell physically because they believed the surgeon would surely kill Mrs. Crawford. Nonetheless, early on Christmas morning, McDowell removed Crawford's tumor, which weighed over twenty pounds. Amazingly, she survived and lived to be seventy-eight years old.

FIGURE 1.2. Portrait of Ephraim McDowell.
From National Library of Medicine, http://ihm.nlm.nih.gov/images/B29869.

Dr. McDowell waited nearly a decade before he published the groundbreaking article that described his successful ovariotomy procedure, "Three Cases of Extirpation of Diseased Ovaria," in the *Eclectic Repertory and Analytic Review* in 1817. After the article's publication, McDowell was largely derided. European doctors were the most vocal in their criticism of him because American medicine was still in its infancy and static and had not produced trailblazing doctors. One of the leading critics, British surgeon James Johnson of the *London Medico-Chirurgical Review*, called McDowell a "backwoods Kentuckian." Johnson wrote, "All of the women operated upon in Kentucky, except one, were negresses . . . [and they] will bear cutting with nearly, if not quite, as much impunity as dogs and rabbits." He finally stated that as doctors, "our wonder [was] lessened," since physicians understood that black women's propensity to handle pain was effortless.[53] In his hometown, too, McDowell did not escape the scathing rebuke of local slave owners who linked the doctor's unorthodox surgical work on Jane Todd Crawford with the episodes of grave robbing he had been associated with in the past. According to Mary Young Ridenbaugh, the doctor's granddaughter and biographer, "his own profession denounced him as a cruel, wicked person, who had no sympathy for man or woman—that he gloried in cutting open the belly of a woman."[54] She recalled how enslaved people responded to her grandfather's physical presence, writing: "The negroes of the village and the surrounding country being naturally ignorant and superstitious, whenever they spied Dr. McDowell walking in the distance, would rush into the nearest building, fearing that he might waylay and

maltreat them. They feared him as they would some beast of prey."[55] The black residents had every reason to fear someone who appeared to experiment on black bodies with no real impunity despite the death of some of his black patients.

Despite the criticisms and fear he faced, McDowell continued to conduct experimental surgical work on women, but now almost all his patients were black. He found four black women who suffered from ovarian tumors in the local Danville area to experiment on over the course of nearly a decade, a stupefying accomplishment given Kentucky's small black population.[56] Gynecology was being formalized and legitimated on the reproductive organs and bodies of black women, yet in the literature doctors published, their bodies were not described as direct contributors to the growth of the new medical specialty. In nineteenth-century America, black women lived on the margins of society. Although black enslaved women represented a disproportionate number of the gynecological cases covered in medical journals, their inner lives remained peripheral in those publications. In their writings, doctors reduced the damaged reproductive organs and illnesses of slave patients to the knowledge they could provide for doctors.

The medical articles of Dr. John Peter Mettauer, another Virginian who became famous as a medical educator and pioneering gynecological surgeon, illustrate how early physicians wrote about enslaved women patients as objects. Mettauer was born into a prominent Prince Edward County slave-owning family in 1787. He followed in the footsteps of his father, who was a well-known surgeon. By the early 1800s, the county, located in the south-central part of the state, had transitioned from a struggling colonial outpost to a peaceful and prosperous area. The soil was fertile, tobacco was the major cash crop, and residents enjoyed successful trade relations, as the county was situated near the Appomattox River. A growing class of yeoman worked in the shops and small mills that dotted the country, and anchoring the economy was a flourishing slave system. Prince Edward County even boasted a free African American community, Israel Hill, named because it was their promised land like the one mentioned in the biblical story in Exodus. Unlike other southern counties, Prince Edward had a leading medical institute, and local residents welcomed the opening of the hospital that Mettauer founded there in 1837.[57]

FIGURE 1.3. Portrait of John Peter Mettauer.

From George Ben Johnston, *A Sketch of Dr. John Peter Mettauer of Virginia: The President's Address to the American Surgical Association, July 5, 1905* (Philadelphia, 1905). Courtesy Historical Society of Pennsylvania.

Three years after he established his hospital, Dr. Mettauer performed one of the country's first successful vesico-vaginal fistula operations on a local white woman. Intellectually curious and ambitious, he performed experimental surgery on two additional local women to repair their obstetrical fistulae. One patient was a white woman and the other an enslaved woman. He successfully repaired the white woman's fistula but was unable to do so with the enslaved patient. During the following four years, Mettauer continued to perform experimental surgeries on the twenty-year-old bondwoman in an attempt to repair her fistula. Growing frustrated with his surgical failures, Mettauer blamed the enslaved woman for the persistence of her condition. He wrote that it was her active sexual life that kept her vaginal tears open and unhealed. Writing about the enslaved woman in an 1847 *American Journal of Medical Sciences* article, Mettauer stated, "The operation was repeated, but with no better success than the first. I continued, however, to repeat the operation twice a year, after the second trial, for eight times, and finally had to relinquish the case. . . . I believe this case . . . could have been cured in process of time, more especially, if sexual intercourse could have been prevented."[58] His language is both telling and jarring because he was so explicit in his description of the enslaved woman's sexual activity. Although his assessment is probably

correct, Mettauer surely knew that enslaved black women had very little control over how their bodies were used sexually. In practice, Mettauer's slave patient had little or no agency to refuse men who wanted to engage in a sexual relationship with her, just as she could not end her participation in a gynecological clinical trial that proved ineffective for years. Mettauer's discussion of his enslaved patient in the *American Journal of Medical Sciences* obfuscated the grim reality that slave women faced regarding sex and their bodies. Perhaps unwittingly, he helped to legitimate another arena that was used to reify race for white Americans. His writing showed how American gynecology was being practiced and also how it was intellectualized in spaces like medical journals. Scholar Saidiya Hartman has theorized that "an inextricable link between racial formation and sexual subjection" was placed on black women in the nineteenth century.[59] And more specifically, Mettauer's narrative described the kinds of risks doctors and surgeons could and did encounter, as sexually active black slave patients served as physical encumbrances that could very much thwart their attempts at curing all women.

In spite of the challenges that Mettauer's enslaved patient faced, as a slave, a sexually active woman, and an experimental surgical patient, her medical example helped to unlock the mysteries that surrounded vesico-vaginal fistulae. Through his radical medical research, his creation of innovations such as lead sutures, and his surgical work in obstetrical fistulae repair, John Peter Mettauer designed a professional and intellectual realm for medical men who would follow in his footsteps.

Like Drs. McDowell and Mettauer before him, James Marion Sims was a southerner who advanced gynecology through his cutting-edge medical experimental work on enslaved women. Born in Lancaster County, South Carolina, in 1813, Sims came from humble beginnings. After finishing his undergraduate studies, he decided to attend Charleston Medical College. His father was contemptuous of his chosen field and stated that his son should be aware "there [was] no science in it . . . and no honor" that could be had.[60] Despite familial protests, Sims left the state to finish medical studies at Jefferson Medical College in Philadelphia.[61] After graduation, he returned to South Carolina to establish a medical practice. However, the deaths of two of his patients ruined his professional reputation, and Sims relocated to Mount Meigs, Alabama. After a few years in Alabama, he had become a well-respected doctor. Sims began publishing articles about his medical work in the 1840s.

FIGURE 1.4. Engraving of James Marion Sims by R. O'Brien.
From National Library of Medicine, http://ihm.nlm.nih.gov/images/B23841.

Dr. Sims was a prolific medical writer who published seven articles between 1844 and 1852.[62] His subjects ranged in scope from dentistry, to pediatric medicine, to general surgery, and finally to gynecology. They featured case narratives and illustrations of both his black enslaved and his white patients. By the 1860s, Sims had become, arguably, the nineteenth century's most famous gynecological surgeon; his experimental surgical work on enslaved women had transformed the medical field. His reputation derived from the consistent positive outcomes he achieved based on the experimental gynecological work he performed, quite an accomplishment for the era in which he lived. Many of his peers could not duplicate successful surgical results during their clinical trials and thus did not achieve the same level of fame that Sims possessed.

Like most men who entered gynecology during the first half of the century, Sims did so because of the urgent needs of women who suffered from a plethora of reproductive ailments. In his autobiography, he wrote about his initial distaste for gynecology: "If there was anything I hated, it was investigating the organs of the female pelvis."[63] Despite his "hatred" of female reproductive organs, however, Sims chose to perform a vaginal examination on one of his patients, Mrs. Merrill, who had been thrown from her horse. His examination revealed that she had a reversed uterus. Remembering a medical lecture he had attended in medical school, he opened Merrill's vaginal cavity wide enough so that the force of air pressure would help to pivot her womb to its correct position. It was literally at this moment that Sims was reminded of three enslaved patients who had earlier visited him because they suffered from vesico-vaginal

fistulae. Sims was now convinced that if he could apply the technique he had used most recently on Mrs. Merrill on the three enslaved obstetrical fistula patients, he could cure them of their condition.

Sims wasted no time in testing his hypothesis. His first enslaved gynecological patient was Anarcha, a seventeen-year-old girl whom the doctor had first assisted during her protracted labor. During the two days she was under Sims's care, he had found that as a result of a difficult birthing process, Anarcha had developed a vesico-vaginal fistula.[64] Before his work on Mrs. Merrill, Sims had told Mr. Wescott, the teen's owner, "Anarcha has an affliction that unfits her for the duties required of a servant."[65] Sims also sent for Betsy and Lucy, who had visited him earlier because of their protracted labor, and leased them from their owners. As Sims later wrote in his memoir, he also "ransacked" the county and found "six or seven cases of vesico-vaginal fistula that had been hidden away for years in the country."[66]

Between 1844 and 1849, Sims experimented exclusively on enslaved women's bodies to aid him in locating the cure for this troublesome gynecological condition. In a speech he made before the New York Academy of Medicine, he explained how he had become a successful gynecologist. "Building a little hospital as a special field of experiment," he told his audience, "I readily got control of these cases, all of them healthy young negro women."[67] Commonly called a "sick house," the sort of "little hospital" that Sims described was an important component of the slave farm.

Antebellum-era physician James Ewell described the sick houses as a "cheap, coarse kind of building." He reasoned that good ones "ought to consist of but one large room, quite open to the top, well aired by doors and windows, and with a plank floor, that it may be frequently washed and kept perfectly clean."[68] Visitors to the South were fascinated by these slave hospitals and often wrote about them when they returned home. According to one such observer, Mr. Nordhoff, "The hospital at Hopeton [a South Carolina plantation] consisted of three wards. . . . One ward was for men, another for women, and the third for confinement cases. Although the women were allowed a month's rest in the hospital after the birth of their baby, they usually preferred their own homes, where they could gossip."[69]

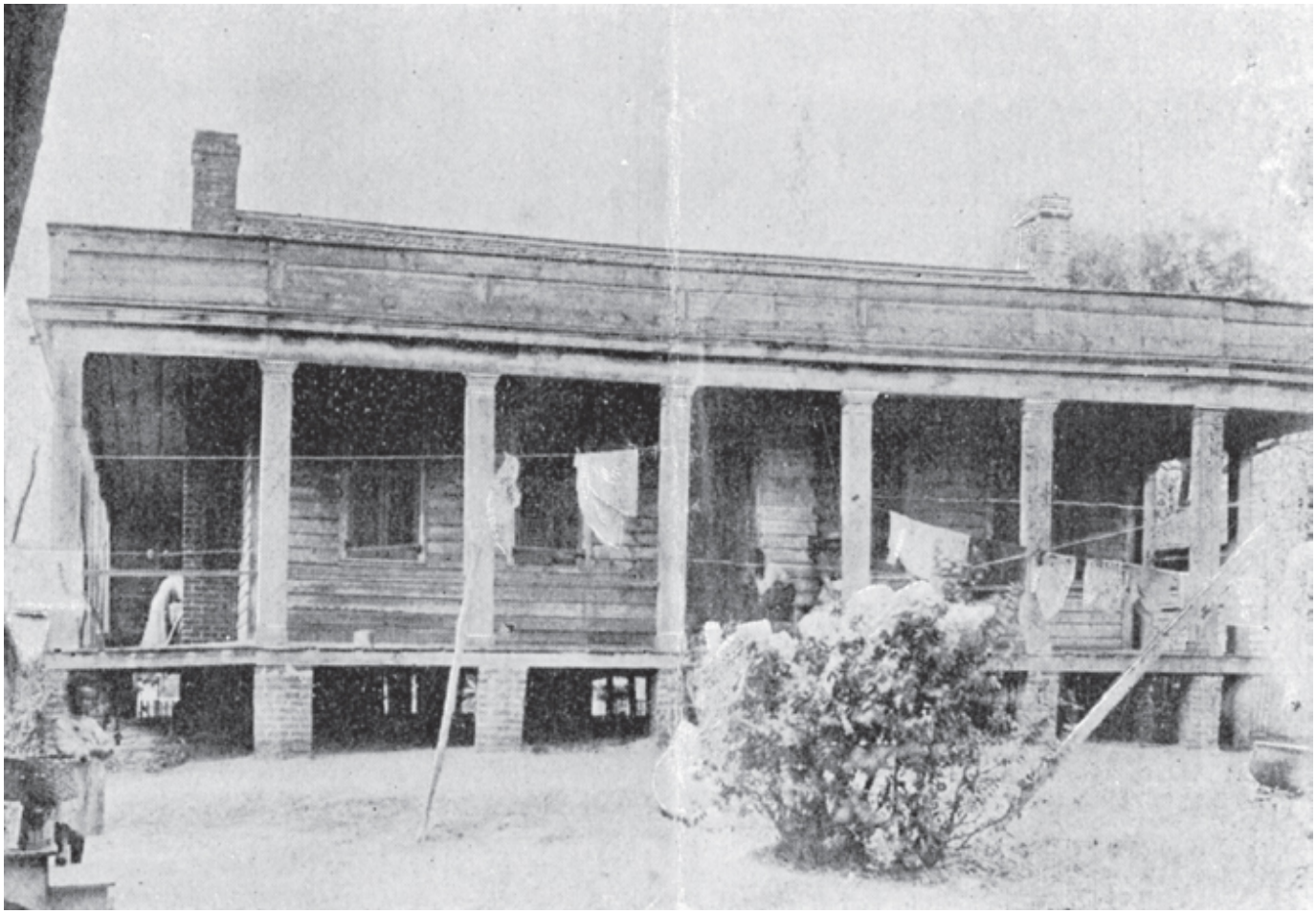

FIGURE 1.5. James Marion Sims's first women's hospital, Montgomery, Alabama (1895), photographed by Edward Souchon. Courtesy of the Reynolds Historical Library at the University of Alabama at Birmingham.

Some slave owners took a dim view of sick houses. They urged fellow slave masters not to erect them, arguing that these facilities had a negative impact on the slave community. For example, Dr. John Douglass, a member of the South-Carolina Temperance Advocate, & c., warned that "sick houses or hospitals [were] unnecessary and injurious."[70] He feared that enslaved workers would become both melancholy and overly stimulated by the scenes of sickness from the hospital. Perhaps in Douglass's estimation, it was more fitting and natural for black enslaved nurses to be subjected to the sights of despair and illness among black people in the seclusion of slave cabins. White doctors, especially those who, like Douglass, cautioned against the introduction of sick houses, either did not consider or did not care that bondwomen resented the white male medical presence in their lives as much as the presence of a slave hospital. Despite the caveats offered by slave-owning doctors and planters, sick houses and lying-in rooms, spaces created for new mothers to recuperate, were becoming more common by the latter half of the 1850s.

The slave women's hospital that Dr. Sims had established proved indispensable to his research, for it allowed him to continue his experimental surgeries on "healthy young negro women." When, after two years, he had failed to cure any of these patients, however, Sims lost the support of the local white community, which included not only white residents who had observed his public surgeries but also the young white medical apprentices who had assisted him at the start of his experimental trials. (One of the latter was Nathan Bozeman, who later achieved fame in gynecological circles and criticized Sims's surgical methods for obstetrical fistulae.) After his white apprentices quit, Sims elected to train his enslaved patients to work as surgical nurses. The peculiarities of slavery meant that these women, all slaves whom Sims owned or had leased, would be trained as skilled medical workers, yet they would still have to labor as domestic and agricultural slave workers. It was a heavy double burden. Their situation illustrates the convoluted nature of nineteenth-century medicine in matters of race, class, gender, and status.

To more fully grasp the nuances of modern American gynecology's origins and expansion, one must consider the lived experiences of some of its first patients, enslaved women. Sims's patients suffered from a debilitating condition that, according to his description, made them "unfit" for the work bondwomen were to perform. Additionally, some of these women were forced to live far from their friends and family for the duration of the experiment. They raised children without the presence of fathers and nursed babies while also healing the scars they bore as experimental patients—and they did so even under the fog of postsurgery opiates that kept them dehydrated, constipated, and bound to their beds for at least two weeks while their bladders and vaginas healed. The women provided labor in the fields and inside the slave hospital that Sims had built for them. He created a rotational work and healing shift for his slave patients; while some women recuperated from surgery, the others labored on his slave farm, in his home, and in the hospital.

After five years of medical experimentation, Dr. Sims performed his thirtieth surgery on Anarcha and successfully repaired her fistula, closing it permanently with silver sutures, his improvement on John Peter Mettauer's lead sutures. Sims repeated the technique on his other vesico-vaginal fistula patients and cured them all of the condition.[71] They could now return to their former homes healed and hopefully be reunited with family and friends. From their slave masters' perspective, they had retained their value as breeding women who also now possessed a skill that could increase their owners' wealth, for they could possibly work as nurses who had trained under a renowned surgeon.

Following the successful conclusion of his five-year experiment, Sims returned his leased charges to their owners, and in 1852, he published "On the Treatment of Vesico-Vaginal Fistula" in the *American Journal of Medical Sciences*. Three years later, he moved to New York and opened the Women's Hospital of the State of New York. Thanks in large part to his experimentation on enslaved black women, Sims had established himself as one of the country's preeminent gynecological surgeons less than a decade after he began his gynecological career.

James Marion Sims's rise from obscurity to eminence followed a trajectory that other elite medical men had created for themselves for decades. Such doctors engaged in innovative experimental medicine; many

relied on a disproportionately large population of enslaved women; and many published their findings in medical journals. The mid—nineteenth century was an era ripe for an enterprising and ambitious white man to ascend. Sims responded to the political climate of the 1850s by marketing himself as not only a doctor but also a medical entrepreneur. He named the position that vesico-vaginal fistula patients assumed during surgery the "Sims position," and he renamed the duckbilled speculum used to examine women's cervixes the "Sims speculum." The increasing ability of Dr. Sims and other men to heal and repair women's bodies encouraged the growth of gynecology as a profession and elevated it to a respected medical specialty. Their medical entrepreneurship also made them wealthy.[72]

In the mid—nineteenth century, men saw themselves as women's "protectors." Gynecology allowed them to enhance this role. Understanding the confluence of race and region is important because of the ways elite southern white men viewed their role as not only the protectors of women but also as "fathers." Many saw themselves as the "great white fathers" of their black slaves. Southern physicians who helped to advance the burgeoning field of nineteenth-century American gynecology also worked feverishly to maintain black women's ability to reproduce often and relatively safely. Thus the repair of any medical condition that could render an otherwise healthy slave woman incapable of bearing children further strengthened the institution of slavery. It was a system that valued enslaved women's wombs, the robustness of their sex lives, and ultimately, the number of children they bore, but it was also one that accorded black women neither respect nor wealth. Because male slave owners frequently sexually exploited the black women they owned, it is entirely conceivable that some doctors had sexual relations with the enslaved women they treated. Thus, many slave-owning physicians, and possibly James Marion Sims, not only served as the figurative fathers of reproductive medicine but also may have been the biological fathers of the enslaved children born during their experimental work in gynecology.

The demography of Sims's slave community illustrates how easily white men had access to black women's bodies. Sims owned and leased twelve females and five males on his farm. All the male slaves were young boys; in total the children ranged in age from two to twelve years old. Of the enslaved women on his farm, only seven or eight had reached childbearing age. Unlike the other slaves owned and leased by Sims, only one person was listed as a mulatto. An 1850 census described a one-year-old girl, the daughter of one of Dr. Sims's enslaved gynecological patients, as having a black mother and a white father. The little girl was the result of the reproductive labor her black mother performed as a slave and also possibly as Sims's gynecological patient and nursing assistant. Enslaved black women bore children for white men all the time, but birthing a child while they served as experimental gynecological patients was exceptional.[73]

Although a census record cannot prove the paternity of a slave child born to a white father, the child's existence gives rise to some critical questions about Dr. Sims's treatment of his enslaved patients. Was his enslaved patient impregnated against her will so that Sims could more easily locate a cure for her obstetrical fistula, since giving birth would reopen the woman's fistula? What other white men had access to this woman's body during her hospitalization and residency on Sims's slave farm? Sims detailed in his autobiography how members of the local white community withdrew their support for his experimental medical work. He suggested their lack of support occurred because of the repeated failures of his gynecological medical experiments. Could there have been another reason, perhaps one Sims did not want to address because of the ethical implications that would surround the birth of the mulatto girl on his slave farm?

Although these questions are speculative in nature, they should be considered serious inquiries about the nature of antebellum-era biomedical ethics and slavery. Although white Americans condemned and criminalized miscegenation, everyone knew that white men engaged in sexual relationships with black women as regularly as they had sex with white women. The presence of mulatto children revealed the hypocrisy of laws that banned interracial sex. Although the answers to these questions remain shrouded, Dr. Sims meteoric rise in the medical world demonstrates how he was still able to gain the trust of a community that had earlier rejected him. In 1848, four years after he began his experimental work, he was elected recording secretary of the Medical Association of Alabama. Nationally, Sims was elected and served as president of the AMA and the American Gynecologic Society decades later.[74]

Gynecological surgeons during the early and mid-nineteenth century were neither exceptionally cruel

nor sadistic physicians who enjoyed butchering black women's bodies, as some scholars have argued.[75] They were elite white men who lived in an era when scientific racism flourished. Ideas about black inferiority were established and widely believed, as was the underlying assumption about black people's intelligence. Black women, particularly those who were enslaved, were a vulnerable population that doctors used because of easy accessibility to their bodies. Further, the value of black women's reproductive labor demanded that it be "fixed" when it was seen as "broken" by those who depended on their labor. As elite medical men like Dr. Sims met "the demands of clinical practice and those of clinical investigation," as medical historian Charles Rosenberg asserts, they were confronted with the challenges of experiencing lives that existed "between humanity and science."[76] This conundrum also included the enslaved, people who were regarded as human beings, chattel property, and clinical matter.

The medical notes and articles of white doctors who treated black women highlight the disdain they had for this group in sometimes unsettling language. The personal papers of a Delaware physician are graphic in their depiction of his handling of a black woman patient he reluctantly treated. In March 1853, Dr. William Darrach visited a black woman patient who lived "in a miserable hovel" over a canal. Her former physician had told Darrach that the patient was about to have an "abortion," which in the nineteenth century meant she was probably going to suffer a miscarriage. As Darrach approached her home, he heard the woman groaning loudly and miserably. He noted that he believed she was faking labor pains. Darrach chided her for her "deception" and left her with her child in the home. He returned "the next day . . . discovered [his] mistake and . . . found that instead of having an abortion she had dropsy."[77]

Black women patients had to navigate their relationships with doctors like Darrach, who detested their blackness and yet needed to repair their bodies. Despite the entrance of white men into gynecology and obstetrics, black women still found ways to provide medical care for themselves outside the gaze of their owners and plantation physicians. Investigating these women's successes and losses, especially in light of the pioneering medical research being conducted at the time, helps to uncover the hidden spaces within slavery. Moreover, understanding enslaved women's experiences in slavery and medicine can create a more comprehensive perspective about this group and their bondage.