JYU DISSERTATIONS 284

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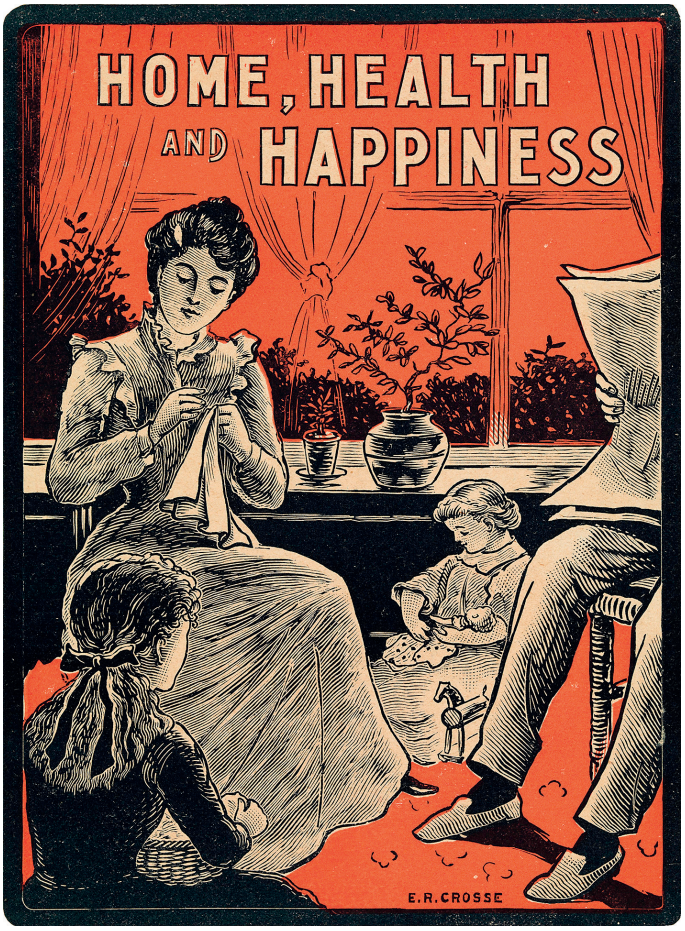
"The Health and Happiness of the Expectant Mother"

Constructions of Pregnancy and Childbirth in British Medical Writings, 1840–1902



UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF HUMANITIES AND
SOCIAL SCIENCES

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Esitetään Jyväskylän yliopiston humanistis-yhteiskuntatieteellisen tiedekunnan suostumuksella
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"– When her confinement is due, send to Moscow for an accoucheur… Let him be here…

The old prince stopped writing and, as if not understanding, fixed his stern eyes on his son.

– I know that no one can help if nature does not do her work, said Prince Andrew, evidently confused. – I know that out of a million cases only one goes wrong, but it is her fancy and mine. They have been telling her things. She has had a dream and is frightened."

Leo Tolstoy: *War and Peace*
Book One: 1805, Chapter XXVIII.
Translated by Louise and Aylmer Maude.
Novel first published in 1869.

ABSTRACT

Niiranen, Anna
"The Health and Happiness of the Expectant Mother": Constructions of Pregnancy and Childbirth in British Medical Writings, 1840–1902
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This dissertation explores the medical perceptions of pregnancy and childbirth in Victorian Britain, published both in popular health manuals intended for use by lay women and in the *British Medical Journal* (*BMJ*, publ. since 1840–). Using methods of close reading and contextual text analysis I have analysed doctors' writings. The *BMJ* was an important arena of joint medical communication and discussion, and a source of information. Popular medical manuals were also educational; guidebooks were constructed on the idea of prevention, self-control, and the body–mind relationship. In this study, "health" is understood as a physical state of healthiness, and "happiness" as a steady state of mind. Emotions were widely discussed in obstetric medicine, foremost fear.

Modern medicine was developed during the 19th century. However, as this study shows, doctors could use various innovations (stethoscope, antiseptic, anaesthesia) very differently and new ideas spread unevenly. For example, the advice given to pregnant women was based on the tradition of the six non-naturals (air, exercise, rest, diet, excreta, and emotions). In the 1880s, doctors could still explain some of the deformities and marks in newborn children by the controversial theory of *maternal impressions*. According to the theory, the pregnant woman's emotions and experiences affected her unborn child, seen directly and visually in the baby after birth.

The study also discusses the discourses of nature in 19th-century medicine. *Natural labour* was a technical term to explain the presentation of the foetus and the need of assistance in childbirth. However, in medical discourse, Nature was the very foundation of good health, a preserver of life, and a capricious destroyer. Male doctors constructed themselves as the protectors and allies of Nature, who stood in the middle of the triangle formed by Nature, pregnant women, and the art of midwifery, medicine, science, and progress; doctors could claim that they also possessed scientific and surgical methods if Nature failed. An ideal doctor was rationally compassionate, sensitive, and competent, being a respected member of the unified medical profession. In reality, medical work involving women's reproductional health was not generally appreciated; it was considered difficult, badly paid, and the competition for patients and a livelihood was hard.

Keywords: Childbirth, Pregnancy, Labour, Obstetrics, Midwifery, Doctors, Patients, Medical history, History of emotions, Gender history, Natural, Nature, Health manuals, *British Medical Journal*, Nineteenth century, Britain, Victorian era.

TIIVISTELMÄ (ABSTRACT IN FINNISH)

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Tässä väitöskirjassa olen tutkinut brittilääkäreiden käsityksiä raskausajasta ja synnyttämisestä. Olen kontekstuaalisen tekstianalyysin ja lähiluvun avulla analysoinut naisille suunnattuja, yleiskielisiä lääketieteellisiä opaskirjoja sekä aikakauslehti *British Medical Journalissa (BMJ,* ilm. 1840–*)* julkaistuja kirjoituksia, kuten raportteja, kirjeitä ja kirja-arvioita. Kummankin aineistokokonaisuuden funktio oli opetuksellinen, mutta kohderyhmä oli eri. *BMJ* oli eri puolella Britanniaa työskentelevien lääkärien oma julkaisu- ja tiedotuskanava ja tärkeä tiedonlähde. Naisille kirjoitetut opaskirjat olivat lehtiä yhtenäisempi ja idealistisempi aineisto. Raskausaikaa koskevat ohjeet rakentuivat oppaissa ruumis (*health*)–mieli (*happiness*) -suhteelle ja ennaltaehkäisyn ja itsehoidon periaatteille. Itsehoito pohjasi *non-naturals* -perinteeseen (raitis ilma, lepo, liikunta, ruokavalio, suolentoiminta & tasainen mieli). Tunteista puhuttiin lääketieteessä paljon, erityisesti pelon vahingollisesta vaikutuksesta.

Moderni lääketiede kehittyi 1800-luvulla. Aikakauden lääketieteessä elivät kuitenkin rinnakkain erilaiset käsitykset ja käytännöt ja lääkärit sovelsivat innovaatioita (mm. stetoskooppi, synnytyspihdit, kivunlievitys) eri lähtökohdista käsin. Perinteisten hoito- ja ajattelutapojen merkitys oli edelleen suuri – esimerkiksi epämuodostumat voitiin selittää vielä 1880-luvulla kiistanalaisella *maternal impressions* -teorialla, jonka mukaan raskaana olevan naisen näkemät ja kokemat asiat saattoivat siirtyä suoraan sikiöön.

Tutkimus osoittaa, että luonnollisuuteen ja luontoon liittyvät diskurssit olivat 1800-luvun mieslääkäreille hyödyllisiä. *Natural labour* oli tekninen termi, jolla kuvattiin sikiön normaalitarjontaa synnytyksessä. Synnytyslääketieteessä *natural* ja *Nature* olivat monimerkityksisiä ja sukupuolettuneita käsitteitä: luonto oli terveyden perusedellytys ja ylläpitäjä, mutta myös oikullinen tuhoava voima. Lääkäreiden mukaan he ymmärsivät ja avustivat luontoa, mutta samalla heillä oli käytössään tieteen, edistyksen, yhtenäisen ammattikunnan, koulutuksen, lääketieteen perinteiden, rationaalisen myötätunnon ja kunniallisuuden luoma kompetenssi ja auktoriteetti. Todellisuudessa alan arvostus oli alhainen, työ vastuullista ja vaikeaa, palkkiot pieniä ja kilpailu potilaista ja toimeentulosta kovaa.

Avainsanat: synnytys, raskaus, synnytysoppi, obstetriikka, lääketiede, lääkärit, potilaat, luonto, luonnollisuus, *British Medical Journal*, oppaat, Britannia, 1800-luku, viktoriaaninen aika, lääketieteen historia.

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PREFACE

"*Whoever is in a hurry shows that the thing he [sic] is about is too big for him.*"
Philip Stanhope, 4th Earl of Chesterfield

In 1893, Dr Jane H. Walker, one of the few female doctors studied in this research, published her popular medical manual, *A Handbook for Mothers*. Walker wrote in the introduction of her guidebook: "There is a wonderful mystery in motherhood". I might say, with this experience, that there is also a wonderful mystery in history research. The academic world might not be "a kingdom of happiness" as motherhood was for Walker, but conducting this research has certainly been a journey to remember.

This study has two supervisors – or (man-)midwives, I could say; Docent Susanna Niiranen and Docent Markku Hokkanen. I thank you both for your instructive comments, much needed support, patience, and – if I may – rational compassion during this long and somewhat difficult process. I think we can now all breathe a sigh of relief: the work is finally done.

I am deeply honoured that Dr Elizabeth T. Hurren and Professor Kirsi Vainio-Korhonen agreed to be the pre-examiners for this study. I thank them both for their positive comments – in the midst of the corona pandemic they found time to concentrate on my research, giving the most encouraging feedback and suggestions for improvements. Professor Kirsi Vainio-Korhonen kindly agreed to be the opponent; as far as D-Day is concerned, my greatest hope is that we will be able to discuss in person.

Glyn Hughes did marvelous work with checking and correcting the language; I thank you with all my heart for your understanding and patience – no knitted socks can ever pay it back! I would also like to express my gratitude to Docent Heli Valtonen, the Head of the Department of History and Ethnology, for offering me a place to work at the *Historica* building; this work would never have been finished without it.

I also thank the Emil Aaltonen Foundation, the Finnish Concordia Fund, the Foundation of Ellen and Artturi Nyyssönen, Vantaan Akateemiset Naiset ry, and the Department of History and Ethnology for the grants they provided.

As every historian knows, libraries and archives are the heart and soul of this work. Consequently, I would like to thank the Interlibrary Loan Service (Jyväskylä University Library) and especially Hannele Kiiveri, who for years very kindly renewed my numerous loans. The staff of the Wellcome Library, London, were also very kind and helpful.

This work would have been so much harder (in fact, quite impossible) without peer support; I thank my colleagues at the Department of History and Ethnology, especially Arja Turunen and Pirita Frigren, as well as my other colleagues (both current and former), including Elina Kauppinen, Saila Leukumaa-Autto, Laura Manninen, Minna Mäkinen, and Silja Pitkänen – I thank you all for keeping

my spirits up and integrating me into the unofficial community of historians and ethnologists.

Last but not least, I thank all my nearest and dearest with all my heart – my friends and especially my own family. The greatest debt of gratitude I owe to my mother: especially during this last couple of years when the whole universe seemed to be against me (or so it felt), you constantly encouraged me to carry on – *kiitos aiti!*

Hence, I dedicate this work to Henriikka, Aino, and Helena – my great-grandmother, my grandmother, and my mother. Writing this study has made me think of you, especially how you handled these things in your own lives.

After all, history is not that far away.

Jyväskylä 14.9.2020
Anna Niiranen

CONTENTS

"*Pregnancy, labour, and suckling, therefore, should be looked upon as one process; conception being the commencement, weaning the close, and labour the connecting link. Thus, a woman may consider herself a mother, not only from the birth of her child, but even from the moment of conception. From that important epoch her duties commence – duties amongst the most sacred and dignified which humanity is called upon to perform.*"

Bull, Thomas, *Hints to Mothers for the Management of Health During the Period of Pregnancy and in the Lying-In Room. With an Exposure of Popular Errors in Connection with Those Subjects and Hints upon Nursing.* London, 1865.

"*One person fears she is pregnant, another hopes she is so, a third supposes she has some disease when she is pregnant, and a fourth imagines herself, and is thought by others, to be pregnant when she has disease. Women are apt to disbelieve what they fear, and give credit to that which they hope for.*"

G. O. Heming, M.D., On the Signs of Pregnancy: Practical Facts and Observations on Diseases of Women, and Some Subjects Connected with Midwifery. *The Lancet*, June 15, 1844.

"*The most natural labour is the labour that is the best managed – not the most neglected.*"

Vincent, Ralph, *Wife and Mother: A Book of First Principles for the Guidance of Young Married Women*. London, 1902.

1 INTRODUCTION: MEDICINE, CHILDBIRTH, AND VICTORIAN SOCIETY

> In no department of the healing art is there a greater need just now for clear and definite principles by which we may shape and guide our future practice. Within the memory of most of us, the changes in this department have been so strange and sweeping, that they constitute little less than a revolution.[1]

In 1875, the English obstetrician Joseph Griffiths Swayne (1819–1903), writing in the prestigious medical periodical, the *British Medical Journal*, demanded better statistics in order to obtain accurate information about contemporary midwifery practices in Britain. In his paper, Swayne also referred to the great changes happening during his own lifetime, which he called "little less than a revolution". As Swayne noted, until the second half of the nineteenth century, the policy "of waiting upon Nature" was preferred in British obstetrics, "giving her [Nature] no assistance until she has proved herself incompetent to do her work".[2] This was a policy of a "somewhat timid *laissez faire*", a fear of crossing the thin line between an appropriate and justified treatment and an excessive and debatable medical intervention, or *meddlesome midwifery*, as overtreatment was commonly called in nineteenth-century obstetrical literature. Indeed, despite that the greater change – what the historian Lisa Forman Cody has called "a uniquely British domestic revolution" – had taken place a century previously, during the eighteenth century, when medical men had entered the lying-in chambers and also started to attend normal deliveries, the ideals and qualifications of a good and competent obstetrician were constantly discussed, defined, and debated throughout the entire nineteenth century.[3]

Swayne's paper also demonstrates another key aspect in nineteenth-century British *obstetrics*, as the medical field concentrating on childbirth was called, alongside *midwifery*, an older and more traditional word for the art of attending

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1 Swayne, J. G., Obstetrical Statistics. The *BMJ*, November 20, 1875, 635.
2 Swayne, J. G., Obstetrical Statistics. The *BMJ*, November 20, 1875, 635.
3 Cody 2008, 3.

childbirth.[4] Even if it was commonly accepted than in ordinary or normal delivery the duties of the doctor were not in fact that many, it was stressed that a good and competent doctor was able to recognise potential risks and was aware of those decisions every practitioner attending labour was potentially facing when treating his midwifery patients in obstructed and complicated cases. As we will later see in this research study, a good reputation, professional credibility, and respectability were everything in the nineteenth-century medical market, but as Swayne noted, medical peers, patients, and their circles all gained from the correct information – in other words, also from mistakes and failures.[5] "All the more honour, then, is due to those practitioners who for the benefit of medical science and for the public good, nobly come forward, undeterred by any fear of risking their reputation", when publishing reports on their professional experiences and failures in medical periodicals and guidebooks, as Swayne underlined in his own statement.[6] Failures were indeed as important as professional success, but as everyone knew, making them public was always risky.

Swayne's paper reflects the mental perspective of nineteenth-century medicine in Britain and more precisely, its dealing with childbirth. Like at all times, also in nineteenth-century Britain, women – albeit not all of them – became pregnant, gave birth, and recovered during *lying-in or puerperium,* meaning the postnatal period immediately following childbirth. Some of these women suffered miscarriages or went into premature labour, and a few were seeking ways to terminate their unwanted pregnancies though it is not known how many exactly. Some women experienced only a little discomfort during the pregnancy months, and some gave birth relatively easily, escaping a greater amount of pain and inconvenience. Some women, however, suffered a wide range of pregnancy- or birth-related complications, and a few of them – albeit only a very small minority – lost their lives during this process, which was called *reproduction* by the nineteenth-century medical profession.[7]

As the British physician and medical author Michael Ryan (1800–1840) noted in one of his numerous manuals: "reproduction is the function peculiar to organised or living beings, which enables them to perpetuate their species [--] It

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4 On terms and concepts, see Chapter 2.1.

5 The "medical market" is here understood as a market of available healers, advice, and cures, including both material and immaterial exchanges and services. Academic medicine and the medical profession were just one party competing for patients and providing treatments and care; in medical encounters, the presence of a doctor was not required, and state intervention could be minimal or non-existing. In the medical market, the reputation and popularity of the healer were important factors. See de Blécourt & Usborne 2004, 2–4.

6 Swayne, J. G., Obstetrical Statistics. The *BMJ*, November 20, 1875, 638.

7 In the nineteenth century, "reproduction" was a relatively new word in the English language, reflecting the biological change in science. Until the late eighteenth century, the word "reproduction" was never used by an English speaker if they were referring to humans. Instead, the word "generation" was preferred. Cody 2008, 20–21. See also Schiebinger 2004a, 11–39; Duden 1991, 28–29.

is from this function that the life and organisation of all animated being emanate."[8] Thus, as was often depicted in nineteenth-century doctors' writings, everything in nature was reproducing, including plants, insects, and birds – and also human beings. Reproduction was seen as a natural part of all life, as the short-lived medical periodical, the *London Journal of Medicine* pointed out in 1850: "[p]rocreative Power is that power inherent in every animal, which, when brought into practical operation by the union of the sexes, assures the continuance of the species. Man, in his animal relations, possesses this power in common with all created beings".[9] Thus, human reproduction was a profoundly meaningful process; it was the very foundation of every society, culture, and nation. However, as the nineteenth-century medical profession generally thought, it was not the same in every culture or even social class.[10]

Research Questions and Methods

In this dissertation, I examine more closely the medico-cultural meanings of two stages in human reproduction, *pregnancy* and *labour,* in the British context over sixty years, from 1840 to 1902, a time frame loosely based on the Victorian era. In the broadest sense, my research is the *history of childbirth*; as the medical historian Adrian Wilson has pointed out, this kind of approach encompasses many different points of view rather than discussing the separate histories of authorised medicine and (male) medical practitioners, female midwives, and parturient women and their circles.[11] However, in this study, I concentrate almost solely on the British medical profession working during the Victorian era; that is to say, the medical profession consisting mainly of medical men who discussed and published extensively on the topic, clearly wanting to represent themselves as the authorised and legitimised experts on reproduction. Consequently, it is especially the themes related to the doctor–patient relationship, gender, representations of the body, and emotions that are discussed in this research; these aspects have always been an inextricable part of medical work, the cultural perceptions and ideals of being a good doctor, medical history, and the history of medical practitioners in general.

The task of this study is to understand how doctors constructed pregnancy and labour in their writings and also their own role in caring for women's reproductional health during the gestation months and when women gave birth to the future generations of Britons. That is to say, I am interested in how the British medical profession wrote *about* and *to* their potential patients – women who lived through the first years of their married life, whether being pregnant or expected

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8 Ryan 1841, 79–80. On the historical background of natural history in eighteenth-century England, see Cody 2008, 8; Schiebinger 2004a.

9 Routh, C. H. F., On Procreative Power. The *London Journal of Medicine*, No. xv, March 1850, 241. See also Sperry 1896, 12–13.

10 On the nineteenth-century perceptions of the birth habits in different cultures, see especially Engelmann, George Julius, *Labor among Primitive Peoples* (1882). Engelmann (1847–1903) was an American obstetrician and gynaecologist who was deeply interested in the anthropological aspect of human reproduction. See also Chapter 5.1 in this study.

11 Wilson, A. 2002, 130–131. See also Duden 1991, 74.

to be so, giving birth, or recovering during the lying-in period. I am particularly interested in how (male) doctors justified their knowledge and their active role in childbirth, especially when historically the female tradition had been so apparent and British midwives were still attending labours, especially in rural and industrial districts. Traditionally, personal experience had been one of the main rationales of the practice of female midwives; childbirth was a common, shared experience between women, being a "female trade" rather than a branch of mainstream academic medicine. Historically, it is indeed interesting to peruse how the nineteenth-century (male) medical profession was constructing its professional authority on pregnancy and childbirth. For example, what were the characteristics of an ideal nineteenth-century obstetrician and what kind of physical and mental qualities were required of a medical practitioner working both with women's reproductive bodies and with their emotions?

Consequently, I scrutinise the methods by which the medical ideas of childbirth were internalised and inscribed within popular medical literature and when doctors shared their experiences and thoughts with their peers in medical periodicals. Comparing these two types of primary sources, my aim is to investigate how pregnancy and labour were to be managed if a lay nineteenth-century woman wished to follow the medically correct instructions and obstetrical ideals of her time, and what these instructions, advice, and ideals were based on. For example, how was pregnancy diagnosed according to the nineteenth-century understanding represented both in the medical manuals and journals, and how should women prepare themselves for birth – which in many cases took place repeatedly and yet most likely was one of the most dangerous single occasions in the female life cycle? Concerning birth, I am especially interested in the concept of "natural labour" in the context of nineteenth-century British medicine; in the medical writings analysed in my research, the concept of "nature" was constantly referred to and discussed. My aim is to explore what the medical profession meant when they discussed "nature" and "naturalness" in connection with childbirth and what in fact was "natural labour" in nineteenth-century obstetrics.

This question was also linked to the ethical aspects and in many ways difficult question of the responsibility of the medical practitioner in obstetrical work, foremost the concept of "meddlesome midwifery" and potential choices made in the complicated and obstructed cases. In the primary sources, this topic was often visibly present; thus, I also analyse the complex relationship between miscarriages, abortion – here meaning an intentional termination of pregnancy –, the obstetrical operation called *craniotomy,* which meant destruction of a foetus in the womb, and the *Caesarean section*, a method of birth involving surgery. My aim is to pay attention especially to the latter; the story of the Caesarean section in nineteenth-century British obstetrics has remained curiously unexplored in the cultural history of medicine even if the operation itself and the obstetrical policy and practices clearly changed over the course of sixty years, from the early 1840s to the end of the nineteenth century. Especially the ethical side of the discussion amongst doctors needs to be examined more closely.

I have investigated the Victorian doctors' constructions of childbirth and pregnancy mainly using two collections of primary sources. First, I have examined medical health manuals, written by the nineteenth-century medical profession, either published by British authors or printed in Britain. The majority of these manuals were intended for use by young, usually recently married women, allegedly with little knowledge or practical experience of pregnancy and childbirth. In total, I have explored thirty popular health manuals concentrating on reproduction, published between 1834 and 1902, distributed in all decades of the Victorian era. All writers of the manuals were medically trained and had gained practical work experience of childbirth; thus, the authors can be considered to possess a reasonably similar kind of socio-educational background.[12] In addition to these popular manuals, I have also analysed professional medical guidebooks, contributed by the most prestigious and well-known obstetricians of the time, proving the existence of an authorised and legitimised side of nineteenth-century midwifery and medicine, cited and quoted also in the popular medical health manuals.[13]

Indeed, this study also discusses the histories of nineteenth-century medicine and medical practitioners – examined in the light of pregnancy and childbirth. I have investigated the literary sources doctors created themselves and partly about themselves: firstly, nineteenth-century health and midwifery manuals, and secondly, medical periodicals, here meaning the *British Medical Journal* (*BMJ*), published since 1840, the year also marking the starting point of this research. In the nineteenth century, the *British Medical Journal* was a weekly-based periodical, discussing many events and aspects of the nineteenth-century world, not just medicine, but also British culture, political events, and the famous people of the time. Topics related to reproduction were an important part of the *BMJ*, including weekly sections, book reviews, doctors' lectures, letters, enquiries, and various advertisements and announcements. Thus, medical journals encompassed many different kinds of narratives, time levels, and intensities and they established a multi-voiced discussion forum for nineteenth-century medical professionals living and working in different parts of the British Empire.[14]

Both types of primary sources analysed in this study – even if the manuals and journals were written by the medical profession belonging to a small, educated elite in nineteenth-century Britain – reveal much of the broader socio-cultural contexts in which they were created.[15] In fact, many times, purely medical or "scientific" matters clearly played a less important role and the writers discussed and described in detail their practical work and patients, professional ideals, contemporary socio-cultural phenomena, and events, hence, in many ways

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12 These manuals are discussed more closely in chapters 2.2 and 3.3.

13 For more detailed information about these writers and their professional networks, see chapters 2.2 and 3.3.

14 On the primary sources, see also Chapter 2.2.

15 It is important to remember that none of the sources analysed in this study were created to meet the needs of history research; they were intended for use by both a lay audience and medical peers. On primary sources in history research, see for example Jordanova 2006a, 37–41.

revealing rich and unique layers of cultural history. Particularly doctors' letters and enquiries sent to the journals have been in many ways an indispensable source in this study. The letters – both short informal notifications asking for help with puzzling problems and longer messages, usually commending the content of the journal – were published in the *BMJ*, describing both actions and observations, revealing much of how nineteenth-century doctors saw their patients, what kinds of challenges they faced in their work, and what kind of practical experiences doctors had of childbirth and of their pregnant and parturient patients. In this sense, the correspondence sections illustrated practical encounters with the patients and the broader ideals and expectations doctors had concerning their work as well as the ideas of being a medical practitioner in nineteenth-century Britain.

In this study, specific biographical data on individual writers is considered less essential; some of the writers were well-known in both genres, meaning that in many instances their professional traces can be tracked down and their contributions found, while others could write only one letter or a short message to the journal, sometimes with their real names, sometimes anonymously without any mention of their professional affiliations or other personal information. In this research, the fact that the letter was published in the journal is taken as an indication that the content had been scrutinised and approved by the editorial staff of the journal; this is sufficient proof of the authenticity and "medicalicity" of the texts evaluated and interpreted in the study. However, it is important to notice that many totally contradictory opinions and views were printed in correspondence columns. Hence, even if the letter appeared in the journal, the opinion did not necessarily represent the *BMJ*'s own policy nor was it a universally accepted perception in nineteenth-century medicine – quite the contrary, the correspondence section shows that many contradictory stances and a considerable range of opinions and agendas could be found side by side; counterarguments and critical comments were even expected of the peer audience. New ideas and innovations were cultivated somewhere between conflicts and mutual agreements.

Thus, some parts of the journals were the creations of both the editorial staff and readers, even if ultimately the editors either approved and published the letters – very likely the published letters were edited – or rejected them; it is not known how many letters were never published and for what reasons they were rejected. What is well known, however, is that some of the topics first discussed in the letters could later end up in the main articles and weekly sections of the journal, emphasising the role of the active subscribers and their contributions in medical journalism and creating new knowledge and practices in medicine.

Rather than concentrating on the writings produced only by the leading authorities in nineteenth-century obstetrical medicine, I have read many kinds of texts – here "texts" means both medical manuals and the content of the *BMJ* – alongside methods of close reading and contextual text analysis. The manuals and journals are compared with one another in order to understand the sources as *texts*, to reconstruct the circumstances in which they were created and originally read, and to analyse and "translate" their meanings – in this process, close

critical reading is an indispensable method when interpreting the past from historical sources. *Close reading* is a method which allows revisiting the text and analysing it from different perspectives and intensities.[16] When analysing the sources the historian is creating new thematic units and networks by reading, deconstructing, and translating the texts, and then making his/her own interpretations of them. From the texts, three traits are examined with particular intensity: the author, the audience, and the message, especially the hidden meanings, internal themes and tensions, and also omissions.[17] Thus, what is not said can be as equally interesting as what is specifically underlined – often even more so.

Contextual text analysis, which can be understood as systematic reading, is interested in texts, meaning what texts reveal about themselves as texts; the potential intentions, motivations, and agendas of the writers are analysed; for example, why the medical manuals were published, for whom the texts were intended, how manuals could be used, and how the writers constructed their own knowledge and understanding about the phenomena in question.[18] These aims, agendas, or intentions may not necessarily be particularly visible – quite often they are not – and without a deeper understanding and critical gaze the historian's interpretations of the past can easily be erroneous and prejudiced; consequently, the context is essential in understanding historical phenomena and people living in the past in their own right. In this, source criticism is a basic tool for a historian to evaluate the texts as historical sources and evidence, including their reliability and relevancy, the contexts, creators and their potential intentions and agendas, and the audience for whom the texts were written and intended. This requires continual vigilance, skepticism, precision, and attention during the research process; as the historian Joan W. Scott has pointed out, conducting research on history is always balancing between facts and interpretation, objectivity and creativity, reality and fiction. Ultimately, a historian is a storyteller who uses different narratives to create stories, to interpret both history and the present at the same time.[19]

Hence, nineteenth-century doctors' constructions of childbirth must be understood in the contexts of the nineteenth-century world, society, medical culture, and language – not how these ideas work in the present day and how "correct" they might be, according to the current understanding. In fact, it is necessary to remember that there is no single meaning for the text and the meanings are never universally shared or accepted – not even for the contemporaries.[20] Consequently, reading primary sources and the making of interpretations are never neutral activities; they require special knowledge, understanding, sensitivity, meticulousness, openness, and respect on the part of the historian who is constructing their

16 See for example Jordanova 2006a, 159–160; Ruiz De Castilla 2018.
17 Ruiz De Castilla 2018.
18 On content analysis, see Krippendorff 2004, xvii–xxiii, 3–12, 18–25, 29–31, 41–43, 90, 341–342.
19 Scott 2011, 203–207.
20 Krippendorff 2004, 22–23. See also Harley 1999, 417–418.

own version of history on the basis of the sources and previous research.[21] In every study, the contexts and primary sources are in a constant dialogue with each other; in fact, it can be argued that the contexts, meaning the frame, circumstances, perspectives, locations, situations, or particular spirits, discussed in a study, are the creation of the historian who, in the broadest sense, is ultimately placing the texts in the context of a whole culture. Indeed, as the cultural historian Peter Burke has noted, there is never just one context but many; they can be literary, linguistic, cultural, political, institutional, or material, some can be local or metaphorical, for example.[22] In this sense, for example certain events and incidents, cultural practices, religious beliefs, legislation, and economic factors are important in order to analyse the texts and to understand their meanings.

I argue that these kinds of holistic yet critical approaches help the historian to notice special elements, literary techniques, and longer continuances and traditions in the texts. There is a particular danger that a small number of primary sources, taken out of the socio-cultural-historical contexts in which they were created, are "made to carry a heavy explanatory load", as the British historian Ludmilla Jordanova has stressed.[23] This is indeed the reason why I have studied both popular medical manuals and medical journals and why the time span is so extensive – more than six decades. A large number of texts of a different kind – including health manuals, printed lectures, hospital reports found in the medical journals, doctors' letters, enquiries, advertisements, and book reviews – enable a historian to understand the limits of different genres and to recognise similarities, literary patterns, and rhetorical techniques used in the primary sources. Thus, the very starting point in this research is the observation that in order to understand the general historical-cultural contexts and especially longer historical traditions, it is not enough to concentrate only on one text type or to read only a handful of advice manuals.

On the other hand, it is worth noticing that in the case of nineteenth-century medical journals, in this study, there is no particular need for quantitative analysis. The writings published were selections with certain purposes and functions, and hence, they only tell about what was printed in the journals, not what generally happened in the birthing rooms across the British Empire. Thus, the various accounts printed in the *BMJ* cannot be generalised or thought to represent nineteenth-century childbirth in general or what took place in average childbirth even if they contain much information about many medico-cultural ideas and practices; the reports were written for the needs of the medical profession, from the perspectives of doctors, for an intended audience consisting of doctors as well. Consequently, the descriptions in the *BMJ* do not reveal or reflect the so-called "reality" of nineteenth-century childbirth; the truth is that neither medical journals nor manuals were created for the needs of a historian who is interested in the history of childbirth or medicine and who is keen to examine and know "the

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21 Jordanova 2006a, 9, 40, 90–94, 102, 144–145; 160–161; Ruiz De Castilla 2018. See also Harley 1999, 418–419, 432–433.

22 Burke 2002. See also Krippendorff 2004, 33–34. See also Davis 1990, 29–30; de Blécourt & Usborne 2004, 2.

23 Jordanova 2006a, 348. See also Harley 1999, 415; Lupton 1996b, 11–19.

actual state of affairs", allegedly documented in the periodicals, as they happened in real life.[24]

In this study, another hypothesis is that popular health manuals were constructed – not only on the basis of medical knowledge nineteenth-century doctors relied on and believed in – but also on medical traditions and literary conventions; thus, the manuals do not reflect some kind of unchanging, independent reality as it was collectively understood by nineteenth-century doctors and their patients.[25]

Considering previous research, however, it seems that on some occasions, when studying only one or two guidebooks, popular medical manuals have indeed been understood very literally, usually as evidence to demonstrate how *little* doctors ultimately knew and understood, how primitive the state of medicine was, how doctors practised their profession single-mindedly without major disagreements or variance, and how female readers were constantly made to feel guilty and culpable without understanding the general literary conventions and historical contexts of the genre of popular health literature. As is discussed later in this study, especially the role of prevention in nineteenth-century medicine and the literary patterns according to which the medical manuals were structured cannot be understood if the traditional theses of medical self-help care are not recognised and analysed.[26]

Thus, in order to understand and conceptualise the relationship between medical thinking and the settings in which it occurred and within which it was practised, I have read a large number of popular medical manuals and gone over every issue of the *BMJ* between 1840 and 1902 in order to understand both longer continuances and changes during the time span analysed in this research. Of course, there are studies in which the selective method based on the sampling units of specific years is necessary, even a precondition, but it is important to notice that in the *BMJ* childbirth was discussed under a wide range of different text types and headings. Some of the most important texts I have found in the medical journals have been the writings with few or no hints on pregnancy or childbirth in their headings, such as doctors' letters, various society and hospital reports, and weekly sections. In many cases, these descriptive and informative documents have not been recorded in the annual indexes of the *BMJ* – this index was incomplete and did not include the whole content of the journal – and thus, finding and collecting them has required much work, time, and reading. Another challenge has been the large amount of texts analysed in this study: the *BMJ* was published weekly (thus, annually there were fifty-two or fifty-three issues) and its content multiplied during the nineteenth century; consequently, in the 1890s, the journal was very different from the one published in the 1840s even if certain

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24 See also *Studying Victorian Childbirth* in this same chapter.

25 On relation between modes of discourse and texts, see LaCapra 1983, 56–61.

26 On the need to discuss the field of *non-naturals* in medical history, see especially Porter 1985, 193. See also Harley 1999, 416. For an example of the latest research, see Cavallo, Sandra & Storey, Tessa (eds.) *Conserving Health in Early Modern Culture: Bodies and Environments in Italy and England*. Manchester: Manchester University Press. 2017. See also Chapter 4.2.

sections remained the same. The fact is that, in order to find all important texts related to childbirth amongst the entire contents of the *BMJ*, there are no shortcuts.

All in all, the study covers more than sixty years from 1840 to 1902, when the first *Midwives Act* was enacted in England and Wales, regulating the work and profession of midwives who traditionally had undertaken deliveries throughout Britain. However, in the eighteenth century, British midwives had already lost their monopoly of midwifery, and during the Victorian era, they were struggling with a declining social and professional status. As is discussed in this study, nineteenth-century doctors, on the other hand, were loudly defending their position and authority over the reproduction process, constantly justifying why they made the best attendants in childbirth and the experts on both the female body and mind – "the health and happiness of the expectant mother" – both aspects examined in this study.

Nineteenth-Century Medicine: The Age of Revolutions?

The nineteenth century, or here defined more precisely as the years between 1840 and 1902, is in many ways an interesting period in the histories of medicine, the medical profession, and childbirth. During the nineteenth century, the British medical profession was growing larger and it was struggling with competition for patients, medical authority, livelihood, and changing social status; it continued to professionalise and specialise while it was constantly re-evaluating its place both in Victorian society and in the medical market. Around the mid-1800s, there were approximately 17,500 regular medical practitioners in England and Wales, and at the beginning of the twentieth century, the number had risen to over 22,600.[27] The first female practitioners received their degrees around the mid-1800s, but they continued to be a small and in many ways underrated minority in a male-dominated branch; according to the historians Pat Jalland and John Hooper, in England and Wales, in 1881, there were 25 female doctors, and ten years later the number was 101.[28] Medical men had gained authority in midwifery in the eighteenth century and during the nineteenth century they were consolidating their position and authority in obstetrics. As Lisa Cody has pointed out, men's medical authority over reproduction had already been accepted and taken for granted by the time Queen Victoria came to power in 1837.[29]

As this is a study of the medical perceptions of childbirth in the Victorian era, it is inevitably also a study about nineteenth-century British medicine. As the

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27 See rations in Digby 1994, 15. According to the medical historian Irvine Loudon, in 1851, there were a little over 19,100 medical practitioners in England and Wales. However, Loudon included the category "other medical men", consisting mostly of medical students, in the total number. In Scotland, the total number of medical practitioners was 3,010, and in London, the medical centre of the Empire, slightly over 5,600. Loudon 1999, 217; Branca 1975, 63.

28 Jalland & Hooper 1986, xi. See also Chapter 3.2.

29 Cody 2008, 10. See also Loudon 1999, 86. According to Irvine Loudon, the previous monopoly of midwives was broken by 1800 and midwifery had become "a routine part of the practice of practically all rank-and-file practitioners".

medical historian W. F. Bynum has underlined, modern medicine – as we understand it – is to a large extent the product of nineteenth-century society.[30] Medicine and many of its specialties, such as antiseptic surgery, and the medical profession itself developed during the nineteenth century. For example, the discoveries of the French chemist Louis Pasteur (1822–1895) and the British surgeon Joseph Lister (1827–1912) had a profound influence on antiseptics, and consequently, also affected the medical perceptions and practices of childbirth and gynaecology.[31] A doctor's white coat and a stethoscope, the well-recognised cultural symbols of medical technology and a doctor's professional ability, authority, and objectivity, both appeared in the nineteenth century, and X-rays, providing a new radical opportunity to see inside patients' bodies, were introduced at the end of the century, in 1895.[32] Hence, Bynum's argument is very correct, but my study also discusses longer traditions in medicine. Medical history is also about continuances and traditions, not only about the dramatic changes, turns, and ideas, often thought to be inevitable "progress" or "revolutions", replacing and changing everything instantly and permanently and producing a better, modernised, and rationalised world.

In the 1990s, when discussing what was then to be called "new social history" with its new critical perspectives and approaches, the historian Natalie Zemon Davis criticised the old history research dominated by teleology and the idea of progress: "old habits of thought are as important as current attitudes, unreflective commitments as important as conscious weighing of interest, and novelty may emerge as readily as readily from improvisation as from planned strategy".[33] Following this thesis of Davis, my research is not a study on progress, new scientific breakthroughs, and technical innovations, meaning who – traditionally including only great medical men – invented what and when. Some of the discoveries and new ideas had a crucial impact on the topics discussed in this work, of course, and they are important in order to understand especially the medico-cultural contexts of the writings analysed, but I am more interested in the broader level of cultural history, including practical advice and instructions concerning both pregnancy and labour. The nineteenth century was a diverse and complex time period in British medicine, mixing the longer traditions and theories dating from Antiquity to new technologies and practices introduced and diffused during the Victorian era. Indeed, if only progress, "revolutions", and dramatic changes are payed attention to, much of the historical diversity, contradictions, and intriguing nuances is lost and the result is a one-dimensional and distorted picture of the past.

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30 Bynum 1996, xi.

31 See Burnham 2005, 31; Lawrence 1994, 65; Bynum 1996, 107–114; Harrison 2004, 120–122. See also chapters 2.1 and 3.2.

32 See for example Bynum 1996, 173–175. See the early example of X-rays in the *BMJ*: Briggs, Henry, Bone Crochet Hook (4 ½ Inches Long) Accidentally Lodged within the Peritoneal Cavity. The *BMJ*, June 10, 1899, 1393. See also Oakley 1984, 28.

33 Davis 1990, 29.

The medical historian James Bradley has divided nineteenth-century medicine in Britain into three levels: "pathology (the study of disease, including etiology, prognosis, and the actual processes of disease); therapeutics (the cure of disease); and hygiene (the prevention of disease".[34] These elements are all important to notice, but in this study, I have been particularly interested in the last mentioned. Considering the history of nineteenth-century medicine it can be argued, of course, that the medical system of *humoralism*, a theory of the imbalance of the four humours of the human body – black bile, yellow bile, phlegm, and blood – causing diseases, was gradually replaced by microscopic medicine, modern laboratory science, and an understanding of the body as consisting of different organs with specialised functions, after the second half of the nineteenth century.[35] But, as I discuss in this study, the idea of prevention and the long medical tradition of the *non-naturals*, meaning diet, exercise, rest, air and ventilation, excretions (with especial attention to the bowels) and the moderation of passions and emotions, in the preservation of health was still an important part of nineteenth-century medicine, especially with regard to how the public was addressed in popular medical writings.[36] In addition, the traditional method of treating the unbalanced state of the body, *venesection*, bloodletting or *phlebotomy*, a surgical cutting of a vein, was still applied in obstetrical medicine after the therapeutic method had largely been abolished elsewhere. The use of leeches, for the same medical purposes, continued to be in practice as well. Within sixty years, different generations of practitioners changed but some of the traditions were persistent and prevailing.

In its entirety, this study concentrates on childbirth in Victorian Britain. Here "British" means a loosely defined geographical area containing at least England, Wales, Scotland, and Ireland, often included the whole British Empire with its colonies and more importantly, the politico-cultural idea of "Britishness". As the title revealed, the *British Medical Journal* was widely read all over the empire and the journal was interested in the medical news reported from all over the world. Undeniably, the British Empire – its presumptuous and aggressive politics and its leading position as the transnational superpower, with a constantly expanding economy, growing industry, and thriving culture – had in many ways an indispensable role in the nineteenth-century world. During the nineteenth century, the population in Britain was rapidly growing; in England, for example, in 1841, the population was 15,113,000 and in 1871, it was more than 21,000,000.[37] This meant that the population was relatively young and the birth rate was high,

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34 Bradley 2000, 27–28.

35 On the history of humoralism, see for example Longrigg 1997, 30–32; Burnham 2005, 44; Nutton 1997, 281–291; Porter & Porter 1989, 170–171. See also Levine-Clark 2004, 88–89; Harrison 2004, 4–5. See also Chapter 5.5.

36 See the latest research on the non-naturals in Cavallo, Sandra & Storey, Tessa (eds.) *Conserving Health in Early Modern Culture: Bodies and Environments in Italy and England* (2017); Kennaway, James & Knoeff, Rina (eds.) *Lifestyle and Medicine in the Enlightenment: The Six Non-Naturals in the Long Eighteenth Century*. London: Routledge (2020). On the non-naturals, see also Wöhrle 1990; Rather 1968, 337-347; Niiranen S. 2019, 54. On nineteenth-century medicine and the heterodox systems of therapeutics, see Bradley 2000.

37 Wrigley & Schofield 1989, 199. See also Harris 1993, 41–60, 62–63.

even if it began to decline around the 1870s. Moreover, as is very well known, the nineteenth century in Britain was the age of the industrial boom, political turmoil, and social reforms and isms; the century was marked by industrialism, imperialism, colonialism, romanticism, modernism, commercialism, capitalism, and the expansion of journalism and urbanisation, inter alia. All in all, it was, as the historian Peter Gay put it, "an age of movement, and of movements".[38]

The Victorians Revisited

The nineteenth century was also the golden age of the European empires and monarchies, foremost in Britain, Germany, and Russia, all connected to each other with close family ties and dynastic marriages. In Britain, Queen Victoria (1819–1901) was on the throne for the most part of the century, being one of the most well-known, or at least one of the most well-connected women of her time. As a granddaughter of King George III (1738–1820) and a niece of his two reigning sons, Victoria acceded to the throne in June 1837, at the age of just eighteen. A few years later, the young Queen married her German cousin, Prince Albert of Saxe-Coburg and Gotha (1819–1861), became the mother of nine children and eventually "the grandmother of Europe", reigning over her expanding empire more than six decades until her death in 1901. Victoria's and Albert's nine children and numerous grandchildren married into the ruling houses and imperial dynasties, and many of them belonged to European ducal houses and aristocracy, producing endless new generations of royalty and nobility. Personally, Queen Victoria herself had – somewhat unwittingly – an impact on the history of childbirth, also discussed in this study. Especially the Queen's decision to try chloroform in the births of her two youngest children in the early 1850s, has often been considered medico-culturally important.

This long period is commonly known as the *Victorian era*, a concept applied also in this study. The term "Victorian", as is well-known, was derived from the name of Queen Victoria – christened as *Alexandrina Victoria* – who was originally named after her German-born mother. At time of the first appearance of the term in the 1880s and 1890s, it was a tribute to the Queen who had reigned longer than many of her subjects could remember; during the last years of Victoria's lifetime, the term "Victorian" bore positive connotations, associated with the old Queen – at that point, a well-respected and iconic figure – and her six decades of reign.[39] However, nowadays, the term is usually closely connected to *Victorian morality*,

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38 Gay 1999, 65. See also for example Harris 1993, 1–40.

39 In English, the Queen's mother was called Princess Victoria of Saxe-Coburg-Saalfeld, or, in German, Victoire von Sachsen-Coburg-Saalfeld. Longford 1964, 23. Queen Victoria, after a decade of isolation after the death of her beloved consort, Prince Albert, returned to public life and was later celebrated in her Golden and Diamond jubilees in the 1880s and 1890s. See the examples of the use of the term *Victorian* and jubilee celebration in the *BMJ*: Humphry, George H., On Taking Pains. The *BMJ*, October 3, 1891, 741–743; An Address on the Progress of Medicine in the Victorian Era. By Mrs. Garrett Anderson, M.D. The *BMJ*, May 29, 1897, 1338–1339. See also the title of the book review On the Progress of Preventive Medicine during the Victorian Era. The *BMJ*, July 28, 1888, 181–182. See also Ward Cousins, J., President's Address Delivered at the Sixty-Seventh Annual Meeting of the British Medical Association. The *BMJ*, August 5, 1899, 330.

or rather, the cultural stereotypes of married women thinking only "of England" when having sex and the hidden underworld of sexual perversions and rampant prostitution.[40] As the historian Michael Mason has pointed out, the term Victorian is negatively loaded in common language: the lay connotations of "Victorian" convey the idea of social restrictiveness and excessive moral propriety and decency, applied primarily to sex and sexuality.[41] According to the very popular and persistent belief associated with the Victorians, people tried to hide all traces of sexuality in their homes by covering the piano legs – bare legs in furniture were allegedly considered indecent. This stereotype of course was nonsense.[42] Moreover, as the historian John Tosh has pointed out, in our minds the roles in Victorian society and families have been stereotypically cast: "the Victorians stood for tyrannical fathers, confined wives, ground down workers and public squalor".[43] In short; in general understanding, "Victorian" is associated with moral hypocrisy, "stuffiness", "pomposity", and "philistinism" with social neglect and aesthetic ugliness: a perfect Dickensian world with caricaturised heroes and villains, flagrant social injustices, and great industrial cities with their gloomy smog.[44]

The truth is, however, that most Victorians – not even Queen Victoria herself – were not in fact Victorians at all, or how the term became constructed later in the twentieth century. In the nineteenth century, bourgeois households – sometimes thought to be the norm – were a minority, many married women worked outside their homes, and so did their underage children. Sex before marriage was commonplace, and death was a common, yet unwelcome visitor in many families, creating many fatherless or motherless children, and parents who

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40 See for example Sweet 2001, ix–xii. See also Branca 1975, 8. Patricia Branca has noted how the question of prostitution has often dominated the discussion on Victorian society, "so that at times one gets the impression that prostitution was unique to Victorian society and a vital counterpart to the sexless Victorian woman". The critical research *City of Dreadful Delight* (1992) by Judith R. Walkowitz explores prostitution in late-Victorian London. See Walkowitz 1992, 1–13. The study by Steven Marcus, *The Other Victorians* (orig. 1964), concentrates solely on pornography in the Victorian world. See Marcus 1985, 4–11.

41 Mason 1995, 3. See also Weeks 1989, 19–33. As the historian Jeffrey Weeks has noted, "The 'Victorian Age' has long been a synonym for a harsh and repressive sexual puritanism".

42 See for example Pearsall 1969, xiii. The historian Ronald Pearsall really believed in this myth: his book *The Worm in the Bud: The World of Victorian Sexuality* (1969) is based on the idea of the sexually repressed nineteenth century. The historian Patricia Branca has noted how Pearsall's study "heavily exploits the sex interests of the general public." Branca 1975, 5. Many contemporary professional historians – whose expertise lies elsewhere than in the Victorian era – have been convinced that female sexuality was universally repressed and the ideal Victorian marriage was described as "chaste and unpassionate". See for example Englund 2011, 285. One origin of the famous and clichéd stereotype of piano legs has been traced to the year 1947, when the historian H. L. Beale spoke about the hidden sexuality of the Victorians in a series of radio programs. The psychoanalyst Edward Glover continued on the theme the following week, thus strengthening the original story told by Beale. Sweet 2001, xii–xv.

43 Tosh 2008, 31. See also Branca 1975, 5. See also Walkowitz 1992, 2–4. On British working-class fathers, see Strange 2015.

44 See Collini 2010, 211; Tosh 2008, 79. See also Branca 1975, 2; Gillis 1996, 6; Walkowitz 1992, 19.

lost at least some of their offspring in their childhood, usually before the children had had their first birthday.[45] It is good to be aware that the idea of sexually repressed Victorians was partly a creation of the next generation who had lived their childhood at the end of the nineteenth century and who re-evaluated their standpoints after the Great War.[46] Partly this critical stance was some kind of intellectual patricide, and partly it was based on a need to emphasise a progressive and evolutionary distinction between different generations. The finishing touch became in the 1960s, at the time of "the sexual revolution", when the term "Victorian" became associated with everything this new hectic and liberated age was not. On the other hand, these so-called "Victorian values" have made historians like Eric Hobsbawm warn against anachronism, the "greatest danger of the historian". Hobsbawm has pointed out that our current attitudes are not the same as those in the nineteenth century. It is very tempting to make these kind of presumptions of temporal and cultural analogy, "since sex seems to be something fairly unchanging and we all think we are expert on it".[47]

Consequently, in this study, I understood "Victorian" as a socio-cultural construction predominantly based on certain decades, not a system of middle-class morality or cultural products with the ideas of particular "Victorian" aesthetics.[48] It is necessary, however, to be aware that much of this discussion and (many of) the cultural-historical stereotypes concerning the Victorians have been focused primarily on the Victorian women, usually meaning white and wealthy middle-class women. As the gender historian Patricia Branca noted in the 1970s, for a long time Victorian culture and Victorian family life was written about "by its critics", more often "stereotyped than studied".[49] This observation fits in with

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45 Tosh 2008, 79. See also Briggs 1988, 11; Mitchinson 1991, 16. Gillis 1996, 4–19. On working-class childhood and children working in agriculture, mines, iron manufacture, and factories, see Hopkins 1994; see also Hopkins 1982. See also Harris 1993, 61–73.

46 Much of the credit has been attributed to the famous Bloomsbury set, and authors like Lytton Strachey (1880–1932), who wrote a critical biography of Queen Victoria (1921) and depicted other famous nineteenth-century figures in his book *Eminent Victorians* (1918). See Collini 2010, 211–212; Sweet 2001, xv–xvii; Mason 1995, 15–16; Vickery 1998, 200–203. The English academic Stefan Collini also mentioned G. M. Young's *Victorian England: Portrait of an Age* (1936) and Kitson Clark's *The Making of Victorian England* (1962) when he discussed the perceptions of the Victorian age and how the individual studies and books have been creating the myth of *Victorian*.

47 Hobsbawm 1998, 278–279.

48 On history, time, and periodisation, see for example Jordanova 2006a, 105–125.

49 Branca 1975, 5–6. See also Nead 1988, 2–10; Vickery 1998, 201. See for example Claudia Nelson's *Family Ties in Victorian England* (2007), cultivating cultural stereotypes of the Victorian family. See Nelson 2007, 47–49. As many historians have pointed out, writers such as William Acton (1813–1875), a British doctor and medical author, have often been referred to as the truthful voice of the nineteenth century British medical profession. Especially a very famous passage of Acton's manual *Function and Disorders of the Reproductive Organs* (1857) has been obsessively re-quoted in countless studies and histories: "the majority of women (happily for them) are not very much troubled with sexual feeling of any kind. What men are habitually, women are only exceptionally". Acton 1862, 101. On Acton and his views, see Mort 2000, 60–63; Marcus 1985, 2–3; Mason 1995, 191–196; Briggs 1988, 23. See also Laqueur 1992, 4. See also Smith 1980, 182–198; Hanson 2004, 59. See the critic for example Hall 2000a, 16. See also Matus 1995, 10–13. See also Nead 1988, 19–20.

the general idea of the Victorian woman, often portrayed dichotomously either as an "angel of the house", a popular metaphor for an asexual, passive, and docile middle-class woman, or "the fallen woman", meaning a prostitute.[50] Patricia Branca wrote her own study in the 1970s, when the Victorian woman was commonly seen as "an odd museum piece", and the common theme in research was discontentment – at that time, second-wave feminist research was moving forward with the new kinds of perspectives and critical approaches reclaiming a history also for women.[51] However, as an outcome, some of the cultural stereotypes were even consolidated; Victorian middle-class women became presented either as the helpless victims of patriarchy, bored objects, or ornamental parasites, who lolled in their nervous disorders and hysterical invalidity, imprisoned inside their homes, or as women who were fighting for more meaningful roles outside the repressive domestic sphere.[52] However, only few fell into the category of the stereotypical "Victorian woman" described above.

It is good to remember, as the British historians Roy Porter and Lesley Hall have noted in their study *Facts of Life* (1995), that topics, such as sex, are not "a natural datum awaiting discovery by doctors, scientists and others"; indeed, as Porter and Hall have underlined, "sex has not (despite some conspiracy theories) been 'concealed' down the centuries by priests and moral vigilantes until finally 'revealed' by radicals and reformers".[53] Porter and Hall have stressed that "sexuality was produced by the production of knowledge about it"[54]. Here Porter and Hall referred to the French philosopher Michel Foucault (1926–1984), who noted in the first part of his influential study *The history of Sexuality* (publ. 1976–1984), that in sex what counts is that it is constantly spoken about, not repressed, denied and "reduced to silence".[55] Foucault himself has pointed out that it is essential to

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50 See example in Christ 1980, 146–162; Nead 1988, 2–3, 5–7. See also Auerbach 1982, 63–108, 150–184; Walkowitz 1992, 21; Vicinus 1980, xiv: "A great deal has been published about Victorian sexuality, but much of it is dubious value". On nineteenth-century prostitution, see Bartley 2000, 2–12, 30–34, 119–128; Walkowitz 1980, 72–93. On the other hand, in the 1970s, the American historian Nancy F. Cott suggested that sexual "passionlesness" actually favoured women's power, self-respect, and moral superiority, emphasising that women could be associated with the ideas of "purity, felicity, and glory" rather than possessing uncontrolled instincts and undisciplined bodies – as men allegedly did. Cott 1978, 228, 233, 235–236.

51 Branca 1975, 6–11. Branca herself emphasised that the middle-class woman in the Victorian period "was a new phenomenon", "the first modernized woman", and that the Victorian age was, in fact, "a dynamic age". See especially two collections of essays edited by the American scholar Martha Vicinus in the 1970s, *Suffer and Be Still: Women in the Victorian Age* (orig. 1972) and *A Widening Sphere: Changing Roles of Victorian Women* (orig. 1977). See also Vicinus 1985. See also Vickery 1998, 197–203.

52 On "female sickness" of the Victorian woman, see especially Ehrenreich & English 1988, 110–115; Duffin 1978. See also Ehrenreich & English 1976, 19–27.

53 Porter & Hall 1995, 8.

54 Porter & Hall 1995, 8. See also Hall 2000b, 261–262.

55 Foucault's three-volume study was published between 1976 and 1984: the first volume, *The Will to Knowledge* (La volonté de savoir), was published in 1976 and the last two parts *The Use of Pleasure* (*L'Usage des plaisirs*) and *The Care of the Self* (*Le Souci de soi*) in 1984. The fourth part was left incomplete when Foucault died in 1984 and hence, was never published. In his study, Foucault concentrates especially on the history of homosexuality and Antiquity; female sexuality is discussed to some extent but the main attention is clearly focused on men. Childbirth certainly was no great

discover who speaks and defines the issues and from which positions and standpoints.[56] Thus, sex or reproduction, as other aspects of human life and culture, are always discursively produced.

A discourse can be defined as a written or spoken communication or debate, "a pattern of words", revealing, constructing, and representing power relations through language. The historian Kathleen Canning has described discourse as "a convergence of statements, texts, signs, and practices across different, even dispersed sites [--] a certain expertise, the power and authority to speak, and the existence of a public sphere that transcends local settings".[57] Foucault himself famously timed the great change in the discourses around the eighteenth century when "a new political, economic, and technical incitement" to talk about sex, health, and bodies emerged. According to Foucault, this led to new kinds of classifications and specifications in many fields of society, especially in medicine.[58] Professionalisation of doctors was one of the major consequences of this process, which in Britain took place in the course of the nineteenth century; laws regulating the title of a "doctor" were enacted, medical education became standardised, and different branches were separated, creating specified expertise and knowledge, as discussed also in this study.[59]

Moreover, Foucault has noted that in the eighteenth century, a "population" – not only individual subjects or "a people" – became a social, economic, and political problem and that matters like the birth and death rates, life expectancy, fertility rates, legitimate and illegitimate births, state of health, diet, living conditions, and illnesses of this "population", were at the very centre of the interests of states and governments. The human life cycle, life span, and ability to work became statistically measurable qualities.[60] In this discourse, the future of the society was tied to the "manner in which each individual made use of his [sic] sex", and, moreover, sex alongside other aspects of human life, became a public issue between the individual and the state, creating "a whole web of discourses, special knowledge, analysis, and injunctions".[61] There was something that Foucault has

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interest of Foucault. See also Canning 2006, 23; Butler 2008, 168–187. See also Jordanova 2006a, 75–76.

56 Foucault 1987, 4, 11.

57 Canning 2006, 76–85. See also Jordanova 2008, 347–348; Jordanova 2006a, 76; Lupton 1996b, 17–19. See also Jokinen, Juhila & Suoninen 2016, 25–26.

58 Foucault 1987, 23.

59 Foucault 2000, 185–193, 231–241; Foucault 2014, 114, 116.

60 Duden 1991, 13.

61 Foucault 1987, 25–26; Foucault 2014, 113–124. See also Jordanova 1989, 25–26, 29; Cody 2008, 16–17. See also Lupton 1996b, 25–27, 30–31. Medicine had power over sex and sexuality; in the nineteenth century, it paid "extraordinary attention to sexual disorders, abnormality and deviance", as Roy Porter has noted. See Porter 1991, 222. Homosexuality of a good example of this policy. In the late-nineteenth century, male homosexuality was constantly discussed and defined both in law and medicine; *Criminal Law Amendment Act 1885* recriminalised male homosexuality in England, Wales, Scotland, and Ireland. Alongside with new branches of psychiatry and criminal justice, medicine was defining acceptable and unacceptable forms of sexuality in nineteenth-century society. See for example Nead 1988, 3; Weeks 1986, 73–79. Sexology, a scientific study of human sexual behaviour, was a production of the nineteenth century. In England, the pioneering role of doctor Havelock Ellis (1859–1939)

called "to be concerned with oneself", "knowing yourself", meaning that an individual could affect – with their own means or aided by the others – "their own bodies and souls, thoughts, conduct, and a way of being", to attain "a certain state of happiness, purity, wisdom, perfection, or immortality".[62] Foucault has pointed out that this knowledge constituted "the fundamental principle" in the modern world; one had to become the doctor of oneself, to practise constant prevention, self-examination, obedience, and contemplation.[63] This process also included reproduction, meaning how women gave birth to the future generations and how children were brought up in families, which have been both the organisms of education and targets of medico-social control, emphasising the role of women as mothers. This is indeed one context within the popular health manuals are examined and analysed also in this study.

Studying Victorian Childbirth

Childbirth, when understood in the broadest sense of the word as containing the whole process of the development of the foetus and the birth of a child, is a deeply meaningful biological-socio-cultural process and life event, regulated by many socio-cultural rituals, rules, beliefs, and practices. As the French historian Jacques Gélis has put it, birth, along with death, have always been "the only certainties" in the lives of all human beings.[64] However, childbearing does not concern only pregnant and parturient women and their closest circle, but also the whole community, society, and the state – in the nineteenth century, the very idea behind reproduction was the future of the British Empire and demographic development of its people. The historian Tania McIntosh has pointed out that childbirth is very essential to how a society sees itself.[65] As McIntosh has also noted, it is "a truism" to say that pregnancy and birth are indeed "at the same time intensely private and uniquely public".[66] However, the line between public and private, personal and general, has never been particularly unequivocal or easy to define when reproduction, especially childbirth, has been discussed. In fact, "public" and "private" have been somewhat slippery concepts in the history of childbirth; it has not always been particularly clear what these concepts have really represented and stood for when they have been discussed both in historical settings and current practices and ideologies. Certainly, "public" and "private"

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was significant, although he was also much criticised. See for example Jackson 1994, 106–127. See also Cook 2004a, 192–206; Lupton 1996b, 26–27.

62 Foucault 1988, 16, 18–47.

63 Foucault 1988, 31, 44–45. See also Foucault 2000, 185–193, 19; Foucault 2005, 40; Foucault 2014, 114, 120–121. See also Lupton 1999, 61–63.

64 Gélis 1991, 5.

65 McIntosh 2012, 13; Treichler 1990, 117–118. However, it is important to notice that the history of childbirth is *not* the history of civilisation itself. According to the scholar Paula A. Treichler, sometimes it has indeed claimed that "the history of obstetrics is the history of civilization itself". As Treichler has noted, this kind of understanding of history is "written by men for men which erases women's contributions to obstetrics and healing and gives men the credit".

66 McIntosh 2012, 2. See also Leavitt 1986, 3; Hanson 2004, 6–7; Treichler 1990, 117; Wertz & Wertz 1977, ix. The American historians the Wertzs stated that "childbirth is at once a creative act, a biological happening, and a social event."

have never been fixed binary oppositions; rather, the line between them has constantly been renegotiated and redefined.

The American gender historian Judith Walzer Leavitt has stressed that historically, women's physiological – at least in theory – ability to became pregnant and give birth and men's inability to do so have "contributed to defining the places each held in the social order".[67] This idea was constantly displayed in the primary sources analysed here this study. For example, in 1859, the British medical man Robert Bakewell declared in his guidebook *A Popular Manual of Female Diseases*: "[c]onsidered physiologically, woman exists for the purpose of reproducing the species".[68] This traditional – the idea certainly did not emerge in nineteenth-century Britain – and somewhat sexist statement can help us to understand that the connections between female citizenship and women's procreative role have always been socially and culturally shaped, and thus, also medical knowledge concerning pregnancy and childbirth has been socio-culturally, politically, and economically constructed; it has not existed somehow biologically or "naturally".

In nineteenth-century medical writings, women's health was understood primarily as reproductional; according to the Victorian medical profession, motherhood was the woman's most sacred duty in life, defining her place in her marriage, family, and society. In this study, I do not discuss how accurate these models were in practice and how women could challenge and protest against these medico-cultural expectations and ideals. What is more interesting is that according to the ideals, this reproductional role was reserved for every married woman, at least if she met the demands and was fit for reproduction, both physically and mentally so. Indeed, apart from being the experts on the female reproductional body and anatomy, nineteenth-century doctors could also claim that they had profound knowledge of the female mind as well.[69] These two aspects – the body and mind – were constantly present in the nineteenth-century medical discourses, and consequently, they are also analysed in this research.

The example of Bakewell also shows that concepts such as "womanhood", "motherhood", "family", or even "childbirth" have never been simply biological or universally understood, or indeed neutral.[70] In fact, I argue that Bakewell's statement can actually demonstrate why the nineteenth-century perceptions of childbirth are historically and culturally significant and why different stages in the reproductional process – here specifically meaning pregnancy and labour – have their important roles in constructing the social order, ideals, and practices

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67 Leavitt 1986, 3. See also Moscucci 1990, 2–4; Jordanova 1989, 19; Oakley 1993, 19; Hall 1991, 19–26; Schiebinger 2004a, 38.

68 Bakewell 1859, 1. See also Scott 1870 [?], 10–11; Stables 1894, 52: "Girls were made and meant to be married." See also Moscucci 1990, 3: "While the male was male 'only at certain moments', though, the female was female 'her whole life': childbearing, suckling, nurturing, constantly reminded woman of her sex". See also Hanson 2004, 57–58. See also criticism in Theriot 1996, 129–130. See also Jordanova 1989, 146. See also Whaley 2011, 48–54. See also Mason 1995, 198–199.

69 See for example Cody 2008, 150–151.

70 See Oakley 1980, 5; Bashford 1998, xvii. See also Moscucci 1990, 28–30. See also Canning 2006, 147–148. See also Schiebinger 2004a, 38.

in Victorian Britain. In social constructivism, the very starting point is that conventional, normative, "neutral", "objective", and "taken-for-granted" knowledge of the world is challenged: all ways of knowing are culturally and socially constructed, as the products of culture and history, social, political, and economic arrangements and agreements, not existing somehow "naturally", stably, or unchangingly.[71] Thus, beliefs, intentions, and cognition are as important as what people have "done", including practices and performances; in fact, medicine has no separate intellectual text and social context, as the historian David Harley has noted.[72] Social constructionism of knowledge was originally advocated in medical history by the British historian Ludmilla Jordanova in the 1990s.[73] Jordanova has stressed that also all medical knowledge, meaning "mentalities, modes of thought, and medical culture", cannot be separate from language, practices and institutions, or indeed interactions in social relations, including intra-professional relations between doctors and encounters with their patients.[74]

Thus, knowledge is produced in and through social processes, between people in their daily activities, social situations, and practices – for example, in affiliations and networks, in creating of authority and the quest for money and professional and social prestige –, revealing the social and conceptual systems for how people have structured their understanding about pregnancy, childbirth, or health, for example.[75] As the sociologist Deborah Lupton has pointed out – following the Foucauldian traditions – these so-called medico-cultural "truths" have been the products of power relations – in fact, "acting in the interests of someone" – and thus, they are also subjects of changes, debates, and counterarguments. In social constructionism, also medical knowledge is regarded as "a series of relative constructions which are dependent upon the socio-historical settings in which they occur and are constantly renegotiated".[76] Consequently, history is not "an incremental progression" towards a more refined, better, or neutral knowledge, as it has often been thought to be especially in the case of the history of medicine and science.[77] Current practices, accounts, and beliefs are certainly not incommensurable with those in the past.

Since the linguistic turn, appearing in the period around the 1960s and onwards, it has been accepted that especially language is a key element in understanding the past – including ideas, social relations, and practices – in its own right. Many historians, such as Kathleen Canning, have illustrated that "rather than simply reflecting social reality or historical context, language is seen instead as constituting historical events and human consciousness".[78] Language is and

71 Burr 2015, 2–5; Harley 1999, 420.
72 Harley 1999, 408, 415.
73 See Jordanova 2006b.
74 Jordanova 2006b, 339, 342–343, 344; Harley 1999, 413–414.
75 Jordanova 2006b, 229–340, 343; Harley 1999, 420–421. On authoritative knowledge and its construction in childbirth, see Jordan 1997, 56–61
76 Lupton 1996b, 11. See also Harley 1999; Jordan 1997, 56–58. See also Fulford 1996, 18, 25; Jokinen, Juhila & Suonila 2016, 26–28.
77 Lupton 1996b, 11–13. See also Jordanova 2006b; Harley 1999. See also Chapter 2.2.
78 Canning 2006, 66. See also Harley 1999, 408–413, 418–424; Jordanova 2006b, 344–348; Fissell 2006a, 386–369, 378–379; Burke 1987, 1–17. On language in history research, see also LaCapra 1983, 18–20.

has been creating, constructing, constituting, and maintaining reality; it reveals and can strengthen or weaken and challenge power relations and hierarchical structures between different agents and actors and creates understanding about the world.[79] Indeed, many scholars and historians, such as Ludmilla Jordanova for example, have noted that words and discourses are never simple descriptions or reflections "of an actual state of affairs", existing in some kind of social or ahistorical vacuum; hence, any human activity or communication, including scientific or medical ideals and practices, cannot be separated from the language in which they are or were expressed.[80] In medicine, categories and concepts are constantly made and remade; as is discussed in this work, medical language – discourses, definitions, terminologies, and other systems of classifications – reveal the historical perceptions of the body, mind, health, illnesses, and how medical practitioners saw their work and patients, inter alia.[81]

In fact, the German historian Barbara Duden has argued that the category of "woman", as we understand it now, is in fact a product of nineteenth-century natural science, made comparable to other categories "with a naturalistic appearance", such as family, reproduction, and sexuality.[82] At the same time, the anatomical knowledge of the woman's body, with its peculiarities differentiated from the male body, was gradually becoming more precise; some of the first illustrations of the female skeleton were published in the eighteenth century and the internal maternal body and the foetus were also depicted in realistic detail.[83] The perceptions and discourses of the body changed, but in the nineteenth century, the medical discourse interwove the body, healthiness, and moral education of mothers into the much larger picture of the future destiny of the state and empire. Thus, woman's health was never a private matter, concerning only individual women and their closest circle. According to the gender scholar Rebecca Kukla, during the eighteenth and nineteenth centuries, maternal bodies became more public and objects of "rigorous scientific surveillance and attention".[84] Many historians have pointed out that at the same time there were growing political, social, and economic interests to define the sexes and justify gender differences in society.[85] Women, as mothers, represented the future of the state, but many social reforms and changes in legislation concerning marriage, family life, and divorce, such as the *Married Women's Property Acts* 1870 and 1882, and the

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79 See for example Lupton 1996b, 11–13, 17–19; Jordanova 2006a, 79–80.

80 Jordanova 1989, 5–6, See also Jordanova 1999, 119; Risse & Warner 1992, 191–193. See also Lupton 1996b, 17–19; Burr 2015, 4–5, 10–11.

81 Fissell 2006a, 374. See also Porter 1985, 186–187; Harley 1999, 420–421.

82 Duden 1991, 21. See also Moscucci 1990, 4.

83 See for example Schiebinger 1987, 46–66; Schiebinger 1991, 184–206. See also Cody 2008, 167–171; Jordanova 1989, 56–62; Jordanova 1999, 183–202. On the anatomical-artistic work of William Hunter, see Porter 2001, 51; on anatomical female wax figures, see Jordanova 1986, 54–58; Jordanova 1989, 44–50; Smith 1996, 49–51. On obstetrical machines used as pedagogical aids, see Lieske 2011, 69–84. On images of the foetus in early modern England, see Whiteley 2019.

84 Kukla 2005, 66. See also Apple 1995, 161–172; Lupton 1999, 59–60.

85 See for example Russett 1989, 3, 6–11. What is more convincing, is that Russett has noted that "race and gender, not infrequently linked, were two of the great themes of nineteenth-century science". See also Theriot 1996, 132–133.

growing demands by women themselves, such as the suffragette movement, also raised concern and worry in society.[86] "[Gender] categories hardened and were made permanent", as the historian Cynthia Eagle Russett has claimed – too eagerly, as it seems.[87] For women coming from different classes, society certainly offered very different kinds of social and economic opportunities.

The British sociologist and feminist scholar Ann Oakley has once stated that childbirth "stands uncomfortably at the junction of the two worlds of nature and culture".[88] "Nature" and "culture" or "civilisation" have been in many ways utilised concepts in the history of childbirth but as a closer analysis reveals, many popular terms associated with reproduction, such as "natural" and even "normal" are in fact historically and socio-culturally constructed and value-laden, even if they are often represented as neutral and objective definitions for "ordinary" or "healthy" delivery, usually meaning vaginal, free from (medical) manipulations and interventions, or births in which there are no life-threatening complications. For example, in 2017, the Royal College of Midwives in Britain announced that its *Normal Birth Campaign* was dropped, after the campaign, run since 2005, made some parturient women feel like "failures", after they had given birth medically aided and not "normally", here meaning a vaginal birth without medical interventions or technology, such as an epidural, Caesarean section, or episiotomy, referring to a surgical incision of the perineum. According to the news item, since the ending of the campaign, British midwives will no longer urge women to give birth "normally", as the campaign originally suggested.[89] A year earlier, in 2016, there was some discussion whether British doctors would have been obliged to inform their pregnant patients of the risks of vaginal birth, often considered a "normal", "right", or "natural" way to give birth. In 2015, in a case in which a neonatal child had sustained permanent brain damage during vaginal birth, the Supreme Court decided in the parturient woman's favour; according to the court's verdict, doctors had not informed the mother of the risks of a small pelvis and diabetes before she went into labour.[90]

Considering the discussion around the *Normal Birth Campaign*, historically, it is extremely interesting that by stating that "doing 'too much too early' can cause just as much harm as doing 'too little too late'", the Chief executive officer of the Royal College of Midwives was in fact very close to the nineteenth-century

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86 See for example Holcombe 1980, 3–28; Branca 1975, 8–9; Hall 2000a, 10–29, 34–46. On the suffragette movement, see also Vicinus 1985, 247–280.

87 Russett 1989, 6. Ludmilla Jordanova has criticised Russett for misunderstanding nineteenth-century science in her article *The Social Construction of Medical Knowledge*. See Jordanova 2006b, 345. See also Matus 1995, 24–36; Moscucci 1990, 4. See also Jordanova 1986, 42–41; Pfeffer 1993, 7–11; Showalter 1990, 8–5. See also Butler 2008, 50. On nineteenth-century legislation and women, see for example Perkin 1989, 10–31, 65–72, 115–129, 292–308.

88 Oakley 1980, 7. See also Matus 1995, 1–17; Lewis 1986, 17; Lupton 1999, 80.

89 See for example Smyth 2017; Vaughan 2017; Sandeman 2017. On "normal" and childbirth, see Oakley 1980, 52–53.

90 Wilson 2016. Generally, information concerning the potential complications of the Caesarean section have been available but doctors have not warned their parturient patients for example about the risks of vaginal and anal tears, occasionally taken place in expulsion of the child, at worst leading to urinary and fecal incontinence, and other gynaecological problems disturbing women's normal life after labour.

medical profession and to the discussion related to meddlesome midwifery in Victorian obstetrics.[91] In fact, I suggest that the example of the well-intentioned but failed campaign of the Royal College of Midwives can demonstrate that the medical discussion of childbirth in the nineteenth century has a particular interest even today. Both nineteenth-century birth practices and ideals can help us to understand what we mean when we are discussing, let's say, "natural" and "naturalness" in connection with childbirth, how women have been advised to take care of themselves during pregnancy, or when debating who is the best person to attend childbirth and why – that is, is the best attendant the partner of the parturient woman, providing emotional support, or a female friend with her own practical experience of giving birth? Moreover, based on the current situation, can we make far-reaching assumptions that the emotions, primarily fear, have been discussed only in the case of modern births? Indeed, as the historian Ornella Moscucci has noted, "many aspects of gynaecology – from the propriety of gynaecological techniques – cannot be fully understood unless the historical settings of gynaecologists as individuals and as a collectivity are examined".[92] This same observation applies equally to obstetrics, a field of study particularly close to gynaecology – a topic discussed in this study.

Chapters

In its entirety, this study is divided into six chapters: an introduction in two parts, a conclusion, and three main chapters, loosely based on the biological order of reproduction. Two main themes, pregnancy and birth, are examined in the light of nineteenth-century British obstetrical medicine and medical writings. The first two introductory chapters present the general context of the topic, the primary sources, methods, and the main concepts. In the second part of the introductory chapters, I also introduce previous research conducted on the topic and discuss what are the ethical peculiarities concerning the history of medicine and more precisely childbirth. The last part of Chapter 2 introduces the general historical context and the primary sources analysed in this research – both nineteenth-century popular health manuals and medical periodicals, the latter meaning the *British Medical Journal* (*BMJ*).

Chapter 3 provides a short introductory background to the history of childbirth mainly in early modern England, discussing the traditional role of midwives in childbirth and how medical men became associated with the practices of childbirth during the eighteenth century. More importantly, Chapter 3 explores the portrait of nineteenth-century medical practitioners – that is to say, how the British medical profession developed during the long nineteenth century and what were the realities and ideals framing practical medical work and especially writings studied in this research. I am particularly interested in the role of gender, embodied in the medical practitioners' bodies, playing an important part in the nineteenth-century doctor–patient relationship and more generally in ob-

91 Smyth 2017; Warwick 2017.
92 Moscucci 1990, 42.

stetrical medicine. In addition, doctors' writings concerning childbirth are analysed more closely in this chapter: I explore the contents and functions of the popular health guidebooks and discuss how professional credibility was constructed in the manuals, and, on the other hand, what kind of information an average lay reader could expect to obtain from the medical manuals written specifically for use by women.

The fourth chapter focuses solely on pregnancy. First, I discuss how pregnancy was diagnosed in nineteenth-century medicine; what were considered the most common signs and symptoms of gestation according to nineteenth-century obstetric medicine, and, on the other hand, what kind of problems doctors could expect to face when the possibility of pregnancy was suspected but not confirmed. I am also interested in the practical medical advice concerning both pregnancy and the pregnant woman; I suggest that in this part of the manuals, the traditional preventative ideas, the *non-naturals,* played an important role, stressing the key role and general responsibility of the patient herself. This part of the study also discusses more closely the complications of pregnancy and especially the concept of *maternal impressions*; I argue that the traditional and controversial theory of how some of the prenatal foetal deformities were explained was still rooted in the minds of ordinary doctors, and in Victorian medicine, the theory was not declared to be as outdated as sometimes claimed. The last part of Chapter 4 deals with unwanted pregnancies in the nineteenth-century context. Termination of pregnancy was called "criminal abortion" for obvious reasons; abortion legislation was gradually tightened, and from 1861, the law was the strictest in Europe. From the medical perspective, however, the question is far from clear; in complicated labours doctors carried out what were in all but name terminated gestations but these operations were difficult for many reasons, above all ethically.

Chapter 5 explores both the practices and ideals of childbirth. First, I analyse the concept of "natural labour" in the context of British nineteenth-century medicine and obstetrics. The Victorians were fascinated by everything concerning "nature" and "the laws of Nature", dictating all human life and the health and happiness of individual human beings, also explaining hierarchal differences between sexes and races. By concentrating on advice given in health manuals, I also explore material requirements for birth: these preparations had both important practical and social functions, not to be ignored or underrated simply because these descriptions are found mainly in popular health literature. Moreover, one particularly important topic concerning childbirth is the question of who were allowed to attend childbirth in Victorian Britain: were men welcomed in the birthing rooms and what happened to the traditional circle of women*, the gossip*, which had been a necessary element of childbirth in early modern England? These questions also reveal what kind of role the emotions, foremost fear, played in nineteenth-century birthing rooms and more broadly, in medicine.

I also examine the introduction of more effective pain relief in the 1840s and investigate how the discourse of pain and the possibility of anaesthesia were presented in popular health manuals. In addition to anaesthesia, the nineteenth-century was also the period when modern surgery was developing, slowly changing

also obstetrical policy concerning the most difficult cases. Here, the cultural medical history of the Caesarean section in nineteenth-century British medicine is a particularly important theme, explaining the complex and often painful question of a doctor's responsibility and choices in obstructed and complicated births. Lastly, I pay attention also to the lying-in period, noticing the discourse of prevention in the advice concerning the recovering maternal body in medical literature. All in all, this research covers more than sixty years of the history of childbirth in Victorian Britain, mainly seen from the perspective of the nineteenth-century medical profession. This is not, however, a study of British doctors *per se*, how their profession developed during the age of Empire; the main focus is on the culture-medical history of childbirth, its traditions and continuances, practices, and also changing ideals.

2 HISTORIOGRAPHY, APPROACHES, AND SOURCES

2.1 How to Conduct Research on the Medical History of Childbirth: Special Questions and Approaches

The medical history of childbirth demonstrates that questions of power, knowledge, authority, and perceptions of the body and gender have been interwoven with medicine, healing, and the relations between doctors and their patients. For example, in the 1970s, the American feminist duo, sociologists Barbara Ehrenreich and Deidre English, famously claimed that ultimately it was doctors who "pass judgment on who is sick and who is well".[93] While this notion certainly waters down much of the complexity, conflicting opinions, and historical diversity of both practices and practitioners in the history of medicine and interactions between the healer and the person who needs medical help, doctors indisputably possess power over the perceptions of health, diseases, healing processes and practices, and the human body – and consequently, what falls into the categories of "normal" or "natural". Thus, it has never been only about *how* patients have been tried to be cured and what kinds of treatments were prescribed; it has been equally important *who* gave the treatments and how their authority and knowledge have been legitimised.

Indeed, in Western societies, physicians are often considered the legitimised experts on medical knowledge and health, based on their standardised education, traditions, ethical codes, and exclusively licensed authority recognised by society and the state. However, as the historian James Bradley has stressed, concepts such as "orthodox", "official", or "legitimate", and consequently also "alternative" or "marginal", have to be used cautiously; "to be alternative is to be other",

93 Ehrenreich & English 1976, 9. See also Worboys 2014, 67. See also Duffin 1978, 40–50. See also Lupton 1996b, 107–111.

as Bradley has pointed out.[94] Authoritative or legitimised knowledge is very persuasive because of its claims of authenticity, competence, ability, reasonability, and almost irresistible "naturalness"; as deterrence, it also possesses the possibility of sanctions. However, in medicine, a diversity or plurality of parallel knowledge systems and healing practices is a historical fact even if "the discursive centrality of official medicine" has often suggested that official or orthodox have automatically been the same as "right", "correct", or "proper". Legitimate and orthodox are always rhetorical constructs, being actively reproduced, not existing as indisputable "facts" or "reality".[95] As Brigitte Jordan, a pioneer of reproductive anthropology, has noted, the power of authoritative knowledge is that "it counts"; consequently, those who have been the supporters and practitioners of "alternative" knowledge systems, have been labelled backward, ignorant, and even dangerous. Indeed, in the context of legitimised medicine, the category of "quacks" has been in many ways useful and necessary, foremostly because quacks have helped doctors to define themselves, *what* they have done and *how* they have done it.[96] The lines between medical systems have never been particularly fixed or indeed binary.

As is discussed in this research, nineteenth-century doctors had clearly constituted themselves as the legitimate experts on reproduction, women's bodies, and female mental health. In their own minds, male gynaecologists and obstetricians had constituted themselves as "the guardians of the interests of women" and "the custodians of female honour", as one member of the *Obstetrical Society of London* expressed it in his speech in 1867:

> We are, in fact, the stronger, and they [female patients] the weaker. They are obliged to believe all that we tell them [--] We, being men, have our patients, who are women, at our mercy; and I think under those circumstances that if we should depart from the strictest principles of honour, if we should cheat and victimise them in any shape or way, we should be unworthy of the profession of which we are members.[97]

The quotation demonstrates that medicine has never been merely about "doctors curing patients". In their writings, nineteenth-century doctors were as important

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94 Bradley 2000, 19. In fact, Western medicine has been a marginal in many parts of the world, being largely unachievable and unavailable. See for example Hokkanen & Kananoja 2019, 5–6.

95 Bradley 2000, 19–20, 32–34; Jordan 1997, 56–61. On medical plurality, see for example Hokkanen & Kananoja 2019, 5–8.

96 Jordan 1997, 56–58. See also Chapter 3.2.

97 The Obstetrical Society. The *BMJ*, April 6, 1867, 396. This speech was made in 1867, when a controversial, yet prominent medical figure, the English gynaecologist and obstetrician Isaac Baker Brown (1811–1873), was expelled from the Obstetrical Society of London. Brown had been carrying out the operation of *clitoridectomy*, a surgical removal of the clitoris, without the consent of his female patients and their circles. By operating on his female patients, Brown had evidently tried to cure women who had suffered from "insanity produced by perpetual masturbation" and various gynaecological problems. Eventually Brown was expelled from the Obstetrical Society of London, losing both his reputation and career for good. See for example Tanner, Thomas Hawkes, On excision of the Clitoris as a Cure for Hysteria, etc. The *BMJ*, December 15, 1866, 672–675. See also Brown 1866. See also Moscucci 1990, 105; Moscucci 1996, 60–69; Mason 1995, 197–198. See also Bartrip 1990, 165–166.

figures as their female patients were – in fact, often doctors were in many ways the central figures.

In this second introductory chapter, first I discuss the connection between doctors, *medicalisation*, and childbirth; the history of childbirth has often been constructed around the medicalisation process, meaning that when medical men became actively connected with childbirth, birth ceased to be something "normal" or "natural" and thus, it became associated with a disease-like state and medical problem needing treatments, active interventions, and "cure". The tendency to see childbirth in this light is very common; this is indeed the reason why I introduce previous research conducted on the history of childbirth in this part of this study. After presenting the general lines in research, I discuss some particular aspects I have considered important when exploring the medical history of childbirth; there are some noticeable pitfalls to acknowledge, primarily a tendency to see the history of childbirth either as ongoing progress where the current moment is taken as a logical endpoint of inevitable improvements, or to romanticize the past by claiming that medicalisation has turned childbirth into something unnatural needing radical interventions and constant surveillance. The necessary approaches – the doctor–patient relationship, the gender question, and the body – are also discussed in this chapter, and after this, I will shortly explain some of the central terms and vocabulary used in this study. Lastly, I introduce the primary sources in more detail.

Medicalisation and Childbirth

Especially in the course of the twentieth century, in the western world, medicine has tightened its grip on human life and a great number of issues, both physiological and psychological, have been defined as "medical", either as diseases, disorders, or syndromes, as the American sociologist Peter Conrad has pointed out, when discussing *medicalisation* in Western societies.[98] It is largely accepted that many aspects and phases of the life cycle have been medicalised but no consensus on the exact definition of medicalisation exists; the term has been defined in contradictory ways, and likewise its exact starting point and when medicalisation ultimately became dominant have been timed differently. However, the actual term 'medicalisation' is not particularly old; it emerged in the social scientific literature during the late 1960s and 1970s. In short, medicalisation can be understood as "to make medical", a process of making nonmedical problems medical, usually "in terms of illnesses or disorders", as Conrad has put it.[99] Conrad himself has described medicalisation as defining "a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it."[100] The problem in question may lead to medico-social control, surveillance, and/or treatment by medical professionals, but not automatically.

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98 Conrad 2007, 3; Conrad 1992, 213. See also Burnham 2005, 6–9; Lupton 1996b, 7.
99 Conrad 1992, 209–210; Conrad 2007, 4–5.
100 Conrad 1992, 211. See also Conrad 2007, 4–6.

Consequently, medicalisation has transformed "the normal" and even everyday life into the pathological, as a "disease", "syndrome", or "condition". This process has had a profound impact on societies; various ideas, ideologies, treatments, interventions, and therapies have "reset and controlled the borders of acceptable behavior, bodies, and states of being", as Conrad has noted.[101] Conrad, and more famously Michel Foucault before him, have underlined that the "medical gaze", discourses, and surveillance are indispensable and fundamental elements of the medicalisation process, even if Foucault has pointed out that the medical gaze has been in fact more than "a gaze"; in medicine, diagnosis has been based on the combination of sight, touch, hearing, and smell.[102] The medicalisation process itself has been closely connected to the long-lasting secularisation of societies, a firm faith in science and progress, and the changing status of the medical profession itself within the last couple of centuries.[103] As Foucault has argued in his early study *The Birth of the Clinic* (publ. orig. 1963), in the course of the eighteenth century, medicine started to supersede the role of religion: "the locus in which knowledge is formed is no longer the pathological garden where God distributed the species, but a generalized medical consciousness, diffused in space and time, open and mobile, linked to each individual existence, as well as to the collective life of the nation".[104] Even if the process was not that straightforward as Foucault here described, consequently, behaviour that was previously considered immoral or sinful by the church was ultimately given a medical meaning, name, diagnosis, possibly a prognosis and medication. For example, infertility was once seen as a moral punishment from the gods, but gradually it became a medical problem rather than being a divine curse.[105]

However, this process of "making medical" is neither inevitable nor immutable. Even if the trend has been towards an expansion to a wide range of different kinds of medical definitions and practices – especially after the Second World War – historically medical categories have not been particularly stable and some aspects of human life have been "demedicalised" at least in the European context, such as masturbation and homosexuality, both considered medical problems and serious moral vices in the nineteenth century, the latter being also a criminal act.[106] Also primary sources studied in my research constantly warned that masturbation, whether it concerned a male, female or a child, ruined health, led to

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101 Conrad 2007, 13. See also Jordanova 2006b, 345–346; Burnham 2005, 6–9.

102 Conrad 2007, 13; Foucault 2005, 1, 202. On smell in practical medical work, see for example Montgomery 1837, 112. See also Chapter 4.1; on postnatal health and smell, see also Chapter 5.6.

103 Conrad 1992, 213–215; Conrad 2007, 5; Mitchinson 1991, 42; Foucault 2014, 114.

104 Foucault 2005, 36.

105 See Pfeffer 2000, 277–283. Another good example of the demedicalisation process is epilepsy and its treatments.

106 See for example Conrad 1992, 224–225; Conrad 2007, 7, 97–113. In England and Wales, *the Sexual Offences Act* 1967 decriminalised homosexual acts between two men over the age of twenty-one. The infamous *Criminal Law Amendment Act* 1885 did not concern homosexual women, only men, and criminalised male homosexuality for more than eighty years to come.

many serious physical and mental disorders, and destroyed "the finer sexual feelings" on marriage.[107] The methods of treating this "self-abuse", "secret vice", or "secret bad habit" were in some cases extremely harsh.[108] "Demedicalisation" means that a problem previously seen as medical is no longer defined in medical terms and medical treatment is considered either unnecessary, inappropriate, or even dangerous – in the most extreme cases, the treatment can be considered criminal or a human rights violation.[109]

Doctors are in many ways a necessary element in medicalisation, but what is often forgotten or ignored is that the involvement of the medical profession may not be automatically required or that their involvement may be marginal. Thus, it is not at all that axiomatic that doctors pass judgment on "who is sick and who is well", even if the medical profession have acted as the "gatekeepers" in medical organisations and institutions or directly on the interactional level in the doctor–patient relationship.[110] For example, various subcultures and groups, and individual patients could have accepted or rejected medicalised definitions; in fact, sometimes they can be more actively involved in the medicalisation process than the medical profession.[111] Especially during the last decades, medical consumerism and individualism have played a growingly important part in the expansion of medicalisation, actively involving also patients; especially the pharmaceutical industry and cosmetic surgery market are a prolific business, offering a wide range of medical products and services for paying customers.[112] For the patients themselves medicalisation can be both helpful and unhelpful, a cause of relief or anxiety. Some trouble, causing real distress, worry, and shame, can be explained by it – and hence, certain symptoms can be recognised, "neutralised", and legitimised in in the eyes of society and the sufferers themselves, and most

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107 Allbutt 1890, 54. See also Laqueur 2003, 25–53, 174–177, 209–210; Mitchinson 1991, 6. The nineteenth-century treatment of female masturbation was both "religious, moral, and hygienic" and physical, such as "constant occupation", residence in the country, avoidance of balls and theatre; a vegetable diet, vaginal injections, hip-baths, leeches to the vulva, venesection, etc. See Ryan 1841, 407–408.

108 It was not at all uncommon for doctors to make enquires about the treatment of masturbation, especially when small children were discussed in medical journals. See for example in the *BMJ*, November 30, 1889, 1259; See the answer in the *BMJ*, December 7, 1889, 1315; see also the *BMJ*, April 10, 1897, 954; the *BMJ*, April 10, 1897, 954–955. In the latter case, the doctor's worry for his patient was very apparent: "Unless stopped now he [a little boy aged six] is sure to be an addition to our asylum." See also Chavasse & An American Medical Writer 1871, 33–34; Sperry 1896, 113–119. On masturbation and women, see Mitchinson 1991, 113.

109 Conrad 2007, 7; Conrad 1992, 224–226.

110 Conrad 1992, 210. Peter Conrad has identified three distinct levels in medicalisation: 1) on the conceptual level the vocabulary is used to define the problem but no treatment is necessarily required nor many medical professionals involved; 2) on the institutional level organisations (such as hospitals) may "adopt a medical approach to treating a particular problem in which the organization specializes"; doctors may act as gatekeepers for benefits that a specific organisation has legitimised by adopting medical definitions and approaches; however, the everyday routine work is not done by medical professionals; 3) on the interactional level, physicians are involved: in doctor–patient interaction, they define a certain problem as medical (by giving a medical diagnosis) and treating the problem.

111 Conrad 1992, 211, 219. See also Theriot 1996, 127.

112 Conrad 2007, 6, 8, 16–17, 133–145. See also Lupton 1996a, 157; Lupton 1996b, 36–40.

importantly, people can get help – but on the other hand, "making medical" can create (intentional or unintentional) restrictions, moralisation, surveillance, and narrow the understanding of what is "normal", necessary, and acceptable. Moreover, as a result, individuals and their lifestyle can easily be blamed for the problems which are caused by social structures and environments rather than by something that is actually done or left undone by the individual sufferers/patients themselves.[113]

It is hardly any surprise that medicalisation targets the most personal and intimate aspects of life. The term usually carries negative connotations and the critique of oppressive over-medicalisation and "inappropriately medicalized problems", often considered a normal part of human life, such as grief or ageing.[114] This kind of a negative and critical tone is very apparent particularly when childbirth and its history has been discussed, especially since the 1960s and 1970s. Indeed, it has been noted that "women's natural life processes, such as pregnancy, childbirth, and menopause, have been the focus of the medicalisation process and that gender has been a key factor both in understanding and defining medicalisation.[115] What is certain is that the discussion around medicalisation and its effects has been politically, socially, historically, and economically charged and reasserts many medico-cultural dichotomies and polarities between different agents, such as the (male) medical profession and female midwives, "medicalised" (a birth under the montypythonian "machine that goes ping") and "natural" childbirth, hospital and home births, civilisation/culture and nature, public and private, and so on.

There has been a consensus that in the course of the twentieth century, in Western societies, childbirth has been "medicalised" and defined as a medical event, despite there having been some attempts to demedicalise labour especially since the 1970s and 1980s with redesigning birthing rooms in hospitals, bringing elements such as water into births and giving birth in a home-like environment, inter alia.[116] It has sometimes been thought that "medicalised birth" reached its peak in the 1950s, when the stereotypical labour in hospital consisted of general anaesthesia, a shaved vulva, and the automatically cut perineum. Moreover, in the mid-twentieth century, most births were transferred to hospitals where babies were delivered by (male) doctors, often seen as a confirming sign of medicalisation.[117]

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113 Conrad 2007, 146–164; Conrad 1992, 223–224. See also Burnham 2005, 39–41.

114 Conrad 1992, 210, 213. Other "natural life processes", as Conrad has called them, have become medicalised including child development, pre-menstrual discomfort (PMS), menopause, aging, and death. Examples of medicalised deviance include madness, alcoholism, homosexuality, transsexuality, eating disorders, child abuse, and infertility. See also Lupton 1996b, 1.

115 Conrad 1992, 222; Purdy 2001, 249, 251. Peter Conrad has listed three examples of the medicalisation of masculinity: andropause, baldness, and erectile dysfunction. Conrad 2007, 23–45.

116 Conrad 2007, 7.

117 See for example Banks 1999, 24–28; Lane 2001, 124–125; Ehrenreich & English 1976, 10: "Since Hippocrates bewailed women's 'perpetual infirmities', medicine has only echoed the prevailing male sentiment: it has treated pregnancy and menopause as diseases [--] childbirth as a surgical event". On the other hand, the historian Philip K.

However, considering specifically the history of childbirth, it is interesting that many historians have timed the starting point of this process very differently; for example, the social historian Joan Lane has illustrated how in seventeenth-century England, pregnancy "increasingly came to be seen as an illness and midwifery accordingly medicalised".[118] The historian Amanda Carson Banks has maintained that in the nineteenth century, the historical experience of physicians – meaning that prior to the 1700s they had been present in labours only in emergency cases – alongside new innovations and obstetrical technology, such as the "extensive" use of the midwifery forceps, caused professional medicine "to systematically understand and define pregnancy and birth as unnatural".[119] Or, as the historians Thomas Laqueur and Lisa Cody have argued, giving birth was no longer "a communal family affair" after the introduction of chloroform and ether in the 1840s, making childbirth medicalised with "the labouring mother [--] barely present herself".[120] The last example is by the historian W. F. Bynum who has argued that by the end of the eighteenth century, the medicalisation of childbirth "was under way"; the greater shift took place in the nineteenth century, when doctors claimed "that childbirth is a pathological [--] process, and therefore by definition required the services of a trained doctor, working in a hospital".[121]

Contrary to many of the conceptions presented above, I argue that – based on the primary sources analysed in my research – the question whether childbirth in nineteenth-century Britain was de facto "medicalised" is not particularly easy to answer. In the views expressed in the previous research, the greatest problem is that "medicalisation" has not been defined properly – what the concept really stands for and what elements it consists of. I fully acknowledge, like W. F. Bynum quoted above, that in nineteenth-century childbirth there were some noticeable features, which can be understood as "medicalised" – the growing interests and the attendance of doctors in childbirth being the most obvious of them. In fact, it can be argued that the primary sources I have analysed in this study – medical journals and manuals – are inevitably "medicalised" because they were created almost solely by the medical profession and to a large extent, for their needs only. Doctors are noticeably present in both types of writings explored in the research. On the other hand, some aspects of medicalisation clearly belonged to twentieth-century societies rather than to the nineteenth-century world; for example, the role of hospitals expanded considerably in the course of the twentieth century – in fact, the whole concept of hospital has changed – whereas in the nineteenth

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Wilson has noted that "at the beginning of the twentieth century, obstetrics as a profession was in its infancy". See Wilson 1996, xvii. See also Conrad 2007, 120; Jordanova 2006b, 345; Oakley 1984, 5, 12. On hospitalisation of birth, see Declercq et al. 2001, 8–25.

118 Lane 2001, 124. See also Donnison 1999, 32–33.

119 Banks 1999, 39. Banks also claimed that in nineteenth-century medicine, birth was increasingly defined as "a dangerous, pathological crisis".

120 Laqueur & Cody 2014, 44. See also Whiteley 2019, 263.

121 Bynum 1996, 203.

century, the majority of women gave birth at home, many of them never in the presence of a doctor.[122]

Consequently, in this study, I am more interested in the concepts of "nature" and "natural" and especially in the question of how the nineteenth-century medical profession constructed and converted the concept of "nature" in their work. "Nature" was both a prescriptive and descriptive category in medicine; thus, it had countless meanings and functions.[123] Nature could be seen as a creator of all existence and a positive force and guide; on the other hand, nature could be an inexplicable, mysterious, and unexplained destroyer. In this study, the main reason justifying the point of view chosen is that "nature" and especially "natural labour" were constantly discussed in nineteenth-century obstetrical writings; doctors clearly constructed themselves as the experts, counselors, and executers of "Nature", combining their own role with longer medical traditions and changing perceptions and ideas of both medicine and childbirth. In this work, the aim is not to emphasise the polarity between "medicalisation"/"civilisation" and "nature", but to show that "nature" – ultimately one of the most complex words in the English language – was a very useful concept for the Victorian (male) medical profession working with childbirth and thus, needing to be analysed more closely.

Previous Research

These perceptions of the medicalisation of childbirth, and, on the other hand, the persistent ideas of "progress", meaning the perceptions of a constantly improving and advancing state of medicine, eventually reveal that the history of childbirth has its very own history – here I specifically mean the European and Northern American context. As Lisa Cody has pointed out, two opposing narratives, "medical glory versus gory misogyny", have existed in the history of midwifery, especially to explain medicalisation of childbirth and (male) obstetricians' part in it.[124] The first narrative is a traditional story of progress, medical glory, and triumphs over ignorance, superstition, and death; that is to say, when the (male) medical profession and "science" took over reproduction and childbirth around the eighteenth century and onwards, midwifery started its indisputable and almost irresistible evolution towards modernisation, rationality, and safety. The other story is a more critical and feminist version of the rise of obstetricians and medical men who denigrated midwives, "magnetically described their own

122 These aspects include the discourse of "biopolitics" and the normalisation process in which citizens are made "docile" and productive bodies by gathering information about the population and then encouraging people to follow the norms by disciplining and normalising individuals. The desired result is the autonomous and self-regulated citizen who is actively minimizing the risks with their own behaviour and advice provided by authorised experts. In the twentieth century, new technologies, such as laboratory tests and ultrasound, routinely belong to antenatal control and monitoring at least in certain countries, such as in the UK and Finland. See for example Lupton 1999, 61–62, 65, 85–86. See also Foucault 2000, 249. See also Porter 1985, 188.

123 Jordanova 2006b, 344.

124 Cody 1999, 478. On historiology of midwifery and childbirth, see especially McIntosh 2012, 5–23.

charms, unnecessary wielded instruments, cruelly thrust them into women, and often killed mothers and infants", as Cody has described the consequences of this darker version of the same story.[125] As a consequence of the latter version, both pregnancy and childbirth became seen as "diseases", needing medical interventions and constant surveillance provided by authorised academic medicine, also securing doctors a prolific business of "delivering babies". It is easy to agree with the gender scholar Eve Keller who has noted that these interpretations have replicated the gender conflict both in the past and in the current practices and ideas; in many cases, male scholars have analysed "with varying degrees of approval the emergence of male-midwifery", while female scholars have discussed "the same set of circumstances with varying levels of disdain".[126]

Indeed, for a long time, the history of medicine was mainly a project of the physicians themselves. Rather curiously, their construction of history was, more or less, a professional self-portrait, emphasising the key and almost exclusive role doctors themselves played in the progress of medicine, healing, and in the evolution of modern science and societies.[127] The narrative of progress was often seamless, failures were rarely discussed (unless they turned out to be successful after all), and the role of the patient was very small if not nonexistent. This version of the history of medicine, as the medical historian Adrian Wilson has described, was "written by men, and mostly about men".[128] The focus was concentrated on the great medical men and pioneering scientific breakthroughs in medicine – that is to say, who did something first – and how heroic men conquered problems almost too impossible to solve. When perusing the nineteenth-century medical literature and especially medical journals, it becomes very clear that doctors were very interested in the past of their own profession and field of expertise; many writers began their stories from Antiquity, justifying their own place in the long lineage of medical men, dating back to the days of Hippocrates, and demonstrating that the history of male-dominated midwifery was in fact ancient.[129] In this context, irregular medicine and the role of self-diagnosis, home doctoring, and folkloric remedies were labelled as quackery, an undesirable and dangerous side effect of orthodox medicine, or gross ignorance.[130] Indeed, as Tania McIntosh has noted, traditionally also the history of maternity and childbirth has been

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125 Cody 1999, 478; Cody 2008, 9. See also Conrad 1992, 213. See also McIntosh 2012, 8–9. See especially Donnison 1999, 46–47; Williams 2001, 232–245.

126 Keller 2003, 64. See also Cody 1999, 478.

127 Burnham 2005, 1–3. See also Jordanova 1999, 73; Porter & Porter 1988, 8.

128 Wilson, A. 2002, 130. See also Porter 1985; Burnham 2005, 82–85.

129 Jordanova 1999, 73. On the history of medical history, historiography, and doctors, see also Huisman & Warner 2004. See for example Davis, John Hall, The Introductory Lecture to the Course of Lectures on Midwifery and Diseases of Women and Children. *The Lancet*, May 13, 1843, 209–216; Aber, T., Address in Medicine. Twenty-Five Years of Medical Progress. The *BMJ*, August 1, 1891, 229–235; Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 300–302.

130 One particularly descriptive example of nineteenth-century history writing was J. H. Aveling's book *English Midwives: Their History and Prospects* (1872). Aveling, himself a medical man specialised in obstetrics, investigated the history of midwifery in light of progress and enlightenment. See for example Aveling 1872, 170. On Aveling, see

the history of the winners, here meaning the (male) medical profession and academic medicine whose presence and narrative were dominant and prevailing for many decades until the new approaches, methods, and sub-fields in history research.[131]

If the histories of the progress in medicine and science were the project of the medical men themselves, the broader social and cultural aspects of the history of medicine and childbirth remained largely unexplored until the 1970s. For example, in the 1980s, the gender historian Pat Jalland argued that the history of childbirth in Victorian and Edwardian Britain was neglected in academic history research because of the claims that the essential female experience of birth had remained the same over time and because of the lack of firsthand testimony by the women themselves.[132] With her own study *Women, Marriage, and Politics, 1860–1914* (1986), Jalland herself proved that these presumptions were not correct, albeit the majority of histories of childbirth have been dominated by the accounts and autobiographical data of middle- and upper-class women, due to the obvious lack of firsthand testimony of working-class or peasant parturients. Personal documents, such as letters, diaries, and memoirs were in many ways indispensable "lifelines" between family members and friends, but in the nineteenth century these intimate sources clearly concentrated on the wealthy and privileged sections of society.[133] Both Jalland's own contribution and the study conducted by the American historian Judith Schneid Lewis, *In the Family Way: Childbirth in the British Aristocracy, 1760–1860* (1986), are perfect examples of research projects utilising personal documents in order to investigate the most important and intimate life experiences and events, such as marriage and childbirth, in people's lives.[134] Both studies paid attention to the practices of childbirth, albeit somewhat briefly, also discussing larger social networks and social-economic contexts of childbearing amongst the British political and aristocratic families analysed in them.

From the 1970s and onwards, what became known as the new social history, including people's history or history "from below", microhistory, women's/gender history, the history of the family, the history of the body, the history of mentalities, sociology, anthropology, and gender and literary studies, have had a major impact on research conducted on medical history and the history of childbirth. Since Jalland's statement made in the 1980s, the situation has indeed changed and an abundance of books and articles has been published about the topic, embracing the questions of gender, social classes, and ethnicity, inter alia. Many

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Donnison 1999, 86; Evenden 2000, 2–3; Moscucci 1990, 71, 73. On "alternative" or "orthodox" medicine, see Bradley 2000.

131 McIntosh 2012, 7. On winners in history, see also Kalela 2012, 98–102.

132 Jalland 1986, 133.

133 Jalland 1986, 3.

134 These studies are not exactly history "from below": Jalland herself studied eminent British political families, including the Asquiths, the Gladstones, and the Chamberlains between 1860 and 1914. The research by Lewis focuses on the British aristocracy, one of the central figures being Queen Victoria. Nevertheless, both studies are extremely useful when conducting research on the history of childbirth in Victorian Britain.

scholars, with such as the British historian Roy Porter (1946–2002) at the fore, have called for medical history studied "from below", meaning especially the patient's point of view and the new critical perspectives on the body. Also my research is indebted to Porter and his surprisingly voluminous and multifaceted contributions to medical history, foremost how Porter has broadened the understanding of the healing practices and socio-economic dynamics in the past, including the historical diversity of alternative medical practices and the academic research written on quackery.[135]

In addition to Porter's works, also numerous studies conducted by Irvine Loudon, a British historian, on medical history have been particularly important, especially concerning the darker sides of the history of childbirth. Loudon's *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800–1950* (1992) is a voluminous and detailed report of maternal mortality in the Western world – from the statistical measurement of mortality to the actual causes of death and the international history of maternal care. *The Tragedy of Childbed Fever* (2000) by Loudon concentrates on the medical history of childbed fever, the most common killer of the parturient women in the nineteenth century. Loudon's (1924–2015) own professional background as a doctor is very apparent in his studies; Loudon also investigated the history of medical education and the development of general practitioners in eighteenth- and nineteenth-century Britain.[136] The medical historian Anne Digby has continued this work, exploring the formation of the British medical profession and economic aspects of healing in the expanding medical market between the eighteenth and twentieth centuries.[137]

Considering the intellectual history of science, medicine, and gender the most vigorous period was around the 1980s and 2000s. Especially two critical studies by the American scholar Londa Schiebinger, *The Mind Has No Sex? Women in the Origins of Modern Science* (1989) and *Nature's Body: Gender in the Making of Modern Science* (1993) broadened the understanding about gendered discourses in early modern science, foremost in biology and medicine. Schiebinger was able to show that apparently value-neutral "science" and "scientific facts" were in fact culturally and politically constructed and gendered, and that especially in the eighteenth and nineteenth century biology became a legitimising factory when sexes and races were put in hierarchical orders; one major result of this development was that women were deliberately excluded from the discourses of science. Similarly, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (1989) by the British historian Ludmilla Jordanova discusses the histories of science, language and art, interweaving these themes with gender. Jordanova has also analysed gendered discourses and the intellectual history of "nature" in her collection of critical essays, *Nature Displayed: Gender, Science and Medicine, 1760–1820* (1999); however, Jordanova has paid attention to the textual levels rather than specifically discussing practices of childbirth

135 See for example Porter 1985; Porter 1989; Porter 1991; 1997; Porter 2001.
136 See Loudon 1992; Loudon 2000. See also Loudon 1999. On Loudon, see also McIntosh 2012, 10–11.
137 See Digby 1994; Digby 1999. See also Peterson 1978.

or nineteenth-century doctors' perceptions of "nature" and how these perceptions were applied in medical writings.[138]

The complex relations between medicine, the medical profession, politics, and women's bodies in nineteenth-century gynaecology are also discussed in the study by the historian Ornella Moscucci, *The Science of Woman: Gynaecology and Gender in England, 1800–1929*, the first edition published in 1990. In addition, Alison Bashford's surprisingly compact yet unique study *Purity and Pollution: Gender, Embodiment and Victorian Medicine* (1998) illustrates how medicine and its practices, the nineteenth-century sanitation movement, and gendered and dichotomous concepts of purity and pollution were embodied both in medical practitioners and nurses.[139]

As numerous examples demonstrate, many medical and gender historians concentrating on the history of childbirth have specifically been interested in the seventeenth and especially the eighteenth centuries.[140] This is probably due to the changes that took place in early modern midwifery, especially the rise of man-midwifery in eighteenth-century England. The portrait of the nineteenth century is more divided and incoherent; the multifaceted narratives have been dominated by the separate histories of Victorian women and the family, the "female question" and the rise of the suffragist movement, the problematic midwife question, and the topics related to social classes, colonialism, race, eugenics, public health, and the general evolution of medicine and science.[141] Considering early modern medicine and the doctor–patient (especially male–female) relationship, Barbara Duden's *The Woman beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany* (1991, publ. orig. 1987 in German) has in many ways been groundbreaking and pioneering research in its genre, discussing the German doctor Johann Storch, his female patients, and eighteenth-century women's agenda with regard to their own health and illnesses. Duden's detailed study analyses the medico-cultural perceptions of the body and women as the subjects of medical treatment and health care. Women's reproductive bodies and the pol-

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138 See Jordanova 1986; Jordanova 1989; Jordanova 1999. On nature in history, see also *Nature and Society in Historical Context*. Teich, Mikulás, Porter, Roy & Gustafsson, Bo (eds.) Cambridge, New York & Melbourne: Cambridge University Press (1997); Daston, Lorraine & Vidal, Fernando (eds.) *The Moral Authority of Nature*. Chicago & London: University of Chicago Press (2004). See also Coates 1998.

139 Moscucci 1990; Moscucci 1996; Bashford 1998; Bashford 2014. See also Kukla 2005.

140 See for example Wilson 1995; Wilson 2013; Gowing 2003; Astbury 2017a; Astbury 2017b; Buckley 2017; Evans & Read 2015; Gélis 1991; Huet 1993; Keller 2003; King 2007. On the history of birth chairs, see Banks 1999. On female patients, see Churchill 2012.

141 On the social history of medicine, see Lane 2001. On the cultural history of pregnancy, see Hanson 2004. On childbirth in nineteenth-century America, see Leavitt 1986; Wertz & Wertz 1977; in Canada, see Mitchinson 1991. On midwives, working-class households, and health-care, see especially Beier 2008; Beier 2004. See also Levine-Clark 2002; Levine-Clark 2004. On nineteenth-century germ theories, see Worboys 2000. On nineteenth-century medicine, see Bynum 1996; Lawrence 1994; Smith 1979; Tosh 1999. On nineteenth-century male sexuality, see Hall 1991; Hall 1992; Hall 2000a; 2018. See also Branca 1975; Davidoff & Hall 1988; Gillis 1996; Bruce 1978; Kilday 2013; Marland 2004; Mason 1995; Mort 2000; Nead 1988; Ross 1993. See also McIntosh 2012.

itics of health in early modern England have been examined in detail by the historians Laura Gowing and Mary E. Fissell; both historians have paid attention to the social and political pressure and control in the female life cycle, and cultural inferiority of the female body in the seventeenth-century world.[142] The research by Lisa Forman Cody, *Birthing the Nation: Sex, Science, and the Conception of Eighteenth-Century Britain* (2008), combines the themes of rising man-midwifery together with the new British identity, politics, and the development of the modern nation during the eighteenth century. In addition, Cody has also explored the role of the lying-in hospitals in the eighteenth century context.[143]

However, the loudest critique aimed against the old-fashioned and male-centered history writing came from another direction. Since the 1960s and 1970s, the second wave feminist movement and feminist research, especially in sociology, criticised the power and control (male) medicine exerted over women's lives and bodies, including reproduction, contraception, and abortion, illustrating both many contemporary socio-political issues in health care and "the cult of female invalidism", allegedly nurtured by the male medical profession since the nineteenth century. Especially traditional views on male-centered "progress" and claims of neutrality in science and medicine were challenged and, correspondingly, women's roles and places were reevaluated, with the clear intention of making women and their agencies visible in male-centered and "neutral"-claimed history research. Special attention was paid to the ways the female body has been discussed and debated, analysed, and argued. Often the female body has been seen as some kind of unhistorical monolete, understood mainly as a deviation from the normalised ideal – that norm was always the white male body and male (hetero)sexuality – without paying much attention to individual differences which are associated with social class, economic status, age, ethnicity/race, place of living, religious beliefs, or sexual orientation, inter alia.

For decades, an endless flow of studies on specifically *the female body* promised some kind of historical peep show, but ultimately the results were often literary and historical dissections of the uterus and the ovaries, or summaries of how classical male philosophers and doctors had written about the anatomical peculiarities found in the female body.[144] Analogously, the male middle-class and heterosexual body, sexuality, and "male maladies" remained curiously invisible and unstudied; during the recent decades, the situation has indeed dramatically changed and many new critical studies have been published on the topics of men, masculinity, and "manliness".[145] Here in my thesis, both the pregnant woman's body and the body of a male medical practitioner are discussed –

142 See Fissell 2006b; Fissell 2017; Gowing 2003.
143 See Cody 2008; Cody 1999; Cody 2004. See also Woods 2007.
144 On the history of female sexuality and the body written from this perspective, see especially Shorter 1983.
145 See for example Mangham, Andrew & Lea, Daniel (eds.) *The Male Body in Medicine and Literature*. Liverpool: Liverpool University Press (2018); Parson, Joanne Ella & Heholt, Ruth (eds.) *The Victorian Male Body*. Edinburgh: Edinburgh University Press (2018). See especially Heholt & Parsons 2018, 12–14. See also the works by John Tosh on nineteenth-century masculinity, for example Tosh 1999; Tosh 2002; Tosh 2005. See

in the case of the (male) doctor, my aim is to analyse especially the gendered rules of touch and how these medico-cultural perceptions and ideals were embodied in the hands of the medical practitioner, even if the physical appearances of (male) doctors are otherwise discussed only referentially.

In their pamphlet *Complaints and Disorders: The Sexual Politics of Sickness* (1973), Barbara Ehrenreich and Deidre English famously accused medicine of being "one of the most powerful sources of sexist ideology in our culture" and in fact "strategic to women's oppression" socially, culturally, economically, and particularly politically.[146] According to Ehrenreich and English, (male) medical science justified sexual discrimination and oppression of patriarchy by underlining biology and the physical differences between men's and women's bodies – the male and his body being the norm and standard. As noted above, this was by no means a unique view but in Ehrenreich's and English's thinking, medicine automatically described and still considered women as either "sick, or as potentially sickening to men".[147] The study by the same scholars, *Witches, Midwives, and Nurses: A History of Women Healers* (1972), went even further. The book claimed that female midwives were systematically prosecuted and executed as witches in the early modern world.[148] However, in the 1990s, the medical historian David Harley was able to show that the common belief about midwives as witches was actually a persistent historical myth. In fact, Harley pointed out that this distorted perception of witch-midwives could be useful in creating "imaginary martyrs" for the modern women's health movement and its political agendas.[149]

This shows that – just as in the case of the traditional history written about progress by doctor–historians – the perceptions of the past did not concern only what happened in the past; they also reflected many contemporary political and social questions and the need to emphasise professional solidarity and traditions

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also Introduction in *Gender and History in Western Culture* 1998, 6; Downs 2004, 73–84; Porter 2002, 246–251.

146 Ehrenreich & English 1976, 9. Ehrenreich's and English's joint work *Complaints and Disorder: The Sexual Politics of Sickness* (pub. orig. 1973) is a somewhat fervent and straightforward pamphlet, emphasising the dominance the (male) medical system has had over women's lives mainly in America. Historically, Ehrenreich and English focused on the years between 1865 and 1920 – "because it witnessed a pronounced shift from a religious to a bio-medical rationale for sexism, as well as the formation of the medical profession as we know it – a male elite with a legal monopoly over medical practice." Ehrenreich & English 1976, 12. See also Ehrenreich & English 1988. See also Canning 2006, 80.

147 Ehrenreich & English 1976, 9. Ehrenreich's and English's books have been widely read and re-quoted, for example by the American feminist Adrianne Rich. See Rich 1997, 135–138. See also Canning 2006, 5–8. See also Oakley 1986, 25–30.

148 In fact, in their introduction to the second edition of the book, Ehrenreich and English confessed that the book was written "in a blaze of anger and indignation". Ehrenreich & English 2010. See also Ehrenreich & English 1976, 35–39. This tone might be partly explained by the fact that the sexist view on womanhood was more often expressed in American medical writings than in British medical texts. See also Jalland & Hooper 1986, 7; Donnison 1999, 17. See also Gillis 1996, 157–158.

149 See Harley 1990, 1–26. Harley criticised both Ehrenreich's and English's books *Witches, Midwives, and Nurses* and *For Her Own Good: 150 Years of the Experts' Advice to Women* (1988) in his article. See also van Teijlingen 2000, 46–47; Riddle 1997, 110–119, 132–138.

shared with the historical predecessors. As Ludmilla Jordanova has pointed out, "liberal feminism" also became "a reason for condemning scientific 'abuse'" both in the history of medicine and in contemporary practices.[150] Moreover, as Anne Digby has noted, some of the feminist scholars paid very little attention to the cooperation between male doctors and female patients, emphasising only the economic and perhaps intellectual exploitation of female bodies.[151] Consequently, the (male) medical profession came to be seen as "the dark side of the force", whereas both female midwives and female patients were collectively considered the oppressed and repressed party in the history of childbirth and more broadly in medicine.

An obvious need for socio-historical recognition has been apparent when the history of midwives has been discussed also academically. Especially since the 1990s, historical and medico-social settings of midwives and their roles in past societies and communities have been analysed from numerous kinds of viewpoints, especially how and where they worked, what kind of position they had in their communities and society, and how educated and experienced midwives were, inter alia.[152] Jean Donnison's critical study *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth* (1988) was one of the most important starting points in this genre, concentrating mainly on the economic and intellectual conflicts between the male medical profession and female midwives in the British context. Another important landmark has been the collection of essays edited by the historian Hilary Marland, *The Art of Midwifery: Early Modern Midwives in Europe* (1993), which presents a pervasive and in many ways intriguing view on the social history of the midwives working in early modern Europe.[153]

Less surprisingly, also the midwives themselves have conducted research on the history of their own profession. The midwife–historians have emphasised – very understandably – the long traditions, respectability, and also the disdain for their work. However, occasionally their version of the story has not been particularly objective; the themes of subjugation, conflict, and professional solidarity and pride – the experience of long-lasting sisterhood – have been reflected in the

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150 Jordanova 2006b, 345. See also Jordanova 1989, 15; Jordanova 2006a, 143–144; Porter & Porter 1989, 175–177. See also Cody 1999, 478; Cody 2008, 9. Ludmilla Jordanova has noted how pioneering feminist research studies taken collectively, have unwittingly reinforced "that sense of female pathology about which eighteenth-century and nineteenth-century medical practitioners wrote so eloquently". See also Jordanova 2006a, 5–6. See also Treichler 1990, 118–119. See also Duden 1991, 22–23. On second-wave feminist history research, see Downs 2004, 20–25. On feminism and medicine, see Lupton 1996b, 131–160.

151 Digby 1994, 301.

152 See also for example Marland, Hilary & Rafferty, Anne Marie (eds.) *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period*. London & New York: Routledge (orig. publ. 1997). See also Evenden 2000. Doreen Evenden's *The Midwives in Seventeenth-Century London* (2000) represents a detailed picture of early modern midwives, many of whom were educated and respected members of their local communities. See also Evenden 1993.

153 See Marland 1993; Marland 2004; Marland 2013. See Donnison 1999; Donnison 2000. The first version of Donnison's study was published in 1977. On Donnison, see for example McIntosh 2012, 9–10.

perceptions of the past.[154] This does not dim the fact that midwives have had their indisputable place in history and the various roles they have occupied must be acknowledged in research conducted on the medical history of childbirth.

How to Conduct Research on the History of Medicine: Some Remarks

Indeed, these many and often contradictory points of view show that also historians do have their special ethical responsibility when turning their "historical gaze" upon the past. In medical history, there is particular vulnerability to see the past in light of the present moment; as the medical historian John Burnham has pointed out, there is a real danger of labelling beliefs, customs, and ideas from the past anachronistically "an error", mistakes, or a fallacy, simply because current knowledge differs from the understanding and perceptions of medicine, the body, health, and mechanisms and treatments of illnesses, ailments, and complications in history.[155] As Burnham has noted, historians should be "searching for understanding", not trying to make "the present look good by denigrating the past".[156] On some occasions, scholars have been inclined to make moralising, colourful, and anachronistic judgements about the ideas, treatments, practices, and practitioners in history. For example, retrospective rediagnosis, as David Harley has called the diagnosis made from the standpoint of current medical understanding, is misleading and in fact anachronistic because the diagnosis relies, not only on the "naïve acts of translation", but also because it "privileges supposedly stable modern categories".[157]

Hence, if the historical and cultural context is ignored in research, one outcome may be that historically medicine can be seen – that is to say, until the end of the nineteenth century – as a thoroughly dangerous and primitive business, and that ultimately doctors were only doing more harm than good. Some historians and other scholars, when discussing nineteenth-century medicine and medical practitioners, have even claimed that patients were "likely to suffer in the hands of the doctor", referring to pre-twentieth-century medical care as "hit-or-miss treatment".[158] Moreover, many historians have had some obvious difficulties in accepting that some practices and treatments, such as venesection and the application of leeches, for example, were an important part of medical treatment in the past; historians have labelled these measurements as irrational and dangerous nonsense, and consequently, have underlined both the injuriousness of

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154 See for example Towler & Bramall 1986. Jean Towler and Joan Bramall both were midwives, with long practical experience of midwifery. See also Borsay, Anne & Hunter, Billie (eds.) *Nursing and Midwifery in Britain since 1700*. Basingstoke & New York: Palgrave Macmillan (2012). One interesting example is also the memoirs of Jennifer Worth, a British midwife working in 1950s in the East End of London, and the period drama series *Call the Midwife!* (BBC, 2012–), based on the biographical account by Worth. See Worth 2002. On historiography of midwives, see McIntosh 2012, 8–12. On problems about writing the history of midwives, see Allotey 2011, 131–137.

155 Burnham 2005, 100; Jordanova 2006b, 341; Risse & Warner 1992, 193. See also Porter 1985. See also de Blécourt & Usborne 2004, 5.

156 Burnham 2005, 100; see also p. 28.

157 Harley 1999, 417, 419. See also Burnham 2005, 76–78; Goubert 1987, 50–51.

158 Duffin 1978, 41; Ehrenreich & English 1976, 37.

the treatments and the state of primitivism of pre-modern medicine.[159] Usually this kind of prognostic point of view notices only the biomedical or mechanical results of treatments and ignores the incommensurability of modern and historical understanding about diseases and cure – especially the role of emotions and hope in the healing process. It is often ignored that doctors and patients genuinely believed in the treatments they were either giving or receiving even if the historian does not. It is indeed easy to accept Roy Porter's notion that modern times are "cure-fixated".[160]

As many examples show, medical history, and particularly research conducted on the history of childbirth, is prone to opposites and dichotomies, often written from the safety of hindsight and from the historians' own time perspective. For example, various obstetrical medical instruments and procedures have often been declared dangerous or unnecessary, such as the midwifery forceps or anaesthesia, and hence, they have been seen merely as the symbols of medical oppression, carelessness, brutality, and dangerousness. For example, according to one historian describing the application of the midwifery forceps in nineteenth-century labours, doctors "did not realize that the woman's death several days later from puerperal fever might have been caused by this 'lifesaving' intervention. It is uncertain whether forceps saved more lives than they took in the days before bacteriology."[161] I argue that this kind of statement is problematic for several reasons. First, there is a general assumption that the midwifery forceps were frequently applied in childbirth, apparently because of the "medicalised" state of childbirth in the nineteenth century; in reality, not all doctors approved of the forceps, or knew how to use them, even if their use became more common during the Victorian era.[162] This kind of statement also suggests that the forceps could do no good; they acted merely as an agent in a fatal infection – the word "lifesaving" is deliberately in quotation marks. Secondly and more importantly, this kind of notion has very little *historical* value, because the writer, a twentieth-century historian, is familiar with the basics of bacteriology, with the mechanisms connecting bacteria, the forceps, and the postnatal gynaecological infection, and more importantly, with how fatal infections can be prevented.

Indeed, it is often expected – sometimes unintentionally, sometimes intentionally – that people who lived in the past knew the same we know now, or at least that they *should* have known. Moreover, these kinds of moralising and omniscient perceptions make a false assumption that the current situation is an endpoint of all progress and claim that people living at this moment are more rational, advanced, and intelligent than their predecessors who lived in a constant state of

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159 See for example Hanson 2004, 21. See also McLaren 1984, 54–55; Lewis 1986, 134; Loudon 2000, 32; Tew 1998, 147.

160 Porter 1985, 193. See also Harley 1999, 420.

161 Wertz 1996, 14. The historian Dorothy Wertz also claimed that "a patient was as likely to be harmed as helped by most treatment". See Wertz 1996, 8. See also McLaren 1984, 54–55.

162 For example, in 1859, according to one statistic collected by a doctor reporting in the *BMJ*, in 1,000 labours, 17 were "instrumental"; in 11 cases, the midwifery forceps were applied. Harrinson, I., Statistics of One Thousand Cases in Obstetrics. The *BMJ*, October 29, 1859, 870; November 5, 1869, 888.

ignorance and superstition. Hence, the present situation is taken for granted, as a logical result or in fact an endpoint of an inevitable and causal evolution or progress. "Teleology still dominates the social history of medicine", as Ludmilla Jordanova has argued.[163] The German historian Robert Jütte has discussed "the trap of progress".[164]

This all, of course, also works the other way around: the past is not a magical wonderland where everything was better and historical people were naturally healthier and stronger than their successors are nowadays. Considering the history of childbirth, it is very tempting to see, for example, that the collective female ritual of birth protected women from the evils of medicalisation, unnecessary and potentially dangerous interventions, and from oppressive, misogynist, and sexist control of patriarchy and medical men. Childbirth – often located somewhere in unidentified historical settings – has sometimes been thought to be more "natural" and less painful, a harmonious event taken place in sisterly solidarity and free from repressive socio-medical control and rules. Indeed, when historians have stated that "in the days when people considered birth a normal process of nature, they were content to allow nature to follow its course", they may suggest that historically all women possessed full control over their own deliveries and reproductive bodies, whereas in modern deliveries they have none.[165] Consequently, especially "nature" becomes a prescriptive, legitimising category also in history research.

The reality is that in most cases, there are scarce first-hand testimonies of the parturient women themselves, and moreover, for a long time, surviving literary descriptions concentrated almost solely on the small and privileged elite. This obvious lack, however, has not been an obstacle in re-creating an idyllic picture of prehistorical childbirth, for example. In reality, there is no way we can safely argue how the Neolithic woman gave birth and how she felt emotionally about her assistants. [166] Birth has always been a socially controlled and culturally

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163 Jordanova 2006b, 350–351. This can be called also "triumphalism", meaning that medicine moves toward "a modernist goal almost irresistibly", especially when changes in mortality rates have been explained together "with assumptions about professionalization and state intervention". This has been particularly clear when doctors have conducted research on their own history. See also Donnison 1999, 9; Goubert 1987, 43–45.

164 Jütte 2008, 5.

165 Banks 1999, 4. According to the historian Amanda Carson Banks, by the turn of the nineteenth century, general practice of delivery "was strikingly different" from what it had been before: "increasingly, birth was something practiced rather than a natural event that occurred". Banks 1999, 33. Indeed, it can be extremely tempting to leave certain aspects or primary sources unnoticed, if they do not fit into this somewhat idealised/degraded version of the past. For example, the historian Edward Shorter mentioned in the 1980's that "it has become fashionable today to argue that in the past times women somehow had 'control' over their own deliveries, and that today they have none. Hence, these traditional procedures are thought to have been better for women." Shorter 1983, 68. See also Porter 1985, 182.

166 It has been suggested, for example, that "this approach [giving birth kneeling or sitting in an assistant's lap] *strengthened the emotional bond* between mother and assistant and built the connection between the community of women and their role in birth." Banks 1999, 1. Italics mine. See also Towler, Bramall 1986, 1–5: "it seems quite likely that the [prehistorical] woman delivered herself in the squatting position [--] she

constructed event with its many indispensable rituals and traditions, social ceremonies, and peer control, emphasising especially various cultural rituals and social hierarchies between different actors, agents, and agendas.[167] Acknowledging this does not deny "the reality" of birth: a child is being born, whether alive or stillborn.

In the history of childbirth, the real danger is in idolising and sentimentalising the past and in picturing the whole reproduction process as being out of touch with society, socio-cultural norms, and the historical contexts. According to Roy Porter, we must avoid "rendering" the past, famously phrased by Peter Laslett as the "world we have lost", and what Porter has called "a Rousseauian version of pastoral, [--] some sort of macrobiotic Golden Age, the bloom of health in the paradise garden just before doctors invented pain and disease to make their cut."[168] I argue that this very much includes also the language used in research. For example, the social historian Tania McIntosh has noted that the history of maternity and midwives has often been written in military language, with book titles containing words like "fights" and "battles". McIntosh herself seems to think that this kind of language and the perceptions of childbirth as a conflict is paradoxical, because to her pregnancy and birth are "quintessentially about nurture and development" – and because of this fundamental setting, apparently to be described with softer metaphors associated with femininity, maternity, growth, and generation.[169]

However, if the history of medicine and medical history of childbirth are discussed, there have probably always been counterarguments, controversies, conflicts, and constant contest and fights between different agents, agendas, practices, and ideals – in fact, the conflict can be the very reason why some primary sources exist in the first place. Moreover, as Deborah Lupton has pointed out, this kind of "military" language is very typical of modern medical and public health discourses and campaigns. In the nineteenth century, military and religious discipline became associated with medical discourses; in medical training and ideals of professional commitment, hierarchies in hospitals, and also with the perceptions of the body.[170] In this study, I do not consider this kind of "military" language unsuitable especially when I discuss the relationship between the medical practitioners and irregulars in the nineteenth-century world. Of course,

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would separate herself from the baby by cutting the umbilical cord with a sharp flintstone, or by biting through it with her teeth, and she would *instinctively* suckle the baby". Italics mine. I found these descriptions extremely interesting, yet somewhat fictional. See also Odent 2015, 13–22; Shorter 1983, 48–49; Chamberlain 2007, 1–3. See also Mitchinson 1991, 75; Mazzoni 2002, 155. See especially McIntosh 2012, 13.

167 See for example Wilson, A. 2002, 129–144.

168 Porter 1985, 182, 194. The writings of the French obstetrician Michel Odent with his nostalgic longings for a midwife "who spent her life knitting silently" can be seen as an example of this kind of thinking. See Odent 2011, 49–50. See also Laslett 1993, 3; Wear 2000, 201–202; Shorter 1983, 48; McLaren 1984, 54–55; Mazzoni 2002, 155.

169 McIntosh 2012, 5.

170 Lupton 1996b, 61–64. See also Vicinus 1985, 89–93; Bashford 1998, 44–45. The discourse of "fight" can be connected especially to the body with its immune system and diseases as enemies to be fought against and to be "destroyed". A disease can even be seen as a microscopic invader of the body. This is a modern way to see the mechanisms of disease.

there is no need to construe and analyse the topic only from this point of view; in this research, I have also investigated the advice concerning the material requirements for birth, which is a perfect example of a non-contentious, battle-free topic. In fact, the nineteenth-century descriptions of the ideal birthing room were rather similar, whether the writer was a midwife or a medical man.

Indeed, in the cultural history of medicine, the aim of the historian is to understand "how people in the past made sense of their lives, of the natural world, of social relations, of their bodies", as the historian Mary E. Fissell has expressed the idea in a nutshell.[171] In cultural medical history, what is interesting and relevant is how people in the past used medical ideas and healing practices and how medico-cultural ideas evolved and were understood at different levels of society, not just amongst the elite or otherwise selected small groups. Indeed, as the medical historian Michael Worboys has noted, historians should not be judging past ideas as "right and wrong", but instead they should be assessing how ideas functioned theoretically and practically for contemporaries.[172] Another historian, Natalie Zemon Davis, has stressed that the historian's role is to read, translate, and interpret "the means of communication and reception, forms of perception, and the structure and production of stories, rituals and other symbolic activities".[173] As already discussed in the previous chapter, this is always inevitably a context-dependent process; many historians and sociologists have pointed out that without historical (and indeed socio-cultural) perspectives and understanding, medical beliefs, practices, and people's reactions inevitably appear "inexplicable, irrational, and self-defeating".[174]

For my part, I am a historian studying the history of childbirth; I have no medical education or practical experiences of medical work. Therefore, estimating the risks of the ideas described or potentially dangerous treatments practiced in the primary sources of this study are beyond my expertise. Consequently, one starting point is that I try to avoid labelling treatments or estimating them as "successful" or "unsuccessful", qualified, effective, potentially harmful, or dangerous. In this study, I agree with John Burnham, who has pointed out that most physicians were trying to offer the best that was available at the time.[175] Of course, doctors were not nearly always successful nor were they able to help their patients – but I argue that also failures and mistakes are an indispensable part of the history of medicine and science; in fact, mistakes and errors can be more revealing than successful breakthroughs or celebrated innovations because ultimately they tell that something was *not* successful. Knowing this can also be significant, even groundbreaking. Moreover, especially doctors' letters sent to the *BMJ* also show that the uncertainty and incompleteness of medicine and medical

171 Fissell 2006a, 365. On the history and methodology of cultural history, see especially Burke 2008.
172 Worboys 2014, 75. See also Jordanova 2006b, 340–341. See also Fissell 2006a, 374.
173 Davis 1990, 29.
174 Lupton 1996b, 15; Jordanova 2006b, 350–351.
175 Burnham 2015, 101. At the same time, I also acknowledge that medicine is not free from deliberate malpractice; medicine and doctors are capable of doing horrible things, as the example of doctor Joseph Mengele working in the concentration camps in Nazi-Germany demonstrates. See for example Pfeiffer 1993, 4, 14, 111.

knowledge have to be acknowledged in research rather than to be condemned automatically as a state of "primitiveness", "ignorance", or "failure". Indeed, medicine is never "completed"; it is in a state of constant change and contest.

Doctor–Patient Relationship in Medical History

One particularly important – in fact indispensable – aspect of medical history is the doctor–patient relationship, also discussed in this research. The patient's view has become growingly important and visible since the introduction of the new social history and the boom in gender studies; in the 1980s, especially Roy Porter called for attention to the sufferers' role in the history of healing, noticing that it had been routinely ignored also by historians whereas academic doctors were clearly overpresented in previous research.[176] As David Harley has pointed out, in the relationship between the healer and the person who is sick or otherwise needing medical attention and care, whether it is the physician and patient, or the midwife/obstetrician and the mother-to-be, it is essential that the relationship is created by "semiotic, ritual and discursive acts", which are effective only in relation to "specific cultural-symbolic and social-structural circumstances".[177] This means that in medicine the patient needed to trust the doctor, his/her abilities and judgements, and the "system of care, as expressed in words and actions, and as embodied in building and people", as Harley has described.[178] All healing is based on trust and authority, uncertainty and hope.[179] In fact, medicine can be understood as the art of managing uncertainty. Hope is a powerful therapeutic agent in its own right, an indispensable element in medicine and the relationship between the healer and the patient, and the larger circle of family and friends.[180] As Roy Porter for example has pointed out, medicine has always been much more than simply "cure"; treatment has involved "complex rituals of comfort and condolence", not only drugs, potions, or special operations performed manually.[181] Thus, the patient–doctor relationship is at the very heart of the ideas of being a good doctor.

The object of this treatment, care, or advice has often been thought to be a *patient* or less suggestively a *sufferer*.[182] The patient has sought help from the doctor because the patient was feeling ill, or s/he was interested in health and wanted to prevent illnesses, pain, or the risks of injury; the patient has viewed the physician as someone who can help and who has special expertise beyond self-help or community care, provided by the patient themselves, their family circle, or irregulars.[183] The patient could have received the help s/he was looking for or be even "cured", but because of this initial setting, s/he was also exposed

176 See Porter 1985.
177 Harley 1999, 433. See also Porter & Porter 1989, 12–13; Burnham 2005, 12–13.
178 Harley 1999, 431. See also Burnham 2005, 11–13.
179 Harley 1999, 427–428. See also Lupton 1996a.
180 Lupton 1996a, 164. See also Marsh 2017, 244: "patients want hope, as well as treatment".
181 Porter 1985, 193.
182 Porter 1985, 181.
183 Mitchinson 1991, 4. See also Porter & Porter 1989, 85–91; Porter 1985, 175. See also Burnham 2005, 37–39.

to emotional dependency, vulnerability, anxiety, and potential humiliations and embarrassment.[184] Moreover, the general circumstances have had an impact on the doctor–patient relationship; people who are feeling unwell and especially those who are seriously ill, have to place their trust in the doctor, with the mixed feelings of fear, dependency, ambivalence, insecurity, uncertainty, resignation, and anxiety – often these feelings concern also a larger group of people close to the patient. The patient wants to believe that the doctor is trying their best with them, while the patient also expects a good doctor to express compassion, empathy, comfort, and consolation.[185] This relationship is based on reciprocality and exchange.[186] However, patients have not been passive and compliant, nor have they always expressed gratefulness or compliance, nor been content with the treatments they were either receiving or being denied.[187] Moreover, it is good to remember that a patient has always been a person, an individual, who has "a life and story beyond being a mere anonymous patient with a disease". [188] In medical history, typically only a very small fragmentary section of the patient's life story is discussed and analysed in the patient reports and other documents; in the primary sources analysed in this study, the patient's version was usually recorded by the doctor reporting on the case, and hence, much was inevitably left untold or could be amended for one reason or another.[189]

The healer, on the other hand, has to have self-confidence and belief in the care s/he is offering to the patient, even if uncertainty is always an inevitable part of medical care – and most doctors have probably acknowledged this. For example, Henry Marsh (b. 1950), a contemporary retired British neurosurgeon and author, has made a simple yet very relevant observation on the medical profession and their work: "[d]octors are humans, just like the rest of us. Much of what happens in hospitals is a matter of luck, both good and bad; success and failure are often out of the doctor's control."[190] However, certain rituals and ceremonies practiced in medicine can help to create trust, authority, and confidence; for example, John Burnham has discussed an "aura of priestliness" in a physician who is playing a role or "performance on the stage of society".[191] Interestingly, Marsh has stressed the complexity of medical work, especially what can be done and what is possible, what is necessary in practice, and when the elusive line of "doing harm" is actually crossed: "[k]nowing when not to operate is just as important as knowing how to operate, and is a more difficult skill to acquire".[192]

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184 Lupton 1996a, 167.
185 Lupton 1996a. Porter 1985, 183.
186 Lupton 1996a, 165.
187 Lupton 1996b, 7, 113–117; Lupton 1996a, 165.
188 Marsh 2017, 64.
189 See also Chapter 2.2.2.
190 Marsh 2015, xi. Marsh's statement echoed what the editor of the *BMJ,* Ernest Hart wrote in 1893: "medical men are not pure creatures of perfect and abstract morality any more than other men". Hart, Ernest, The Medical Profession, the Public, and Medical Etiquette. The *BMJ*, October 21, 1893, 883. See also Porter 1985, 193.
191 Burnham 2005, 12. See also Lupton 1996a, 164; Lupton 1996b, 106. See also Foucault 2000, 252–253. See also Harley 1999, 427–431.
192 Marsh 2015, xi.

This idea is very close to the discussion related to meddlesome midwifery in nineteenth-century obstetrics, as is discussed in further chapters in this study.

Indeed, many scholars have stressed that medical ideas are never separate from patients; medicine is not simply "a branch of science" but primarily a practice, and interactions between different actors and agents, foremost between the healer and the patient, have always been an indispensable part of it.[193] This shows that the emotional side is also an inseparable part of the healing process, including the emotions of the doctor, even if they have rarely been discussed in medical history. Also Henry Marsh has noted the complex relationship between compassion and responsibility in medical work; in medicine, as Marsh has stressed, patients become "objects of fear as well as of sympathy", ultimately acknowledging that it is "much easier to feel compassion for other people if you are not responsible for what happens to them."[194] In fact, Marsh has preferred the concept "rational compassion" instead of empathy; Marsh has pointed out that doctors need to suppress their "natural empathy", to unlearn it, if they are to function effectively and to perform necessary operations and administer treatments, causing pain, distress, and even the risk of death for their patients.[195] I have found this concept useful also in this research; I suggest that the concept of "rational compassion" reveals different kinds of metalevels in medical work, including the emotional aspects, practical knowledge, and in many ways the exceptional responsibility of medical practitioners.

Indeed, the persona of the practitioner has been seen as inseparable from a successful healing process. Especially a good reputation of the doctor was tied seamlessly into the process of establishing trust between the practitioner and his/her patients.[196] In this study, especially the questions of decency and decorum were an essential part of the work of the nineteenth-century (male) obstetrician, at least if the doctor wanted to become generally respected and successful in his business.[197] As I discuss further in this study, a male doctor could be considered sexually potentially dangerous in relation to the parturient woman's body, moral self, and social order; thus, the complex boundaries of proper behaviour, the rules of decorum, especially how the doctor was allowed to see and touch the body of the female patient, were constantly renegotiated both in practical work, medicine, and society.[198] Especially touch was indispensable in obstetrics but how it was done, was carefully regulated in medical ethics and etiquette and discussed also in popular medical writings.

In this research, women are studied both as patients and doctors, albeit an academically trained female physician was a somewhat rarely seen figure in the primary sources analysed here. In medical periodicals, women represented all

193 Jordanova 1989, 17. See also Mitchinson 1991, 4–5; Jordanova 2006b, 355; Porter 1985, 175.
194 Marsh 2015, 216.
195 Marsh 2017, 118, 132. On the history of empathy, see Boddice 2018, 55–56. On empathy in medicine, see also Lupton 1996a, 160–161. See also Gerlander 2003, 56–58.
196 Harley 1999, 414, 428, 430; Lane 2002, 233. On the reputation of a doctor in early modern England, see Wear 1993, 98–125.
197 Jordanova 1989, 32–33.
198 Lupton 1996a, 165. See also Fissell 2006a, 366, 368–369.

social classes of British society – as Lisa Cody has noted, doctors "entered into relations with women of all socio-economic ranks, from beggars to aristocrats" – but on the other hand, upper- and middle-class women clearly dominated the genre of popular health literature.[199] Thus, women were mostly in the position of a *patient,* but not automatically an object of a male gaze or medical oppression: the women discussed were either pregnant, or expected to be so, they were giving birth, and recovered from childbirth during the lying-in period. Professor of Philosophy and Mental Health, William Fulford has noted that usually the role of patient means a loss of autonomy, ceasing to be a full agent.[200] However, being pregnant or giving birth does not automatically mean the status of being sick or a sufferer even if in some cases these roles have not been so far apart. Nor were these women discussed just as the passive objects of medical attention and interventions; they clearly observed themselves, marked signs in their bodies, took part in the treatments, and occasionally, also co-operated with the medical profession even if their positions were never equals. Hence, I do not consider that female patients were particularly attached to the role of the patient, nor were they inclined to some kind of masochism, gaining sexual gratification from being subordinated and dominated by the male medical profession/patriarchy/male-dominated society, as it sometimes has been suggested.[201]

Indeed, this kind of reading concentrating only "patientness" can easily produce unintentional, negative viewpoints; sometimes, women have been seen merely as the helpless victims of medical control, surveillance, and power, or, more disturbingly, of their own physiology.[202] The feminist scholar Nancy Theriot has called this a "victimization model"; in this kind of discourse, female "patientness" has been underlined, and women have been seen as passive recipients or repressed objects without any agency of their own.[203] Moreover, sometimes the story of medicine has been told from the narrative of how the patient *lost* their independence, agency, and self-sufficiency when modern medicine was taking shape. Consequently, when healing was becoming more medicalised, patients became lesser in every respect, merely objects, and new technology and treatments were only used to control, monitor, and supervise them, not to treat them or improve their state of health. My aim is not to promote modern medicine or to claim that it is somehow omnipotent. However, at worst this kind of perception can unintentionally suggest that suffering in history was somehow beautiful or "natural" because patients were more self-reliant and free from repressive

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199 Cody 2008, 197.

200 Fulford 1996, 17. See also Lupton 1996b, 84–85, 97–100.

201 This approach has been visible in the 1970s feminist discourse; see for example the discussion of Victorian corsetry in Roberts 1977, 554–569. See also Ehrenreich & English 1988, 270–285.

202 In this regard, the study by Edward Shorter *A History of Women's Bodies*, is a good example. Shorter's controversial study sees all women captured inside of their own reproductional bodies and the victims of "reproductional forces". Many historians, such as Barbara Duden, have heavily criticised Shorter's views. See Duden 1991, 22. See also Jordanova 1989, 10. See also Digby 1994, 259–260; Porter & Porter 1989, 173–174.

203 Theriot 1996, 124–126; Brock 2018, 144. See also Porter 1985, 182. See also Keller 2003, 63–64.

medical control or indeed, the horrors of medicalisation.[204] On the question of childbirth, it is worth noticing that in the most challenging midwifery cases – even if these cases have always been rare in comparison to all births – giving birth has not been merely difficult – it has been physically impossible.[205]

In fact, it can be argued that the choice of a research topic and the primary sources studied have their own impact on how womanhood or motherhood is understood in history and what kinds of discourses are dominant in the research. Thus, paradoxically, even if the aim of the study is to criticise cultural stereotypes, it can end up reinforcing them.[206] In this research, I acknowledge that the medical professional was only one group discussing reproduction – here specifically meaning pregnancy and childbirth – in nineteenth-century British society, albeit an authoritative and loudmouthed one. I notice that the writings related to childbirth and reproductional female health were only one part of the whole picture; in reality, nineteenth-century women also had other meaningful roles in their lives, perhaps not visible in the primary sources but existent, nevertheless. Moreover, pregnancy and childbirth meant different things to different women; for some women motherhood was indeed the most important mission in their lives, "a kingdom of heaven", as it was described by the doctor Jane H. Walker in her manual *A Handbook for Mothers* (1893), while some found motherhood a difficult or even impossible role to bear.[207] Primary sources analysed in this research, including popular health manuals, clearly demonstrate that in practice, also doctors knew this very well.[208] Indeed, it is crucially important to acknowledge that nineteenth-century women were not a homogenous group, nor were the doctors treating them.[209]

Gender: A Useful Category in the History of Medicine?

When discussing the history of childbirth, including the doctor–patient relationship and relations between male doctors, female patients, and society, one comes to agree that gender is indeed a "useful category of historical analysis", as the title of the influential article (1986) by the American historian Joan W. Scott suggests. The roots of gender history were in the 1970s, in American feminism and study of women's history; the key idea was to reveal and challenge the relationality of a normative definition of femininity and social quality of distinction

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204 See for example Porter 1985, 182.

205 See for example Lewis 2018, 20.

206 See especially Brock 2018, 143–144. The historian Claire Brock criticised especially Mary Poovey's article "Scenes of an Indelicate Character": The Medical "Treatment" of Victorian Women (1987), in which Poovey concentrated on the passive character of women and described medical treatments (notice the quotation marks in the title) of the Victorian medical profession. See Poovey 1987. See also Downs 2004, 21–22.

207 Walker 1893, 2. See also Levine-Clark 2004, 57.

208 This question is discussed in Chapter 4.4. See also Moscucci 1990, 36–37.

209 As the historian Christopher Lawrence has noted, the medical profession held opinions about politics, the role of women, religion, and the poor, but their "attitudes and their naturalism were part of the culture of that class [they belonged to], not of an independent medical profession". Thus, being a medical practitioner was not the only attribute to define these people and their perceptions and opinions. See Lawrence 1994, 71.

based on two oppositional sexes, "the social organization of the relationship between sexes", as Scott has put it.[210] Scott has summarised that "gender" ultimately means "knowledge about sex differences"; the gender historian Kathleen Canning has defined gender as a category "of social analysis that denotes the relational character of sexual difference".[211] Gender as a socio-cultural category has made woman visible in history as active participants while it has also problematised and challenged especially traditional male-centered and dominated "universal" and "neutral" history, acknowledging the historical-cultural constructions of the categories of "men" and "women", and, as Joan Scott has stressed, creating "analytic distance between the seemingly fixed language of the past and our own terminology".[212] Hence, even if the definitions of sex and sex differences are often expressed in law-like statements and apparently timeless perceptions of what "man" and "woman" are, what they have been, and indeed, many times, what they ought to be, socio-culturally, "male" and "female" have never been "natural facts", existing simply biologically to be categorised on the basis of the reproductive organs or anatomy.[213]

In fact, the concept of gender helps us to notice that also "neutral" biology has its own history; it is a socio-cultural category – in fact, the word "biology" was invented in the early nineteenth century – which "has marked and distorted" the perception and relation of the sexes, as the German historian Gisela Bock has illustrated.[214] Biology, as a system of categorisation, is never neutral or free from prejudices, ideologies, values, or language in which it is constructed. For example, in the 1990s, the anthropologist Emily Martin famously analysed the medical language of reproductive biology and demonstrated that when human conception was described in scientific textbooks and models, eggs and sperm were given stereotypical and in fact distinctively gendered roles with specific courtship and mating behaviour. The female reproductional system was evaluated by words indicating a decline or failure, such as "ceasing", "dying", and "losing", whereas the male system was described in a more positive light, being both constantly "productive" and "active". The egg, given a female role of the passive "hard-to-get prize", nurturing mother, or a dangerous and aggressive *femme fatale*, was waiting for the sperm, which was seen as the active and heroic party in conception and the rescuer of the withering and soon-to-die egg.[215] Martin's now classic

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210 Scott 1986, 1054. See also Canning 2006, 5–12; Scott 1991, 42–61; Scott 1999, 199–201; Introduction in *Gender and History in Western Culture* 1998, 1–16; Bock 1998, 25–35; Churchill 2012, 6. On Scott, see for example Downs 2004, 92–94. See the critic of Scott in Boydston 2008.

211 Scott 1999, 2; Canning 2006, 4. See also Canning 2002, 10–11; Butler 2008, 54–59, 194–202. See also Lupton 1996b, 24–30.

212 Scott 1986, 1055, 1075, 1074. See also Scott 1999, 15–27. See also Bock 1998, 25; Downs 2004, 2–6. See also Oakley 1985, 161; Jordanova 1989, 4; Matus 1995, 7–8.

213 Moreover, it is important to notice that this kind of binary categorisation between two sexes is not enough, even if non-binary classification and intersexual variations are not discussed in this study.

214 Bock 1998, 30–31.

215 See Martin 1996, 323–339. See also Martin 1989, 42–53; Jordanova 1989, 143; Schiebinger 2004a, 13–25. Anne Dally has noted that in medicine, infertility has often been seen as a problem in a woman rather than in a man, see Dally 2001, 20. See also Lupton 1996b, 70–71.

example demonstrates what the American historian Londa Schiebinger has pointed out in her studies: gender hierarchies and cultural definitions have been brought into scientific language, usually giving male qualities priority and emphasising male dominance and allegedly heterosexuality in all the natural world.[216] It is clear that historically, the nineteenth-century language was equally charged with more or less unintentional gender-based rhetoric, discourses, and narratives.

Indeed, gender is one of the most profound dimensions in human life, a constituent of basic identity and classification in human interaction and communication, in every community and culture.[217] However, these perceptions are never universally understood or manifested; they are always "context-specific" and "context-dependent", the products of the history of culture, science, and of gender relations themselves, as Gisela Bock has stressed.[218] As the example of the egg–sperm discourse analysed by Martin shows, masculine and feminine attributes are defined in relation to each other and gender is a constitutive element of social relationships "based on perceived differences between the sexes", which also signify relationships of power, as Joan Scott herself has noted.[219] Scott has called for questioning the fixity of "timeless performance in binary gender representation", noticing the role of political and social institutions and organisations, scientific and legal doctrines, cultural representations, and rituals in the creating of gender and gender relationships.[220] Thus, gender is constantly produced – constructed, legitimated, challenged, and maintained – within societies and cultures.[221]

One cultural-historically particularly meaningful aspect – seen also in this study – has been the dichotomous distinction between the appeal of women as natural and men as cultural. As Ludmilla Jordanova has pointed out, our culture has been largely based on the imperative form of the dichotomy, "where two opposed terms mutually define each other"; in the sex–gender division "considerable rhetorical emphasis was placed on gender being about culture, where sex differences were about nature", as Jordanova has noted.[222] Nature and femininity have been in an intricate yet inseparable relationship with each other, emphasising taxonomic categorisation between men and culture and the persistent association of women with nature.[223] However, these categorisations have never been fixed or indeed strictly oppositional. As my study ultimately shows, "nature"

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216 See for example Schiebinger 2004a, 17, 18–24. See also Lupton 1996b, 132–133.
217 Jordanova 1989, 3. See also Jordanova 1999, 7–8. See also Bock 1998, 29.
218 Bock 1998, 29. See also Duden 1991, 117: "No morphological element nor any process such as the flow of semen or the monthly bleeding has been seen at all times and everywhere as unique to a specific gender. Only when such elements are seen by the eye whose vision is shaped by its cultural milieu do they become sexual characteristics." See also Boydston 2008, 560.
219 Scott 1986, 1067–1068. See also Jordanova 1989, 4, 66; Matus 1995, 8–11, 21.
220 Scott 1986, 1068. See also Downs 2004, 93–94.
221 Scott 1999, 3.
222 Jordanova 1989, 21, 23; Jordanova 1999, 7. See also Chapter 5.1.
223 Jordanova 1999, 21–22, 164–165; Jordanova 1989, 19–21. See also Scott 1986, 1067; Moscucci 1990, 3–4. See also Chapter 5.1.

was in fact a very useful concept for the nineteenth-century (male) medical profession; male doctors could overcome these traditional dichotomies between masculine/feminine and culture/nature whereas their main competitors, female midwives clearly could not. Moreover, the nineteenth-century discourses of childbirth demonstrate that "nature" encompassed multiple – in fact, sometimes perfectly contradictory – meanings in Victorian medicine. God/Nature was the ultimate guardian of health. Traditionally in medicine, nature's most profound function was to protect the body from harm, as Barbara Duden has stressed, but this was only a starting point, as is discussed further in this study.[224]

Historically, women have been seen as "first and foremost members of their sex", whereas men have not been automatically or primarily associated with their reproductive bodies or sexual organs; in medicine, men were treated as individuals rather than collectively as "the mass of men", unless some other socially meaningful category, such as class or age, was specifically emphasised and brought forward.[225] Thus, in medico-social constructions and discourses, women could be seen as profoundly similar, whereas men were less so.[226] Gender has been in many ways an important legitimising factor in Western societies; it has been based on the notion that physical and mental differences have provided a legitimised premise on social order and hierarchies in societies and formed a basis for why women could be considered either inferior to men or completely different from them, the binary and complementary opposition or the "opposite sex".[227]

In medicine, gender has been a central metaphor and a tool of categorisation; it has constantly been present in language, in conceptions and definitions, practices, pictures and illustrations, and in the perceptions of the body, inter alia (see also *The History of the Body*).[228] In the history of childbirth, this is particularly visible; the basic idea was, of course, that women became pregnant and gave birth, whereas men did not. Women's bodies were designed for reproduction, as the statement by the nineteenth-century medical man Robert Bakewell, already discussed in the Chapter 1, clearly demonstrates.[229] However, the medical profession, as the experts on both the human body and reproduction process, clearly noticed that strict definitions were often inadequate whenever they met their patients in real life. In practical medical work, womanhood – both the physiology and various social roles of females – was constantly redefined and renegotiated: for example, some female patients did not have a uterus or ovaries – the women

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224 Duden 1991, 172.
225 Jordanova 1989, 14, 83; Bock 1998, 30–31. See also Moscucci 1990, 2–3.
226 Jordanova 1989, 42.
227 Scott 1986, 1067; Bock 1998, 31–32; Scott 1986, 1067–1070. See also Schiebinger 1991, 224–227; Schiebinger 2004a, 38–39; Jordanova 1989, 19–42. See the critique of "gender" in Boydston 2008, 575–579.
228 Jordanova 1989, 144. See also Lupton 1996b, 69–71.
229 See Chapter 1. See also Bock 1998, 30: "[l]ong before biology existed, Jean-Jacques Rousseau, for example, made a similar point, but in exclusively cultural terms: 'The male is male at certain moments, the female is female all her life'".

had been born without them – and yet they were still considered *women* and not anti-women or men.[230]

The binary opposition has not concerned only the culture–nature dimension; the discussion of gender in the nineteenth century has partly been based on the strict division between public and private, and the division of "separate spheres", based on gender lines. "Private" was associated with femininity and the importance of marriage, family, and motherhood specifically in women's lives, whereas men were connected to the public realm and publically noticeable agency. Thus, based on this idea, the "private sphere" of family and household was considered the "only conceivable site of female agency or power", while male authority and influence were visibly public; men's roles as husbands and fathers were considered less meaningful or indeed less important.[231] This idea of the complementary division between sexes was rooted especially in the study *Family Fortunes* (orig. 1987) by the historians Leonore Davidoff and Catherine Hall, discussing the separate spheres and gendered division middle-class Victorian women and men occupied both at home and in public life.[232] *Family Fortunes* shows especially the role of Protestant evangelical religion in Victorian middle-class family life; as many historians have illustrated, the cult of domesticity emphasised morality, religiosity, purity, and virtue in nineteenth-century middle-class women.[233]

However, this model has faced much criticism; it has been shown that the specifically Victorian construction of separate gendered spheres was recognised as only one variation "rather than a prescriptive or representative model", as for example Kathleen Canning has underlined.[234] The historian Amanda Vickery has illustrated – using the example of *Family Fortunes* – that many accounts show that there was an expansion of the female role outside the domestic sphere and not a reduction, questioning the ideal of the separate spheres associated namely and only with the Victorian world.[235] For example, Lisa Cody has discussed "heterosociality", meaning that during the eighteenth century, both women and men, and adults and children spent time together in homes, also entering public spaces together.[236] The gendered roles and practices concerning Victorian family life are not discussed here in my study, but it is worth noticing that it has not always been particularly clear what "public"/ "publicity" and "private"/"domestic"

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230 See for example Magee, W., Case of Absence of External Genitals, and Formation of an Artificial Vagina. *The Lancet*, June 23, 1842, 575–576. See also Scott 1986, 1056; Matus 1995, 21–22, 25.

231 Canning 2006, 17–18, 67; Jordanova 1999, 169; Cody 1999, 479. See also Cowing 2003, 29; Vickery 1998, 197–220; Adams 1996, 75–77. See also Downs 2004, 43–47, 55.

232 See Davidoff & Hall 1988. On *Family Fortunes*, see Vickery 1998, 204–208; Downs 2004, 56, 68–70.

233 Bashford 1998, 9.

234 Canning 2006, 21–22. See also Cody 2008, 14–15; Showalter 1990, 8–9; Vickery 1998, 201–210; Levine-Clark 2004, 7–8, 71–72; Mitchinson 1991, 16–17. See also Downs 2004, 149–150. Compare to Davidoff 1997, 85–100; Hall 1998, 181–195; Hall 2000a, 15–16. See also the supportive discourse of the theory in Lewis 1984, 75–136.

235 Vickery 1998. Alison Bashford has argued that the spheres were indeed gendered but they were never "separated"; hence, a strict division between separate spheres is artificial. Bashford 1998, 8–9. See also Cody 2008, 14.

236 Cody 2008, 15.

have meant and stood for both in historical settings and when historians have discussed them in research.[237] Indeed, these models of "separate spheres" cannot be generalised to all historical settings nor are they fully relevant beyond cultural stereotypes and ideals; everyday life was more varied than the persistent stereotypes associated with the Victorian family and the cult of domesticity have often suggested.

Moreover, as especially the historian John Tosh has shown in his influential study *A Man's Place: Masculinity and the Middle-Class Home in Victorian England* (1999), nineteenth-century men were an indispensable part of domestic life and they were expected to be so, in order to be fully masculine and respected in their communities.[238] The male doctors, analysed here in my study, can be used as an example of how marriage and family life played an indispensable part in the lives of Victorian men; in a professional sense, for example, in creating a professional reputation, marital status and fatherhood could be beneficial – in fact, often a precondition for professional success. The emotional side was also an indispensable part of the nineteenth-century doctors' writings; indeed, as I have already discussed in this chapter, women's "patientness" has been analysed in numerous studies whereas *male* doctors – here I mean their *gendered* roles in families and codes of conduct, including their masculinity and "manliness" interwoven together with the emotions and marital bonds – have remained unexplored for a surprisingly long time. The sex of doctors was of course considered self-evident – meaning that they were men and not women – but otherwise their masculine identities have been explored primarily in the context of professionalism and the discourse of science, not of how doctors' emotions affected their decision-making and their ability to work in practice.[239]

The History of the Body

The question of gender is of course inseparably interwoven with perceptions of the body. In this work, the body is at the centre of the medical narrative and attention – discussed both privately and publicly, represented in cultural perceptions and practical interactions – in abstract ideals and very concrete advice concerning the gendered pregnant/parturient female body. As the historian Mary E. Fissell has noted, the cultural history of medicine has been interested especially in two areas: the sociology of disease and the history of the body.[240] In this research, I have concentrated on the latter, discussing both the pregnant/parturient female body and the medico-cultural ideals embodied in the medical practitioners, foremost in their hands. The doctors' body was usually constructed on the

237 See particularly Vickery 1998, 218–219.

238 Tosh 1999, 1–8, 195–197. Indeed, as Tosh had noted, the Victorian ideal of domesticity was "in all respects the creation of men as much as women". See also Tosh 2005, 331. On working-class fathers, see also Strange 2015, 114–144. Compare Tosh to Nelson 1995.

239 See for example Introduction in *Gender and History in Western Culture* 1998, 5–7. See also Chapters 3.3, 5.3, and 5.5.

240 Fissell 2006a, 369–371.

basis of masculine ideals and the touch of a male practitioner was understood in relation to the body of the female patient.

In medical history, the body is not just an individual anatomical entity, consisting of bones, organs, flesh and blood, or bodily functions to be analysed or to be treated "medically".[241] Thus, the body cannot be taken for granted, as "an unchanging biological reality", existing without historical contexts and socio-cultural ideals, meanings, and definitions, as Barbara Duden has pointed out.[242] For example, in surgery the patient's body has literarily been the material on which the surgeon has worked, providing a basis of practical medical work.[243] However, even the most daring surgeon does not operate on his/her patient without specific knowledge about the body, its structures and anatomical features and trust in his/her own skills and expertise, including necessary technology, which are always historically and culturally constructed, not existing biologically/physically nor reflecting some kind of independent or immutable universal "reality". Moreover, this knowledge is situated in the medical practitioner's body – his/her practical skills and knowhow, and thus, also the practitioner's body – both the concrete body and the abstract ideas of it – is meaningful.[244]

Both Barbara Duden, in her study *The Woman beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany* (1991), and Roy Porter, who wrote the first version of his influential article *History of the Body* in the same year, have noted that the human body, too, has its own history. The body is always experienced, performed, and expressed within its own historical context; the body is controlled and projected according to particular cultural systems, both privately and publicly, individually and within social groups, possessing "a plurality of competing meanings", as Porter has illustrated.[245] Thus, the body cannot be treated as a biological given, "but must be regarded as mediated through cultural sign systems", always connected to a particular time and culture, class, gender systems, and circumstances.[246] The body is both a representation and metaphor, a physical entity and symbol, "a chain of mediations, a social construction", as the medical historian Michael Sappol has pointed out.[247] In everyday life, the body goes often relatively unnoticed or it can even be taken for granted, but usually when special feelings, emotions, and sensations, such as pain or pleasure, are felt and experienced, people become conscious of their bodies – especially the restrictions of it.[248]

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241 Porter 1991, 215. See also Sappol 2014, 29–35. About the nude body in Victorian art, see Smith 1996, 25–44, 68–95, 216–237.

242 Duden 1991, 3.

243 Schlich 2018, 4.

244 See especially Schlich 2018, 5–10. In fact, the historian Thomas Schlich has noted that "technology" has three layers: first, there is the physical level, meaning the instruments used in the operation. Then there is the activity and *what* the surgeon actually does. Thirdly, technology is "what people know", meaning *how* the surgeon performs the operation, including the relevant knowledge, knowhow, and practical skills.

245 Porter 1991, 208–209, 215. See also Foucault 2014, 117; Lupton 1996b, 21–22.

246 Porter 1991, 215. Jordanova 1989, 13; Lupton 1996b, 22.

247 Sappol 2014, 34.

248 Lupton 1996b, 20.

The body is familiar and very well known. Everyone has a body, which encompasses both sameness and difference, individuality and collectivity at the same time. In the early modern world, as Roy Porter has noted, everything was explained by analogy with the body, a common shared symbol – for example, how societies were organised and how the cosmos worked.[249] The perceptions of the body changed around the end of the eighteenth century when understanding about the new modern body was created; Michel Foucault has famously discussed the power of the new policy of clinical examination and dissecting the patient, creating an understanding of a body consisting of specialised organs rather than unbalanced humours.[250] However, as Barbara Duden has pointed out, the modern body was not the result of the developments only in medicine; indeed, this was a much wider process, influenced by economics, politics, and the individualism of the growing bourgeois class. The body became a central place "in the self-image of the bourgeois classes", a powerful method of social classification, as Duden has stressed.[251]

The historian Michael Sappol has pointed out that the nineteenth-century narrative of the body was based on the struggle between "civilization and savagery, mind and body, reason and superstition, morality and brutality".[252] The fifth struggle was between filth/contagious and cleanliness/purity/hygiene. It is easy to agree with the medical historian Bruce Haley, who has argued that in the nineteenth century, people were obsessed by health and were conscious of their bodies, which also defined their relationship with their environment. The Victorians – if only they could afford it – travelled to the seaside to take care of their health, they took pills and potions, and constantly discussed the various symptoms and sensations felt and experienced in their bodies.[253] This ongoing worry about health – or the lack of it – was not exaggerated in vain; the Victorians had their good reasons to be worried about contagious diseases, such as cholera, raging in the 1830s and 1840s, tuberculosis, which was the deadliest disease in the nineteenth century, and epidemics of influenza, typhus, and typhoid, killing hundreds of thousands of people.[254]

Doctors have had their specific role as both advisers and healers of the body. In practical medical work – at least since the nineteenth century – the doctor has had unique access to the body; the doctor has a legitimate right to examine and

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249 Porter 2002, 235. See also Duden 1991, 106–112. On the body, see also Lupton 1996b, 21–22, 56–57.

250 Foucault 2005, 152–180; Duden 1991, 3–4. On eighteenth-century perceptions of the body, see Duden 1991, 106–112. On surgery and the body, see Schlich 2018, 5–6.

251 Duden 1991, 4–5, 13, 16.

252 Sappol 2014, 9–10. Sappol discussed the British military history and "a civilizing mission in the nineteenth century" but the idea was the very same in medicine.

253 Haley 1978, 3, 6, 8, 18–23. For example, the biographer of Queen Victoria, Elizabeth Longford made a comparison between her own age – the 1960s – and the Victorian Era and noted that if her contemporaries were interested in sex, their predecessors constantly discussed death, which can be seen as one aspect of health. Longford 1964, 310–311.

254 See for example Haley 1978, 6–8. See also Bashford 1998, 3–8; Bashford 2014, 59–80; Bynum 1996, 73–87.

touch the patient's body, even the most intimate parts of it.[255] Michel Foucault has discussed how around the eighteenth century, doctors became experts and advisers on the body, "if not in the art of governing, at least in the art of observing, correcting and improvising the social 'body' and in maintaining it in a continuous state of health."[256] For Foucault, the body was the site of control, surveillance, monitoring, regulation, and disciplinary power.[257] Doctors' mission was to teach about the fundamental rules of hygiene of the body and mind, the *non-naturals*, including healthy dress, exercise, cleanliness, air and ventilation, diet, and rest/sleep. In popular manuals, the discourses of self-control, proper behaviour, decency, and cleanliness/hygiene were indeed very visible. This demonstrated that the nineteenth-century medical profession very much relied on the old Roman saying "Mens sana in corpore sano", combining health with happiness and keeping the individual person healthy and well-balanced through moderation, the right kind of diet, exercise and fresh air, an appropriate portion of rest and daily activities, hygiene, and a steady, sound mind.[258] As the doctor Jane H. Walker wrote in her popular health manual at the end of the nineteenth century: "[t]he body should be considered as an instrument to be kept in order."[259] Moreover, the body was also a "temple of the soul", to be treated with "respect and reverence", as another nineteenth-century doctor Gordon Stables described in his manual in 1894.[260]

In medicine, the body can be the clean or contaminating body, the sick or healthy body, the disciplined or unruly body, the fat or thin body, the living or dead body – obviously, these categories are not fixed or oppositional.[261] Considering this study, what is more interesting, is that the body is often gendered; in medical history, the specifically reproductive body has been a female one with its distinguishing features compared to the male body, which has often been considered the norm and the standard of "normal" and "ability". Indeed, until recent decades, the male body has been scrutinised in medical history comparatively rarely – unless intertwined together with social class, whereas women's bodies have been "the stuff of history", as Mary E. Fissell has pointed out.[262] This argument can be understood in different ways, but Fissell has noted that the female reproductive body, which has the power to produce new life, is a powerful symbol, especially when gender relations are being analysed in history. The ideas of

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255 See for example Lupton 1996a, 165.
256 Foucault 2014, 121. See also Duden 1991, 9, 13–15. See also Lupton 1996b, 23–24.
257 Foucault 2000, 39–40, 185–190; Foucault 2014, 120–121. See also Lupton 1996b, 23, 30–32.
258 Porter 1985, 193; Porter & Porter 1988, 43; Smith 2007, 120. See also Foucault 2014, 118–120; Goubert 1987, 52–54; Haley 1978, 19–22; Duden 1991, 14–15; Storey 2020, 293–294.
259 Walker 1893, 6. See also Sappol 2014, 5.
260 Stables 1894, 52.
261 Lupton 1996b, 20.
262 Fissell 2006b, 1. See also Porter 1991, 220–221. See also Canning 2006, 115–116; Levine-Clark 2004, 5. See about the female body in art and representations of dissections using the female corpse in Jordanova 1989, 98–110. See also Lupton 1999, 60.

women's reproductive bodies have been the "maps of gender relations".[263] As Fissell has noted, the maternal body can be seen as a microcosm of relations between genders, revealing social, cultural, political, and economic discourses, practices, and ideals.[264]

In 21st-century neo-liberal societies, the pregnant body has been surrounded by "a complex network of discourses and practices directed at the surveillance and regulation", concerning both the maternal body and the wellbeing of the foetus, as for example Deborah Lupton has pointed out.[265] Women's reproductive bodies could be seen both as the objects and subjects of control and surveillance. These webs of Foucauldian discourses of discipline, normalisation, and the constant demand to take care of oneself, have a long history; for example, the gender scholar Rebecca Kukla has argued that in the late eighteenth century bodies, especially mothers' bodies, become "peculiarly public"; this kind of discourse was strengthened during the nineteenth and twentieth centuries. Kukla herself has devised two imaginary mother figures, the "fetish mother" and the "unruly mother". The fetish mother has been portrayed as a perfect and uninterrupted whole, an ideal, who is experiencing her motherhood in harmony with her foetus/child. Her maternal body is well-ordered and "natural", and thus, must be protected from unnecessary and "unnatural" medical interventions.[266] The unruly mother, on the other hand, must be regulated and controlled, because she is inclined to volatility, fragility, hysteria, and every kind of dependency, "with a little resistance against temptation, craving, and the extremities of passion".[267] As Kukla has noted, the fetish mother is "a romantic idealized, character", while the unruly mother is "an object of distrust and disdain", and hence, always potentially dangerous and contaminating.[268] The historian Tania McIntosh has used the much simpler terms of "good mothers" and "bad mothers"; good mothers were dedicated to motherhood and followed advice and instructions they were given, bad mothers were ignorant and feckless, constituting a danger, not only to themselves and their children, but also to the whole race and nation.[269]

These models – even they are expressed in fictional binary categories – are based on the idea that the maternal body is "responsible for the production of human and social nature, properly governed by normative laws of nature, and easily corrupted and interrupted", as noted by Rebecca Kukla.[270] As Michel Foucault and Barbara Duden have argued, since the eighteenth century, it was no longer sufficient that the body was only productive – it needed to be controlled and dominated, disciplined and arranged in hierarchical orders.[271] According to medico-cultural ideals, the body was intended to be healthy and strong but in

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263 Fissell 2006b, 13. See also Duden 1991, 8–12; Schiebinger 2004a, 38. See also Burnham 2005, 47–50, 52.
264 Fissell 2006b, 156, 195; See also Canning 2006, 170–189; Butler 2008, 219–223.
265 Lupton 1999, 59; see also pp. 60–61.
266 Kukla 2005, 82–83. See also Lupton 1999.
267 Kukla 2005, 83–84.
268 Kukla 83–85.
269 McIntosh 2012, 14. See also Lupton 1999, 78, 81–82. See also Skeggs 1997, 41–48.
270 Kukla 2005, 85. See also Gowing 2003, 5.
271 Duden 1991, 9–15; Foucault 2000, 39–43, 185–190. See also Lupton 1996b, 30–32.

medical discourse, the body was always potentially and very likely to be fragile, unreliable, contagious, and contaminating, that is to say, attracted to diseases. As the historian Lesley Hall has pointed out, this has been the case also when the male body was discussed in nineteenth-century medicine; the male body was negatively associated with venereal diseases, meaning syphilis or gonorrhea, especially amongst specifically defined social groups, such as soldiers and sailors. Masturbation was another major medico-moral vice inflaming panic in the nineteenth-century world. [272]

This mysterious connection between the body, mind, and health was especially significant during the reproductive period when the woman, as a mother, was a microcosm in one person and a key aspect in the future of the whole nation. In childbirth, the attention was focused on the female body because the woman's body was the very place of the reproduction process: the conception took place hidden inside the female body, the foetus developed in the uterus, and in the final phase of pregnancy, the same body brought forth the child to the outside world. Barbara Duden has pointed out how the power of life and death was embodied by all women "in their capacity as 'the vessels of life and death'", particularly by the "ambiguity of their womb". [273] In this sense, the reproductional/pregnant/maternal body was constantly changing; some of the bodily signs of pregnancy were more visible for everyone to see, some were recognised only by an experienced "medical gaze", as a combination of sight, touch and the sense of hearing and smell, and some were individually experienced only by the women themselves. Moreover, some of the signs were more mental, noticeable in changing moods recognised by the mother-to-be herself and her closest circle.

In the nineteenth-century world, considering the mind–body relationship, pregnancy was, confusingly enough, not always something concrete, what the woman actually *did*, as it was also about what she *was* – biologically, physiologically, and almost mechanically.[274] Indeed, it is crucial to understand that nineteenth-century doctors stressed that the pregnant woman in fact was already a *mother*, from the moment of conception and during the whole period of pregnancy. The historian Judith Lewis has argued that many nineteenth-century manuals ignored "biological reality" and suggested that motherhood began only after the child was born.[275] Medical manuals studied in this research, however, do not support this argument. In fact, I argue that the main title of this research study, a quotation taken from the health manual *Confidential Talks with Husband and Wife* (1900) by the medical author Lyman B. Sperry, "the health and happiness of the expectant mother" can be seen as the key concept in nineteenth-century medical advice concerning pregnancy and childbirth. In nineteenth-century thinking, a woman who was pregnant was already a *mother*, as the expression "expectant

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272 Hall 2018, 159–176.

273 Duden 1991, 8. On the changing discourse of the womb in early modern medicine, see Fissell 2006b, 53–89. See also Lupton 1999, 59–61.

274 See Boddice 2019, 88. The historian Rob Boddice has argued that "the affective character of human experience depends, essentially, on what a human *does*, and what a human does is dependent in turn on what a human *is*."

275 Lewis 1986, 73.

mother" suggests.[276] "Health and happiness" is of course a popular phrase, but in this study "health" is understood as the physical healthiness or wholeness of the body, and "happiness" as good mental health – combining these two indispensable aspects, the body and mind together. Health was always a desired state of the body and a foundation of good life; happiness was a steady state of mind and moderation, uncorrupted by fear and other undesired emotions.[277]

Hence, also emotions are an indispensable element in the nineteenth-century perceptions of childbirth. Traditionally, the body has been considered inferior to the mind; this binary hierarchy has underlined the body as ambiguous, weak, fragile, unstable, polluted, and liable to get sick. The mind, on the other hand, has been associated with self or soul, the immaterial essence of a person, regarded in religious systems as immortal or eternal, unlike the physical, decaying body. However, mind and body have had a complex, culture-dependent relationship; they are closely related and dependent on each other, but "the territories" of mind and body have never been fixed or permanent, as Roy Porter has noted.[278] Emotions are neither purely bodily nor merely mental: generally, the concept of "emotion" has no clear or single meaning; historically, it is close to "affections" and "passions", but here "emotion", loosely defined, means a mental feeling connected with physical or bodily movements as they began to be understood in the nineteenth century.[279]

As the medical historian Fay Bound Alberti has pointed out, emotions are physical and lived experiences, felt in the body, but they are also "learned and behavioral systems, revealed through gestures, posture, and a series of display codes".[280] Indeed, emotions are, as the historian Rob Boddice has noted, central to experiences, the "effects of historical circumstances and a cause of their change"; emotions are always historical, not universally shared or understood without the cultural context and language within which they were felt, expressed,

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276 The title of this research is the quotation taken from the health manual *Confidential Talks with Husband and Wife* (1900), see p. 186: "The treatment a pregnant woman receives from her husband and other members of the family during the entire period of gestation is a matter of supreme importance, for it not only determines in a large measure *the health and happiness of the expectant mother*, but also that of the anticipated child." [Italic mine.] See also Conquest 1849, ix–x.

277 On the meaning of health, see for example Porter & Porter 1988, 21–38. See also Porter 1985, 192: "[h]ealth is the backbone of social history, and affliction the *fons et origo* of all history of medicine". See also Duden 1991, 142–147. On emotions in nineteenth-century texts, see for example Stables 1894, 32–35. On happiness, see Boddice 2019, 43–46, 174–187.

278 Porter 1991, 224, see also pp. 206–208, 212–213, 215. See also Porter 2002, 245–246. Jordanova 1989, 26–28; Alberti 2006, 4–7. On the body in medicine, see also Lupton 1996b, 20–49, 86–87.

279 On the history of the concept of "emotion", see especially Dixon 2012; Dixon 2006, 24–27. According to the historian Thomas Dixon, the word "emotion" was derived from the French *émotion*; in the nineteenth century, it became a theoretical category in mental science, replacing "passions" and "affections". For example, the English physician Charles Bell argued that "emotions" were certain changes or affections of the state of mind, which could be seen in the body, in bodily movements for example. See also Duden 1991, 142–149; Alberti 2006, 4–16.

280 Alberti 2006a, xvii.

experienced, and also controlled.[281] When reading nineteenth-century medical manuals and medical journals, it becomes very clear that emotions were constantly present in the advice and instructions given; how emotions, most of all fear, affected the physical and mental well-being of the pregnant or parturient woman but also how doctors described their own emotions in practical medical work. Emotions could be both harmful and beneficial; fear was generally considered negative but for example, hope was seen as indispensable in medicine and healing.[282] Hence, in this study, I also analyse the meaning of the emotions in nineteenth-century medicine and demonstrate how the emotions were discussed especially in relation to pregnancy and childbirth.

Indeed, nineteenth-century medicine was constantly re-evaluating and redefining the lines between the female/maternal body and mind; on the other hand, it was a question of the physical entity and well-being of the female body but also of the complex relationship between the pregnant woman and the foetus developing inside of her body. These boundaries of separateness and dependency have never existed merely biologically; they have been constituted and constructed within the ideals, norms, and practices of each culture and, in this sense, particularly the roles of religion and ontological systems have been significant. Considering this study, this was especially apparent when medical ethics, the doctor's responsibility, as well as intentionally induced abortions were discussed both in medical periodicals and popular health manuals. Abortions are analysed in relation to an obstetrical operation called *craniotomy*, which in all but name was a termination of pregnancy in obstructed labour. Many accounts demonstrate that craniotomy – even when preformed for justified reasons, that is to say, to save the mother's life – was a difficult medico-moral question for many nineteenth-century doctors.

Considering the pregnant woman–foetus relationship and advice given to women for preparing their bodies and minds for pregnancy, I have been particularly interested in the theory of *maternal impressions*, or *maternal marks*, which troubled doctors' minds throughout the whole nineteenth century, even if many previous studies have claimed that this theory had been discarded in medicine around the late eighteenth century. The controversial theory of *maternal impressions* was used to explain some of the physical deformities or birthmarks seen on a newborn child. *Maternal impressions* was a pregnancy-related phenomenon; according to the theory, deformities were developed in tandem with the maternal mind, imagination, strong emotions, and various experiences (frights, dreams, cravings etc.). The theory and its resilience reveal that new ideas did not spread evenly in nineteenth-century obstetrical medicine. Moreover, the popularity of the theory proves that the idea of prevention concerned also the maternal mind, just the body.[283]

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281 Boddice 2018, 18. See also Alberti 2006a, xiv–xvii. See also Dixon 2006.
282 See for example Dixon 2006, 32–34.
283 See Chapter 4.3.

Language of Labour

While many midwifery practices and some of the dynamics in the doctor–patient relationship have changed since the nineteenth century, the language of labour occupied doctors' minds also in nineteenth-century obstetrics; how to communicate with the female patients in vis-à-vis encounters, how to write to lay women in an understandable manner in popular health manuals, and what kinds of terms and expressions were employed in peer communication when doctors sent their letters and notifications to the *BMJ*. The language of labour includes the question of which concepts and words have been considered correct, appropriate, informative, normative, or unsuitable by doctors discussing childbirth in the current practices and by various scholars investigating the historical settings. As the blog post published in the *BMJ* in 2018 demonstrates, in current practices, the language used – including the verbs – is essential to "effectively communicate options, recommendations, and respectfully accept the woman's fully informed decision" in childbirth.[284] Much attention has been paid especially to the parturient woman's agency, autonomy, and subjectivity in labour; at worst, language can objectify the woman and see her only as some kind of human container and biological mechanism "for producing a baby".[285]

Indeed, as noted in the previous chapter, language creates and maintains power relations and agencies also in medicine. However, language and its meanings change, as the *BMJ* described in 1891, "language, like trees, being in constant process of growth and increase".[286] As an example – at end of the nineteenth century, the obstetrical use of the verb "to confine" was found difficult and confusing, due to its various meanings in everyday language. According to the *BMJ*, at the beginning of the nineteenth century confinement had meant "confinement to the patient's room by ordinary illness", not necessary solely by giving birth.[287] In 1891, one subscriber had made an enquiry about the obstetrical vocabulary, suspecting that the use of "confine" was not correct: "is there any justification for this use of 'confine' as applied to the doctor? Surely the child is the confining cause, and Nature, doctor, and midwife are the releasing agents."[288] The accurate verb, according to the writer, was "deliver". The *BMJ* replied that the noun "confinement" and the verb "to confine" had been used since the late eighteenth century; "as the 'accouchement' [labour] 'confines' the patient to her room, the doctor who attends her may in like euphemism be said 'to confine' her, that is, he is the active cause + Nature of her delivery, which modern delicacy preferred to

284 Mobbs, Williams & Weeks 2018. See also Lupton 1996a, 159–161.
285 Mobbs, Williams & Weeks 2018.
286 Adherent Membranes and the Queen's English. The *BMJ*, May 16, 1891, 1110.
287 Adherent Membranes and the Queen's English. The *BMJ*, May 16, 1891, 1110. According to the historian Judith Lewis, the verb *confined* (associated with childbirth) first appeared in the 1770s, and its popularity grew while the expression *lay-in* and *brought to bed* gradually became archaisms. The word *confinement* was a relatively modern term, dated around the 1770s. Lewis 1986, 288–289. On definitions and terms of foetal mortality and stillbirth, see also Woods 2009, 14–35. See also Gélis 1991, 142–143.
288 Adherent Membranes and the Queen's English. The *BMJ*, May 16, 1891, 1110.

call her 'confinement'".[289] Interestingly, the journal also noted that the verb "confine" was in turn becoming indelicate.[290] Indeed, as the 2018 blog post in the *BMJ* pointed out, the language of labour "signals the nature of the relationship" between the parturient and medical attendant, and ultimately "can deny or respect a woman's "ownership" of her labour.[291] In the current language of labour "giving/gave birth" is considered better than "delivering"/"delivered", which is thought to take away the woman's own agency in childbirth; parcels and pizzas are delivered, not babies.[292] However, the historical contexts of the terms and concepts must be understood when discussing the nineteenth-century world and medicine.

In this study, when referring to the whole branch of medicine dealing with childbirth, I shall use the terms *midwifery* and *obstetrics* interchangeably. Irvine Loudon has pointed out that these two terms were used interchangeably in the past – in fact, these terms do not indicate who attended labours, midwives or doctors, or possibly both.[293] Another term for obstetrics was *tokology*, but it was rarely used in nineteenth-century Britain. The historian Judith Lewis has pointed out that the English upper class adapted French euphemisms particularly in the late eighteenth century; expressions like *enceinte* and *accoucheur* replaced more or less traditional English words for "being with child" and a "man-midwife". Lewis has noted that this new kind of obstetrical vocabulary, often based on French euphemisms, substituted common words for pregnancy and childbirth, such as "breeding" and "with child", which in return, became archaic. Popular French terms and words, such as *enceinte* ('pregnant', 'expecting', 'expectant'), *accouchement* ('childbirth', 'midwifing'), and *accoucheur* ('male doctor', 'man-midwife', 'obstetrician') were adopted in the English language during the eighteenth and early nineteenth century.[294] The language of pregnancy among the middle and upper classes was influenced by "politeness, sensibility and changing notions of modesty", as the historian Joanne Begiato has pointed out.[295] These spe-

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289 Adherent Membranes and the Queen's English. The *BMJ*, May 16, 1891, 1110. See also Martin 1989, 57–67. On medical language in the eighteenth century, see Lawrence 1995, 215–216.

290 Adherent Membranes and the Queen's English. The *BMJ*, May 16, 1891, 1110. As the journal noted, since the eighteenth century, there had been "that tendency to euphemism in the matters supposed to be indecent or indelicate, which characterizes our modern womanhood."

291 Mobbs, Williams & Weeks 2018.

292 See for example Astrup 2018; Mobbs, Williams & Weeks 2018.

293 Loudon 1997, 1051. See etymology explained in the 1840s, Swayne, J. G., Introductory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 21, 1846, 498. Compare to Caton 1999, 86.

294 Lewis 1986, 72. See also Cody 2008, 3–4; Wilson 1995, 175; Fissell 2017, 117–121. This was noticed also by the *BMJ*, see Adherent Membranes and the Queen's English. The *BMJ*, May 16, 1891, 1110. The term *enceinte* and its etymology was often examined in nineteenth-century medicine; see for example Chavasse 1866, 45; Stables 1894, 176–177, 179. See also Tanner 1871, 48. See also Chapter 4.2.

295 Begiato 2017, 15. See also Gillis 1996, 162, 166–167; on the language related to nineteenth-century family life, see also in Gillis 1996, 74–76. The historian John R. Gillis has claimed that this new language "reinforced the notion of the mother as an object to forces beyond her control". Gillis also noted that terms like "in the family way",

cial conceptions and changing discourses reveal the professionalisation and specialisation of the medical profession: adapting new tactful, decent, and sensitive language, the (male) medical profession was able to advertise their services to their female patients and to assert that they were capable of dealing with every aspect of the reproduction process in the manner that was understandable and appealing for their potential patients and their circles.[296] No doubt, the special vocabulary also maintained the sense of professional integrity.

In the nineteenth-century texts analysed in this study, a medical professional or a doctor who specialised in childbirth, was called either a *man-midwife*, *accoucheur*, or *obstetrician* – sometimes *he* was simply referred as a *doctor, physician, medical attendant,* or a *medical man*. In medical periodicals, the most often used term was an *accoucheur*; in the popular health manuals, the title of the doctor specialised in childbirth varied more.[297] In any case, as I discuss in this study, the prototype of the nineteenth century doctor was nearly always male; nineteenth-century medical terminology and concepts revealed that the field of midwifery had changed within the previous century and male dominance in academic midwifery had already been established at the time when my study begins in the 1840s.

As many historians have emphasised, until the seventeenth century, no word existed for a male birth attendant – not in English nor any other language.[298] The old term *midwife* refers to the words "with-woman", *mid* and *wife*.[299] The word *man-midwife* was derived, of course, from the traditional term *midwife,* with a direct reference to the gender of the attendant, presented in terms of the already established female system.[300] However, the brand new term, *obstetrician,* for the male attendant, was a creation of the early nineteenth century, based on the old Latin word for midwife, "obstetrix", literally meaning "a woman who stands before".[301] In the 1820s, the British physician and medical author Michael Ryan had

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"expecting", and "in a delicate condition" became popular. The last mentioned, however, was rarely used in the medical texts studied in this research. On the changing language of medicine, see also Lawrence 1995, 212–220.

296 See Chapters 3.2 and 3.3.

297 *Doctor*, or *physician* was a "holder of a doctor's degree from some university, and the title of doctor belongs exclusively to him", as the popular medical dictionary *Doctor at Home* explained the medical title in 1891. See *Doctor at Home* 1891, 618. According to Irvine Loudon, the term "general practitioner" was first used (in the modern sense) around the early nineteenth century. It came into everyday language in the second half of the nineteenth century, after the enactment of the 1858 *Medical Act*. See Loudon 1999, 1. See also Chapter 3.2. The titles were also explained for example in Ballantyne 1889, 13.

298 Donnison 1999, 11, 23. See also Cody 2008, 41; Wilson 1995, 164–165.

299 Borsay & Hunter 2012, 2; Whaley 2011, 91. Adrian Wilson has argued that one possible term for the man-midwife had been "midman". Wilson 1995, 112.

300 According to Lisa Cody, the word *man-midwife* made its first "metaphorical" appearance in 1625 and a year later, it was used to describe an actual medical attendant. Cody 2008, 41. The famous nineteenth-century surgeon Anthony Carlisle misattributed the origin of the word claiming that it was derived from two Saxon words *mead*, a reward, and *wife*, "from the fact that the midwife was the person who received the present or reward for assisting at a delivery, and attending upon her sister woman". Calisle quoted in *The Accoucheuse versus the Accoucheur* 1864 [?], 19–20. See also Schiebinger 1991, 106–108.

301 Donnison 1999, 11–12. See also for example Thomas 1891, 459; Foster 1892, 2433.

proposed the term *obstetrician*, "in place of man-midwife, midwifer, and accoucheur, and physician-accoucheur", and, according to Ryan himself, he also introduced the term *obstetricy* (*ars obstetricia*).[302] It is impossible to verify if this really was the case, but in any case, the terms "obstetricians" and "obstetrics" became more common during the nineteenth century and they were often found in the primary sources analysed here in my study.

2.2 Primary Sources

2.2.1 Advice to a Young Wife: Popular Medical Guidebook Literature

The most important collection of primary sources in this research are the popular medical guidebooks and health manuals written by the nineteenth-century medical profession: general practitioners, physicians, obstetricians, and surgeons, who had received medical degree in British medical schools or elsewhere in Europe; especially for women, medical training and degrees were often easier to obtain elsewhere than in Britain.[303] The term "popular" itself is ambiguous and to be used cautiously, but here I do mean that these books were not aimed at medical peers, but at the much larger audience who were literate and maybe had some practical experience of childbirth, but no formal medical education. In this sense, the distinction between the medical writer and the lay reader, always a potential patient, was clear and it was constantly emphasised within the genre.[304] According to the scholar Pamela K. Gilbert, "popular" can be understood as "beliefs and practices widely shared across the social spectrum and promulgated in publications and activities".[305] However, this definition does not pay attention to the hierarchal system between the writers and their audience. Writers' authority,

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302 Ryan 1841, 3. By doing this Ryan had included diseases of women and new-born infants under one science and art by emphasising that midwifery and obstetrics included "the anatomy, physiology, pathology, and therapeutics peculiar to women, together with the science of reproduction, its phenomena, its consequences, parturition, puerperal, and infantile diseases." See also Swayne, J. G., Introductory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 21, 1846, 497.

303 See for example Bynum 1996, 206–208; Digby 1999, 156; Watts 2007, 128. When selecting popular manuals for this study, I have trusted the information the writers gave about themselves in their writings. The title page is usually very informative; it contained the titles and professional and educational affiliations of the writers, possibly some references to their current post and memberships of medical societies. The general idea was to promote their professional competence and reliability. On the terms "manual", "guide", and "handbook", see Seigel 2014, 30–31.

304 See Wear 1992, 17–19. See also Fissell 1992, 72; Jordanova 1999, 103, 105; Jacyna 1992, 252; Gevitz 1992, 240. See example in the manual of Henry Thomas Scott: "medical books and prescriptions, except in the hands of professional men, are usually misapplied, and become mischievous, and even dangerous [--] The greatest care will be taken not to enter upon or treat any subject beyond which the capacity of a person entirely unacquainted with medicine can readily follow and thoroughly comprehend". Scott 1870 [?], 1, 3–4.

305 Gilbert 2014, 127.

dominance, and deference were always manifested in popular literature; the idea constructed within the genre was that the authors knew best and they had all the medical knowledge, traditions, and practical knowhow on their side, whereas the implied readers clearly did not have access to these indispensable qualities and qualifications.[306]

Professional midwifery literature, written by male physicians and man-midwives for their peers and female midwives, had already a long tradition in Britain. The first midwifery book published in English, *The Byrth of Mankynd* from the sixteenth century, was a translated version of the texts of Soranus, a Greek physician living around the year 100 of the Common Era.[307] The first original English work on midwifery was written by William Harvey (1578–1657), the first doctor also to explain the human circulatory system, whose manual *De Generatione Animalium* was first written in Latin and then translated into English in 1653.[308] Since Harvey, who sometimes was referred as "the father of English Midwifery", physicians, surgeons, and midwives (both female and man-midwives) had growing access to information found in numerous professional manuals published in English.[309] Improving technologies and infrastructure and new ideas of education and learning gradually changed print culture in Europe in the sixteenth century and onwards; books, including medical literature, were slowly becoming cheaper and available to the new audiences.[310]

The tradition of popular advice books and manuals is also long, despite their publication always having been connected to the general development of printing and literacy.[311] Historians, like Marsha Urban, Roy Porter, and Mary E. Fissell, have demonstrated that in early modern England, around the seventeenth century and onwards, there was a considerable increase in books, pamphlets, newspapers, and almanacs published for lay readers in English. Even if seventeenth- and eighteenth-century books on parenting were mainly directed to men rather than women, some of the advice and conduct manuals were written specifically for women; the topics covered themes on marriage and motherhood, including domestic life, cooking, recipes and household remedies, children's moral and religious upbringing, and wider social and ethical duties of an individual.

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306 Jacyna 1992, 252. See also Lupton 1999, 61–62.

307 Towler & Bramall 1986, 45–47. See also Gowing 2003, 17–20; Evenden 2000, 6–7; Donnison 1999, 20–21. On English vernacular medical texts, see Wear 2000, 40–45.

308 Towler & Bramall 1986, 71–72; Riddle 1997, 160–162; Harrison 2004, 31–32. See also Aveling 1872, 35–37.

309 See Cody 1999, 485–486. According to Lisa Cody, between 1671 and 1798, only six British women wrote midwifery manuals, while dozens of male authors produced more than two-hundred texts during the same period. See also Gowing 2003, 111–112; Kukla 2005, Evenden 2000, 7–13; 77–80; Keller 2003, 64–68; King 1995, 184–194; King 2007, 1–8; Hobby 1999, xvi–xx. On medical texts, see King 2007, 42–52; Donnison 1999, 28–29.

310 See for example Briggs & Burke 2016; Porter 2001, 26–27; Smith 2002, 250–253.

311 Urban 2006. 36. At the beginning of the eighteenth century, the literacy of the lower classes was below 50 per cent, while the gentry and peerage was universally more literate. Ibid. See also Branca 1975, 11–17; Porter 1992a, 2–10; Lane 2001, 23–24; Towler & Bramall 1986, 64–71; Porter 1985, 183; Porter & Porter 1989, 197–201; Smith 2002, 250–251; Jordanova 1999, 104; Gowing 2003, 10; Read 2013, 9–10.

From the seventeenth century onwards, women became also "a subject *in* discourse by publishing their own advice books" for women, as Marsha Urban has pointed out.[312]

As Roy Porter has illustrated, popularisation has always been a historically significant part of medical enterprise.[313] Vis-à-vis consultations with patients and calls were, of course, an indispensable part of practical medical work, but through their literary work, doctors could also reach out to those women they might otherwise not meet in real life, or if they did, their encounter took place unexpectedly, usually in a case of emergency. In fact, early modern medicine had been notably literary; for example, Barbara Duden has shown that in eighteenth-century Germany, it was very common that doctors and their patients did not meet face to face; rather, their relationship was based on communication via letters, reports, and various requests.[314]

Popular manuals were a perfect way to promote and advertise the work and professional competence of their writers, meaning here the university-trained medical practitioners. A book could never substitute for the presence of a doctor but manuals presented the necessary information in a compact and easily understood form while inculcating self-reliance in their readers. Indeed, manuals were a perfect attempt to disseminate knowledge and practices for lay people, embodying the "ideals of Enlightenment of human progress and popular education", as the medical historian Guenter B. Risse has discussed.[315] In broader terms, guidebooks can be understood as a part of the 'civilizing process', defined by the German sociologist Norbert Elias, as the existing technology, type of manners, scientific knowledge, and religious ideas and customs, understood as a certain cultural self-consciousness and a manifestation of reformist ideas. In this sense, ignorance and apathy could be seen as barbarism, conveniently presented as necessary motives for the educational writings.[316] In doctors' minds, they possessed correct information and understanding, which placed them in a highlighted position and gave them special authority over their readers, who, in return, were the target of the civilising and educational mission. However, this was by no means a one-way process, and moreover, doctors were protected by their own codes of honour, meaning especially controlled behaviour, decorum, compassion, and respectability. These qualities and ideals were well presented also

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312 Urban 2006 33–34. See also Fissell 2006b, 1–8; Fissell 2017, 118; Loux 1987, 88–89; Porter & Porter 1989, 197–201; Porter & Hall 1995, 33–36; Porter 1996, 106–107; Porter 2001, 26–27; Watts 2007, 46; Schiebinger 1991, 37–41. On women and print culture in the eighteenth century, see also Shevelow 1989, 1–21. The historian Ginnie Smith has noted that lay and what she called "semi-profession" works were often "slim, small, cheap, and of the earlier 'miscellaneous' (or almanac) format", whereas more professional writers wrote "longer, more heavily structured works, of higher price and larger size". Smith 2002, 263. For example, John R. Gillis has argued that seventeenth- and eighteenth-century books on parenting were mainly directed to men rather than women. Gillis 1996, 157.

313 Porter 1992a, 2. See also Stolberg 2004, 89–90.

314 Duden 1991, 81–83.

315 Risse 1996, 186. See also Porter 1992a, 4–5.

316 Elias 1978, 3–7, 36–40, 44–48. See also Porter 2001, 31.

in popular medical literature, as I discuss in the subsequent chapters of this research.

While printing became more widespread and the prices decreased, books became "instruments of utility", improvement, and education, as was pointed out by the historian Richard D. Altick.[317] The idea was, of course, that every reader was capable of understanding the content of each popular manual without specific education and professional capacity. David Harley, for example, has paid particular attention to the complexity of medical consultation and guidance: every healer, "from university graduates to village wise women, had to provide explanations that satisfied those who consulted them."[318] In the case of health manuals, this was achieved by language and writing, but Harley also noted that medical writing could be seen as a competition for the control of meaning "rather than as simply self-advertisement".[319] This is true, but I also argue that popular health manuals can also be seen as professional business cards of the medical profession. Manuals were a perfect way of creating a convincing and compelling picture of a competent professional who was able to handle his cases with both skill and tact. In their writings, doctors could address their message directly to their female readers using narratives shaped by "fiction, case histories, and reportage", as Ludmilla Jordanova has pointed out, while they could present their main competitors, midwives, in a less positive and unflattering light.[320] Especially the narrative of an ignorant nurse/midwife was a continual discourse in nineteenth-century British medical literature, clearly serving the purposes of the (male) medical profession.

The nineteenth century was a time of a mass reading; cheap printed matter, such as books and periodicals, became more accessible, especially for the members of the growing middle class but also for working-class readers. Printed products became cheaper and better distributed, thanks especially to the expanding railway network and public libraries. People had more leisure time and money to spend on books, and the general circumstances of reading at home were gradually improved by artificial lightning and the rising standards of living.[321] It was books for the masses; people could choose from a wide range of household manuals, marriage guides, and a wide range of women's and men's magazines, guiding people on how to dress themselves, how to raise their children, how to medicate themselves, how to choose a suitable husband or wife, and how to conduct themselves and be courteous in society. Popular manuals like Isabella Beeton's (1836–1865) *The Book of Household Management,* first printed in 1861, were hugely popular, containing food recipes, practical tips on "the arts of Cooking, Baking, Brewing, Washing, and Ironing", hosting guests, arranging a nursery, and home

317 Altick 1967, 26; see also Briggs & Burke 2016.
318 Harley 1999, 414.
319 Harley 1999, 414–415.
320 Jordanova 1999, 116. See also Risse 1996, 188; Jacyna 1992, 263.
321 See for example Altick 1967; Briggs & Burke 2016, 94–98, 105–112, 116–120. See also Gilbert 2014, 126–127.

doctoring.[322] Richard D. Altick has discussed "the spirit of self-improvement", meaning the need for diversion, the desire to keep up with the events of the "fast-changing world", an opportunity for self-expression, and new chances in life.[323] Self-cultivation and learning were indeed greatly valued in nineteenth-century society.

I would like to point out that in this research I do not discuss those manuals written by non-medical lay people whose expertise lay elsewhere than in the medical matters of childbirth.[324] However, it is crucial to acknowledge that in the nineteenth-century medical market, the distinction between regulars and irregulars was sometimes blurred and women also sought help from quack and alternative medicine, traditional home doctoring, and family recipe books, just like people had done in the previous centuries.[325] The culture of self-help was dominant in the nineteenth century, and moreover, in working-class communities, the role of a *handywomen*, a *wise woman,* or a *bona fine* midwife was especially important. An untrained wisewoman provided health advice and practical help, being an indisputable and trusted member of the local community, unlike medical men who were usually called for in cases of emergency only.[326] As the medical historian Lucinda McRay Beier has pointed out, in working-class people's lives the presence of the doctor was "rare and anything but routine".[327] In medical matters, women also consulted each other; this fact was well known by the medical profession, as I will discuss in this research. In the medical discourse, however, female peer support was often found to be both dangerous and inadequate, liable to create false beliefs and needless worries, qualities doctors were so fiercely trying to fight against.

Roy Porter has listed the four "essentials" for the existence of the genre of popular medical literature; first, there must exist authorised regular medicine;

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322 The quotation taken from Warren 1865, iv. Mrs. Beeton's surprisingly detailed book contained advice also on motherhood and wet nursing. See Beeton 1861, 1020–1060. See also Branca 1975, 12–13. See also Sweet 2001, 107–119.

323 Altick 1967, 97–98, 240–259. See also Vicinus 1985, 4.

324 A good example is Mrs. Warren's manual *How I Managed My Children from Infancy to Marriage* (1865). In her book, Mrs. Warren described her own family life in detail while she was giving her practical advice on the diet, medicine, and education of children. She clearly was well acquainted with the medical ideals of her time and followed medical discourses in her writings. See for example Warren 1865, 31.

325 See on Isabella Beeton in Branca 1975, 16–17. See the nineteenth-century disapproval of informal health experts in Scott 1870 [?], 2. See also Porter 1992a, 1; Wear 1992, 17–19; Porter 1985, 188, 190; Porter 1996, 97; Wear 1987, 244–245; Porter & Porter 1989, 34–52, 89–114; Duden 1991, 74–78; Wear 2000, 49–67. See also Digby 1994, 62–68; Foucault 2014, 118–119; Porter 2001, 152–153; Holloway 1998, 77–83. On women, home doctoring, and recipes, see also Watts 2007, 46–47; Whaley 2011, 150–173. On "alternative" or "orthodox medicine", see Bradley 2000, 19–20, 31–34.

326 Beier 2008, 9, 35–87; Moore 2013, 703–713; Wear 1992, 17–19; Ross 1993, 176. As Lucinda McRay Beier has noticed, informal health experts were trusted more because they understood the financial and living circumstances of their peers, unlike formally qualified doctors. This was also very much a financial question; an amateur expert was much cheaper than a professional doctor or trained midwife. See also Chapter 3.2.

327 Beier 2008, 35.

secondly, there are doctors who spread it; thirdly, books are "a medium of diffusion", and lastly, there must be a literate audience.[328] In nineteenth-century Britain, doctors' professional expertise in the reproductional process had already been largely accepted in society.[329] As the historian Marjorie Levine-Clark has argued, managing female health "meant persuading women of the necessity of a (male) physician's supervision".[330] This idea was shared by the historian Sheena Sommers, who has noted that in their writings, male practitioners "quite successfully presented themselves as the necessary intermediaries between women's bodies and reproductive knowledge".[331] Sommers has also argued that medical writings were primarily a discourse between men and only secondarily, a discourse on women.[332] Thus, it was more than presumable that the (male) medical profession published their popular manuals on midwifery, spreading their understanding of childbirth, sharing advice, and promoting their work and professional competence in obstetrics also among their potential lay readers.

The gender scholar Rebecca Kukla has divided the genre of medical guides into two kinds of texts; first, there are professional medical textbooks, apparently "dry, value-free, and objective" (which they obviously are not, as Emily Martin, for example, has shown), and secondly, "chatty" guidebooks for young women and mothers, discussing various issues of womanhood and motherhood.[333] The titles of the popular health manuals examined in this research reveal that the target audience consisted of lay women, usually younger ones planning to marry or already married, often with small children; for example, "a guide for women", "every mother's handbook", "married woman's adviser", or "a young wife's advice book". The book itself was "a medical friend", "a popular manual", "a guide", or "a handbook", consisting of "advice", "hints", or "letters" to its readers. Some of the authors emphasised that their books were, in fact, written for both "married and single" women, as everyone ought "to be fully aware of all that pertains to the married state", as one guidebook explained the matter.[334] However, there was an on-going renegotiation of what really was a necessary amount of information and how "chatty" these manuals were in reality. As will be shown later in this research, contraception as a general topic and practical

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328 Porter 1992a, 8. Between 1486 and 1604, a total of 153 medical titles were published in English, with 392 known editions. In 1604, there was approximately one advice book in use for every twenty people. In the eighteenth century, vernacular medical works were indeed "an expanding market". Smith 2002, 251.

329 I am aware that that there was not complete and absolute acceptance; pamphlets such as *The Accoucheuse Versus the Accoucheur* by "a London Physician" were published in the nineteenth century, criticising especially male obstetricians. As Ludmilla Jordanova has noted, attacks against man-midwifery were often literary; various printed matter, such as pamphlets, were written and made, promising to expose the abuse committed by man-midwives. Jordanova 1999, 14. See also Cody 2008, 204.

330 Levine-Clark 2004, 30; Jordanova 1989, 31.

331 Sommers 2011, 92. See also Mitchinson 1991, 58; Jordanova 1989, 31.

332 Sommers 2011, 92. See also Mangham & Depledge 2011, 3; Gélis 1991, 45.

333 Kukla 2005, 78–80. See also Porter 1992a, 9. One individual genre in popular advice manuals and periodicals was advice literature for girls, see for example Marland 2013. Hilary Marland has noted that the emergence of "healthy girlhood" coincided with the rise of female doctors in the late 1800s.

334 Surgeon & Accoucheur [anonym.] 1900–1909 [?], 153–154.

hints on birth control, for example, were not usually discussed in nineteenth-century popular health manuals; this topic was also missing from the medical periodicals.

It can be argued that the *implied reader* of these manuals, as the German literary scholar Wolfgang Iser has described the hypothetical reader to whom a text is addressed, was not in fact the pregnant woman herself. Rather, this person was placed somewhere between the pregnant/parturient woman and the doctor. The implied reader was a third person, like a friend or a husband, but this reader was never identified directly. S/he was someone who clearly understood medicine and medical practices even if more professional terms were often explained and the language was reportedly simplified.[335] Occasionally, the writers could address the reader directly, discussing also a hypothetical connection between the writer and reader, but this was a carefully chosen rhetorical device, used only in a handful of manuals.[336] This indirect approach style can be partly explained by the long literary traditions and conventions of the genre. No doubt, the general context also mattered: many nineteenth-century medical writers gave public lectures on sanitation, medicine, and the prevention of diseases, educating both smaller and larger audiences in societies and clubs, institutions, social gatherings, and other public places. These public lectures were also printed and distributed in journals, magazines, and pamphlets. Some of the manuals studied in this research were in fact the literary results of public lectures and discussions; one such example was *A Wife's Domain* (1860) by an anonymous author, which was based on the lectures delivered at a maternity hospital, aimed at working-class women.[337]

Why, then, were popular medical guidebooks, concentrating reproduction and motherhood, published and why was the whole genre so successful? This question is also discussed in Chapter 3.3, but as the historian Marsha Urban has argued, historically every stage of childbirth exposed women to discomfort, pain, and "the possibility of death" and these somewhat gloomy expectations explained why women sought guidance and advice from the medical profession, specialised in these questions.[338] According to the less dramatic explanation, pregnancy, childbirth, and motherhood constituted a significant part of the female life cycle and women were understandably interested in something that so essentially concerned their everyday life, their hopes and fears, and social and

335 See Iser 1978, 27, 34–38. As Iser has argued, the *implied reader* is a construct, a transcendental model and "in no way to be identified with any real reader". Iser discussed fiction but this same idea goes for health manuals – the hypothetical reader was always more or less imagined and idealised. See also Gevitz 1992, 240.

336 See especially the manual by Gordon Stables *The Wife's Guide to Health and Happiness* (1894).

337 See the Preface in Philothalos 1860, v. See also the review on the manual in the *BMJ*, September 22, 1860, 745. See also Peterson 1995, 22.

338 Urban 2006, 11.

cultural expectations.[339] This proves, as Andrew Weir has pointed out, that people were not just passive readers of these books but took "an active interest in bringing it together."[340]

The primary function of health manuals and popular guidebooks was primarily to guide women through their early married life and the first years of motherhood, furnishing them with medically correct information. In doctors' thinking, there was an obvious need for medically correct information, and thus, for their expertise, knowledge, and experiences. As Michel Foucault has argued, since the eighteenth century, the medical discourse has emphasised that "the consciousness of each individual must be alerted", and thus, every citizen was to be informed of what medical knowledge was both necessary and possible.[341] Healthy individual bodies represented "a healthy social organism", liable to corruption and degeneration, as the scholar Catherine Gallagher has analysed this new body-political discourse.[342] Moreover, as doctors feared, if no easily adapted yet medically correct information was available, people would turn to self-medication, or, what was considered much worse, to quackery and quacks, who wanted to take advantage of people who were desperately seeking help for their problems. The nineteenth-century medical profession was always defined in relation to irregulars and quackery. During the long nineteenth century, the medical profession itself was gradually becoming more unified, regulated, and trained with a standardised education, as I will discuss in Chapter 3.

Some scholars have suggested that the narrative of fear, including highly emotional language, and constant feeling of guilt and danger, were cultivated in the popular texts addressed to women and mothers.[343] However, as I argue, the narrative is, in fact, rather similar to that in those popular medical guidebooks written for use by young men, especially when doctors discussed the moral and physical dangers of masturbation.[344] In fact, I argue that these kinds of advice were expected from the medical profession because they had the expertise in and knowledge of the human body, preserving health, and the treatment of various illnesses. In addition, I suggest that this was rather the narrative of *worry*, because the very distinct discourses in popular advice were based on the ideals of following "the laws of Nature" and the persistent idea of prevention. Indeed, "prevention is easier than cure" was the medical slogan of the nineteenth century, found in almost every manual I have read for this research.[345] Thus, positive change

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339 Branca 1975, 75; Keller 2003, 64–65.

340 Wear 1992, 35.

341 Foucault 2005, 36. See also Foucault 1988. As Ludmilla Jordanova noted, medicine was profoundly literary in the eighteenth century (and onwards). Jordanova 1999, 117. See also Porter & Porter 1989, 33–52; Gallagher 1987, 84–86.

342 Gallagher 1987, 84.

343 Åström 2015, 113–126. Indeed, in her article, Berit Åström discussed the "medicalization" and "demonization" of motherhood at the end of the nineteenth century, claiming that middle-class mothers were "generally blamed" for infant mortality. See also Kukla 2005, 20.

344 Stolberg 2004, 98–99; Hall 1992, 293–315; Hall 2018, 169–176.

345 See for example Chavasse 1866, 103; Chavasse & An American Medical Writer 1871, 215; Weatherly 1882, 7; Stables 1894, 183; Stacpoole 1894, 89; Vincent 1902, 56;

towards better health and remediation was always possible, and the active preventive role of the woman/patient in self-controlling, self-managing, and taking precautions was an essential part of this. The prize for following "the rules of Nature" was indeed a happy and healthy life, normal pregnancy, and in every respect healthy children.

On the one hand, doctors' belief in science, progress, and the constantly advancing state of medical knowledge was a continuing discourse throughout the entire nineteenth century.[346] The historian Jane Lewis has noted that in the medical discourse – including in the manuals – women were not seen as individuals but rather through the all-embracing discourse of motherhood; health for women "was held to be synonymous with healthy motherhood".[347] Thus, every woman was a potential mother; during the nineteenth century, family and maternal duties were increasingly becoming matters of state, and health manuals written by the medical profession for mothers were a central element in this state campaigning.[348] The American historian Rima D. Apple has shown how a new concept of *scientific motherhood* was introduced in the nineteenth century, even if the idea was rooted more firmly in the twentieth-century United States. Basically, scientific motherhood was "the insistence that women require expert scientific and medical advice to raise their children healthfully", while doctors could present this necessary "scientific" and "neutral" information in their manuals and journals, as did other non-medical authors, such as social educators and reformers – and also mothers themselves, to some extent at least. "Giving birth made a woman a mother in the physical, biological sense only; a good mother had to learn about mothering from authoritative sources", as Rebecca Kukla has put it, meaning that the woman was both responsible and incapable at the same time.[349] However, this was not merely a one-way process, as women took part in the discussion, albeit not from an equal or plenipotentiary position, and with a considerably less authoritative voice.[350]

On the other hand, it is necessary to remember that the major and also a noticeably gendered problem in investigating women's past are the limitations concerning the surviving historical records and the lack of first-hand testimony

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Swayne 1893, viii. See also Herman 1891, 65: "Prevention is better than cure". Corfield, W. H., Introductory Lecture to the Course of Lectures on Hygiene and Public Health. The *BMJ*, June 18, 1870, 617–619. See also Kukla 2005, 85, 127; Jordanova 1999, 115; Porter & Porter 1988, 258–261; Porter 2001, 153. See more about the history of prevention in medical history, Smith 2002, 249–282. As Ginnie Smith has noted, following preventive methods in health care was not necessary expensive for the patient but required certain "strength of personal conviction". However, taking care of health could also be "an item of fashionable expenditure, stretched as far as the purse allowed." See also Chapter 4.2.

346 Quotation taken from Scott 1870 [?], 4. See also Risse 1996, 149.

347 Lewis 1984, 32.

348 Schiebinger 2004a, 66. See also The Profession of Motherhood. The *BMJ*, September 30, 1893, 752.

349 Apple 1995, 167. See also Lupton 1999, 62; Oakley 1984, 37–45; Lewis 1980, 61–82, 89–109; Dwork 1987, 124–166; Beier 2008, 265–267; Yeo 1999. See also Skeggs 1997, 42–48. See also Allbutt 1897, introduction [no page number]; Conquest 1849, 117–126; Chavasse 1872, 111–118, 164–166. See also Stables 1894, 26–27.

350 Apple 1995, 161–178.

of the women themselves. Historically, it is justifiable to investigate the discourses expressed in popular health manuals, but it is good to be aware that they consisted of ideals and expectations, not the reality and real-life experiences per se, even if some writers had been motivated by their own practical work. Moreover, as the historians Pat Jalland and John Hooper have noted, in the nineteenth century, men published more than women about the female life circle – menstruation, childbirth, maternity, and the menopause – and that men shaped the social images and consequently also female stereotypes much more than women did themselves.[351] Hence, it is hardly any surprise that in these manuals, the female life circle and the ideals concerning women's lives were constructed around the reproduction process, despite Jalland and Hooper also believing that "many women demonstrated a healthy skepticism about some medical theories on the female life cycle.[352] This is, however, a difficult question to investigate in practice, due to lack of first-hand evidence.

Nevertheless, also the ideals and expectations can give much information about the practices of nineteenth-century childbirth. Indeed, the popular health manuals can be studied literally; how doctors advise their readers on the matters concerning pregnancy and labour – how to eat, dress, sleep, rest, bathe, and exercise, for example. In the nineteenth century, antenatal care as a concept did not exist, nor did regular routine medical supervision during pregnancy or lying-in.[353] It can be argued that, due to this fact, there was an existing demand for the popular health manuals. However, beneath the "chatty" educational and ideal top layer there also lay a deeper and more persistent socio-political worry about social problems and the future of the nation and the whole British Empire. Throughout the nineteenth century, British medical writers and the public at large fretted about the infant and maternal mortality rates, both of which were frightfully high and persistent. The famous nineteenth-century doctor Thomas Hawkes Tanner estimated in the 1870s that "more than one-fourth – in the unhealthy districts of some large manufacturing towns, not less than one-third, and even a greater proportion [--] are cut off within the first five years after birth".[354] The first year was the most critical one in human life; as the statistics published in 1866 demonstrated, nearly a quarter of all deaths in England were made up of

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351 Jalland & Hooper 1986, ix. See also Gélis 1991, 45. On ideology and practice, see also Risse & Warner 1992, 199–203.

352 Jalland & Hooper 1986, xi.

353 Oakley 1984, 11.

354 Tanner 1871, 34–35. See also Conquest 1849, 112–126. See also Reynolds 2016, 1; Wrigley 1987, 133–145; Wrigley & Scofield 1989, 249–257; Harrison 2004, 60–61. Some of the greatest killers amongst children were whooping cough, smallpox, scarlatina, croup, measles, scarlet fever, diphtheria, diarrhoea, and atrophy. Diarrhoea was a particularly common and quick killer as it could cut down its victims in 48 hours. All in all, scarlet fever was the main cause of childhood death; 95 percent of all cases were children under the age of ten. This dreadful rate of child mortality was partly explained by the socio-economic background of families; children born into working-class families were in much greater danger of dying before their fifth birthday than their middle- or upper-class contemporaries. Reynolds 2016, 2–12; Hopkins 1994, 113–115. See also Jordanova 1999, 149. See also Woods 2007.

children under one year.[355] This was, as Tanner described, "a terrible destruction of life".[356]

And so were the countless women, who died in the prime of their lives, from pregnancy-related complications, giving birth, or shortly after labour.[357] In nineteenth-century Britain, health officers collected and reported the detailed statistics regarding births, deaths, and diseases; doctors carefully analysed the statistics in their writings, while continuing to discuss public health, contagious diseases, high infant and maternal mortality rates, and social conditions people were living in.[358] Since the eighteenth century, statistics had become an important way of ascertaining various aspects of the state of health of a particular nation. A larger and healthier population and workforce meant wealth, prosperity, and also military strength.[359] In this picture, maternal mortality was an ongoing worry.[360] For example, in his extensive research *Death in Childbirth* (1992), the historian Irvine Loudon has calculated that in 1874, 69.3 mothers per 10,000 births died, which was the highest rate of maternal mortality in Loudon's study.[361] However, these rates are only directional; since 1874, the cause of every death had to be certified by a doctor – before the 1870s, the registration of the cause of death was voluntary. The statistics were not precise or consistent but maternal mortality was a horrible reality too important to be left unnoticed.

However, the concrete loss of mothers and children was not the only cause for concern. Especially in the second half of the nineteenth century, there was also a growing fear of the social and racial degeneration of the British people. The birth rate in Britain had begun to fall in the mid-1870s, and urban poverty and the fear of both physical and moral deterioration due to alcohol and venereal disease epidemics were seen as considerable and acute social problems. Many thought that especially poor families were too large, and the morally questionably and less intelligent and healthy sections of society reproduced whereas their

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355 Tanner 1871, 36. As the historian Eric Hopkins has argued, children under the age of one were "peculiarly susceptible to infections resulting from contaminated food and personal dirtiness", possibly also malnutrition. Hopkins 1994, 113. O the concern over the infant mortality in the early twentieth century, see Lewis 1980, 27–41. See also Beier 2008, 269–271; Wohl 1984, 10–42.

356 Tanner 1871, 35. See also for example Milson Rhodes, J., Infant Mortality. The *BMJ*, August 16, 1902, 456–457.

357 Loudon 2000, 6. As Loudon has estimated, amongst women of childbearing age, maternal mortality was second only to tuberculosis in the leading causes of death. In the 1890s, maternal deaths accounted for 8.8 per cent of total deaths in women of childbearing age. Approximately eleven women died every day in childbirth, whereas 42 died of tuberculosis. Loudon 1992, 162–165. See also Beier 208, 267. See also Chapter 5.5.

358 Beier 2008, 152. See also Dwork 1987, 22–51; Leavitt 1986, 24–26; Laqueur & Cody 2014, 40–41. See for example Routh, C. H. F., On Procreative Power. The *London Journal of Medicine*, No. xv, March 1850, 240–264; Swayne, J. G., Obstetrical Statics. The *BMJ*, November 20, 1875, 635–638.

359 See for example Moscucci 1990, 11–12; Harrison 2004, 64–68; Duden 1991, 13. On the science of probabilities and statistics, see also Lupton 2003, 5–8.

360 See for example Porter 1998, 376–377, 464–465; Jordanova 1999, 148–149. See for example Mortality Due to Child-Bearing in England. The *BMJ*, December 30, 1876, 858–860; Deaths in Childbed. The *BMJ*, June 25, 1898, 1669–1670; September 17, 1898, 839–840.

361 Loudon 1992, 24.

"betters" did not.[362] This discussion clearly also concerned the British upper class whose physical and mental health was allegedly in great danger because of an overly luxurious, unhealthy, and idle lifestyle. The British Empire was its people and this was seen, by all accounts, as a horrible waste of human lives and great potential. This was indeed one aspect lying behind the popular medical literature; as the historians Thomas Lacquer and Lisa Cody have noted, "how people died was a matter of public urgency".[363] How people reproduced was equally important; women, as wives and mothers, represented the future of the nation, a matter too fundamental to be ignored. "The tree is known by its fruits", as was meaningfully pointed out also by the medical author Lyman Beecher Sperry in 1900, whose two popular manuals have been analysed in this study.[364]

For this research, I have examined thirty popular health manuals in total, intended for use by lay women, written by members of the British medical profession, the majority of them by medical men. In addition, I have also included professional obstetrical literature aimed at medical peers and midwifery guidebooks intended for use by medical students and female midwife trainees. The popular manuals were distributed in all decades of the Victorian era, published between 1834 and 1902. The oldest individual popular guidebook was *The Signs, Disorders and Management of Pregnancy*, published in 1834 by Dr Douglas Fox.[365] The first edition of Thomas Bull's *Hints to Mothers* came out three years later, in 1837. It became hugely popular and was reprinted several times afterwards – for example, the 1879 version of Bull's manual was already the twenty-seventh revised edition of the medical bestseller.[366] Pat Jalland has claimed that the original *Hints to Mothers* was "a first advice manual solely devoted to antenatal care" but that is not the case.[367] The shortest individual guidebook was *The Wife and*

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362 Pfeffer 1993, 1–29; Wrigley & Schofield 1989, 245; Robb 1997, 58–71; Showalter 1990, 4–6; Burnham 2005, 41–43; Mort 2000, 133–141; Beier 2008, 165; Russett 1989, 67–68; Nead 1988, 118–121; Gilbert 2014, 129. Indeed, the fear of overpopulation and the fear of national destruction due to low population growth have varied in the discourses of reproduction and the social-political-economic future of nations; the birth rate has been "inextricably" linked to a nation's economic growth. Thomas Malthus was probably the most famous and influential writer to discuss this question in the late eighteenth century. See also Foucault 2005, 192–195; Canning 2006, 40; Gallagher 1987, 83–105; Yeo 1999, 204. See also Haycraft, John Berry, The Milroy Lecture on Darwinism and Race Progress. The *BMJ*, February 24, 1894, 402–404.

363 Laqueur & Cody 2014, 53.

364 Sperry 1900, 136. See also Stables 1894, 90–93.

365 I have included Fox's guidebook in my primary sources mainly because its content does not differ from the later texts. Quite the contrary, it revels much of the attitudes of the medical profession working in the 1840s and 1850s.

366 I have been reading different editions of the guidebooks, but by and large, I have preferred later editions of the books, mainly because they contain more information especially in their prefaces. In some instances, availability of the primary sources in Finland has been a practical problem while conducting this research – thus, I have also read the American editions of the books originally published in Britain, found scanned versions on the Internet.

367 Jalland 1986, 137. See also Towler & Bramall 1986, 146–148. For example, the manual of Douglas Fox was published some years earlier. It contained also a section on the medical management of children. On the other hand, *Hints to Mothers* had tips on suckling. Moreover, it is difficult to define what the content really was about since no manual was "solely devoted to antenatal care". All manuals stressed different things;

Mother's Guide; or a Few Plain Rules for Pregnant Women (1841) by Robert Hills, containing only sixteen pages – albeit compact and short in pages, Hill's compact literary work was as informative as its more voluminous companions.

Generally, popular health manuals were usually much wider in topics, containing approximately one hundred to two hundred pages or more. The content was often based on the biological order of the reproduction process: usually, first pregnancy was introduced, with some general remarks on married life and puberty; the typical and less common signs, symptoms, and disorders of pregnancy; then the general management of pregnancy (including diet, rest, exercise etc.), risks and the prevention of miscarriage, calculating the due date, and advice concerning labour and lying-in, including hints on nursing the baby. Usually, the last and the largest part of the book dealt with children and family life. The content could be wide and extensive; for example, the manual of Lionel Weatherly (1882) included separate chapters on general family hygiene and sanitation, giving practical hints on the location and drainage of the house, for example.[368] Some guides also contained sections on the management of puberty, including menstrual hygiene, and management of health during the "change of life", meaning menopause. Some guidebooks concentrated solely on female diseases; therefore, they cannot be understood as representative examples of the general idea of the reproduction process and *normal* pregnancy and childbirth. Remembering this, they are all the same demonstrative examples of nineteenth-century medical understanding.

On the other hand, the focus of the popular manuals was often on infancy and questions of motherhood, and pregnancy and labour were only a short introductory section at the beginning of the book. However, I have excluded these larger themes concerning Victorian family life and children/childhood from this research, as I am interested in the beginning of the reproduction process; pregnancy months, labour, and also to some extent, lying-in, the latter lasting in practice only some weeks after labour. In addition, childlessness or *barrenness*, as the state of not having children was often called, is a topic too complicated to be discussed in this work, as are the theories of conception and especially women's role in it.[369] In my study, the starting point is that impregnation had already taken place and the women discussed were already pregnant, or they were believed to be so. Moreover, I focus entirely on the woman's side of the process and do not discuss the foetus/child.[370]

Furthermore, I would like to point out that by concentrating on the nineteenth-century medical profession and their views on childbirth, my intention is

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some were concentrating on motherhood, some on pregnancy, and some were more about labour and lying-in.

368 Weatherly 1882, 7–27. See also Adams 1996.

369 See especially Thomas Laqueur's influential yet controversial study *Making Sex: Body and Gender from the Greeks to Freud* (Laqueur 1992, pub. org. 1990). See the critique of Laqueur's theories in Cody 2008, 12–15; Green 2010, 146–162.

370 On the history of foetus, see for example Woods 2009. See also Astbury 2017b.

not to ignore or understate the work and traditions of British midwives nor underestimate the long history of their profession.[371] However, it is far more complicated (though not impossible) to find primary sources created by the nineteenth-century midwives themselves. One especially interesting example is the guidebook written by the trained midwife, Mrs Baker. Much is not known about Baker, not even her first name, but her manual *The Companion to the Lying-in Room: or, Hints on the Management of the Infant and Mother during "the Month"* was published in 1856, nevertheless. The guide was intended for professional use by women working as monthly nurses. According to her own book, Baker herself had been a monthly nurse for sixteen years. In addition, she revealed that she was also a mother herself, and, hence, had lots of experience of childbirth, gained both professionally and in private life. What is more interesting is that, based on her manual, she was well acquainted with contemporary medical literature, mentioning for example the works of Robert Gooch (1784–1830), a famous English physician-obstetrician.[372] Gooch's manual *An Account of Some of the Most Important Diseases Peculiar to Women* (1831) was also discussed and requoted in the manuals written by nineteenth-century medical men studied in my research.

However, Baker's manual can be seen in another context: while giving her practical hints on the management of both the labouring woman and the child, Baker clearly also had a larger social mission. Baker emphasised the importance of medical training and defended midwives against the persistent accusations of ignorance and incompetence, as she explained to her peer readers: "[t]here are many books written exposing the ignorance of nurses, but none to correct it."[373] This observation was more than true; "ignorant" was the most commonly used adjective when the British medical profession discussed midwives and criticised their role in childbirth and especially the lack of standardised education and regulation. Hence, Nurse Baker represents British midwives in this study, reminding us that the writings of the (male) medical profession were not as objective, fair, and free from professional competition and denigration as doctors suggested them to be. Otherwise, midwives are discussed only in connection with nineteenth-century doctors and customs of childbirth; hence, this is not a study on nineteenth-century midwives per se.

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371 On midwives in medical history, see Burnham 2005, 25–26. Jane Sharp, living in seventeenth-century London, was the first English midwife to publish a book on midwifery, *The Midwives Book; or the Whole Art of Midwifery Discovered* in 1671 (see Sharp 1999). However, not much is known about Sharp; see for example Towler & Bramall 1986, 91–95; Keller 2003, 64; Hobby 1999, xi–xxxiv; Evenden 2000, 10–11; King 1995, 184–185.

372 See Baker 1856, 5–11. See also the manual by Mena Drew, *Monthly Nursing* (1891). On Gooch, see Marland 2004, 29–31.

373 Baker 1856, 6.

2.2.2 Medical Periodicals: *British Medical Journal*

If the popular health manual industry flourished in the Victorian era, the long nineteenth century was also the golden age of medical periodicals in Britain.[374] The nineteenth century was indeed the age of mass media and mass press.[375] Hundreds of new medical journals were launched during the century, but only few of them survived, above all, *The Lancet* and the *British Medical Journal (BMJ)*.[376] In 1840, the latter was a newcomer; the first issue of the new weekly-based periodical was published in October 1840. For most of the first seventeen years, the title of the new journal, struggling for its existence for the first two turbulent decades, was the *Provincial Medical & Surgical Journal* (*PMSJ*).[377] As the name revealed, the editors of the new journal and most of its subscribers were allegedly provincial medical men working around Britain.[378] However, in reality, the *BMJ* was "increasingly London-centered, despite its claims to a provincial orientation", as the medical historian Jeanne M. Peterson has noted.[379]

The newly launched journal was closely linked to the *Provincial Medical and Surgical Association* (*PMSA*), known since 1856 as the *British Medical Association*,

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374 W. F. Bynum and Janice C. Wilson have divided the medical periodicals into five different classes; first, general periodicals aimed at the whole of the medical profession; secondly, specialist periodicals; thirdly, the scientific journals containing non-clinical material; fourthly, periodicals disseminating information on health from the standpoint of orthodox medicine; and lastly, the unorthodox journals concerned with phrenology, homeopathy or hydropathy. However, the boundaries of these classes were not definite. The general medical periodicals dominated the first third of the nineteenth century, but specialisation and the growth of the whole medical branch changed the dynamic in medical publishing. Bynum & Wilson 1992, 32. See also Beetham 1996, 45–46; Altick 1967, 318–364.

375 Beetham 1996, ix. On mass press and weekly family magazines, see for example Mitchell 1980, 29–51.

376 Peterson 1995, 22, 28, 30–31; Bartrip 1990, 8; Bynum & Wilson 1992, 29–34; Loudon & Loudon 1992, 49–53; Brock 1992, 71. More than a hundred new titles were launched between 1800 and 1840 alone; moreover, between 1800 and 1899, 220 new medical journals were founded, concentrating on general medicine, and another hundred were specialised periodicals. In total, 479 or 485 journals, depending on the calculator, "with some claim to being 'medical' had made at least a brief appearance in Britain". Peterson 1995, 29; see also Bynum & Wilson 1992, 32. The first medical journals were published in the seventeenth century but the eighteenth century was the century when the specialist medical series emerged. See Porter 1992c, 7–9.

377 Between 1842 and 1844, the journal's name was the *Provincial Medical Journal and Retrospect of the Medical Sciences* until it was changed back to the *Provincial Medical & Surgical Journal*. From 1853 to 1856, the name was the *Association Medical Journal*. In addition, I have included all four volumes of the *London Journal of Medicine* in my primary sources. The short-lived journal was founded by the medical journalist John Rose Cormack in 1849; it was published between 1849 and 1852, until it was amalgamated with the *Provincial Medical & Surgical Journal [PMSJ]*. Unlike other weekly-based journals, the *London Journal of Medicine* was a monthly publication, with twelve issues per year.

378 As the *Introductory Address* of the first issue noted, the journal hoped for "the assistance of the many gifted individuals to be found among our provincial brethren". Introductory Address. The *PMSJ*, October 3, 1840, 1–4.

379 Peterson 1995, 38. On London-centered medical publishing, see Bynum & Wilson 1992, 34–35. By 1870s, the *BMJ* had part-time reporters in Edinburgh, Dublin, Liverpool, and other great cities. Bartrip 1992, 138.

originally founded in 1832.[380] The association was a professional union for all medical doctors working in the provinces, outside of London, which was the indisputable centre of medical publishing as well as the capital of the whole British Empire. By 1840, when the *Provincial Medical & Surgical Journal* began its weekly appearance, there were already 1,200 members in the *PMSA*, and the association was expanding with its membership constantly rising.[381] In 1856, the *PMSA* adopted a new name, the *British Medical Association,* and consequently the periodical was re-named as the *British Medical Journal* in 1857.[382] The name went unchanged for more than 130 years until 1988, when the title was shortened to *BMJ*, and since 2014, the journal, currently ranked as one of the most influential medical periodicals in the world, has officially been known as *The BMJ*, the shortened version I use also in this research.[383]

From the very beginning, the *BMJ* has had many competitors in medical journalism. By 1840, *The Lancet*, a well-recognised and high-level journal, had already established its leading position amongst the British medical periodicals. It was founded in 1823 by Thomas Wakley (1795–1862), a radical provincial surgeon settled in London. Wakley, an "inimitable and partisan editor", was no doubt the most famous and influential medical journalist of the nineteenth century, known nation-wide, stamping *The Lancet* with his own personality, and challenging the existing norms and directions in nineteenth-century medical printing.[384] *The Lancet* was a reformist, polemic, active, and highly controversial journal with a social and political agenda: it was fighting against nepotism, corruption, quackery, and incompetence, attacking its many enemies in a very aggressive manner.[385] *The Lancet* introduced a new type of weekly-based medical journalism, giving space for correspondence, news, and political comment, a publishing policy later successfully followed also by the *BMJ.* But, as the historian Jean Donnison has pointed out, the radical journal was "anti-midwife, and indeed anti-feminist".[386] In this sense, it was certainly not the only one.

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380 Bartrip 1990, 6–7; Loudon 1999, 280–281; Lane 2001, 25; Roberts 2009, 39. The association was founded in Worcester by a physician Charles Hastings and some 50 of his colleagues.

381 Bartrip 1990, 6–23, 29. Indeed, since 1842 the *PMSA* supplied the journal as a benefit of its membership.

382 See the *BMJ*, January 3, 1857, 9.

383 Bartrip 1990, 33; Bartrip 1992, 126. There is nothing uncommon about the fact that the *BMJ* changed its name several times: quite the contrary, it was a common publishing policy that the periodicals were re-named. See for example Porter 1992c, 8–9; Bynum & Wilson 1992, 38–39.

384 Bartrip 1990, 9–12; Loudon & Loudon 1992, 60–62. Bynum & Wilson 1992, 36; Pladek 2011, 560–586. Wakley was also a Member of Parliament and a coroner in Middlesex. See more about Wakley in Sharp 2012, 1914–1921; Peterson 1978, 25–27, 169–170.

385 *The Lancet* was aptly named: a lancet can mean a sharp surgical cutting instrument or a type of window. Indeed, Wakley's journal had many enemies: in an editorial, *The Lancet* noted somewhat delightedly that Sir Anthony Carlyle, a famous English surgeon and an adversary of *The Lancet*, had difficulties even being in the same room with the journal he so fiercely detested. See, Sir A. Carlyle and The Lancet. *The Lancet*, January 11, 1840, 557. On Wakley and quackery, see Porter 1989, 223–231; Porter 2001, 250–254.

386 Donnison 1999, 65. It is difficult to find the writings of female medical professionals in *The Lancet*, whereas in the *BMJ*, at least Elizabeth Garrett Anderson, one of the

The *BMJ* fought and eventually found its own place in medical printing. However, it was not until the 1860s and 1870s that it started to grow and gained medical prestige, finally surpassing the circulation of *The Lancet*.[387] The last three decades of the nineteenth century were the editorial reign of the English surgeon Ernest Hart (1835–1898), who had taken charge of the *BMJ* in 1867.[388] Hart successfully edited the journal until his death in 1898, being a somewhat Thomas Wakley -like figure, with a controversial reputation and many enemies both in medical publishing and British society.[389] However, it was during Hart's long and successful editorship when the majority of innovations in British medicine were first reported in the *BMJ* rather than anywhere else, and by the end of the nineteenth century, the journal was already the world's highest circulation medical periodical.[390]

On the other hand, the appearance and finally the success of the *BMJ* was connected to the wider changes in society, such as the specialisation of medicine during the nineteenth century, the development of more systematic medical education, and the establishment of voluntary and public hospitals and new medical societies in the provinces.[391] Especially general practitioners (GP), who constituted over 90 per cent of all medical practitioners in Britain, were the significant majority of the subscribers to the general medical periodicals, such as the *BMJ*.[392] Moreover, medical publishing greatly benefitted from the improving infrastructure all over the growing Empire; the *PMSJ* was founded in 1840, the same year when the penny post was introduced in the United Kingdom. Since the launching of the new journal, high-speed presses and postal services gradually improved and the new railway network was growing larger, transporting people, knowledge, and also medical periodicals to their subscribers living and working all over the empire.[393] The new improved infrastructure guaranteed that every individual issue was, at least in theory, up-to-date and fresh, containing the recent news and events of the medical world. One consequence of this logistical development was that periodicals were also materially more fragile than

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most famous medical women in nineteenth-century Britain, was an occasional contributor in the 1890s.

387 Bartrip 1990, 71; Bartrip 1992, 137. In 1867, the circulation was around 2,500 and by the end of the nineteenth century, it was already 20,500.

388 Bartrip 1990, 63–69. Hart, who became the longest-serving editor of the *BMJ*, had previously worked for *The Lancet*. He had a somewhat interesting reputation.

389 There was a one-year break from 1860 to 1870 when Hart was briefly replaced. See Bartrip 1992, 134–138. After Hart's death in 1898, Sir Dawson Williams became the new editor, continued his work until 1928. Bartrip 1990, 90–92, 181.

390 Bartrip 1992, 135–138. At the end of the nineteenth century, the circulation exceeded 21,000 per annum.

391 Bynum & Wilson 1992, 31. See also Loudon & Loudon 1992, 63–64; Peterson 1978, 5–39; Jordanova 1999, 74.

392 Loudon & Loudon 1992, 64; Hart 1992, 228–246; Worboys 2000, 21.

393 Bartrip 1990, 8–9; Bartrip 1992, 129–130; Beetham 1996, 10; Briggs & Burke 2016, 94–98, 121–125, 130–141.

books, printed on cheap paper without covers, ready to be perused by their subscribers.[394]

The *Provincial Medical & Surgical Journal,* and afterwards the *BMJ,* like its main competitor *The Lancet*, was a weekly-based, up-to-date scientific periodical, with clinical lectures, weekly columns, book reviews, obituaries, medical advertisements, hospital and medical society reports, announcements, and correspondence columns, including letters to the editor and readers' poems, various enquiries, requests, and answers.[395] The latest inventions and new medical breakthroughs were presented in the journals, many of which directly concerned childbirth, such as the introduction of chloroform in the 1840s and the appearance of antisepsis around the 1870s.[396] All in all, the content of the periodicals was surprisingly wide; nearly every aspect of human life was discussed in the journals, including the safety of travelling by train, medical benefits and risks of cycling, the famous literary figures of the day, the latest political events, news concerning the members of the Royal Family, and distressing incidents happening in Britain or elsewhere in the world, such as the infamous Jack the Ripper murders in 1888 in Whitechapel, London.[397]

The content, both informative and entertaining, was very appealing also to lay readers, despite that during the nineteenth century periodicals did acquire a more professional tone, while their content grew larger, new columns and sections were added, and medical language and concepts clearly became more diversified and specialised.[398] As the historian Margaret Beetham has argued, medical periodicals had a distinct pattern, as each number was "both its moment and of a series, different from yet the same as those which have gone before", making it relatively easy to follow the specific narrative absorbed by the individual journal.[399] As a result, there were different metalevels and time spans in the same

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394 Beetham 1996, 9. As the historian Kathryn Shevelow has argued, particularly popular titles were passed around from hand to hand, to friends and relatives. Individual issues were collected and bound into books, especially if the subscriber was wealthy. Shevelow 1989, 26. See also Altick 1967, 318.

395 The generic term "periodical" includes "all serial forms of print", such as newspaper, journal, review, and magazine. The *BMJ* was a professional medical journal, but its content was rather similar to other periodicals of the time. See Beetham 1996, 9. Moreover, it also developed visual conventions and techniques through illustration; the *BMJ* also contained pictures, advertisements, and new medical inventions, but altogether, it was more about texts. See more about nineteenth-century advertisements in periodicals in Beetham 1996, 142–145.

396 Bartrip 1990; 125–136; Porter 1992c, 16–19; Loudon & Loudon 1992, 56–57.

397 See for example Bartrip 1990, 148–151; Loudon & Loudon 1992, 56; Peterson 1995, 22; Beetham 1996, 12; Walkowitz 1992, 191–228. On curious medical cases, such as the case of the exploding teeth or the seventy-year-old mother-to-be, discussed in medical periodicals, see Morris 2018.

398 Peterson 1995, 24, 31–35; Loudon & Loudon 1992, 56–57. As Margaret Beetham has pointed out, nineteenth-century Britain had become a literary society, reading all kinds of periodicals. There was a publishing industry specifically for nineteenth-century women; on women's magazines, see Beetham 1996, 1–3, 6–8, 10. See more about eighteenth-century periodicals and their readers in Shevelow 1989, 22–57.

399 Beetham 1996, 12–13. The nature of periodicals is peculiar. Indeed, being a part of a continuum, journals were also of their particular moment; "the series is open-ended and fluid but each number is contained", as Beetham has argued. The letters section

journal. Moreover, the whole issue could be read – at once or over a longer period – but more often a reader could simply pick out those articles they considered interesting, useful, or otherwise meaningful to them. There is evidence that nineteenth-century laymen and clergy, for example, also read medical periodicals and occasionally they even took part in discussion.[400] Moreover, the *BMJ* was well known also outside of Britain, in continental Europe, the United States, and Canada, and the journal itself was well connected to the world outside of the British Isles.[401]

Indeed, medical journals were interested in everything concerning human life and their content was, as the historian M. Jeanne Peterson has put it, the "increasingly successful efforts of doctors to claim authority over many aspects of human life and experience".[402] This is very true, but more importantly, medical periodicals offered and fostered a unique place for the common background, shared experiences, professional discussion, and the continuing communication between doctors.[403] Medical journalism created, maintained, and legitimised the sense of community among the medical profession, constantly renegotiating their position in society. As the historians Jean and Irvine Loudon have noted, journals "fostered the new and growing sense of corporate identity amongst general practitioners", who worked all around the empire and who did not know each other in real life.[404]

In this sense, medical journals had indeed an important and in many ways indispensable educational function, as the Manchester doctor Thomas Radford – discussed later also in this study – described in 1851: "it is [--] the duty of the practitioner truthfully to register his unsuccessful cases, as well those which terminate successfully", noticing that, "[e]very medical practitioner ought to have sufficient moral courage to stand against both professional and popular opinion".[405] This professional openness was extremely important, as Michel Foucault has pointed out in his study *The Birth of the Clinic*; Foucault noted how the mistakes made in medical teaching could be more useful than successes, leaving a

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is a good example of this policy; doctors could take part in the discussion and returned to different topics in their answers, after many issues had been published since the original message.

400 Loudon & Loudon 1992, 57. See for example the discussion in *The Lancet* in 1840s about fathers attending childbirth. One correspondent was, according to his own words, "a non-professional reader" of the journal. However, he had been present at two of his wife's labours and supported men's right to do so. He used only a pen name "F", when writing his letter to the editor. See "F" [anonym.] Husbands at Accouchements. *The Lancet*, February 26, 1842, 759–760. See also Chapter 5.3.

401 Burnham 1992, 165–182; Digby 1999, 82. See for example Obituaries. The *BMJ*, June 17, 1893, 1300. The journal published an obituary of Wolmar Schildt (1810–1893), a doctor working in Jyväskylä, a small town in Finland, at that time a part of the Russian Empire.

402 Peterson 1995, 22.

403 Porter 1992c, 11.

404 Loudon & Loudon 1992, 64.

405 Radford, Thomas, Cases in Midwifery. The *PMSJ*, May 28, 1851, 287. See also J. G. Swayne's article in the *BMJ* in 1875 quoted on page 1. See also Ovariotomy. General Retrospect. The *PMSJ*, January 8, 1851, 23–24.

more permanent impression on the students.[406] Indeed, in this sense, every subscriber and contributor was both a potential student and a teacher. In addition, medical journals clearly completed and filled the gaps in professional literature: it was possible to ask peers if, for example, medical literature failed to give answers to puzzling questions.[407] Confessing one's inadequate professional knowledge and failing to provide an answer in front of the patient was always risky but in medical periodicals, it was both acceptable and sensible to consult other doctors – to a certain point at least.

On the other hand, medical periodicals were clearly all about the professional reputation, respect, authority, and knowledge of an individual doctor. For many practitioners, who never had an opportunity to publish an entire book of their own, medical periodicals offered a unique chance to present and share their experiences and accounts and take part in the wider discussion.[408] Thus, readers were not a passive audience but took an active part in bringing the content of the journal together. It is possible to argue that the publishing policy both *expected* and *allowed* readers to participate in creating the content with their letters, comments, enquiries, and answers, usually published in the last section of the journal. The letters were sometimes identified by the real names, titles, and affiliations of their writers, or occasionally only by pseudonyms, hiding the true identity of the correspondent. In this sense, medical periodicals were not the publications of the small privileged elite, even if the members of the medical profession constituted a literate professional elite amongst the British people. On the other hand, as Roy Porter pointed out, medical periodicals "could offer a speedy way to establish priority"; in fact, publishing was a *sine qua non* condition for professional reputation and fame, that is to say, to exist and to really *be someone* in nineteenth-century medicine.[409] Prestigious medical men (and more rarely also women) published their lectures on scientific discoveries and technical innovations, practical cases, and their visions of the current state or future of medicine.[410] The medical journal such as the *BMJ* was indeed a perfect testing area for new ideas and practices.

It can be safely argued that midwifery and gynaecology were an indispensable part of the content of the *BMJ* from the very beginning; for example, the very first issue of the *Provincial Medical and Surgical Journal*, containing 16 pages, included three book reviews on midwifery and "diseases peculiar to women".[411] For this study, I have been particularly interested, apart from the doctors' letters

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406 Foucault 2005, 73. Here Foucault was referring to the lecture of Pierre Jean Georges Cabanis, an eighteenth-century French philosopher.

407 See for example Devis, H. F., Puerperal Pneumonia. The *BMJ*, April 4, 1891, 755–756.

408 Loudon & Loudon 1992, 65; Shevelow 1989, 48, 101–116; Mangham & Depledge 2011, 3.

409 Porter 1992c, 13. See also Lane 2001, 23–24. In fact, Irvine Loudon has argued that one reason for the tragic fate of the infamous Hungarian obstetrician Ignaz Semmelweis (1818–1865) and the first decades of silence surrounding his important findings could be explained by the fact that Semmelweis failed to publish his results. See Loudon 1995a, xivii–xlviii. See also Chapter 5.5.

410 As Roy Porter pointed out, in the eighteenth century, some of the leading medical figures, such as William Hunter, never printed their lectures, apparently because they did not want to jeopardize their lecturing income. By the nineteenth century, this policy had changed. Porter 1992c, 12. See also Mangham & Depledge 2011.

411 See The *PMSJ*, October 3, 1840, 4–5.

sent to the journal, in the patient reports and case studies published in medical periodicals. In the history of medicine, this kind of material created by the doctors themselves, is "a key document, central to understanding the discourse and practice of medicine", as the medical historians Guenter B. Risse and John Harley Warner have illustrated.[412] Michel Foucault has noted that medical observation is always dominated by language, time, and memory. In the patient record or a case study, written by the healer, the symptoms and the state of the most important physiological functions are described, then "the patient or his [sic] entourage is questioned as to his general appearance, his occupation, his past life", the progress of the disease is explained, and lastly, the convalescence.[413] A patient record is a case study of a patient or patients, consisting of medically relevant pre-information about the patient, called *anamnesis*. Sometimes the *prognosis*, the likelihood of surviving was told. It also included the *diagnosis*, the signs and symptoms, and identification of a disease or complication; the treatment, and lastly, the result or the current state of the case, if known.

Patient records, reports, and case studies, varying in length and in detail, are a rich and in many ways unique source of information, especially when pursuing the cultural history of medicine from clinical case histories and patient notes.[414] In addition, they provide an insight into medical ideals and knowledge, healing and also relations between the doctor and the patient and his/her circle, and the larger social and cultural context of the time they were created in. As Guenter B. Risse and John Harley Warner have argued, patient records and reports are the "surviving artefacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relationships are expressed."[415] Indeed, patient records tell us about both the daily life and the routines of sickness and health, examinations, medications, the customs of the sickbed, and the perceptions of the medical profession, including the recovery or dying of patients, pain and suffering, but also ideals, cultural codes, hopes, and expectations. They also reveal how and when medical aids were used in practice, such as the stethoscope or the midwifery forceps, for example. Moreover, patient records reveal changes and continuances in disease classifications, unsuccessful and satisfactory treatments, concepts, definitions, and the models explaining the causes and mechanisms of diseases.[416] They allow us to understand "why doctors did what they did, what expectations they held about their own clinical interventions, and how they explained their actions and perceived their consequences."[417] Indeed,

412 Risse & Warner 1992, 184.
413 Foucault has divided the third stage of observation into four headings: "evolution of the symptoms, possible appearance of new phenomena, stage of secretions, and the effect of medication used". See Foucault 2005, 137–138. See also for example Guy, W. A., Introductory Lecture, Delivered at King's College, October 1, 1842. The *PMJRMSM*, October 8, 1842, 27–28. See also Levine-Clark 2004, 81, 83.
414 Risse & Warner 1992, 185. See also about casebooks in Churchill 2012, 17–27.
415 Risse & Warner 1992, 189. See also Goubert 1987, 47–48; Risse 1987, 176–200. On medical and case books in early modern England, see also Churchill 2012, 17–27.
416 Risse & Warner 1992, 192. See also Porter & Porter 1989, 144–152.
417 Risse & Warner 1992, 200.

as David Harley has noted, "medical knowledge is not merely representational; it is always praxis".[418]

However, it is necessary to acknowledge that the patient reports and case studies published in medical periodicals were usually about exceptional cases, and, hence, they usually reveal very little about what took place in average childbirth.[419] Thus, as a primary source, they might create a false picture of actual medical practices taking place in nineteenth-century birthing rooms; perfectly normal labour was often professionally less interesting than an obstructed or otherwise complicated case, demanding medical care, radical interventions, and morally challenging decisions. Hence, childbirth, when described and reported in medical periodicals, can easily be seen as a much more difficult and dangerous business than it was in reality. The majority of nineteenth-century women gave birth without major complications, but their experiences and narratives are not usually found in the patient records and reports. In my research, I focus especially on the educational aspects of the writings; because complicated/obstructed cases were rare and not every doctor had a chance to witness them in practice or during their training, one inevitable result was the spreading of detailed information about the experiences of those who knew about them and had come across them in practical work. As Michel Foucault has stressed, in medicine there has been a "very wide recognition of the need for teaching through practice itself".[420]

Moreover, it is also good to remember that medical journals are mainly about the voices of the medical profession, and more precisely they consisted of the voices of medical *men*. As the gender historian Eve Keller has noted, since the eighteenth century, midwifery texts focused on the particular experiences and expertise of individual practitioners – thus, they are not particularly objective and cannot be treated so.[421] In this sense, the reports also tell much about their creators, not only about medical "facts" or patients and their ailments. As Roy Porter has noted, utilising patient records usually means that "you can only know about the sick through doctors' eyes".[422] In this sense, these documents contained only those facts an individual doctor considered important and worth describing.[423]

The purpose of the reports and case studies was, of course, to be scientific, objective and neutral, and to clarify the patient's "subjective, confusing, uncertain, and contradictory description", as the historian Roselyne Rey has pointed out.[424] On the other hand, it is very presumable that the individual doctor wished

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418 Harley 1999, 414.
419 Risse & Warner 1992, 188. See also Porter 1985, 181.
420 Foucault 2005, 69.
421 Keller 2003, 68, 77. See also Porter 1985, 188; Digby 1997, 291–305.
422 Porter 1985, 182. As Porter has noted, this is the reason why "we have admirable histories of epilepsy and hysteria, but significantly none of epileptics or hysterics". However, it would be extremely difficult to write about the history of the parturients, because they were much more than just women giving birth. See also Risse 1987, 175–176. See also Duden 1991, 68.
423 See Duden 1991, 67.
424 Rey 1995, 100.

to present his own encounters and actions in as positive a light as possible, without losing face or his professional credibility. Moreover, very often a short letter or a case study is the only evidence left and it is impossible to verify if the account actually happened quite as told. Thus, it is possible and even likely that some of the writers misunderstood or altered the facts reported, kept silent, did not want to or could not tell the truth, or lied about their cases – sometimes to protect their patients, sometimes to avoid blame. I also acknowledge that I cannot know all the affiliations, religious, ideological, political and social connections, or general appreciation, prestige, or family or other relations of these particular writers I have studied in this research. Indeed, it is necessary to remember that there has always been a gap between what was *written* and what was *done* in practice.[425]

On the other hand, such records are unique in many ways; in fact, we might never have got a chance to know any of the details of these particular cases if the doctors had not chosen to write about them and to publish their accounts in the medical periodicals. And, as the historian Marjorie Levine-Clark has pointed out, patients were never silent in medical case notes.[426] Mary E. Fissell has argued that whereas early modern medicine was dominated by the client or patient, around the nineteenth century, their voices disappeared from medical records.[427] Based on the *BMJ*, this kind of process was not particularly straightforward: especially in the matters related to pregnancy and childbirth, the patient's own story was still an important part of the case's narrative, and diagnosis (meaning the possibility of pregnancy) was still negotiated between the doctor and patient, even if the new diagnostic battery expanded and amplified of the patient's story.[428]

Sometimes it is even possible to hear these women talking with their own voices. Patients' words and reactions were sometimes documented in the reports, even if the dialogue was recorded by someone else, usually by the doctor who discussed the case with his peers. These accounts were not representative and information could be medically irrelevant on a larger scale, but historically they are intriguing, nevertheless. They confirmed that medicine is always taking place in a certain time and place and that patients were not just the passive "victims" of doctors, medicine, or the medicalisation process. For example, in 1891, after a successful Caesarean section, a young woman called "A. T.", when recovering from the difficult and risky operation, told her doctor that she was "in a new world, but feels very hungry".[429] While staying in the hospital where she had

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425 On texts, interpretations, and the historian, see LaCapra 1983, 26–27, 35–61.

426 Levine-Clark 2004, 80. See also Stolberg 2004, 95; Digby 1994, 183; Risse & Warner 1992, 190; Duden 1991, 83.

427 Fissell 1991, 92–106.

428 See for example Digby 1997, 298.

429 Cameron, Murdoch, On the Relief of Labour with Impact by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 513–514. The woman, "A. T.", aged 23, was unmarried and a primipara. After the successful operation, the woman was given hot water, then hot water, milk, toast, and tea, which obviously was not enough, as the doctor reported: "[she] says she would be quite well if I would just give her a good bowl of porridge and a cauf (chaff) bed." Ibid. See another case in which a labouring woman died due to malpractice. In labour, the woman had screamed at the doctor: "For God's sake leave me alone, for you are pull-

been operated on, the recovering woman married the father of her child. The doctor reporting the case, a Scottish pioneer of Caesarean section, Murdoch Cameron (1847–1930), had the wedding party, "a peculiar company", photographed in the backcourt of the hospital; two other Caesarean section patients acted as bridesmaids.[430] These kinds of moments, the blinks of an eye in the past, are very revealing, breaking the medical jargon and reminding us that ultimately we are discussing real people living in the past with their hopes, dreams, expectations, and also fears.

Indeed, as Roy Porter has argued, the accounts of doctors in medical periodicals and advice and self-care manuals are not that far away from the patients' views, because they tell about sufferers' emotions and the responses around them, and the subjective perceptions of health, pain, and illnesses/diseases.[431] Porter has noted that patients were agents rather than simply "patients"; they took care of their own health and they were expected to do so.[432] In this sense, both the patient and the healer had the same purpose. As David Harley has noticed, in their presentation and analysis of signs and symptoms of pregnancy, both patients and practitioners revealed "the social and conceptual systems" structuring their understanding of health and disease.[433] No doctor could make a diagnosis without consulting his patient and listening to their account first. In obstetrics, the women themselves and occasionally also their partners and wider family and neighbourly circle were the primary source of information, especially when doctors needed to know specific and intimate details about the menstruation cycles or any abnormalities in reproductional health.[434] On the other hand, the patients' personal narrative was always viewed with some suspicion – sometimes with good reason. Some patients misread their own state of health, or were unable to describe their experiences and sensations, and sometimes they also had motives of their own not to tell the truth, to remain silent, or fabricate the possible signs and symptoms they either experienced or did not.[435] It is good to remember that patients have never been a homogenous group; in fact, the only thing uniting them is ultimately their "patientness".

Generally, patient reports as historical documents often reveal detailed information about an individual patient; her age, her physical appearance and mental features, social status, current state of health, and more importantly, her reproductional history, including how many living and dead children the woman had had, how many miscarriages and/or premature labours she had experienced, and other gynaecological problems she had possibly suffered from.

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ing my entrails out". This was indeed what the doctor was doing. Jones, T. S. Rupture of the Vagina, With Protrusion and Laceration of the Intestines. The *PMSJ*, August 7, 1844, 283. See also Levine-Clark 2004, 81–82; Marland 2004, 101.

430 Cameron, Murdoch, On the Relief of Labour with Impact by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 514.

431 Porter 1985, 183. See also Harley 1999, 420–421.

432 Porter 1996, 91. See also Duden 1991, 75–77.

433 Harley 1999, 421; Risse & Warner 1992, 189–190; Bar-On 2004, 42.

434 Porter 1985, 179–182; Jacyna 1992, 256–257; Porter 1989, 94; Bar-On 2004, 41–42. See also Levine-Clark 2004, 80–81, 83; Alberti 2014, 166.

435 Rey 1995, 100.

Occasionally, the same information extended to her mother and other (female) relations as well. Often the patient record revealed the place of residence, such as the town or the street address where the doctor had treated his patients, and nationality, race, and/or religious affiliation.[436] Thus, for contemporaries, the identification of an individual patient would have been relatively easy, since the family affiliations, occupations, hometown, or a lying-in hospital (if the woman had been giving birth in hospital) were usually mentioned. However, generally doctors anonymised their patients, using only the initials, usually adding the marital status ("Mrs. W–"), if the patient was married, or their occupation/other affiliations if the case was about an unmarried woman. However, this policy was not systematically followed, and occasionally, the full name of the patient could be found printed in the journal, most often the surname ("Mrs. Mason"), sometimes both the first name and the surname.[437]

It seems that this anonymizing policy and the manner chosen to describe an individual patient was partly based on the patient's social class and background. Probably the most extreme case I have been able to find was dated in the 1850s when a doctor reported on the case of a woman in her twenties, "a finely formed, but sickly looking servant girl"[438]. In his report, the doctor revealed the woman's whole name, occupation, hometown, and discussed her gynaecological history in detail. The physical appearance of the patient was also described, including the body, breasts, sex organs, and internal genitalia. However, the most shocking aspect in the report is the manner in which the doctor depicted the woman's very intimate life; she reportedly masturbated and was promiscuous, living together with a married man at the time when her case was discussed in the medical press. In this case, the low social status of the patient, her economic background, sexual behaviour, and alleged disregard for the social norms clearly had an impact on how the male doctor discussed the health problems of his working-class female patient.[439]

As Guenter B. Risse and John Harley Warner have illustrated, sometimes it is indeed possible "to relate the healers' actions to their ideas, writings, and to

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436 See for example Churchill 2012, 28–33. See also Foucault 2005, 71–72, 136, 137. As Foucault noticed, at the Edinburgh clinic (apparently in the late eighteenth and early nineteenth century), medical observation consisted of four series of questions: the patient's age, sex, temperament, and occupation, patient's symptoms, the origin and development of the disease, and more distant causes and earlier accidents. Women's childbirth history was extremely important when the doctor was constructing the case. See also Jacyna 1992, 256; Alberti 2014, 109–112.

437 See Porter 1992c, 15.

438 Waddington, Edward, Masturbation in a Female Apparently without an Uterus; With Remarks. The *Association Medical Journal*, July 29, 1853, 672–673.

439 As Elaine Showalter has noted, uncontrolled sexuality of women was closely associated with insanity but that was not case with this particular patient: the problem was merely gynaecological. Showalter 1985, 74. On gender and class of the patient in medicine, see also Risse & Warner 1992, 197–198; Porter 1992c, 16. On the other hand, some doctors also expressed their sympathy if the woman was poor; one doctor discussed the "hard labour in bonnet-ironing, poverty, and grief" of his female patient. No name was mentioned in this case. See Blackmore, Edward, Observations of the Nature, Origin, and Treatment of Puerperal Fever. The *PMSJ*, April 2, 1845, 210. See also Pfeffer 1993, 43.

the patient's social class."[440] Based on the reports and pictures published in the journals, working-class people's and especially working-class women's rights to privacy were considered less important than their better off contemporaries.[441] Indeed, the case of a young working-class woman can be compared with the case of a "gentleman, of high education", published in the same year and in the same journal. According to the doctor reporting on this case, the man in question had an extremely short penis, causing some practical problems concerning married life. When discussing the case, the doctor emphasised that "for obvious reasons, I avoid names, and any address that might risk the slightest indication of the parties referred to".[442] Thus, patients' class, social status, financial ability, and gender clearly all mattered in medicine. Moreover, occasionally, medical periodicals contained pictures of the patients in question, often deformed or otherwise physically very distinct. In midwifery reports, some of the pregnant or parturient women posed without any clothes on – physically, these women were unusually short in stature, with serious pelvic deformities and other noticeable physical features. When paging through medical periodicals, it is not unusual to see pictures (both drawings and photographs) of death foetuses, depicting physical deformities and missing limbs, for example.[443] However, while they clearly interested the nineteenth-century medical profession, I have chosen not to analyse these pictures in my study.

In this study, I follow the anonymised policy of the journals, and do not use the whole name of the patient even if the name is documented in the patient record or found elsewhere in the journal.[444] By doing this I want to respect the privacy of these people whose most intimate and private lives are concerned, even if they died more than a hundred years ago and lived in a different cultural context than I do. I acknowledge that these people were real individual persons living in a certain historical age and thus, they have every right to be remembered, but I think that telling the whole name does not bring anything new or relevant

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440 Risse & Warner 1992, 187. See also Moscucci 1990, 85; Churchill 2012, 27–33.

441 Beier 2008, 147. See also Leavitt 1986, 200–201. See also Schiebinger 2004b, 393–395.

442 Noble, Daniel, Is Hypospadias a Bar to Marriage? The *Association Medical Journal*, March 18, 1853, 236.

443 This was obvious especially when doctors reported cases in which working-class women, some of whom were extremely short, and suffered from serious malformations of the pelvis. The reports contained pictures of the woman, posing naked to the camera, usually their faces uncovered. In addition, some journals contained pictures or photographs of dead foetuses which were presented as medical specimens. See for example Scott, Alexander, Notes on the Birth of a Double Foetus Resembling the Siamese Twins. The *BMJ*, June 8, 1889, 1288–1289; Brown, William, A Case of Gastro-Schisis. The *BMJ*, January 4, 1890, 14; Cameron, Murdoch, Remarks on Caesarean Section, with Notes of a Second Successful Case. The *BMJ*, March 15, 1890, 583–585. On Victorian nudes and photography, see Smith 1996, 55–62; on nineteenth-century medical photographs, see Stephens 2011, 87–99.

444 On the other hand, I use the whole name of the doctors, if the name is mentioned and the name is somehow relevant; the work of doctor was public and these particular writers have chosen to write with their own names. However, the journals allowed doctors to publish their writings – various enquires, questions, and comments – anonymously, and thus the true identity of the writer is not always known. See also Risse & Warner 1992, 189.

to these cases. I could not be systematic in revealing the names because this information was not always recorded in the journals. Moreover, these nineteenth-century women have no opportunity to debar their cases from being studied and written about in this study. Nor is it at all clear whether the authors had the consent of their patients when doctors reported the cases in medical periodicals; very likely some did not. Moreover, the reports analysed here concerned only a very small section of the lives of these women; hence, reports reveal very little or nothing about the larger context of the people described in them. Often the matters also concerned a much larger group of people, including families, friends, and neighbours; sometimes the cases published in the periodicals were particularly sensitive and painful, including rapes, incest, domestic violence, abortions, and infanticides.[445]

Let me give an example. In 1885, the *BMJ* published a short report of a girl, aged fourteen, who had given birth to a child, apparently after a full term pregnancy, without anyone knowing that she was in fact expecting. It turned out that the father of the baby was the stepfather of the girl.[446] Even if it was not specifically stressed, it is clear that sexual abuse and rape(s) had taken place inside of this particular family and the subsequent pregnancy was a traumatic experience for everyone involved. Thus, it is obvious that in this kind of case, publishing the names would be highly unethical if they had been given in the journal (they were not in this case). Nevertheless, when investigating incidents like this one, the historian needs to be extremely sensitive and cautious when revealing intimate and delicate details of individual persons, even if the journals were printed and widely distributed in large amounts and they are generally to be found in almost every library and in scanned versions on the Internet. This fact does not diminish the historian's responsibility to discuss his or her cases with understanding, tact, and compassion; the role of a historian is not to be sensational and reveal *everything* s/he has been able to dig up from the primary sources. On the other hand, the undeniable fact is that the history of childbirth also contains in many ways unpleasant, painful, and disturbing things – most of all pain, suffering, and death – but they are an indispensable part of the story, not to be censored or obscured simply because the historian studying them finds the topic difficult or somehow objectionable.[447]

Medico-culturally, the case of the fourteen-year-old parturient is nevertheless very descriptive because it reveals how women living in the same household observed the menstrual and reproductive health of their female family members

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445 See some examples of the cases of domestic violence, pregnancy, and the death of the pregnant woman in Barrett, John, On the Character and Mode of Infliction of Wounds of the Female Pudenda, Considered in Reference to Criminal Charges. The *Association Medical Journal*, June 28, 1856, 538–540; Prichard, Arthur W., A Case of Bullet Wound of the Pregnant Uterus. The *BMJ*, February 8, 1896, 332–333.

446 Eddowes Legat, A., A Young Mother: Unsuspected Pregnancy. The *BMJ*, October 10, 1885, 699. The girl "had been deterred by threats from telling anyone of the criminal connection", that is to say, she was raped by her stepfather. The *connection* was a very common word for sexual intercourse in nineteenth-century medical discourse. See also Tanner 1860, 9–10. On incest in the families and the social stain, see Beier 2008, 229–231.

447 See for example Vainio-Korhonen 2017, 29–47.

and neighbours. Moreover, the case demonstrated that the signs of pregnancy were not always easily recognised – a fact also acknowledged by the nineteenth-century medical profession. In this particular case, the girl's mother had been "dosing her with the usual old woman's remedies" when her period suddenly ceased; moreover, the neighbours had said that such abnormalities in the menstrual circle were perfectly normal for a young girl, and that "she would get all right again".[448] Yet no one suspected her being pregnant; the girl's family and friends had noticed that the girl was growing stout and the mother had even put her to walk some days before she went into labour – in order to lose some weight. The doctor reporting on the case, on the other hand, was baffled by the easiness of the labour, mainly because the parturient was so exceptionally young. Indeed, teen pregnancies such as this one were often reported in medical journals but they were always rare exceptions and on no account a norm in the context of nineteenth-century Britain.[449]

Essentially, one aim of publishing a case such as this one was to remind doctors that the possibility of pregnancy was always to be borne in mind when female health was discussed in medicine, as I illustrate in the further chapters of this research. However, before that, I briefly introduce the history of childbirth before the 1840s, paying attention especially to the obstetrical change in the eighteenth century, when medical men entered the birthing rooms, and then discussing how the British medical profession developed in the Victorian era.

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448 Eddowes Legat, A., A Young Mother: Unsuspected Pregnancy. The *BMJ*, October 10, 1885, 699. See also for example Williams 2011, 67–69.

449 See for example the case of 12-years-old girl in the *BMJ*, March 12, 1881, 418; 14-year-old girl in the *BMJ*, March 1, 1884, 445; 12-year-old girl in the *BMJ*, June 16, 1888, 1285. One writer even noticed that the mother of Henry VII, Margaret Beaufort, was 13 when she gave birth to the future king in 1456, see the *BMJ*, August 11, 1888, 330. In 1887, one doctor made an enquiry about an unmarried girl who had concealed her pregnancy from her parents. Only her sister, one married neighbour, and the doctor knew about the pregnancy and delivery. The doctor wanted to know whether it was his duty to tell the girl's parents; the journal thought that it was not. See the *BMJ*, April 16, 1887, 853.

3 MOTHERS, MEDICAL MEN, AND OBSTETRICS IN NINETEENTH-CENTURY BRITAIN

3.1 Man-Midwives on the Horizon!: A Short History of Childbirth prior to the 1840s

As many historians have illustrated, before the eighteenth century, normal childbirth was not usually the business of a male doctor.[450] Women in labour and lying-in were almost exclusively attended by midwives, who were more or less experienced and trained women, being the authority on the world of birth and on reproductional knowledge in practice.[451] For centuries, the work of midwife was a female occupation, though midwives were by no means a homogenous and equally skilled and experienced group. However, various historical sources demonstrate that they made vaginal examinations, they supported women in labour and undertook normal deliveries, they baptised children in cases of emergency, and testified and acted as expert witnesses in courts in cases involving bastardy, accusations of ante-nuptial fornication, rape, concealed pregnancies, abortions, and infanticide.

Historical records show that many midwives were respected members of their communities; some of them were literate, often wives or widowers of equally respected, prosperous, and influential parishioners.[452] Word of mouth

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450 This subchapter concentrates on the obstetrical change that took place in early modern England, as a result of previous research conducted on the topic. England has clearly dominated history research, and thus, it is worth noting that such studies have not been carried out for early modern Wales or Scotland, for example. See for example Muir 2020.

451 On the history of midwives, see for example Donnison 1999, 11–33; Towler & Bramall 1986, 1–62.

452 Gowing 2003, 71–73, 159; Towler & Bramall 1986, 53–55; Evenden 1993, 9–23; Evenden 2000, 112–120, 123–125; Harley 1993, 35–39; Lane 2001, 120–121; Cody 2008, 44–45; Wilson 1995, 25–27, 30–33; Wilson 2013, 156–157, 163–165; Donnison 1999, 14–17; Moscucci 1990, 43–44. However, as David Harley has pointed out, it is difficult to

recommendations and a good reputation established the profession while their practice "could be expected to cover a wide spectrum of social and occupational groups", as the historian Doreen Evenden has argued.[453] Their work offered them also an opportunity for considerable independence; midwives received a fee for their work, and they were not dependent on the social status of their husbands but rather on their own experience, reputation, knowledge, traditions, and the promotion of their work.[454] Moreover, their work was licensed, but this licensing system began to break down around the eighteenth century.[455] In early modern Europe, midwives even had their own oath, defining the professional, ethical, and moral requirements and codes of the office, though not every midwife took it.[456] All in all, before the eighteenth century, pregnancy and childbirth were considered "a mysterious affair", belonging to the private world of women, the practical reproduction process being almost entirely under the management of women. Men were largely, but not totally, excluded from normal labour. However, this visible absence of men did not mean that men – as husbands, fathers, relatives, and friends – were not interested in childbirth, the births of their children, or the reproductional well-being and health of their wives and other female relatives.[457] Their actual presence may have not been needed in labour, but men were emotionally and socially very much involved, all the same.

Early modern English childbirth and lying-in have sometimes been called *the collective female ritual*, based on the woman who was giving birth, the knowledge and experience of the midwife, who was in charge of the birth and who received a fee for her work, and the attendance of female participants, the *gossip*.[458] The gossip women were often relatives, including the labouring

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estimate the real social and educational status of midwives because "precise information is scarce and of dubious representatives". Harley 1993, 31, 34–38; Hess 1993, 49–50; Wiesner 1993, 79–88; King 1993, 119–125; Lane 2001, 123. On midwives in eighteenth-century Wales, see Muir 2020.

453 Evenden 1993, 17; Evenden 2000, 93. See also Foucault 2005, 100.

454 David Harley has argued that the most important qualifications of midwives were indeed discretion and modesty. Harley 1993, 35. As Doreen Evenden has noted, often traditional knowledge and skill was passed down from generation to generation "within the system of unofficial apprenticeship", from mother to daughter. Evenden 2000, 59–61. Wiesner 1993, 77; Cody 1999, 479–480. On untrained midwives in working-class districts, see Beier 2008. On eighteenth-century Finnish midwives trained in Sweden, see Vainio-Korhonen 2012, 70–107.

455 The Church of England was responsible for the licensing of midwives in England. The licensing of midwives began somewhere around the sixteenth century, possibly earlier, but it was not customary. If the midwife wished to be licensed, she had to supply a testimonial, pay a fee (usually a large sum of money), and take an oath. Towler & Bramall 1986, 55–62; Evenden 2000, 24–27, 34–38, 174–175; Wilson 2013, 160–161; Lane 2001, 120–123. On the regulation and supervision of midwives in eighteenth-century Holland, see Marland 1993, 192–206.

456 Moscucci 1990, 44; Evenden 1993, 19; Donnison 1998, 19–20; Marland 1993, 198; Evenden 2000, 27–31; Gowing 2003, 42, 159. In fact, the oath varied greatly, see for example Wilson 2013, 161.

457 Evans & Read 2015, 3–23. Adrian Wilson has suggested that also men had their own social arrangements during childbirth. See Wilson 2013, 154. See also Churchill 2012, 12–13; Mann 2005, 137–157; Cody 1999, 481; Cody 2008, 41; Gowing 2003, 156; Gillis 1996, 162; Hess 1993, 64–65.

458 See Cody 2008, 31–39; Evenden 2000, 80–87; Wilson, A. 2002, 133–141; Wilson 1996, 1–2, 25–26; Wilson 2013, 153–210; Bar-On 2004, 36–37; Donnison 1999, 14; Moscucci

woman's own mother, friends, and/or neighbours, playing an active role in the events as advisers, consolers, judges, and the source of information relevant to the patient's reproductional history and the general course of events.[459] In *the ceremony of childbirth*, as Adrian Wilson has described the occasion of birth, this female network gathered in the house of the soon-to-be-mother: the room the mother-to-be occupied was a separate social space, segregating the woman from the normal daily routine and leaving men and children outside. All daylight and air were excluded from this room or space, windows were shut and darkened with curtains, and the whole party, including the mother- to-be, drank *caudle*, a hot alcoholic drink flavoured with sugar, egg, and spices.[460] Prayer, girdles, charms, herbs, opiates, venesection, caudle, and ointments were variably used during labour, in order to relieve the pain and to speed up birth; the labouring woman herself was allowed to walk, or she stood, or lay down.[461] When the baby was born, it was swaddled – a practice strongly condemned by the nineteenth-century medical profession, who also endlessly promoted good ventilation and quietness of the birthing room.[462] A month later, after the period of social isolation, the new mother was allowed to enter the outside world and the ceremony of churching reintegrated her back into her normal social life.[463]

However, as the historian Laura Gowing has noted, this "all female world of childbirth could be beset by conflicts and tensions"; not all women having a child were married and some were excruciatingly poor, excluded from the civilising rituals of birth and the company of the gossip.[464] Some historians have been apt to depict this early modern childbirth as a harmonious and idyllic event, taking place in mutual solidarity, harmony and respect, to emphasise the contrast

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1990, 43; Gillis 1996, 161–165. It seems that unmarried women also attended early modern labours. See Gowing 2003, 158. See also Muir 2020, 408–414.

459 The members of the gossip could, for example, pass important information about the progress of labour to the surgeon, who was called in case of an emergency; indeed, "they acted as intermediaries between the healer and the community with which s/he was unfamiliar". On the social role of the gossip, see Bar-On 2004, 36–53.

460 Evenden 2000, 82–83; Wilson, A. 2002, 134–135; Wilson 2013, 153–159; Gowing 2003, 149–176; Cody 2008, 34, 36; Lewis 1986, 196–198; Digby 1994, 270. As Gowing has noted, these descriptions of early modern birth are based on prescriptive and literary sources concentrating on the elite. Thus, it is impossible to know how many women actually followed these practices in reality.

461 Cody 2008, 36; Wilson 2013, 158–159; McLaren 1984, 50–52. On medieval childbirth and the use of belt, see Powell 2012, 798, 800–801; Fissell 2006b, 14–16; Morse 2019. On charms, see Ritchey 2019, 174–188. See also French 2016, 129–130, 133–136; Gélis 1991, 136.

462 See for example Hills 1841, 12. See also Jordanova 1989, 31; Wilson 2013, 159; Wilson 2014, 35; Moscucci 1990, 12; Lewis 1986, 194.

463 Cody 2008, 39; Lewis 1986, 200–202; Evenden 2000, 31–34, 84–85; Wilson 2013, 4–6, 201–210; Wilson 2014, 35–53. Adrian Wilson has argued that churching was a highly popular service amongst women themselves; it was a women's own ritual and a celebration of a safe deliverance.

464 Gowing 2003, 45, 150–161; Cody 2008, 37; Kilday 2013, 57. According to Adrian Wilson, over 90 per cent of births took place within marriage. The midwife could interrogate the labouring woman in order to find out the identity of the child's father. Some women could also express that they were not particularly pleased with the individual midwives and their deficient capabilities. Wilson 2013, 7, 26, 217. See also Gowing 2003, 117–118, 161–162, 179; Wilson 1995, 27–28.

with medicalised and hospitalised modern birth – also forgetting that the primary sources usually described birth amongst the small and wealthy elite. However, despite that relations between the mother, midwife, and the gossip could be tense and unpleasant, the collective and public ritual of childbirth, with its ceremonies and female participants acting as witnesses, also protected women socially.[465] Secret birth was always a potential danger in society; concealed pregnancy and birth was associated with unwanted pregnancies, intentional abortions, and infanticides, considered serious crimes.[466] The network of women – family members, friends, servants, and neighbours – controlled and observed each other; they noticed abnormities in each other's menstrual cycles and changes in general health. Reproduction has always been controlled from below, by society and the (female) community, and various social and cultural rituals have been an integral part of the process.[467]

However, around the eighteenth century, a new kind of practitioner, a *man-midwife* emerged on the stage of childbirth. As Lisa Cody has noted, in Britain, "the traditional set of gender and reproductive relations" changed fundamentally during the eighteenth century.[468] Adrian Wilson has timed the great change between 1720 and 1770 when childbirth gradually became closer to medicine and this obstetrical change or the so-called revolution took place.[469] Before the eighteenth century, men – at least surgeons – were allowed to enter the lying-in chamber only in cases of extreme emergency, as a last resort when all other means had failed. Simplifying, in practice, *normal* and spontaneous birth was not the interest of the male medical profession, even if men had already constituted themselves as literary experts on women's reproductional health.[470]

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465 Bar-On 2004, 38; Gowing 2003, 151, 153–155; Cody 2008, 36; Donnison 1999, 14; Kilday 2013, 58–64. See also Leavitt 1986, 38.

466 See for example Kilday 2013, 18, 23–31, 40–64, 137–150; Gowing 2003, 71, 149; Wilson 2013, 55–59. Adrian Wilson has argued that in early modern England very few unmarried women killed their newborn child; he estimated that approximately 1 in 50 might have done so. The more common practice, yet still very unusual, was to leave the child somewhere to be found, in order to give the child "a better chance in life than was otherwise available". See also Kilday 2013, 84–90. See also Williams 2011, 67–82.

467 On the various discourses, see especially Gowing 2003, 51, 64–65, 69. See also Duden 1991, 86. See the nineteenth-century example of a woman who gave birth extremely quickly; the child fell on the floor and died. Two women had witnessed the case and were able to confirm that there had no intention to destroy the child and that the case was indeed an accident. Death of a Child from injury, Depended on Forcible Expulsion. The *PMSJ*, April 29, 1846, 199.

468 Cody 2008, 3. See also Harley 1993, 39–42; Porter & Porter 1989, 174–183; Loudon 1992, 166–171; Donnison 1999, 34–52; Lewis 1986, 86–91; Lane 2001, 123–125. Indeed, this was in fact the British "revolution"; in France and British North America, the change was not so dramatic in the eighteenth century. See for example Leavitt 1986, 36–39.

469 Wilson 1995, 1–7. See also Evenden 2000, 176–182. Before the eighteenth century, midwifery was considered to be a lay craft, not medicine. See also Moscucci 1990, 10; Loudon 1999, 85–94.

470 Wilson 1995, 1, 47–49. See also Moscucci 1990, 46–47; Evenden 1993, 19; Marland 1993, 203–204; Cody 2008, 3, 192. Also female midwives performed various operations in emergencies, see Donnison 1999, 12; King 2012, 109; Moscucci 1990, 48. On men writing about childbirth, see for example King 1995, 185–194. See also Chapter 2.2.

Before the eighteenth century, the presence of a male physician in childbirth was in fact often a very bad sign: labour was badly obstructed and normal vaginal delivery was not possible, thus, the baby was cut out of the womb in a Caesarean section or the foetus was removed in pieces with special instruments, such as crochets and hooks. This latter operation was called either *craniotomy*, perforating the skull of a living or dead foetus, or *embryotomy*, reducing the size of the foetus by cutting it into pieces in the womb and then delivering the pieces.[471] The aim of this brutal operation was to save the life of the labouring woman; in the British medico-cultural context, a Caesarean section was considered a death sentence for the parturient woman and therefore it was not performed, unless the mother was already dead. For the foetus, craniotomy meant inevitable destruction, but for the labouring woman it offered a slight chance to survive.[472] However, it is necessary to notice that in the total numbers of births, craniotomy and embryotomy were indeed extremely rare and they were always dreaded exceptions, and by no means the norm.[473]

What was significant in this new eighteenth-century man-midwife or *accoucheur* was that he was not called upon *only* when labour became obstructed and desperate measures were required. On the contrary, he was now also delivering *normal* births and his presence in childbirth was intentional, planned, and arranged in advance. Traditionally, the explanation for the rise of man-midwifery was linked to both *fashion* and the *forceps* – aristocratic women preferring the presence of the man-midwife over that of female ones – who allegedly did not master forceps delivery nor complicated labours.[474] The midwifery forceps – the medical aid the nineteenth-century medical man Gordon Stables described as "those cross-legged, silver-spoon looking business" – was the invention of the Chamberlens, a French Huguenot family settled in England in the late sixteenth

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471 Operation descriptions in detail, see Ryan 1841, 251–255. Cody 2008, 40. Adrian Wilson has argued that the operation of craniotomy was performed only if the foetus was dead but this is not the case. In the nineteenth century, the operation was sometimes performed even if the foetus was alive. This was not deliberate cruelty by the doctor but the only available method in order to save the life of the labouring woman who would otherwise die. Wilson 1995, 20–21, 50–53; Wilson 2014, 3. See also Evenden 2000, 101–102. On postmortem Caesarean sections in the late Middle Ages and early modern period, see Foscati 2019. See also Chapter 5.5.

472 See Gowing 2003, 168–169; Cody 2008, 3, 40; Evenden 1993, 19; Wilson 1995, 22.

473 According to Irvine Loudon, English accoucheurs carried out about 4–6 craniotomies in every 1,000 deliveries, whereas in Catholic France, the number was one in every 2,000–3,000 deliveries. In France, a Caesarean section was performed more often, even if it was an extremely difficult operation and the chance of the labouring woman surviving was minimal. See Loudon 1992, 134. See also Chapters 4.4 and 5.5.

474 Wilson 1995, 3–4; Porter & Porter 1989, 181; Moscucci 1990, 47–48; Loudon 1999, 89–94. However, as Wilson has argued, the forceps were not in fact the key to the lying-in room, as they were only used in case of emergency. See Wilson 1995, 100–101. However, for example W. F. Bynum offered the forceps and fashion as the explanations for the eighteenth-century obstetrical revolution. Bynum used William Hunter as an example of the eighteenth-century *accoucheur*, but failed to mention that Hunter was against the forceps. See Bynum 1996, 202; King 2012, 111, 115. As Helen King has noted, in the case of the midwifery forceps, the intention was to demonstrate that man-midwifery was in fact "ancient", whereas otherwise male doctors presented themselves as "modern". See King 2012, 115. On different interpretations, see Wear 1996, 122–124.

century.[475] The forceps remained a family secret for more than a century; during the eighteenth century, the midwifery forceps began to gain growing attention amongst the medical profession. For example, the doctor and author J. H. Aveling (1828–1892), when writing the history of midwives in the 1870s, celebrated the reinvention of midwifery forceps in the eighteenth century as a key object for this new obstetrical revolutionary "thunder". For Aveling, the forceps were "the imperishable symbol and weapon under and with which all the battles of the approaching revolution were to be fought and won".[476] This kind of point of view was by no means uncommon: for example in 1879, the *BMJ* was no less enthusiastic in its words. The journal claimed that "no instrument in the whole range of medicine" had saved more human lives and spared human suffering than the forceps.[477]

However, in reality, not all doctors approved of nor used the obstetrical aid. Moreover, the forceps and other obstetrical instruments were rarely deployed, because they required special skills and knowledge. The person using the aid, when making impetuous moves or not knowing how to handle the instrument, could cause the birthing woman and the unborn baby considerable damage and pain – sometimes the consequences could be permanent, life-long, or even fatal.[478] "The forceps is a powerful instrument for good or for evil, according to the skill of the operator", as one writer described the medical aid later in the 1870s.[479] Even if the obstetrical instrument has sometimes been associated with the eighteenth century, it can be safely argued that the nineteenth century was "the epoch of the forceps", as one doctor described in 1886.[480] New models, often named after their famous inventors, were presented in medical periodicals, often with high hopes, as one writer described the general expectations amongst the medical profession: "the more perfect we make it [the forceps] the more lives we save, and the less need will there be of recourse to craniotomy".[481]

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475 Stables 1894, 225. On midwifery forceps, see Towler & Bramall 1986, 77–81; Wilson 2014, 4; Wilson 1995, 53–57, 65–74; Cody 2008, 42–43; Lewis 1986, 88–89.

476 Aveling 1872, 86. See also for example The Discussion on the Forceps. The *BMJ*, July 19, 1879, 96.

477 The Discussion on the Forceps. The *BMJ*, July 19, 1879, 95–96.

478 See for example: Trial for Manslaughter in Midwifery Practice. The *BMJ*, April 9, 1870, 365; Edgeworth, F. H., Case of Bilateral Facial Paralysis, Due to Injury by Forceps at Birth. The *BMJ*, January 6, 1894, 11; Erskine, James, Accidental Removal of Auricle by Midwifery Forceps, and Successful Application of Artificial Auricle. The *BMJ*, January 4, 1902, 14–15. In the first case, a young and inexperienced apprentice, when attending labour alone, applied the forceps and, detaching the womb from the vagina, caused serious laceration and, eventually, the death of his patient. See also Denman & Ryan 1836, 76–81, 88–89. See also Moscucci 1990, 49–50; Cody 2004, 331.

479 Swayne, J. G., Obstetrical Statics. The *BMJ*, November 20, 1875, 636; Radford, Thomas, Observations on the Caesarean Section and Other Obstetric Operations. The *BMJ*, March 25, 1865, 289–290. Compare to Donnison 1999, 42–43. See also Toogood, Jonathan, On the Practice of Midwifery, with Remarks. The *PMSJ*, May 22, 1844, 103–104. See also Niven, D. G., Case of Protracted Delivery: With Remarks. The *PMJRMS*, May 21, 1843, 124–126. See also for example Donnison 2000, 106–108; Leavitt 1986, 44–56; Mitchinson 1991, 210–215.

480 Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 623.

481 Lambert, William Osborne, Barne's Forceps: Suggested Additional Improvements. The *BMJ*, August 29, 1891, 484. See the advertisements for the forceps in the *BMJ*; February 21, 1880, 287; June 26, 1880, 976; January 14, 1893, 76; January 28, 1893, 183;

However, the explanation for the rise of man-midwifery was far more complex than simply the reappearance of the forceps. According to Adrian Wilson, the eighteenth-century transformation of childbirth was not assimilated directly into wider changes in medical culture, and moreover, the change in fact happened in Georgian England.[482] Physicians had already begun to specialise in gynaecology, "the sister science" to midwifery, and their knowledge of female anatomy was growing more detailed, but on the other hand, before the nineteenth century, the treatment of women's diseases was not the concern of any specific medical practitioner.[483] Wilson has argued that the success of man-midwifery was possible because women supported man-midwives: Wilson has noted that in fact the making of man-midwifery was the work of women themselves.[484] This might be too straightforward an argument, but no doubt, women played an important role in the eighteenth-century medico-cultural turn. As one nineteenth-century doctor, quoting James Blundell (1790–1878), an English obstetrician who was the first doctor to perform a successful blood transfusion, said: "[i]f you can get the ladies on your side, you may consider your fortune as nearly made; for they are very active friends".[485]

Indeed, many historians have demonstrated that the rise of man-midwives was connected to the change in the patient–doctor relationship; the new fashionable male practitioners, called *accoucheurs,* were able to win the confidence of women (and also their husbands) coming from urban and aristocratic families.[486] Moreover, man-midwives transformed secret knowledge of womanhood and reproduction "into topics fit for public discussion and display", to be explored and discussed *scientifically*, as Lisa Cody has pointed out.[487] Man-midwives themselves were often notable public figures; some were even public celebrities, such as the Scottish surgeon and man-midwife William Smellie (1697–1763) and his pupil William Hunter (1718–1783), a famous anatomist-surgeon, both of whom

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November 18, 1893, 1110. See also An Improved Midwifery Forceps. The *BMJ*, February 23, 1889, 423. See also Leavitt 1986, 44–48, 50.

482 Wilson 1995. See also King 2007, 67–105; Loudon 1992, 165–171. Elsewhere in Europe, midwives still took care of the majority of births and their position and appreciation remained stronger than in Britain. For example, in eighteenth-century Finland – then the easternmost part of the Kingdom of Sweden – midwives were even trained at the expense of the communities in which they were expected to work after completing their studies. These midwives had their professional oath, special training lasting for four years, and a well-respected position in society. See Vainio-Korhonen 2012.

483 Moscucci 1990, 7, 13; Cody 2008, 41; King 2012, 112–113. It seems that midwives also practised gynaecology. According to Ornella Moscucci, the word "gynaecology", the science of woman, first appeared in its modern spelling in the eighteenth century. The quotation "the sister science" is taken from Byer, J. W., Introductory Remarks by the President on Puerperal Fever, Uterine Cancer, and the Falling Birth-Rate. Sixty-Ninth Annual Meeting of the British Medical Association. The *BMJ*, October 5, 1901, 941.

484 Wilson 1995, 192. See also Digby 1994, 260.

485 James Blundell quoted in Ballantyne 1889, 4.

486 Cody 2008, 3, 196. See also Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 301: "the introduction of the forceps, that the practitioner to effect delivery with safety both to mother and child, came gradually to calm her fears and to win her confidence for the aid of the accoucheur". See also Digby 1994, 260–262. Compare to Donnison 1999, 40.

487 Cody 2008, 10. See also Lewis 1986, 88–89.

lectured publicly, published extensively on midwifery, and attended births of the high and mighty of British society.[488] For men like Smellie and Hunter, midwifery offered a way to high society, wealth, and a prestigious professional reputation.[489]

As Lisa Cody has argued, these new man-midwives helped to "develop a new model of masculine comportment" that was appealing to both male and female followers, and moreover, the man-midwife promoted discussion about gender identities, even if man-midwifery also faced opposition and suspicion.[490] This new man type was complex yet diplomatic; both a heroic, masculine figure, and on the other hand, he was also sensitive, understandable, and showed gentlemanliness towards the sufferings of his female patients and their circles. In short, the successful eighteenth-century man-midwife was both "objective and empathetic, rational yet tender", as Cody has put it.[491] Obviously, the nineteenth-century medical profession wanted to represent themselves as the heirs of this new tradition, while also being harbingers of inevitable progress and the new, better future. As one writer noted in a 1840s *The Lancet*, "[the-man midwife] is an importation, and not a very ancient one. Truly, he was imported with the progress of civilisation and of science".[492]

3.2 Respect, Reputation, and Responsibility: Nineteenth-Century Medical Practitioners, Medicine, and Childbirth

In 1894, Queen Victoria, herself a mother of nine children, expressed her view on the current state of British obstetrics in her letter to one of her numerous granddaughters: "[w]hile *German Oculists* & *even Surgeons* are *cleverer* than *ours*, – there

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488 Cody 2008, 152–197; Wilson 1995, 123–131, 175–181. Smellie was a supporter of the midwifery forceps whereas Hunter was not, famously saying: "where they save one, they murder twenty". See quotation in Wilson 1995, 3. See also King 2007, 139–140; Lewis 1986, 85.

489 Cody 2008, 155; Lawrence 1995, 204.

490 Cody 2008, 11, 13; Lewis 1986, 87. Especially some female midwives fiercely opposed their male competitors, such as Elizabeth Nihell (1723–1776), a London midwife who had been trained in France. Nihell published her manual *Treatise on the Art of Midwifery* in 1760, attacking especially William Smellie and his methods. Towler & Bramall 1986, 104–106; Donnison 1999, 43–44, 46–47; King 2012, 108–109.

491 Cody 2008, 187, 190–192, 195; Lewis 1986, 87, 103, 110; Keller 2003, 77–78. See also Wilson 1995, 192; Porter & Porter 1989, 181; Moscucci 1990, 50; Lawrence 1995, 204; Jacyna 1992, 255; Hanson 2004, 19–20. Eighteenth-century man-midwives, such as William Hunter, socialised with their patients, played cards and drank tea with them. They could also assist in socially delicate cases, when their aristocratic patients gave birth out of wedlock. On Hunter, see Porter 1987a, 222–224; Porter 2001, 175–176, 224–225. On the ideal of an unselfish and heroic doctor, see Porter 2001, 258–260.

492 R. S. [anonym.], Attendants at Accouchements. *The Lancet*, February 26, 1842, 760. See also Murphy, Edward W., Introductory Lecture on the History of Midwifery. The *BMJ*, May 14, 1864, 523–528.

is *not* a doubt that in the particular line of *childbirth & women's* illnesses the English are the *best* in the World, more skilful & *much* more *delicate*".[493] However, this somewhat patriotic opinion of the Queen was not shared by everyone, occasionally not always by the Queen herself, who generally detested the reproductional expectations placed on a woman, famously discussing "those nasty doctors" with her female relations.[494] But as one of the most well-known medical woman of her time, Elizabeth Garrett Anderson (1836–1917), who was the first female medical practitioner to qualify from the British medical school, underlined in 1898, in general medical studies, midwifery could be "squeezed into a few weeks", thus leaving many graduating doctors with scanty practical experience of childbirth after finishing their training.[495] As Garrett Anderson pointed out, the majority of students and their teachers trusted in learning midwifery later by "experience", *after* they had already graduated and were practising medicine in lying-in hospitals, infirmaries, and private practices. This experience, as Garrett Anderson noted, was very expensive, because experience "based upon ignorance" was "a bad teacher".[496] At worst, the practical situation could be, as described in 1843, that young medical men attending midwifery cases were guided only by "a few hasty instructions from their master, and assistance of a friendly nurse".[497]

As the medical historian Anne Digby has observed, in nineteenth-century Britain, the professional landscape in medicine was complex, regional characteristics were great, and regulation varying.[498] During the nineteenth century, three traditional medical estates, *physicians*, *surgeons*, and *apothecaries*, were transforming while medical qualifications, control, and education were being re-defined, standardised, and specified. Historically, medical men had been divided – somewhat heterogeneously – into three different estates. *Physicians*, who were the

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493 Queen Victoria to her granddaughter Victoria of Battenberg, September 6, 1894. Hough 1975, 126. See also for example Dinner of the Obstetricians and Gynaecologists of the Empire. The *BMJ*, July 12, 1902, 139–140. On the differences between Britain and German medical systems and education, see van Heteren 1995, 286–330.

494 See for example Queen Victoria to her eldest daughter Victoria, March 24, 1858. *Dearest Child* 1964, 77–78; June 15, 1859. *Dearest Child* 1964, 195; July 11, 1860. *Dearest Child* 1964, 265. See also The Queen and Her Medical Advisers. The *BMJ*, June 19, 1897, 1579–1586; Sir Charles Locock. Obituary. The *BMJ*, July 31, 1875, 151. On Queen Victoria's early motherhood, see also Ward 1999, 277–289. See the critique in Ryan 1836, 126.

495 Garrett Anderson, Elizabeth, Deaths in Childbed. The *BMJ*, September 24, 1898, 927. See also The Address in the Section of Obstetrics and Gynaecology. The *BMJ*, September 18, 1897, 726. See also Leavitt 1986, 42–43; Smith 1979, 22–23; Moscucci 1990, 68–69. See more about Elizabeth Garrett Anderson in Perkin 1993, 38–39; Digby 1994, 294–295; Donnison 1999, 81; Watts 2007, 127, 130; Miss Garrett. The *BMJ*, April 23, 1864, 452. On female doctors and hospitals, see Elston 2001, 73–99. See also Rentoul, Robert, The Education of the Student in Practical Midwifery. The *BMJ*, September 28, 1895, 808; Rentoul, Robert, The Education of the Student in Practical Midwifery. The *BMJ,* November 23, 1895, 1320–1321. On the situation in Canada, see Mitchinson 1991, 172–175.

496 Garrett Anderson, Elizabeth, Deaths in Childbed. The *BMJ*, September 24, 1898, 927. See also Playfair 1876, 7.

497 Reviews. The *PMSJ*, December 16, 1843, 210. See also Playfair 1893a, vii–viii. See also for example Obstetric Teaching and Puerperal Mortality. The *BMJ*, October 5, 1878, 527–528.

498 Digby 1999, 3–4.

most distinct group amongst medical professions, were university graduates and at the very top of the medical hierarchy, often with prestigious connections and wealth, but not necessarily with practical knowhow. A typical physician was merely "a thinker, not toucher", as Roy and Dorothy Porter have described; physicians' diagnoses were based on visual observation and the description of the patient rather than detailed physical examination or interventions.[499] *Surgeons* were in the middle of the medical hierarchy; they were not trained in universities but apprenticed, some of them living "in the grey areas between respectability and gentlemanly rank", as the medical historian Susan C. Lawrence has pointed out.[500] They practised the manual part of medicine, that is to say, they performed surgical operations, pulled teeth, amputated limbs, and dressed wounds and ulcers. The third estate, *apothecaries*, were the largest order of medical practitioners who sold drugs and offered medical care as well. They were often respectable tradesmen but rarely gentlemen, being "doctors" of the lower classes, as Irvine Loudon, for example, has described.[501]

These three groups constituted a medical profession prior to the 1850s and the *1858 Medical Act*, but as many historians have illustrated, medicine often happened outside these categories; a large proportion of people were treated by other than the three established medical estates, and various healing practices existed alongside the more professional sphere of physicians, surgeons, and apothecaries.[502] Thus, midwives or wise-women, being the traditional group attending childbirth, were just one group amongst the *irregulars*, as these healers providing alternative medical care have been called.[503]

The main structure of the newly organised medical profession was created by the middle of the nineteenth century.[504] There had been growing discontent and a fear of losing professional authority to irregulars; medical education was notoriously uneven and there was no state control or licensing system to separate

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499 Porter & Porter 1989, 74–75. See also Porter 1996, 92–93; Bynum 1996, 2–4; Lane 2001, 1, 12, 15; Weatherall 2000, 10, 33. The oldest universities in England, Oxford and Cambridge, offered medical education only to a small group of medical men. Thus, some British physicians studied at European universities, such as at the University of Leiden. In the eighteenth century, the Scottish universities in Edinburgh and Glasgow replaced the Dutch education. See also Porter & Porter 1989, 17–18, Lawrence 1995, 200–203. Physicians often lived near royal or aristocratic residences and during the season, some stayed in spa towns. The care and advice they provided were expensive, making them unavailable for most. Lane 2001, 15–16; Moscucci 1990, 8–9; Digby 1994, 12–13, 20, 109, 170–171, 187; Loudon 1999, 19–20; Porter 2001, 171–172.

500 Lawrence 1995, 203. See also Moscucci 1990, 52–53; Peterson 1978, 10–11; Porter 1996, 93; Bynum 1996, 4–5; Lane 2001, 16. On the medical apprentice, see Loudon 1999, 39–48.

501 Lawrence 1994, 203; Moscucci 1990, 60; Lawrence 1994, 12–14; Bynum 1996, 5–6. On all three medical estates, see also Porter 2001, 171–174.

502 Lawrence 1994, 8–9, 36–37; Moscucci 1990, 9; Loudon 1999, 19–22; Smith 1979, 418–420; Churchill 2012, 8–10. See also Digby 1994, 29, 30, 107. Anne Digby has noted that in reality the distinctions between the three medical estates were not clear-cut. On cunning-folk medicine, see also Davies 1997.

503 See for example Loudon 1999, 8.

504 See for example Loudon 1999, 3; Loudon 1996, 219–247; Peterson 1978, 5–6. See also Bradley 2000, 31–33.

a regulated practitioner from an irregular one.[505] *The 1815 Apothecaries Act* was the beginning of regulation of the medical profession in Britain but ultimately the act did not solve the problems of medical training, nor the position of general practitioners, druggists, and midwives, for example.[506] The *1858 Medical Act* was an attempt, after long debating and countless failed bills, to create a definition of the training and a status of medical doctor, in addition to a general state regulation system in medicine, but eventually it was a disappointment to many, above all to general practitioners. The act did not outlaw unorthodox practitioners, herbalists, or homeopaths, as it merely protected the title of "doctor".[507] Thus, as Anne Digby has stressed, in the mid-1850s medicine was only very slowly moving towards the key elements of professionalism, including homogeneity of the members, equal education, and training providing "a minimum level of standards", and control over the monopoly of medical practice, all purposes doctors were so desperately trying to achieve.[508]

Furthermore, the new *1858 Medical Act* did not require registered practitioners to hold a license in obstetrics.[509] For example, in the 1840s and early 1850s, regulation in midwifery was minimal: as Judith Schneid Lewis has pointed out, theoretically anyone who wished, could establish himself or herself in the practice of a midwife – or a man-midwife, or more fashionably an *accoucheur* – before the year 1858.[510] In fact, it was not until 1886 and the *Medical Act Amendment Act* that all medical students had compulsory examination in medicine, surgery, and midwifery.[511] Thus, in the nineteenth-century, the medical field was uneven and the standards of obstetrics inadequate: an average medical man, after finishing his training, was not necessarily fully competent in handling especially complicated labours nor had the necessary knowledge of the mechanism of childbirth in general. Hence, the criticism of Elizabeth Garrett Anderson was indeed justified.

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505 Loudon 1999, 132–133; Loudon 1996, 222–233; Peterson 1978, 5.

506 See for example Loudon 1999, 167–207; Loudon 1996, 233–236. See also Peterson 1978, 21–23; Digby 1994, 28; Digby 1999, 43–48; Lane 2001, 29–30; Burnby 1995, 23, 31; Moscucci 1990, 61–62.

507 Loudon 1999, 297–301; Loudon 1995b, 233–245; Digby 1994, 7, 19–20, 31, 57; Digby 1999, 32–39, 47; Peterson 1978, 30–39; Roberts 2009, 37–56; Poovey 1987, 149–150; Porter 2001, 255–257; van Heteren 1995, 288; Moscucci 1990, 66; Bynum 1996, 179–180. Throughout the nineteenth century, the ongoing theme in the *BMJ* were the letters and comments on the question of who was a doctor; see for example the *BMJ*, December 27, 1862, 669–670. See also Ballantyne 1889, 13–14.

508 Digby 1994, 28. See also Lane 2001, 11. See also Lawrence 2004.

509 Moscucci 1990, 66; Loudon 1999, 141. On the popularity of midwifery courses in the eighteenth century, see Burnby 1995, 26. See also Lawrence 2004.

510 Lewis 1986, 86–87; Donnison 1999, 54.

511 Loudon 1999, 298; Loudon 1996, 228; Digby 1994, 31, 267; Digby 1999, 38, 200–208; Peterson 1978, 278–279; Smith 1979, 22–24; Moscucci 1990, 74; Worboys 2000, 20–21. See also the discussion in the 1860s and the suggestion of Robert Barns in order to improve midwifery in medical training in Moscucci 1990, 68. See the examples of the questions asked in medical examination papers in 1860 in St. Andrews University. The *BMJ*, October 1860, 807. See also Rentoul, Robert, The Education of the Student in Practical Midwifery. The *BMJ,* November 23, 1895, 1320–1321; The Practice of Midwife. The *BMJ*, May 16, 1896, 1239. On the situation in the United States, see Borst 1995, 93–101.

On the other hand, as Lisa Cody has argued, in the eighteenth century, man-midwives had already launched their own revolution in medical education. Until the early eighteenth century, there had been two routes to the profession; the first, an elitist and expensive way was to take a degree at Oxford or Cambridge. The second choice was to serve as apprentices to already established surgeons or apothecaries.[512] New man-midwives gave public lectures on midwifery and published illustrated manuals and atlases of maternal and foetal anatomy. Moreover, medical education was concentrating in London, Edinburgh, Glasgow, and Dublin, on a small number of teaching hospitals, most of which had been founded in the eighteenth century.[513] Especially Scotland and its universities played an important part in medical education and research.[514] As Cody has observed, during the eighteenth century, most prominent man-midwives were commoners from Scotland, who had moved to the big cities like London and established their careers with the help of their prestigious patients, medical societies, and recently established lying-in hospitals. As Cody has argued, eighteenth-century Scottish man-midwives "emphasized their masculine authority, their disdain for popery, and their patriotism", helping to create a *British* identity.[515] Many nineteenth-century obstetricians followed in the footsteps of their eighteenth-century predecessors carrying the traditions of the Scottish colleges. Some of the most famous Victorian obstetricians were, in fact, Scottish, such as James Young Simpson (1811–

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512 Cody 2008, 161; Peterson 1978, 5–8; Porter & Porter 1989, 20; Bynum 1996, 2–3; Loudon 1995b, 230; Geyer-Kordesch 1995, 94; Lane 2001, 26. Indeed, students at Oxford and Cambridge were usually those with wealth and connections; some simply bought their degree in medicine.

513 Loudon 1995b, 229, 230. See also Peterson 1978, 3, 15; Moscucci 1990, 51–52; Digby 1994, 12–13; Digby 1999, 68–76; Burnby 1995, 27–28; Risse 1996, 178–186; Bynum 1996, 3–6; Cody 2008, 153–157. The Universities of Edinburgh and Glasgow offered the best possible education in obstetrics and gynaecology; the faculty of medicine was established at the University of Edinburgh in 1726 and by the end of the eighteenth century, it was the leading centre of medical education in Europe. Edinburgh had the first Professor of Midwifery, Joseph Gibson, who was appointed by Edinburgh Town Council in 1726. Cody 2008, 156; Geary 1995, 51; Geyer-Kordesch 1995; Jacyna 1995, 141–151; 96–101, 106; Donnison 1999, 35. See also Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 300. Moreover, the structure of Scottish medical corporations differed from England; for example, Glasgow had a Faculty of Physicians and Surgeons, whereas in England the three corporations were more divided. See Moscucci 1990, 53.

514 In Scotland, medical students studied midwifery for six months, which was considerably longer than in London, for example. Moscucci 1990, 69. See also Lawrence 1994, 16–19; Digby 1994, 54; Donnison 1999, 35–36; Weatherall 2000, 11; Worboys 2000, 21. See also Madden, Thomas More, An Address Delivered at the Opening of the Section of Obstetric Medicine, at the Annual Meeting of the British Medical Association. The *BMJ*, August 18, 1888, 343–344. This particular address celebrated the work of William Smellie, William Hunter, and James Young Simpson.

515 Cody 2008, 152–154, 158, 186, 220; Moscucci 1990, 51, 54. Indeed, many eighteenth-century Scottish medical men seized the moment when entering midwifery, whereas many of their English peers seemed to have ignored this possibility. According to Cody, many Scots were mocked for their accents and manners in England but it did not stop their success. See also Madden, Thomas More, An Address Delivered at the Opening of the Section of Obstetric Medicine, at the Annual Meeting of the British Medical Association Held in Glasgow, August, 1888. The *BMJ*, August 18, 1888, 343–344.

1870), two of his students James Matthews Duncan (1826–1890) and William Smoult Playfair (1836–1903), Murdoch Cameron (1847–1930), and John William Ballantyne (1861–1923), all being very well recognised and respected figures in both medical literature and journals.

One result of this "period of medical reform", as the period between the late eighteenth and the middle of nineteenth century has been called, was the appearance of a new form of medical professional, a *general practitioner* (GP).[516] As Irvine Loudon has argued, the general practitioner, who belonged to the largest group of medical practitioners in nineteenth-century Britain, had evolved from the surgeon-apothecary and eighteenth-century man-midwife.[517] The general practitioner was no harbinger of modern disease and microscopic-centred medicine, as Anne Digby has pointed out; quite the contrary, he personified more "traditional 'whole-person' medicine".[518] The general practitioner, whose historical portrait is often stamped with retrospective nostalgia, was namely a family doctor, not too expensive but familiar and sensitive, and what was most important, expected to deal with a wide range of medical conditions with skill, experience, and tact.[519] Childbirth was one very important area of operation of general practitioners.

However, despite these educational differences and distinctions between medical estates, nineteenth-century doctors themselves understood themselves namely as the professionals of medicine; they constantly emphasised long traditions, collective identity and solidarity, and the internal integrity of their profession. A practitioner was always a part of the group bound together with loyalty; "gentlemanly and honourable kind of professional and kindly intercourse" should exist between the members of the medical profession, as one writer noted in 1843.[520] Doctors were an "imagined community", fostering a sense of communality and fellowship, common traditions, and shared symbols.[521] At the same time, doctors excluded "the others" outside of this professional circle, and guarded and redefined the line between respectable medical men and those they had declared "quacks" or non-professionals. Authority was gained by following

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516 Digby 1999, 2; Loudon 1996, 219, 240–245; Worboys 2000, 20–22. On the period of medical reform and the evolution of hospitals, see Loudon 1999; on eighteenth-century hospitals, see Lane 2001, 82–95.

517 Loudon 1999, 2, 24, 93, 225. See also Donnison 1999, 35; Moscucci 1990, 58–59; Lane 2001, 47–48; Loudon 1996, 228. According to Irvine Loudon, the term "general practitioner" was slowly adopted into the general language, coming into common usage in the second and third decades of the nineteenth century. See also Accoucheurs. *The Lancet*, April 20, 1844, 134–135.

518 Digby 1994, 101. See also Worboys 2000, 21; Porter 2001, 255–257.

519 Loudon 1999, 275–279; Loudon 1996, 240–245; Digby 1994, 101–102; Worboys 2000, 21; Porter 2001, 262.

520 Shearman, E. J., Case of Perforation of the Bladder by Mistake during Parturition. The *PMSJ*, December 30, 1843, 243. See also Sheen, Alfred, An Address on the Relation of the Medical Profession. The *BMJ*, November 8, 1884, 896–901: "What is medical etiquette? In its general principles, I would say it is a mere question of common sense and gentlemanly feeling. We should be loyal and honest to one another". See also Ballantyne 1889, 3–4, 7. See also Worboys 2000, 21–22; Digby 1994, 61.

521 An "imagined community" is a term introduced by the political historian Benedict Anderson in the 1980s. Originally, Anderson used the concept to describe how nations, nationality, and nationalism were socially constructed and imagined. See Anderson 2007.

the norms and standards of medical practice.[522] Ludmilla Jordanova has aptly pointed out that eighteenth-century man-midwives saw themselves as "not quacks and not midwives", defining themselves "in more subtle ways in relation to their patients depending on the latter's wealth, status and gender".[523] Redefining the line between professionalism and quackery was indeed very characteristic of the nineteenth-century medical men.

In nineteenth-century medicine, a quack was a very important figure; s/he was someone "supposedly practicing medicine in bad faith", as the term was used in early modern England, according to Roy Porter. A quack was someone abnormal or a pretender; s/he was always represented as potentially dangerous, someone who "drummed up custom largely through self-orchestrated publicity; who operated as individual entrepreneurs rather than as cogs in the wheels of the medical community [--] and who depended heavily upon vending secret nostrums", as Porter has described.[524] For example, Ernest Hart, the editor of the *BMJ*, noted in 1893 that a quack was a "reader of riddles" and "a conner of conundrums".[525] A quack was deemed an imposter who lacked formal education, degrees, and certifications; he or she wanted to gain from other people's misery and distress, shame, desire to look or feel better, or actual hypochondria, disguising it in hullaballoo and bombast, a circus-like show, false testimonials, exaggeration, flattery, and miraculous recoveries. A stereotypical quack loved advertisements and self-boasting "of the most fantastic, false, and dangerous character", as Hart described.[526] All in all, the term was negatively loaded, stigmatizing, and invariably defined by someone else than by the "quacks" themselves. Quackery *looked* like medicine, and a quack *looked* like a doctor, often imitating the treatments, drugs, publications, and special language of regulars.[527]

As doctors wanted to emphasise, quackery was against everything the medical profession held dear: the ideas of science, progress, and respectability.[528] However, in reality, the line between quackery and the respectable and orthodox profession of medicine was far from clear. As Roy Porter has argued, there had been a long-running struggle between "orthodoxy and fringe, centre and periphery, establishment and radicals, corporatism and populism".[529] Eventually it was

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522 Porter 1989, 63–64.

523 Jordanova 1999, 13. See also Mason 1995, 187–188. On female quacks, see Porter 1989, 82–85. See also Roberts 2009, 41–42.

524 Porter 1989, vii. See also Loudon 1999, 14; Smith 1979, 333–342; Digby 1994, 27, 62–68; Burnham 2005, 23–24.

525 Hart, Ernest, The Medical Profession, the Public, and Medical Etiquette. The *BMJ*, October 21, 1893, 884. Hart quoted the famous writer and essayist Samuel Johnson, *Dr. Johnson* (1709–1784), who defined quack as follows: "a vain, boasting pretender to physic, one who proclaims his own medical abilities in public places; an artful, tricking practitioner in physic."

526 Hart, Ernest, The Medical Profession, the Public, and Medical Etiquette. The *BMJ*, October 21, 1893, 884. See also Sperry 1900, 221–222.

527 Porter 1989, 1–8, 94–95, 97–122; Porter 1987b, 73–95.

528 Porter 1989, 12; Loudon 1999, 2, 210–214; Lane 2001, 9.

529 Porter 1989, 16. See also Porter 1987b, 76–77; Loudon 1999, 13–28; Digby 1994, 24–25. See also Duden 1991, 73–78.

also competition over patients, professional reputation and prestige, money, politics, and the power over medical definitions, concepts, and treatments.[530] Moreover, the services of established medical practitioners were often beyond the lay people, being both too expensive, intimidating, and suspicious or otherwise unavailable.[531] For many, non-professional medicine was also a necessity or a hobby – in the eighteenth century, these semi-professionals had occasionally been educated men, such as clergymen, but home doctoring, domestic remedies, and neighbourly support have always been an indispensable part of self-medicine and healing.[532] Thus, these so-called professionals were not usually the first or even the second choice in sickness. Especially female midwives maintained an important role in poor, industrial districts.[533] Indeed, as W. F. Bynum has stressed, if an individual patient wished to consult the healer, "they were free to do so, so long as that healer had not misrepresented himself [or herself]" as a medical doctor.[534] Patients had their autonomy to choose between different healers and "from a wide range of strategies", concerning their health and sickness.[535]

Thus, even if at a certain distance the medical profession seemed monolithic in its attempts to control, regulate, and standardise the medical field and to define its medico-moral codes and teaching, nineteenth-century medical men and a few women were not a particularly homogenous group. Practitioners were divided by the place they were living (particularly doctors living in cities and rural doctors), where and how they were educated, how well they were connected with their medical peers and society, what kind of social background they had, and what their social-economic situation was after they had established a medical career.[536] The profession itself was divided into different groups, and new ideas and news of medical inventions and breakthroughs were spreading unevenly – there was an ongoing interplay between the traditional and scientific, as Anne Digby has observed – all new ideas and practices also faced opposition, criticism, and, occasionally, disinterest and direct apathy.[537]

Moreover, doctors were constantly struggling for position, status, and power, even if medicine was becoming socially more acceptable, and occasionally even a route to genteel and social prestige. In the nineteenth century, the medical profession was growing larger, it was becoming growingly popular as a career, and eventually there was an over-producing of general practitioners.[538]

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530 See for example Loudon 1999, 7, 18.

531 Porter 1989, 21. See also Porter 1996, 98; Mason 1995, 187–188; Loudon 1999, 101–103; Digby 1999, 99. On cunning-folk, see also Davies 1997.

532 See for example Loudon 1999, 14–16; Porter 1996, 96–114; Holloway 1998, 82; Beier 2002, 119–121.

533 See for example Loudon 1999, 15–16; Beier 2002, 121.

534 Bynum 1996, 179; Lane 2001, 29–30;

535 Digby 1994, 300. See also Porter 1996, 94.

536 Mitchinson 1991, 23–24; Loudon 1999, 199–206; Digby 1994, 25–27; Digby 1999; Smith 1979, 346; Peterson 1995, 36.

537 Digby 1994, 5, 69. See also Worboys 2000, 3–5; Bynum 1996, xi–xii. As W. F. Bynum has noted, also more traditional members of the profession and those who were not interested in "the claims of science within medicine", benefitted from that credibility that science gave the medical profession collectively.

538 Loudon 1996, 240–245; Loudon 1999, 129, 189, 208, 214–223; Digby 1999, 40–43, 66–67, 93–106. Lane 2001, 26, 30.

As Digby has pointed out, practising medicine and making money "coexisted in an uneasy – if necessary – symbiosis".[539] Thus, making a decent medical living could be difficult and the competition for patients was hard. As for example Irvine Loudon has stressed, nineteenth-century medicine has to be understood in the context of the struggle for patients, for rank, and position in society. The growth of medical education, medical registration, the development of hospitals, and the growing importance of the discourse of medical science and laboratory medicine obviously had their significance in medical work, but ultimately these aspects did not concern the life of an individual practitioner personally as much as a decent livelihood and the ideals of class, respectability, and social position.[540]

At the beginning of the nineteenth century, midwifery had been a routine part of most medical practitioners' work, but one of the greatest problems was the low appreciation of midwifery within medicine itself.[541] For example, William S. Playfair called obstetrics "the Cinderella of medicine", because the branch was ignored and excluded from mainstream medicine.[542] This put the idea of progress in a complex relation with obstetrics and its position in the medical field. As one doctor wrote in the 1840s: "[m]idwifery is considered by some members of our profession too unimportant a branch of medicine to engage the attention of scientific men, who contend that the practice is degrading, and ought to be left to old women and nurses".[543] The low appreciation of midwifery was partly explained by the fact that obstetrical work was not particularly easy; the work of an accoucheur was not pleasant because of the burden of professional responsibility, the strict moral codes defining the patient–doctor relationship, and the constant fear of complications and misdiagnosis. Moreover, practical midwifery called for patience and time; as Alexander Russell Simpson (1835–1916, not to be confused with his uncle James Young Simpson), a professor of midwifery from Edinburgh, stressed in 1898, "it cannot be done in the course of an afternoon walk. It means the occupation of hours – it may be of a whole day or a whole night [--] No; it is not fair."[544]

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539 Digby 1999, 93, 137–148, 161–162. See also Porter 2001, 144–145.

540 Loudon 1999, 274. See also Peterson 1978, 91–98; Smith 1979, 346; Digby 1994; Watts 2007, 65–67. On gentlemanliness in Victorian England, see for example Tosh 2002, 455–472; Boddice 2016, 1. See also Nead 1988, 28–29. See also Accoucheurs. *The Lancet*, April 20, 1844, 134–135. See also for example C. [anonym.] Midwifery Engagements. The *BMJ*, October 23, 1880, 689.

541 See for example Yeniyurt 2013, 22, 25–26. See for example Accoucheurs. *The Lancet*, April 20, 1844, 134–135.

542 Playfair, W. S., Introductory Lecture on the Progress of Obstetrics. The *BMJ*, May 4, 1872, 463. See also Loudon 1996, 228; Loudon 1992, 173–174; Loudon 1999, 91; Lane 2001, 125; Yeniyurt 2013, 22.

543 Toogood, Jonathan, On the Practice of Midwifery, with Remarks. The *PMSJ*, May 22, 1844, 103.

544 Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 302. See also Swayne, J. G., Introductory Lecture on Midwifery Delivered at the Bristol Medical School. The *PMSJ*, October 21, 1846, 497–501. See also Welch 1838, 61: "is attended with great anxiety, broken health, immense fatigue, and a considerable interruption to health". See also Digby 1999, 202; Peterson 1978, 99–100; Leavitt 1986, 154. On A. R. Simpson, see Obituary. Sir Alexander Russell Simpson. The *BMJ*, April 15, 1916, 572–574.

Why, then, midwifery was seen as so important for a medical practitioner, especially for a general practitioner? As Alexander Russell Simpson pointed out at the end of the nineteenth century, in medical work, many forms of diseases "may come and they may go from the visiting list, but the midwifery cases go on for ever".[545] What Simpson here noted and what in fact was very true, was that the majority of the cases of a general practitioner were either children or women, most of whom were gynaecological and obstetrical cases.[546] As for example Ornella Moscucci has argued, midwifery had become established "as an entrée into general practice"; first, the young practitioner attended childbirth and then remained in contact with the family, treating its members whenever they needed medical assistance and consultation.[547] Thus, making a decent medical living, a general practitioner needed to know his gynaecology and midwifery. For a young general practitioner, this was particularly important, as Alexander Russell Simpson pointed out; "[i]t is the only gate into general practice that is always open everywhere".[548]

Being a good doctor, however, was not an easy task. As was constantly reminded, book learning and teachings in medical schools, understanding of "the laws of Nature", and technical skills alone did not make a doctor. *Medical etiquette*, or *bedside manner*, were discussed both in professional literature and popular health manuals; that is to say, how a doctor should meet his patients, particularly when the patient was female and the doctor was male. In 1879, the *BMJ* noted in its editorial that "outside critics" had complained that medical men were often "too apt to assume an abrupt and cold manner" towards their patients, treating them "rather as impersonal elements in a scientific problem", than individuals who had feelings.[549] It seems that the journal was somewhat surprised by this accusation, reminding readers that an ideal doctor was always an educated, cultivated, and right-minded gentleman, with the right kind of moral qualities, "large and liberal knowledge", kindness, tenderness, patience, thoughtfulness,

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545 Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 302. See also Peterson 1978, 99–100; on female patients in early modern England, see Churchill 2012, 43–54.

546 Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 302. As Simpson mentioned in his article, one country practitioner he was familiar with had 60 cases in one month, of whom 11 were men, 34 women (13 general cases, 6 gynaecological, and 15 obstetrical), 15 children, and 15 infants. Ibid., 301. See also Swayne, J. G. The Address in Midwifery. The *BMJ*, August 15, 1863, 178: "Every general practitioner will bear [sic] me out when I say that midwifery, in the sense now used, or, as it is more correctly termed, 'obstetric medicine', constitutes at least one-third of his practice."

547 Moscucci 1990, 57–58; Digby 1999, 202–203; Loudon 1992, 185.

548 Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 301. See also Digby 1994, 254–257. On the other hand, Amanda Carson Banks has argued that doctors considered babies "a point of good business". While this argument was partly true, doctors also acknowledged that in midwifery, a patient call was not a sufficient source of income; deliveries could last days but the fee was still the same. Banks 1999, 40.

549 Medical Manners. The *BMJ*, October 11, 1879, 583. See also on intra-professional medical etiquette in Garrett Horder, T., Proceedings of Sections; Section of Ethics. Intra-Professional Etiquette. The *BMJ*, September 14, 1895, 635–636. See also Peterson 1978, 83, 156; Porter 1987b, 78.

courtesy, and "a sense of just dignity". A good doctor treated his patients in the same manner, as the journal stressed: "it is not possible to have one natural manner for the poor and another natural manner for the rich".[550]

Explaining the importance of medical decorum in his little work for midwifery students, *Medical Etiquette* (1889), John William Ballantyne, the Scottish physician, pioneer of ante-natal care, and one of the most famous obstetricians at the end of the nineteenth century, noted that medical education gave very few instructions for future doctors on how to meet their parturient patients in real life encounters.[551] The greatest principle was, according to Ballantyne and as was also stressed by the *BMJ*, that doctors "should treat all patients, both rich and poor, paying and unremunerative, with same courtesy, kindness, care, and sympathy".[552] Ballantyne reminded the students that poor patients, even if they were met in hospital and dispensary practice, were equally sensitive as their better-off contemporaries. Indeed, if the doctor was rude and domineering, or unsympathetic towards the poor lying-in hospital patients, it was "very difficult to modify this habit when we have to do with the middle or upper classes".[553]

Indeed, a good reputation was indispensable in the medical market. Every practitioner was to keep in mind that women talked about the medical staff they were attended by, compared their experiences, and warned about incompetent and rude behaviour if they had come across a medical man who was ill-mannered and unkind. As Alexander Russell Simpson pointed out in his article in 1898: "[e]ach time it is whispered among the ladies that he [the doctor] is specially skilful in the handling of his confinement cases, the rumour of his skill and kindness must fall on the ear of someone who will say to herself: 'My time is coming; I must have him to attend on me'".[554] In the struggle for patients and livelihood, this was particularly important. However, a good reputation could be destroyed, not only by acting in an ungentlemanly way, but also if the patient "in puerperal

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550 Medical Manners. The *BMJ*, October 11, 1879, 584. This was especially important in the hospital work as in in the hospital the doctor met "the poorest, the most suffering". See also Toogood, Jonathan, On the Practice of Midwifery, with Remarks. The *PMSJ*, May 22, 1844, 103. See also Digby 1994, 77, on medical altruism, see pp. 249–253, 310. As Anne Digby has observed, the role of the doctor was indeed often "caring" rather than "curing". See also Porter 2001, 143–144. On medical gentlemanliness, see Lawrence 1995, 204–205; Porter 1989, 92; Lewis 1986, 87–88, 90–92, 103. See also Denman & Ryan 1836, 25–26; Ryan 1836, 48, 56; Ryan 1841, 169. On politeness, see also Elias 1978, 38–40, 100–106. On doctor–patient relationship, see for example Gerlander 2003. On medical ethics, see also Wear 1993, 98–125; Porter 1993.

551 On Ballantyne, see for example Oakley 1984, 46–50. The manual of medical ethics written at the beginning of the nineteenth century, see Percival 1803.

552 Ballantyne 1889, 3–4; Medical Manners. The *BMJ*, October 11, 1879, 584. On medical ethics and etiquette, see also Digby 1994, 59–62, 77–78.

553 Ballantyne 1889, 3.

554 Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 301. See also Swayne, J. G., Introductory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 28, 1846, 513–514; Ryan 1836, 69, 131–135. See one example of the damaged reputation of a practitioner in West, R. U., Fatal and Other Cases of Puerperal Mania. The *Association Medical Journal,* August 11, 1854, 716–718. See also Ryan 1836, 134. See also Digby 1999, 202; Peterson 1978, 106–107, 106–107, 126–132; Jalland 1986, 136; Loudon 1999, 117; Lane 2002, 233–235.

state" died – that is to say, if the parturient woman died of childbed fever, for example.[555] One doctor noted in 1843 how he felt sympathy for all his "professional brethren who have suffered from this cause".[556] Death in childbirth was easily associated with professional incompetence and ignorance.

A good doctor was supportive and capable of psychological reassurance and retaining the patients' confidence and trust, without telling actual lies, offering "hope, comfort, and consolation", as one writer noted in 1846.[557] An ideal medical practitioner was trustworthy and discreet; a doctor was a keeper of family secrets and a witness of the most intimate and personal experiences in human life. As the 1860s popular manual *The Wife's Domain* reminded its readers, a good doctor did not talk to anyone about his patients, "not even to his own wife" – noticing that "a babbling doctor is a dangerous character and a nuisance".[558] Moreover, a bad doctor was inclined to petulance, coldness, roughness, hurry, and impatience, and in matters of childbirth, potentially inclined to meddlesome midwifery.[559] On the other hand, a bad doctor was also weak, insecure, timid, and nervous, being indecisive and unable to make quick judgements and perform the necessary treatments and operations, knowing that he caused the patient inevitable distress and pain, even the risk of death.[560] In obstetrics, complicated situations, when all remaining options were often equally bad, were particularly demanding for the practitioner, as I will discuss further in other chapters in this study.

Court cases, patient records, and letters sent to the medical periodicals revealed that despite the high moral expectations and codes of professional honour, some practitioners actually abandoned their patients if their obstetrical cases turned worse or turned up drunk in the birthing room.[561] As Jacques Gélis has

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555 See for example Swayne, J. G., Introductory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 28, 1846, 513–514.

556 McEgan, W. B., Malignant Puerperal Fever. To the Editors of the Provincial Medical Journal. The *PMSJ*, November 25, 1843, 146–147. See also Digby 1999, 202–203; Lewis 1986, 116–117.

557 Swayne, J. G., Introductory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 28, 1846, 513. See also Ryan 1836, 150; Ryan 1841, 169. W. F. Bynum has argued that doctors often kept their dying patients in the dark until they decided on the right time to reveal the truth, "believing that hope was literally one of the best medicines available". See Bynum 1996, 211; on patient-practitioner trust, see Churchill 2012, 82–89; Porter 2001, 227–228; Digby 1992, 77–78. See also Jacyna 1992, 258. See also Lupton 1996a.

558 Philothalos 1860, 31–32. See also Turner, Thomas, Introductory Address. The *PMSJ*, October 17, 1840, 37. See also Lewis 1986, 110–111; Digby 1994, 265.

559 Philothalos 1860, 31–32. See also Medical Manners. The *BMJ*, October 11, 1879, 584; Accoucheurs. *The Lancet*, April 20, 1844, 134–135; Ryan 1841, 21. See also Forceps Practice. The *BMJ*, May 14, 1859, 391–392.

560 See for example King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturient. The *Association Medical Journal*, November 4, 1853, 965–969.

561 On drunken doctors and childbirth, see for example The Week. The *BMJ*, March 12, 1859, 211–213. In this case, the doctor tried to perform a craniotomy, using considerable violence, ultimately killing his parturient patient. See also Forceps Practice. The *BMJ*, May 14, 1859, 391–392. In this case, the doctor, appearing "intoxicated", lacerated the patient's vagina with the forceps; the parturient died undelivered "after lingering some days".

pointed out, the attendant's incompetence, ill-judged interventions, panic, and lack of skills could sometimes lead to horrible consequences.[562] For example, in 1844, in the case of haemorrhage during complicated childbirth, a doctor originally engaged to attend labour simply disappeared, as his peer described: "[i]n [- -] this case, which required much personal exertion, I was entirely deprived of the services of the party in previous attendance, who, frightened at the serious aspect which the case put on, had taken to his heels before my arrival and never returned."[563] In 1901, one retired surgeon commended in the *BMJ* the case of a working-class woman, who had died after three individual doctors had refused to attend her. The distraught husband of the woman had tried to call for help, but doctors merely responded that they had not been "engaged" in advance and the husband could not afford to pay their fees.[564] The original correspondent found the conduct of his peers "shocking", despite the court eventually declaring that the woman's death had resulted from "natural causes" and not from neglect or malpractice. The case demonstrated that doctors' ethical codes and medical oaths were in reality a far more complex matter than their professional ideals led to believe.[565] It also showed what Anne Digby has observed – the capacity "to meet the doctor's bill was a factor of growing importance" in medical practice.[566]

On the other hand, decency and codes of decorum had a lot to do with the practical interaction between the doctor and the patient. According to the popular medical saying, a good surgeon needed "an eagle's eye, a lady's hand, and a lion's heart".[567] As many accounts showed, a nineteenth-century *accoucheur* needed mainly his hands and heart; visual perception was often seen as less crucial than touch and personal stamina, even if the importance of the sense of sight was becoming growingly more important during the nineteenth century, espe-

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562 Gélis 1991, 231.

563 Davies, John Hall, Cases in Midwifery. Haemorrhage both before and after the Removal of the Placenta. *The Lancet*, March 30, 1844, 42. See also Swayne 1893, 1; Ballantyne 1889, 5. See also Serious Charge against a Surgeon. The *BMJ*, November 14, 1857, 952–953; Trial for Manslaughter. The *BMJ*, May 9, 1863, 492–493.

564 Ince, John, Doctors and Midwives. The *BMJ*, October 19, 1901, 1209–1210. The woman had been attended by an uncertificated midwife who, once realizing that she was unable to help the woman, sent the husband to get a doctor. However, one of the doctors justified his decision not to attend the case by saying that he "did not follow midwives". To him this was a question of power, authority, and medical prestige. See also Gratuitous Services: Their Reward. The *BMJ*, March 19, 1864, 317–318.

565 See also the responses Doctors and Midwives. The *BMJ*, October 26, 1901, 1300. One doctor reminisced about the case when he saved the life of his parturient patient, only to be left without his fee and with his clothes spoiled. "After this case succeeding on many others, I fully resolved not to attend another unless previously engaged or the people were well known to me". See also Doctors and Midwives. The *BMJ*, December 28, 1902, 1873.

566 Digby 1994, 2, 19. See also Lewis 1986, 92–94. See also Malet, Henry, The Relations of Medical Men to Their Patients and of the Profession to the Public. The *BMJ*, July 26, 1902, 234–236. See also Midwifery Fees. The *BMJ*, July 9, 1887, 76.

567 Swayne, J. G., Introdutory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 28, 1846, 512. See also Marsh 2015, 31. Ballantyne wrote in his little book of medical etiquette: "in medicine, as much or more than in all other professions, it is necessary to have a steady hand, the acute eye, and the unclouded brain". Ballantyne 1889, 7.

cially due to artificial light and the use of instruments. Thus, the medical attendant did *not* need to *see* the patient's body; the most important and informative sense in obstetrics was in fact *touch*.[568] As one writer noted in 1853, touch was indeed "the eye of the accoucheur".[569] Touch, physical contact with hands and body, has always been a culturally regulated and severely restricted interaction between the healer and the patient. The doctor had in many ways unique access to the patient's body and the touching of the body was becoming a central feature of the medical encounter; the touch of a doctor was often authoritative, expressing a culturally validated system of knowledge and values, as for example the British author and birth activist Sheila Kitzinger has noted.[570] Kitzinger herself divided touch in childbirth into seven different categories: blessing touch, comfort touch, physically supportive touch, diagnostic touch, manipulative touch, restraining touch, and punitive touch.[571] This division, however, does not include sexual and indecent touch, which are morally impropriate and corruptive, and were a constant threat in the nineteenth-century medico-cultural discourse of obstetrics and gynaecology.[572]

In obstetrical work, the gaze and touch of a male doctor were always potentially indecent, disagreeable, and sexually and morally threatening, both to the patient and her husband, as well as to her family and the whole of society. As Lisa Cody and Roy Porter have both observed, anti-obstetrical literature portrayed man-midwives as potential sexual predators, ready to molest the body of their female patients – and, what was possibly even more disturbing, ready to violate the husband's rights to his wife's body.[573] Traditionally, a physician had kept his distance when treating his patient according to non-interventionist policy, mainly discussing the possible symptoms and giving his advice on diet, exercise, and general hygiene. Barbara Duden has noted how the patient's body had been surrounded by "a kind of personal sphere that could be physically penetrated only in legitimate relationships" – and how doctors did not usually belong to this carefully defined group.[574] However, since the early nineteenth century, doctors could examine their patients using "a battery of new diagnostic

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568 Bull 1865, 183. See also Swayne 1884, 4–5. See also King, George, On the Comparative Size of the Hand of the Accoucheur and of the Female Pelvis. The *PMSJ*, January 8, 1851, 7–10. See also Porter 1987a, 213; Digby 1994, 184–185; Donnison 1999, 23–24. See also Leavitt 1986, 41. On touch in early modern England, see Churchill 2012, 64–71, 78. See also Lawrence 2004, 170–175.

569 King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturient. The *Association Medical Journal*, November 4, 1853, 965: "In operative midwifery it is our sheet anchor; and it is this index and a small hand that enable us to distinguish the state and condition of the presenting parts, and by the exercise of this sense we can only ascertain and judge of what is going on".

570 Kitzinger 1997, 210. See also Porter 2004. See also Duden 1991, 85. On touch and tactility, see Harvey 2003.

571 Kitzinger 1997, 217–229.

572 See for example Gilman 2004, 198–224; Harley 2003, 1–21; Porter 2004, 179–197.

573 Cody 2008, 207–210; Porter 1987a, 210, 210–224; Porter 2001, 223–227; Porter 2004, 185–187; Moscucci 1990, 82, 118–119; Lane 2001, 125; Churchill 2012, 87–89; Sommers 2011, 96–97. See also Bashford 1998, 70–73. On the husband's rights to his wife's body and the fear of infidelity and cuckoldry, see Gowing 2003, 58, 177–179. See also Man-Midwifery. The *BMJ*, January 9, 1864, 58; February 20, 1864, 219–220.

574 Duden 1991, 85.

technology", such as the stethoscope and vaginal speculum, offering the doctor a chance to observe pathological changes and signs within the patient's body.[575] The new medical policy and new technical devices offered physicians powerful methods to diagnose their patients by looking, touching, and listening – occasionally also by smelling.[576] The stethoscope, the instrument of both touch and auscultation, was the invention of a French physician, René Laennec (1781–1826), made in 1816.[577] It has sometimes been argued that by the mid-nineteenth century, the stethoscope had already begun to symbolize the medical profession itself.[578]

In the nineteenth century, the vaginal speculum changed the policy of touch in gynaecological medicine.[579] The speculum, an ancient instrument, was recreated and popularised at the beginning of the nineteenth century by the French gynaecologist Joseph Récamier (1774–1852).[580] It allowed the doctor to observe for example changes in the colourisation of the vagina, if pregnancy was suspected.[581] The speculum made the new medical gaze even more detailed and specific, allowing the practitioner to see the patient internally, the very intimate parts that had previously been hidden from the practitioner's eyes. As the historians

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575 Porter 1987a, 212–213; Porter 2004, 179–197; Harrison 2008, 57–58; Weatherall 2000, 36–37. Unlike Joanna Begiato has claimed, the stethoscope was not a particularly new invention in the 1880s; in fact, it was the invention of René Laennec, who devised the first version of the stethoscope in 1816. The device allowed doctors to listen to their patients' bodies; in obstetrics, the stethoscope was particularly useful, if the doctor only knew how to use the device. See Begiato 2017, 24.

576 See for example Routh, C. H. F., On Some of the Symptoms of Early Pregnancy. The *BMJ*, November 26, 1864, 593–596. On medical senses, see Nutton 2004, 7–16. See also Lawrence 1994, 31, 67; Digby 1999, 188–193; Bynum 1996, 33; Porter 2001, 89–90. Medicine had growingly become more and more interventional in relation to the body already around the eighteenth century when doctors started to take part in dissections, which began to be seen as an essential part of medical work; see for example Lawrence 1995, 201, 206–212, 220. On smell and the miasma theory in medicine, see Wear 1996, 137–139.

577 On the use of stethoscope in midwifery, see Anderson, A., On the Stethoscopic Examination on the Pregnant Uterus. The *PMSJ*, February 17, 1844, 400–401; King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturient. The *Association Medical Journal*, November 4, 1853, 966; Salter, Hyde, On the Stethoscope. Clinical Lectures Delivered at Charing Cross Hospital. The *BMJ*, January 31, 1863, 105–108; February 7, 1863, 133–135; Spencer, W. H., On a New Form of Stethoscope in Its Relations to the Theory and Practice of Auscultation. The *BMJ*, March 28, 1874, 409–411. See also Bynum 1996, 37–41; Nicolson 2004, 134–153; Alberti 2014, 62, 71–74.

578 Bynum 1996, 41; Riddle 1997, 219. See also Harley 1999, 427.

579 Moscucci 1990, 112. See also Gélis 1991, 49–50; Yeniyurt 2013, 23–40; Oakley 1984, 25–26; Porter 1987a, 212; O'Dowd & Philipp 2011, 397–400. See also Bynum 1996, 37–41, 49–50. Concerning popular health manuals, Robert Bakewell carefully explained the speculum to his female readers, its appearance, materials, use, and the general policy of using the aid. Bakewell 1859, 70–72. See also The Speculum in Ancient Surgery. The *BMJ*, November 9, 1889, 1055. See also Ryan 1841, 159; Tanner 1860, 4, 103–113; Playfair 1876, 138–141.

580 Yeniyurt 2013, 23–40; Smith 1979, 16–17; Moscucci 1990, 112, 114. See also Bashford 1998, 72. See for example Toogood, Jonathan, On the Use of the Speculum. The *PMSJ*, May 1, 1841, 86. See also Tosh 1999, 153–155.

581 See the colourisation of the vagina explained in Allbutt 1890, 6–7; Montgomery 1837, 126–128; Ryan 1841, 157; Tanner 1860, 119–120: "The shade is commonly of a livid purple or port wine hue". See also Drew 1891, 21–22.

Ornella Moscucci and Kathryn Yeniyurt have both noted, during the second half of the nineteenth century and especially after the *Contagious Diseases Acts* in the 1860s, the speculum also became "an instrument of the state", as it was used in examining women who were suspected of working as prostitutes and carrying venereal diseases. However, the speculum was not universally approved of by the nineteenth-century medical profession; some considered its use unnecessary and immoral while others fought for its professional legitimacy and respective utility, often with variable success.[582]

Nevertheless, during the nineteenth century, the medical gaze was becoming more interventional and physical; in obstetrics and gynaecology this aspect was particularly obvious in vaginal examination, the *examination per vaginam, introducing* or *application of the hand* or *taking or trying a pain* in labour, which could be performed with or without the speculum. Both medical periodicals and popular health manuals constantly demonstrated that vaginal examination was usually met with some difficulty by the patients themselves who felt that their modesty was threatened and their intimate integrity and respectability were questioned by the male doctor. Indeed, medical writers noted that especially when doctors were dealing "with the opposite sex", the duty of the doctor was to guarantee that the examination was as free from disagreeableness as possible. For example, Thomas Bull described the etiquette of gynaecological examination in his popular manual; first, the doctor requested permission to carry out an examination through the female friend, mother, or a nurse who was also present in the situation. Then the patient placed herself in the bed upon the left side, drew her knees up, and bent the body forward. A blanket or a sheet was thrown over the woman, the curtains were drawn down, and the examination room darkened.[583] The consent of a patient was needed before the procedure: in 1885, one doctor even pondered the possibility, in order to protect himself and his professional reputation, of requesting the woman to sign a certificate allowing the doctor to make the vaginal examination if no chaperon was available.[584] It is not known whether this policy was actually followed – very likely not – but the letter demonstrated how important the question of decency was in practical work, as was maintaining professional respectability and a good reputation.

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582 Yeniyurt 2013, 23–40; Moscucci 1990, 111–113, 123. See also Sigsworth & Wyke 1973, 91–99; Poovey 1990, 29–45; Nead 1988, 22, 144; Pfeffer 1993, 43; Lewis 1984, 85, 89. See also Bartrip 1990, 93–98. See also for example Speculum Cases. The *BMJ*, June 13, 1857, 513.

583 Bull 1865, 183. See also Denman & Ryan 1836, 27–30; Ryan 1836, 72–73, 146–150, 251–253; Montgomery 1837, 112–130; Ryan 1841, 37–38, 160–161; Tanner 1860, 69, 94–98; Black 1888, 53–54; Allbutt 1890, 20, 53; Vincent 1902, 16–17. On the examination described in a professional manual, see Ballantyne 1889, 5–6; Swayne 1893, 2–10; Herman 1891, 85–86; Playfair 1893a, 350–352. As Allbutt noted, "[w]henever an examination is required, a woman should always take a companion with her. Observance of this practice would save much sorrow to both patient and doctor". As Lucinda McRay Beier has observed, in the early twentieth century, a working-class woman meeting a doctor alone was "sinful". Beier 2008, 220; Smith 1979, 16. See also Porter 2004, 185–187, 192–194; Lewis 1986, 112–113.

584 M. D. [anonym.], Vaginal Examination. The *BMJ*, January 31, 1885, 264. See also Graily Hewitt, Vaginal Examinations of Unmarried Women. The *BMJ*, April 1, 1876, 430.

Medicine is and was always created in the interaction between the healer and the patient, and when doctors discussed their midwifery cases and their patients, they also defined themselves in relation to medical ideals, general expectations, and moral codes. Generally, the qualities wanted in a good accoucheur were "knowledge, patience, prudence, firmness, promptitude, and dexterity", and – what was perhaps the most important thing of all – "knowing when they [more interventional operations] ought to be performed", and when not.[585] "Sound judgement and firm determination, without rashness" were called for; this demarcation was particularly important in midwifery, due to risk of meddlesome midwifery.[586] Moreover, an ideal accoucheur had a good constitution, meaning that he "was capable of enduring great fatigue and waiting, so wanted during the long hours of delivery".[587] In 1894, the *BMJ* pondered the general physical appearance of a good obstetrician: should he be "a lady's man", with "a good presence, a soft voice, a gentle hand", or be more unappealing and untidy in his appearance, mainly to "not excite the jealousy of husbands".[588] While the question of the right kind of appearance ultimately remained open, the most important qualities, apart from professional skills, physical strength, and suitable age – not being too young or too old – were listed as follows: "cleanliness, cleanliness, and yet again cleanliness".[589] "Let him wear a beard if he will, but let his

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585 Accoucheurs. *The Lancet*, April 20, 1844, 135. See also Chavasse 1866, 154. See also Lewis 1986, 109–110.

586 Toogood, Jonathan, On the Practice of Midwifery, with Remarks. The *PMSJ*, May 22, 1844, 105.

587 Toogood, Jonathan, On the Practice of Midwifery, with Remarks. The *PMSJ*, May 22, 1844, 103. See also Welch 1838, 61: "[work] is attended with great anxiety, immense fatigue, and considerable interruption to health". See also Servus [anonym.] Holidays and Midwifery Engagements. The *BMJ*, July 1, 1882, 41. See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 228–229. On physical and mental problems of the medical profession, caused by over-work and overstrain, see Digby 1999, 280–285. On "manly vigour", including strength and decisiveness, see Tosh 2002, 460; Tosh 2005, 331–335.

588 An Obstetrical Problem. The *BMJ*, December 1, 1894, 1260–1261. The journal noted that in the end, appearance did not matter, although it was said that "the cultivation of a bearish manner has sometimes been thought to be an element in the successful practice of gynaecology". The beard was volitional, but cleanliness, on the contrary, was not. See also Peterson 1978, 101, 156; Bashford 1998, 142–145. On beard and manliness, see Schiebinger 2004a, 120–125. On the appearance of a doctor, see also Ryan 1836, 61–62.

589 An Obstetrical Problem. The *BMJ*, December 1, 1894, 1260–1261. The appearance of an individual doctor was hardly ever described nor was their clothing. In 1884, the *BMJ* presented new "antiseptic surgery and operating coats", mentioning that before new Listerian [antiseptic] surgery, doctors usually operated in their cast-off coats. The new attire included a long waterproof jacket in three different lengths, a shorter jacket, and an apron, to be used also in midwifery practice. As the journal noted, cleanliness was "next to skill", and the duty of the doctor was to fight against all "septic influences". Ward Cousins, John, Antiseptic Surgery and Operating Coats. Reports and Analyses, and Descriptions of New Inventions. The *BMJ*, April 19, 1884, 769. See also Macdonald, Angus, The Communicability of Puerperal Fever by the Medical Attendant. The *BMJ*, November 13, 1880, 771–774. See also Playfair 1893a, 348–349. See also Porter 2001, 265–268.

nails never be 'in mourning' [short], as the French say, and let him be neither sparing nor infrequent in his ablutions"[590].

The work of an accoucheur (and that of a midwife) was indeed the work of the hands. The hands were the most important instrument of the person who was attending and assisting labours; it was the hands that examined the cervix, observing the general progress and potential complications, they examined the position of the presenting part of the foetus, and supported the perineum when the child was born. Considering the importance of the hands as concrete obstetrical tools, the hands as physical body parts or in relation to the female body were rarely discussed in professional medical literature. One of the rare exceptions was dated to the 1850s, when the physician-accoucheur George King paid particular attention to the size of the hands in obstetrical work. King noted that "an enormous large hand" was "a highly improper instrument" in midwifery; "monstrous large hands and arms (as large as a sign-post)" could cause pain and unnecessary inconvenience, especially if the doctor was forced to pass up the whole hand into the birth canal.[591] As King described, in the case of "a delicate young girl, about 16 or 18, with contraction of the vagina, and with flooding or preternatural presentation", the idea of a doctor with extra-large hands was indeed "frightful".[592]

The ideal hands of an obstetrician were small and delicate, with "very thin and slender arms".[593] They were not, however, female hands, often seen as impatient, unskilled, and contaminating – or, too soft or indecisive.[594] The gender historian Eve Keller has pointed out that in the seventeenth- and eighteenth-century medical discourses, the male hands were guided by the masculine attributes of reason, objectivity, and scientific knowledge, associated with respectability, compassion, patience, and modesty.[595] As the obstetrician Sir William O. Priestley noted in 1895, "a mere skilful pair of hands, unless, dominated by intellectual

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590 An Obstetrical Problem. The *BMJ*, December 1, 1894, 1261. See on midwives and the nails, Puerperal Infection. The *BMJ*, February 12, 1898, 454. See also Unskilled [anonym.], The Use of Antiseptics in Midwifery. The *BMJ*, February 6, 1897, 379. On gloves in medicine, see Lynn Thomas, J., On the Value of Gloves in Operative Work, With a Note on the Cleansing of the Hands. The *BMJ*, January 21, 1899, 140–142. See also Cant, W. J., Gloves in Operative Work. The *BMJ*, February 4, 1899, 316; Spencer, Herbert, R., A Discussion on the Treatment of Fever Following Delivery. Sixty-Seventh Annual Meeting of the British Medical Association. The *BMJ*, October 14, 1899, 965–967. On gloves in medicine, see also Bashford 1998, 144; Shorter 1983, 133.

591 King, George, On the Comparative Size of the Hand of the Accoucheur and of the Female Pelvis. The *PMSJ*, January 8, 1851, 7–10. See also King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturient. The *Association Medical Journal*, November 4, 1853, 967. See also Aveling 1872, 123–124. See also Towler & Bramall 1986, 105–108.

592 King, George, On the Comparative Size of the Hand of the Accoucheur and of the Female Pelvis. The *PMSJ*, January 8, 1851, 7–10. See also Bashford 1998, 72–73.

593 King, George, On the Comparative Size of the Hand of the Accoucheur and of the Female Pelvis. The *PMSJ*, January 8, 1851, 7–10.

594 Shall We Have Female Graduates in Medicine? The *Association Medical Journal*, August 2, 1856, 653–654. On competent female hands, see especially *The Accoucheuse versus the Accoucheur* 1864 [?], iii–iv. See also Sommers 2011, 93; Grant 2011, 139. On female hands in medicine, see Brock 2018, 139.

595 Keller 2003, 71–72. See also Bashford 1998, xii–xiv.

capacity and a high sense of responsibility, may become potential of more harm than good".[596] The hands of female midwives were depicted as potentially destructive, capable of ignorance, violence, haste, and self-promotion, being the very instrument of meddlesome midwifery.[597] Moreover, female hands were contaminating, making women both dangerous and vulnerable at the same time.[598] Especially the historian Alison Bashford has discussed the complex relations of cleanliness and purity, the discourse of sanitation, contamination, and embodiment in the Victorian era, noticing that both patients and practitioners were always sexed – a statement which seemed "too obvious".[599] Female midwives were easily associated with impurity, ignorance, and incompetence, embodied especially in their hands whereas male doctors were guided by the opposite attributes.

On the other hand, the *cleanliness* of hands, whether they were male or female hands, was both an abstract ideal and a very concrete demand; every obstetrician ought to be "scrupulously clean in his person and habits", as the professional textbook *Obstetric Aphorisms* explained in its 1893 edition.[600] This was an ongoing debate but around the 1870s and onwards, after the discoveries of Louis Pasteur in bacteriology become known and the work of Joseph Lister on asepsis was debated, the discourse of "cleanliness, cleanliness, and yet again cleanliness" became a more and more acute question, and *antiseptic midwifery* was named as the primary condition for the progress in obstetrics, together with surgery.[601] Alison Bashford has argued that in the 1860s, as a result of the development of an-

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596 Priestley, William O., An Address Delivered at the Opening of the Section of Obstetric Medicine and Gynaecology. The *BMJ*, August 3, 1895, 287.

597 Keller 2003, 71–72. See also Bashford 1998, 35–39.

598 Traditionally, the touch of a menstruating woman had been contaminating and destructive; anything she touched, was soiled and wasted. See for example Gélis 1991, 13–14. On puerperal fever and hands, see Worboys 2000, 104. However, Michael Worboys has argued that germ theories of disease and health were not "particularly gendered" (see pp. 285–286). In light of the patient records published in the *BMJ*, I found this interpretation too straightforward.

599 Bashford 1998, xiii, 35.

600 Swayne 1893, xi. As one writer noted, when discussing contamination of childbed fever in 1843, "the hand and arm are the chief instruments of contact", and thus, also contagion. Stors, Robert, Observations on Puerperal Fever, Containing a Series of Evidence Respecting Its Origin, Causes, and Mode of Propagation. The *PMSJ*, December 2, 1843, 169. The writer discussed also the clothes of the practitioner, noticing that it would be wise to change them when meeting midwifery patients, especially the coat. See also Elkington, Francis, Observation on the Contagiousness of Puerperal Fever and Its Connection with Erysipelas. The *PMSJ*, January 13, 1844, 287.

601 See for example Smyly, William J., Address in Obstetrics. The *BMJ*, August 11, 1900, 339–340; Galabin, Alfred Lewis, Inaugural Address on Modern Progress in Obstetrics and Gynaecology. The *BMJ*, March 16, 1889, 577–580; Antiseptic Midwifery. The *BMJ*, February 24, 1894, 423. See for example Bashford 1998; Leavitt 1986, 155–167; Worboys 2000, 73–74, 80–84, 150–192. As Michael Worboys has argued, in nineteenth-century medicine, there was a plurality of germ theories and the change in them or "bacteriological revolution" was complex and uneven. According to Worboys, Lister's understanding of septic infection had been "crude" and he was much criticised for it. The general understanding was, however, that the ideas and methods of Lister "had helped to bring about a change in the culture of surgery". See p. 192.

tisepsis, the touch of a male accoucheur "came to be constructed as contaminating one, morally and physically".[602] However, this discussion is in fact much older, even if the introduction of antiseptics did *de facto* change the medical discourse in *surgical hygiene*.[603] By the end of the nineteenth century, antiseptic midwifery and surgical cleanliness had gradually become accepted, and their absence was now rendered "one liable to professional homicide", as the list of obstetrical aphorisms published in the *BMJ* noted in 1881.[604] In accordance with the principles of antiseptic midwifery, all doctors and nurses were advised to wash their hands with water, soap, and a solution of corrosive sublimate or other antiseptic, and to use a nailbrush when they attended women in their confinements.[605]

Indeed, it can be argued that both *medical etiquette* and the discourses of *science, progress* and *cleanliness* protected the woman's feelings of discretion and respect, the doctor's professional and personal reputation, and sexual norms of society. As Roy Porter has noticed, the patient was always "a moral self, integral and inviolable, yet also a diseased body needing treatment".[606] A good doctor knew and remembered his limits and the rules of propriety, practising his art "*cautiously, chastely, and honourably*", as Michael Ryan instructed his fellow doctors in 1836.[607] This was interwoven together with respectability, containing ideas of class, gender, and especially sexuality; respectability was "the means by which morality was made public", as the sociologist Beverley Skeggs has noted.[608] It

602 Bashford 1998, 72–73, 128–132.

603 W. F. Bynum has argued that ultimately it was the microscope that gave medicine its scientific authority. Bynum 1996, 123; on bacteriology, see pp. 127–137. In surgery, carbolic acid or phenol was used as an antiseptic, the former being strongly advocated by Joseph Lister, who introduced the famous carbolic acid spray in 1871. See Worboys 2000, 81–82, 95.

604 Obstetrical Aphorism. The *BMJ*, November 26, 1881, 884. Compare to Smith 1979, 275. See also Leavitt 1986, 160–165. On hygiene and antiseptic midwifery in popular medical literature, see chapter 5.

605 See for example Playfair, W. S., Introduction to Discussion on the Prevention of Puerperal Fever. The *BMJ*, November 12, 1887, 1034–1036; Cullingworth, Charles, An Introductory Address on Puerperal Fever, a Preventable Disease: A Plea for the More General Adoption of Antiseptic in Midwifery Practice. The *BMJ*, October 6, 1888, 746. See also The Nail-Brush Question. The *BMJ*, December 1, 1888, 1236–1237; Smyly, William J., An Address Delivered at the Opening of the Section of Obstetrics at the Annual Meeting of the British Medical Association. The *BMJ*, August 1, 1891, 241; Jardine, Robert, Aseptic Midwifery. The *BMJ*, September 17, 1898, 782–784. See the early example of the use of chloride of lime, Stors, Robert, Observations on Puerperal Fever, Containing a Series of Evidence Respecting Its Origin, Causes, and Mode of Propagation. The *PMSJ*, December 2, 1843, 163–169. See also Herman 1891, 65–68. See also Worboys 2000, 183–184; Wall 2018, 81; Bashford 1998, 142–147; Jones et al. 2018, 577–604.

606 Porter 1987a, 210.

607 Ryan 1836, 68. See also Lewis 1986, 103.

608 Skeggs 1997, 1–3. In short, as Beverley Skeggs has argued, respectability "informs how we speak to, how we classify others, what we study and how we know who we are (or are not)." In the nineteenth century, it became "a property of middle-class individuals defined against the masses". See also Bailey 1998, 30–35: "Respectability primarily enjoinded moral rectitude, but in addition, it also demanded economic continence and self-sufficiency", including self-discipline and self-improvement.

was underlined, however, that the male practitioner was not in fact a human being in the fullest meaning of the word. For example, new technical devices raised moral concern about the relations between a medical man, the body of his female patient and the risk of sexual danger, but as the *BMJ* argued in 1857, the potential abuse of the speculum or stethoscope formed "no argument against its legitimate use", as it was always scientifically justified.[609] Some years later, another writer claimed, when discussing the use of a stethoscope in the examination of a female patient, that the doctor was "a being of no sex", represented as "a mere machine".[610] This was particularly the case of a vis-à-vis consultation; if a male doctor happened to see the bare breast of his female patient, a true professional experienced no sexual feelings nor did he consider his patient a desirable sexual being.[611] In other words, the doctor was interested in the reproductive body of his female patient but only as a professional, in a desexualised and depersonalised way. He was in the service of medicine and science only.

Hence, even if a nineteenth-century doctor was a *man* and he clearly was a gendered human being – that is to say, he was *not* a *female* – he was not a man *with* sexual urges. A "real man" was self-disciplined, able to control his feelings and his body, as Lesley A. Hall has described the nineteenth-century masculine ideals.[612] A female patient was always safe with a male doctor, he was "a friend indeed as one in need, and a friend trusted to a degree above almost any other", as was told in 1902.[613] However, some twenty years earlier, the *BMJ* warned its male readers against too friendly relations with their female patients referring to the recent court case, which had taken place in 1884, and in which the infuriated husband had assaulted and attacked a medical man. The doctor had anonymously received a gift, a ring, from his female patient, a married woman who had recently given birth. The journal presented the doctor as an innocent party but noted that a good obstetrician constantly remembered that too friendly relations with the female patients were always potentially risky: "[w]e are strongly of opinion that the more strictly and exclusively professional the intercourse of

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609 The editorial comment of the *BMJ* on the letter of a reader, The *BMJ*, June 13, 1857, 513. The original writer suspected that the London air and the speculum treatment had killed a "well educated and elegant young lady", who was suffering from tuberculosis. See also Lupton 1996b, 118–119.

610 Salter, Hyde, Clinical Lectures Delivered at Charing Cross Hospital. On the Stethoscope. The *BMJ*, February 7, 1863, 134. On "the sexless machine", see Bashford 1998, 116–117. See also how the patient can be viewed as a technical object in Lupton 1996b, 119.

611 Salter, Hyde, Clinical Lectures Delivered at Charing Cross Hospital. On the Stethoscope. The *BMJ*, February 7, 1863, 134. As the writer noted, a doctor saw twenty breasts in a day, and thus, "thinks no more of seeing a female chest than he does a female tong". He stressed the importance of respect and tact in the situation; according to him, female modesty was indeed natural ["There is a very good French proverb to the effect that 'Modesty is the rampart that nature has raised around virtue'"]. See also Ryan 1841, 168. On the physician's hands and touch in relation to the patient's body, see Stephens 2011, 89–99. See also Sommers 2011, 98–101.

612 Hall 1992, 303. See also Yeniyurt 2013, 34–36; Bashford 1998, 42. See also Begiato 2018.

613 Malet, Henry, The Relations of Medical Men to Their Patients and of the Profession to the Public. The *BMJ*, July 26, 1902, 234.

medical men and female patients, the better for all parties", noticing that "[i]t is impossible to be too careful, and difficult to be careful enough."[614]

This discussion of sexual codes and moral risks of medical encounter did not, however, include the possibility that the doctor specifically treating women could or should have been a female one. Women's sex was both an excuse to exclude them from the medical profession and a threat, because of the very obvious argument that a female doctor was personally familiar with female bodies and ailments in the way a male doctor could never be.[615] In popular medical literature the practitioner was almost always male: the implied doctor was simply "he" or he was referred to directly as a "medical man". Jane H. Walker (1859–1938), when writing her guidebook in the 1890s, was one of the few authors to recognise the gender difference. Walker noticed that the doctor could be, in fact, female: "A call from a doctor, 'be it he or be it she', is very reassuring, as no one else can give a really accurate opinion as to whether everything is going on favourable."[616] Others, Gordon Stables leading the way, devoted a considerable amount of time and effort to explaining why men made the best obstetricians. Stables argued in his manual that it was actually parturient women themselves who preferred male doctors:

> Are ladies right in preferring the services of a doctor during confinement? I have never happened to hear their arguments pro and con, but I am inclined to think that they are right in having the male physician. You see, in all matters of sickness, pure and simple, in most of the thousand and one ailments to which human flesh is heir, in the cases that is, where it is merely a matter of see, consider, and prescribe, the woman-doctor may "work awa finely" as the Scots cannily phrase it; but, in matters surgical, where not only skill, but actual strength, courage, and daring, to say nothing of coolness, are required, most ladies, I believe, would say, "Commend me to the man."[617]

The opinion of Gordon Stables was certainly not unique. Especially women's capability to perform surgical operations was questioned in many instances.[618] The

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614 Medical Men and Their Female Patients. The *BMJ*, November 22, 1884, 1026.

615 Moscucci 1990, 73. See also Digby 1994, 18–19. On women and practice of medical care, see Whaley 2011.

616 Walker 1893, 102. Compare to pp. 132–133. See on Walker in Digby 1999, 166; Elston 2001, 79–80, 82. On female doctors and professional credibility, see for example Bashford 1998, 85–105.

617 Stables 1894, 219. See also Digby 1999, 165, 172. Stables compared the treatment of midwifery cases to those situations when men and women faced a case of burglary. A man was a true hero, whereas a woman would simply try to hide herself: "A woman, to make use of homely illustration, may know quite as well as a man how to expel a burglar, theoretically, that is; but when it comes to practice I think she would rather lock her bedroom door, the burglar being on the other side. I tell you, reader, it takes a man to crawl along a dark passage, at midnight, with a 5lb. dumb-bell in each hand, and tackle a robber armed with knife and revolver." See also Tosh 2002, 460.

618 "R. S." [anonym.], attendance at accouchements. *The Lancet*, February 26, 1842, 760; "A Subscriber" [anonym.], Incompetency of Female Accoucheurs. *The Lancet*, February 26, 1842, 760-761; Kirkby, T. W. B., Midwives and Midwifery. *The Lancet*, February 26, 1842, 761–762; Shall We Have Female Graduates in Medicine? The *Association Medical Journal*, August 2, 1856, 653–654. On women practitioners, see Digby 1999, 154–186; Brock 2018. Nancy Theriot has argued that women's menstrual cycle was seen as a biological obstacle to a medical career. I have not found such arguments,

discourses of *science,* career, and professionalism were reserved for men only and a capability of performing surgical operations, such as craniotomy and a Caesarean section, was seen as an indispensable qualification in nineteenth-century midwifery.[619] As Ornella Moscucci has noted, male obstetricians and gynaecologist were the greatest opposition to female practitioners in the nineteenth century.[620] In 1859, when Elizabeth Blackwell (1821–1910), a British physician with a foreign degree, became the first woman in Britain to have her name on the Medical Register, the *BMJ* asked, in a somewhat sexist and condescending tone, was not the idea of a female practitioner "lamentably ridiculous". "Call to mind all things that are done in the ordinary course of hospital duties, or even of general practice in town or country; and imagine, good reader, if you can, a British lady performing them."[621] A few years earlier, the *Association Medical Journal* discussed "petticoated doctors"; in the case of a female doctor, a gendered female body alone was an obstacle to professional credibility and stamina.[622] However, not every medical man was against *medical women* or *lady doctors*, but they formed a minority amongst the male practitioners. For example, the editor of the *BMJ*, Ernest Hart, gave his conditional support to female doctors even if he believed that medical women could never be equals to men.[623]

The truth was that in the nineteenth-century world, a medical career was not easily achieved by women; they faced continuing discrimination, systematically lower incomes, and constant underrating of their talents and abilities. The number of female practitioners rose only very slowly; in 1871, there were only

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whereas women's mental abilities, mainly courage and boldness, were considered inadequate. See Theriot 1996, 137.

619 See for example *The Lancet*: "the practitioner of midwifery must be both a physician and a surgeon". Accoucheurs. *The Lancet*, April 20, 1844, 134. *The Lancet* argued that "a general practitioner" and the titles "physician-accoucheur" and "surgeon-accoucheur", "if they mean anything, imply nor merely useless but suicidal distinctions". See also Kirkby, T. W. B., Midwives and Midwifery. *The Lancet*, February 26, 1842, 761–762. On the complex relationship between women and science, see Watts 2007. See also Schiebinger 1987, 68–72; Bashford 1998, 85–105.

620 Moscucci 1990, 73.

621 Room for the Ladies! The *BMJ*, April 9, 1859, 292. See also for example Lady Surgeons. The *BMJ*, April 2, 1870, 338–339. See also Burnham 2005, 26; Mort 2000, 86; Moscucci 1990, 72–73; Geyer-Kordesch 1995, 108; Smith 1979, 380–382; Digby 1994, 290–292; Bynum 1996, 206–208; Elston 2001, 79. On the medical-women question in the Victorian medical press, see Moulds 2018, 1–13. Some of the first female doctors were wealthy women, coming from privileged families, thus having better chances than most of their less wealthy female contemporaries did. On Blackwell, see for example Donnison 1999, 79; Watts 2007, 126–127. See also Vertinsky 1990, 111–126, 132–141. See also Mitchinson 1991, 27–28.

622 Shall We Have Female Graduates in Medicine? The *Association Medical Journal*, August 2, 1856, 653–654. See also Watts 2007, 130–131. Dr James Barry (1789–1865) was an Irish-born military surgeon who also performed the first successful Caesarean Section in Africa. Barry was born as a woman but lived his adult life as a man. On Barry, see for example du Preez 2012; Bashford 1998, 85; Porter 2001, 269–271; James Barry 2018.

623 Bartrip 1990, 170–174. See for example Aveling 1872, 159. See also Room for the Ladies! The *BMJ*, April 9, 1859, 293; Female Doctors in Medicine. The *BMJ*, July 5, 1862, 11–12; Female Physicians. The *BMJ*, July 26, 1862, 96. See also Medical Education of Women; The Qualification of Female Practitioners. The *BMJ*, September 7, 1895, 608–609; Qualification for Female Practitioners. The *BMJ*, August 28, 1897, 545–546.

eight female doctors in England, and at the turn of the twentieth century, the number was slightly over 200.[624] "Expected judgement, decision, and promptness in action" were masculine attributes, whereas "sympathy, tenderness, and devotion to duty" were symptomatic of females.[625] As Ludmilla Jordanova and Alison Bashford have noticed, masculinity was connected to reason and intelligence, knowledge, dominancy, objectivity, and observation, femininity to the passions and emotions, obedience, superstition, religiosity, and custom learning.[626] Indeed, the nineteenth-century male medical profession constantly redefined gender-based qualifications both amongst their own peers and in relation to female midwives and medical practitioners. Lisa Cody has noted that obstetrics was seen as "an objective body of knowledge about the invisible world of life", which was acquired through clinical practice, reading, collecting, dissecting, and debate, inter alia.[627] As Cody noted further, these qualities were something from which most women, "no matter how learned", were almost automatically excluded.[628]

On the other hand, the feminist historian Anne Dally has discussed "macho medicine", closely connected to "heroic medicine", meaning that male doctors were more willing to perform more radical and interventive operations and to give large doses of drugs than their female colleagues. To Dally, this masculine tradition meant that the (male) doctor ultimately refused to do what the patient demanded and hoped for.[629] For example, experimental surgery was tested on women more often than on men. However, this kind of model of some kind of toxic masculinity, associated with adjectives such as aggressive, crude, penetrating, dominant, and ruthless, cannot be placed directly into nineteenth-century

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624 The exact number has been disputed; for example, Patricia Vertinsky has calculated that in 1895, there were 264 female practitioners, whereas F. B. Smith has stated that the number was 212 in 1901. According to Anne Digby, in 1900, there were 258 medical women in Britain. See Vertinsky 1990, 132; Smith 1979, 382; Digby 1999, 29. See also Porter 2001, 269–271. See also Digby 1994, 18. On gender-based discrimination in Germany, see Usborne 2001, 109; on the situation in America, see Leavitt 1986, 110–111.

625 Room for the Ladies! The *BMJ*, April 9, 1859, 293. See also Burt, Charles, Medicine as a Profession for Women. The *BMJ*, October 4, 1902, 1017. See female medical students in Cambridge in Weatherall 2000, 242–245. See also Dally 2001, 11: "qualities commonly attributed to 'femininity', gentleness, caring, consideration for others." See also Shall We Have Female Graduates in Medicine? The *Association Medical Journal*, August 2, 1856, 653–654: "The tender hand, the tender voice, and thoughtful mind" of a female nurse. See also Tosh 2002, 460: "Manly vigour included energy, virility, strength [--] decisiveness, courage and endurance". See also Watts 2007, 130–131; Russett 1989, 40–43; Jordanova 1989, 31.

626 Jordanova 1989, 20, 31–32, 38, 59; Jordanova 1986, 42–67; Bashford 1998, xiii. On women in nineteenth-century universities, see for example McWilliams-Tullberg 1980, 117–145. See also Schiebinger 1991, 216–220, 266–267.

627 Cody 2008, 277. See also Digby 1994, 290–292. On dissecting the criminal bodies in the eighteenth century, see Hurren 2016. See also Hurren 2012.

628 Cody 2008, 277.

629 Dally 2001, 9–21. Dally has argued that macho medicine is "aggressive, penetrative and sometime ruthless" and, moreover, the radical operations were often done on women rather than men. According to Dally, cliteridectomy was "one of the most macho operations ever devised". See also Risse & Warner 1992, 198; Usborne 2001, 117–120; Oakley 1980, 10–18; Vertinsky 1990, 114–119; Duffin 1978, 42–43. See also Donnison 1999, 65.

medicine.[630] As I have already discussed, the reputation of a (male) practitioner was intertwined with his behaviour and respectability, decorous gentlemanliness, and compassionate rationality; a bad reputation meant bad business. In eighteenth-century aristocratic circles, for example, the accoucheur had often been more dependent on his aristocratic patients rather than the other way around – emphasising the patient's social status, class, and wealth in relation to medicine and medical practitioners. Moreover, as the American scholar Nancy M. Theriot has shown, also nineteenth-century female doctors took part in the gender science interactions and participated in the process of medicalising woman – as did also some of the female patients themselves.[631]

Thus, female patients were not collectively passive victims of medicine and male doctors automatically oppressive even if femininity and women were considered inferior to men and the justifications for *natural differences* and hierarchical and often polarised positions between the sexes were based on biology, as I discuss more closely in Chapter 5. Gynaecological surgery certainly became increasingly experimental and interventionist; also healthy ovaries were operated on and the gynaecological discourse was associated with a wide range of women's physical and mental problems. However, patient reports published in the *BMJ* show that quite often the reason for the risky operations was in fact tumours and large cysts in the ovaries, causing real discomfort and pain for the patient. In the medical journals, these operations were also vociferously opposed by some doctors; modern surgery was only developing and operations were highly risky.[632] Thus, male gender was not an automatic allegory of medical injustice and systematic oppression of the female patient; what the different arguments in fact reveal is the complexity of genders in nineteenth-century medicine.

Indeed, nineteenth-century medicine was a peculiar mixture of compassion and humanity, rules of decorum, constant testing, long and persistent traditions, unevenly changing ideas and new innovations, mistakes and failures, disinterest and apathy, constant redefining and specification, economic competition, and professional self-promotion and self-interest. During the nineteenth century, the British medical profession was gradually transforming from three estates into a more unified profession. Simultaneously medical training and the internal integrity of the profession were constantly fostered in publications and ethical codes,

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630 Dally 2001, 11. See also Digby 1994, 259–260.

631 Theriot 1996, 124–125, 133–139. See also Lewis 1986, 108–112, 115–116, 121. See also Levine-Clark 2004, 19, 79–81; Levine-Clark 2002, 175–195.

632 Moscucci 1990, 105, 108–109, 134–164. See also Worboys 2000, 169; Oakley 1980, 13; Showalter 1990, 131. The first successful ovariotomy was performed by the American surgeon Ephraim McDowell, who had studied medicine in Edinburgh. In 1809, he operated his patient, who had a large tumour in her ovaries. The first operation in Britain was performed in 1824. The youngest patient I have found in the *BMJ* was four months old baby girl, having "a thick walled cyst" in her ovary, survived from the surgical operation performed in 1898. See Power, D'Arcy, A Case of Successful Ovariotomy in a Child Four Month Old. *The BMJ*, March 5, 1898, 617–618. See also O'Dowd & Philipp 2011, 404–409; Frampton 2018, 176–177. See also for example Lawson Tait, One Hundred and Thirty-Nine Consecutive Ovariotomies Performed between January 1st, 1884, and December 31st, 1885, Without a Death. The *BMJ*, May 15, 1886, 921–924. On gynaecological surgery in nineteenth-century Canada, see Mitchinson 1991, 252–277.

and medical training became standardised and new laws were enacted to protect the status of the "doctor". Nineteenth-century doctors also wanted to act as leading literary experts on women's reproductional health, as it is discussed in the next subchapter.

3.3 "The Only Guides to Be Safely Trusted": Popular Health Manuals and Networks of Knowledge

As I have already noted in the introduction of the primary sources studied in this research, in their writings, authors of popular health manuals combined a personal enlightenment project, built on their experiences gained in practical work, with a general mission concerning society and the future of the whole British Empire. In this sense, personal was indeed political: for the women reading popular textbooks, the authors generally promised that by following the advice they provided, the future delivery would be safer, quicker, and easier, and the future health and happiness of the mother herself was secured. In addition, another desired result was "a finer race of children", summarised by Pye Henry Chavasse in the 1860s.[633] As for example the historian Marjorie Levine-Clark has shown, this concern over the future of the nation and empire was very visible in the Victorian discussion about female life and women's role in society.[634] Hence, all doctors stressed the importance of mothers in the project of the building of society and the Empire, as did also Jane H. Walker, one of the few female doctors studied in my research: "the whole of the future of her [the mother's] country and of the world depends upon this work of hers."[635] This initial setting stressed the women's role and gave them a certain prestigious position, but at the same time, the gendered political-cultural ideals and idealisation of women allowed them very limited space in society, making them suitable for wives and mothers only.[636] Marriage and motherhood were indeed thought to be women's mission in life, the "sole profession of the best of women", as the *BMJ* underlined in 1893.[637]

Some historians have emphasised that popular health manuals, written by the medical profession, were an imperfect and often inadequate source of information. Books allegedly offered little "concrete advice beyond the very simple

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633 Chavasse 1866, 57. See also Stables 1894, 206: "The reward of such obedience is a great one, and three-fold – a safe and easy confinement, a speedy convalescence, and a healthy, bright, and happy child!" See also p. 221. See also Vincent 1902, v–vii.

634 See Levine-Clark 2004. See also Schiebinger 2004a, 66,

635 Walker 1893, 1, see also pp. 15–16, 112. For example, Dr Douglas Fox discussed "the welfare of society" in 1834 when he introduced the content of his manual. Fox 1834, iv. See also Tilt 1851, 41; Chavasse 1866, 2.

636 See for example Weatherly 1882, 8–9; Sperry 1900, 20. See also The Profession of Motherhood. The *BMJ*, September 30, 1893, 752. See also Levine-Clark 2004, 21–22, 41, 55; Russett 1989, 125; Nead 1988, 26; Mitchinson 1991, 14–16, 33–34, 152–153; Jordanova 1989, 62.

637 The Profession of Motherhood. The *BMJ*, September 30, 1893, 752. See also for example Davidoff & Hall 1988, 335–343.

rules on moderation in diet, exercise and the importance of fresh air", as Patricia Branca, for example, has argued.[638] Branca even claimed that due to this failing popular manuals increased women's anxieties rather than allayed them.[639] However, as my sources reveal, traditionally these pieces of advice, called the *non-naturals*, were considered the very foundation of health and happiness of every individual, and the nineteenth-century self-help manuals very clearly followed this preventive tradition of healthcare and self-treatment. In this sense, the 1902 guidebook *The Wife and Mother* by the Harley Street doctor Ralph Vincent followed the same pattern and traditions as the manuals published seventy years earlier in the 1830s. Moreover, it is important to remember that popular manuals were in fact *meant* to be imperfect collections of information; the very idea was that book reading and self-help guides did not replace professional attendants and the indispensable encounter between the doctor and patient in person. Writers stressed that in the hands of ignorant persons, medical books were "misapplied", mischievous, and even dangerous.[640] All writers emphasised that in the case of emergency, the only right decision was to call in a medical practitioner, who was "the firmest friend" in need, capable of helping and healing, unlike unqualified laypersons or quacks.[641]

In fact, doctors themselves constantly stressed that their popular manuals were collections of advice "for the preservation of health", not *curing* diseases or treating medical complications.[642] As Roy Porter has noted and as was also discussed in the previous chapter, in the nineteenth-century, medicine became authorised, and consequently, "lay physic" was considered "bad physic".[643] On the other hand, general ignorance or apathy were equally undesirable; the truth was that both healthy and sick people medicated themselves, "whether doctors liked it or not", as Porter has pointed out.[644] Thus, it was important to collect and publish information and stimulate people's involvement and self-cultivation in taking care of their own health, especially to encourage them in the prevention of diseases and complications, according to the correct principles of medicine, and more importantly, the "laws of Nature". Many writers noted that generally women wanted to do things right but they lacked correct information or were careless otherwise. Husbands were often depicted as even more ignorant than their young wives – on those rare occasions when they were addressed directly in the genre concentrating solely on female diseases or childbirth.[645] It is very

638 Branca 1975, 66.
639 Branca 1975, 66, 77.
640 See especially Scott 1870 [?] 1–3. See also Stables 1894, vii; Vincent 1902, vi; Fox 1834, iv; Welch 1838, 115; Kittoe 1845, vii.
641 See for example Stables 1894, 189, 237.
642 See for example Welch 1838, 2; Conquest 1849, viii–ix, 3; Davies 1852, v.
643 Porter 1996, 107. See also Preface of Weatherly 1882, 3: "This is not a book of Home Doctoring".
644 Porter 1992b, 221; Porter 1996, 107. See also Digby 1999, 99. See also Stables 1894, viii: "I deprecate and deplore self-doctoring". See also Scott 1870 [?], 1–3; Bakewell 1857, 5–7.
645 See for example Walker 1893, 20, 35. See also Philothalos 1860, 4–5; Welch 1838, 21; Allbutt 1888, Introduction [no page number]. See also Vincent 1902, 13–14. Ralph

presumable, however, that men also read the popular health guides written for use by females even if the titles of these handbooks referred to women only. For example, Lesley A. Hall has shown that many early twentieth-century men were very familiar with the marriage manuals whose intended audience consisted solely of women.[646]

Medical writers of these manuals stressed that their manuals were written expressly for lay persons or "non-medical readers" – in this way, they also addressed potential professional peer readers, noticing that the text was deliberately simple and free from technical expressions and professional terms which were intended for practitioners only. At the same time, writers reminded their potential peer readers that the manuals contained very little new or interesting in a professional way; the nature of the guidebooks was in fact conservative and traditional rather than innovative or radical.[647] For example, Gordon Stables stressed in 1894 that his manual was "a hand-book, pure and simple, for ladies who are wives".[648] Generally, some of the technical and special medical expressions and terms were explained in the text and occasionally special glossaries of medical terms and concepts were included in order to help the implied lay reader to understand the message.[649] Some writers also explained female physiology and special anatomical features, such as the function of the uterus and the ovaries, but this policy was not systematical or the realisation particularly specific and detailed.

As the writers generally acknowledged, writing for non-professional readers was in fact extremely difficult; how much information was enough, how much was too much, and how to discuss the various issues in "a non-technical manner", understandable also for the lay audience.[650] In this sense, knowledge was indeed power. However, generally, the language in popular manuals and guides books was described as "concise and plain"; the aim was that a person without medical education could "readily follow and thoroughly comprehend" the text, as, for example, Henry Thomas Scott noted in his manual, published in

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Vincent stressed that it was the husband's duty to know all limitations "which sometimes pregnancy, sometimes her menstrual cycle" placed upon his wife; otherwise he was not to complain if in later years he found himself with "the burden of an 'invalid wife'". Gordon Stables, on the other hand, emphasised that it was namely the husband's duty to take care of the drainage in the house. Stables 1894, 183. See also Chavasse & An American Medical Writer 1871, 363–431; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 153.

646 Hall 1991, 84–88; see men writing about their wives and marital/sexual difficulties, pp. 89–113.

647 See for example Fox 1834, iii–iv; Davies 1852, v; Welch 1838, 113–114; Bakewell 1859, v; Vincent 1902, v–vii. See the example of the advertisement of the manual by Dr Henry Davies, *The Young Wife's Guide during Pregnancy and Childbirth* (1852) in the *Association Medical Journal*, January 7, 1853, 26.

648 Stables 1894, 212.

649 See for example Walker 1893, 246–248; Vincent 1902, vi.

650 See for example Vincent 1902, vi. See for example Welch 1838, 1; Harvey 1863, 2; Scott 1870 [?], 1–3, 8. As Scott described his method of writing, every detail was "most carefully weighted by the author" and compared with "standard medical works".

the 1870s.[651] This was very important in all doctor–patient interaction, not just in the written word. As John William Ballantyne advised future obstetricians in his little booklet *Medical Etiquette* (1889), a humane, approachable, and trustworthy manner and understandable language were indispensable in practical work. As Ballantyne reminded his younger peers, medical practitioners were often inclined to "clothe their words in grandiloquent phrases from silver tong, and to put on a mysterious omniscient and loftily condescending manner as a garment".[652] This was in many ways problematic.

Both in popular medical literature and in real life encounters, it was equally important that the patient understood what the doctor was saying, and vice versa. "What, for instance, can be said for the man who informs an anxious mother that her darling child has *polio-myelitis anterior acuta*, when 'infant's palsy' would convey clearly enough to her mind what was the matter with her baby?", asked also Ballantyne in his guide for midwifery students.[653] Likewise, it was crucial that the lay vocabulary for various conditions, such as for menstruation, was known to the medical practitioner, in order to understand what their patients were describing and what they wanted their doctors to understand.[654] Especially sensitive topics like menstruation were often discussed using coded language and euphemisms; for example, *out of order* – simply meant that the woman had her menses, occasionally women referred to their menses only as *they* or *them*.[655] *Being unwell*, a term for menstrual periods, was far better known in nineteenth-century texts, frequently used by both the medical profession and by women themselves.[656] Knowing the right terms was an important key to success, as one writer

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651 Scott 1870 [?], preface. See also Welch 1838, 1–2; Bakewell 1859, v; Philothalos 1860, 1–2; Weatherly 1882, 3; Black 1888, v; Stables 1894, vii–viii; Vincent 1902, vi.

652 Ballantyne 1889, 6. See the advice concerning the patient in Bakewell 1857, 7–8. See also Fissell 1991, 103.

653 Ballantyne 1889, 6.

654 Ballantyne 1889, 6. See also Ryan 1841, 66. The menstrual terminology used in medical literature and the vernacular was diverse: *regular, poorly time, the courses, the monthly flow, menses, the change, the flowers, nature, indisposition, periodical* or *female health*, *accustomed periodical illness or menstrual illness, the usual monthly period,* and *the courses*. See for example Waller, Charles, Lectures on the Function and Diseases of the Womb. *The Lancet*, December 7, 1839, 393–396; Wiltshire, Alfred, Lectures on the Physiology and Pathology of Menstruation. The *BMJ*, February 9, 1884, 253–256. See also Ryan 1841, 66; Hills 1841, 5; Kittoe 1845, 32; Davies 1852, 3; Chavasse 1866, 38; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 185; Allbutt 1890. On the vocabulary of menstruation, see Gélis 1991, 10–11; Renne & de Walle 2001, xix–xx; Read 2013, 24–38; Green 2005, 51–53.

655 See for example Walker 1893, 8. This coded language concerned also men; for example, the last Empress of Russia, Alexandra Fjodorovna (1872–1918) and her husband, Tsar Nicholas II, had their own private code words for menstruation, such as "B", M-me. B", "Becker", Engineer-mechanic" or "eng.-mech.". The couple used these words when they referred to the menstrual cycles both of the Empress herself and their four daughters. Alexandra Fjodorovna herself was the granddaughter of Queen Victoria of England. See the examples in Fuhrmann 1999, 61, 62, 236. See also Read 2013, 82–83, 92–93.

656 See for example Conquest 1849, 19. See also Ryan 1841, 66; Walker 1893, 7. See also Lane 2002, 222–223; Read 2013, 29–30. Wendy Mitchinson has argued that the term "unwell" was used because "no one knew much about the monthly cycle", but it can be said that the term revealed also that discomfort and inconvenience were often

noted in 1839: "[y]ou should be always be aware of their meaning when your patients thus express themselves, or they will have but a poor opinion of your knowledge of female disorders."[657]

As the titles of manuals mentioned, the typical implied reader was a young, usually recently married woman, with insufficient knowledge of married life, pregnancy, and childbirth. Occasionally, also more mature and experienced readers were addressed in the prefaces and introductions, but generally readers, mainly due to their young age and inexperience, were, supposedly, "too bashful and too sensitive" to talk to their male doctors *vis-à-vis,* or to ask directly about the intimate questions relating to the female body, sex, reproductional health, pregnancy, and what really took place in the birthing rooms, for example.[658] Many medical writers acknowledged that the confidential relationship between a male doctor and a female patient was not automatically formed, nor was the encounter relaxed and easy. Especially gynaecological problems were often hidden or left unspoken, and the patient submitted herself "to great inconvenience or pain for prolonged period", rather than discussing the intimate and potentially embarrassing symptoms openly with her doctor.[659] This openness, or rather, the lack of it, was always culturally regulated and controlled; for example, Lucinda McRay Beier has illustrated how in nineteenth-century working-class culture, women who talked about sexual matters, especially with men, risked their reputation. The woman could easily be taken for "loose" if she was too open and frank.[660]

This medico-cultural uneasiness was also recognised in the genre of popular health literature. Many medical writers expressively discussed the "false delicacy" or "false modesty" of women, emphasising that it was always pointless and often hazardous.[661] Thus, the written and published words by a professional were justified, as for example Thomas Bull noted in his manual: "[s]he will find no difficulty in reading information for which she would find it insuperably difficult to ask."[662] Indeed, manuals were constructed in a "delicate" and simple manner that they could be read without "a blush", as William Hamilton Kittoe pointed out in the preface of his manual *The Ladies' Medical Friend* (1845).[663] This consideration certainly reinforced the idea that the male medical profession was capable both of taking care of their patients' bodies and of being sensitive, trustworthy and compassionate as well. Consulting equally ignorant and unexperienced young friends was considered both dangerous and foolish; as many writers noted, women

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connected to the menses, including pain, cramps and practical troubles with the menstrual flow. Mitchinson 1991, 90. See also Beier 2008, 206–221.

657 Weller, Charles, Lectures on the Function and Diseases of the Womb. *The Lancet*, December 7, 1839, 393– 396. See also Delaney, Lupton & Toth 1988, 115–118.

658 See examples Chavasse 1866, vii–viii; Davies 1852, iii–iv; Hill 1841, Preface [no page number]; Harvey 1863, 2

659 Priestley, William, O., Two Lectures; Introductory to the Clinical Course on the Diseases of Women and Children. The *BMJ*, February 23, 1861, 189. See also Davies 1852, v–vi; Welch 1838, 48; Kittoe 1845, 9; Harvey 1863, 80.

660 Beier 2008, 215, 273.

661 See for example Bull 1837, 134–135; Fox 1834, v; Black 1888, 16; Vincent 1902, v. See also Tanner 1860, 70.

662 Bull 1865, vi; Bull 1837, iii. See also Chavasse 1866, vii–viii.

663 Kittoe 1845, viii.

tended to tell horror stories to each other, exaggerating especially negative and painful experiences and thus creating many false beliefs, superstitions, prejudices, and needles fears.[664] Strong emotions were always potentially dangerous during pregnancy and childbirth, but ignorance was no bliss either.

It is clear, however, that due to the intimate and delicate nature of these manuals, they were clearly intended to be studied alone rather than being read aloud within a group. Early modern reading was often a group activity but nineteenth-century health manuals contained intimate and personal information in such details that their readers were recommended to withdraw into the "privacy of the chamber" with the book, which was "not intended for publicity of streets, or to satisfy the curiosity of the vicious", as the controversial doctor Henry Arthur Allbutt instructed his readers.[665] Especially the sexual content of the book was often a source of embarrassment.[666] However, more detailed information about the reading process is difficult to obtain; Pat Jalland, for example, noted that the women in her study, all members of eminent British political families, did not refer to the popular health and childbirth manuals, but rather to the verbal guidance they had received from medical practitioners, some of whom were the leading authorities on women's diseases and obstetrics. Even then, as Jalland has pointed out, the general tone was sceptical when women discussed the doctors they had been attended by.[667]

Doctors' own professional experiences and practical work clearly had an impact on the making of their popular literary contributions. In their practical work, many medical practitioners had met women who had no idea of the mechanisms of birth, or who had not recognised even the very basic signs and symptoms of pregnancy in their bodies.[668] For example, in the preface of his manual *The Young Wife's Guide* (1852) Henry Davies described his own experiences with his patient, a young, recently married lady, who suddenly went in labour – without knowing that she had been, in fact, pregnant:

> The author [Davies] was sent for in a hurry, and she [the patient] was much astonished on being told that she was about to become a mother, for which no preparations whatever had been made. Fortunately her labour progressed very gradually; a

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664 See for example Bull 1837, iv, 1–2; Welch 1838, 2–4; Chavasse 1866, viii; Walker 1893, 14, 20, 114–115; Vincent 1902, v, 2. See also *On the Evils Resulting from Rising Too Early after Childbirth* [publish date unknown], 28–29.

665 Allbutt 1890, 51. About early modern reading, see Fissell 1992, 76–77; Briggs & Burke 2016, 53–54. Ginnie Smith has noted that one book may have passed through many readers; and its content may also have been transmitted orally. She also noted that from the individual's point of view "the chief bar was time to read and absorb the knowledge, and money to acquire it". Smith 2002, 253, 256. See also the Preface in Chavasse 1866, vii: "This work is not written to satisfy idle curiosity, but to give useful – nay, indispensable information, – not otherwise readily obtainable".

666 Beier 2008, 235.

667 Jalland 1986, 135. Jalland has pointed out that women were not necessarily happy with their doctors, however famous they might have been. See also Stolberg 2004, 94; Porter & Porter 1989, 200–201.

668 See also Beier 2008, 227; Fisher 2011, 37–42.

> nurse was procured, and before night (it being Saturday) baby linen, &c. was provided. She was delivered of a girl on Sunday afternoon.[669]

As Davies reminded his lay readers, in a different situation, the results of unexpected pregnancy could have been catastrophic. If the woman had not been married, the child was stillborn or had died during labour, and pregnancy had not been known by the members of her family, friends, and community, the unhappy woman could easily have been accused of foul play, the wilful intention to conceal her state and to destroy the child. As Henry Davies pointed out, this kind of case – a woman not knowing about her state – was not unusual, as "every medical man of large experience can testify".[670]

The example related by Henry Davies demonstrated what many medical writers knew from their personal experiences: correct and reliable information could be difficult to obtain.[671] Friends were considered unreliable and dangerous, but, on the other hand, many writers pointed out that doctors were not in fact the only source of information. The role of a young girl's mother was stressed when basic information, for example, about menstrual health was to be delivered to a girl going through her *menarche*, the first menstrual cycle. As Gordon Stables noted at the end of the nineteenth-century, at the ideal level, between the mother and daughter, "there should exist the greatest frankness".[672] Stables stressed that three words coming from the mother were the very basic thing every girl needed to know: "[i]t is natural".[673] However, the reality was often very different from ideals. As for example Lucinda Beier has argued, sex was rarely discussed between parents and children in working-class families – at least not before the children were in their teens.[674] On the other hand, Gordon Stables also noted that this could be an educational task of the midwife or "a female licentiate in midwifery", even if he otherwise detested female doctors.[675] Stables acknowledged that

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669 Davies 1852, vi.

670 Davies 1852, vi. See also Ryan 1836, 273–276; Mann 1893, 146–152; A London Physician [anonym.] 1891, 184–188; Lewis, Thomas, Case in Which Pregnancy Was Unattended with the Usual Signs, and in Which Parturition Was Occurred without Labour-Pains [etc.]. *The Lancet*, May 21, 1842, 284.

671 See for example Vincent 1902, v.

672 Stables 1894, 119. See also Kittoe 1845, 5, 10; Allbutt 1890, 9, 52; Vincent 1902, 2–3: "Some girls, blessed with wise mothers, have been well tended during their girlhood, and they have had the advantage of especial attention at that time of puberty. But many girls have not been so fortunate". See also Tanner 1860, 41. On sex education at the end of the nineteenth-century, see Nelson 1997, 98–116. See sex discussed in the manual intended for young women in Sperry 1896, 11–43, 113–119, 126–128.

673 Stables 1894, 119. See also Tilt 1851, 19–21, 44–45, 70; A London Physician [anonym.] 1891, 6–7; Sperry 1896, 50–51. Compare to Vincent 1902, 3. As Lucinda Beier has argued, mothers instructed their young daughters how to manage (and conceal) menstruation. Another important source of information for young girls were usually schoolteachers. See Beier 2008, 236. See also Tilt, E. J., On the Management of Women, at First Menstruation. The *PMSJ*, April 16, 1851, 206–210. See also Marland 2013, 51–59.

674 Beier 2008, 212, 213. As Beier has noted, it was important to know the social limits of conversation; it was socially objectionable if children knew "too much", or if women talked about sex with men – they were labelled as "loose". Too talkative men were considered rude. See Beier 2008, 215.

675 Stables 1894, 119.

women were often more willing to speak to another woman "about matters they would not dare to broach even to a medical man".[676] Otherwise, he had some obvious difficulties in accepting his female peers.

However, generally, most of the popular health manuals dealing with reproduction were clearly aimed at middle-class readers; possibly because they were the most likely to resort to the services of doctor and because middle-class patients possessed the necessary wealth. They also shared a similar kind of socio-economic and cultural background with the writers of these manuals. In the popular medical texts, female readers were often expected to live in large town houses or country residences, to be able to afford their own carriages, to have time for daily walks in the parks, to follow specific diets, and to have separate rooms that could be temporarily turned into birthing or lying-in rooms.[677] On the other hand, luxurious couches, soft mattresses and cushions, too active social life, and too fashionable and expensive clothes were considered dangerous, but it is obvious that not even all middle-class families could afford them anyhow. However, many writers mentioned that the price of their manual was deliberately low. Mary E. Fissell has noted that the cheapness of popular manuals did not necessarily mean that their readers were poor or that the content was less valuable; books were merely more available when the price was not a problem. People of all social levels read cheap prints.[678]

The few manuals addressed expressly to working-class women were *The Wife's Domain* (1860) by an anonymous writer *Philothalos*, and the guidebooks by Henry Arthur Allbutt, who published his manuals *Counsel to a Young Mother* and *Every Mother's Handbook* at the end of the nineteenth century.[679] In reality, in their lives, working-class women were less likely to meet a doctor in person and the medical practitioner was a rarely seen figure in the working-class house. Hence, it is obvious that working-class women were not generally the primary target audience of the manuals studied in this research. As Lucinda McRay Beier has argued, working-class women had limited time to read, and in some households, book reading was not generally considered a proper pastime. If working-class women were looking for medical information in the written word, it was usually obtained from magazines and newspapers rather than from books, which were

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676 Stables 1894, 119.

677 See especially the manual of Ralph Vincent, *The Wife and Mother* (1902), whose implied reader was a wealthy woman with her own town house, carriage, and a special bed designed especially for childbirth. See another example in Conquest 1849, 14. See also critiques in Branca 1975, 12–15, 52–53; compare to Duffin 1978, 33. See on differences between working-class and middle-class health cultures in Beier 2008. See also Leavitt 1986, 85; Vertinsky 1990, 16–17. See also Marland 2004, 17–18. See also Gilbert 2014, 129–130. On issues of social class, see also Lupton 1996b, 110.

678 Fissell 2006b, 7. See also Fissell 1992, 74–75. Compare to Stolberg 2004, 95. On the price of books, see Altick 1967, 260–317. See also Bakewell 1859, iii.

679 Allbutt, for example, announced at the very beginning of his handbook that "this book is intended mainly for the wives of working men". Not all authors were this precise concerning their implied readers. See Allbutt 1890, 1.

more expensive than cheaper magazines and took a much longer time to peruse.[680] Some medical writers contributed to both genres; for example, Florence Stacpoole, author of many popular health manuals, including *Advice to Women on the Care of Health before, during, and after Confinement* (1893), also wrote an advice column in the *Woman's Weekly*.[681]

All in all, the tone was more practical and direct in working-class health manuals: the medical writers clearly acknowledged the lower economic situation of their implied readers. Authors were aware that many women worked in factories and shops at least before their marriage – and how some continued to earn their wages even after the nuptials.[682] Especially the preface of Henry Arthur Allbutt's manual *The Wife's Handbook,* was free from all kind of sentimentality and idealisation of motherhood and family life, which otherwise was very typical of the genre: "[n]ow, as this book is intended mainly for the wives of working men, I have no intention of burdening their minds with anything but actual and well-known signs – symptoms which will tell them that they are going to be mothers".[683] Interestingly, Allbutt also suggested that working-class women were more familiar with their own bodies, as well as the bodies of their female friends, including the sexual organs. Allbutt advised his readers to observe the discolouration of the vaginal passage with a small looking-class and a good light. The woman could detect this valuable sign of pregnancy independently by herself, or the better, assisted by her husband or a female neighbour.[684] This kind of practical hint was never included in the manuals intended for middle- or upper-class women – usually, this sign was observed solely by the doctor.

More generally, the writers of the popular health manuals presented doctors as medically qualified, the safest option in need, and capable of taking care of most cases – unlike the patient relying on self-treatment or the "ordinary remedies" applied by nurses and midwives. Thus, popular health manuals were also a very visible sign of the knowledge and professional competence of medical

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680 Beier 2008, 316–318. See also Branca 1975, 14. On weekly family magazines, see Mitchell 1980, 29–51. On prejudices against reading, see also Altick 1967, 132–133. See also the little booklets published by the Ladies' Sanitary Association: *The Worth of Fresh Air* 1858 [?]; *The Cheap Doctor* 1858; *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown].

681 Beier 2008, 322. However, this column was published in the twentieth century (in 1919 and onwards), whereas Stacpoole's health manual was published at the end of the nineteenth century. It was not, however, addressed specifically to working-class women. On women's magazines, see Beetham 1996.

682 Philothalos 1860, 6, 14, 83–84. The writer expected that the husband was able to support his wife, but he also noted that some women were "obliged to earn a livelihood, and not seldom even to support an entire family, working away from home [--] Pursuing her avocations until within few days, sometimes up to the day of her confinement, the poor mother is compelled by poverty to resume her duties in the course of three, six, or eight days after, when she ought still to be in bed and carefully tended."

683 Allbutt 1890, 5. The manual of Philothalos discussed motherhood in a very sentimental way, see for example Philothalos 1860, 34–35.

684 Allbutt 1890, 6–7. Vaginal discouloration was an extremely valuable sign, as Allbutt noted; in non-pregnant woman, it was a rosy colour, but in a pregnant woman, it turned "to a violet hue". See also Chapter 4.1. See also The Blue Coloration of the Vagina during Pregnancy. The *BMJ*, October 13, 1888, 829–830. See also Stables 1894, 165.

practitioners, especially when doctors were fighting against "the flourishing state of quacks and quackeries", as Robert Hall Bakewell explained in his manual in the late 1850s.[685] Despite their ongoing attempts to take over childbirth and to control the discussion about reproduction and the female body, the British medical profession had problems accepting that about a half or 60 per cent of all labours were still attended by female midwives.[686] Regionally and socio-economically, the proportion of midwife-regulated labours varied greatly; in small villages, it was something between 40 and 90 per cent, in certain areas of large manufacturing towns, from 75 to 90 per cent, whereas in smaller towns, the share was considerably smaller, only 5–10 per cent.[687] However, the exact number of midwives is not known; for example, in 1892, the estimated number was somewhere between 7,000 and 15,000 midwives, but these figures are not necessarily reliable.[688] Some midwives provided only occasional services, while others made a more regular living by attending labours and lying-ins.

Midwives, here collectively understood as trained midwives, *handywomen* (untrained midwives), and monthly nurses, were less expensive – and less intimidating – persons, whereas a doctor was a rarely seen figure especially in working-class households.[689] Moreover, monthly nurses offered practical services that did not belong to the doctor, which was much appreciated by new mothers and their families. As doctor Robert R. Rentoul noted in 1890: "[t]he fact that the midwives wash the mother and baby, prepare food for the mother and baby, call and wash both daily for six to ten days, and so does the work of both doctor and nurse, makes a few prefer their wider services to that of the doctor".[690] Practical and routine care work and nursing were considered less valuable than academic-learned medicine. Nurses took care of their patients – dealing with symbolically contaminating bodily fluids and discharges – fed them, changed their nightgowns, and made their beds.[691] Doctors could occasionally insert a catheter, take the patient's temperature, administer an enema, or tie an obstetrical binder after labour, but usually they did not take part in sick bed routines, and their physical contact with the patient's body was therefore more occasional.

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685 Bakewell 1859, iv. See also Welch 1838, 4.

686 The *BMJ* estimated in 1884, based on the calculations of Aveling, that midwives attended from 30 to 60 per cent of the deliveries. See Ignorant and Reckless Midwives. The *BMJ*, September 6, 1884, 478–479. See also Loudon 1992, 178; McIntosh 2012, 34.

687 Loudon 1992, 176–178. See also Smith 1979, 55–56; Moscucci 1990, 70–71; Donnison 1999, 85.

688 Loudon 1992, 174; Nuttall 2012, 130–131. See also Rentoul, Robert Reid, The Registration of Midwives and Their Power to Practice Independently of the Profession. The *BMJ*, November 22, 1890, 1174: according to the estimate, there were from 10,000 to 13,000 midwives in England. See also Branca 1975, 79–80.

689 Reid 2011, 380–397; McIntosh 2012, 36; Beier 2008, 55–63; Beier 2004, 400; Branca 1975, 80.

690 Rentoul, Robert R., The Midwives Registration Bill. The *BMJ*, June 21, 1890, 1471. See also Cullingworth 1884, 23–76. See also Loudon 1992, 180–181; McIntosh 2012, 38; Beier 2004, 400; Borsay 2012, 24–25. On Rentoul and his views, see also Donnison 1999, 129, 131, 136.

691 See for example Conquest 1849, 41. See also Lane 2001, 126–130. Irvine Loudon has argued that trained midwives refused to wash their patients; it was not considered "proper". Loudon 1992, 181. See also McIntosh 2012, 38; Williams 1991, 233. On nurses and hierarchy, see also Lupton 1996b, 121–123.

In nineteenth-century medical literature, a midwife or a monthly nurse was systematically described as ignorant, incompetent, careless, and reckless.[692] It was acknowledged that midwives could be experienced, but – as their opponents claimed – their experience was not scientifically qualified; for example, midwives lacked indispensable knowledge of anatomy, human physiology, and cleanliness.[693] At worst, midwives were depicted as dangerous and impatient, inclined to hurry and meddlesome midwifery, unable to understand Nature and her laws, and thus, potentially risky for mothers and their unborn children. Especially poor women, who traditionally were attended by untrained *handy women* and *wise women*, were allegedly in the greatest danger.[694] This kind of view stressed that the unorganised and irregular work of a midwife was a practical necessity and not a passionate vocation; this was considered less respectful than an altruistic, selfless, self-sacrificing, and almost martyrish mission in medicine.

Alison Bashford has argued that the narrative of nurses change around the middle of the nineteenth century; "the old nurse" was depicted as a "large, elderly, disordered", and dirty working-class-woman, with loose morals and interest in money and alcohol, whereas the trained "new nurse" was a younger, unmarried, and chaste middle-class woman, who was moral, pure, uniformed, and controlled both inside and outside.[695] Bashford has stressed that both figures were fictitious, but based on the sources studied in this research, this categorisation was not that clear and distinct when midwives were discussed in British medical journals and especially popular health manuals.[696] Moreover, as the Canadian historian Wendy Mitchinson has pointed out, and what my own primary sources also show, it is very likely that many doctors did not have a realistic knowledge of midwives. Physicians came into contact with a midwife usually only if she was not able to handle a difficult labour and was subsequently forced to call for a doctor, who then finished the case.[697]

In fact, in popular health manuals, choosing a good and competent monthly nurse was often described as a difficult, if not an impossible task. For example,

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692 See for example The Obstetrical Society of London. The *BMJ*, January 1, 1859, 9–10; Ignorant and Reckless Midwives. The *BMJ*, September 6, 1884, 478; Censure on a Midwife. The *BMJ*, February 4, 1899, 294; See Bakewell 1859, 117. See also Oakley 1993, 66–67; Loudon 2001, 180; Towler & Bramall 1986, 138; King 2012, 112–121; van Teijlingen 2000, 44–45; Whaley 2011, 107–108. The history of English midwives, written by the nineteenth-century physician, see Aveling 1872. See also for example Digby 1994, 268–269.

693 See for example Bakewell 1859, 117–120. As David Harley has noted, traditionally, midwifery was regarded as a skill that could be learned by experience. Harley 1993, 28.

694 See for example Atthill, Lombe, An Address on the Education of Midwives, Considered in Connection with the Midwives Registration Bill. The *BMJ*, February 21, 1891, 393. See also for example Puerperal Infection. The *BMJ,* February 12, 1898, 454; Coleman, Gerald, Ignorant and Reckless Midwives. The *BMJ*, October 11, 1884, 747.

695 Bashford 1998, 21–61. See also Mottram 2001, 137–146; Hallett 2012, 46–54; Jones et al. 2018, 577–604. See also for example Nursing as a Profession. The *BMJ*, January 4, 1873, 14. On nurses, see also Vicinus 1985, 85–88.

696 See for example Wood, Miles A., Skilled Monthly Nurses. The *BMJ*, November 7, 1874, 601; "L.M." or Nurse. The *BMJ*, March 5, 1898, 639–640. See also Williams 1991.

697 Mitchinson 1991, 172. See also Loudon 2001.

Gordon Stables claimed that one of the main reasons why doctors attended labours in the first place, was "an absence of complete confidence in the skill and ability of the midwife".[698] According to doctors, midwives and nurses were especially liable to gossip and tell horror stories about their former cases gone wrong.[699] These stories evoked fears and horror in a parturient, and in return, created complications and unnecessary pain. An ideal nurse was of a good moral character and "a kind and loving disposition", sympathetic and "kindly-faced", fond of children, not too old and not too young; she was "free from deafness", obedient, "good-tempered and very willing to oblige".[700] In addition, she was either married or a widow, took good care of her personal hygiene and that of her patients, and was not familiar with alcohol. There was a long tradition and folklore connecting midwives to alcoholic beverages, but this association was also a reference to the famous nineteenth-century literary character, the drunken nurse *Sarah* or *Sairey Gamp*, created by Charles Dickens in his novel *Martin Chuzzlewit* (1843–1844).[701] The character of Gamp haunted nineteenth-century midwives, being a perfect caricature of an incompetent, ignorant, and drunken midwife in the minds of the male medical profession, who were in fact more than willing to reproduce this fictitious, cultural image in their writings.[702]

Until the beginning of the twentieth century, the work of a midwife was almost completely free from restrictions. Thus, due to the lack of standardised education, unified examinations, licensing system, and regulation, midwives were particularly vulnerable to criticism, scorn, and doctors' professional disdain and prejudices. Some of the midwives were qualified, perfectly competent, and

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698 Stables 1894, 218.

699 "[S]ome nurses have tongues that are too long". Stables 1984, 217. See also Black 1888, 48–49; See also Imprudent Nurses. The *BMJ*, April 18, 1891, 869–870. On choosing the nurse, see also Conquest 1849, 13.

700 Black 1888, 48; Stables 1894, 216–217; Bull 1865, 168–170; Chavasse 1866, 116–125; Chavasse & An American Medical Writer 1871, 225–229: Drew 1891, 38; Vincent 1902, 40; A London Physician [anonym.] 1891, 293–294; Stacpoole 1894, 113; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 231–236. See also Towler & Bramall 1986, 52, 106–110; Gélis 1991, 103–106.

701 See for example Donnison 1999, 45–46; Donnison 2000, 108–109; Towler & Bramall 1986, 139, 169–171; Lane 2001, 121–122; Porter 2001, 195; Banks 1999, 67; Bashford 1998, xv, 28–30, 78–88; McIntosh 2012, 30; Mottram 2001, 137; Beier 2007, 86; Borsay 2012, 23–24. See also for example The Mortality from Puerperal Fever. The *BMJ*, April 17, 1897, 1019: "ignorant women of the Sarah Gamp type"; Junior, G. P. [anonym.], Tips to Midwives. The *BMJ*, January 5, 1901, 55; [several letters] The Medical Profession and Midwives, The *BMJ*, January 19, 1901, 180–181; The Second Reading of the Midwives Bill. The *BMJ*, March 1, 1902, 537. See also Chavasse 1866, 119; Stables 1894, 217; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 232. See also Lewis 1980, 143, 150.

702 Interestingly, in 1846 the medical man J. G. Swayne discussed the history of midwifery, noticing that in France, "*sages femmes*" were more qualified and possessed a certain degree of education, "[--] unlike the ignorant and drunken Mrs. Gamps, of England". Swayne talked about the famous French midwives such as Louise Bourgeois, and her English peers Elizabeth Nihell and Sarah Stone, noticing their role in early modern midwifery. However, he misattributed credit when naming Mary Donally, an Irish midwife who performed the first Caesarean section in Britain, as "Marie Dunally", a French midwife. Swayne, J. G., Introductory Lecture on Midwifery Delivered at the Bristol Medical School. The *PMSJ*, October 21, 1846, 499. See also Watts 2007, 66.

experienced, but the problem was there was no standardised system of education and regulation.[703] For example, Nurse Baker reminded readers in her 1856 manual that all nurses should be trained properly, preferably in some lying-in hospitals. Moreover, quite understandably, Baker would have welcomed especially a more positive attitude on the part of the medical profession:

> I feel persuaded that if the medical profession would cultivate the nurse's service more, and to undertake to teach them those things of which they think them so ignorant, much advantage would accrue to all parties, especially to the patient.[704]

It is likely that Nurse Baker did not live long enough to see the turn of the century and the enactment of the first *Midwives Act*. The discussion on midwives continued with bitter arguments and prolonged debate for many decades, culminating in the 1890s. However, it was not until 1902 that the law was finally passed; the *Midwives Act 1902* laid down rules about certification, regulation, examinations, and training of midwives, creating the Central Midwives Board to control entry into the profession.[705] The law started to limit especially working-class access to traditional neighbourhood midwife activity.[706] It was during the twentieth century when midwifery was standardised, medicalised, and institutionalised, and also midwives gradually became "agents of official state-sponsored medicine" in Britain.[707]

Medical manuals and especially letters published in the medical periodicals show that when discussing their female peers, sometimes referred to as "lady doctors", or midwives, the tone adopted by the nineteenth-century medical profession was far more misogynist and pronounced than when they wrote about their female patients. A female patient was not a professional or economic threat, unlike a female peer who was competing for the same patients and fees. Moreover, a patient was always a potentially medically important and interesting case, a sufferer in need, whereas a female nurse or midwife was a competitor, who was

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703 See for example Ignorant and Reckless Midwives. The *BMJ*, September 6, 1884, 478–479; Aveling, James H., Are Midwives to Be Abolished or Bettered? The *BMJ*, November 22, 1890, 1172–1174; Atthill, Lombe, An Address on the Education of Midwives, Considered in Connection with the Midwives Registration Bill. The *BMJ*, February 21, 1891, 393–395. See also Aveling 1872, 159–160, 169–182. On trained and certificated midwives at the end of the nineteenth century, see Hannam 2001, 81–98; Mottram 2001, 134–146. See also Loudon 2001, 180–187; Towler & Bramall 1986, 138–151, 160–169; Donnison 2000, 101–115; Nuttall 2012, 128–144; Smith 1979, 41–47: Williams 1991. See the situation in Canada in Mitchinson 1991, 165–168.

704 Baker 1856, 7–10.

705 Donnison 1999, 123–184; Towler & Bramall 1986, 164–169, 177–193; McIntosh 2012, 18, 12–44; Beier 2008, 277–278; Reid 2011, 380–382; Mottram 2001, 135–141; Nuttall 2012, 128–144; Digby 1994, 267–269. See the situation in the United States, for example Borst 1995, 13–36, 85–89; in the Netherlands, Marland 2001a, 173–177. See for example Aveling, J. H., On Instruction, Examination, and Registration of Midwives. The *BMJ*, March 22, 1873, 308–310; The Registration of Midwives. The *BMJ*, November 22, 1873, 608; The Education of Midwives. The *BMJ*, December 6, 1873, 676–678; The Proposed Registration of Midwives. The *BMJ*, May 21, 1892, 1092–1094; The Midwives Bill. The *BMJ*, March 18, 1899, 679–680.

706 See for example Beier 2008, 25.

707 Beier 2004, 402. See also Hunter 2012, 151–170. Compare to Bashford 1998, 21.

also lower in the professional and social hierarchal order.[708] For example, Anne Digby has argued that surgeons showed sympathy and understanding for their patients' feelings and did not treat them "simply as clinical material".[709] According to the medical periodicals, some parturient woman detested "man-midwives", but in the case of an emergency, were treated by them, nevertheless.[710] Many historians have also demonstrated that early modern male physicians were not at all that aggressive, invasive, and unsympathetic towards their female patients as sometimes it has been presumed.[711] For example, Lisa Cody has shown that eighteenth-century man-midwives did not automatically look down on their female patients, nor did they view pregnancy as a disease or labour as automatically difficult and complicated.[712] Cody has made a comparison between eighteenth-century accoucheurs and their Victorian successors, calling the nineteenth-century male obstetricians "misogynistic".[713] The historian Marjorie Levine-Clark has argued, however, that in practice, Victorian doctors did not automatically consider the female body as weak and unstable nor did the medical profession define womanhood automatically as unhealthy or "sickening". Especially working-class women inhabited the reproductive body but in practice, they also endured and performed hard work.[714]

As many historians have pointed out, social class, status, and income clearly had an impact on how doctors saw their patients, but generally, nineteenth-century doctors discussed the sufferings of their patients with sympathy and the patient's opinion was occasionally requested concerning the treatment, at least in cases of risky operations.[715] In practical situations, a female patient was often merely a *patient*, a self, rather than specifically a *female* body, automatically sick or weak because of her sex. Indeed, when discussing their cases in the medical periodicals (and also in popular/professional guidebooks), most doctors wrote about their patient at least with some respect, tact, and understanding. Eve Keller has discussed the ideal type of medical practitioner who possessed, not only "individual sovereignty, rational prowess, and discrete manual dexterity", but who

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708 See for example Bashford 1998, 44–48. On the methodological notions, see also Jordanova 2006b, 342–343.

709 Digby 1994, 278.

710 See for example King, George, Placenta Praevia. The *Association Medical Journal*, July 19, 1856, 603–604. In this case, the parturient woman, "a timid nervous lady", had "a great objection to man-midwives"; her previous deliveries had been easy.

711 See for example Churchill 2012, 36.

712 Cody 2008, 165, 166.

713 Cody 2008, 148; Cody 1999, 486.

714 Levine-Clark 2002, 182–183; Levine-Clark 2004, 4–11, 170–175. See also Poovey 1995, 124–125.

715 See for example Norman, George, Case of Ovariotomy. The *PMSJ*, January 8, 1851, 5–6: "I then explained to the patient the nature of the disease, told her that an operation had in some instances been successful [--], but that the risk was great and the result doubtful. She replied that she had expected I should make the proposal to her, that she has quite made up her mind, and was ready to undergo the operation". Anne Digby has argued that this kind "tender-hearted sympathy" became "less fashionable" in the twentieth century and was replaced with "more professionally detached qualities", namely equanimity. Digby 1999, 235. See also Digby 1994, 259–260; Bynum 1996, 177. On sympathy in nineteenth-century science, see also Boddice 2016.

was also able to be "generous and compassionate to those who suffer".[716] This kind of compassionate rationality worked especially when doctors constructed themselves as "obstetrical heroes", with exclusive knowledge and decorous professionalism.[717] Doctors were often sympathetic and some were clearly upset if their patients went through agonizing experiences or died during pregnancy or in childbirth.[718] As one doctor described his emotions on such an occasion, "although it may be foolish to say so, I must confess that I have never lost a lying-in patient without feeling deeply distressed".[719] There was of course always a fear of losing professional credibility, but no doubt this was also a question of humanity, too.

Traumatic and painful experiences clearly bothered some medical practitioners; for example, in 1853, one doctor described his horror when the craniotomy operation went wrong and the foetus, becoming stuck in the birthing canal, did not die as planned, making "a most frightful noise" which the doctor and his colleague assisting in the operation could not forget.[720] These were, very understandably, topics that were never discussed in popular literature; these kinds of stories were intended for peers only, who could have similar kinds of experiences or who could end up in the same kind of distressing situations. In fact, I argue that this side of emotional distress – fear, fatigue, sorrow, or panic – has been largely ignored in medical history, especially how the emotions affected doctors' decision-making and their ability to work in practice.[721]

However, there were, of course, some notable exceptions to this policy of compassionate rationality. It appears that occasionally womanhood, the female mind, and the woman's reproductional body were pathologised and medicalised, and the greatest problem was the sex of the patient rather than some specific disease, known complication, or distressing life situation. For example in 1888, in the case of an alcoholic woman who had become "profoundly melancholic" and started to drink after the death of her child, health problems and eventually the death were diagnosed as *amenorrhea*, an absence of menstruation.[722] The doctor reporting on the case concentrated on the woman's sexual organs and missing

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716 Keller 2003, 77–78. See also Cody 2008, 186–189. On pity, compassion and humanity, see also Boddice 2019, 140–144; Boddice 2018, 55–56.

717 Keller 2003, 76, see also p. 63.

718 Porter 1985, 193. As Porter has noted, treatment was much more than just drugs; it involved "complex rituals of comfort and condolence". See also Cody 1999, 489.

719 West, R. U., Fatal and Other Cases of Puerperal Mania. The *Association Medical Journal*, August 11, 1854, 716. See also Leavitt 1986, 22–23.

720 King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturient. The *Association Medical Journal*, November 4, 1853, 966. See also Copeman, Edward, Rare Cases in Midwifery. The *BMJ*, May 10, 1862, 489–491.

721 See for example The Caesarean Operation: Its Scientific Aspect. The *BMJ*, June 1861, 612–614. Compare especially to Ehrenreich & English 1976; Tew 1998. On the life and emotional side, foremost failure and despair, in the work of Edward Jenner (1749–1823), a famous English physician known as the pioneer of the smallpox vaccine, see Boddice 2019, 124–130. See also Alberti 2006a, xiii–xxiii. On surgery and emotions, see Brown 2018; Brown 2019.

722 Burford, G. H., Hospital for Women. Amenorrhea Associated with Alcoholism. The *BMJ*, June 30, 1888, 1883. See also Levine-Clark 2004, 131–133. See Also Risse & Warner 1992, 190–191, 197–198.

menstruation rather than discussing the trauma and pain of losing a child. Hence, it was the dysfunctional female body that was breaking down rather than the mind of a grieving parent. In this sense, this confirms the cultural idea that females were often studied for their deviations. In popular health manuals, women were sometimes seen as a collective femaleness and not as individuals; their "physical conformation, constitutional disposition, temperament, sympathy, and extreme nervous susceptibility" made them *women*, as was described by William Hamilton Kittoe in the 1840s.[723]

In their own writings, doctors also described themselves – often revealing the ideals, expectations, and realities framing medical work and hierarchical relations between different practitioners. Indeed, popular health manuals, professional literature, and medical periodicals constituted a complex network of references, quotations, and dedications. For example, popular manuals were occasionally, albeit not systematically, dedicated to someone, usually to medical colleagues or to prestigious professional role models of some kind. One of the few writers to notice their own family members was Edward John Tilt (1815–1893), an English physician, who wrote both popular health manuals and made more professional contributions in medical periodicals, and whose manual *On the Preservation of the Heath of Women* (1852) was dedicated to his own wife.[724] The manual of Lyman B. Sperry, concentrating on married life, *Confidential Talks with Husband and Wife* (1900), paid respect to the memory of both his mother and wife. Interestingly, Pye Henry Chavasse's manuals *Advice to a Wife* (1866) and *Aphorisms on the Mental Culture and Training of a Child* (1872) were dedicated to his patients, from whom Chavasse had received, according to his own words, "so much confidence, courtesy, and kindness".[725] Other acknowledgments were usually less personal, emphasising hierarchical relations between practitioners; for example, Chavasse's other best-seller *Advice to Mothers* was dedicated to Sir Charles Locock (1799–1875), Queen Victoria's personal physician, who had also commended the content of Chavasse's guidebook.[726]

In fact, manuals and their acknowledgments quite often revealed who was *who* in nineteenth-century medicine and society. For example, Robert Hills dedicated his little book *Wife and Mother's Guide* (1841) to his more famous colleague, John Tricker Conquest (1789–1866), hailing him as "one of our greatest living masters".[727] Conquest, in turn, expressed his admiration for James Young Simpson (1811–1870) at the beginning of his own manual *Letters to a Mother* (1849). Simpson had introduced chloroform into medicine only a year earlier, assisted by one of his students famous in his own right, James Matthews Duncan (1826–

723 Kittoe 1845, 8.

724 Tilt 1852, iv: "To whom can I so appropriately inscribe a little work on the Preservation of the Health of Women as to her whose health is to me dearer than all earthly blessings?" On Tilt, see also Edward John Tilt. Obituary. The *BMJ*, December 23, 1893, 1411.

725 Chavasse 1866, v.

726 See the examples in Chavasse 1870, 13, 31, 40, 60–61.

727 Hills 1841, Dedication [no page number]. See also Death of Dr. Conquest. The *BMJ*, November 10, 1866, 519; November 17, 1866, 564–565.

1890).[728] Duncan received his own tribute from the anonymous writer of *Girlhood and Wifehood*, a popular manual published around the beginning of the twentieth century; the writer himself had been the "humble pupil" of Duncan.[729] James Young Simpson, generally recognised as one of the greatest medical men of his time, was clearly an inspiration for the younger generations of British medical practitioners. This admiration, however, was not without discord; as his former student William Smoult Playfair (1836–1903) noted in 1898, Simpson was also thought by some to be "ill-balanced and impulsive, lacking in judgement, and unreliable", but Playfair considered his teacher and mentor a "genius", calling him "that wonderful man".[730] At the end of the nineteenth century, also Gordon Stables (1894) praised the famous Scotsman to his female readers:

> My old friend, Sir J. Simpson, it was, who first found out the value of chloroform in labour. All honour to his ashes. He was the cleverest and boldest operator I have ever known and yet a man of the greatest manners, and possessed of as kind heart as ever beat within a human breast.[731]

Despite these respectful words and his admiration, Stables dedicated his manual to his far less famous friend "Dr. Alfred Upton, of Brighton".[732]

In their popular writings, doctors could combine their own expertise and experiences with more professional medical works. Some prestigious British medical authors, such as Edward John Tilt, William F. Montgomery (1797–1859), Thomas Hawkes Tanner (1824–1871), and William S. Playfair were often referred to and requoted also in popular health manuals.[733] The influence of a classic could be long lasting; for example, Montgomery's professional guide *An Exposition of the Signs and Symptoms of Pregnancy*, published in 1837, was requoted even at the end of the nineteenth century.[734] However, it seems that the manual of William S. Playfair, *A Treatise on the Signs and Practice of Midwifery* (publ. orig. 1876) was *the* obstetrical book in the late nineteenth century. For example, in 1898, one

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728 See the dedication in Conquest 1849, see also pp. 51–52.

729 Surgeon and Accoucheur [anonym.] (1900–1909?), vii.

730 Playfair, W. S., A Valedictory Lecture on the Progress of Obstetrics and Gynaecology. The *BMJ*, March 19, 1898, 741: "and in a certain sense all this is true [--] But his boundless and contagious enthusiasm, his commanding personality [--] and lovable disposition, which made him never see anything but good in others who would admit no good in him, combined to make him a leader and a teacher such as I have never seen equalled in the past and never expect to see in the future."

731 Stables 1894, 226. See Simpson discussed also in Stacpoole 1894, 101–102. See also Chavasse 1866, 150. See also Playfair, W. S., A Valedictory Lecture on the Progress of Obstetrics and Gynaecology. The *BMJ*, March 19, 1898, 741.

732 See Stables 1894. On the other hand, many writers did not dedicate their books to anyone; Florence Stacpoole, for example, expressed her gratitude to "Dr. Berry Hart, of Edinburgh, for having kindly read the proper-sheets and made some valuable suggestions" but did not address anyone else. Stacpoole 1894, 2.

733 On Tilt, see for example Allbutt 1890, 56; Weatherly 1881, 110; on Playfair, see for example Stacpoole 1894, 3, 17–19, 24–25, 34–36, 46–47; on Tanner, see for example Chavasse 1866, 11, 49, 139; Scott 1870 [?], 24–25, 81, 121; Stables 1894, 144–145, 151, 199. See also Obituary: Thomas Hawkes Tanner. The *BMJ*, July 22, 1871, 110–111.

734 See for example Harvey 1863, 6–8, 11–14; Chavasse 1866, 45; Stables 1894, 176–177. See also Heming, G. O., Practical Facts and Observations on Diseases of Women, and Some Subjects Connected with Midwifery. *The Lancet*, June 15, 1844, 409.

writer explained in the *BMJ*, "if a man comes to a midwifery case, and finds an arm protruding, it is too late to think of reading up his Playfair".[735] Playfair was the professional hero also of Florence Stacpoole, who called him "the high authority" in her popular manual *Advice to Women* (1893).[736] Playfair himself had a close-knit relationship with the British royal family: he attended Queen Victoria's two daughters-in-law and at least one granddaughter when they gave birth.[737] However, in the genre of popular health literature, direct references to the content of medical journals were much rarer. For example, Henry Thomas Scott made only one reference to *The Lancet,* but this was merely a short article on fashion in the weekly section rather than a lecture of some prestigious medical author, for example.[738] Pye Henry Chavasse, who occasionally also contributed to the *BMJ* and its predecessors, referred occasionally to the content of the medical journals in his popular guidebooks.[739]

Professional credibility and social prestige were also tied up with practical work and experiences gained with patients. In their prefaces, many writers mentioned their positions in various midwifery institutions and extended practical experiences.[740] Some also acknowledged that their literary work had benefitted from the co-operation with their own patients. For example, when writing his manual *The Wife and Mother* (1902), Ralph Vincent had had practical hints from

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735 Simpson, A. R., An Address Delivered at the Opening of the Section of Obstetrics and Diseases of Women. The *BMJ*, July 30, 1898, 302. See also Playfair, W. S., A Valedictory Lecture on the Progress of Obstetrics and Gynaecology. The *BMJ*, March 19, 1898, 741–744.

736 Stacpoole 1894, 49. Stacpoole was very familiar with professional medical literature and also quoted other medical authors, but Playfair was found in every chapter of her manual. She referred both to Playfair's professional manual *The Science and Practice of Midwifery* and to the address Playfair delivered to the British Medical Association in 1887. In her manual she also included Playfair's whole letter, which he wrote about the death of Princess Charlotte of Wales, who died infamously in childbirth in 1817. See Stacpoole 1894, 85, 86, 95–98; see also Chapter 5.5. See also Black 1888, 48.

737 Playfair was the personal obstetrician of Princess Louise Margaret, Duchess of Connaught, the wife of Prince Arthur, the second youngest son to Queen Victoria. See for example The Duchess of Connaught. The *BMJ*, March 4, 1882, 314. See more about Playfair and the first delivery of Marie of Romania, the granddaughter of Queen Victoria, in Pakula 1998, 96–97; Marie, Queen of Roumania 1934, 314–315. See also Lewis 1986, 3.

738 See Scott 1870 [?], 17. See The Nemesis of Fashion. *The Lancet*, January 29, 1870, 168. In fact, there is no exact year of publication for the Scott's manual and the book has been dated based on this reference. Gordon Stables mentioned in his manual (1894) that *The Lancet* had recommended citrate of iron and quinine for menstrual difficulties, but did not mention when and where he had seen this recommendation. See Stables 1894, 132. See also Stacpoole making a reference to the *BMJ*, see Stacpoole 1894, 80. The original article was published in the *BMJ*, Cullingworth, Charles J., Introductory Address on Puerperal Fever a Preventable Disease. The *BMJ*, October 6, 1888, 746.

739 See Chavasse 1866, 40. See the original text in the *BMJ*, November 21, 1863, 552. Chavasse was also aware of the article written about the diet of lying-in in the *BMJ*, see Reports of Societies: Liverpool Medical Institution. The *BMJ*, December 12, 1863, 648–649. Chavasse 1866, 176, making a reference to the letters sent to the *BMJ*, see the *BMJ*, November 19, 1864, 589–591. See also Chavasse 1866, 112; the original text in *The Lancet*, July 20, 1850. See the example of the longer report by Chavasse; Chavasse, Pye, H., Case of Extra-Uterine Pregnancy. The *Association Medical Journal*, November 30, 1856, 1071–1073.

740 See for example Bull 1837, iv; Hills 1841, 16; Scott 1870 [?], Preface [no page number].

"a lady, whose knowledge of the necessities and of the technical details was of the greatest assistance".[741] Henry Davies, on the other hand, had asked his female patients to check his guidebook *The Young Wife's Guide* (1852) and to make comments and suggestions for improvements, which were published in the second edition of the manual. One of these trusted patients was a married woman with "twelve living children" – probably the most convincing and reliable commentator Davies could wish for. The woman had asked advice on "distressing restlessness" during the last months of pregnancy, and, in return, she gave her own hints on nursery discipline.[742] This was of course a very effective rhetorical way to both increase the credibility of the book and to confirm the capability of its author in the eyes of potential female readers.

Credibility in obstetrics could come from another, more personal and intimate direction. Many doctors were married men with children of their own, although it is impossible to estimate how many. William Hamilton Kittoe, for example, wrote in 1845, when discussing the professional reputation of a male doctor attending female patients, that the medical practitioner was "generally a husband and father" himself, and therefore, reliable and respectful in every respect.[743] Marriage certainly gave a male practitioner both confidence and social credibility, especially in the eyes of potential female patients; a wife and the security of family life served particularly young doctors who were establishing their careers and practice.[744] Gordon Stables was one of the few writers who disclosed his own personal background and marital status in the preface of his book: "my advice may be deemed none the less valuable, in that I am a married man myself, and as far as family goes, very much married."[745] However, this personal merit did not work the other way around. Female doctors never made any references to their potential personal experiences as wives and mothers: they merely spoke about their patients and presented anecdotes they had heard or read elsewhere.[746] Female doctors clearly constructed their obstetrical self-portrait specifically as medical professionals, and not as females or mothers, with the female reproductive body or personal experiences of their own. Being specifically a *female* doctor was certainly not a benefit in seeking professional accreditation and competence in the eyes of their male peers.

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741 Vincent 1902, 64.

742 Davies 1852, viii, 23: "In the interval which has elapsed since the publication of the first edition the author has had some observations kindly communicated to him by patients whose opinions he requested". See also Chavasse 1870, xii–xiii.

743 Kittoe 1845, 174.

744 See for example Peterson 1978, 92, 107–108. As M. Jeanne Peterson has pointed out, doctors often married daughters of their peers. See also Ryan 1836, 138. See also Tosh 2005, 331–335. Not all, however, recommended marriage for medical men, see especially Marriage of a Medical Man Not Advisable. The *BMJ*, November 23, 1861, 570. See also Brown 2014, 27–28.

745 Stables 1894, viii. See also Ryan 1836, 138–140.

746 See for example Stacpoole 1894, 6, 26; Walker 1893, 12. According to Nancy M. Theriot, female doctors "saw the domestic lives of the majority of women as oppressed with physical labor and physiological worry that was happily absent from most of their lives". Theriot 1996, 138–139. See also Bashford 1998, 85–86, 94–105.

On the other hand, the intention of the manuals was not only to educate their readers, but also to entertain and enlighten them. Some authors, such as Pye Henry Chavasse and Gordon Stables blended together various religious texts, poems, and moral aphorisms in their manuals; the result was a mixed combination of different medical and non-medical discourses and literary genres.[747] Especially Gordon Stables (1840–1910), a navy doctor and author of many adventure books for boys, was prone to fictional, yet educational stories. Stables' manual *The Wife's Guide to Health and Happiness* (1894) began with a Cinderella-styled tale of an idealised married couple living in the countryside, clearly reflecting the romantic ideals of its writer.[748] Stables also told a highly ideological and demonstrative story of two fictional young women, one called *Jenny Rae*, a miller's daughter, living happily in the countryside according to the laws of nature; consequently, she had a large and healthy family and she also enjoyed a happy married life. The antonymous figure, *Miss Evelyn Graham,* spent her short life in luxury, in the contaminating town air, avoiding all exercise and spending her days in idleness and badly ventilated rooms; she was pale and delicate, her marriage was short and unhappy, and her only child died prematurely, as also did Miss Evelyn herself.[749] The message of the story was highlighted on purpose. Stables himself clearly was a profoundly religious person, combining his conservative religious stance with elements of social Darwinism, believing in moral decline and bodily degeneration, especially amongst the British upper class.[750] As a result, his manual was the most ideological, opinionated, and sentimental of all the popular textbooks I have studied in this research.

Historically, it is very difficult to estimate the actual influence of the popular medical literature, that is say, how widely these books were read and how intensively women followed the rules doctors presented for them in literary form. Patricia Branca has suggested that there was growing concern and demand for "information on the most basic aspect of motherhood", which, according to Branca, demonstrated that especially the Victorian middle-class woman did not find the role of motherhood as "natural" as it has been traditionally thought.[751] I find this argument debatable, especially as the historian Ruth Robbins has pointed out that buying a book and reading it are not the same thing.[752] Robbins

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747 Chavasse quoting the Bible, see for example Chavasse 1866, 57, 134. See also Stables 1894.

748 Stables 1894, 13–22. The main female character of the tale by Stables, *Oddity: or One Day in a Wedded Life* was called Oddity. She was a child-like character, married to an artist called Jack Ruskin, and living in the countryside, closely connected to nature and the non-naturals. Apparently, Oddity and her husband represented an idyllic married couple to Stables.

749 Stables 1894, 146–149. See also Wear 1996, 129–132; Ganev 2007, 40–50. See also Hills 1841, 16; Kittoe 1845, 3–4, 16; Bakewell 1859, 40–41. See also Chapman, Wm, Early Parturition. The *Association Medical Journal*, February 9, 1856, 114.

750 Stables 1894, 24, see also p. 89: "soon degenerate from effeminacy to positive idiocy, and so die away, in obedience to the laws of Nature, which pre-ordains the fittest to live". This clearly was a typical feature in Stables' books; also his manual for young girls contained similar kind of stories. See also Stable's view on educated women on p. 38. See also Marland 2013, 1–2; Ganev 2007, 42–43, 48–49.

751 Branca 1975, 78.

752 Robbins 2009, 7. See also Jordanova 1999, 105; Hall 1991, 83–84.

has also made the very essential remark about the role of the reader; it is not at all clear who was reading and *how* they were reading, "(passively and/or aggressively, straight or against the grain)".[753] Lesley A. Hall has shown how, for example, cookery books reflected and encouraged changes in culinary practices; that is to say, that they both reflected and produced reality. It is very likely that readers were "picking out tips useful for running their own lives where tradition and upbringing did not help them".[754] Readers did not necessarily have to swallow the whole content of the manual at once, to follow every single piece of advice, or even to agree with the content; they could simply choose those parts their found useful or otherwise interesting for themselves. Disinterest or apathy were also possible reactions.

It is hardly any surprise, however, that the authors of these guides and manuals were convinced that their work had a profound influence and women studied the content of the writings and applied at least some of the advice to their daily practices. For example, one of the most well-read doctors of the century, Pye Henry Chavasse (1810–1879), rejoiced in the preface of the seventh edition of his manual *Advice to a Wife* (1866) that there had been a real need for medically correct information, written in simple and understandable language: "[t]he sale of this work has, in Medical literature, been almost unprecedented – fifteen hundred copies of it have been sold in the last twelve months".[755] The manual of Henry Arthur Allbutt, a controversial best-seller *The Wife's Handbook,* published originally in the 1880s, had sold more than 250,000 copies by 1900.[756] Allbutt's guide was heavily criticised for its content, but both Chavasse's *Advice to a Wife* and another bestseller *Hints to Mothers* by Thomas Bull were recommended on several occasions, when "books for newly married ladies" were required by the doctors in the *BMJ*, on behalf of their female patients.[757] In 1898, in the review of the latest, revised edition of Chavasse's *Advice to a Wife on the Management of Her Health*, published almost two decades after the death of its author, the manual was described as a "classic". The book itself was read by many generations, as the reviewer remarked: "Chavasse we have always with us. Our fathers and grandfathers have found it good and have handed it down to us".[758]

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753 Robbins 2009, 7. On the reading process, see Fissell 1992, 79–82; Porter & Porter 1989, 200–201; Jordanova 1999, 103, 105; Porter & Hall, 1995, 6–7.

754 Hall 1991, 84.

755 Chavasse 1866, Preface ix for the 1864 edition of his book. Two years later, when the seventh edition was released, Chavasse could claim that "not a copy [of his book] remains unsold [- -] to meet the enormous demand, five thousand copies of *this* edition are *now* published: which is more than equivalent to the average of three *ordinary* editions." See also Chavasse 1870, ix–x.

756 Fisher 2011, 27.

757 See for example Books for Newly Married Ladies. The *BMJ*, August 10, 1895, 403. The journal mentioned that these were the "two books which have been much used for the purpose mentioned." See also the *BMJ*, May 21, 1898, 1371; Domestic Handbooks. The *BMJ*, July 31, 1897, 322. These manuals were read also in America and Canada. See for example Mitchinson 1991, 33. See also Books for Mothers. The *BMJ*, March 7, 1896, 638; Family Medicine. The *BMJ*, August 8, 1896, 367. On Allbutt, see Chapter 4.4.

758 Notes on Books. *The BMJ*, July 9, 1898, 89. The 14th edition of the book was revived by Fancourt Barnes. Chavasse's other manual, *Advice to a Mother*, was also re-printed

Hence, how medically correct and orthodox were these manuals and how detailed information could women expect to find in them, especially when medical periodicals constantly warned against the "modern craze for amateur doctoring"?[759] To answer this question, I have analysed the book reviews, published in the medical periodicals. Based on the recommendations by the *BMJ*, it can be argued that manuals, such as those written by Pye Henry Chavasse for example, reflected some of the general ideals of the nineteenth-century medical profession, such as the idea of prevention. Book reviews show that generally, popular medical guidebooks were accepted as necessities; they consisted of correct information in an easily understandable form while they also encouraged their readers to always consult professionals and not to rely on home doctoring or quackery.

For example, in the 1890s, the popular guidebook *Handbook for Mothers* (1893) by Jane H. Walker, was reviewed both in the *BMJ* and in *The Lancet*. As the reviewer in the *BMJ* noted, Walker's book was "a praiseworthy attempt" to give its middle-class readers "some plain and useful" hints on pregnancy, childbirth, and childcare.[760] However, the book was criticised for its advice concerning diet: according to the *BMJ*, the antenatal diet discussed in the book, consisting of oranges, apples, lemon juice, and rice, was not considered sufficient at the critical time of pregnancy.[761] In fact, Thomas Bull's manual *Hints to Mothers* faced the same kind of criticism in 1871.[762] Otherwise, Walker's manual was praised for its practical and sensible approach: "[w]hen a woman buys a book of 'advice to mothers' she wants plain common sense advice and simple information, not poetry nor theology".[763] The review of Florence Stacpoole's manual, in 1891, noted that many

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and re-read throughout the nineteenth century, long after the death of its author. See for example Queries. The *BMJ*, May 21, 1898, 1371. See the obituary of Chavasse in the *BMJ*, September 27, 1879, 521: Chavasse, a fellow of the Royal College of Surgeons, worked in Birmingham but his name was "more generally associated with various popular medical works dealing with maternal cares and duties, numerous editions of which have been published, and whose usefulness is furthermore exemplified by their translation into near every European language and also into several of the languages of Asia".

759 The expression "amateur doctoring" taken from: A Handbook for Mothers [A Book Review]. The *BMJ*, January 20, 1894, 131.

760 A Handbook for Mothers [A Book Review]. The *BMJ*, January 20, 1894, 131. See also the review of the manual of Florence Stacpoole: Advice to Woman on the Care of the Heath before, during, and after Confinement [A book Review]. The *BMJ*, December 17, 1892, 1343. The book got good reviews: "is well and clearly written and full of practical hints". See also a praiseful review of the manual *Woman's Words to Women on the Care of their Health in England and in India* by Mary Scharlier. The *BMJ*, September 19, 1896, 755: "This small but most excellent and useful little book, written by one of our most highly qualified lady doctors, may be highly praised, and should be read and consulted by all young and married women both in England and in India". Unfortunately, this book was not available for my research.

761 See Walker 1893, 31–33: "All food taken during pregnancy should be as plain and simple as possible". In her book, Walker discussed the woman who lived on a light diet of oranges and apples and whose delivery had been quick and "almost painless". She recommended light diet, "consisting largely of fruits, raw or stewed, rice, sago, and a small quantity of fish or meat", to her readers.

762 See Miller, Hugh, On the Diet of Parturient Women. The *BMJ*, April 29, 1871, 445.

763 A Handbook for Mothers [A Book Review]. The *BMJ*, January 20, 1894, 131. Another manual by Walker, *A Book for Every Woman*, was reviewed in three years later: "The

popular works on motherhood were generally stamped with "the offensive sentimentality", very typical of the genre.[764]

It seems that writers, such as Gordon Stables in front, clearly, had not read these reviews. Stables too – like his nineteenth-century peers, however, believed that doctors' literary work had a lot of weight when women were trying to find reliable information about pregnancy and how to take care of themselves during the critical gestation months – the next topic in this study.

book is decidedly slight and sketchy, but, nevertheless, a readable and an amusing one". In this book, however, the chapter on the "importance of good cooking" was "excellent", unlike in Walker's previous guide *Handbook for Mothers*. See A Book for Every Woman [A Book Review]. The *BMJ*, April 3, 1897, 860.

764 Notes on Books. The *BMJ*, January 24, 1891, 184. Generally, Florence Stacpoole's manuals were well received, see for example the review on *A Homely Talk on Health* (1893) in the *BMJ*, December 9, 1893, 1279.

4 "LIKE A FRUIT OF EVERY OTHER KIND, THE CHILD IN THE WOMB REQUIRES A CERTAIN AMOUNT OF CARE OF ITS PRESERVATION AND PERFECTION": PREGNANCY IN VICTORIAN BRITAIN

4.1 "Symptoms that Will Tell Them that They Are Going to Be Mothers": Managing Medical Uncertainty of Pregnancy

Pregnancy had an indispensable part in the nineteenth-century world; as the historian Jacque Gélis has noted in his study on early modern childbirth, it was "an essential element in the 'human landscape' of the past centuries".[765] In this chapter, I discuss pregnancy in nineteenth-century British medicine; how gestation was diagnosed, based on the typical signs and symptoms described in popular medical literature, how pregnancy was managed, and what kind of advice pregnant women were given by the Victorian medical profession. This was important because at least in the lives of most married women, pregnancy occurred more or less regularly. For example, around the 1850s, British aristocratic women had approximately six living children, and, in addition, many suffered from miscarriages and premature labours, even if the exact number of aborted pregnancies or stillborn children in the nineteenth century is not known.[766]

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765 Gélis 1991, 45.

766 See for example Tanner 1860, 12–13. For example, Thomas Hawkes Tanner knew one patient who had been pregnant twenty-five times, giving birth to nineteen living children. Tanner 1860, 12. In comparison, in America, at the beginning of the nineteenth century, white women bore more than seven living children. By 1900, the average number was 3.56 children. See Leavitt 1986, 14, 19; Lewis 1986, 6. See also The Registration of Stillbirths. The *BMJ*, December 19, 1891, 1319.

However, the period of pregnancy was not the same for everyone; some pregnancies were welcomed and even anticipated, while some were not. Moreover, women stood in very different positions in the reproduction cycle; some were at the beginning of their married life, possibly fearing barrenness, and therefore, very anxious to become pregnant. Many were having their children in rapid succession, some of them feeling a loss of control over their lives and bodies, and some women were already approaching the menopause, hoping to avoid yet another round in this ongoing cycle of gestations, deliveries, and lactation. At best – or at worst – the successions of pregnancy, childbirth, and breastfeeding could last more than thirty years; approximately from the fifteenth to the forty-fifth or forty-eighth year of age, as for example Thomas Hawkes Tanner defined "the limits of the generative faculty in women".[767] However, too early and too late pregnancies were considered potentially risky and they were not usually recommended.

Thus, recognising an existing pregnancy was of the greatest importance, but as it was generally acknowledged in nineteenth-century obstetric medicine, confirming the state was not always particularly easy. The time before the fourth month was often stamped with uncertainty and doubt, due to the possibility of misdiagnosing the symptoms and signs, and also the very potential risk of miscarriage.[768] Many medical authors noted that occasionally women believed that they were expecting when they were not, misreading their bodily signs and symptoms that otherwise indicated that they were suffering from illnesses of some kind. Secondly, some women systematically denied the possibility of pregnancy even if they were indeed with child, and thirdly, the pregnancy could be an ectopic pregnancy, or the result was not a full nine-month pregnancy and a living child but a spontaneous termination of gestation at some point of the process.[769] Many historians have noted that women were often reluctant to announce their pregnancy in the early months, keeping it in secret until the growing abdomen usually revealed the actual state of affairs. As Laura Gowing, for example, has pointed out, in early modern England, in most cases women took uncertainty of early pregnancy for granted; many potential signs were often open to various interpretations and eventually it was time alone that revealed if the result was a living child.[770] When discussing uncertainty of early pregnancy, Barbara Duden has used the expression "the context of ambiguous corporeality", noticing how most eighteenth-century women lived in a state of ambiguity for the most part of their adult life.[771]

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767 Tanner 1860, 8–9. One topic in the health manuals was the age of the parturient, that is to say, how young girl could become pregnant and, on the other hand, how old was the oldest woman known to have given birth. See for example Tanner 1860, 9–10. See also Jalland 1986, 139–140.

768 See for example Jalland 1986, 140–143; Gowing 2003, 118–119.

769 Leith Napier, A. D., The Diagnosis of Spurious and Doubtful Pregnancy. The *BMJ*, November 7, 1891, 988–991. See also Gooch 1831, 191–208; Swayne 1893, 39–40. See also Duden 1991, 159–162.

770 Gowing 2003, 119–120. See also Read 2013, 83–84. See also for example Barnes, Robert, The Diagnosis of Early Pregnancy. The *BMJ*, December 19, 1868, 631–632.

771 Duden 1991, 158.

Medicine works with the practical observations and interpretations of the healer and the description of the patient, which can be understood as subjective aberrations or changes from the normal state of health. Pregnancy, as noticed constantly, was not a disease or a disease-like state, but complexly, it was not a perfectly normal state either. Pregnancy was considered a natural state of married women, but on the other hand, it was also "naturally accompanied by pain, more or less severe, and often by considerable danger", as Florence Stacpoole reminded her readers in 1894.[772] Michel Foucault, for example, has noted how diseases are observed in terms of symptoms and signs, the symptom being the visible form in which the disease is presented, such as a cough or pain felt in the body. The sign serves as an announcement, often obliquely and unexpectedly; it tells what will happen, what has happened, and what is currently taking place in the body. Thus, it provides a basis for recognition. According to Foucault, signs and symptoms are the same thing, "the only difference being that the sign says the same thing that is precisely the symptom [--] Thus 'every symptom is a sign' by right, 'but not every sign is a symptom".[773] Indeed, Foucault has discussed medicine as an uncertain kind of knowledge.[774] The *Provincial Medical Journal and Retrospect of the Medical Sciences* noted in 1842 that symptoms are "literally things that happen together in a sick person".[775] Thus, symptoms were "diagnostic signs", but as the writer noted, not all signs were symptoms "for they may be impressions on our senses, derived from the mere physical changes in the structure of the body."[776]

In pregnancy, the line between a sign and a symptom was less than clear. No sign or symptom alone was considered decisive, as it was usually "the combination of symptoms taken collectively", as for example Henry Davies noted in his manual.[777] Individual differences between women could be great; as many medical writers acknowledged, some women felt "much better, both mentally and bodily, when pregnant, than at other times".[778] For some, on the other hand, pregnancy was suffering from "nine months' illness", that is to say, from various physical ailments and mental discomfort.[779] For example, Michel Foucault has stated that historically symptoms of pregnancy could be divided into eight degrees: in the first month, the disappearance of menstruation and nausea or vomiting; then an increase in the size of the womb in different pregnancy months, and the "extension of the womb over the pubic bones" and "the projection of the whole hypogastric region". The last degrees of symptoms were the spontaneous movement of the foetus, *quickening*, felt by the pregnant woman herself around the fifth month, and lastly, the movements of "tossing and displacement", felt at

772 Stacpoole 1894, 1, 31. See also Philothalos 1860, 45–46.
773 Foucault 2005, 110, 113–114, 196.
774 Foucault 2005, 196, see also pp. 197–200.
775 Symonds, Dr., Introductory Lecture to the Course on the Theory and Practice of Medicine. The *PMSJ*, October 22, 1842, 63.
776 Symonds, Dr., Introductory Lecture to the Course on the Theory and Practice of Medicine. The *PMSJ*, October 22, 1842, 64.
777 Davies 1852, 2.
778 Welch 1838, 11–12; Fox 1834, 7; Bull 1837, 55–56; Stacpoole 1894, 57.
779 Welch 1838, 11.

the beginning of the last month.[780] According to Foucault, each of these eight signs carried one eighth of certainty, and the first four "constitute a half certainty".[781] These kinds of lists, however, had only little value in real life. In the early modern world, for example, the missing of a menstrual period was considered only a minor indicator of existing pregnancy: it was not uncommon that malnourished women menstruated irregularly.[782]

Basically, nearly all medical popular health manuals divided the most typical, traditional, and distinct signs and symptoms into four main categories; firstly, missed monthly periods, secondly, *morning sickness*, thirdly, certain bodily changes, especially in the breasts and abdomen, and fourthly, *quickening*, the first movements of the foetus felt by the pregnant woman around the fourth or fifth pregnancy month. In addition to these main categories, there was a group of minor signs and symptoms, generally thought to be common, such as heartburn, palpitation, costiveness, flatulence and diarrhoea, irritable bladder and incontinence, cramps and swellings, and changes in mood.[783] These signs and symptoms could be divided differently; for example, Henry Davies noticed in 1852 that "demonstrative" signs were those typical four signs mentioned in every popular guidebook. Davies called minor symptoms "presumptive", not necessarily occurring in every pregnancy, such as disturbed sleep, nightmares, and toothache, troubling some women but not every individual. In addition to the demonstrative and presumptive signs and symptoms, there were "individual" symptoms, like salivation, "which to [women] themselves are an assurance of their state".[784] On the other hand, for example Henry Arthur Allbutt separated the symptoms and signs into two different classes, the *subjective* and *objective* ones. The former were those which the pregnant woman felt and knew herself – such as the stoppage of menstruation, morning sickness, salivation, and quickening. The objec-

780 Foucault 2005, 126–127.

781 Foucault 2005, 127.

782 See for example Read 2013, 83; Duden 1991, 159–160. Compare to Gélis 1991, 46. See also Kilday 2013, 56–58.

783 See for example Fox 1834, 3–5, 39–42; Bull 1837, 66–72; Welch 1838, 6–7, 43–46; Kittoe 1845, 142; Philothalos 1860, 37–40; Weatherly 1882, 55–56; Black 1888, 22–30; Walker 1893, 68–70; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 171–172. See also Tanner 1860, 423–424; Playfair 1893a, 248–250.

784 Davies 1852, 3. Also J. T. Conquest discussed "presumptive" and "demonstrative" symptoms in his manual, see Conquest 1849, 20–23. However, as Thomas Hawkes Tanner noted, in Britain, there was no unanimous classification of the signs of pregnancy, see Tanner 1860, 43–44. See also Playfair 1893a, 154. On salivation as a sign and its treatment, see for example Bull 1837, 85–86; Fox 1834, 51; Davies 1852, 20–21; Harvey 1863, 66; Black 1888, 12, 28; Allbutt 1890, 7; Stacpoole 1894, 40; Stables 1894, 166; Tanner 378–381; Playfair 1893a, 234–235. On teeth and pregnancy, see for example Fox 1834, 50; Bull 1837, 83–85; Conquest 1849, 37; Davies 1852, 20; Bakewell 1859, 107–108; Harvey 1863, 67–68; Chavasse 1866, 82–85; Weatherly 1882, 52; Black 1888, 29; Allbutt 1890, 7; Walker 1893, 43–45; Stacpoole 1894, 49–50; Stables 1894, 199; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 169–170; Tanner 1860, 377–378; Playfair 1893a, 235.

tive symptoms were, according to Allbutt, more visible to others, such as the visual changes in the maternal body, the growing abdomen being the most noticeable objective sign.[785]

However, while it was very important for every woman to understand and recognise these changes and signs taking place in her own body and mind, some physical signs were meant to be observed by the practitioners only. These included especially the signs located in the sexual organs.[786] Some of the signs, especially those taking place in the breasts or the discolouration and feel or texture of the vaginal passage, demanded a certain intimacy between the observer and the expectant woman and also special knowledge of the female body.[787] In nineteenth-century obstetrical medicine, observing and examinations were done using all senses; for example, Thomas Hawkes Tanner discussed "a peculiar smell of vaginal mucus", being "musty, something like that of spermatic fluid or liquor amnii".[788] One especially interesting sign mentioned in the popular manual of Henry Arthur Allbutt (1890) was "the sounds of the child's heart heard when the ear is placed on the woman's abdomen or body".[789] It is worth noticing that this was the only the second time when the possibility of hearing the foetus's heartbeat was mentioned in the non-professional medical context. In medicine, auscultation became growingly important during the nineteenth century, but, on the other hand, it was often noted that observing foetal and placental sounds demanded constant practice and lots of experience. Even the most experienced practitioners could be erroneous in their judgement.[790]

Hence, in real life, diagnosing pregnancy on the basis of signs and symptoms was not at all clear, especially during the first months of uncertainty – quite

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785 Allbutt 1890, 5–8. See also Barnes, Robert, Remarks on the Diagnosis of Early Pregnancy. The *BMJ*, December 19, 1868, 631.

786 See for example Philothalos 1860, 40; Harvey 1863, 14–15; Welch 1838. See also Black 1888, 12: "There are other signs which are of very great value to the physician in ascertaining the existing pregnancy; but as these require medical skill for their appreciation, they do not fall within the scope of the present work". See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 164–165.

787 Allbutt 1890, 5, 7. See also Black 1888, 12. See also Montgomery 1837, 99–111; Tanner 1860, 46, 119–120. See also Routh, C. H. F., On Some Symptoms of Early Pregnancy. The *BMJ*, November 26, 1864, 593: "The principle symptoms [--] are, cessation of menses; the purple colour of the vagina; the peculiar character of the urine, which contains kyestine; the velvety feel of uterine cervix; the enlargement of the breasts and womb; with the peculiar character of the areola." See also Barnes, Robert, The Diagnosis of Early Pregnancy. The *BMJ*, December 19, 1868, 631–632; The Blue Coloration of the Vagina during Pregnancy. The *BMJ*, October 13, 1888, 829–830. See also Playfair 1893a, 151–153, 164–173.

788 Tanner 1860, 121. Tanner himself, however, did not consider the smell a reliable sign of pregnancy. See also Dodd, A. T., On the Signs of Pregnancy. The *PMSJ*, August 7, 1841, 365–368; Barnes, Robert, Remarks on the Diagnosis of Early Pregnancy. The *BMJ*, December 19, 1868, 631–632.

789 Allbutt 1890, 5. Compare to Harvey 1863, 14–15. See also Stables 1894, 167. See also for example Kilday 2013, 56–58.

790 Gélis 1991, 49. On auscultation and the placental souffle, see also Routh, C. H. F., On Some Symptoms of Early Pregnancy. The *BMJ*, November 26, 1864, 593. See also Drew 1891, 24; A London Physician [anonym.] 1891, 180, 204–208. See also Tanner 1860, 99–113; Playfair 1893a, 166–173. See also for example Dodd, A. T., On the Signs of Pregnancy. The *PMSJ*, August 7, 1841, 365–368.

the contrary, sometimes it was considerably difficult.[791] For the medical professional, misdiagnosed pregnancy was always a humiliation; professional reputation suffered and mistakes in diagnosis also meant the doctor's social credibility was at stake.[792] Every practitioner had to remember that certain bodily signs could be misleading; for example, missed periods were not necessarily a sign of pregnancy, and, on the other hand, the woman could have her vaginal discharge, closely resembling menstruation, continuing even if she was in fact pregnant.[793] Confirming pregnancy was by no means a slight task; the patient's reputation was always jeopardised if the doctor, for example, misdiagnosed the cases concerning paternity, "bastardy, and female violation", meaning rapes and cases of adultery.[794] Thus, the doctor's testimony could have serious consequences and "disastrous results"; marriages could end up in humiliating divorces and a permanent social stigma, children born to married women were declared illegitimate, and properties and estates were re-arranged and inherited differently if there was any kind of uncertainty or suspicion about the time of conception or other circumstances of pregnancy.[795]

Moreover, women themselves could give very convincing yet erroneous statements. This meant that the practitioner was sometimes placed in puzzling situations – how much could doctors rely on the account of the female patient, when she was describing the possible signs and symptoms either taken place or

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791 See for example Ryan 1841, 151; Tanner 1860, 1; Harvey 1863, 11; Mann 1893, 112–113; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 156–157. See also Playfair 1893a, 154. See also for example Galabin, Alfred L., A Case of Ovariotomy Performed during the Sixth Month of Pregnancy without Interruption to Gestation. The *BMJ*, March 13, 1880, 397; Tyler Smith, A Case of Spurious Pregnancy. Hospital Reports. The *Association Medical Journal*, February 9, 1856, 101–102; Barnes, Robert, The Diagnosis of Early Pregnancy. The *BMJ*, December 19, 1868, 631–632; Cases Illustrating the Diagnosis of Pregnancy. Middlesex Hospital. The *BMJ*, January 4, 1879, 12–13; Napier, A. D. Leith, The Diagnosing of Spurious and Doubtful Pregnancy. The *BMJ*, November 7, 1891, 988–991. About diagnosing pregnancy in early modern England, see also Gowing 2003, 118–120. See also Jalland 1986, 140–141; Williams 2011, 72–73.

792 See for example Montgomery 1837, ix, 30; Harvey 1863, 14. See also Dodd, A. T., On the Signs of Pregnancy. The *PMSJ*, August 7, 1841, 365–368.

793 See for example Bull 1837, 29–40; Walker 1893, 8. See also for example Dodd, A. T., On the Signs of Pregnancy. The *PMSJ*, August 7, 1841, 365–368.

794 Ryan 1841, 152. See one descriptive example told in a popular manual, in Ryan 1836, 12–14. See also Tanner 1860, 26–30; Harvey 1863, 54–55. The most infamous case, "a painful affair", was Lady Flora Hastings (1806–1839), an unmarried lady-in-waiting to the Duchess of Kent, Queen Victoria's mother, who was rumoured to be pregnant by John Conroy, much-hated comptroller of the Duchess. Lady Flora was suffering from symptoms resembling pregnancy, but in reality, the symptoms were caused by a cancerous liver tumour. The Queen's doctor, Sir James Clark misdiagnosed Lady Flora's condition, believing her to be pregnant, causing a scandal in the court. The lady-in waiting died and the reputation of the Queen, who at first had believed the account of her doctor, suffered. See Sir James Clark. Obituary. The *BMJ*, July 9, 1870, 53–54. See also Gowing 2003, 147.

795 See for example Montgomery 1837, 29–38, 251–252; Tanner 1860, 126, 186–188, 202–206; Ryan 1836, 192–195, 201–203, 244, 274; Harvey 1863, 53–55; Mann 1893, 112, 168–177; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 179. See also for example G. O. Heming, On the Sings of Pregnancy: Practical Facts and Observations on Diseases of Women, and Some Subjects Connected with Midwifery. *The Lancet*, June 15, 1844, 408; The Premature Infant in His Legal Aspect. The *BMJ*, May 17, 1902, 1227. See also Gélis 1991, 63. On issues related to inheritance, see also Foscati 2019, 474–479.

missing in her body. In this sense, a female patient certainly was not a passive victim of the medical profession and the "medical gaze"; in fact, the woman's own observations and descriptions concerning her own body played an important role in confirming the state. There is evidence that women actually lied about the signs and symptoms, or concealed necessary information for motives of their own.[796] However, occasionally women and their circle clearly did not recognise or were not aware of the signs or symptoms of pregnancy, and on some occasions, also doctors and midwives, called for to assist with an obscure illness, failed to notice them. This was not a deliberately concealment of pregnancy or a secret birth but a *cryptic pregnancy*, complete unawareness of existing gestation.[797] Some physical signs could be disputable and be confused with other conditions and bodily symptoms; thus, the woman could go into labour and gave birth without knowing her actual state until the baby was born. For example, in 1885, a young married woman suffered from what her husband and friends believed to be "a bilious attack", but eventually the doctor noticed that actually it was commenced labour. The woman gave birth to a child, to the great surprise of the family and especially of the new mother herself.[798] In some cases, it was indeed very difficult to separate cryptic pregnancies from willful concealment of gestation and infanticide, a crime.[799] This proves, as Laura Gowing has noted, that women's bodies were "ultimately unreadable"; their mysteries "could mean sin, crime, disorder or murder".[800]

Generally, however, it was unmarried women who were believed to be at the greatest risk of hiding their state or deliberately misinterpreting the signs and symptoms taking place in their bodies. As Laura Gowing has pointed out, illegitimate pregnancy "brought danger and discredit"; it was a social stain and shame.[801] This was not a class-related question, because women in every social class conceived and gave birth out of wedlock, as Robert Gooch, one of the leading obstetricians of the time, mentioned in his obstetrical manual (1831): "[s]ingle women sometimes become pregnant in all ranks of life, not only among the low but among the high, and not only among these but in the middle".[802] For example,

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796 As one writer noted in 1896, "[S]ometimes the mistake arises from a too implicit trust in human nature". Robson, Mayo, An Address on Some of the Relations of Pregnancy to Surgery. The *BMJ*, April 11, 1896, 893. As Robert Bakewell wrote in the 1850s: "medical men so often hear the most solemn assurances, which the event proves absolutely untrue". Bakewell 1859, 32. See also Tanner 1860, 26. See also Priestley, William O., Two Lectures; Introductory to the Clinical Course on the Diseases of Women and Children. The *BMJ*, February 23, 1861, 190–192.

797 For example Michel Ryan argued that it was "now decided, that a woman may become pregnant, and be ignorant of it until the time of labour". Ryan 1836, 259. See also Tanner 1860, 27–30; Welch 1838, 10–11. See also Lewis, Thomas, Case in Which Pregnancy Was Unattended with the Usual Signs, and in Which Parturition Occurred without Labour-Pains. *The Lancet*, May 21, 1842, 284. On cryptic pregnancies in premodern Finland, see Rautelin 2015, 663–685.

798 Burges, R. E., Labour Mistaken for a "Bilious Attack". The *BMJ*, May 9, 1885, 940.

799 See for example Gowing 2003, 139–145, 151–154; Kilday 2013, 18. See also Williams 2011, 67–82.

800 Gowing 2003, 147. See also Kilday 2013, 16, 121, 137–150.

801 Gowing 2003, 138. See also Kilday 2013, 17, 35–36. See also a manual discussing the symptoms of pregnancy in a servant in Welch 1838, 9. See also Williams 2011, 67–82.

802 Gooch 1831, 209. See also Tanner 1860, 27–28.

in 1896, one doctor described his patient, "a spinster lady of position, aged 49, who has missed her periods, and who has developed an abdominal swelling", who was in fact pregnant, even if being "evidently deluded" that she was not.[803] Another leading medical author of the early decades of the Victorian era, William F. Montgomery, met an unmarried woman who insisted that she was not pregnant, even if she had gone into labour and the feet of the child were already "beyond the external parts".[804] Montgomery noticed that the attempts to conceal pregnancy and "the pertinacity and apparent innocence" with which pregnancy was denied were sometimes "quite incredible"; some women had stained their linen with blood in order to create an illusion of menstrual flow, and thus conceal the well-known sign of gestation.[805] On the other hand, women were clearly interpreting some of their bodily sensations as the signs of pregnancy, even when they were not in the family way. Many doctors reported on such cases.[806] For example, in 1843, one writer described how his "educated ear" and thirty years of practice disagreed with the story of a woman who herself was convinced that she was indeed pregnant and already in labour. The woman, a mother of two, "felt very indignant" when the doctor explained that her symptoms were in fact enteritis, and only simulating pregnancy.[807] It was well known that especially uterine tumours and dropsy acted similarly to pregnancy, causing similar kinds of sensations in the body.[808]

Usually the first distinct and tangible sign of pregnancy was the cessation of menstrual bleeding. Menstruation, a regular monthly flow, was an important indication of female health, fertility, and occasionally also disease; their periodicity, consistency, colour, and quantity were closely observed and discussed both by women themselves and by medical practitioners.[809] In the human body bleeding or haemorrhage is often a sign of disease or injury, but as the medical histo-

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803 Robson, Mayo, An Address on Some of the Relations of Pregnancy to Surgery. The *BMJ*, April 11, 1896, 893–894.

804 Montgomery 1837, 31: "[the woman in labour] persisted that she had never incurred the risk of impregnation, thought it was ascertained that she had lain in twice before".

805 Montgomery 1837, 31. See also for example Welch 1838, 9–10; G. O. Heming, On the Sings of Pregnancy: Practical Facts and Observations on Diseases of Women, and Some Subjects Connected with Midwifery. *The Lancet*, June 15, 1844, 408. Also tight-lacing could be used, in order to hide a changing figure. On the other hand, according to Michael Ryan, women could also feign pregnancy, using napkins and cushions, to increase their size. Ryan 1836, 245. See also Tanner 1860, 70–71. See also Williams 2011, 73–75.

806 See for example Tanner 1860, 30–32. See also Bakewell 1859, 47; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 163.

807 Barbieri, M., Case of Enteritis, Simulating Pregnancy, and Labor at the Full Period. Retrospect of the Medical Sciences. The *PMJRMS*, March 9, 1844, 459–460. According to her testament, the woman had also quickened.

808 See for example Kittoe 1845, 94–97; Harvey 1863, 14, 18; Bakewell 1859, 96.

809 Renne & de Walle 2001, xiv, xx–xxiii; Churchill 2012, 93–106, 151–158; Read 2013, 4, 15; Green 2005, 51. Compare to Strange 2006, 607–625. See also Levine-Clark 2002, 184. See also for example Walker 1893, 7–8.

rian Monica H. Green has indicated, menstruation was a symbol of female difference, "serving as a marker of both female fecundity and female physicality".[810] For women themselves, the suppression of menses, "ceasing to 'see anything'", was usually the first indication that they were in the family way, being "tolerably conclusive" but not depended upon.[811] All writers stressed that *ceasing to be unwell* or *the stoppage of the courses*, could be also caused by other reasons as well, for example by consumption, exposure to cold, vaginal or uterine obstructions, severe mental emotions and shocks, or with newly married women, "first sexual embraces, too often excessive and hurtful".[812] Corporeal ambiguousness of menstruation demonstrated how emotions could affect the body in very direct ways.[813] On the other hand, amenorrhea could also indicate incapacity to conceive, which was a medical problem requiring special intervention and treatments. Nevertheless, women were advised to pay close attention to the dates of the menses; calculating the potential due date was based on the last appearance of the monthly flow.[814]

Morning sickness was an established and well-known term used of sickness caused by gestation. For example, Henry Arthur Allbutt explained the origin of the designation in his manual: "[t]he vomiting, as a rule, comes on in the morning on rising from the bed, and is therefore called 'the morning sickness'."[815] Morning sickness was usually explained by nerve irritation, "the sympathetic nerve communicates to the stomach the sensitiveness of the womb".[816] Most writers agreed that morning sickness could occur soon after conception, but most frequently, it commenced after the second or third pregnancy week, continuing approximately three months until the time of quickening.[817] While nausea clearly was an unpleasant symptom, women were occasionally consoled that "a sick pregnancy" was "a safe pregnancy".[818] Not all, however, suffered from it; therefore, it was not usually considered a particularly reliable sign. Nor was it a disease-like state in its milder forms – however, occasionally women felt so nauseated that they were able to drink only iced water and were at risk of miscarrying,

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810 Green 2005, 52. See also Kittoe 1845, 30; Tilt 1851, 43–72; Weatherly 1882, 28; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 159–161. See also for example Montgomery 1837, 41–52. See also Gélis 1991, 46; Gowing 2003, 118–119. See also Delaney, Lupton & Toth 1988, 19.

811 Walker 1893, 8; Harvey 1863, 15. See also for example Welch 1838, 7; Tilt 1851, 75; Weatherly 1882, 32; Cullingworth 1884, 1–2; A London Physician [anonym.] 1891, 27–28, 188–189; Vincent 1902, 34–35. See also Gélis 1991, 46; Churchill 2012, 155–158.

812 Allbutt 1890, 6. See also Bull 1837, 38–40; Bull 1865, 47–57; Welch 1838, 8, 14; Kittoe 1845, 48; Harvey 1863, 15–17; Scott 1870 [?], 26; Black, 1888, 6; A London Physician [anonym.] 1891, 28–43; Walker 1893, 7–8; Stables 1894, 134–135. See also Tanner 1860, 50–55; Playfair 1893a, 155–156. See also Levine-Clark 2004, 109–116. See also Cody 2008, 32.

813 See especially Duden 1991, 142–147.

814 See for example Walker 1893, 7; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 183.

815 Allbutt 1890, 6. See also Conquest 1849, 26–27; Tanner 1860, 56; Chavasse 1866, 85–89; Weatherly 1882, 33.

816 Surgeon & Accoucheur [anonym.] 1900–1909 [?], 165. See also Bull 1837, 40–41; Welch 1838, 14; Chavasse 1866, 47. See also Walker 1893, 9; Stacpoole 1894, 31–33.

817 Bull, Thomas, 40–41; Walker 1893, 9. See also Playfair 1893a, 156–157.

818 See for example A London Physician [anonym.] 1891, 190; Chavasse 1866, 88; Stacpoole 1894, 32; Sperry 1900, 182.

but they were a small minority, found mainly in medical journals.[819] Milder forms of sickness were treated with magnesia, chamomile or clove tea, coffee, laxatives, lemon juice and lime water, or soda water, and champagne.[820]

The woman's body was at the centre of the pregnancy and thus, also many signs could be observed within the body. Visible changes and various bodily sensations were taking place in the body – the breasts were enlarging and often painful, excreting milk, the veins became blue, and the nipples and the areolas around them altered both in colour and structure, making them a very distinct bodily sign, noticed both by mothers themselves and by their medical attendants.[821] Moreover, the veins in the legs and the anal area become more apparent; varicose veins could be painful and many women suffered also from piles.[822] The skin cracked and was stamped with stretch marks. General physical appearance and the face underwent some changes as well: "the features acquire a peculiar sharpness", as was noticed by Gordon Stables in his manual in the 1890s.[823] The abdomen grew larger usually only after the fourth pregnancy month; thus, the state become more evident to the outside observer around halfway through gestation or afterward. However, even this was not a certain sign; some medical manuals noted that many married women had a "tendency" to "stoutness", easily associated with pregnancy and especially with a growing abdomen.[824] Usually, doctors pointed out that these bodily changes, alterations, and enlargements took place individually in every woman and they were not necessary confirmatory signs of pregnancy.

However, *quickening* – "the first sensation experienced by the mother of the *life* of the child within her womb" – was traditionally considered an important and reliable sign, usually looked forward to by the pregnant women themselves

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819 See for example Bull 1837, 56–65; Bull 1865, 70–78. See also Inman, Thomas, On Morning Sickness: Its Significance as a Symptom. The *BMJ*, March 24, 1860, 223–225. See on more serious case of sickness in pregnancy, Copeman, Edward, On the Treatment of Severe Vomiting Pregnancy. The *BMJ*, September 28, 1878, 460–461; Horrocks, P., Severe Vomiting in Pregnancy: Miscarriage: Death, with Remarks. The *BMJ*, July 4, 1885, 13–14.

820 See for example Bull 1838, 15–16, 58–65; Welch 1838, 15–17; Davies 1852, 5–6, 12; Philothalos 1860, 41–42; Weatherly 1882, 42–44; Stacpoole 1894, 33–39; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 166.

821 See for example Harvey 1863, 18–19; Conquest 1849, 22; Bull 1865, 58–62; Scott 1870 [?], 33; Chavasse 1866, 48–49, 75–81; Black 1888, 8–9; Allbutt 1890, 8; Walker 1893, 9–11; Stables 1894, 164–165; Stacpoole 1894, 4–5; Vincent 1902, 35–36; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 161–162; Tanner 1860, 57–60. See especially Montgomery 1837, xiii–xxi, 56–74; Playfair 1893a, 158–161. See a reference to Montgomery in A London Physician [anonym.] 1891, 193–194. Tanner also observed the long vertical line developed in the woman's abdomen; this mark was not usually mentioned in the popular health manuals. Tanner 1860, 68. On silver lines on the skin, see Black 1888, 10–11; Drew 1891, 22.

822 See for example Bull 1837, 42–47, 76–82; Bull 1865, 89–96; Conquest 1849, 32; Tanner 1860, 45, 406–410; Weatherly 1882, 49–51; A London Physician [anonym.] 1891, 226–227; Walker 1893, 52–56, 61–63; Stacpoole 1894, 47–49; Stables 1894, 198; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 172–176.

823 Kittoe 1845, 142. See also Stables 1894, 165–166. See also Gélis 1991, 47.

824 See for example Walker 1893, 11, 26.

"as the event which is to confirm their hopes".[825] Quickening was often described similarly to the way Thomas Bull did in his manual: the sensation felt was like "a bird fluttering within the woman".[826] According to the popular medical writers, this feeling was often so unexpected and sudden that the pregnant woman could faint, or fall "into a hysterical paroxysm".[827] In fact, John Harvey described the sign using the words "[the] sensation is one of fear or awe".[828] The traditional idea behind the term was that the foetus became alive, *quick*, when its movements were felt for the first time and confirmatory certainty of pregnancy was established by the future mother-to-be.[829] Historically, it was often seen as a line marking a stage when the foetus became a living thing, albeit practical understanding and various interpretations of quickening were often far from clear.[830] This traditional theory, however, was attacked by the nineteenth-century medical profession; doctors noted that the whole term quickening was erroneous because in their view, the foetus was alive from the moment of conception and was already distinctly a human being, as I illustrate also in Chapter 4.4 discussing abortion.[831]

Indeed, the independent role of medical observation was coming more and more significant during the nineteenth century, whereas quickening began to lose its meaning.[832] For example, the whole word *quickening* disappeared from juridical definitions in 1837, but it was not, however, totally eliminated from obstetrics. Especially in popular health manuals, quickening continued to play a significant role when women were advised to recognise the signs and symptoms of gestation in their own bodies. For example, Henry Arthur Allbutt thought it "a most valuable sign" still in 1890.[833] Rather – apart from the contradiction between the traditional etymology of the term and the idea of the foetus being alive from the moment of conception – the actual problem concerning quickening was

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825 Bull 1837, 50–51; Walker 1893, 11–13; Tanner 1860, 75. See also Conquest 1849, 19; Harvey 1863, 20–21; Weatherly 1882, 33–34; Black 1888, 9; Allbutt 1890, 8–9. See also Duden 1993, 58–59, 79–82; Mazzoni 2002, 60–62, 68; Gowing 2003, 121–122.

826 Bull 1837, 50, 90–91. See also Chavasse 1866, 50; Walker 1893, 12; Stacpoole 1894, 7.

827 Bull 1837, 50; Bull 1865, 65–66. See also for example Welch 1838, 35–36; Conquest 1849, 19; Davies 1852, 6–7; Black 1888, 9; Walker 1893, 12; Stables 1894, 163; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 164.

828 Harvey 1863, 20. See also Playfair 1893a, 162.

829 On the history of quickening, see for example Duden 1993, 78–82; Gowing 2003, 121–122; Gélis 1991, 48–49.

830 See for example Gélis 1991, 48–49; Gowing 2003, 121. See also for example Black 1888, 9; Stacpoole 1894, 7–8. See also Duden 1993, 59.

831 See for example Welch 1838, 36–37; Kittoe 1845, 145; Conquest 1849, 19; Davies 1852, 6–7; Harvey 1863, 21; Chavasse 1866, 50–51; Black 1888, 9; Allbutt 1890, 8; Stables 1894, 163; Stacpoole 1894, 7; A London Physician [anonym.] 1891, 196–197. Writers emphasised that the haptic feeling was in fact a mechanical sensation, caused by the growing foetus touching the parts "which before this period it could not do", as was explained by J. T. Conquest in his manual. Conquest 1849, 19. See also Montgomery 1837, 75–90; Tanner 1860, 71–73. See also Chapter 4.4.

832 See for example Tanner 1860, 76. Tanner also noted that some doctors used to dip their hands in very cold water, and then laid them upon the belly in order to "aggravate these movements"; Tanner, however, did not recommend the practice. See also Duden 1993, 94–98; Mazzoni 2002, 61–69; McLaren 1984, 139–143.

833 Allbutt 1890, 8. See also Kittoe 1845, 143; Stables 1894, 163–164. Compare to Welch 1838, 36–37; A London Physician [anonym.] 1891, 196–198. See also McLaren 1984, 139, 142.

that it was a curiously objective sign, and, occasionally, also a very unreliable sensation felt inside the secret parts of the female body.[834] It was a haptic sign recognised namely by the pregnant woman herself: it was not something a (male) doctor could have measured or diagnosed independently without cooperation with the pregnant patient herself. In fact, the doctor needed to rely on the woman's observations concerning her own body and what took place inside of it. Moreover, it was stressed that some women could not feel the movements at all, misread them, or embarrassingly confused the sign with flatulence or other bodily symptoms.[835]

In her study *The Woman beneath the Skin* (1991), discussing female patients, the body, and medicine in eighteenth-century Germany, Barbara Duden has argued that quickening, "an inner touch experienced only by women", has gone unobserved and unnoted in medical history.[836] However, in nineteenth-century medical sources, such as in patient reports, for example, it is relatively well documented, albeit not directly by pregnant women themselves. Moreover, many patient reports and doctors' letters show that in the nineteenth century, personal experience of pregnant woman was still often considered stronger evidence than "the medical gaze", here meaning clinical observation. For example, in 1843, this tension between personal female experience and medical observation was confirmed by one writer whose patient had been convinced that she was pregnant and had indeed quickened: "I listened to all she had to say, but gave no opinion, thinking that a woman who had had four children must know more about the sensation of quickening than I did."[837] However, it was eventually revealed the woman was not expecting: she was suffering from hydatid in her uterus, causing symptoms closely resembling pregnancy – sensations felt inside the body, weight gain, and an increased size of the abdomen. The woman had prepared baby's clothes, and – after what seemed a full term of pregnancy – she called the nurse and the neighbours to attend her delivery. But there was no baby.[838] As the reports published in medical periodicals demonstrated, this was not at all a unique

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834 Gowing 2003, 121. Compare to Duden 1993, 80, 83. Barbara Duden has expressed the view that the decreasing significance of quickening was simply a loss for all woman and a victory for (male) doctors, who "[--] wanted to challenge the court's reliance on women and jury matrons. They sought to promote themselves as medical experts". This argument waters down the fact that probably also many women sought after more reliable and quicker methods of confirming pregnancy than simply the bodily sensation they possibly experienced only after being in the family way for several months already. See also Mazzoni 2002, 61–62, 68.

835 See for example Scott 1870 [?], 25; Walker 1893, 13; Stables 1894, 163–164. See also Duden 1993, 94–95. One such woman was Queen Mary I of England who believed herself to be pregnant; in reality, she was suffering from a uterine or ovarian tumour of some kind. See for example Harvey 1863, 22; Montgomery 1837, 79–80; Tanner 1860, 77. See also Playfair 1893a, 162–163.

836 Duden 1993, 80–81.

837 King, George, Case of Hydatids in the Uterus. The *PMSJ*, July 1, 1843, 266. The patient had told the doctor: "I know now what is the matter with me; I am certainly in the family way, and I must be gone three or four months, for I quickened last night". See also Montgomery 1837, 80–82.

838 King, George, Case of Hydatids in the Uterus. The *PMSJ*, July 1, 1843, 266–267. The first vaginal examination was made after the woman had gone into labour, or how she believed herself to be. Eventually, the woman "passed a large piece of 'flesh' as

case, even if the causes of these presumed quickening cases varied from vivid imagination and harmless flatulence, or "wind", to more sinister causes, such as dropsy or gynaecological tumours, for example.[839]

Quickening was also a very useful mark when the potential due date was estimated. In first pregnancies, quickening took place around the third or at end of the fourth pregnancy month, but usually writers noted that it was felt differently by different women.[840] For example, Queen Victoria was very aware of the meaning of quickening and the method of calculation of the due date. She tried to time her granddaughter Victoria of Battenberg's (1863–1950) first pregnancy in 1884:

> I understand that the *last time* you were *unwell* [the menses] – ended on the 17th May? & that you felt sick already when you returned from Russia at the end of June. This led me to calculate that the event [childbirth] shld. take place between the 20th & 27th or so of Feb: & this was what Dr. Hoffmeister thought. Now Ludwig [the princess's husband] writes you only felt the 1st movement at the end of Oct: wh. you thought was at 4 months & ½. Now are you sure of that? It is often so slight at 1st that one hardly *rely on that* for time.[841]

The Queen was, in fact, very precise in her calculations: the baby was born on February 25, 1885 – exactly as her English great-grandmother had predicted.[842]

Indeed, as many writers noted, it was very important to time pregnancy and to reckon the due date correctly. There was always a risk that the woman would go into labour quite unexpectedly when she was away from home, and, moreover, it was necessary to arrange nurses and doctors in advance and to collect and prepare everything needed for the baby.[843] Usually doctors calculated normal pregnancy to last approximately 280 days, thirty-nine to forty weeks, or

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she called it". It was saved and later examined by the doctor, proved to be the hydatid mass, not a foetus. See also Tanner 1860, 31–32. See also Welch 1838, 10–11; A London Physician [anonym.] 1891, 199–200. See also a similar kind of case in Brown, Chas. R., An Obstetric Incident. The *BMJ*, February 15, 1879, 257.

839 See for example Tanner 1860, 77; Montgomery 1837, 91–98. See also Conquest 1849, 22–23; Black 1888, 10; Walker 1893, 13. See also Duden 1993, 94–95.

840 See examples of timing quickening in Bull 1837, 51–53; Walker 1893, 12. See also Gowing 2003, 121–122, on timing labour, see pp. 145–148.

841 Queen Victoria to her granddaughter Victoria of Battenberg, October 8, 1884. Hough 1975, 70. The Queen's granddaughter, Princess Victoria of Battenberg, née Princess Victoria of Hesse and by Rhine – married to the Prince Louis (Ludwig) of Battenberg, later Mountbatten – had been born in the presence of her English grandmother and was now preparing to give birth for the first time. See also Bull 1837, 51; A London Physician [anonym.] 1891, 197–198; Stables 1894, 173.

842 The child, Princess Alice (1885–1969) was born at Windsor Castle, at the presence of her maternal great-grandmother, Queen Victoria. In 1903, Princess Alice married Prince Andrew of Greece and Denmark; their youngest child was Prince Philip (b. 1921), the Duke of Edinburgh, and husband of Queen Elizabeth II.

843 See for example Stacpoole 1894, 12; Stables 1894, 173–174. See also Buckley, Thos. W., Novel Method of Delivery at Sea. The *BMJ*, August 22, 1885, 344; see the case in which the child was born in a pot in Brand, Alex. Theodore, Case of Triple Birth. The *BMJ*, October 27, 1888, 936. See also Stables 1894, 173–174. See also Lewis 1986, 165–167.

nine calendar months and one week, or ten lunar months.[844] The moment of conception was not, however, always clear and uncertainty left room for different calculations and estimations, as the letters sent to the *BMJ* showed; the exact commencement of pregnancy was often difficult to calculate precisely because the mechanisms of fertilisation and the female endocrine system were not known in the nineteenth century.[845] However, in order to help their readers to estimate the potential due date, medical authors often included specific timetables of the last menstruations and estimated dates of delivery when the commencement of parturition was expected to take place.[846] Estimating the time of delivery could be difficult, especially if there was some uncertainly about the last menstruation; therefore, it was always the *probable* rather than the *exact* date.

4.2 "Diet, Clothing, Rest, Fresh Air and Attention to the Bowels": The Tradition of Non-Naturals and Nineteenth-Century Antenatal Care

For every Victorian woman who found herself pregnant, there was a battery of advice and instructions to be followed – at least, if she was interested in the genre of popular health literature. This subchapter discusses more closely how medical manuals advised their readers to take care of their health during pregnancy months. As many medical writers noticed, pregnancy was always associated with hopes and fears – and many uncertainties.[847] The writers generally stressed that even if pregnancy was not an illness per se, it was a special and in many ways peculiar phase, "a temporary alteration in the condition of the animal economy", in a female life cycle.[848] In advice and hints concerning the critical period

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844 See for example Hills 1841, 5; Davies 1852, 7; Harvey 1863, 23–29; Bull 1865, 142–145; Chavasse 1866, 112–114; Walker 1893, 84–87; Stacpoole 1894, 3, 8–13; Stables 1894, 167–168. See also Ryan 1836, 259–264; Montgomery 1837, 251–283; Simpson 1871, 81–95; Mann 1893, 168–173; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 179–186; A London Physician [anonym.] 1891, 210–218. See also Ballard, Charles, Case of Prolonged Gestation. The *BMJ*, January 12, 1884, 56; Prolonged Pregnancy. The *BMJ*, November 9, 1901, 1427–1428. See also Tanner 1860, 185–189, 192–209; Playfair 1893a, 138–141, 178–184. See also Gélis 1991, 61–63.

845 See for example Barnes, Robert, Protracted Pregnancy. The *BMJ*, April 2, 1870, 350; G. P. [anonym.], Duration of Pregnancy. The *BMJ*, November 29, 1884, 1107; Ringrose Gelston, Robert, Duration of Pregnancy. The *BMJ*, December 13, 1884, 1219; Prolonged Gestation. The *BMJ*, March 16, 1889, 634. See also Duration of Pregnancy. The *BMJ*, February 22, 1890, 440; Prolonged Gestation (?). The *BMJ*, December 26, 1896, 1860; Prolonged Pregnancy. The *BMJ*, November 9, 1901, 1427–1428. See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 179.

846 See for example Harvey 1863, 29–46; Bull 1865, 146–157; Scott 1870 [?], 39; Stacpoole 1894, 9; Stables 1894, 168–172. See also Weatherly 1882, 35–37; Black 1888, 12–13; Cullingworth 1884, 3–5; A London Physician [anonym.] 1891, 214–218. See also Chavasse 1866, 112–115.

847 Conquest 1849, 1. See also Davies 1852, 1.

848 Davies 1852, 8. See also Conquest 1849, 25–26. See also for example Beatty, Thomas Edward, Address in Midwifery, Delivered at the Thirty-Seventh Annual Meeting of the British Medical Association. The *BMJ*, August 7, 1869, 137.

of gestation, there were a few characteristics: first, a deep mistrust of modernisation, urbanisation, and civilisation, and secondly, a deep trust in control and discipline over self and the idea of prevention. Much of the practical advice concerning pregnancy given to future mothers was based on the idea of prevention; the long tradition of "to preserve disease and to avoid disease", as John Tricker Conquest explained the principles of health in his guidebook in the 1840s.[849]

Medical writers stressed that the implied reader herself was ultimately responsible for her own health and that of her future child; the doctor should and could help, but ultimately the patient herself was obliged to follow the rules accordingly.[850] The price of neglecting these rules was seen in the child; as William Hamilton Kittoe's guidebook in 1845 noticed: "[t]here cannot be the least doubt, that the mode of life of the mother, the state of her mind, health, diet, and exercise, will indirectly affect the infant."[851] In addition, pregnant women were encouraged to follow the instructions in order to have a "much safer and better confinement" and a quick recovery. Medical manuals promised that the baby was healthier and the mother herself was more likely to keep her good health also in old age, after *the change of life*, a common term for menopause.[852] Few would disagree with such prospects.

During the Victorian era, people were constantly advised to live according to "Nature and her laws" and the preventive measures, "Dr Diet, Dr Quiet, and Dr Merryman".[853] The ideal of prevention had a long tradition in medicine; thus, it was not an invention of early feminist or nineteenth-century public reformers, as some historians have claimed.[854] Preventative ideals, or the six *non-naturals*, *res naturales*, "Natural Things", went back to Roman medicine and Galenic-Hippocratic means of hygiene. "Fresh air, abundant out-door exercise, good plain food, frequent bathing, warm and sufficient clothing, and freedom from any over-taxing of the brain and nervous system", had all together had an indispensable role in maintaining health and preventing diseases and complications.[855]

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849 Conquest 1849, 3. See also for example Allbutt 1890, 9. See also Smith 2007, 217; Duden 1991, 20–21; Cavallo 2017; Castiglioni 2017.

850 Stables 1894, 221. See also for example Walker 1893, 36; Stacpoole 1894, 14; [Anonym.] Surgeon & Accoucheur [anonym.] 1900–1909 [?], 176. See also Duden 1991, 15; Marland 2013, 59–65. See also Foucault 2000.

851 Kittoe 1845, 160. See also Scott 1870 [?], 35; Sperry 1900: "The real welfare of each human being is largely determined before it is born".

852 See for example Stacpoole 1894, 15–17; Stables 1894, 176.

853 Chavasse 1872, 43. See also Cavallo 2017, 1–4, 9–12; Porter & Porter 1988, 261: "Dr Merryman, Dr Diet and Dr Quiet". The origin of the couplet is in Salerno, see Chamberlain 2007, 14. See also Digby 1994, 201. See for example Conquest 1849, 3; Harvey 1863, 3–4. See also Bakewell 1857, 41. See also Gélis 1991, 76. See also Porter 2001, 154–155.

854 See for example Vertinsky 1990, 115–116. Patricia Vertinsky has claimed that feminist reformers believed that they could rescued women "from twin evils of physiological ignorance and heroic medicine" by arguing that women should take more responsibility of their own health, that is to say, of preventive hygiene, such as pure air, loose clothing, and exercise. Vertinsky did not notice that this practice had already a very long tradition in medicine. Compare to Marland 2013, 2–4.

855 Bakewell 1859, 17. See also for example *Doctor at Home* 1891, 401; Drew 1891, 31; Walker 1893, 5–6; Stables 1894, viii; Vincent 1902, 5–6; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 11, 176–177, 201–202. See also Smith 2007, 74–75, 120–121; Porter

Hence, misusing the non-naturals meant illnesses and bad health. For example, in early modern Europe, patients were both expected and encouraged to take responsibility for their own state of health and to resort to self-help, before consulting doctors.[856] As Barbara Duden has noted, since the eighteenth century, the non-naturals of the classical tradition were revived, but in the modern world where everything could be "scientifically measured, understood, and correspondingly manipulated", prevention "became an undertaking that was, in theory, feasible and planable".[857] Medication had of course its own indispensable role also in pregnancy; drugs were prescribed in certain cases and for certain symptoms, for example for nausea or prevention of miscarriage. Castor oil, rhubarb, magnesia, salts, and various other aperients, potions, and drugs were prescribed but doctors constantly warned against their excessive use.[858] In medical manuals, giving advice and prescribing drugs was finding a balance between correct treatment and potential misuse of dangerous substances.[859]

The family historian John R. Gillis has argued that historically pregnancy "went unmarked"; according to Gillis, there were no "changes in behavior or dress, no efforts to collect baby clothes or pick out the name".[860] Many nineteenth-century medical writers noted that especially younger women were reluctant to reveal their state, hiding all traces of gestation with clothes and lacing their waists with corsets. However, historians like Pat Jalland have pointed out that keeping pregnancy a secret for the first months was not a sign of particular "Victorian prudery". Most women feared that they had misdiagnosed themselves, and in addition, there was always the potential risk of miscarriage – making it harder to bear if a larger circle of people had known about gestation.[861] However, as the medical manuals analysed in this research show, guidebooks as collections of advice, did not support this idea of culturally silenced pregnancy. As I will discuss below, baby clothes made before the due date were, apart from being a practical necessity, socially an important visible sign of established pregnancy. Moreover, the advice concerning pregnancy was an important part of health campaigns, aimed especially at women; as Barbara Duden has noted, these hy-

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1996, 99; Porter & Porter 1988, 30–31, 261–265; Porter 1996, 95, 99; Risse 1996, 150–151; Emch-Dériaz 1992, 135–153; Wear 2000, 154–209; Smith 2002, 257–266; Cavallo 2017; Castiglioni 2017; Astbury 2017b, 80–81; Donato 2017; Storey 2020. See also Barnes, Robert, On the Causes, Internal and External, of Puerperal Fever. The *BMJ*, November 12, 1887, 1041. See also Haley 1978, 17; Digby 1994, 200–201. See also Thomas 1891, 605.

856 See for example Porter & Porter 1989, 33–53; Donato 2017; Storey 2020.

857 Duden 1991, 14, see also pp. 75–76. See also Jordanova 1989, 26; Haley 1978, 23–25; Harrison 2004, 58–61; Donato 2017, 175–176. See also Foucault 1988.

858 See for example Fox 1834, 24, 29, 68; Davies 1852, 14–15; Bakewell 1859, 105; Philothalos 1860, 45; Harvey 1863, 10, 62; Chavasse 1866, 68–73; Chavasse & An American Medical Writer 1871, 187; Weatherly 1882, 45; Black 1888, 24; Walker 1893, 49–51; Stables 1894, 195. See also Tanner 1871, 48.

859 On the pharmaceutical industry in the nineteenth century, see for example Lane 2001, 161–168.

860 Gillis 1996, 160. Compare to Gélis 1991, 45.

861 Jalland 1986, 142. See also Beier 2008, 221–226.

gienic rituals were "rituals of demarcation", which had both personal and political significance in controlling the ideal disciplined body, the integrity of the class, and the future of the whole society and nation.[862]

However, when John R. Gillis argued further that most women continued their normal routines until the delivery, health manuals indeed encouraged women to spend their pregnancy in as normal a way as possible, staying active and involved with their normal social engagements and household duties, or "active useful occupation", which Pye Henry Chavasse described as "the best composing medicine in the world".[863] Based on the popular health manuals, pregnancy certainly was no excuse for idleness or "the cult of female invalidism", stereotypically associated with Victorian middle- or upper-class femininity. For example, the feminist scholar Lorna Duffin claimed in the 1970s that "a [Victorian] pregnant woman was ill. The more time she spent in lying immobile and inactive in bed, the better".[864] Duffin also illustrated how this female invalidism was supported, or even encouraged, by the medical profession.[865] However, in their manuals, nineteenth-century doctors greatly disapproved of women who were liable to spend their time in indolence, using pregnancy as an excuse to recline on the "softly cushioned sofa", as for example Thomas Bull noted in his guidebook.[866] This kind of invalidism was a self-made state, close to idleness, self-indulgence, immorality, and hypochondria, the *malade imaginaire* – all to be strongly condemned.[867] In fact, idleness was considered the source of "misery, anguish, and suffering in train" affecting particularly pregnant women.[868] For example, Jane H. Walker stressed that a pregnant woman was not a "piece of egg-shelled china"; what she was, was "a normal muscular human being performing a normal healthy function".[869]

Hygiene was an indispensable part of the general management of successful pregnancy. Originally, hygiene was an art of health, coming from the Greek word "Hygeia" or health.[870] As the historian Virginia Smith has shown, the concept can be divided into three parts. First, there is "cleanliness", the very foundation of being "clean", representing the animal and human side of keeping the

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862 Duden 1991, 14–15. See also Foucault 1988; Foucault 2000.

863 Chavasse 1866, 21, 27: "Occupation improves the health, drives away *ennui*, cheers the heart and home". See also Lewis 1986, 124–127.

864 Duffin 1978, 32. See also Ehrenreich & English 1976, 19–27: "She was the social ornament that proved a man's success: her idleness, her delicacy, her childlike ignorance of 'reality' gave man the 'class' that money alone could not provide". See also Wertz 1996, 14; Digby 1994, 277. On gendered and class-based invalidism in the Victorian era, see Frawley 2004, 21–25, 42–51, 179–183. See also Nead 1988, 29–32. See also Branca 1975, 52–53.

865 Duffin 1978, 26. See also Branca 1975, 66, 70.

866 Bull 1837, 22. See also Montgomery 1837, 13–14; Conquest 1849, 6–8; Davies 1852, 10–11; Harvey 1863, 5; Chavasse 1866, 56; Chavasse & An American Medical Writer 1871, 91; Weatherly 1882, 40; Stables 1894, 83–85, 163. See also Warren 1865, 8–9. See also Jalland 1986, 136–137.

867 See for example Chavasse 1866, 33–34. On the discourses of hypochondria, see Frawley 2004, 69–74; Porter & Porter 1988, 203–210; Porter 2001, 158–161.

868 Chavasse & An American Medical Writer 1871, 175; Stables 1894, 27–28.

869 Walker 1893, 78.

870 Wear 2000, 155. See also Smith 2007, 74–75, 94–95.

external surface clean with washing, grooming, or bathing. "Purity", on the other hand, is a man-made cultural concept, connected to metaphysical, religious, or supernatural ideologies of divine perfection, pollution, and a dualistic order of hierarchical polarities, between "right"/"good" and "wrong"/"bad", for example. As Virginia Smith has noted, purity has had a huge impact in the history of personal hygiene and also medicine, determining what was clean or pure, and what, on the other hand, was not. Moral dirtiness and impurity were associated closely with filth, smell, disorder, disease and ill health; morality, in return, was represented in order, cleanliness, purity, chastity, skill, and health. For example, Gordon Stables discussed keeping the blood "pure" or "purifying" it, when he meant healthiness.[871] The last and third category of cleanliness, "hygiene", means wholesomeness and human healthiness, "the regimen of health" associated with vigour and strength, closely related to preserving health and preventing illnesses, and thus associated with medicine and healing.[872] Hygiene was understood as "the art of preserving the health", based on the tradition of non-naturals and the idea of total health or wholeness, especially "mens sana in corpore sano", a healthy mind in a healthy body.[873]

Doctors, working with health and illnesses, prevention and healing, operated with all three categories. Traditionally, physicians used the construct of non-naturals to inform their patients about benefits of a lifestyle they considered healthy, and this was the policy followed also by the Victorian medical profession. In popular health literature, patients were encouraged especially to avoid excess and pursue moderation and balance in their lives. Jane H. Walker, for example, discussed "sanity, purity, and self-control" in her manual, interweaving them into a general discourse of antenatal hygiene.[874] Thus, cleanliness was also responsibility and morality, making "minds more pure and holy", an abstract idea of purity, austerity, and goodness.[875] The famous and much-quoted nineteenth-century medical dictum "cleanliness is next to godliness", "luxury [--] free to all", combined these different aspects of cleanliness.[876] Soap could be seen to wash away both actual dirt and to restore moral balance and respectability in society.[877] Hence, medically good hygiene was both cleanliness of the body and the absence of dirt and contaminating matter, such as bacteria, but it was also a professional

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871 Stables 1894, 83. See also Bashford 2014, 74. See also Vicinus 1985, 77–78.

872 Smith 2007, 3, 17–44. On the complex relations of purity, cleanliness, sanitation, pollution and gender, see also Bashford 1998. See also Risse 1996, 151; Emch-Dériaz 1992, 138; Smith 2002, 270. See also Douglas 2003, 46–52, 78–92, 236–260. See also Lupton 2003, 39–45; Lupton 1996b, 32–36.

873 See for example Corfield, W. H., Introductory Lecture to the Course of Lectures on Hygiene and Public Health. The *BMJ*, June 18, 1870, 617–619. See also Haley 1978. See also Bashford 2014, 5.

874 Walker 1893, 22, 23, see also pp. 2–3: "we must be wise, pure, and clean ourselves if we would give noble sons and daughters to our country".

875 Chavasse 1866, 11–12: "A dirty man has generally a dirty mind!"

876 See for example Harvey 1863, 8; Stables 1894, 42. See also Obstetrical Aphorisms. The *BMJ*, November 26, 1881, 884. See also Briggs 1988, 10. See also Porter & Porter 1988, 35–36; Smith 2007, 3, 226; Bashford 2014, 5.

877 Skeggs 2004, 4.

capacity very clearly distinguishing it from quackery and non-professionals, who were associated with dirtiness, danger, disorder, and immorality.[878]

The nineteenth-century discourse of hygiene was particularly complex and contentious. It had mixed traditions of Galenic-Hippocratic medicine with a new understanding of microscopic science and medical inventions, and since the 1870s, growing understanding of bacteriology and antisepsis, combined with the contemporary discourse of sanitation and traditional holistic ideas of the mind and body.[879] However, as the medical historian Mark Harrison has pointed out, the word "sanitation" had no fixed meaning in the nineteenth century; sometimes it could mean the improving sewage systems and water-supplies, sometimes it was used loosely to mean "anything pertaining to health".[880] The traditional system of hygiene had been based on the idea of the balance/imbalance of bodily fluids – usually meaning blood, phlegm, yellow and black bile – and restoring the balance by the removing of bad humours using venesection, purgatives, enemas, and emetics, for example.[881] Illness was understood as depletion and corruption, health was associated with preservation, conservation, and restoration – a free flow of the fluids through the body, or "generous input and easy outflow", as Roy and Dorothy Porter have put it.[882] In this system, each body was its own individual entity, easily unbalanced and corrupted; thus, sickness was something very personal and internal, expressed and described specifically by the patient.[883] This long tradition was still very visible in nineteenth-century popular medical manuals and medical journals, combining new ideas and older traditional visions of constitutional and environmental (im)balance and the body, as it is discussed in this chapter. For example, in 1839, doctors could still note that "[t]he practice of rational medicine is impossible without the attention to the humours".[884]

On the other hand, medical texts also demonstrated that these cultural ideals of cleanliness, purity and hygiene were also deeply gendered. In many cultures, women have been the main polluters with their reproductive bodies. For example, Alison Bashford has argued that women "embodied the power of contamination".[885] The female body was affected, not only by the monthly menstrual cycle, often called "the cleansings", but also by *the whites*, meaning a vaginal discharge, breastmilk, and *lochia*, a postnatal vaginal discharge, containing blood,

878 See for example Jones 2011, 205; Marland 2001b, 159; Hall 2000a, 32; Cavallo 2017. See also Douglas 2003, 125–126.

879 See for example Haley 1978; Bashford 1998; Worboys 2000; Alberti 2014, 18–21, 114, 118–119. See also Douglas 2003, 85–87.

880 Harrison 2004, 110.

881 Smith 2007, 93–98. See also King 2013, 25–47; Emch-Dériaz 1992, 134–153; Wear 2000, 37–40; Lane 2001, 1–2; Gowing 2003, 2; Harrison 2004, 18–19; Boddice 2019, 55–57. On cleansing the system, see Porter & Porter 1988, 50–52. On the use of venesection in pregnancy, see for example Welch 1838, 41–42. See also Alberti 2014, 166–168.

882 Porter & Porter 1988, 51; Harley 1999, 416. See also Levine-Clark 2004, 88.

883 Porter 1996, 95; Emch-Dériaz 1992, 136; Bashford 1998, 132–134. See also Read 2013, 15; Levine-Clark 2004, 88; Newton 2017, 109–110; Alberti 2006b, 2–3.

884 Ancell, Henry, Course of Lectures on the Physiology and Pathology of the Blood, and Other Animal Fluids. *The Lancet*, October 5, 1839, 50.

885 Bashford 1998, 38.

tissue, and mucus.[886] Barbara Duden has pointed out that it was the monthly rhythm of menstrual discharge that constituted womanhood, not the blood itself; women's leaking bodies were wetter and colder than male bodies, and they were considered also softer and weaker.[887] Childbirth was, of course, one of the major transitional states in human life, with its ritualistic rules of purity and practices of cleanliness. New discoveries in microscopic science, understanding of bacteria, and antiseptic policy changed the ideas of "clean" and hygiene, but, on the other hand, these old and gendered traditions and perceptions were still very persistent. Especially the act of touching with its moral connotations, was at the centre of this question of cleanliness, purity, and hygiene, especially when a closer physical contact between the male doctor and the female patient became more routine during the nineteenth century, as I have discussed in Chapter 3.2.[888]

The ideals of the pregnant body and the discourse of hygiene were closely associated also with clothing and covering the human body. Dress played an essential role in the performance and representation of nineteenth-century femininity, protecting, reflecting, and embellishing the body and identity, but what was more important in the medical discourse was that the right kind of clothing maintained health and prevented illnesses – based on the idea of the non-naturals. The medical discourse emphasised that the wrong kind of dress endangered the natural balance and the functions of the body, that is to say, respiration, digestion, circulation, and locomotion, making the wearer ill and possibly even killing them.[889] Nineteenth-century doctors were alarmed especially by the news of arsenic dresses and other poisonous substances found in clothing: doctors were involved with reformistic dress movements around the second half of the nineteenth century, discussing many dangers of fashion.[890] Constantly changing fashion was often referred to as "monstrous" or unnatural; fashion was Vanity Fair, frivolous, tyrannical, and dangerous.[891] Thus, choosing the right garments was

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886 Smith 2007, 34, 190–191; Duden 1991, 108–119; Wear 2000, 141–142; Bashford 1998, xi–xvii, 34–39; Gowing 2003, 2, 22–26; Stolberg 2020, 210–211. In early modern childbirth, a parturient woman was given hot drinks and the birthing room was heated, based on the Galenic traditions. On whites, see for example Welch 1838, 47–54; Tanner 1860, 439–441; Bull 1865, 112–115; Chavasse 1866, 96–100; Scott 1870 [?], 23–24; Weatherly 1882, 47–48; Black 1888, 33–34; Drew 1891, 17–18, 26; Walker 1893, 56–58; Stacpoole 1894, 55–56; A London Physician [anonym.] 1891, 128–141; Stables 1894, 140–149. See also Douglas 2003, 84, 157–159, 218–220.

887 Duden 1991, 113. See also Read 2013, 2, 16–21; Green 2005, 53–57; King 2013, 38–40; Alberti 2006b, 3–4; Alberti 2014, 19–20, 33, 36; Handley 2016, 20–22. See also Levine-Clark 2002, 184–185; Moscucci 1990, 19–20. See also Storey 2020, 297–299.

888 See for example Porter 2004, 179–197. See also Lupton 2003, 140–141.

889 See for example Walker 1893, 23–24. On dress and femininity, see Nead 2013, 489–507. On the dressed body, see Entwistle 2001, 33–55.

890 On arsenic scandal and the dangers of clothing, see Matthews David 2015. See also for example Cheyne, R. R., Arsenical Poisoning by Articles of Dress. The *BMJ*, November 21, 1874, 643–644; Arsenic in Ladies' Dresses. The *BMJ*, November 20, 1875, 648. On nineteenth-century reformistic dress movements, health, and the medical profession, see Cunningham 2003.

891 See for example Scott 1870 [?], 16–17. Women interested in their appearance were often labelled as the "slaves of fashion" or "martyrs of fashion". See for example Weatherly 1882, 14; Scott 1870 [?], 16–17. On vanity and criticism of women's fashion, see Nead 2013, 490–499. On the other hand, also some men wore corsets, some for

not about style, trends, or elegance; to the medical profession, above all, it was a matter of health and hygiene – both of the mother and the unborn baby.[892]

Clothing was often discussed in nineteenth-century popular health manuals, and doctors clearly wanted to present themselves as the authorities on choosing the right and healthy garments to wear. Hence, medical writers were eager to give their advice on dressing the maternal body, even if in reality they were "seldom listened" to, as Jacques Gélis has put it.[893] More generally, writers noted that the very natural function of clothing was to protect the wearer from the weather and to cover the body according to the cultural rules of nakedness and decorum. However, the potentially esthetic values or social messages of clothes did not generally interest medical writers, most of whom were men writing about women's fashion. Not particularly surprisingly, male doctors were often criticised for their obvious lack of practical experiences of women's clothing.[894] Indeed, nineteenth-century doctors usually failed to give concrete practical hints on dress, mainly discussing general ideals of health and hygiene in their manuals.

On the other hand, it is necessary to remember that in the nineteenth century, unlike in the following century, mass-produced maternity clothing was not available. Thus, when women sewed their own dresses, they often left extra fabric in the seams to be let out if the wearer later found herself in the family way. Generally, doctors noted somewhat unhappily that beyond "letting out" their clothes and making "alterations in the girth of waistbands", pregnant women made very little changes in their clothing.[895] Nineteenth-century fashion was particularly demanding for the body because of tight-fitting dresses, emphasising both the small waist and smooth silhouette, especially after the *princess dress* became fashionable around the 1870s and onwards. For example, the eighteenth-century clothing style, with convertible stomachers, aprons, loose waistcoats and bedgowns, had been adapted relatively easily to the needs of a constantly changing maternal body.[896] The medical ideals of nineteenth-century pregnancy clothing were mainly borrowed from Antiquity; many writers referred to Ancient Rome and the custom of loosening the waist, tracking the origin of the popular French euphemism *enceinte* ('pregnant') to the Latin word *incinta* ('unbound').[897]

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health reasons, others for appearance. Steele 2011, 36, 38–39. See also Cunningham 2003.

892 On choosing the right kind of shoes, stockings, and garters, see Walker 1893, 24–25; Bull 1865, 27; Vincent 1902, 25; Welch 1838, 12; Davies 1852, 9–10.

893 Gélis 1991, 80. See also Jalland 1986, 142–143. For an example of a medical manual concentrated entirely on healthy clothing, see Stacpoole 1891.

894 See for example Caplin 1864, viii–xi.

895 Vincent 1902, 25. On dress collections and preserved nineteenth-century maternity clothes, see Fisk 2019.

896 On maternity dress in the eighteenth century, see Waterhouse 2007, 53–64; O'Toole 2016, 26–32. On eighteenth-century stays, see also Sorge-English 2011, especially pp. 100–111. The word "waistcoat" could often used for the "jumps", meaning a loose garment related to stays to support the torso.

897 See for example Scott 1870 [?], 18; Chavasse 1866, 45, 53; Stables 1894, 176–177, 179. See also Black 1888, 15; *Doctor at Home* 1891, 168; Kittoe 1845, 17; Bull 1865, 26. Compare to Gélis 1991, 67. See also Sanitary Reform in Dress. The *BMJ*, September 17, 1887, 634–635.

Medically ideal pregnancy clothing was summed up by Robert Hills in his 1841 manual: "[t]he dress should be light, loose, easy, and warm".[898] Especially the looseness and lightness of the dress was constantly discussed and debated; heavy skirts and too warm fabrics were considered dangerous and the extra weight on the waist allegedly corrupted normal bodily functions.[899] The main medical attention was, however, clearly focused on the use of the corset or *stays*, a special undergarment worn to shape and support the torso.[900] The dress historian Leigh Summers has called the corset "the most illuminating icon of the Victorian era, heavily pregnant with feminine metaphors and associations".[901] Indeed, the styles and details of the sleeves, necklines, and hemlines changed but the corset remained an indispensable garment in nineteenth-century Britain. However, it was not just a piece of underwear as it was closely associated with the social class and morality of the wearer and a barometer of general respectability; women who did not use stays were considered "loose", meaning morally questionable, careless, or even potentially promiscuous.[902] Even the most disadvantaged working-class woman could buy her garments second-hand or make her own stays.[903]

Indeed, it was the Victorian women themselves who chose to wear corsets; in nineteenth-century Britain, stays were an indispensable sign of respectability, self-discipline, and beauty, not an instrument of male subordination, female oppression and passivity, or an expression of submissive-masochistic femininity, as it has sometimes been suggested.[904] For example, Leigh Summer has argued that the so-called "Victorian" attitudes toward sexuality, reproduction, and the pregnant body prohibited doctors from advising their readers on corsetry:

> So intense were the taboos surrounding the nineteenth-century gravid uterus that they almost silenced the usually vocal medical profession [--] Physicians who ordinarily railed against corsetry in the nullipara [woman who has never given birth] female remained obdurately mute about the use of corsetry during pregnancy.[905]

This, however, is not exactly the case. Popular guidebook literature *did* contain advice on the dress of pregnant woman and the garment mostly discussed in

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898 Hills 1841, 7. See also for example Davies 1852, 9; Bakewell 1859, 14; Philothalos 1860, 48; Tanner 1871, 48; Black 1888, 15; Walker 1893, 23–25; *Doctor at Home* 1891, 163; Stacpoole 1891, 56–58; Stables 1894, 176–179; Vincent 1902, 24. See also Mitchinson 1991, 66–69. See also Castiglione 2017, 63–64.

899 On varicose veins and swelling of the feet were treated by elastic stockings, see for example Kittoe 1845, 150; Walker 1893, 62; Stables 1894, 198; Conquest 1849, 34. See also Allbutt 1890, 11–12.

900 On skirts and heavy layers of fabric, see for example Stacpoole 1894, 23–24. See also Nead 2013, 494.

901 Summers 2003, 2. According to Leigh Summers, many women wore their corsets throughout their lives from early childhood into old age and death. Summers 2003, 5. Compare to Shorter 1983, 28.

902 Summers 2003, 2, 5, 19–21, 24, 40–41; Steele 2011, 18–27, 49. See also Cunningham 2003, 22; Entwistle 2001, 41. See also Sorge-English 2011, 193–195.

903 Summers 2003, 10–14, 24; Waugh 2000, 79; Steele 2011, 39–40, 47–48. See also Sorge-English 2011, 165–166.

904 See especially Roberts 1977. See also Steele 2011, 1–2, 35, 60–61. See also Nead 2013, 501–502. See also Caplin 1864, xii.

905 Summers 2003, 38.

them was indeed the corset. In nineteenth-century medical discourse, the corset was closely associated with miscarriages, declining birth rates, and a wide range of female maladies. Many authors, however, noted that while women were accustomed to wearing corsets and did not "throw them aside" when pregnant, the practice of *tightlacing*, wearing tightly laced stays in order to decrease the waist size, was unanimously condemned.[906] Thus, corsets as supportive undergarments were accepted whereas the practice of tightlacing clearly was not.

As John Tricker Conquest described in his manual (1849), tightlacing, which was to "modify, alter, and distort the frame", was "a gross violation of Nature's laws".[907] It was Nature that was demanding "more and more room for the gradual development of the child"; if this was not the case, the foetus became badly nourished, and was "frequently born delicate, emaciated, feeble, and stunted", likely to suffer and die young.[908] Any kind of unnatural restriction and pressure – whether it was upon the expanding waistline or the breasts, subsequently needed in the vital action of breastfeeding – was considered injurious, or, in fact "sheer madness".[909] The list of these potential derangements of the female system was long and somewhat gloomy: "frightful deformities of the bony structure", indigestion, constipation, hysteria, spinal diseases, pains, swellings, varicose veins, headache, nausea, "tendency of diseased lungs" and consumption, faintness, heart disease, and "displacements of the womb".[910] In addition, tightlacing was associated with miscarriages, intentional abortions, and complicated deliveries – "horrible confinements which frequently result in the death of both mother and child" – as Henry Thomas Scott warned about the fatal results of tightlacing.[911] For doctors, unnatural use of the corset provided a convenient explanation for certain medical conditions and complications, for example miscarriages, otherwise left lacking any logical cause.

Why, then, did women continue to lace their waists even if they were pregnant and doctors spoke out loudly against the use of a tight-laced corset? This custom suggests that the medical discourse was considerably weaker than social pressure, cultural conventions concerning socially acceptable appearance, and women's own agency concerning their clothing. Medical writers themselves often argued that "mistaken feelings of delicacy" persuaded women to try to con-

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906 Bull 1865, 24–26. See also Kittoe 1845, 18–19; Weatherly 1882, 39–40; A London Physician [anonym.] 1891, 251–252; Walker 1893, 26; Stables 1894, 176–177: "Wearing very tight stays at any time, I look upon as incipient suicide; but it is murder and suicide both to wear such a garment when *enceinte*." See also Playfair 1893a, 346.

907 Conquest 1849, 8. See also Weatherly 1882, 14–15; *Doctor at Home* 1891, 807–809; Stacpoole 1894, 22–23; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 218–219.

908 Bull 1865, 24–25; Conquest 1849, 9. See also Stables 1894, 177–178.

909 Walker 1893, 26. See also for example Bull 1865, 25; Chavasse 1866, 53–54; Tanner 1871, 48; Black 1888, 16; Stables 1894, 178; Stacpoole 1894, 23.

910 See for example Scott 1870 [?], 17–18; Conquest 1849, 8–9; Chavasse 1866, 53–54; Weatherly 1882, 13–15; Stacpoole 1894, 23.

911 Scott 1870 [?], 17. See also Bull 1865, 25; Walker 1893, 27; Stables 1894, 177–178; Stacpoole 1894, 23.

ceal their state with the help of clothes; especially women in their first pregnancies were inclined to make "great errors in dress".[912] Some writers acknowledged that the dress and drapery could be arranged to "hide the alteration in the figure" thus creating "general thickness", but this was a question of the individual wearer's taste rather than a generally accepted custom.[913] This was not, however, to be confused with "Victorian" prudery; as Judith Schneid Lewis has pointed out, for example, many aristocratic women continued to attend social engagements even when heavily pregnant, wearing brightly coloured and tight dresses.[914]

Moreover, women were afraid that gestation changed their bodies permanently; thus, it is very likely that future mothers wished to preserve their figures with the help of the stays.[915] For example, Florence Stacpoole understood this need, but reminded her readers that "*good binding after confinement*" was the correct method of preserving the pretty figure, not tightlacing before it.[916] Clearly acknowledging that women did not easily give up their corsets – especially those who were inclined to stoutness – medical writers recommended elastic belts and bandages to give much needed support during the time when the abdomen was growing monthly and also the breasts needed extra support.[917] For example, Jane H. Walker discussed the special hygienic corset, with shoulder-straps and no bones or a steel busk. Another suitable garment was "a well-fitting" belt, abdominal bandage, or a special knitted corset.[918] Moreover, the right kind of corset was elastic and flexible, having two lacings on each side of the torso, to lessen the potentially dangerous pressure caused by the lacing.[919] The most important thing was, as Ralph Vincent reminded his readers, "[n]o women can expect to be or look slim in the later months of pregnancy".[920]

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912 Bull 1865, 24; Black 1888, 16; Stables 1894, 177. See one fatal example in the *BMJ,* Worley, W. C., Case of Sudden Death Ten Days after Labour. Obstetric Memoranda. The *BMJ*, May 7, 1870, 459. In this case, the married woman had concealed her state lacing her waist for an unknown reason; she died of embolism ten days after confinement. See also Playfair 1893a, 346.

913 Walker 1893, 25.

914 Lewis 1986, 124–128. See also Jalland 1986, 142.

915 For example, Jane H. Walker noted that married women were inclined to stoutness, and moreover, the breasts needed extra support: "[--] there is nothing more ugly or ungraceful than the appearance of general untidiness, bulkiness, and shapelessness which is presented by a stout matron who wears no stays". Walker 1893, 26.

916 Stacpoole 1894, 23. See also A London Physician [anonym.] 1891, 252. As Ralph Vincent noted, this was not a question of vanity but of health and strength, see Vincent 1902, 28.

917 See for example Bull 1837, 93–94; Conquest 1849, 35; Bull 1865, 24–27; Chavasse 1866, 82; Walker 1893, 26. See also New Abdominal Belt. The *BMJ*, August 19, 1882, 316. See also Gélis 1991, 79–80.

918 Walker 1893, 28, 70–71. See also for example Black 1888, 15; Allbutt 1890, 11–12; Vincent 1902, 26. See also Bull 1865, 26; Conquest 1849, 10. See also New Abdominal Belt. The *BMJ*, August 19, 1882, 316; [Ab]domen Belt Corset. The *BMJ*, November 25, 1893, 1158.

919 Bull 1865, 25–26; Vincent 1902, 25–28, 32; Davies 1852, 9–10; Stables 1894, 179. Henry Arthur Allbutt recommended special knitted corsets and the use of an abdominal bandage, see Allbutt 1890, 11–12.

920 Vincent 1902, 25.

In the British Isles, "in this constantly changing climate of ours", as Dr Lionel Weatherly pointed out, clothing was also a matter of great practical importance.[921] The body's temperature – and changes of climate and of temperature more generally – were directly connected to the general health and mental well-being of the expectant mother. Healthy recommendable materials were especially wool and flannel, both breathable and warm; cotton and linen were considered too cold and damp, especially in underclothing.[922] The active life style suggested for all pregnant women, including daily outdoor exercise, demanded practical, healthy, and warm clothing.[923] Exercise was warmly recommended for all women; it was natural and indispensable in every way, as was pointed out also by Pye Henry Chavasse: "[t]here is nothing standing still in Nature. If it were, – the creation would languish and die!"[924] In popular health literature, regular exercise was the cure for everything – if the woman wanted to be physically healthy in every respect, "retain her bloom and her youthful appearance", to look "charming in the eyes of her husband", and keep her mind free from worries and lowness, she needed to take her daily exercise.[925] As Pye Henry Chavasse pointed out in the 1870s – rather cheerfully – walking exhilarated the mind "like a glass of champagne, but, unlike champagne, it never leaves a headache behind".[926]

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921 Weatherly 1882, 13. See also Kittoe 1845, 21.

922 See for example Walker 1893, 24–25; Allbutt 1890, 11–12; Stables 1894, 176; Weatherly 1882, 15, 17; Black 1888, 15; *Doctor at Home* 1891, 342; Stacpoole 1891, 33–34, 37; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 54–56. The only one to criticise the use of wool was Ralph Vincent who recommended more luxurious materials like merino wool and silk. Vincent 1902, 24. See also The Choice of Clothes. The *BMJ*, April 28, 1883, 830; Woollen Winter Underclothing. The *MBJ*, November 5, 1887, 1006–1007; Pure Wool Clothing. The *BMJ*, April 14, 1888, 831; All-Wool Underwear. The *BMJ*, December 15, 1888, 1343–1344; Dress in Hot Weather. The *BMJ*, August 20, 1898, 493–494.

923 See for example Allbutt 1890, 12. Clothing was closely linked to weather conditions as Pye Henry reminded his readers: daily exercise, mainly walking, was indispensable for the health of the woman – no matter what the weather was like: "If the day be cold, and the roads be dirty [- -] I should advise my reader to put on thick boots and a warm shawl, and to brave the weather." Chavasse 1866, 3. See also Weatherly 1882, 16. See also Vertinsky 1990, 71–73, 75

924 Chavasse 1866, 4–5. See also Chavasse & An American Medical Writer 1871, 94–95, 174–175. See also Bakewell 1859, 11–13, 19–20; Black 1888, 16–17; Stables 1894, 66, 74, 84–86, 181–182; Stacpoole 1894, 24–27; Vincent 1902, 21. On exercise in English/British culture since the Renaissance, see Smith 2007, 201–204, 217–218, 236–238, 277. See also Marland 2013, 2–3; Hassan 2003, 90–95; Smith 2002, 259, 265. Compare to Macrae 2015, 739–742: "the nineteenth century can be identified as an anomaly in the otherwise supportive view of exercise during pregnancy which existed between the fifteenth and eighteenth centuries". See also Levine-Clark 2004, 22–23. On exercise and sports in Victorian culture, see also Haley 1978, 123–140.

925 Chavasse 1866, 4. See also Weatherly 1882, 17–18; *Doctor at Home* 1891, 864–867; Stacpoole 1891, 25–26; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 12–13. See also Porter & Porter 1988, 263–265; Smith 2007, 201; Gilbert 2014, 140–148.

926 Chavasse & An American Medical Writer 1871, 90.

Firstly, exercise was a perfect way to enjoy fresh cool air. A pregnant woman was in fact breathing "for two", as Jane W. Walker stressed in her manual.[927] Air was connected to the traditional theories about miasma, with contaminated bad air causing diseases and fresh air preventing them.[928] In nineteenth-century medicine, oxygen equalled health and purity, Carbon dioxide, on the other hand, was dangerous: bad, contaminating air was to be found in crowded, badly ventilated rooms, especially in ballrooms and other social gatherings of high society.[929] Secondly, apart from breathing healthy fresh air, outdoor exercise provided sunlight, which was both a disinfectant and an indispensable element "to all animal and vegetable life".[930] Thirdly, exercise in fresh air was directly associated with easy deliveries; exercise improved the muscular system and breathing, it strengthened the blood and the whole body.[931] This idea was also shared by Queen Victoria who compared the confinements of her youngest daughter Beatrice and her granddaughter Victoria of Battenberg, who gave birth to their firstborns in 1886 and 1885 respectively: "[Beatrice is] so wonderfully well. She was very active and took good walks daily [--] She had only 9 hours to suffer & you [Victoria of Battenberg] – 20! It is inconceivable the difference, but I think she walked much more than you did."[932] Also the *BMJ* noted in 1895 that in the prevention of maternal rickets, exercise and fresh air were indispensable, alongside a sufficient diet.[933]

Hence, despite the persistent cultural stereotypes associated with the Victorian middle-class woman, nineteenth-century doctors did not encourage women to "female invalidism". Quite the contrary, doctors complained that pregnancy was constantly used as a convenient excuse for "habits of laziness and torpidity".[934] Exercise, when not too excessive or intensive, was beneficial in many ways; the ordinary recommendation was usually an hour's walk in the fresh air every day, avoiding too long and fatiguing journeys.[935] Household duties, as important as they were, were not sufficient for maintaining muscular fitness and a

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927 Walker 1893, 33.

928 See for example Davies 1852, 10. See also Bad Air and Bad Health. The *BMJ*, October 17, 1891, 862. See also Bashford 1998, 5, 17; Porter 1998, 406–409; Smith 2007, 98, 216–219; Gélis 1991, 76–77; Worboys 2014, 75.

929 See for example Stacpoole 1894, 17–19; Stables 1894, 181–182.

930 Stables 1894, 70–74. See also Barnes, Robert, Discussion on Puerperal Septicaemia. The *BMJ*, September 16, 1893, 626. See also Kittoe 1845, 3–4.

931 See for example Stacpoole 1894, 24–27; Bull 1837, 21–23; Stables 1894, 181. Interestingly, singing was also one way to improve breathing, see Stacpoole 1894, 27.

932 Queen Victoria to her granddaughter Victoria of Battenberg, November 23, 1886. Hough 1975, 84. See also Queen Victoria to her granddaughter Victoria of Battenberg, October 26, 1886. Hough 1975, 83. See also Jalland 1986, 138. See also Chavasse 1866, 57. See also Castiglioni 2017, 64.

933 Garrod, Archibald E., & Morley Fletcher, H., The Maternal Factors in the Causation of Rickets. The *BMJ*, September 21, 1895, 707–711. On maternal rickets, see for example Loudon 1992, 130–143.

934 Harvey 1863, 5.

935 See for example Bull 1865, 19–24. See also Gélis 1991, 77–78; Vertinsky 1990, 70–73; Jalland 1986, 138–139; Porter & Porter 1988, 34–35; Marland 2013, 89–103; Wear 2000, 160–161. See especially a story told by Jane Walker about a woman undertaking her husband's work in Walker 1893, 77.

good physical condition.[936] Likewise, driving in a carriage in the park provided fresh air but not much needed muscular exercise. Horse riding was a better choice, even if not all agreed that riding was safe for a pregnant woman.[937] On the other hand, bicycle riding become popular at the end of the nineteenth century, causing some medical debate on whether this new form of exercise was advisable if the cyclist herself was with child.[938]

Personal cleanliness and hygiene were also an indispensable part of healthcare during pregnancy. Doctors remarked that while bathing was in fact necessary to everyone, "for the sake of cleanliness, comfort, and health", it was even more so for the pregnant woman.[939] Doctors promised a less troubled pregnancy and easy confinement if the woman took care of her personal hygiene. "It makes one feel clean and sweet and wholesome [--] that it not only improves our physical constitution, but likewise our moral character, and makes our minds more pure and holy", Pye Henry Chavasse also promised.[940] Especially the state of the bowels was an indispensable part of hygiene and of the wholesome balance and well-being of the body and mind. As Virginia Smith has noted, in Greek humoral theory, good bowel movements were "a sign of a healthy body getting rid of its dangerous wastes", keeping the body "open".[941] Constipation was particularly dangerous especially in the case of pregnant women; loaded bowels meant long and painful labours. Hence, purgatives, enemas, syringes, and emetics constituted an important part of antenatal medical care and self-treatment.[942] Popular health manuals contained many recipes for their lay readers; women were advised to prepare enemas and emetic drinks, take drugs, and baths, often consisting of Epsom salts or Seidlitz powder, or poppy heads and laudanum.[943]

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936 On women and active social life, see Jalland 1986, 138–139.

937 Bull 1837, 117; Chavasse 1866, 6; Chavasse & An American Medical Writer 1871, 98. See also Harvey 1863, 5–6; Davies 1852, 10; Stacpoole 1894, 26–27; Vincent 1902, 21.

938 See for example Allbutt 1890, 41. Allbutt did not discuss cycling during pregnancy but, nevertheless, he considered it a very suitable form of exercise for all women, at least "for all those who can afford the luxury". See also Vincent 1902, 21. See also Bicycle or Horse Exercise for Women. The *BMJ*, March 30, 1895, 720; Cycling for Women. The *BMJ*, October 26, 1895, 1079; Cycling for Women. The *BMJ*, December 21, 1895, 1582–1583; Turner, E. B., A Report on Cycling in Health and Disease; Cycling for Women. The *BMJ*, June 6, 1896, 1399; Bicycling and Pregnancy. The *BMJ*, March 19, 1898, 802; the *BMJ*, March 26, 1898, 867. See cycling used as a method in abortion, Ransom, W. B., On Lead Encephalopathy and the Use of Diachylon as an Abortifacient. The *BMJ,* June 30, 1900, 1590–1591. See also Vertinsky 1990, 75–83; Marland 2013, 103–118.

939 Walker 1893, 28.

940 Chavasse 1866, 11. See also Stacpoole 1894, 27–29; Philothalos 1860, 49–50; Walker 1893, 28–31; Stables 1894, 179–180.

941 Smith 2007, 97. See also Porter & Porter 1988, 50–52; Stolberg 2020.

942 See for example Fox 1834, 33–34; Bull 1837, 67–75; Bull 1865, 79–84; Chavasse 1866, 68–72; Welch 1838, 27–31; Conquest 1849, 29–31; Harvey 1863, 10–11; Black 1888, 23–25, 46; Walker 1893, 45–51; Stacpoole 1894, 40–46; Stables 1894, 196–197; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 27–31. See also Tanner 1860, 394–398; Playfair 1893a, 233–224. See also Gélis 1991, 81–82; Gastiglione 2017, 67–68; Stolberg 2020, 206, 210.

943 See for example Welch 1838, 29–31, 44–45; Allbutt 1890, 41; Walker 1893, 38, 58–61; Stables 1894, 141–142. Compare to Vincent 1902, 7–8.

Shower-baths and sitz-baths were also recommended for women who were suffering from various gynaecological problems, such as painful menstruation, pruritus of the vulva, sometimes called "irritation of the private parts", or leucorrhea, *the whites*, a state demanding extra medical care.[944]

However, sometimes domestic hygiene was not enough. A change of scenery was often recommended in popular medical literature. Women were advised to travel to the seashores to bathe in the sea water, especially if they were, for example, suffering from gynaecological problems or recovering from miscarriages, and therefore needing a break from their marital routines and daily household duties.[945] The right kind of environment was medically indispensable; as the historian Andrew Wear has noted, people generally believed that healthy places meant healthy bodies.[946] An unhealthy environment made people sick and prevented them from getting better and stronger. Especially sea air was considered suitable for recovering patients and people needing general strengthening of their system. English seaside holiday culture had already been established during the Georgian period (1760–1830), and during the Victorian age, travelling to the coast and visiting spas became immensely popular. First, it was a privilege of the small and fashionable aristocracy, but gradually, middle-class people could also travel to enjoy the healthy sea air, salt water, and coastal scenery. At the end of the nineteenth century, coastal tourism had become a common pastime of the masses; also working-class women were recommended to take a trip to the seaside, or alternatively, to spend their time in the countryside, a possibility provided by a constantly expanding railway network.[947] As the historian John Hassan has noted, sea bathing was highly ritualised, surrounded by social and med-

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944 See for example Chavasse 1866, 13, 99; Allbutt 1890, 13, 15; Walker 1893, 58–59, 62–63. On water and cleaning see, for example Smith 2007, 39–42.

945 See for example Welch 1838, 53; Black 1888, 42; Stables 1894, 133. See also for example Radford, Thomas, Cases in Midwifery: With Remarks. The *Association Medical Journal*, January 19, 1856, 45–46; Graily Hewitt, Diagnosing and Treatment of Diseases of Women. The *BMJ*, January 25, 1862, 84–85; Harrison, John, Vomiting of Pregnancy Treated by Hypodermic Injections of Morphia. The *BMJ*, April 3, 1869, 306–307; Sea-Bathing. The *BMJ*, June 30, 1883, 1294. On bathing culture in Europe, see Smith 2007, 102–111, 122–125, 168–178, 201–212, 244–246. See also Lewis 1986, 132–133; Pfeffer 1993, 41.

946 Wear 1996, 133; Wear 2000, 184–207; Porter & Porter 1988, 156–158; Porter 1996, 95. See also Churchill 2012, 166–176; Gélis 1991, 76–77; Donato 2017, 170–173; Gage 2017; Storey 2020, 299–301. See also Bashford 1998, 17. See also Ryan 1836, 36.

947 See for example Allbutt 1890, 41: "a trip to the sea-side for several weeks will do her much good. A residence in the country, with cheerful friends, is beneficial". On seaside bathing culture and health in Britain, see Hassan 2003, 15–22, 28–84. Sea air was recommended for many conditions, such as for gout, tuberculosis, and melancholia. Seaside towns and the sea itself provided "scenic setting, climate, scope of physical exercise and, [--] opportunities for sun-bathing", being a contrast and antidote to urbanising and industrialising towns with their polluted air and hectic lifestyle. Hassan 2003, 75. See also Porter & Porter 1988, 196–198; Porter 2001, 165–169; Gilbert 2014, 134–140; on physicians and seaside bathing and baths see Digby 1994, 212–223. See also Coates 1998, 160–161; Smith 2007, 244–246; Bonea & al. 2019, 18–19, 89–100.

ical protocols, due to the therapeutic nature of the treatments and occasional nudity of patients.[948] On the other hand, for pregnant women, bathing in the actual sea could be dangerous and thus, not always recommended.[949] However, healthy seawater could also be created artificially.[950]

Healthy seaside or country life was presented as a stark contrast with modern life in urban cities. Living in towns was depicted as dangerous and unnatural; urban environments were the places of coal fires, manufacturing and industry, diseases, bad air, pollution, and hurry. Modern urban life was contaminating and corruptive, destroying the health and lives of people living in them. This, however, was not a particularly new discourse in medicine; there was a long historical tradition associating countryside life with healthiness, fertility, and morality, and the cities and towns with unhealthiness, dirty, diseases, and barrenness.[951] Moreover, urban life was connected with the immorality of luxury and idleness – soft cushions, sofas, couches, and feather beds were the cultural symbols of a hedonistic lifestyle, threatening especially female reproductive health.[952] As Pye Henry Chavasse wrote in his manuals, too easy living was always potentially dangerous and unnatural; "[u]nfortunately this is an age of luxury. Everything is artificial,

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948 Hassan 2003, 17, 38–39. On English spas and water cure, see also Adams 2015. See the example of the patient staying at a seaside place, Massiah, B. J., Pregnancy after Gastro-Jejunostomy. The *BMJ*, October 28, 1893, 943. See also Oliver, George, The Therapeutics of the Sea-Side: With Special Reference to the North-East Coast. The *BMJ*, November 1870, 550–551. See also Kittoe 1845, 243–245. See also Chavasse 1870, 252–253; Chavasse 1872, 176–180.

949 Scott 1870 [?], 82, 119; Harvey 1863, 9; Bull 1865, 29; Chavasse 1866, 14, 35–36, 55, 98, 108–109,; Black 1888, 17–18; Stacpoole 1894, 28–29. See also Bull 1837, 112–114; *Doctor at Home* 1891, 3–4. See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 43–46. See also Stables 1894, 180.

950 Scott 1870 [?], 119: "Form for a Salt-water Bath as a substitute for sea bathing, when it cannot be procured. Bay salt, 2 pounds; Epsom Salts, 3 OZ; Glauber's salts, 1 pound; water, 30 gallons. To be used every morning, after which the surface of the body should be thoroughly rubbed with coarse towels." See also Chavasse 1866, 14; Chavasse & An American Medical Writer 1871, 108; Kittoe 1845, 245–252; *Doctor at Home* 1891, 3–4. On water and health, see Smith 2007, 39–44, 76–83, 105–111, 204–207, 219–220, 291–295. See also Adams 2015.

951 See for example Wear 1996, 129–137; Bynum 1996, 64; Porter 1998, 406–407; Wear 2000, 160–165, 191; Coates 1998, 34–35; Ganev 2007, 42–48; Gélis 1991, 76–77; Levine-Clark 2004, 23–25. On industrialism and nineteenth-century cities, see Wohl 1984, 205–220; Haley 1978, 10. See also for example Ryan 1831, 57–58. See also Smith 2007, 285–287. See also Levine-Clark 2004, 106–107; Nead 1988, 39–44.

952 See for example Hills 1841, 6; Philothalos 1860, 6; Harvey 1863, 4, 50; Chavasse 1866, 10–11. Chavasse compared a bulldog living like its owners – "fed upon chicken, rice, and delicacies, and made to lie upon soft cushions" – to an idle and inactive woman, who eventually was "unfit to perform the duties of a wife, and the offices of a mother." That is to say, the natural state of both human beings and their domesticated animals had been corrupted with the wrong kind of diet. See also Kittoe 1845, 8–9; Chavasse & An American Medical Writer 1871, 84–88, 94–95, 102–104; Vincent 1902, 13. See also Playfair 1894b, 5. See also for example Woodhouse, R. T., Case of Puerperal Convulsions. The *Association Medical Journal*, May 17, 1856, 405; Bayes, William, On Female Sterility, with Some Practical Suggestions for Its Removal. The *Association Medical Journal*, September 23, 1853, 326–328. Compare to Chapman, Wm, Early Parturition. The *Association Medical Journal*, February 9, 1856, 114. See also Ganev 2007, 45.

and disease and weakness follow as a matter of course."[953] Especially urban upper-class women were at the greatest risk; due to their unnatural life habits, – allegedly, they spent their time in hot and badly ventilated rooms, they danced too much, wore the wrong kind of dresses, and had little or no exercise – they suffered from miscarriages, their deliveries were more complicated, and their children were deemed to be "poor, puny and sickly creatures".[954] This kind of rhetoric was particularly noticeable in the manual of Gordon Stables (1894).

However, healthy fresh air was not found only at seaside places or in the countryside. Ventilation and the free play of air was an indispensable part of maintaining health, to be organised in every house and especially in every bedroom.[955] Exposure to carbonic-acid gas, a constant danger of every bedroom, was described by Pye Henry Chavasse as "inhaling poison" and breathing "the contaminated air".[956] Especially working-class houses were often damp, crowded, poorly ventilated, and the sewage system was deficient if not non-existent.[957] Ventilation, that is to say, keeping the windows open regularly especially in the mornings, was basic hygiene in every household.[958] In medical literature, an ideal bedroom had large windows and a fireplace to maintain ventilation – in reality, an unachievable dream for many. Moreover, a good woman went to bed early and woke up after eight hours' sleep; late hours in badly ventilated, overcrowded, and hot rooms were particularly harmful to health.[959] The need for rest,

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953 Chavasse 1866, 4. See also Ganev 2007, 48.

954 See for example Stables 1894, 124; Chavasse 1866, 10–11; Chavasse & An American Medical Writer 1871, 103, 131–132. See also for example Woodhouse, R. T., Case of Puerperal Convulsions. The *Association Medical Journal*, May 17, 1856, 405–406. See also Ganev 2007, 42–48.

955 On cool air and heath, see Smith 2007, 216–218. See also for example Chavasse 1866, 6–10.

956 Chavasse 1866, 6–8, 20, 58. See also Chavasse & An American Medical Writer 1871, 99–101; Allbutt 1890, 12; Vincent 1902, 17–18. See also *The Worth of Fresh Air* 1858 [?]. Also Queen Victoria was obsessed about the right temperature and good ventilation: "I asked you several questions on a separate paper about your health, cold sponging – temperature of your rooms etc. and you have not answered one!". Queen Victoria to her eldest daughter Victoria, the Princess Royal, February 22, 1858. *Dearest Child* 1964, 55–56. See also Handley 2016, 95–108.

957 See for example Beier 2008, 41–44; Wohl 1984, 61–70, see also pp. 328–385; Smith 2007, 285–291, 297–299; Haley 1978, 8–9; Levine-Clark 2004, 119–121; Nead 1988, 118–199; Gilbert 2014, 132–134; Hopkins 1982, 17–23. On Victorian architecture and doctors, see Adams 1996. See also Philothalos 1860, 47. On the question of sanitation, see for example Weatherly 1882, 21–27; Stables 1894, 183–185. See also House-Warming and Ventilation. The *BMJ*, January 31, 1863, 118; Corfield, W. H., Introductory Lecture to a Course of Lectures on Hygiene and Public Health. The *BMJ,* June 25, 1870, 645–646.

958 See for example Chavasse 1866, 6–9, 19–21, 57–60, 65–66; Weatherly 1882, 25–27; Black 1888, 19; Allbutt 1890, 12–13; *Doctor at Home* 1891, 74–75, 851; Walker 1893, 33; Stacpoole 1894, 17–19; Stables 1894, 182–183; Vincent 1902, 17–20; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 15–17. See also *The Cheap Doctor* 1858; *The Worth of Fresh Air* 1858 [?]. See also Ryan 1836, 33. See also Ventilation. The *BMJ*, June 21, 1862, 653–654; The Air of Bedrooms. The *BMJ*, September 27, 1890, 746; Why not Ventilate? The *BMJ*, April 23, 1898, 1092–1093. See also Marland 2013, 68–69; Bashford 1998, 5–6, 17–18; Adams 1996, 49–50.

959 See for example Chavasse 1866, 17–18; Chavasse & An American Medical Writer 1871, 135–136, 183–185; Black 1888, 18–19; Stables 1894, 182–183, 188; Vincent 1902, 20. See also Smith 2007, 154; Gélis 1991, 80–81.

a key to both physical and mental health, was constantly emphasised: "[e]arly to bed and early to rise, Makes a man healthy, wealthy, and wise", echoed the home-doctoring manual *Doctor at Home,* stressing the meaning of both sleep and useful wakefulness – and self-control.[960]

Diet was also an indispensable part of the medical principles during pregnancy; thus, it was not only a source of nourishment but also a cure and a preventive part of the medical treatment and well-being of the individual patient.[961] "We all know that health and a good appetite usually go together", noted also Graily Hewitt, one of the leading obstetricians of the time.[962] Doctors knew that many women suffered from what was called "chronic starvation", disguised as "female delicacy" or "weakness". Thus, a sufficient and healthy diet was "the best lifeguard which she [the pregnant woman] has against many of the complications incident to this critical period": it was known, however, that a diverse and healthy diet was not possible for everyone, especially for those who were positioned low on the social ladder.[963] The diet recommended was to be "good, plain, nourishing", not too rich nor too plentiful.[964] Writers stressed particularly that the pregnant mother was *not* to eat for two; in fact, many noticed that morning sickness itself was an indication that no extra food was needed during gestation.[965] Sago, arrowroot, porridges, and rice puddings were suitable food items, as well as chicken and white fish. Vegetables and fruits, such as figs, prunes, cauliflower, and beans were good for the bowels, especially if the woman was suffering from constipation or piles. Pastry, fats, sweets, pickles, seasoned and spiced foods were bad for the health and digestion, alongside pork, veal, and cheeses.[966] Occasionally, the *BMJ* also criticised the advice given to pregnant women in the popular medical literature: for example, Thomas Bull's highly popular manual *Hints to Mothers* was criticised for its advice concerning diet, which was found insufficient and too light.[967]

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960 *Doctor at Home* 1891, 397. See also for example Chavasse 1866, 19; Walker 1893, 34–35; Stables 1894, 31, 66–70, 93–94. See also Newton 2017, 11–113; Handley 2017. On sleep and healthiness, see also Handley 2016.

961 On pure foods and diet, see Smith 2007, 212–216. See also Wear 2000, 169–178, 203–207. See the example of the treatment of piles with diet in Walker 1893, 54–55.

962 Graily Hewitt, The Question of Food in Obstetric and Gynaecological Practice. The *BMJ*, August 4, 1883, 224.

963 Miller, Hugh, On the Diet of Parturient Women. The *BMJ*, April 29, 1871, 445. See also Graily Hewitt, The Question of Food in Obstetric and Gynaecological Practice. *The BMJ*, August 4, 1883, 224. On nineteenth-century diet, see Wohl 1984, 48–52. See also Smith 1979, 203–215; Levine-Clark 2004, 128; Hopkins 1982, 24–25, 108–114.

964 See for example Walker 1893, 31–33; Welch 1838, 64–66, 68–69; Hills 1841, 7. See also Porter & Porter 1988, 48; Porter 2001, 83–86. See also Diet in Pregnancy. The *BMJ*, October 19, 1901, 1187–1188.

965 See for example Walker 1893, 14, 31; Fox 1834, 15–18; Bull 1837, 18–19; Welch 1838, 66; Conquest 1849, 4–5; Chavasse 1866, 62, 90–91, 106; Weatherly 1882, 38–39; Stables 1894, 186. Compare to Gélis 1991, 82.

966 See for example Fox 1834, 10–15, 18–20; Bull 1837, 20–21, 74–75, 109–110; Kittoe 1845, 165; Bakewell 1859, 14; Philothalos 1860, 46; Chavasse 1866, 63–64, 74; Chavasse & An American Medical Writer 1871, 181–183; Black 1888, 13–14, 42; Allbutt 1890, 10–11; *Doctor at Home* 1891, 346–347; Walker 1893, 31–33, 52, 54–55; Stables 1894, 57–65, 186–188; Stacpoole 1894, 19–22, 40–42; Vincent 1902, 22–23. See also Tanner 1871, 47–48. See also Gélis 1991, 82–83.

967 Miller, Hugh, On the Diet of Parturient Women. The *BMJ*, April 29, 1871, 445.

Occasionally, albeit not customarily, doctors also discussed sex, *marital embraces*, *sexual congress,* or *sexual connection*, during pregnancy. Historians have suggested that the attitude towards pregnancy sex has always been negative and pejorative – especially in the Christian tradition, sex was not permitted during the pregnancy months – and occasionally primary sources have supported this idea.[968] For example, the American author-historian Hannah Pakula argued in her massive biography of the Empress of Germany, Victoria (1840–1901), the eldest daughter and the namesake of Queen Victoria, that at least in the case of the mother-Victoria, the pregnant royal mother had to give up sex every time she was expecting a child. Pakula quoted two American sources in her study; M.D. Emma F. Angell Drake's manual *What a Young Wife Ought to Know* and Edward B. Foote's *Plain Home Talk*, both highly critical in their views on sex during pregnancy.[969] Interestingly, another American manual, Dr Genevieve Tucker's *Mother, Baby, and Nursery* (1896), was equally pejorative in its views on sex. Tucker called "coition" during pregnancy a "perversion", claiming that "[i]t blights and blasts, if it does not destroy, the life of the child".[970] In the review of the book, the *BMJ* marked, however, how "[s]ome may think such a subject better left untouched in a popular work; but if it be referred to at all, it should be with knowledge", noticing with a somewhat sarcastic tone that if something poorly argued was said repeatedly, "it therefore *must* be true".[971]

In the British medical context, the general tone was indeed slightly different. In the early 1840s, Michael Ryan, for example, noted that sexual desire "may be increased, diminished, and even abolished" during pregnancy – however, apparently he was talking more broadly about the animal kingdom and not solely about human beings.[972] Ryan noted that "the act of reproduction" could cause miscarriage or premature labour, adding that in the case of pregnancy, the act should "be performed with gentleness, and only when nature dictates".[973] The British manuals usually mentioned sex negatively in connection with potential miscarriage; if there was a real danger that the woman was likely to abort, she was advised to live separately, to undergo "a temporary divorce", from her husband.[974] If the woman had a *habit of miscarriage*, meaning that all her pregnancies were likely to end prematurely at a certain point of gestation, this advice was

968 Jütte 2008, 21. See also Gélis 1991, 85–86.
969 Pakula 2002, 103–104.
970 Tucker 1896, 40.
971 Notes on Books. The *BMJ*, November 13, 1897, 1431: "Dr. Genevieve Tucker can only procure acceptance for her views by adducing facts in their support; reiteration of extravagant statements does not commend them to the medical public".
972 Ryan 1841, 157. See also Harvey 1863, 80. See also Crawford 1994, 89.
973 Ryan 1841, 157. See also Ryan 1831, 68; Ryan 1837, 40; Chavasse & An American Medical Writer 1871, 73–74.
974 J. G. [anonym.], Prevention of Habitual Abortion. The *BMJ*, January 10, 1885, 109. See also Ryan 1837, 250; Tanner 1860, 256; Chavasse 1866, 107; Chavasse & An American Medical Writer 1871, 218; Black 1888, 43–44; Walker 1893, 74. On the negative discourse concerning pregnancy sex, see Robb 1997, 64.

more obligatory.[975] In normal circumstances, couples expecting a child were encouraged to "immoderate sexual intercourse", if the future parents could not abstain from it altogether.[976] This was important because everything the future mother – and occasionally also the father – did, affected the child, sometimes with very direct and noticeable results, as I discuss in the next subchapter.

4.3 Maternal Impressions and Miscarriages: Complications of Pregnancy

Pregnancy, as natural a state as it was considered for every married woman, could also be unpleasant and marked with various physical and mental ailments, disorders, and complications. As discussed in the previous chapter, "improper habits and modes of living; by too sedentary a life; by too rich and delicate a diet; by late hours, crowded rooms; and many similar and equally enfeebling and detrimental practices" could lead to serious consequences both in pregnancy and in childbirth.[977] In popular health literature, this list of potential dangers, and, on the other hand, the belief in the preventative powers of the non-naturals and self-control remained relatively unaltered for sixty years. In this sense, the manuals of Thomas Bull (1837) and Gordon Stables (1894), for example, followed this same traditional policy of antenatal care. But even if pregnancy constituted a risky period in women's lives, nineteenth-century doctors believed that in general married women were healthier than their unmarried fellow sisters. The natural functions of the female body and reproductive organs were fulfilled when the woman was pregnant or breastfeeding.[978]

It was acknowledged, however, that during pregnancy some women were liable to many troubles and ailments. For example, morning sickness – nausea or vomiting –, was one of the most common ailments of pregnancy, but when excessive, it was also troublesome and potentially risky for the well-being of the woman and the foetus. Women could also suffer from diarrhoea, piles, leucorrhoea, bladder problems, heartburn, pruritus of the vulva, and pains and cramps

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975 See for example Bull 1837, 114–115; Harvey 1863, 51; Black 1888, 43–44; Walker 1893, 82. See also J. G. [anonym.], Prevention of Habitual Abortion. The *BMJ*, January 10, 1885, 109.

976 See for example Harvey 1863, 51; Kittoe 1845, 167; Walker 1893, 23: "there is much to be said in favour of entire abstention from sexual intercourse during pregnancy; but without rigidly pressing this point, there can be no doubt that extreme moderation is then highly necessary, and not only the child, but the parents will gain by this exercise of self-control." In Henry Arthur Allbutt's guidebook, "only a moderate amount of sexual connection" was recommended during the lying-in – that is say, sex was not entirely banned. See Allbutt 1890, 28; Allbutt 1897, 23. On sex during menstruation, see Kittoe 1845, 34. On breast-feeding and sex, see Perry 1992, 130–132. See also Lewis 1986, 167.

977 Conquest 1849, 24.

978 See for example Kittoe 1845, 17; Bakewell 1859, 19, 30, 35. See also Mitchinson 1991, 34.

in the sides, legs, or back, and some were liable to palpitation, faintness, headaches, and sleeplessness – all troublesome and unpleasant symptoms, making everyday life difficult, sometimes even disturbingly so. However, some historians have tended to over-analyse the popular health manuals and the potential antenatal ailments listed in them; scholars have emphasised that the lists of symptoms echoed the understanding of pregnancy as a pathological state or a medical condition rather than a "natural" or "normal" physiological process.[979] I argue that the discourse is more complex than that; it is important to recognise that the idea was not that *all* women suffered from *every* possible symptom mentioned or described in the medical texts.[980] Rather, it was a question of possibility, not the ultimate fate, likely to happen in *every* pregnancy and to *every* woman. On the other hand, one problem could also be the cyclic nature of these disorders; some women were pregnant repeatedly, without major breaks from the reproductive rhythm, sometimes found to be unbearable and objectionable.

Deborah Lupton has pointed out in her studies how in Western societies, *risk* has been a central discourse surrounding pregnant women, both risks threatening women and, on the other hand, the risks threatening the foetus. The woman's body and mind have been "the maternal environment" of the foetus, making the woman both responsible for the foetus' wellbeing and also the subject of "others' appraisal and advice", surveillance, and control – sometimes, also of their blame and reproach.[981] This was also the case in the advice concerning maternal self-control and self-improvement in the Victorian era; as I discuss in this chapter, the risks of maternal emotions played an important role in antenatal care and in the advice given in popular health manuals – not just hints on dress, diet, or exercise. In this sense, nineteenth-century manuals certainly encouraged their readers' self-treatment, self-control, and responsibility, but no doubt guidebooks also offered ritualistic comfort and the hope that by close attention and care, daily routines, and prescriptions, a sufferer could have some control over the potential risks. Occasionally, it was also noticed that while some symptoms could be highly unpleasant and distressing, they were not medically dangerous per se. As Pat Jalland, for example, has observed, some women whose lives she investigated, suffered from pregnancy-related problems, such as morning sickness, but usually it was noticed that these kinds of ailments were only "temporary discomforts and derangements".[982] This was also the case with popular manuals.

In minor ailments, self-treatment was usually encouraged and even expected. For example, some minor gynaecological problems were occasionally treated with leeches. Leeches (lat. *hirudo medicinalis*), parasites attached to the skin and sucking the blood of their host, had been used for medical purposes since the ancient cultures of Babylonia, Egypt, and China. The application of leeches was a part of the humoral theory, maintaining the balance of the body by bloodletting and other methods of evacuation, making leeches the doctors' little

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979 See for example Wood 2017, 45.
980 See for example Hills 1841, 6; Conquest 1849, 20, 22; Stables 1894, 206.
981 Lupton 1999, 59–64; Lupton 2003, see esp. pp. 25, 88–91.
982 Davies 1852, 8. See also Jalland 1986, 138. Compare to Marland 2004, 24–25. See also for example Walker 1893, 7.

helpers in practice.[983] Their use was common in self-treatment especially in the 1840s and 1850s, but there are several mentions of leeches also at the end of the nineteenth century. They were used both externally and internally for headaches, stomach pains, piles, and various gynaecological problems; leeches were also applied in more serious cases of puerperal convulsions and childbed fever, as I will illustrate later in Chapter 5.5.[984] For example, in 1894, in his manual, Gordon Stables recommended application of leeches "to the lips of the womb" to those women who were suffering from scanty menstruation and who lived in parts of the country where the services of a doctor were not generally available.[985] Thus, leeches were a part of nineteenth-century medical self-help, very much like prescriptions and potions, baths, laxatives, emetics, enemas, and vaginal douches, for example.

On the other hand, some antenatal ailments described in manuals were mental rather than physiological. The topic of prenatal mental health certainly was not a culture-medical taboo in nineteenth-century medicine. Doctors described the changes in the woman's mental health just as they described the changes taken place in the pregnant body. Many doctors believed that women were liable to mental disturbances during the pregnancy months, as for example William Kittoe described in the 1840s: "it is well known that every pregnant female is generally more irritable and sensitive than usually".[986] According to Kittoe, these changes in mood appeared individually: "some [women] are exhilarated, others depressed; some become exceedingly nervous, bilious, or hysterical; [whilst] others again enjoy better health than at any other former period of their lives".[987] From the point of view of the medical profession, in this sense, the female system was unpredictable during pregnancy, as it was impossible to know in advance who was "in the highest possible spirits" and who, on the other hand, was not. Every woman was her own individual case.

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983 On leeches, see Kirk & Pemberton 2013; Lane 2001, 46. For practical hints on the application of leeches, see Bakewell 1857, 18–20.

984 See for example Bull 1837, 63. For sickness and stomach pains, Bull recommended "the application of nine or twelve leeches to the stomach, and pieces of soft linen rag well soaked with laudanum". See also Bull 1865, 110–111, 348–351; Fox 1834, 35, 47–48, 52; Welch 1838, 33; Tilt 1851, 117–119; Davies 1852, 12, 17–19; Bakewell 1859, 26, 77–79, 106; Scott 1870 [?], 21; Black 1888, 22; *Doctor at Home* 1891, 478–479; Allbutt 1897, 115; A London Physician [anonym.] 1891, 87, 100. See also for example Edwards, Conway T., Case of Ovarian Tumour Impending Delivery. The *PMJRMS*, July 30, 1842, 327–328; Application of Leeches to the Cervix Uteri. The *BMJ*, May 10, 1862, 494. See also Kirk & Pemberton 2013, 70. See also Chapter 5.5.

985 Stables 1894, 135, 138. Stables recommended that a midwife or a "handy nurse" could pass the speculum and apply the leeches. He noticed, somewhat condescendingly, that the doctor was the best person to know whether the simply operation was done properly. Kate Fisher has found out in her oral history research on the history of nineteenth-century birth control that at least one working-class woman had tried abortion by putting a piece of bark [slippery elm] and a leech inside of her, in order to procure abortion. This was the only case in Fisher's interviews when leeches were mentioned in connection with abortion. Fisher 2011, 53–54.

986 Kittoe 1845, 162.

987 Kittoe 1845, 162. See also Welch 1838, 5–6; Davies 1852, 9; A London Physician [anonym.] 1891, 208–209, 223.

Popular health manuals show that some women were clearly affected – or they were expected to be so – by fears and anxiety associated with the complications of pregnancy, the event of labour, the possibility of pain and injuries, and future motherhood. Especially women who were about become mothers for the first time were at risk of despondency or lowness. "All is strange is to her. She thinks she will suffer more than in reality she does. Her ignorance causes her terror", noted also Henry Arthur Allbutt in his guidebook, published in the 1890s.[988] The unknown was frightening and strange, with exposure to vulnerability and danger, but doctors reassuringly noted that medically correct information was the best way to calm unnecessary and excessive fears.[989] Doctors reminded their readers that most pregnancies were usually free from serious complications and in most cases women survived labour without suffering too much. "A well-formed healthy woman has rarely anything to fear", as Henry Arthur Allbutt consoled his readers.[990]

Emotions, when excessive and continual, broke the harmony and balance between the body and mind; emotions affected the body in very direct ways. This was the case especially when pregnant women were in question. Thus, cheerfulness, optimism, and general calmness were generally regarded as desirable qualities for successful pregnancy; according to Jane H. Walker, the aim was "to maintain a cheerful and equal habit of mind, which will materially aid her [the mother] in keeping well".[991] Walker recommended that the future mother should think "about bright and happy things".[992] However, a certain lowness was often expected during the pregnancy months, and especially changes in mood. "The lively disposition will often become sad, and the depressed enjoy the highest flow of spirits".[993] Some women were "extremely depressed and apprehensive" when being in the family way.[994] This state had many names; *despondency*, *lowness*, *oppression*, *nervousness*, *mental depression,* or *depression of spirits*.[995] In fact, lassitude and weariness could be seen as a general symptom of pregnancy, confirming the state.[996] On the other hand, the most anxious and nervous woman could also become content, happy and healthy when in the family way. For example, the anonymous author of the manual *Girlhood and Wifehood,* published at the beginning of

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988 Allbutt 1890, 16–17. See also Philothalos 1860, 38–39.

989 See for example Hanson 2004, 13–14.

990 Allbutt 1890, 17. See also Kittoe 1845, 170. See also Chapter 5.5.

991 Walker 1893, 7. See also Bull 1865, 34–36; Black 1888, 20; Stacpoole 1894, 53. On the connection between psychological state and health in early modern England, see Churchill 2012, 180–194. See also Gélis 1991, 83; Newton 2017, 117–119; Duden 1991, 144–149.

992 Walker 1893, 23.

993 Hills 1841, 6. See also Kittoe 1845, 162–163; Conquest 1849, 11–12; Stables 1894, 204–205; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 158. See also Montgomery 1837, 149–151; Tanner 1860, 123–124.

994 See for example Fox 1834, 58–60. See also Philothalos 1860, 38–39.

995 See for example Welch 1838, 6; Kittoe 1845, 142; Conquest 1849, 38–39; Chavasse 1866, 6, 15; Black 1888, 20; Stacpoole 1894, 53. On more serious mental diseases, for example insanity during pregnancy, see Tanner 1860, 318–333, 416–418. See also Castiglioni 2017, 69–72.

996 See for example Welch 1838, 11–12; Hills 1841, 6; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 157.

the twentieth century, described a case of "a woman of most irritable temperament". According to the author, the woman and her family "had learned from experience to hail with joyful anticipations the lady's pregnancy, as a period when clouds and storms were immediately changed for sunshine and quietness".[997]

The maternal mind and strong emotions were closely associated with a somewhat controversial yet widespread and much discussed theory of *maternal impressions, maternal marks,* or *external impressions*, explaining how at least some of the foetal malformations and abnormalities were formed during the nine-month pregnancy period. Historians and other scholars, such as Philip K. Wilson, Marie-Hélène Huet, and Jenifer Buckley, when investigating the phenomenon, have preferred the term *maternal imagination*, but in the nineteenth century, the most common and often used term in medical journals was *maternal impressions*.[998] The theory itself has a long history. The classical philosophers in Antiquity had discussed the power that a mother's experiences, especially frights, and strong emotions had over the foetus during pregnancy. In the Renaissance, artists and various scholars were greatly interested in monsters reputedly created by the maternal imagination, frights or longings, and in the eighteenth century, sensational cases like the one of Mary Toft's (c. 1701–1763), an English village woman who claimed to have delivered sixteenth rabbits as a result of maternal longings, were discussed and debated, defended and opposed.[999]

Historians have often located the phenomenon of maternal impressions in the eighteenth century; most have argued that in medicine the theory was discarded around the late eighteenth century or by the early nineteenth century, at the latest.[1000] Philip K. Wilson has noted that in the nineteenth century, maternal

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997 Surgeon & Accoucheur [anonym.] 1900–1909 [?], 158. See also Stacpoole 1894, 57.

998 According to Buckley, other terms used for the phenomenon have been *maternal imprinting*, *congenital deformity*, *maternal fleshmark*, and *maternal imagination*. See Buckley 2017, 3; Wilson, P. 1992, 63–84; Wilson, P. 2002, 2. In the nineteenth century, these terms were rarely used, at least in the *BMJ* and the popular guidebooks studied for this research. Jane H. Walker, for example, used the term "external impressions" in her popular manual for mothers. The 1860s manual *Wife's Domain* discussed "mothers' mark" or "skin blotches". See Walker 1893, 17–18; Philothalos 1860, 150.

999 Huet 1993, 1–8, 13–35; Wilson, P., 1992, 63–85; Gowing 2003, 127–138; Cody 2008, 120–151; Kukla 2005, 13–19, 69; Gélis 1991, 51–58, 260–269; Buckley 2017, 10–25; Read 2017, 141–144; Mazzoni 2002, 15–16; Boucé 1987, 86–99; Fissell 2006b, 64–69, 157–162. Compare to Hanson 2004, 13, 26–29. Clare Hanson has argued that the concept was taken up in medical discourse in the eighteenth century but the theory is actually much older also in medicine. Many historians have been especially interested in the case of Mary Toft, see for example Wilson, P., 1992, 63–64; Wilson, P. 2002, 5–6; Cody 2008, 124–151; Buckley 2017, 39–40, 51–57. However, Toft and her children-rabbits were not discussed in nineteenth-century medical literature; at least I have not able to find any trace of her in my primary sources. The case was a public humiliation for some members of the eighteenth-century medical profession who, at first, genuinely believed in the Toft case.

1000 See Buckley 2017, 93–95; Kukla 2005, 14, 16, 69; Huet 1993, 1, 7–9; Hanson 2004, 26–27; Fissell 2004, 67. Moreover, historians have argued that the theory of maternal impressions continued to be influential mainly in nineteenth-century fiction. See especially Huet 1993, 126–162; Buckley 2017, 97, 223. On maternal imagination and art, see Betterton 2006, 80–97. On maternal imagination in the Netherlands, see also Marland 2001b, 158.

markings were sometimes understood as "signs of morality" or an attempt to explain, for example, twin births.[1001] However, the patient records and doctors' letters sent to the *BMJ* clearly show that in nineteenth-century medicine, the theory was still firmly rooted in the minds of ordinary medical men, and also pregnant women themselves used it to explain some of the deformities, abnormalities, or visual marks in their newborn children. As one writer noticed in 1885, the belief in maternal impressions was "by no means rare" amongst medical men even if "scientific reasons" had been given "to show the probable fallacy of these views".[1002] As late as in the 1880s and 1890s, an abundance of letters can be found in the *BMJ* to describe, for example, frights experienced by pregnant women with these alleged impressions then being transmitted to their unborn children.[1003] Moreover, the accounts demonstrated that even if respected and much-read medical authors found the theory of maternal impressions to be unconvincing, irrational, and merely folklore, many ordinary practitioners continued to believe in the analogy between the maternal imagination and deformities, and moreover, were willing to share their experiences with their peers in prestigious medical journals.[1004]

In short, the concept of maternal impressions meant that the pregnant woman's "mental, moral, and physical state" affected her unborn child, seen directly and visually in the baby after birth, such as in the form of various deformities, birthmarks and moles, harelips, and other very distinct abnormalities in the child's body, often referred to as *monstrosities* in contemporary medical literature.[1005] As Jacques Gélis has explained, it was commonly believed that during pregnancy "the child saw what the mother saw, heard what she heard and felt

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1001 Wilson, P. 2002, 13.

1002 Smith, Noble, Heredity and Maternal Impressions in Relation to Congenital Deformities. The *BMJ*, October 2, 1885, 672. See also Maternal Impressions. The *BMJ*, December 19, 1891, 1322. See also King, George, Cases of Monsters. The *Association Medical Journal*, June 14, 1856, 507; Brendon, J., Deformity of the Ear through Maternal Influence during Pregnancy. The *BMJ*, September 4, 1869, 284; Holmes Joy, J., Maternal Impressions. The *BMJ*, August 14, 1875, 219.

1003 See for example Hurley, J., Maternal Impressions. The *BMJ*, March 1, 1884, 446; Lewis Jones, H., Maternal Impression. The *BMJ*, February 23, 1895, 417; Jenkyns, J., Maternal Impressions. The *BMJ*, March 2, 1895, 474. This abundance of stories can partly been explained by the principle of how the journals worked in general; when one doctor wrote to the periodical and described the case he had been involved with, his peers usually shared their experiences, thus these stories can often be found in series in subsequent issues of the journal. See also Wilson, P. 2002, 7–8. See also Philothalos 1860, 149–150.

1004 The letters had a certain pattern; first, the writer acknowledged that the theory of maternal impressions was not generally supported in medicine, labelled as "vulgar errors" or "old-midwifery superstitions". Next, the correspondent described the case he had been involved with, remarking that there were peculiar coincidences between the maternal experiences during pregnancy and the appearance of the child. Then, the writer could acknowledge the reliability of the participants involved in the case. See for example Brydon, James, Maternal Impressions. The *BMJ*, December 27, 1884, 1320; Brendon Curgenven, J., Deformity of the Ear through Maternal Influence During Pregnancy. The *BMJ*, September 4, 1869, 284.

1005 The quotation is taken from Payne 1878, 94. See for example Montgomery 1837, 12–18; Lee 1875; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 194–195. See the etymology of the word "monster" in Huet 1993, 6. See also Wilson, P. 2002, 4. See also Bourke 2005, 84–86. See also Fissell 2006b, 65.

what she felt".[1006] Maternal impressions revealed the complex relation between the woman's body, her mind, senses, emotions, and morality, the external world, and the foetus during pregnancy, which was both a mysterious yet common phase in the female life cycle. The theory was based on the idea that the body of a pregnant woman was permeable and impermeable at the same time; the female maternal body was its own closed entity and the foetus within the uterus was hidden and protected from sight. Yet the external world had a direct effect on this mysterious triangle between the maternal mind, pregnant body, and the foetus, the mother being a filter and the agent, a subject and object, between the impressions and the child, forming a complex unity transmitting influences and changing material. The maternal body was indeed part screen, part filter.[1007]

Maternal power, in this sense, was active and creative, but more often it had accidental and hazardous effects, eventuellement not controlled by the pregnant woman herself. Thus, maternal imagination was potentially dangerous, at least suspicious, haphazard, and highly unpredictable, even if mothers were constantly encouraged to govern their feelings and manage their conduct during pregnancy. Moreover, the theory of maternal impressions challenged natural laws and the very essence of humanity and revealed hierarchies in gender relations; that is to say, how children usually physically resembled their parents, both mothers and fathers, even if the role of the father was traditionally considered more important in this sense.[1008] The father was often seen as a creative positive force, whereas a woman merely provided material or was the one whose impression was more detrimental.[1009] On the other hand, the exact moment of conception could also be significant; if the woman was thinking of or seeing something unusual during sex and impregnation, this vision or thought could be imprinted in the child.[1010]

Maternal impressions also blurred the profound differences between species, disrupting the order of Nature; man was the crown of creation and distinctly

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1006 Gélis 1991, 53. See also Oakley 1984, 23–25.

1007 Gélis 1991, 53. See also Mazzoni 2002, 32, 32, 37; Kukla 2005, 13–14. On emotions and the body, see Alberti 2014; Duden 1991, 142–149.

1008 Gillis 1996, 183–184; Huet 1993, 4, 26, 40–41, 51; Gélis 1991, 55–56. Traditionally, the father, allegedly being the more active partner in conception, was thought to provide the soul for the foetus; the woman was merely a supplier of matter and a more passive vessel for the child to develop until it was ready to be born. On the discussion of moral regeneration and the feminist discourse at the end of the nineteenth century, see Robb 1997, 62. See also Mazzoni 2002, 16; Gowing 2003, 112–113; Fissell 2006b, 199–217. See also McLaren 1990, 19–21.

1009 On paternal imagination, that is to say the father's private thoughts and feelings at the point of the orgasm and conception affecting his child, see Buckley 2018, 194–220. See also Gélis 1991, 36–37, 55; Kukla 2005, 15; Gowing 2003, 131; Huet 1993, 13–14; Kueny 2019, 57–58. Paternal impressions were not often discussed in the *BMJ*; one rare exception was the case of Dr. La Torre presented in the *BMJ* in 1888; La Torre believed that the father's health and strength had a great influence on his child, including the sex of the child. See also Consanguinity, Conception, and Malformation. The *BMJ*, July 4, 1891, 22; The Development of the Foetus. The *BMJ*, October 6, 1888, 774–775. In fact, in 1877, the *BMJ* asked why the phenomenon was not called "father-marks", see Maternal Impressions. The *BMJ*, June 6, 1877, 748. See also Tanner 1860, 235.

1010 See for example Kukla 2005, 15. See also Payne 1878, 93–95.

not an animal. As Marie Hélène Huet has illustrated, maternal impressions created unnatural analogies and resemblances between humans and animals.[1011] In the letters and reports published in the *BMJ*, both domestic and wild animals, such as rats, mice, dogs, bears, and fish were often mentioned as the origins of congenital deformities and maternal marks.[1012] For example, in 1889, one correspondent described a baby girl born without arms or legs to a woman whose elder children had been healthy and physically normal in every respect. The reason for the baby's very unusual appearance was eventually traced back to pregnancy: "[t]he only way she [the woman] could account for anything being wrong this time [during pregnancy] was that, on going in next door where a fishman [sic] lived, she had 'seen fish that she never thought existed'", as the doctor reported in his letter.[1013] The strange looking fish had occupied the woman's mind and this unnatural fixation explained why the child's very abnormal appearance was analogical to a fish. The story was supported by the woman's husband.

Besides animals, equally popular explanations were various frights and fears, particularly strong emotions like sorrow, sudden surprises, excess in any form, dramatic events, accidents, or bad dreams experienced by the pregnant woman.[1014] A medical book, with frightful anatomical illustrations, could be hazardous, as were anatomical exhibitions and such.[1015] Going to the theatre or an

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1011 Huet 1993, 4; Gélis 1991, 56; Gowing 2003, 131–132; Boucé 1987, 94; Porter 2001, 51–57.

1012 Occasionally, these various reasons could be found in one singular case; see for example the mother who gave birth to child missing a toe. The parturient woman had instantly asked the doctor to check the baby's toes after its being born. The woman had had a nightmare during pregnancy in which a rat had eaten her toe, the same one that was missing from the newborn child. The husband confirmed the story, both of them being "[--] most trustworthy people". See Brydon, James, Maternal Impressions. The *BMJ*, December 27, 1884, 1320. See the same story told two years later, Brydon, James, Maternal Impressions. The *BMJ*, April 3, 1886, 670. See also Allison, John, Acephalous Foetus. The *PMJRMS*, December 17, 1842, 225–226; Mulvany, J., Remarkable Monstrosity. The *BMJ*, June 2, 1883, 1063. See on maternal impressions produced by dogs, Tubbs, W., Influence of Mental Impressions on the Foetus in Utero. The *PMJRMS*, December 31, 1842, 268–269; Garraway, Edward, Maternal Impressions. The *BMJ*, February 15, 1868, 158; Dutt, A. C., An Anencephalous Monster. The *BMJ*, May 1, 1897, 1090; Booth, John, A Maternal Impression. The *BMJ*, September 16, 1899, 760.

1013 Grevely, Harry, Case of Amelus or Limbless Monster. The *BMJ*, June 8, 1889, 1289. In this case, the female child lived a month. The head and body were well developed but she had no arms, hands, or legs. The letter also contained a picture of the child.

1014 See for example Barrett, Alfred E., Maternal Impressions. The *BMJ*, April 10, 1886, 725: "During the early months of pregnancy, the patient had lost a child, and grieved and cried very much about it; and when she found that her baby was blind, she at once attributed the defect to her inordinate grief". See also Huet 1993, 48. See also Whitfeld, H., The Hereditary Transmission of Mental and Physical Impressions: How and When Produced. The *BMJ*, June 7, 1862, 601–602; Raverty, G. A., A Case of Monstrosity. The *BMJ*, June 9, 1883, 1116; Style, Mr. R., Anencephalic Foetus Born Alive. The *BMJ*, October 4, 1890, 824. On emotions and the body, see for example Alberti 2014, 8, 12, 17, 20; Duden 1991, 142–149.

1015 On the "doctor's book", see Brydon, W. Mr., Maternal Impressions Affecting Foetus. The *BMJ*, July 17, 1886, 142. On the curiosity exhibition and pregnancy, see Johnston, B. R., Twin-Monstrosity: Alleged Maternal Impressions. The *BMJ*, March 28, 1885, 653. See also Montgomery 1837, 12–14.

art exhibition could also create unexpected marks, noticed only afterwards.[1016] Seeing a person, dead or alive, with deformities or some kind of distinct physical features was one the most common explanations for maternal impressions. This included one's own family members. In one particular family, a woman gave birth to a "limbless monster"; it was revealed that the mother had given birth to a dead child a year earlier and was frightened by "the mutilated remains" of it.[1017] The third group were birthmarks and moles caused by longings or "cravings", as they were often called in popular medical manuals; these were often associated with food.[1018] For example, a red birthmark, a resemblance to a special food article, could be explained by the longings of the mother when being pregnant and her craving for red berries, such as strawberries or raspberries.[1019] A woman's desire was indeed so powerful as to be seen in the next generation, but in the medical literature the usual advice was to leave cravings unfulfilled, labelled as nonsense and potentially dangerous.[1020] Writers noted that neither the woman nor her child suffered if the strange cravings were left unfulfilled – even if a woman herself could claim that was the case.[1021]

Very prominent and visual deformity was always a serious aberration in society and community, and thus required an explanation. The concept of maternal impressions clearly provided one, logical in one sense, explaining hidden mysteries of nature, the relationship between the mother and foetus, and some of the mechanisms of how the foetus was developing and growing in the womb. The analogy between different agents was simple, but on the other hand, the theory left plenty of room for interpretations. Pregnant women themselves were clearly very familiar with the idea of maternal impressions. It seems that some

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1016 See for example Garraway, Robert, Maternal Impressions. The *BMJ*, January 30, 1886, 237: "A lady of refined tastes was in the habit of sitting before a group of statuary, with one little figure of which she was greatly enamoured. This was a 'Cupid reposing'; his cheek resting on the back of his hand. When her baby was born, his resemblance in form and feature to the little Cupid was at once striking". See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 196–197, 200; Sperry 1900, 188. See also Huet 1993, 49; Gowing 2003, 130.

1017 Ceasar, Richard T., Case of Amelus or Limbless Monster. The *BMJ*, March 9, 1889, 525. As the writer noticed, "How far we can call this a case of maternal impression I will leave your readers to decide." The doctor blamed the nurse for letting the woman see the dead child, missing its arm, which had been amputated in obstructed delivery. See also a case of shooting, Maternal Impressions. The *BMJ*, June 18, 1898, 1640. See also Cornish, James, On the Influence of the Mother on the Child. The *PMSJ*, May 30, 1849, 306.

1018 Certain coloured moles, for example, were sometimes associated with red berries, such as raspberries and strawberries. On maternal impressions and cravings for apples, see Forbes, F. W., Maternal Impressions (?). The *BMJ*, June 3, 1893, 1162. On maternal cravings in early modern Europe, see Gélis 1991, 56–58. See also Mazzoni 2002, 11–12, 19–22; Wilson, P. 1992, 69; Kukla 2005, 1; Gowing 2003, 130; Boucé 1987, 88.

1019 See for example Bull 1837, 6–8; Fox 1834, 27; Sperry 1900, 215.

1020 See also Gélis 1991, 56–57. See also Buckley 2017, 197; Mazzoni 2002, 19; Cody 2008, 33. On husbands and injurious cravings in early modern literature, see Read 2017, 136–137. See for example Vincent 1902, 37.

1021 See for example Bull 1837, 17–21; Bull 1865, 15–17; Welch 1838, 7–8; Scott 1870 [?], 35; Walker 1893, 15–16, 40–41; Stacpoole 1894, 22; Vincent 1902, 36–37; Montgomery 1837, 150–152; Tanner 1871, 48. See also The Longings of Pregnant Women. The *BMJ*, November 6, 1897, 1356.

women could even utilise the theory, for example to explain marital adultery and the physical appearance of the child if it did not resemble the assumed father.[1022] More often the theory of maternal impressions caused stress and anxiety in women: many writers acknowledged how pregnant women were terrified of seeing "anything dreadful or unusual", and thus, unwittingly marking their unborn children or harming them otherwise.[1023] Florence Stacpoole, for example, discussed "apprehensions", meaning that occasionally pregnant women were full of "fancies and fears", either because they feared that unpleasant things they saw had been transmitted into the foetus or that they automatically assumed that the foetus had died if they could not feel its movements.[1024]

Many contemporary writers – and also some historians – have pointed out that the need for an explanation usually came only afterwards if the baby was born carrying some distinct marks on its body.[1025] As some medical writers noted, the situation demanded tact and sensitivity on the part of a medical practitioner: "[a]nyone who has witnessed the heart-sickness of a mother when she learns she has given birth to a deformed child, will think twice before he asks her to search her mind for a possible cause of such a misfortune in mere anticipation of its occurrence."[1026] Occasionally doctors' letters revealed that the possibility of maternal impressions was required from women but many times, no single reason was found, and, on the other hand, sometimes the parturient woman herself had expected her child to be physically marked somehow.[1027] In fact, as Jenifer Buckley has stressed, pregnant women had only their own word that their case was maternal impressions.[1028] The descriptions reveal that that the idea was often

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1022 See for example Mother's Mark. The *BMJ*, November 16, 1878, 756; Payne 1878, 97, 100. See also Huet 1993, 22–23, 73, 81–82; on the black skin colour of the child born to a white woman, see Gowing 2003, 133–134; Fissell 2006b, 207–208. See also Walker 1893, 17. See also Schiebinger 2004a, 136.

1023 Walker 1893, 17. See also Bull 1837, 4. See also for example Nicholas, G. E., Are Arrest of Development, Monstrosities, etc., Attributed to Mental Emotions of the Mother? The *Association Medical Journal*, November 11, 1853, 1003–1004.

1024 Stacpoole 1894, 56.

1025 See for example Walker 1893, 18. See the letter of a doctor in the *BMJ*, Richardson, R. Tippets, Arrest of Development in Utero. The *BMJ*, February 6, 1886, 278. The doctor described the child, then asked "Can anybody tell me the cause of this freak of Nature?" See also Maternal Impressions. The *BMJ*, June 6, 1877, 748–749. See also Lee 1875. See also Gélis 1991, 54.

1026 Roberts, C., Maternal Impressions and Congenital Deformities. The *BMJ*, October 10, 1885, 722. See also Black 1888, 19–20; Walker 1893, 137; Swayne 1893, 24. See also Gélis 1991, 58.

1027 See for example Graham, A., A Case of Malformation. The *BMJ*, December 8, 1883, 1125: "The mother, who is a young delicate woman, can remember nothing, such a fright or a dream, to account for this freak of nature". See also Hinton, Joseph, Case of Monstrous Birth. The *BMJ*, February 21, 1863, 191–192; Influence of the Mother on the Foetus. The *BMJ*, August 5, 1865, 131–132; Graham, T. H., Effects of Mental Shock upon the Foetus in the Fifth Month of Pregnancy. The *BMJ*, January 18, 1868, 51; Webb, William, Maternal Impressions and Congenital Deformities. The *BMJ*, November 7, 1885, 900; McMahon, J. T., Congenital Deformities. The *BMJ*, November 14, 1885, 944; Cook, H. D., A Case of Malformation in a Newborn Child. The *BMJ*, June 14, 1890, 1366; Glegg, Wilfred, Case of Anencephalic Foetus. The *BMJ*, April 8, 1899, 850.

1028 Buckley 2017, 69.

fixed in the woman's mind, at least afterwards if the child had some kind of abnormality in its body.[1029] This could be one single account or merely a feeling that the woman "had felt different all along" during pregnancy.[1030] Reputedly and quite understandably, some parents were also very much interested to know "the likelihood of its recurrence in the event of other children being born to them".[1031]

The exact concept or mechanisms of maternal impressions were never defined precisely. For example, the manual of John Harvey (1863) discussed maternal emotions produced "through some unknown sympathetic action" when referring to harelip in a child.[1032] Some historians have noted that the theory "proclaimed the dangerous power of the female imagination", but also the body.[1033] The theory showed how the causes of these mishaps, taken place both in and to a pregnant woman, could manifest themselves far removed from the original locations, to be seen only in a child.[1034] In this sense, the theory certainly questioned the idea that the woman herself knew what was best for her; especially maternal cravings and longings for particular food articles were considered deceptive and fallacious.[1035] Philip K. Wilson has argued that women were shamed and blamed, feeling permanent guilt for their children's physical and mental disabilities. Socially, monster birth could be seen as a visible punishment of moral faults, a personal burden and social embarrassment.[1036] Doctors' letters revealed very little of this side of the phenomenon; they merely traced the origin of the visual marks directly after birth and did not discuss emotional and social aspects of the deformities, which came only after the doctor was no longer in touch with the family. According to Philip K. Wilson, at least some midwives could use deformed children as "a rhetoric device" to warn pregnant women against somehow placing themselves in harm's way by their conduct.[1037] On the other hand, as Roy Porter has pointed out, some eighteenth-century physicians could use the theory as a useful tool to inspire confidence and optimism, a certain kind of positive

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1029 See for example Maternal Impressions Affecting Foetus. The *BMJ*, July 17, 1886, 142. See also a case in which the woman insisted her child was marked even if it was not, "M. D." [anonym.], Maternal Impressions. The *BMJ*, March 29, 1884, 653. See also Bull 1837, 4.

1030 See for example Allison, John, Acephalous Foetus. The *PMJRMS*, December 1842, 225–226; Randall, A., Maternal Impressions and Congenital Deformities. The *BMJ*, October 10, 1885, 722. See also Buckley 2017, 69.

1031 Noble Smith, Heredity and Maternal Impressions in Relation to Congenial Deformities. The *BMJ*, October 3, 1885, 672. The writer suggested that every medical practitioner who was interested in the topic should collect their patients' impressions *before* labour and then compare these stories to the condition of the newborn child. This had been done by the famous eighteenth-century man-midwife William Hunter, but obviously not every member of the nineteenth-century medical profession was aware of this. See for example the reply to the letter, Roberts, C., Maternal Impressions and Congenital Deformities. The *BMJ*, October 10, 1885, 722. See also Bull 1837, 14–15.

1032 Harvey 1863, 8.

1033 Huet 1993, 1. See also Boucé 1987, 93; Fissell 2006b, 64–66.

1034 Duden 1991, 150.

1035 Mazzoni 2002, 15; Buckley 2017, 6, 13. See also for example Walker 1893, 14–16; Stacpoole 1894, 22.

1036 Wilson, P. 2002, 17. See also Huet 1993, 21; Gélis 1991, 14–15, 263–267; Kukla 2005, 19, 70–73; Gowing 2003, 127; Porter & Porter 1988, 167.

1037 Wilson, P. 2002, 9. See also Whitfeld, H., The Hereditary Transmission of Mental and Physical Impressions: How and When Produced. The *BMJ*, June 7, 1862, 601–602.

placebo effect, in their pregnant patients.[1038] Some doctors also defended their patients by declaring that particular women had been "very sensible" or "of cheerful disposition, but not of very excitable and imaginative temperament", and thus not liable to harm their unborn children in any way, not even by their imagination.[1039]

The theory of maternal impressions remained controversial in medical literature and the discourse was extremely contradictory. Lisa Cody and Rebecca Kukla have argued that the theory could help eighteenth-century man-midwives to authorise themselves as the experts, not only on the female body, but also on the female mind, feelings and emotions, and, to justify why women, with their indispensable reproductional mission and being more emotional and fragile than men, belonged to the domestic sphere rather than to that of public action.[1040] This argument is undoubtedly correct, but eighteenth-century man-midwives had not invented the theory nor did they share the same opinion about it. Jacques Gélis has emphasised that doctors resorted to theory when they were otherwise unable to explain "the pathological problems of a birth".[1041] However, Gélis failed to notice that the theory was widespread and culturally very well known; it was not only found in medical discourse, and moreover, women themselves could believe in the theory even when their doctors did not. Furthermore, maternal imagination was never considered the *only* possible cause of foetal deformities and other visible marks seen in the child.[1042]

Interestingly, in popular health literature, conversely to the letters published in the *BMJ*, the theory of maternal impressions was usually found to be old-fashioned. For example, in 1837, Thomas Bull attacked the theory in his popular manual, claiming it to be nonsense.[1043] To Bull, the most typical marks in the child, "an extra toe, or finger, or hare-lip [--] was the creation of nature's will, and not the production of human caprice or fancy".[1044] Some writers acknowledged that a serious shock or long-lasting mental disturbance might have a lasting effect

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1038 Porter 2001, 24. See also Buckley 2017, 195; Bourke 2005, 85–86.

1039 "Butler Lane, M.D.", Mental Influence of the Mother on the Child. The *PMSJ*, March 7, 1849, 124–125.

1040 Cody 2008, 145–151; Kukla 2005, 17–18, 69–73. Compare to Buckley 2017, 93. See also Mazzoni 2002, 17, 35.

1041 Gélis 1991, 54. In fact, Gélis has argued that "[d]octors who told such tales in all seriousness were doing little to disguise their ignorance".

1042 Huet 1993, 6. See also Kukla 2005, 11. See also Buckley 2017, 93. See also Greene, W. T., Congenital Malformations. The *BMJ*, December 14, 1867, 547–548; Ramsay Smith, W., Hereditary Malformation of the Hands and Feet: With Operation on One Subject. The *BMJ*, July 7, 1894, 8–11.

1043 Bull 1837, 3–17. Bull discussed the famous experiments done by William Hunter; Hunter inquired of women in his lying-in hospital whether they had felt some disappointments, longings, or surprises during pregnancy, then examined their newborn children. Hunter did not find any connections between maternal impressions, pregnancies, and possible malformations. See also Walker 1893, 17–18; Kittoe 1845, 160–162. See also Cody 2008, 145–149.

1044 Bull 1837, 14, see also pp. 3–17; Bull 1865, 37–45. Compare to Welch 1838, 7–8: "The causes of the marks upon a child, which are called 'mother's marks' [--] still remain amongst the inscrutable secrets of nature". See also Ryan 1837, 243–244. See also Gibbs, Robert, Maternal Impressions and Congenital Deformities. The *BMJ*, November 28, 1885, 1046.

on the foetus, but the theory was regarded as absurd for the most part.[1045] On some occasions, the discourse, however, was particularly mixed; while Jane H. Walker did not believe in maternal impressions per se, she noticed that everything the mother experienced affected the foetus, nevertheless.[1046] Walker underlined that the life of the "embryo is months long, a gradual process, just as everything else in nature is gradual" – therefore, a single accident could not explain deformities.[1047] Also an anonymous medical author Philothalos believed that many abnormalities in children could be explained by the fact that women had neglected the policy of non-naturals, foremostly exercise during pregnancy. However, he also pointed out that the opinions of the medical profession were "various and conflicting".[1048]

Thus, it is safer to argue that in nineteenth-century medicine, different and often contradictory discourses co-existed concurrently and diversely, and the shift from traditional beliefs to more "scientific" ideas was eventually very slow and uneven. Understanding of heredity and the growing fear of degeneration changed the medical discourse during the nineteenth century, alongside embryology and the findings of Charles Darwin, for example, but how they were interpreted by ordinary practitioners was often complex and contradictory. The influence of "the physique, ages, habits, diseases, and the sanitary and social surroundings of the parents", alongside the traces of family-history, were analysed and discussed when deformities were studied in medicine.[1049] This orientation and the discourse of degeneration became very visible during the second half of the nineteenth century, even if the *BMJ* underlined in 1885 that heredity was ultimately "a tendency, not an unalterable fate".[1050] For example, the corruptive influence of alcohol, called *stimulants*, was often carefully explained in health manuals written for use by women. The moralising discourse was the strongest at the end of the nineteenth century but voices on the risks of alcohol abuse were not

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1045 Walker 1893, 17–18, 21. See also Bull 1865, 34–37; Black 1888, 19–20; Stacpoole 1894, 56. See also Lee 1875.

1046 Walker 1893, 17–19, 21–23. See also Welch 1838, 55; Black 1888, 20; [anonym.] 1900–1909 [?], 191–199.

1047 Walker 1893, 18.

1048 Philothalos 1860, 48, 150. See also Welch 1838, 8. See also Whitfeld, H., The Hereditary Transmission of Mental and Physical Impressions: How and When Produced. The *BMJ*, June 7, 1862, 601–602.

1049 Roberts, C., Maternal Impressions and Congenital Deformities. The *BMJ*, October 10, 1885, 722. See also the subsequent letter, Morgan, John H., Maternal Impressions and Congenial Deformities. The *BMJ*, October 17, 1885, 762: "[--] the subject has been trashed out by Darwin". See also Smith, Noble, Heredity and Maternal Impressions in Relation to Congenital Deformities. The *BMJ*, October 2, 1885, 672–673; The Warnings of Heredity. The *BMJ*, September 26, 1885, 606–607. See also Playfair 1893a, 289–291. See also for example Walker 1893, 21–22; Sperry 1900, 196–217. See also Huet 1993, 103–123. See also Lauder Brunton, T, Twenty-Five Years of Medical Progress. The *BMJ*, August 1, 1891, 229–230. See also Wilson, P. 2002, 16–17, on teratology, see pp. 11, 13. On Darwinism and degeneration, see Berry Haycraft, John, The Milroy Lectures on Darwinism and Race Progress. The *BMJ*, February 17, 1894, 348–350; February 24, 1894, 402–404. See also Duden 1991, 151–153.

1050 The Warnings of Heredity. The *BMJ*, September 26, 1885, 607. See also Are We Degenerating? The *BMJ*, August 18, 1894, 373–374.

silenced in the 1840s and 1850s either.[1051] Alcohol was commonly used for medical purposes but its use was controlled by the practitioner.[1052] Generally, it was thought that pregnancy and alcoholic beverages were not compatible with each other. According to Gordon Stables, for example, the use of stimulants led to "wholesome ruin, crime, and disease", and a newborn born to an alcoholic mother was already "a drunkard" and potentially imbecilic.[1053]

Eugenics and the fear of degeneration became an increasingly important topic at the end of the nineteenth century. As Jane H. Walker wrote in 1893, "[t]hose who through any recklessness or wantonness on the part of father and mother are born with a tendency to consumption, epilepsy, insanity, strumous ailments, &c., [--] have a right to ask bitterly why they were brought into the world at all."[1054] This kind of discourse legitimised doctors' authority to decide on people's right to marry and to have children – at least in the minds of the doctors themselves.[1055] Interestingly, at the end of the nineteenth century, the theory of maternal impressions also worked the other way around. In the feminist-eugenics discourse, the theory was marketed as the mother's ability of making "better babies". If the woman was to improve her intellect and abilities, she could produce a healthier and mentally more capable future generation of children.[1056] For example, in 1871, the medical authority Thomas Hawkes Tanner noted that "all great men" had had mothers "remarkable for their mental endowments and activity".[1057] Indeed, in 1894, the *BMJ* noted with content that girls were currently taking much more exercise than their mothers had done and, hence, the future health of the nation was not necessary gloomy.[1058] This idea reinforced the image

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1051 Gordon Stables was the most outspoken in this sense; he warned quite graphically how narcotics and alcohol ruined the physical health and morality of a woman. Stables 1894, 93–107. See also Fox 1834, 21; Philothalos 1860, 22–25. See the example in medical periodicals, Edis, Arthur W., Severe Vomiting in Pregnancy, Due to Alcoholism: With Remarks. The *BMJ*, October 10, 1885, 697–698; The Increase of Female Inebriety and Its Remedy. The *BMJ*, October 1, 1892, 751–752; Female Inebriety. The *BMJ*, October 8, 1892, 804–805; Ballantyne, J. W., The Problem of the Premature Infant. The *BMJ*, May 17, 1198–1199. See also Fox 1834, 20–21. See also Wohl 1984, 59–61.

1052 See for example Philothalos 1860, 25; Chavasse & An American Medical Writer 1871, 119–121; *Doctor at Home* 1891, 757–760; Allbutt 1890, 9–10. See also Eastwood, J. W., The Use of Alcohol in Health and in Disease. The *BMJ*, September 7, 1872, 266–268.

1053 Stables 1894, 99, 107. On women's secret drinking, see Bonea & al. 2019, 119–148.

1054 See for example Walker 1893, 21–22; Sperry 1900, 37–43. See also Stables 1894, 89: "I shall say nothing about the positive sin against the offspring of such a career [spending evenings in stuffy hot rooms], but it would be less cruel to weaklings born of parents, such as these, if they were smothered in their cradles".

1055 See for example Walker 1893, 21–22; Kittoe 1845, 11; Bull 1865, 8; Stables 1894, 123, 125–127; Stacpoole 1894, 21. See also Marriages by the Microscope. The *BMJ*, May 10, 1879, 712; Is It Proper for Consumptives to Marry? The *BMJ*, February 4, 1871, 123–124; "A Perplexed Member" [anonym.], Marriage: Idiocy. The *BMJ*, October 29, 1881, 730; Marriage and Amenorrhea. The *BMJ*, November 26, 1898, 1663. See also for example Chavasse 1872, 65; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 154–156. See also Brown 1866, 75. See also Beier 2008, 147–148, 165; Jalland 1986, 84–87.

1056 Robb 1997, 62–63. See also Gélis 1991, 55. See also Kukla 2005, 70–73; Marland 2013, 12–13; Bourke 2005, 86. See for example Sperry 1900, 210–215.

1057 Tanner 1871, 50. See also Payne 1878, 92–93; Allbutt 1890, 29–30.

1058 Are We Degenerating? The *BMJ*, August 18, 1894, 374. Compare to Philothalos 1860, 48.

of women as the keepers of the future of the British Empire and healthiness of its subjects.

All in all, the concept of maternal impressions encouraged women to self-control and responsibility, good behaviour, healthy habits of life, and the general idea of prevention, creating an ideological construction very suitable also for medical practitioners.[1059] Even if many writers of popular manuals did not directly believe in the controversial theory of maternal impressions, nearly all writers noted that a mother's "state of mental depression", and "moral feelings and affections" affected the foetus, nevertheless.[1060] That is why manuals advised their readers and their circles to pay extra attention to the steady and preferably happy state of mind during the pregnancy months; both the pregnant woman and her child suffered from constant antenatal stress and anxiety.[1061] Some writers even stressed that there was "a need for kindness", and it was especially the husband's duty to provide a worry-free atmosphere at home.[1062] John Tricker Conquest summed up the prenatal policy in 1849: "[s]urely it is unnecessary [--] to point out the necessity which exists for the pregnant female carefully to keep watch over herself, to check the wayward fancies common to this period, and to subdue, on their first rising, ill-regulated desires. Calmly and considerately, cheerfully and equably".[1063] The happiness of the expectant mother was indeed a matter of great importance in nineteenth-century obstetrical medicine.

The conduct and self-control of the expectant woman was also at the very centre of the prevention of miscarriage. In popular medical manuals, miscarriage, or *mishap* or *abortion*, was presented as a constant and potential threat of every pregnancy, likely to take place if the mother-to-be and her circle were not careful enough.[1064] As Barbara Duden has noted, the discussion concerning miscarriage

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1059 Hanson 2004, 28–29. See also Buckley 2017, 202; Mazzoni 2002, 35, 65; Gélis 1991, 83–84. See also Lupton 1999, 62–63. In early modern England, see Gowing 2003, 127, 131. See the discourse of "moral discipline" in Tanner 1871, 49–51; Kittoe 1845, 162–163; Conquest 1849, 11; Davies 1852, 11; Bull 1865, 4; Stacpoole 1894, 16–17; Stables 1894, 84–90, 175. See also Warren 1865, 31; Walker 1893, 16–17, 22–23. See also Whitfeld, H., The Hereditary Transmission of Mental and Physical Impressions: How and When Produced. The *BMJ*, June 7, 1862, 601–602.

1060 See for example Bree, C. R., Case of Puerperal Convulsions Occurring at the Eight Month of Uterine Gestation, Successfully Treated by the Induction of Premature Labour. *PMSJ*, May 1, 1844, 60–61: "I have seen the same symptoms [fits] induced by strong mental emotions. *They always indicate great danger*, and must be met promptly." See also for example Black 1888, 20; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 176.

1061 See for example Harvey 1863, 7; Welch 1838, 4; Kittoe 1845, 26; Stables 1894, 204. See the example of antenatal stress and sorrow, Priestley, W. O., On the Occasional Latency and Insidiousness of Grave Symptoms in Connection with the Puerperal State. The *BMJ*, August 22, 1885, 337–339. This discourse was not particularly new, as Laura Gowing has shown, see Gowing 2003, 127.

1062 Garraway, Robert, Maternal Impressions. The *BMJ*, January 30, 1886, 237: "For my part, I consider a woman's surroundings during the period of gestation by no means a matter of indifference; and no careful husband would so regard it". See also Walker 1893, 35; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 192.

1063 Conquest 1849, 12. See also Stables 1894, 175, 221.

1064 On these terms, see Stacpoole 1894, 58. See also Priestley, W. O., The Lumleian Lectures on the Pathology of Intra-Uterine Death. The *BMJ*, March 26, 1887, 660–669;

revealed the idea that hidden in women "were death *and* life".[1065] Like the advice concerning pregnancy and general antenatal precepts, the discourse of miscarriage in health manuals was based on the idea of prevention: if the woman was not cautious enough and did not follow the hygienic preventive rules, she could easily lose her unborn child.

Terminologically, the critical line was in the seventh pregnancy month; before that, a spontaneous termination was called a *miscarriage* or *abortion*; after the end of the sixth month, a *premature labour* or *premature confinement*.[1066] Concerning the foetus, the line between miscarriage and premature labour was critical, marking "the period before which the child has little chance of being born alive, whereas after this date it may with care be reared."[1067] Traditionally, it was believed that a seven-month old child could survive whereas an eight-month could not; however, nineteenth-century doctors systematically emphasised that this was not true.[1068] Medical writers stressed that while the foetus was alive from the moment of conception, it could not survive without the mother's body until the very last pregnancy months.[1069] There were only a few rare exceptions found in the medical journals; for example, in 1842 *The Lancet* reported the case of a premature child, first believed to die soon after its birth in the sixth pregnancy month. A baby girl was born without its fingernails, its skin "florid and thin", and a "thick, dark down" covering the head instead of hair.[1070] The child was unable to suck and it was nursed first with a quill and then by teaspoon. This medical marvel, greatly occupying doctors' minds, survived the first critical months but died after being "seized with measles" at the age of five months.[1071]

It was generally believed that miscarriage was very common; it was estimated that one or two out of every ten pregnancies terminated before its time.[1072] Usually miscarrying took place in early pregnancy, between the eighth and

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April 2, 1887, 714–718; April 9, 1887, 768–772; April 16, 1887, 811–819. See also Jalland 1986, 160–170. See also Gélis 1991, 216–221.

1065 Duden 1991, 162.

1066 See terms explained in Hills 1841, 5; Davies 1852, 23; Chavasse 1866, 101; Scott 1870 [?], 40; Allbutt 1890, 16; Walker 1893, 72, 82–83; Stables 1894, 207; Stacpoole 1894, 58–59. See also Tanner 1860, 211; Playfair 1893a, 293. See also Hooper 1860, 10–11. See also for example Horrocks, Peter, A Discussion on Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 943–946. See also Gélis 1991, 222–225.

1067 Surgeon & Accoucheur [anonym.] 1900–1909 [?], 206–207.

1068 See for example Tanner 1860, 217; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 207–210. On traditional beliefs, see for example Gowing 2003, 112; Fissell 2006b, 152; Gélis 1991, 64–65; Kueny 2019, 68.

1069 See for example Stacpoole 1894, 58–59; Stables 1894, 206. See especially Playfair 1893a, 294. See also for example Ballantyne, J. W., The Problem of the Premature Infant. The *BMJ*, May 17, 1902, 1196–1200; Shepherd, Thomas W., Survival of a Premature Child Weighing Less than Two Pounds. The *BMJ*, May 24, 1902, 1264.

1070 Tait, W., Birth of a Living Child on the 179th Day. *The Lancet*, April 23, 1842, 119–120. The writer paid considerable attention to explaining that the parents of the child were respectable in every respect and that the impregnation had taken place "on the morning after the wedding". The child was first weighed forty days after birth; the measurements were 3 pounds and 13 inches.

1071 Ibid.

1072 See for example Playfair 1893a, 293. See also Walker 1893, 72–73. See also Lewis 1986, 142–143; Loudon 1992, 108.

twelfth week.[1073] As writers noted, sometimes there was no single reason to explain it, but sometimes some distinct diseases such as smallpox or malaria, or problems with the placenta could cause miscarriage, sometimes also something that the mother had done, such as "over exertion", dancing, running, jumping, lifting heavy weights, excessive exercise or sex, falls, blows, great pain, too light a diet, careless or excessive use of purgative medicine, stimulants, or the practice of tightlacing.[1074] Strong emotions, such as shock, fright, joy, excitement, anger, long-lasting sorrow or sudden grief, as I have already illustrated in this chapter, were particularly dangerous during pregnancy months.[1075] All pregnant women were potentially susceptible to miscarriage, but upper-class women who lived "in gaiety and luxury" were in the greatest danger; according to the nineteenth-century medical discourse, their bodies were weak, constitutions delicate, and their luxurious feather beds and over-heated rooms potentially risky.[1076] Moreover, modern life and the many novelties of the industrial age could threaten the natural process of reproduction, such as railway journeys. For example, in 1840 *The Lancet* reported the case in which a woman had gone to a visit her friends, became ill and eventually suffered miscarriage, caused either by "having eaten too heartily of some rich and unusual food" or "travelling by railways for the first time".[1077] Indeed, no woman could be too cautious.

Generally, all writers acknowledged that the treatment of abortion was more difficult than its prevention. For example, Thomas Bull wrote how the medical man could do "little to arrest a miscarriage" when the process was "once set up".[1078] Popular health manuals advised their readers to send for a doctor but it was not explained what the practitioner actually did when he arrived. Nevertheless, treatment of miscarriage and the time following was very crucial for the future health and happiness of women. Generally, doctors recommended absolute rest and keeping the mind "perfectly tranquil and easy"; a change of scenery was

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1073 Hills 1841, 6; Walker 1893, 72. Compare to Playfair 1893a, 295.

1074 Bull 1837, 102–106; Welch 1838, 55; Hills 1841, 6; Kittoe 1845, 152, 166–167; Davies 1852, 24–26; Bakewell 1859, 109; Harvey 1863, 50–52; Chavasse 1866, 102–103; Weatherly 1882, 57–58; Black 1888, 38–39; *Doctor at Home* 1891, 538–539; Drew 1891, 32–33; Walker 1893, 73–78; Stacpoole 1894, 59–60; Stables 1894, 208–209; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 212–213. See also Tanner 1860, 221–227; Playfair 1893a, 298.

1075 See for example Welch 1838, 55; Bull 1837, 101, 104–105; Harvey 1863, 52; Tanner 1871, 50; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 215. See also Buckley 2017, 66–67. See on strong emotions and childbirth, Bree, C. R., Case of Puerperal Convulsions Occurring at the Eight Month of Uterine Gestation, Successfully Treated by the Induction of Premature Labour. The *PMSJ*, May 1, 1844, 60–61. See also Kittoe 1845, 252–260; Stables 1894, 204. See also Playfair 1893a, 299.

1076 See for example Harvey 1863, 50. See also Bull 1837, 105; Stables 1894, 89–90. See also for example Bayes, William, On Female Sterility, with Some Practical Suggestions for Its Removal. The *Association Medical Journal*, September 23, 326–328. As a result of luxury, upper-class women also matured earlier, see also Playfair 1893a, 70–71.

1077 Ray, Charles, Retained Placenta after Premature Labour. *The Lancet*, December 12, 1840, 406. See also Rankin, D. R., Railway Travelling and Abortion. *The Lancet*, June 1, 1844, 325. See also Chavasse & An American Medical Writer 1871, 214; Black 1888, 38; Walker 1893, 76; Stacpoole 1894, 59–60; Stables 1894, 209. On the dangers of railway travelling, see for example Bonea & al. 2019, 16–17.

1078 Bull 1837, 99. On the management of miscarriage, see for example Swayne 1893, 110–111.

often necessary.[1079] Woman were treated with cold water and vinegar and by keeping the room light and airy; coolness and cold were associated with health and bodily balance.[1080] Medical writers stressed that generally the risks of miscarriage were taken too lightly and women themselves paid too little attention to their bodies and minds, forgetting the indispensable idea of prevention. This clearly was a reference to induced abortion, the inevitable other side of the discussion concerning miscarriages and their prevention. In fact, when doctors were discussing prevention of miscarriage, they feared that their advice could be taken as hints on procuring *criminal abortion*, as an intentional termination was commonly called in nineteenth-century medicine. Therefore, it is not a surprise that the medical profession underlined the criminality of the procedure when the topic came up in their manuals.[1081]

According to the nineteenth-century medical discourse, miscarriage was often "prone to occur again", creating *a habit of miscarriage*, sometimes destroying the future health of the woman and leaving her permanently without living offspring.[1082] Moreover, medical writers noted that while miscarriage was a considerable medical risk, emotionally it was always devastating, a great disappointment, which reputedly destroyed happiness in marriage.[1083] As Henry Thomas Scott described the subject in the 1870s, barrenness caused "domestic infidelity"; it was a source of anxiety, annoyance, distress, and worry.[1084] However, in reality, not every woman was hoping to get pregnant, and for some, pregnancy was indeed an unwanted catastrophe and a source of continual dread and fear, as I discuss in the next subchapter.

1079 Hills 1841, 7. See also Bull 1837, 107–125; Welch 1838, 39–40, 60; Kittoe 1845, 154; Black 1888, 39–45; *Doctor at Home* 1891, 539–541; Stables 1894, 210; Stacpoole 1894, 61–65; Vincent 1902, 38–39. See also Treatment of Abortion. The *BMJ*, June 23, 1894, 1367. See also Playfair 1893a, 302–306. See also Lewis 1986, 144–149.

1080 See for example Hills 1841, 7; Welch 1838, 39–40; Harvey 1863, 55–56; Black 1888, 40–41; Walker 1893, 80–82; Stables 1894, 210.

1081 See for example Black 1888, 36–44; Walker 1893, 78–79. This topic is discussed more closely in the next subchapter, see Chapter 4.4.

1082 See for example Hills 1841, 5; Bull 1837, 98–99, 104–105; Welch 1838, 58; Kittoe 1845, 152; Bakewell 1859, 109; Black 1888, 37; Walker 1893, 75–76. On women having continual miscarriages, see Jalland 1986, 164–165. See also One-Child Sterility. The *BMJ*, May 26, 1888, 1128.

1083 See for example Davies 1852, 23–24; Bakewell 1859, 18; Bull 1865, 120. See also Jalland 1986, 160–168.

1084 Scott 1870 [?], 31. See also for example Davies 1852, 23; Chavasse 1872, 43–44. See also Edis, Arthur W., On sterility. The *BMJ*, June 24, 1882, 935–937; Matthews Duncan, J., The Gulstonian Lectures on Sterility of Women. The *BMJ*, February 24, 1883, 343–345; March 3, 1883, 393–395; March 1, 1883, 443–445; March 17, 1883, 497–500; March 24, 550–552; March 31, 1883, 604–606; April 13, 1883, 701–708; April 21, 1883, 753–755; Croom, J. Halliday, Introduction to a Discussion on Obstructive Dysmenorrhoea and Sterility. The *BMJ*, October 20, 1888, 870–872; Madden, Thomas More, On the Treatment of Sterility in Women. The *BMJ*, April 21, 1888, 844–846. Thomas Hawkes Tanner estimated in 1860 that one marriage in every ten was childless, and the portion of children born out of wedlock was "more than six per cent". Tanner 1860, 13, 15. See also Lewis 1986, 76–77; Pfeffer 1993, 1–46.

4.4 "Removing the Obstructions": Unwanted Pregnancies

Women's position in past societies has often gone hand in hand with the right to decide over their own bodies – whether the woman has had the right to choose *when* and *if* she wants to have children and whether there has been a legal and safe way for her to either prevent possible pregnancy or to terminate it. The number of children has never been a private matter, nor has it ever been, in fact, a matter of choice. This has been a question of class, time, and place, but in many cultures it has often been the woman's duty and special service to give birth to an heir to her husband and family, preferably a male one.[1085] Moreover, children have often come in rapid succession; both a woman's physical and mental health could be jeopardised if procreation continued without any breaks and the timing of the new pregnancy was wrong. However, generally in nineteenth-century health manuals motherhood was presented as the main goal and a lot for all women – at least if the woman was not somehow physically deformed or suffered from tuberculosis, or traces of mental illnesses.[1086] Female life without marriage and children was described as gloomy and incomplete in every way. A husband was *a man* and a rescuer, as for example Gordon Stables illustrated the ideal to his female readers: "[i]t must be something in the shape of a man [- -] he may have no great amount of good looks, nor height of body, nor depth of mind; still he is a man, and he will save her from shipwreck", that is to say – "the [--] darkness of old-maidenhood".[1087] A husband provided livelihood, home, and children, but marriage was also good for health in many ways.[1088] Celibacy was potentially dangerous, but so was excessive sex.[1089]

Even if nineteenth-century medical men acknowledged that giving birth could be highly risky for some individual women and that certain members and groups of society were not suitable for nor capable of procreation, the majority of doctors did not provide practical advice – at least publicly – concerning contraception, meaning the intentional prevention of conception and the employment of preventives. Contraception was believed to permanently damage fertility and health and encouraged selfishness, sexual immorality, pleasure-seeking, and

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1085 See also McLaren 1978, 71; Jalland 1986, 139–140; Lewis 1986, 60–62.

1086 See for example aristocratic British women and their reproductive duty in Lewis 1986, 60–62.

1087 Stables, 1894, 46. See also Bakewell 1859, 18. On unmarried women and social shame, see Gélis 1991, 19; Lewis 1984, 3; on spinsters in nineteenth-century Britain, see Jalland 1986, 253–289.

1088 See for example Bakewell 1859, 59. See also Ganev 2007, 43–46. See also Mitchinson 1991, 60–62; Gélis 1991, 15–22; Hall 2000b, 269–270.

1089 See for example Kittoe 1845, 48, 116; Bakewell 1859, 19, 30; Allbutt 1890, 58–59; Ryan 1831; Ryan 1836, 225; Ryan 1837, 46; Ryan 1841, 91; Chavasse & An American Medical Writer 1871, 65; Sperry 1900, 108–111, 113–120. See also McLaren 1990, 48–49; Mason 1995, 217–218; Porter & Porter 1988, 51; Smith 1980, 193–195; Crawford 1994, 85–89; Mitchinson 1991, 61–62, 105.

promiscuity in society.[1090] As the historian Kate Fisher has noticed, ignorance often implied "moral purity, innocence and respectability".[1091] Moreover, contraception was closely associated with abortions and infanticides, being somewhat a taboo in nineteenth-century medicine. The court case against the author of *The Wife's Handbook*, the radical neo-Malthusian doctor Henry Arthur Allbutt, in 1887, demonstrated that popular medical writings were supervised by the authorities and that writing about contraceptives could damage the professional career of an individual physician.[1092] Allbutt, who eventually lost his license to practice medicine because of his writings, was indeed one of the few writers who advised his readers on the use of preventives. He provided practical hints for both men and women, discussing vaginal douches and injections, pessaries, and condoms.[1093] As Allbutt himself noted, ignorance was no answer when it came to sex and the possibility of conception: "[a]ll is left to blind chance or to abstinence from sexual connection".[1094] Thus, it was far wiser to *prevent* conception than resort to illegal and dangerous methods only afterwards.

Postponing the marriage and sexual abstinence could be used so as to limit the number of children; however, *coitus interruptus,* withdrawal, or "avoidance of climax" was not recommended by the nineteenth century medical profession.[1095] Some kind of rhythm method and calculating safe days was also discussed but the greatest problem was the unreliability of the timing of the safe

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1090 Pfeffer 1993, 9–10, 16; Brookes 1988, 11; Mason 1995, 184–185. According to Robert Jütte, the word "contraception" is not a nineteenth-century term, arguing that it was first used by the German sexologist Max Marcuse in 1919. Kate Fisher, on the other hand, has noted that the origin of the term was in 1860s America. Jütte 2008, 2–3; Fisher 2011, 49. Henry Arthur Allbutt, for example, discussed "preventing conception", or "limiting the family" in his manual. See also Ryan 1841, 105. See also Steele Perkins, Geo., The Traffic of Abortifacients. The *BMJ*, February 25, 1899, 506.

1091 Fisher 2011, 27, see also pp. 37–48.

1092 See for example H. A. Allbutt v. the General Council. The BMJ, July 13, 1889, 88. See also Batrip 1990, 168–169. The German historian Robert Jütte has noted that the topics contraception and abortion were removed from the midwifery manuals during the eighteenth century. According to Angus McLaren, the first book published in England on birth control was Richard Carlile's *Every Woman's Book: or What is Love* (1826). However, Carlile was a reformist and publisher, not a doctor. Lynda Nead has argued that George Drysdale was the first physician to defend publicly contraception in his book *Physical, Sexual and Natural Religion* (1855). Jütte 2008, 75; McLaren 1990, 183; Nead 1988, 20. See also Cook 2004b, 53–54. On the case of Allbutt, see also Himes 1970, 251–256; McLaren 1978, 132–133; Hall 2000a, 43.

1093 Allbutt 1890, 47–51. The other writer giving hints on contraception was Lyman Beecher Sperry in his manual *Confidential Talks with Husband and Wife* (1900), see pp. 139–165. Interestingly, Henry Arthur Allbutt discussed also traditional beliefs he did not share, for example that sneezing or coughing directly after intercourse could prevent conception. See also Jütte 2008, 43; Branca 1975, 129–138; McLaren 1990, 58.

1094 Allbutt 1890, 47–51. In the nineteenth century, during the interwar period and afterwards, the situation was already very different: as Kate Fisher has noted, sex and marriage manuals became best-sellers in Britain. Fisher 2011, 5. See also Cook 2004b, 341–346.

1095 See for example Sperry 1900, 146–149. On the history of contraception, see McLaren 1990, 23, 25–26, 185–186, 188–189; Jütte 2008, 144–156; McLaren 1978, 119–120; Riddle 1997, 10–30; Beier 2008, 258–261. On withdrawal, see Cook 2004b, 42–53. On abstinence in the nineteenth and twentieth centuries, see Szreter 1996, 367–439. See also Fisher 2011, 87, 112–113; Weeks 1989, 44–48.

period in a woman's menstruation cycle.[1096] Usually doctors advised their readers that the safest period was in the middle of the menstrual cycle; the endocrine system and hormones involved in reproduction were not known in the nineteenth century.[1097] However, pessaries, plugs, sponges, douches, and potions had a long history; their use was primarily a woman's business, indicating that women have been taking control of their reproductive bodies and actively seeking effective contraceptives.[1098] Interestingly, for example Henry Arthur Allbutt noted that the woman could use the pessary without knowledge of "the husband".[1099] All these methods, obviously, required at least some knowledge and skills. The condom, on the other hand, was a product of the early modern period, but its main function was to protect its user, the male, from venereal diseases.[1100]

Otherwise, the topic of contraception was largely missing from popular health manuals, with only two notable exceptions.[1101] Firstly, doctors paid a considerable amount of attention to reminding female readers that prolonged breastfeeding, despite the common belief, was not an effective and safe method of limiting the family. As Angus McLaren, a Canadian historian of sexuality, has noted, breastfeeding as a contraceptive method has a long history. McLaren has argued that especially members of the female elite often considered breastfeeding unpleasant and unsuitable for their status, and thus, they chose not to nurse their own children.[1102] This idea of avoiding nursing was strongly attacked by the

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1096 For example, Henry Arthur Allbutt mentioned at the very beginning of his manual that no woman "[--] under forty-five years of age can consider herself *safe*. She may at any time conceive." Allbutt 1890, 5. See also Drew 1891, 7. Usually doctors believed that the safe time was in the middle of the menstrual cycle. See also for example Bull 1837, 126; Kittoe 1845, 140; Davies 1852, 8; Harvey 1863, 25–26; Stables 1894, 167; Sperry 1900, 155–157; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 180. Compare to Montgomery 1837, 256; Conquest 1849, 18–19. See also McLaren 1990, 187.

1097 See for example O'Dowd & Philipp 2011, 33–35, 255–275.

1098 For example, the Greeks knew many recipes for potions believed to have contraceptive effects. For example, leaves or barks of hawthorn, ivy, willow, and poplar were used, as well as juniper berries, cedar gum, alum, copper sulphate, and honey and peppermint. The Greeks also believed in protective amulets and talismans, also used in the Middle Ages. McLaren 1990, 26–28, 157. See also McLaren 1978, 120–125. See also Szreter 1996, 399, 420–421; Mason 1995, 58–59; Jütte 2008, 42–49; Riddle 1997, 234–235. See birth control and men in Hall 1991, 91–99. On consumer markets and contraception, see Jones 2015, 734–756. See the example of vaginal injections, Acworth Angus, J. Retention of Broken Glass in the Vagina for Seven Months. The *BMJ*, November 28, 1885, 1016.

1099 Allbutt 1890, 50. These nineteenth-century condoms were not particularly practical; a condom, a *letter* or a *sheath* was reusable, made of rubber; a skin version needed to be soaked in water before use. The manual of Henry Arthur Allbutt described also a device (a condom-pessary) that could be used by both a man and woman. See also McLaren 1990, 167; McLaren 1978, 227.

1100 See for example McLaren 1990, 157–158, 183–184; McLaren 1984, 82–85; Cook 2004b, 137–139; Jütte 2008, 45, 96–105, 152; Lane 2001, 36–38. On the growth of birth control products, including condoms, see Jones 2015, 734–756. See also Sperry 1900, 153–155.

1101 This was indeed also in the case of medical periodicals; contraception is notably absent from the *BMJ*. See also Bartrip 1990, 169–170.

1102 McLaren 1990, 18, 26, 117, 162–163. As McLaren has noted, breastfeeding was often prolonged from eighteen to twenty-four months, and thus, the practice postponed a subsequent pregnancy on average by "about eleven months". On breastfeeding and contraception, see also McLaren 1984, 66–70, 124; Jütte 2008, 65; Fildes 1986, 107–108, 121. See also Kittoe 1845, 122.

nineteenth-century medical profession, who constantly stressed the importance of breastfeeding. The historian Wendy Mitchinson, on the other hand, has claimed that in nineteenth-century Canada, nursing was considered "a natural phenomenon and part of nature's way of providing food for the child", and thus it was favoured by the medical profession as a "natural" method of birth control.[1103] In Britain, this certainly was not the case; practically almost all authors of popular medical manuals noted that prolonged breastfeeding was not a particularly effective nor healthy method of limiting the number of children. Doctors noticed it was very unreliable and potentially dangerous; both the mother and her child suffered physically and mentally if nursing was prolonged *unnaturally*, that is to say, beyond nine months. It was acknowledged that the practice was common especially amongst the poor but quite unanimously the medical profession considered it harmful. If a new pregnancy was established while still breastfeeding, the mother should wean her child. Otherwise, all parties would suffer, including the foetus.[1104]

Another topic often mentioned in guidebooks was abortion, here meaning an intentional termination of pregnancy procured by the pregnant woman herself or by another party. As the historian Barbara Brookes has argued, society's attitudes to abortion and its (ille)legitimacy reveal anxieties over family, sexuality, secularism, the birth rate, and gender roles and rights.[1105] Doctors, being the experts on reproduction and the female body, were in the key position when unintentional miscarriage and abortion were discussed and defined; in fact, some historians have suggested that the growing hostility towards abortion was the result of the new role men had gained also in midwifery and the assumption "of their right to interfere in women's childbearing".[1106] In any case, the question of reproduction was approached from the more scientific point of view; since the eighteenth century, anatomical pictures depicted foetuses in detail, making them human-like, almost like newborn babies.[1107] New technologies and policies in medicine, including the general discussion on medical ethics, allowed closer physical examinations while the definitions in law became constantly more precise, determining gender roles and the rights of the foetus in respect of the pregnant woman and her body. Indeed, it can be argued that the law and the medical profession eventually protected the *male's* right to have children rather than the

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1103 Mitchinson 1991, 150. See also McLaren 1978, 125; Cook 2004b, 36; Lane 2001, 36; Hall 1991, 93–94. See also Duration of Lactation. The *BMJ*, February 12, 1898, 474.

1104 See for example Bull 1837, 30–32; Welch 1838, 84; Davies 1852, 3; Harvey 1863, 26; Scott 1870 [?], 74; Allbutt 1890, 27–28; Walker 1893, 122–125; Allbutt 1897, 85–86; Vincent 1902, 78–79. Compare to Harvey 1863, 26. See also Tanner 1871, 60. See also McLaren 1990, 188. However, unlike McLaren has argued, extended nursing was not attacked only by "some birth controllers", but also in almost all the popular manuals published by medical writers and intended for use by women. See also Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 944–946. See also Duration of Lactation. The *BMJ*, February 12, 1898, 474–475. See also McLaren 1990, 56.

1105 Brookes 1988, 1. See also McLaren 1978, 12; McLaren 1984, 109–110; Jones 2011, 200; Kilday 2013, 78–90.

1106 Keown 1988, 22. See also McLaren 1990, 158–159, 195; Brookes 1988, 24–25; McLaren 1978, 117; Riddle 1997, 224–225.

1107 On depicting foetuses, see for example Gélis 1991, 50. See also Gowing 2003, 122–127.

rights of women concerning their own bodies and lives.[1108] The abortion question also raised constant worry over population, both its *quantity* and *quality*, economy, morality, and the future of the whole nation.[1109] In addition, Christian tradition and teachings, especially of the Catholic Church with its highly negative stance on contraception and abortion, have had a long-lasting effect on the question.[1110]

In nineteenth-century Britain, abortion was strictly forbidden in law. As the President of the *Obstetrical Society of London* noted in 1901, the prevention of criminal abortion was indeed ultimately "in the hands of the State".[1111] The first stricture against the prohibition of abortion was revised by the 1803 *Lord Ellenborough's Act*.[1112] The act was an attempt to notice abortion as a widespread social problem and to punish abortion also *before* quickening; this was a notion against the popular belief that termination before the first movements of the foetus was not the destruction of a living human being. Historically, quickening had been an important line marking the point when the foetus was "animated", being provably alive.[1113] The abortion law was strengthened in 1828 and 1837 respectively; first, the use of instruments "or other means whatsoever" was prohibited, and in 1837, the traditional quickening distinction was dropped and the word disappeared from the law. Some historians have argued that this new understanding underrated the woman's experience of foetal movements as a reliable and important point of development, but, as the primary sources of my study clearly show, in the nineteenth-century popular health manuals, quickening was still represented as a very important and confirming sign of established pregnancy.[1114] The 1861 *Offences Against the Person Act* finalised the trajectory; after

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1108 See Riddle 1997, 70; Keown 1988, 22–24, 38. On foetal images in early modern Europe, see Gélis 1991, 50–51.

1109 Especially the neo-Malthusian movement was influential in modernising and urbanising Europe, discussing the social impact on fertility. The movement was based on the ideas of Thomas Malthus, an English cleric and economist, who personally opposed contraception, but who also noted, as Angus McLaren has pointed out, that poverty was a problem "caused by the poor which they would have to solve themselves". The growth of population was indeed bad; one answer to this social problem was birth control. Neo-Malthusian activists published their own propaganda, including manuals, causing also worry and moral resentment amongst doctors. See McLaren 1990, 181–183; McLaren 1978, 43–58; Jütte 2008, 106–144. On birth control and eugenics, see McLaren 1978, 141–154. See also Mason 1995, 258–283; Jones 2011, 199.

1110 See for example McLaren 1990, 190; McLaren 1984, 58–62, 115–120; Brookes 1988, 7, 26; Fisher 2011, 150–156; Riddle 2008, 126–127, 157–159.

1111 Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 946.

1112 Some nineteenth-century writers explained the content of the law in their popular manuals, see for example Kittoe 1845, 159; Allbutt 1890, 46–47. See the situation before the 1803 *Lord Ellenborough's Act,* in Keown 1988, 3–12; Riddle 1997, 128–131. See also Ryan 1836, 243–243. See also Percival 1803, 78–80.

1113 Many nineteenth-century medical writers stressed specifically that quickening made no moral difference, see for example Chavasse 1866, 50–51. See also Chapter 4.1. See also historical definitions of foetal vitality in McLaren 1990, 82–84, 160; McLaren 1984, 109–110, 138–139; McLaren 1978, 31; Riddle 1997, 3, 29, 32, 77–81, 94–100, 222–224; Keown 1988, 3–4.

1114 Riddle 1997, 4; 206–211; Keown 1988; McLaren 1984, 140–142. Angus McLaren has noted that quickening gave the patient some power, when she was determining the

the act was enacted, abortion law was the strictest in Europe.[1115] Since 1861, attempted abortion was punishable whether the woman was pregnant or not. However, even if abortion was a criminal and clandestine act, it did not prevent women from seeking it – far from it.

All accounts clearly show that abortion was an extremely difficult issue for the nineteenth-century medical profession. For doctors especially, termination was both a professional question and a matter of deeply personal conviction and moral stance. For many writers, pregnancy was the natural consequence of sex and therefore any willful effort to destroy the foetus was a crime against the natural order of life as well as being a direct act against God's and human laws.[1116] As Lyman Beecher Sperry wrote in his manual in 1900: "[t]he natural consequence of marriage is sexual congress, conception and the development of children".[1117] Doctors represented marriage as natural and themselves as marriage and family counsellors and confessors, as Angus McLaren has argued and which popular health manuals I have studied also demonstrated.[1118] Doctors believed that an ideal marriage was based on the desire to have children and raise them up, healthy children being a sign of God's or Nature's blessing; thus, enjoying sexual pleasures without bearing children was highly suspicious, selfish, and potentially immoral.[1119] On the other hand, the general idea of reproduction did not mean a rejection of marital intimacy and happiness, as Hera Cook has noted; according to Cook, the successful manuals presented sexual activity as "pure, clean, and a physical source of love between a man and a woman"[1120]. In fact, some writers like Sperry wrote beautifully about sex and the mysterious connection between the married partners:

> the act should be entirely free from shame, fear, pain or discomfort for either party [--] [sex] increases the love and regard of husband and wife to each other, gives new zest to legitimate activities, clears the brain of its clouds and makes one more energetic and efficient.[1121]

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signs of pregnancy, making it "necessary" to be sacrificed to the medical profession "who asserted that they alone could make such decisions". This was maybe the case in abortion but otherwise the distinction was not so black and white. See also Ryan 1836, 174–175, 281. See also Chapter 4.1.

1115 See for example Jones 2011, 196–197; Moore 2013, 704–705. See also Kilday 2013, 80–81. For an explanation of the situation in 1860, see Tanner 1860, 71–72.

1116 Sperry 1900, 159–161. On the rights of nascent life see McLaren 1990, 31, 61; as McLaren noted, in the ancient world, the foetus "[--] was never more than potentially human".

1117 Sperry 1900, 45. See also Riddle 1997, 73, 83.

1118 McLaren 1978, 118. See for example A Perplexed Member [anonym.], Marriage: Idiocy. The *BMJ*, October 29, 1881, 730.

1119 See for example Ryan 1837, 25–26; Sperry 1900, 27–28, 35. On Christian tradition, pleasure, and marriage, see McLaren 1990, 80.

1120 Cook 2004b, 197. See also Crawford 1994, 84–88.

1121 Sperry 1900, 111, 118. See also Allbutt 1890, 59; Ryan 1837, 138, 191; Ryan 1841, 86; Chavasse & An American Medical Writer 1871, 70–71. William Hamilton Kittoe provided hints on the use of lubricants, such as almond oil, cold cream, and egg white. Kittoe 1845, 109. Some writers of health manuals noted, however, that the beginning of married life could be challenging for women, possibly regarding the excitement of

Family life, built on this very foundation, was a bliss, fulfilling its natural function in society, emphasising the profound meaning of children both in marriage and society.

However, as historians have demonstrated, around the 1850s and onwards, especially middle class couples began to practise family limitation. The birthrate began to decline, which indicates that some kind of contraceptive method was deployed successfully. In 1860s England, an average married couple had approximately six children; in the last decade of the 1800s, the number had declined to four.[1122] Angus McLaren has argued that this decline of fertility was the result of abstinence rather than of some new radical contraceptive device. However, McLaren has also illustrated that high fertility prior to the 1850s did not indicate the lack of fertility control or the absence of knowledge of contraceptive methods. People have always controlled the number of offspring, for example by (postnatal) abstinence, age of marriage, residence and sleeping patterns, diet, and suckling.[1123] In nineteenth-century medicine, this kind of non-active prevention was also offered in those cases in which the woman's life was at risk and some kind of birth control would have prevented the possibility of a new risky pregnancy.[1124] For example, in 1867, a woman, "four feet in height, and very rickety", whose previous two deliveries had been complicated, was advised to live separately from her husband, after her second confinement had ended in craniotomy and "a small attack of peritonitis".[1125] The woman, however, refused to do this, pointing out that next time her delivery could be by Caesarean section, in order to have a living child. Following her third pregnancy, the woman was indeed operated on but she died "of exhaustion" four days after the operation.[1126] The case demonstrated what Barbara Brookes has said; "[p]regnancy, whatever its

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recently started sex life; see for example Walker 1893, 4; Vincent 1902, 3–4. On Sperry, see Hall 1991, 64–65.

1122 McLaren 1990, 179; McLaren 1978, 11; Cook 2004b, 11–12, 14. See also Szreter 1996; Fisher 2011, 1–2; Beier 2008, 243; Beier 2004, 386; Nead 1988, 19–20; Tosh 1999, 156.

1123 McLaren 1990, 186; McLaren 1984, 2–4, 57, 65–67; Cook 2004b, 40; Mason 1995, 52. On infanticide used as a family planning method in history, see Kilday 2013, 3–5. See also Beier 2004, 387.

1124 As Angus McLaren has noted, doctors warned some women to avoid pregnancies, "but rarely would say how". McLaren 1990, 196. See also Ryan 1836, 222. See also for example Greenhalgh, Robert, Craniotomy in Deformed Pelvis. The *Association Medical Journal*, May 20, 1853, 441; Giroude [anonym.] An Obstetric Question. The *BMJ*, October 28, 1882, 870; see the answers: An Obstetric Question. The *BMJ*, November 11, 1882, 975.

1125 Greenhalgh, Robert, A Clinical Discussion on the Caesarean Section: And Its Claims as an Operation of Selection. The *BMJ*, November 30, 1867, 486–487. The woman had experienced two craniotomies, meaning that she did not have any living children. See also Greenhalgh, Robert, Craniotomy in Deformed Pelvis. The *Association Medical Journal*, May 20, 1853, 441; Radford, Thomas, Observations on the Caesarean Section and on Other Obstetric Operations. The *BMJ*, April 29, 1865, 423.

1126 Greenhalgh, Robert, A Clinical Discussion on the Caesarean Section: And Its Claims as an Operation of Selection. The *BMJ*, November 30, 1867, 486–487. The woman ignored also medical advice concerning diet prior to the delivery; without the knowledge of her doctor, she had eaten "pork chops, heavy cook-shop, pudding, potatoes, cheese, and beer" only some hours before the risky operation. The baby, "a vigorous female child" survived at least the operation. See also Fisher 2011, 81–82.

risks, was consonant with women's maternal role, while abortion [and contraception] clearly was not".[1127]

Medically, abortions were also dangerous; they risked the woman's health and life, and jeopardised her reproductional future.[1128] Doctors knew that abortion was always a risky procedure, due to the possibility of haemorrhage, inflammations, sepsis, lacerations, embolism, and poisoning. Thus, when the topic was discussed in popular health manuals, the general tone was gloomy, threatening, and demonising, constituting a general warning; the woman could easily lose her health or life, and the risky attempt to get rid of the foetus would (most likely) not be successful anyhow. Doctors clearly expressed their negative views on abortion, condemning it in the very strictest terms; for example, William Hamilton Kittoe called it "a crime of the most diabolical, revolting, and inhumane nature".[1129] Pye Henry Chavasse described termination as "a crime of the deepest dye; viz., a heinous murder".[1130] This might have been a collective and public declaration on behalf of the whole profession, consolidating the idea that abortion simply was no option. A woman who was reading a popular medical manual was given an impression that abortions were not within the expertise of doctors – at least of those who were honourable members of their profession – which, of course, was not quite the truth.[1131] Some members of the medical profession procured abortions but it is impossible to know what their real motives were – an unselfish and humane desire to help or willingness to gain from other people's distress. In any case, they risked a lot if they were caught: their career, reputation, and livelihood.[1132]

1127 Brookes 1988, 125.

1128 Mann 1893, 126–128. On the discourse of danger, see for example Bull 1837, 104; Kittoe 1845, 158–159; Chavasse 1866, 51; Black 1888, 38; Walker 1893, 78; Vincent 1902, 16. Sympathy, on the other hand, was clearly a completely different matter; Chavasse even wrote that no woman who had induced abortion was to be pitied if "fearful consequences" ensued – "she richly deserves them all!". Chavasse 1866, 51. On mortality related to abortion, see especially Loudon 1992, 107–116.

1129 Kittoe 1845, 159.

1130 Chavasse 1866, 51. See also Welch 1838, 57; Tilt 1851, 73–74; Black 1888, 38; Walker 1893, 78; Stables 1894, 209; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 226–227. See also Ryan 1836, 265. See also Steele Perkins, Geo., The Traffic of Abortifacients. The *BMJ*, February 25, 1899, 506.

1131 Some writers stressed the honour and respectability of the medical profession in relation to abortion, see for example Kittoe 1845, 159; Chavasse 1866, 51. See also a case in which a "a gentleman of high social position" asked a doctor to perform an abortion on the governess of his children, Beatty, Thomas Edward, Address in Midwifery, Delivered at the Thirty-Seventh Annual Meeting of the British Medical Association. The *BMJ*, August 7, 1869, 141.

1132 See for example Conviction for Manslaughter by Procuring Abortion. The *BMJ*, January 23, 1886, 175. Occasionally, the doctor procuring the abortion was also the father of foetus. See for example Shapter, Thomas, Report of the Trial of a Medical Practitioner, on a Charge of Intent to Procure Abortion. The *PMSJ*, April 10, 1844, 18–22; April 17, 30–34. In this case, the doctor was in a relationship with an unmarried woman who became pregnant; she was given savin and "other drugs". As Barbara Brookes has noted, doctors who were prosecuted for criminal abortion were removed from the medical register, losing their license. Brookes 1988, 57. See also McLaren 1978, 83; Beier 2008, 251. See also Ryan 1836, 265, 268–273.

For the medical profession, the negative discourse of criminal abortion was obvious for various reasons. First and most obviously, of course, abortion was illegal. Secondly, the idea of abortion was in a conflict with the idea of healing and curing patients. As the historian Michael Mason has noted, birth control was "to act outside the therapeutic realm".[1133] Even the Hippocratic Oath, an ancient Greek medical text from the fifth century BCE taken as an oath by physicians, mentioned pregnant women and the possibility of termination of gestation.[1134] Many popular writers constantly stressed that life began already at conception; it was sacred and needed protection especially by the medical profession. Abortion also revealed the social stigma of barrenness, which can be seen as the opposite of termination. Childlessness and infertility, seen as medical problems in nineteenth-century medicine, were always depicted as a deep personal tragedy, female failure, shame, and a source of unhappiness.[1135] Moreover, as Angus McLaren has noted, abortion was associated with quacks, midwives and other "non-professionals" represented as morally repulsive, dirty and dangerous charlatans; they procured abortion with their suspicious potions and noxious treatments, not suitable for a respectable practitioner.[1136] The other argument of McLaren's, on the other hand, is less convincing; he claimed that doctors were "slow to interest themselves in preventive medicine".[1137] As I have already discussed, nineteenth-century medicine – at least in terms of how the public was addressed – was still very much based on the idea of prevention. This, however, did not clearly concern the prevention of pregnancy.

According to the definition of the medico-legal manual *Forensic Medicine and Toxicology* (1893), abortions were produced either by mechanical methods, "used directly to the uterus or its contents", by drugs and herbs administered by mouth, and by "general violence", usually meaning jumping and violent exercise, lifting heavy weights, jumping and falling down the stairs, hot baths, excessive vomiting, bleeding, or more rarely actual violence, such as a blow to the stomach.[1138] In nineteenth-century medicine, it was commonly noticed that tightlacing

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1133 Mason 1995, 187.

1134 "[--] [S]imilarly I will not give to any woman an abortive remedy [--] we will give no drugs, especially not help to procure abortions". See the oath quoted in O'Dowd & Philipp 2011, 603–604. Brookes 1988, 54; Riddle 1997, 2, 38–40. On the history of the Hippocratic Oath, in fact a collection of medical writings, see especially Nutton 1993.

1135 McLaren 1984, 3, on barrenness in early modern England, see pp. 33–44. See also Lewis 1986, 76; Gélis 1991, 15–16; Hall 1991, 164–166.

1136 McLaren 1978, 118, 240–241. See also Mason 1995, 187–190; Keown 1988, 24, 161. See also Usborne 2001, 120–124; Jones 2011, 203.

1137 McLaren 1978, 118. On McLaren's interpretations, see Szreter 1996, 50–52.

1138 Mann 1893, 121, 126. See also Ryan 1836, 270–271, 276; Bull 1837, 103; Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 944–945. See also McLaren 1984, 100: "There are four main types found in early modern England [to procure abortion]: by magic, by physical means, by pessary and by herbal potion". Angus McLaren has also discussed fumigations, cataplasms, and poultices used for example by Greek women, but they are not mentioned in nineteenth-century texts. McLaren 1990, 29. See also Brookes 1988, 3–4; Fisher 2011, 55–56; Jones 2011, 197–198; Kilday 2013, 83.

could cause miscarriages, which, "when willfully induced", was a crime.[1139] The extensive use of purgatives and enemata, in an era so fascinated by the state of the bowels, was always potentially risky. Women relied also on very ordinary household items, such as knitting needles, crotchet hooks, pencils, and hairpins.[1140] Apparently, also some kind of instruments specifically designed for the purpose, "with a little pointed stilette", or medical aids, such as the stylet of a catheter and such like, were made and used, but it is impossible to estimate how common these kinds of self-made medical aids were.[1141]

The abortifacient qualities of many plants and other substances were also well known. Plants, or "herbs", like colocynth or bitter apple (*Citrullus colocynthis*), pennyroyal (*Mentha pulegium*), aloes, and savin (*Juniperus sabina*) were amongst the most traditional abortifacients.[1142] This kind of herbal self-medicine had a long tradition in the history of contraception. Poisonous substances, such as copper sulphate and lead, mercury, nitric acid, and also various drugs, such as *ergot of rye*, fungus grown on rye known to cause uterine contractions, *Cantharides* or *Spanish fly,* a poisonous substance secreted by a little green beetle, and *quinine*, a drug isolated from the bark of *Cinchona* tree, were used both by women and abortionists seeking effective abortifacients. However, their use was highly risky, as many accounts in medical periodicals demonstrated.[1143] Drugs and potions, being an indispensable part of the Victorian self-medicating culture and

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1139 Walker 1893, 27; Stables 1894, 177–178. See also Fissell 2006b, 69. See also Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 946.

1140 See the case in which an ordinary woman's hairpin was used by "a married woman with several children". In this case, the woman had first taken "herbs", then used the hairpin. A Correspondent [anonym.], A case of Self-Induced Instrumental Abortion. *The BMJ*, July 15, 1899, 187–188. See also Mann 1893, 126.

1141 See the court case Regina v. Collins. Medico-Legal. *The BMJ*, July 9, 1898, 122–130. In court, one witness told that he had heard of such instruments being used but he had never seen one. The patient in this case had died of the wound in the womb, caused by an artificial termination of pregnancy. On "a silver hook", see Wherry, George, Criminal Abortion; A Foetus of Three Months Cut up while in the Uterus; Peritonitis, Recovery. The *BMJ*, June 4, 1881, 880–881; Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 944.

1142 See for example M. D., D.Sc. [anonym.], Abortion Advertisement. *The BMJ*, March 12, 1898, 739; Mann 1893, 121–123; Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 944. See also Black 1888, 38. See also Brookes 1988, 5; McLaren 1984, 102–106; McLaren 1978, 241–242; Riddle 1997, 22–26, 31, 40–63, 67–69, 102, 106, 124, 146–148, 150–151, 155, 183–193, 211–213, 229–232, 238; Siedlecky 2001, 103–105; Kilday 2013, 83.

1143 See a case in the *BMJ:* The case of Fatal Attempt to Procure Abortion: A Letter from Joseph Stephens. *The BMJ*, October 29, 1864, 503–505. A patient, living "in a state of concubinage" with two previous children, was four months pregnant. She died after taking "large doses of tincture of ergot and oil of pennyroyal for many weeks". The doctor was convinced that the woman died from ergot poisoning, after she had become "impatient at the want of effect" and taking too large a quantity of medicine too many times. See on the use of different abortifacients: Shapter, Thomas, Report of the Trial of a Medical Practitioner, on a Charge of Intent to Procure Abortion. The *PMSJ*, April 10, 1844, 18–22; The *PMSJ*, April 17, 1844, 30–34; Trials for Procuring Abortion. The *Association Medical Journal*, August 12, 1853, 715–716; Lead as an Abortifacient. The *BMJ*, December 2, 1899, 1593; Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 944. See also Brookes 1988, 4–5; Riddle 1997, 198–199, 202–203, 229; Jones 2011, 198. On ergot

domestic medicine, were easy to obtain and relatively cheap. Women's journals and magazines quite openly advertised *female pills*, promising *to bring periods on, prevent large families,* or *remove the obstructions* – all euphemisms and code language for abortion.[1144] A woman using drugs needed no extra help, making it easier to keep illegal abortion secret – at least as long as no problems occurred. However, women could also turn to their friends, family members, and partners/husbands before they sought amateur abortionists or more professional help.[1145]

As Barbara Brookes has argued, abortion represented a survival strategy to which also married women resorted, especially to prevent "the hardship that another child would bring".[1146] One doctor reported on his patient who allegedly "brought on miscarriage" on herself 35 times but it is very likely that this was some kind of record rather than the norm.[1147] Abortion was also used as a back-up method if other, usually unreliable contraception methods had failed.[1148] Indeed, married women made up a large portion of the cases reported in the medical periodicals. Moreover, abortion was characteristically a working-class method of limiting the family, being "hidden but collective and social action", as the historian Simon Szreter has noted.[1149] Ralph Vincent, an upper-class doctor, writing his manual in the early twentieth century, presented married women seeking ways to "bring the period on" as vain and selfish, who were only interested in social engagements and amusements.[1150] However, in reality, the circumstances and motives varied but the result was the same: a new child was a burden and unwelcomed.

The accounts show that the circumstances of conception and the age and status of the pregnant woman affected attitudes towards abortion; a young raped

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in medicine, see Tansey 2001, 195–209; Siedlecky 2001, 102–103; Bennett & Bentley 1991, 333–343.

1144 See for example Abortion Advertisement. The *BMJ*, February 26, 1898, 578; Abortion Advertisement. The *BMJ*, November 1898, 1898, 1572; Abortion and Child Murder. The *BMJ*, December 21, 1895, 1583; Abortion and Child Murder. The *BMJ*, December 21, 1895, 1583–1584. See also McLaren 1978, 79; Riddle 1997, 235. On availability of drugs, see Porter 1989, 228; Porter 1996, 110–111; Lane 2001, 35–36. On the contemporary criticism of the availability of drugs in British society in relation to abortion, see for example Vincent 1902, 8–9, 15–16. See also Sperry 1900, 160–162. See also Moore 2013, 705–708.

1145 See for example Brookes 1988, 30–35; Beier 2008, 97–99. On gender difference and the role of men in birth control, see Fisher 2011, 56–65, 95–102, 189–235; Hall 1991, 96–99.

1146 Brookes 1988, 3. See also Jones 2011, 197. On infanticide as a birth control method in the Victorian era, see Kilday 2013, 137–150. See also Beier 2008, 245; Beier 2004, 287.

1147 H. S. [anonym.] Self-Induced Instrumental Abortion. The *BMJ*, September 10, 1898, 749.

1148 McLaren 1990, 189. As McLaren has noted, abortion demonstrated the woman's control over reproduction, as it does not require the co-operation of the male partner, that is to say, it is not taking place during sex. See also McLaren 1984; Fisher 2011, 199; Beier 2008, 97, 244–251.

1149 For example, Pye Henry Chavasse claimed that abortion was "the heinous and damnable sin of a single woman". Chavasse 1866, 50. Angus McLaren has noted that culturally, abortion has often been associated with unmarried woman, usually a domestic servant, who was first seduced and then became pregnant. See McLaren 1984, 91–94; Lewis 1984, 17–18; Szreter 1996, 52, 424–431; Fisher 2011, 125–126; Jones 2011, 197.

1150 Vincent 1902, 15.

girl was more likely to arouse sympathy than a married childless woman, who was sidestepping her most natural and sacred duty as a mother.[1151] For example, in 1898, in his letter to the *BMJ* one doctor reminisced about when he was called to see a young married woman, who had produced an abortion using a long wooden knitting needle, after failed attempts made by "the usual various drugs", very likely meaning the most common abortifacients, such as ergot of rye, savin, or pennyroyal.[1152] The doctor found out that sometime before the incident, the woman had "acquired veneral trouble" from her husband; in other words, she was most likely suffering from syphilis. The infection had transmitted to her child during the previous pregnancy or birth, causing either serious malformations or the death of the foetus/child. Despite the doctor speaking strictly about the criminality and the dangers of self-inflicted termination, the woman, at that point suffering from gynaecological inflammation and a high fever, had clearly made up her mind. She replied that she "would rather die than bring another child into the world".[1153] The doctor, clearly representing a new generation of the medical profession interested in antisepsis and bacteriology, was distressed both by the incident and the fact that the woman had used a knitting needle – "without having even first washed it".[1154]

On the other hand, from the medical point of view, the abortion question was far from clear and unambiguous. In their practical work, doctors occasionally met a situation in which they technically terminated gestations, albeit these cases were rare in comparison to all births.[1155] Also *Forensic Medicine and Toxicology* noted that the definition of criminal abortion did not provide "for the induction of premature labour by medical men", in order to save the mother's life, or "from other proper motives".[1156] In most cases, British medical culture regarded the life of the mother as more valuable than that of the foetus. Medical procedures, such as craniotomies, embryotomies, and induced labours, were, in all but name,

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1151 Brookes 1988, 8. See also Beier 2008, 247–250; Kilday 2013, 82–83.

1152 Huskie, James, Self-Induced Instrumental Abortion. The *BMJ*, October 1, 1898, 1014–1015.

1153 Huskie, James, Self-Induced Instrumental Abortion. The *BMJ*, October 1, 1898, 1014–1015. On maternal syphilis and foetal death, see Woods 2009, 232–235; Cook 2004b, 80–82: Smith 1979, 112–113; Lane 2001, 151–153; Fildes 1988, 71–72, 216–217, 238–240. See also Levine-Clark 2004, 138–139. See also Horrocks, Peter, A Discussion on the Causation, Prevention, and Treatment of Miscarriage. The *BMJ*, October 5, 1901, 944–945; Ryan 1841, 89. On syphilis and pregnancy explained in popular health manual, see Bakewell 1859, 92–93. See also Dunn, R. William, Treatment of Syphilis. The *BMJ*, June 25, 1864, 696.

1154 Huskie, James, Self-Induced Instrumental Abortion. *The BMJ*, October 1, 1898, 1014–1015. As Angus McLaren has noted, contraception was employed both to limit the number of children and "to ensure their health". McLaren 1990, 165. See the abortion case in which the woman boiled a catheter and sank it in carbolic acid before using it, Edin. [anonym.] Self-Induced Instrumental Abortion. The *BMJ*, September 3, 1898, 657.

1155 Keown 1988, 40, 49–83. See also McLaren 1984, 123, 125–129. See also Jones 2011, 197, 204.

1156 Mann 1893, 119. See also Radford, Thomas, Observations on the Caesarean Section and on Other Obstetric Operations. The *BMJ*, April 1, 1865, 313–315. In the twentieth century, medically, abortion has been possible to save the life of the mother, prevent permanent physical or temporary illnesses, preserve mental and physical health, and on the basis of eugenic and economic reasons. See for example Keown 1988, 78.

terminations of pregnancy, even if they were presented as therapeutic operations, "employed in good faith", as the *BMJ* noted in 1878.[1157] As the Manchester doctor and a firm supporter of Caesarean section, Thomas Radford, explained in 1845, if pregnancy would "threaten to destroy the woman", certain operations were justified, even though he generally detested craniotomies and considered them morally unsustainable.[1158] Also *Forensic Medicine and Toxicology* acknowledged that "under certain conditions", the termination was "universally admitted", noticing that it was important that practitioners acted openly, giving their reasons for the procedure, thus avoiding the danger of being prosecuted for procuring illegal abortions.[1159]

Professional medical literature suggested that some women knew very well that medical practitioners could procure terminations in certain medically justified circumstances. Thus, certain procedures could be requested by the patients, in order to have an abortion, more or less directly and discreetly, as *Forensic Medicine and Toxicology* reminded its readers:

> Such women will go to the consulting room of a medical man, or to the out-patient room of a hospital, and state that they are suffering from displacement of the womb [--] It is needless to say that inquiries as to the possibility of pregnancy are skillfully evaded, and as the fraud is attempted in the earliest months, a medical man off his guard is easily deceived.[1160]

Such cases were also reported in medical periodicals, albeit only rarely. In one such case, dated 1879, the alarmed doctor described in the *BMJ* how two women, the older one "respectably dressed", and the younger, a woman in her early twenties, asking the doctor whether labour could be "brought on [--] before its time" for the younger woman who apparently was five months pregnant.[1161] The women had heard that in the case of their neighbour, the same doctor had induced labour for a woman who had a deformed pelvis and whose previous delivery had been by craniotomy. Now they were asking for the same procedure. Quite expectedly, the doctor refused to help the women, as he explained in his letter: "I am convinced that the idea of crime never occurred to either of them until I put it before them: and they seemed most astonished that I regarded the

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1157 The New Criminal Code in Relation to Medical Evidence: Killing of Unborn Children: Abortion: Rape. The *BMJ*, July 20, 1878, 106.

1158 Radford, Thomas, A Few Practical Observations on Abortions, &c. The *PMSJ*, September 17, 1845, 577–578. See also Radford, Thomas, Observations on the Caesarean Section and on Other Obstetrical Operations. The *BMJ*, April 8, 1865, 341–344; April 15, 1865, 365–367; April 29, 1865, 423–428. See also Keown 1988, 61–62. This question is discussed also in Chapter 5.5.

1159 Mann 1893, 119. See also The New Criminal Code in Relation to Medical Evidence: Killing of Unborn Children: Abortion: Rape. The *BMJ*, July 20, 1878, 106. See also Ryan 1836, 268.

1160 Mann 1893, 125. See also Brookes 1988, 3; Duden 1991, 94.

1161 Hickingbotham, James, A Popular View of Abortion. The *BMJ*, April 5, 1879, 535. See also Phillips, John, Craniotomy: The Present Limits of the Operation. The *BMJ*, June 1, 1889, 1219–1221.

matter as out of the common routine of professional work".[1162] It is clear that doctors who wrote in the medical periodicals could never have confessed publicly to helping women to induce an illegal abortion. The function of these kinds of letters was, in fact, to warn of the possibility of foul play. A good doctor was always cautious and remembered that not everything they heard and what their patients described was quite as told, especially when pregnancy – or the possibility of it – was discussed between doctors and their female patients in nineteenth-century obstetrics.

1162 Hickingbotham, James, A Popular View of Abortion. The *BMJ*, April 5, 1879, 535. See also the case in which the woman asked for abortion directly and when the doctor refused, she did it herself with "a thick bone crochet needle", Davies, E. T., Self-Induced Instrumental Abortion. The *BMJ*, September 17, 1898, 841. See also Ballantyne, Alexander, Presidential Address on the Responsibilities of the Medical Attendant. The *BMJ*, January 22, 1898, 197–199; Drage, Lovell, The Midwives Question. The *BMJ*, October 12, 1901, 1112: "Very few physicians who are engaged in gynaecology and midwifery will deny that they are too frequently asked to procure abortion for ladies." See also Drew 1891, 34–35.

5 "THE ACT OF LABOUR COMES ON IN A GREAT VARIETY OF FORMS": GIVING BIRTH IN VICTORIAN BRITAIN

5.1 "Trying to Arrive at a Practical Definition": The Concept of *Natural Labour* in Nineteenth-Century Obstetrics

As I have discussed in the previous chapters of this study, the reproduction process as whole was seen as a normal part of the married female's life cycle; pregnancy, as Jane H. Walker explained, was "perfectly natural, requiring no abnormal effort on the part of the woman".[1163] This certainly was the ideal but not necessarily the reality. In this next chapter, I concentrate solely on childbirth; material requirements of birth, attendants, pain relief, complications related to delivery, and lastly, also the lying-in period. Childbirth – here meaning the moment of giving birth – as many writers noted, was likewise "a natural process"; labour was "the process of expulsion of the child from the womb into the world", as the medical student guide *First Lines in Midwifery* (1891) briefly explained the key idea.[1164] The ideal was that pregnancy and childbirth were only a temporary alteration in the female system, even if they often took place regularly and sometimes without any major breaks from the rhythm. Thus, generally, in nineteenth-century medicine, childbirth was not viewed, as has been sometimes claimed, as "an inherently dangerous 'disease state'".[1165] However, it was in many ways a peculiar phase in the lives of parturient women and their circle.

When reading nineteenth-century medical periodicals and medical health manuals, one realizes very quickly that the concept "nature" or "natural" lies at

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1163 Walker 1893, 15, see also p. 7. See also Beier 2008, 274; Beier 2004, 395.

1164 Herman 1891, 21. On the whole process of delivery explained, see Conquest 1849, 40–66.

1165 See for example Banks 1999, xxi.

the very centre of nineteenth-century obstetrical-medical discourse. At first, it seems a relatively simple concept, but, as a closer examination shows, it is an ideologically charged, often contradictory and culturally loaded term. In fact, there can be many "natures" in the same text whose meanings are far from clear or unequivocal. For the historian of childbirth, "nature" or "natural" is certainly a very complex and difficult concept to work with, especially because of its countless meanings and various different contexts in which it has been discussed in the past – and nowadays. Thus, it is necessary to remember, as Ludmilla Jordanova has pointed out, that "authoritative knowledge" of Nature, "Nature's laws", and natural relations have always been imagined, "actively created".[1166] They are not "real", as if existent without the social and cultural constructions and contexts they are discussed within. Indeed, as the historian Jeffrey Weeks has argued, there have been "as many natures as there are conflicting values".[1167] This certainly is very true; the flexible concept has been used to justify perfectly contradictory points of view, to legitimise – as Weeks has described – "our basic evil, and to celebrate our fundamental goodness".[1168]

Originally, the word *natura* was derived from *nascitura* (lat.), meaning "birthing"; as Barbara Duden has pointed out, "nature brings forth both lifeless and living beings."[1169] In Greek philosophy, *physis* meant "nature"; *physics* was "the study of nature" and one derivative of the term became to mean doctor, *physician*.[1170] This – even if the foundation of Western medicine – however, is only the very starting point. The historian Peter Coates has divided the understanding of nature in the Western world into five different categories. Firstly, nature can be seen as a physical, concrete place, a world or a globe, with geology, plantae, and wildlife. Secondly, nature can be understood as the collective phenomena of the world or universe in which humans can be included or excluded. However, what is more interesting concerning the history of childbirth, nature can be seen as an "essence, quality and/or principle that informs the workings of the world or universe", or as an inspiration, resource, guide and authority. In addition, nature can be viewed as the conceptual opposite or a dichotomy of culture, science, civilisation, and society: in this sense, humans do not belong to nature but nature can belong to humans.[1171]

The last meanings of the concept reveal especially the evergoing and unsolved tension between nature and humans; how close we, meaning all human beings, are to nature and what is really our place in this system – for example,

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1166 Jordanova 1999, 1–2.
1167 Weeks 1986, 62. See also Jaritz & Winiwarter 1997, 91–93.
1168 Weeks 1986, 62.
1169 Duden 1993, 104–105. On the various meanings of the world "nature", see especially *Oxford English Dictionary*.
1170 See for example Naddaf 2005, 3, 11–12. See also the definitions of "Nature" and "physics" in medical dictionaries, for example in Parr 1819, 6, 173; Hooper 1860, 98; Gould 1890, 297, 343; Thomas 1891, 437, 537; Foster 1892, 2575. See also French 1993, 162–171.
1171 Coates 1998, 3. As Coates has noted, nature has "both concrete and abstract meaning". See also Jordanova 1989, 41–42; Kukla 2005, 54–55. On differences of rustic and urban, nature and culture, see Porter 1997, 177–192. See also Kittoe 1845, 163. See also *Oxford English Dictionary*.

whether we own special rights over nature, possibly endowed by a higher authority, such as Nature herself or God, "the Author on nature" or "the Supreme Being", or whether nature ultimately rules over us. Especially in nineteenth-century popular medical literature and also in broader cultural understanding, nature was often seen as the creative and controlling (working actively or passively) force in the universe, sometimes as or in a relation with God/"Mother Nature", and his/her laws which guided and controlled human activities.[1172] Many nineteenth-century writers believed that God, "the Creator of all things", had given the immutable laws of Nature, to be obeyed by humans.[1173] "Nature" could also be an autonomic godlike force, seen as an indispensable guide or teacher, with hidden, yet capricious wisdom. For example, in the manual *The Ladies' Physician* (1891), an anonymous physician-writer summarised this idea: "nature is a great teacher, a great saver as well as a great destroyer."[1174]

As Peter Coates has pointed out, nature has often been assumed to be "an objective reality with universal qualities unaffected by considerations of time, culture and place".[1175] Thus, nature has been seen as something profoundly essential, normal, common, logical, reasonable, and innate, yet dictatorial and unrelenting. When something was natural, it was "immutably fixed"; it was fundamentally right, good, legitimate, justified, sacred, true, original, uncorrupted, or normative and prescriptive, a symbol of beauty, innocence, wealth, morality, virtue, and fertility. Nature, so to speak, was constitutional or omnipotent, "a byword of authenticity", as Peter Coates has put it.[1176] Indeed, Jeffrey Weeks has also noted, "claims of the 'Natural', are amongst the most potent we can make. They fix us in a world of apparent solidity and truth, offering an affirmation of our real selves, and providing the benchmark for our resistance to what is corrupting, 'unnatural'".[1177] To be a really effective, operational, and powerful concept, "nature" always requires an opposite, a counterforce, something that can be seen as "unnatural", meaning false, bad, corruptive, anomalous, preposterous,

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1172 Coates 1998, 4, 9. See also Jordanova 1989, 14; Jordanova 1999, 57–58, 89, 91; Harley 1999, 411; Schaffer 1997, 124–143; Moscucci 1990, 29–30; Schiebinger 2004a, 9; Haley 1978, 3–4; Puff 2004, 232–233. See also Bayertz 1997, 364–380; Cadden 2004, 207–231. See also for example Stables 1894, 111–112; Parr 1819, 6.

1173 Duden 1993, 105; Schiebinger 2004a, 9. See particularly the manual of Gordon Stables, who discussed both "the laws of God" or "the Hand that guides" and Nature, or "Nature's God". In Stables' manuals, Nature was a personified female force who talked to the reader: "'Take exercise', she says, 'recreative pleasant exercise by day, and when night falls I will bring you rest'. And she never breaks that promise." Stables 1894, 66. See also pp. 23, 111–112. See also Welch 1838, 85; Conquest 1849, 3. See also French 1993, 167–171. On God, Nature and the non-naturals, see Newton 2017, 108.

1174 A London Physician [anonym.] 1891, 222. See also Walker 1893, 36; Stables 1894, 111–117. See also Puff 2004, 232–233. On the discourse of nature in a non-medical manual, see for example Caplin 1864, 4.

1175 Coates 1998 1. Peter Coates quoted Raymond Williams who has argued that "'Nature' [is] perhaps the most complex word in the [English] language". See also Mitchinson 1991, 39; Jordanova 1999, 13.

1176 Coates 1998, 9. See also Jaritz & Winiwarter 1997, 93; Bayertz 1997, 364–380; Porter & Hall 1995, 79; Schiebinger 1991, 215; Cadden 2004, 207–231; Puff 2004, 232–253; Lupton 1996b, 126.

1177 Weeks 1986, 61–62. See also Jordanova 1999, 19.

perverse, chemical, atypical, and/or artificial. Thus, nature can represent harmony, purity, stability, order, and predictability, but, at the same time, nature can equally be wildness, vulnerability, chaos, and disorder.[1178] Florence Stacpoole, for example, called nature both "the great despot" and "Old Mother Nature" in her manual.[1179]

The concept of nature reveals that dichotomies, dualism, and polarities are very deep in culture, they are a "fascinating historical phenomena" and social-cultural constructions, as especially Ludmilla Jordanova has shown in many instances. In many religions and ideologies, the world has been divided by dualistic principles: dark and light, left and right, cold and hot, feeling and reason, private and public, passive and active, nature and culture/civilisation/society, body and mind, woman and man, and so on.[1180] Even though these taxonomic categories have never been static or universally valid, the hierarchical division reveals that "natural" is also essentially a very gendered concept. Traditionally, women were believed to be closer to nature than men, who represented culture, stableness, reason, and analytic deduction.[1181] Women were seen as bearers of tradition whereas men represented modernity, science and progress. Thus, complexly, women were defined as natural – in one sense superior – but consequently also as subordinate.[1182] Especially human pregnancy has been seen as the "eminent analogy" to nature's constant action; as Barbara Duden has argued, traditionally, the power of life and death was embodied in women and their bodies, the "power and task of infusing life and destroying it".[1183] Because of this power, motherhood was growingly seen as a *natural* role for women whose reproductional bodies eventually defined their place in society. Women's existence was rooted in biology and in their capability to give birth. Indeed, femaleness and naturalness "were hard to keep apart", as Jordanova has pointed out.[1184]

Historian and scholars, such as Barbara Duden, Ornella Moscucci, and Rebecca Kukla have timed the modern concept of nature at the end of the eighteenth century when it was created as "an organizing category of thought".[1185] The con-

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1178 Kukla 2005, 55. See also Coates 1998, 6–7; Herlitz 1997, 163–174; Borgström 1997, 332–345; Bayertz 1997, 370–374; Park 2004, 50–73; Puff 2004, 235–245.

1179 Stacpoole 1891, 10.

1180 Jordanova 1999, 7–8, 19, 164–165, 179; Jordanova 1986, 4–5, 43–45, 50; Jordanova 1989, 20–21, 59. See also Schiebinger 1991, 233–237; Moscucci 1990, 4, 28–30. See also Hall, S. 1997, 234–238. See also Stables 1894, 51–52.

1181 Mitchinson 1991, 31; Moscucci 1990, 29–30, 33; Jordanova 1989, 15, 19; Duden 1991, 20–21; Bashford 1998, 98–99; Schiebinger 2004a, 55–56; Weeks 1986, 85–89; Bloch & Bloch 1986, 32–38. See also Stables 1894, 51–52. Nature can also referred to the female genitalia or menstrual discharge, see for example *Oxford English Dictionary*.

1182 MacCormack 1986, 7.

1183 Duden 1993, 105; Duden 1991, 8. See also Jordanova 1989, 15, 20.

1184 Jordanova 1999, 35; see also pp. 167–169; Jordanova 1989, 18–29. See also Coates 1998, 143; Moscucci 1990, 2–5, 29–33; Levine-Clark 2004, 21–22.

1185 Duden 1991, 20; Moscucci 1990, 29; Kukla 2005, 34. See also Schiebinger 1991, 215–216; McCormack 1986, 20; Jordanova 1989, 27–28. On the concept in early modern Europe, see Gélis 1991, 76.

cept was politicised especially in the age of Enlightenment and the French Revolution of 1789.[1186] As Rebecca Kukla has argued, when something had before been natural when it had stayed pure and uninterrupted or uncorrupted by human intervention, in the eighteenth century it became something that needed "to be *actively* restored through proper human practice", and whose laws could be investigated and capitalised.[1187] Nature could be mastered by science, and this new scientific order, as the historian Londa Schiebinger has described, was reciprocally grounded in Nature and her laws.[1188] This setting also became a base of scientific sexism and racism, when the notions of sexual and racial differences were constantly discussed and everything and everyone was given their "natural" places in this great order. The eighteenth century was "the great age of classification"; the otherness could be found in females or in those who represented other races. A nature-culture division or taxonomy made differences even more permanent, fixed – or indeed – natural.[1189]

This taxonomic categorisation between nature and culture has not been particularly beneficial for women. As Duden has noted, it made possible sexist and racist definitions of women; it gave a "scientific" and normative base to the fixed claims that women were inferior to men, and more precisely, this division was involved in creating a racialised woman, "the primitive woman", who was living more closely to nature than her Western, civilised "sister woman". These two types of women co-existed in the nineteenth-century medical discourse, both culturally charged and stereotyped, co-existing in uneasy but close relation with each other.[1190] Evidence of natural differences, moral and intellectual development, and justification for racial, sexual, and cultural hierarchies was now sought in human anatomy, particularly in skeletons. The European male, with his cranial capacity, was seen as the most developed human type, "the standard of excellence", whereas white women and "negroes" were automatically placed below him. As Londa Schiebinger has pointed out, "race, like sex, penetrated the entire

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1186 See Jordanova 1999, 86–100; Kukla 2005, 29–60; Schiebinger 1991, 215–233; Schiebinger 2004b, 385–386; Cosslett 1994, 47; Moscucci 1990, 13, 29–30; Bloch & Bloch 1986, 26–38. Also attitudes toward breastfeeding and its naturalness changed during this period, see for example Fildes 1988, 111–126; Schiebinger 2004a, 67–70; Kukla 2005, 31, 83. See also Oakley 1993, 130–134. On breastfeeding in early modern England, see Gowing 2003, 198–201. See the examples of breastfeeding and nature in nineteenth-century medical discourse, Stables 1894, 233; Black 1888, 75–80; Welch 1383, 77–78; Allbutt 1890, 27.

1187 Kukla 2005, 32; Duden 1991, 20–21. See also Herlitz 1997, 163; Park 2004, 73. On the impact of Romanticism on the concept of nature, see also Coates 1998, 3, 8, 110–139.

1188 Schiebinger 1991, 215; Schiebinger 2004a, 146. See also Duden 1991, 21; von Engelhardt 1997, 195–206; Moscucci 1990, 3–5; Kukla 2005, 34–35; Jordanova 1989, 24. On Darwinism and nature, see Coates 1998, 139–144. See also Ryan 1841, 34–35.

1189 Schiebinger 2004a, xi–xii, 115–142, 145–160; Schiebinger 1991, 220–230; Duden 1991, 24–25; Jordanova 1989, 8; Cody 2008, 16, 27–29, 150; Coates 1998, 80–81, 82–109; Moscucci 1990, 3, 40–41; Bloch & Bloch 1986, 37–38; Sommers 2011, 89; Levine-Clark 2004, 21–22; Porter 1998, 378–379. On otherness and racial stereotypes, see also Hall, S. 1997.

1190 Duden 1991, 24. See also Porter & Porter 1988, 179–182. See also Watts 2007, 62–64.

life of the organism".[1191] The female pelvis became an important tool of categorisation in relation to the male skull: male and female bodies were seen as complementary, or more precisely, "the superior female pelvis complemented the superior male skull".[1192] Schiebinger has also noted that the question of the pelvis and its size eventually naturalised women's role as mothers, belonging to the private world rather than in public, and creating a powerful image of the childlike woman.[1193]

The nineteenth-century British woman lived in material abundance in the most advanced society in the world, but rather than making her stronger and capable of surviving pregnancy and childbirth, her "civilised", urban and "unnatural" environment and habits of living weakened, softened, and corrupted the natural female body.[1194] Moreover, because of modern life, the female body suffered and was becoming somehow lesser in every respect; women's lifestyle was "unphysiological", unlike their "savage-sisters" who knew nothing of tightlacing or badly ventilated rooms so corruptive to health.[1195] For example, John Tricker Conquest, writing in the middle of the nineteenth century, described how childbirth in Asia, Africa, or the West Indies was safer because life was more "simple and abstemious" and how people had not lost contact with their natural bodies.[1196] Indeed, many nineteenth-century writers genuinely believed that "savage women" did not suffer in labour "to the same extent as more civilised women" did.[1197] In an article published in the *BMJ* in 1899, one writer summarised this cultural-obstetrical idea: "[n]ow savage women, generally speaking, have large pelves, and bear children with small heads, hence the ease of their labour".[1198] Many accounts in medical periodicals and medical guidebooks demonstrated

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1191 Schiebinger 1991, 211, see also pp. 206–212. See also Schiebinger 2004a, 116–120, 131–142, 145–183; Cody 2008, 238–268; Moscucci 1990, 4, 13–17, 28, 32, 38; Grant 2011, 136–138. On Darwinism, natural selection and the capacity of the brain, see Kuper 1997, 281–285; Moscucci 1990, 21–22, 28–32; Lewis 1984, 82–84. See also Russett 1989, 2–7, 11–12, 24–28, 33, 35.

1192 Schiebinger 1991, 209; Schiebinger 1987, 43, 64–66. See also Cody 2008, 238, 248, 252; Moscucci 1990, 38–39. See also Reid, G. Archdall, The Causes Which Render Difficult the Labours of Civilised Women. The *BMJ*, October 14, 1899, 983–984.

1193 Schiebinger 1991, 209–213; Schiebinger 2004a, 156–161, 179–183; Schiebinger 1987, 42–43, 65–66; Duden 1991, 24–25. See also Cody 2008, 150, 249, 254; Moscucci 1990, 4–5, 31–32, 37–39; Jordanova 1986, 49; Russett 1989, 29, 33, 54–55; Mitchinson 1991, 36–38. See for example Stables 1894, 37, 47, 51–52. See also Mann 1893, 75. See also Priestley, William O., Two Lectures; Introductory to the Clinical Course on the Diseases of Women and Children. The *BMJ*, February 16, 1861, 161.

1194 See for example Conquest 1849, 50. See also Mitchinson 1991, 71–73; Cody 2008, 27.

1195 See for example Walker 1893, 36–37. See also Stacpoole 1891, 38–40.

1196 Conquest 1849, 47, 48, 50. Compare to Cosslett 1994, 9–10, 40–46. See also Ryan 1841, 60–61; Chavasse & An American Medical Writer 1871, 77–80. See also Beatty, Thomas Edward, Address in Midwifery, Delivered at the Thirty-Seventh Annual Meeting of the British Medical Association. The *BMJ*, August 7, 1869, 137–138.

1197 "Couvade" or Male Child-Bed. The *BMJ*, August 29, 1891, 490; Reid, G. Archdall, The Causes which Render Difficult the Labours of Civilised Women. The *BMJ*, October 14, 1899, 983–984. See also Schiebinger 2004a, 156–160; Cody 2008, 265.

1198 Reid, G. Archdall, The Causes which Render Difficult the Labours of Civilised Women. The *BMJ*, October 14, 1899, 983–984. See also Comparative Obstetrics. The *BMJ*, June 5, 1886, 1072. See also Ryan 1841, 34–37; Conquest 1849, 50. See also Cody 2008, 249–255; Schiebinger 2004a, 156–161, 183.

that nineteenth-century doctors were very interested in the practices of birth in different cultures; medical periodicals published countless reports on birthing and lying-in customs in various parts of the world, discussing the differences between the civilised world and the savages.[1199]

Also people living in Britain were categorised and placed in hierarchical orders. According to Gordon Stables, for example, gypsies were one particular group in which trouble at childbirth was seldom known. Gypsies allegedly lived closer to nature, and hence, they were easily associated with the ideal of "the primitive woman".[1200] In Britain, also class mattered in this respect. It was generally assumed that women coming from the lower classes survived better and suffered less than their aristocratic or middle-class contemporaries did.[1201] In reality, as for example the social historian Ellen Ross has discussed, many working class women suffered from poverty, a monotonous diet, repeated pregnancies, and general hardship of life.[1202] This did not prevent doctors from comparing different classes and groups with each other. Hence, Western culture and civilisation, the whole British society and the constantly expanding Empire, were both an indisputable achievement of progress and science, and yet at the same time, the modern, civilised, and urban life style was potentially a threat to all that was "natural", and primarily to women's reproductional bodies and the process of childbirth.[1203] To compensate this imbalance, women needed help and assistance from medicine and modern science.[1204]

However, nature and women/femininity were not automatically commensurable. Nature was also associated with health, a normal and desirable state of affairs. Health was to be achieved "through an understanding of nature and an ability to follow her precepts", as Ludmilla Jordanova has argued.[1205] In medicine, the belief in the healing power of Nature was widespread; it was Nature who

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1199 Conquest 1849, 49. On birthing customs in different cultural contexts, see for example: Obstetrics in the Sandwich Islands. The *BMJ* December 14, 1872, 661; Midwifery in Siam. The *BMJ*, May 1, 1880, 682; Midwifery in the Caucasus. The *BMJ*, October 8, 1887, 783; Hospital Midwifery in Kazan. The *BMJ*, July 8, 1889, 28–29; The Hindu Lying-In Chamber. The *BMJ*, June 6, 1891, 1242; "Couvade" or Male Child-Bed. The *BMJ*, August 29, 1891, 490; Barbaric Midwifery. The *BMJ*, April 30, 1892, 927; Parturition in Savages. The *BMJ*, October 7, 1899, 936. See also The Pelvis as a Sign of Race. The *BMJ*, November 2, 1878, 672. See also Moscucci 1990, 23–24.

1200 Stables 1894, 142–143. According to Stables, in Scotland people lived particularly healthily, see p. 178. See also Breen, John, Observations on the Practice of Artificially Dilating the Os Uteri. *The Lancet*, May 11, 1844, 215.

1201 See for example Barnes, Robert, On the Causes, Internal and External, of Puerperal Fever. The *BMJ*, November 12, 1887, 1041. See also Porter 1992b, 222–223; Loudon 2001, 183–184. On primitiveness and respectability, see Skeggs 2004, 37–38.

1202 Ross 1993, 47–50, 54–63, 72, 78, 124–131, 143–147. See also Beier 2008, 67–69. On working-class females and medicine, see Levine-Clark 2004. See also Philothalos 1860, 9–25, 56–58, 75, 83–85.

1203 See for example Kukla 2005, 30–34. See also for example Vincent 1902, 12–13.

1204 See for example Cody 2008, 265. See also Instrumental Assistance in Parturition. The *BMJ*, January 28, 1899, 214–215.

1205 Jordanova 1999, 16. Indeed, as Jordanova noted, "Hygeia and Nature walked hand in hand". See also Jordanova 1989, 83. See also Walker 1893, 36. See also Newton 2017, 108–109.

ultimately knew best and who guided people according to her secret and omnipotent, yet sometimes erroneous wisdom.[1206] For example, a popular home-doctoring book *The Doctor at Home and Nurse's Guide* (1891) relied on the traditional care of health, that is to say, on the power of both nature and the non-naturals: "[r]emember that the restorative powers of nature are great, very great; and consequently many disorders will be cured by time, mild diet, cheerful conversation, rest and pure air, without medicine."[1207] This thesis was found also in popular health manuals: George Black, for example, noted in his 1888 manual that health and happiness were only possible "by attending to Nature's dictates and obeying her laws".[1208] Nature described here was precautionary and acted through self-healing, acting through the body.[1209] Disobeying natural laws meant illnesses, pain, and death. In this kind of rhetoric, "nature" could indeed mean the body's own power of healing itself, as distinguished from medical skill and treatment.[1210] This guidance could be automatic, taking place without direct human interference. For example, after childbirth, nature was "acting to drive out some cloth or other matter from the womb, which, if retained there, would set up fever and inflammation", as Henry Arthur Allbutt described the very *natural* mechanism of the female reproductional body.[1211] Or, as Gordon Stables noted, feet and legs "were made for" walking, and walk one must, because "Nature knew what she was about when forming these".[1212]

Rebecca Kukla has argued that when discussing childbirth, "natural" was associated with freedom from artificial manipulations and interventions only later during the twentieth century.[1213] The line of development, however, is not as simple as Kukla's argument is proposing. The very popular concept of "meddlesome midwifery" in nineteenth-century obstetrics demonstrated that interventions were easily associated with unnecessary interference, over-treatment, and doing actual harm. Indeed, the very basic and often-quoted ideal in nineteenth-century obstetrics was: "[w]ait until you see what Nature can effect; do not interfere until she fails".[1214] For example, in 1898, Robert Milne Murray, a Scottish surgeon, wrote a long article in the *BMJ* on the use of midwifery forceps; Milne Murray noted that the forceps, when used *correctly*, shortened the sufferings and diminished the risks. Interestingly, he, too, referred to the medical aphorism, "none wiser than this" – "Wait till you see what Nature can effect – not

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1206 See for example Porter & Porter 1988, 258–259; Lewis 1986, 129–130; Duden 1991, 170–173. See also for example Stables 1894, 111–112, 187; Bakewell 1857, 6–7; Walker 1893, 36: "Pregnancy [--] ought to be attended with little more than occasional inconvenience and malaise, as long at least as the dictates of Nature are obeyed and a rational life led".

1207 *Doctor at Home* 1891, 562. See also Haley 1978, 15–16.

1208 Black 1888, v, 1. See also Welch 1838, 14, 83. See also Hooper 1860, 98. See also Jordanova 1999, 1.

1209 Duden 1991, 172. See for example Black 1888, v.

1210 See *Oxford English Dictionary*.

1211 Allbutt 1890, 26. See similar kinds of examples in Welch 1838, 12; Walker 1893, 51; Stables 1894, 195.

1212 Stables 1894, 84. See similar kinds of examples in Welch 1838, 67; Walker 1893, 117.

1213 Kukla 2005, 21, 89.

1214 See for example British Medical Association. Section of Obstetrics and Gynaecology. The *BMJ*, August 6, 1898, 362. See also Bakewell 1859, 121.

what she can endure", adding also that "[n]o one need to imagine that this can be read as an apology of meddlesome midwifery".[1215]

Indeed, throughout the nineteenth century, the obstetric virtues were time and patience; good timing was everything but patience was the best guardian.[1216] This meant that every practitioner should ask was it safer to act, to be "meddlesome", or to wait before applying medical aids, such as the forceps, for example.[1217] Knowing this was a special skill and expertise; writers stressed that only doctors had understanding of this very profound knowledge. In medical ideals, a good obstetrician did not trust implicitly midwifery books or medical authorities, who were often mistaken. Quite the contrary, as one doctor advised his peers in the 1860s, "let your study be the bedside of your patient, and your book, the book of Nature".[1218] Thus, according to the ideals, a good obstetrician was a peculiar combination of book learning and practice, training, and personal experience.

As the doctor Joseph Griffiths Swayne argued in 1846, in the majority of cases, the work of an obstetrician was, in fact, "to sit by the bedside and watch a strictly natural process, occasionally performing little and trifling duties".[1219] This was certainly the ideal but not always the reality. Nevertheless, this kind of discourse was often expressed in popular health manuals, with their authors stressing that in "natural labour", the doctor's duties very "very light indeed". For example, as Gordon Stables wrote in 1894, it was not the doctor who was "bringing the child to the world" – "properly speaking", it was nature.[1220] The role of doctor was to watch the case and to ensure that everything was going well. In practice, this meant that the doctor's presence in the birthing room was not

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1215 Milne Murray, R., A Discussion on the Use and Abuse of Midwifery Forceps. The *BMJ*, August 20, 1898, 472–475. See also a comment in the *BMJ*, September 10, 1898, 749. The penname "An Irish Graduate" thanked Milne Murray for his "admirable address" and noted that midwifery was a practical subject; every medical student was to be taught to use the forceps in practice. "Until this is done the teachers of obstetrics cannot be freed from blame for much of the injury that may result from an improper use of forceps". See also Section of Obstetrics and Gynaecology. British Medical Association. The *BMJ*, August 6, 1898, 362. On the use of midwifery forceps, see also Playfair 1894b, 14–18.

1216 See for example Swayne, J. G., Introductory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 28, 1846, 513. See also Meymott, Henry, Meddlesome Midwifery. The *BMJ*, May 5, 1883, 808: "Patience is the most effectual handmaid of nature". See also Chavasse 1866, 154. See also Wall 2018, 53.

1217 See for example Le Paige, J. F., On Axis-Traction in Delivery with Obstetric Forceps. The *BMJ*, October 20, 1883, 768–769; A Discussion on the Use and Abuse of Midwifery Forceps. The *BMJ*, August 20, 1898, 473. See also Midwifery Practice. The *BMJ*, May 14, 1859, 391–392: "We are so accustomed to quote the saying that 'meddlesome midwifery is bad', that the majority of us believe there is no such thing as meddlesome midwifery". See also Stables 1894, 225. See also Leavitt 1986, 47–56.

1218 Murphy, Edward, Introductory Lecture on the History of Midwifery. The *BMJ*, May 14, 1864, 528. See also Weatherill, Thomas, Fatal Midwifery. Coronary's Inquest. *The Lancet*, April 10, 1841, 104; Ryan 1841, 10; Tanner 1860, 2. See also Porter 2001, 146–147. On idea of learning through a book of nature, see Coates 1998, 60. See also Smith 2007, 217–218. See also Keller 2003, 78. See also Wear 1993, 98–125.

1219 Swayne, J. G., Introductory Lecture on Midwifery Delivered at the Bristol Medical School. The *PMSJ*, October 21, 1846, 498. See also Chavasse 1866, 131–137; Stables 1894, 225; Herman 1891, 65. See also Leavitt 1986, 61.

1220 Stables 1894, 224. See also Denman & Ryan 1836, 36; Stables 1894, 225.

needed for the whole time. For example, Pye Henry Chavasse stated in his manual: "if the labour be going on well, he [the doctor] has no business needlessly to interfere [--] in a natural labour, it is surprising how very little his presence is required", adding then how "Nature hates hurry and resents interference!"[1221] In other words, interference *was* meddlesome midwifery. As Chavasse continued:

> in every well formed woman, and in every ordinary confinement, Nature is perfectly competent to bring a child into the world without the assistance of man, and that is only an ignorant person who would, in a natural case of labour, interfere to assist Nature! Assist Nature! Can anything be more absurd! [1222]

In fact, when nineteenth-century male doctors wrote about childbirth, it was female midwives who were repeatedly associated with hurry and impatience, and being, therefore, guilty of meddlesome midwifery more often than the (male) medical profession. Confusingly, doctors could also complain that midwives could leave things undone, and waiting too long, when prompt action was the only possibility.[1223] Traditionally, female midwives let what was sometimes called "the invisible midwife, Dame Nature", take her course.[1224] Midwives, as women, were closely associated with nature, and were sometimes represented as gentler and more sympathetic than male doctors.[1225] In nineteenth-century medical periodicals, it was, however, more often midwives who were connected to meddlesome midwifery and unhygienic methods when treating their parturient patients.[1226] For example, Pye Henry Chavasse wrote in his popular manual in the 1860s: "I firmly believe, – that a woman would stand a much better chance of getting well over her confinement *without* assistance, than, if she had been hurried, *with* assistance."[1227] It is clear that this criticism was not aimed at his academic male peers.

While almost everyone shared the idea that meddlesome midwifery was "bad midwifery", some argued, however, that too much was left to nature, that is to say, as little as possible was done and many doctors were too careful and timid in their practical work. At the end of the nineteenth century, obstetrical policy was becoming more interventional but this process was not systematic and

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1221 Chavasse 1866, 132–133, 154. See also Bakewell 1859, 121; Bull 1865, 188–189.

1222 Chavasse 1866, 136. See also Ryan 1837, 273; Bull 1865, 188; Walker 1893, 177.

1223 See for example The Midwives Registration Bill. The *BMJ*, January 24, 1891, 195.

1224 Porter 1987a, 216. The quotation taken from Aveling 1872, 39. See also Towler & Bramall 1986, 74–75; Donnison 2000, 109; King 1995, 189–190; Schiebinger 1991, 110; Wilson 2014, 34.

1225 For example Schiebinger 1991, 110. See especially the anti-midwife pamphlet *The Accoucheuse versus the Accoucheur* 1864 [?]. See also Bashford 1998, 98–99; Donnison 2000, 101–115; Mitchinson 1991, 162–163; Tew 1998. Compare to Gélis 1991, 133–135. Jean Donnison has claimed that around the seventeenth century, "Mother Nature" "had ceased to exist" because of the new mechanist masculine philosophy. It is clear, however, that Donnison was not familiar with the nineteenth-century medical discourse analysed in my research. Donnison 1999, 32–33. On the positive view on midwives in history, see especially Tew 1998.

1226 See for example Swayne 1893, 61. See also Aveling 1872, 38–39. See also Jordanova 1986, 52–53; Wilson 2013, 157–158; Sommers 2011, 94–96; Bashford 1998, 96–99; Keller 2003, 71–73.

1227 Chavasse 1866, 131–132.

unproblematic.[1228] Some historians have argued that obstetrical policy changed dramatically around the 1870s, but based on the primary sources studied in my research, this change was not as extreme and sudden as sometimes claimed.[1229] However, drawing the line was not easy. For example, Ralph Vincent in his manual (1902) critically commented that if the "natural process" of childbirth could not be disturbed – that is to say, no instruments were used – then disease and death were to be accepted as "essential features of nature".[1230] Vincent stressed that "the crude process nature" was often "terribly cruel to the individual"; thus, as he argued, when leaving things to nature, it only sanctioned neglect.[1231] Vincent's manual was the most "medicalised" of the manuals I have analysed in my study; for example, in his manual, the parturient woman was advised to stay in bed during every stage of labour, and chloroform was administered freely.[1232] The readers of Vincent's manual, wealthy middle- and upper-class women, certainly had more money to follow the instructions and also to arrange the material requirements of birth according to the advice given.

Considering the exact definitions, in nineteenth-century obstetrical discourse the opposite of "natural" was not in fact "unnatural".[1233] The often cited categorisation was created by the famous eighteenth-century accoucheur Thomas Denman (1733–1815), who was some kind of professional role model for many nineteenth-century medical men. Denman's categorisation of "natural labour" was based on the presentation of the foetus and the need of assistance: in the first category, in *natural labour*, the head of the baby was the presenting part: this kind of labour was usually "normal", uncomplicated, and required only a little assistance. In *preternatural labour,* the presenting part was some other than the head, usually the breech.[1234] In *complex* or *difficult labour,* delivery was complicated by haemorrhage, syncope, convulsions, or prolapsion of the umbilical cord, for example. The last category, *instrumental labour*, required special obstetrical instruments, usually meaning the midwifery forceps.[1235]

1228 See for example the manual of Florence Stacpoole (1894); Swayne 1893, 61. See also Dunn, Robert, On the Statics of Midwifery, from the Records of Private Practice. The *BMJ*, November 12, 1859, 927; McCartney, G. D. R., On the Use of the Vectis in Assisting Parturition. The *BMJ*, December 14, 1867, 542; Swayne, Joseph Griffiths, On the Use of Obstetric Instruments. The *BMJ*, May 29, 1869, 487–488; MacCarthy, G. D. R., On the Use of Instruments in Obstetrical Practice. The *BMJ*, October 24, 1874, 524; Swayne, J. G., Obstetrical Statics. The *BMJ*, November 20, 1875, 635–638; Priestley, Sir William, Meddlesome Midwifery. The *BMJ*, August 20, 1898, 477; Donovan, William, Aseptic Midwifery. The *BMJ*, October 15, 1898, 1197; Smyly, William J., Address in Obstetrics. The *BMJ*, August 11, 1900, 339–340. See also Lewis 1986, 154–155.

1229 See for example Smith 1979, 16–18. See also for example Milne Murray, R., A Discussion on the Use and Abuse of Midwifery Forceps. The *BMJ*, August 20, 472–476. See also Stables 1894, 225: "So long the as things go straight, he [the doctor] has no right to interfere, and no need either".

1230 Vincent 1902, 53–54. On Vincent's view on midwifery forceps, see p. 51.

1231 Vincent 1902, 54.

1232 Vincent 1902, 54.

1233 On unnatural, see especially Puff 2004, 244–245.

1234 See for example Denman & Ryan 1836, 22–24, 106–113; Simpson 1871, 45.

1235 Davis, David D., "An Address to the readers of The Lancet. *The Lancet*, November 28, 1840, 330. See also Harrinson, I., Statistics of One Thousand Cases in Obstetrics. The *BMJ*, October 29, 1859, 870–871.

Thus, what is significant about this categorisation is that in nineteenth-century obstetrical-medical language, the definition of "natural labour" was technical rather than ideologically constructed. For example, pain relief – its naturalness or unnaturalness – was never mentioned in this context. Denman's definition, however, was not the unique one of its kind. At the end of the nineteenth century, doctor Robert R. Rentoul collected more than twenty different definitions of *natural labour*, from the well-known medical authors and authorities, such as Hippocrates ("When the head or breech presents."), William Smellie ("A natural labour is one in which uterine action alone accomplished delivery."), Thomas Denman ("Every labour shall be called natural if the head of child present [sic], if the labour is completed within twenty-four hours, and no artificial assistance is required."), John Tricker Conquest ("When the occipito-vertex presents, when there is sufficient room in the pelvis to admit of easy descent of the head: when the occiput emerges under the pubic arch, when no manual interference is needed, when labour is completed in a moderate time, and when the mother and infant are well"), and James Young Simpson ("The head alone presenting, the labour terminated in twenty-four hours)".[1236] In short, in nineteenth-century obstetrics, *natural labour* usually meant that the presenting part was the head, instruments were not used, and labour did not last longer than a specific time, usually twelve or twenty-four hours.[1237]

The most ambitious attempt to define "natural labour" was made by Robert R. Rentoul himself. In the 1890s, when the new bill of the *Midwives Act* was under debate, one aspect in the discussion was the definition of "natural labour". The new bill stated that a midwife could act "in cases of natural labour", whereas a doctor's help was needed in complicated and prolonged cases. The problem was, however, that no one really knew what this "natural labour" actually meant.[1238] It took 17 lines and more than 150 words from Rentoul himself to find "a practical definition" for the slippery term.[1239] "Natural labour" was, as Rentoul listed its characteristics, a birth of one living child, the vertex presenting, taking place within twelve hours from the commencement of the first stage of labour, in the ninth calendar month. Furthermore, no instrument or manual operations were required during the delivery. The mother, healthy in every respect and free from diseases, was alive thirty-one days after childbirth, and did not suffer from lacerations or childbed fever.[1240] What is particularly interesting in this definition is

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1236 Rentoul, Robert R., What is a Natural Labour? *The BMJ*, January 4, 1896, 48–49. See also Simpson 1871, 1; Herman 1891, 24. See also Lombe Atthill, An Address on the Education of Midwives, Considered in Connection with the Midwives Registration Bill. The *BMJ*, February 21, 1891, 394.

1237 See for example Barker, L. S. A., Medical Reform and the Midwives Bill. The *BMJ*, November 18, 1899, 1447. See also Ryan 1841, 166; Scott 1870 [?], 50. See also Fissell 2006b, 150.

1238 Atthill, Lombe, An Address on the Education of Midwives, Considered in Connection with the Midwives Registration Bill. The *BMJ*, February 21, 1891, 394.

1239 Rentoul, Robert R., What is a "Natural Labour"? The *BMJ*, January 4, 1896, 48–49.

1240 Ibid. See also Townsend Barker, Wm. J., Medical Reform and the Midwives Act. The *BMJ*, November 18, 1899, 447.

that the "naturalness" of each individual labour could be decided only afterwards when the delivery was finished, and not before.[1241] However, less surprisingly, Rentoul's ambitious attempt was not generally appreciated by his peers. One commentator called the definition "perhaps the most grotesque of all".[1242]

When discussing nature and childbirth, doctors were also defining the "naturalness" of their own role, especially the questions concerning professional-ethical responsibility, the content of the concept of meddlesome midwifery, and the relationship between male doctors and their female patients. Barbara Duden has noted that the eighteenth-century doctors she investigated, viewed themselves as gardeners, lending their support to nature.[1243] Similarly, their nineteenth-century successors understood themselves as the guardians of nature but also the agents of science and humanity.[1244] As one correspondent wrote in 1901, "[n]ature is certainly first, but the medical attendant should be her intelligent assistant".[1245] These two aspects by no means excluded each other; rather they complemented and reciprocally ratified the two points of view. For example, Robert Barnes, an English obstetrician, wrote in 1894 how the "advance of science brings us more and more in accord with the law of Nature".[1246] To Ralph Vincent, the highest surgical skill was also "a thing of nature".[1247]

Indeed, as Professor Karín Lesnik-Oberstein has argued, "nature" is never sufficient alone, even if different movements and agents have tried to proclaim that they have a more subtle understanding of what is "natural", and hence, "right" or "true". As Lesnik-Oberstein has pointed out, the scientific system has all the knowledge, analytic modes of thought, interventions, technological procedures, and the general idea of progress on its side, whereas the natural ultimately only has "its 'naturalness".[1248] Thus, the latter is always "lesser", easily associated with traditions, ignorance, and superstitions, inter alia. For example, according to Ralph Vincent in 1902, the idea of "leaving nature to herself" only provided "sanction for neglect"; to Vincent, the most natural labour was one that

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1241 See also Treichler 1990, 117; Wall 2018, 161–162.

1242 See the responses in the *BMJ*; Boulton, Percy, What is a Natural Labour? The *BMJ*, January 11, 1896, 113; Brassey Brierley, Jas., What is a Natural Labour? The *BMJ*, January 18, 1896, 179–180; Fraser, Wm., What is a Natural Labour? The *BMJ*, January 18, 1896, 180. See the response of Rentoul, the *BMJ*, January 25, 1896, 243.

1243 Duden 1993, 65. See also Lewis 1986, 129; Wilson 1995, 178, 199.

1244 Denman & Ryan 1836, 144: "with the laws of nature, science, and humanity". See also the idea of the body as a garden in Chavasse 1872, 137–138.

1245 Barron, A. C., The Third Stage of Labour. The *BMJ,* October 19, 1901, 1246. See also Sandwith, Humphry, On the Indication for Manual Interference and Other Agencies in the Treatment of Abortions. The *BMJ*, July 13, 1867, 22; Jardine, Robert, Aseptic Midwifery. The *BMJ*, September 17, 1898, 782–784. See also Bull 1837, 140. See for example Strange, William, The Aetiology and Pathology of Sporadic Puerperal Septicaemia. The *BMJ*, December 22, 1883, 1230: "If you ask anything about treatment, I can say only that the almost sole indication is to keep the patient alive, in the hope that nature will eventually gain the victory over the destroyer." See also Newton 2017, 108.

1246 Barnes, Robert, An Introduction to a Discussion on the Introduction of Labour. Section of Obstetrics medicine and Gynaecology. The *BMJ*, December 22, 1894, 1419.

1247 Vincent 1902, 54.

1248 Lesnik-Oberstein 2011, 218. See also Jordanova 1989, 33, 37. See also Jordan 1997, 72.

was "the best managed – not the most neglected".[1249] In fact, nineteenth-century doctors could successfully combine naturalness with the medical and scientific discussions. Nature could be "imitated"; Nature could even be seen as a physician, "a best ally", a "guide, philosopher, and friend", as one writer described it in the *BMJ* in 1866.[1250]

On the other hand, many historians have shown that eighteenth-century man-midwives were sometimes seen as unnatural figures or monsters, a "hermaphroditic designation" – half men, half women – because they uneasily represented the new ideas of science and male ambition and authority rather than female traditions, and moreover, because as men, they could always potentially violate female modesty and the rules of decorum.[1251] This demonstrated how nature had – amongst its countless meanings and connotations – an erotic dimension. For example, gardens bore erotic connotations, a woman's body was traditionally seen as a field or "garden", "nature" was a term for women's genitalia, and the foetus was a "fruit".[1252] The countryside, nature seen as a concrete place, was feminine territory whereas a city was often expressed with masculine metaphors.[1253] Science was no erotic-free area either; Ludmilla Jordanova has discussed the discourse of "unveiling nature", that is to say, how science was constantly undressing nature, often understood as a young woman, removing her secrets and revealing "the truths" – and how the langue of science was erotically charged.[1254] Since the late sixteenth century, Nature was personified as a lactating female figure, often naked or partially clothed.[1255] Londa Schiebinger has pointed out how also allegories of science had traditionally been female figures, but how in the late nineteenth century, a single male figure working alone in a laboratory in a white coat became a predominant symbol of science and scientific work, adapted also in medicine.[1256]

At the same time, the discourse of science also both protected and served male doctors, turning their "unnaturalness" – that is to say, their unfemininity and the fact that they lack first-hand experiences and authenticity of childbirth – into competence, authority, and professionalism. As I have already discussed,

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1249 Vincent 1902, 54.

1250 Radford, Thomas, Observation on the Caesarean Section and on Other Obstetric Operation. The *BMJ*, March 18, 1865, 263; Cox, Frederick, Labour Complicated with Rapture of the Uterus. The *BMJ*, January 27, 1866, 92–93. See also Risse & Warner 1992, 202.

1251 Jordanova 1999, 23–27, 33–34, 39; Kukla 2005, 90–92; Cody 2008, 205–210; Schiebinger 1991, 106–109. The quotation is taken from Shandean, A., "Midwives". The *BMJ*, June 28, 1890, 1524.

1252 See for example Chavasse & An American Medical Writer 1871, 83: "A wife may be likened to a fruit tree, a child to its fruit". Jordanova 1999, 21, 39. See also Gélis 1991, 31–32, 35–36, 72; Fissell 2006b, 32; on earth's fertility, see Schaffer 1997, 126–127, 129. On sexual metaphors of milkmaids and ploughmen in the English countryside, see Ganev 2007, 40–67. See also Gowing 2003, 113. See also *Oxford English Dictionary*.

1253 Jordanova 1986, 44; Jordanova 1989, 21–23.

1254 Jordanova 1989, 87–110; Jordanova 1999, 84.

1255 See for example Park 2004, 50–73. See also Cadden 2004, 207–231; Jordanova 1999, 35; Jordanova 1989, 134–135.

1256 See for example Schiebinger 2004a, 67. On female allegories of science, see Schiebinger 1991, 119–136, 144–150, 236. See also Chapter 3.2.

according to the cultural codes of decorum, it was unnatural and highly improper that a man other than the husband of the woman was allowed to touch female genitals. As the historian Sheena Sommers has illustrated, male doctors were capable of transcending the limitations of their own sex, as a sharp contrast to the practice of female midwives.[1257] This also gave the medical profession legitimation in their fight against ignorance and superstitions and ratified their justifications why they were best suited to taking care of childbirth. In their writings, doctors constructed themselves as the protectors and preventives of Nature, like interpreters of some kind, who stood in the middle of the complex triangle between Nature, pregnant women, and the art of midwifery, medicine, and science. Hence, the medical profession had its specific and indispensable place in society, in accordance with nature and her laws, as the popular health dictionary *Doctor at Home* pointed out: "[o]n the other hand, some diseases are curable only by medicine. Here, in prescribing the appropriate medicine, in the right dose and manner, the skill of the physician is often strikingly displayed, and the patient certainly, and sometimes, speedily, recovers."[1258]

Rebecca Kukla has argued that the twentieth-century "natural childbirth movement" has preserved gender roles and ideologies.[1259] The medicalisation of childbirth has been heavily criticised especially by the natural childbirth movement since the 1930s and the publication of the first book, *Natural Childbirth* (1933) by the British-born obstetrician Grantly Dick Read (1890–1959). Read, who is probably the most famous advocate of the natural childbirth movement, claimed that childbirth in essence was a "natural, joyous process", and painful only because of "unnatural" fear.[1260] In this sense, he was very close to his nineteenth-century peers who constantly discussed the dangers of strong emotions, foremost fear. Read's ideology was based on glorification, idealisation, and mystification of motherhood/womanhood, sentimental language, religion, and "a simplistic opposition of nature and culture" – very similarly to his peers in the nineteenth century.[1261] Indeed, as Rebecca Kukla has noted, "natural childbirth" has often invoked the fetishistic language of nature/naturalness "to give some labouring and mothering practices a moral value in virtue of their [--] freedom from alien penetrations".[1262] This kind of understanding tends to forget that in all cultures, reproduction is socially determined and controlled by different levels of society and community, also from below; the process has always been controlled by "a vast range of rules, regulations, taboos, charms, and herbal remedies", as for example Angus McLaren has stressed.[1263]

1257 Sommers 2011, 90, 93. See also Chapter 3.2.
1258 *Doctor at Home* 1891, 562. See also Risse & Warner 1992, 192, 202.
1259 Kukla 2005, 88.
1260 Wertz & Wertz 1977, 183–185.
1261 Wertz & Wertz 1977, 184, 186; Cosslett 1994, 10–27; Cosslett 1996, 174; Caton 1999, 173–190. According to the Wertzes, Read was, in fact, "Victorian", especially how he associated "motherhood with femininity, with purity, piety, and submissiveness". Moreover, Read clearly idealised large Victorian families.
1262 Kukla 2005, 222. See also Porter 1989, 231; Mazzoni 2002, 157–158. See especially Banks 1999, 92–93. See also Wertz & Wertz 1977, 195.
1263 McLaren 1984, 2. See also Mazzoni 2002, 161.

Indeed, critics of medicalisation have argued that childbirth has allegedly been turned into something unnatural, a disease-like state demanding surgical intervention and constant medical surveillance. The historian of childbirth, Marjorie Tew, for example, has stated in her critical study on maternal care that obstetricians have failed to make childbirth safer, calling the rise of man-midwives and the masculinisation of obstetrics a "bluff".[1264] Moreover, the natural birth movement has often depicted women as victims who lost traditional control and power over childbirth to medical science and men.[1265] While an actual theft might have taken place, this kind of understanding of history is nevertheless very selective.[1266] The discourse of "natural childbirth" tends to emphasise a great division between "natural" and "medicalisation"; these discourses are polarised and inevitably stereotyped. For example, the current discourse of "natural childbirth" suggests that if the woman is giving birth vaginally, no pain relief or other medication is used, and if the birth is attended preferably by lay persons rather than (male) practitioners, birth is more "natural". Hence, "natural childbirth" is understood as "somehow a more admirable accomplishment than 'medicalized childbirth'", as Rebecca Kukla has put it.[1267] In this context, "natural" equals safe, virtuous, and non-chemical, as opposed to "artificial" and "injurious". Moreover, childbirth itself is in fact seen as a natural thing because everything in nature reproduces or breeds; occasionally, it is taken for granted that every woman is capable of giving birth if only exercising "natural" methods and relying on her own body rather than on medicine, the medical profession, and the treatments they are providing.[1268] Hence, "medicalised birth" can be seen as a failure, or a disappointment, in every respect a less fulfilling experience than "natural labour", which, allegedly, is controlled by the labouring woman herself.

Grantly Dick Read has sometimes been credited with introducing the ideal of "the primitive woman" into obstetrics, but as it has already been shown and discussed in this chapter, this theory is actually much older.[1269] What is more significant about Read's criticism of medicalisation and the whole history of "natural labour", is that "natural labour" or "natural childbirth" is actually quite often a male-authored concept. In the twentieth century, many of the leading figures in the natural birth movements have been men, such as Read and the developer

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1264 Tew 1998, 375, see also pages 380–382.

1265 See for example Cosslett 1996, 47–76; Mazzoni 2002, 159–161.

1266 See for example Mazzoni 2002, 155.

1267 Kukla 2005, 222–223. See also Michie & Cahn 1996, 44–55; Lupton 1996b, 146–150.

1268 See Mazzoni 2002, 157. See also Treichler 1990, 129–130; Gélis 1991, 8. See also Lupton 1996b, 126.

1269 To Read, the "primitive woman" was a Belgian peasant who knew "naturally" and instinctively how to give birth. See Cosslett 1996, 176. In 1942, Read published his second book *Childbirth without Fear,* which became hugely popular especially in the United States. However, to Read, "natural woman" was a very much cultural construct, with "anti-feminist implications", as the scholar Tess Cosslett has argued. As the Wertzes noted, Read "wished to free women from fear, but not from family and home." Cosslett 1996, 175; Wertz & Wertz 1977, 185. See more about Read in Cosslett 1994, 9–21. See also Tew 1998, 40–41, 96–97. See also Banks 1999, 89–100; McIntosh 2012, 13–14.

of the Lamaze technique, Fernand Lamaze (1891–1957).[1270] Also nineteenth-century medical men could justify their role in the birthing room by claiming that they both understood Nature and her laws but that they also possessed scientific, surgical methods if labour became complicated or obstructed. In this sense, it can be argued that the discourse of "nature" and "natural" greatly benefited the male medical profession.

5.2 "Light, Airy, and Well-Ventilated": An Ideal Birthing Room and Material Requirements for Birth

In the 1850s, Nurse Baker pointed out in her manual that not every childbirth was alike. As Baker reminded her readers, all women were different and circumstances of each delivery varied greatly: thus, "[e]very confinement needs a different treatment, so that to lay down some definite and absolute rule is quite absurd, although it is frequently said by some, You must do *this* and *that*".[1271] Also the nineteenth-century British medical profession stressed the special circumstances of every individual delivery. However, the popular health literature usually recommended certain material requirements for the birthing room, prepared well in advance. In this subchapter, I discuss the ideal nineteenth-century birthing room, both concrete objects, such as the bed and bedclothes, but also immaterial requirements, such as the hygiene and quietness of the space reserved for labour and lying-in. These recommendations and ideals were significant because in nineteenth-century Britain, the majority of births took place at home. A hospital birth was not usually an option; in the nineteenth century, only a small minority of women gave birth in hospital, and usually only because they had no other choice.[1272] Moreover, as the historian Lindsay Granshaw has discussed, pre-modern hospitals were often places of political and social control, obedience, and charity rather than medicine or "science".[1273] The place of birth certainly mattered; for example, most aristocratic women gave birth in London, making it a distinctive public event and presentation of power and social prestige, especially when the future heir of an eminent aristocratic and political family was born.[1274]

1270 Cosslett 1996, 179; Cosslett 1994, 13; Caton 1999, 190–196. The Lamaze technique, or psychoprophylactic method, was based on relaxation and special breathing techniques. See Wertz & Wertz 1977, 192–194; Cosans 2004, 267–269.

1271 Baker 1856, 15. See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 264.

1272 On lying-in hospitals, see for example Evenden 2000, 186–199; Moscucci 1990, 75–101; Beier 2008, 128, 264–265. See also Mitchinson 1991, 43–45; Leavitt 1986, 171–195. See also Foucault 2014, 122–123. See also Loudon 2000, 58–74. Compare to eighteenth-century lying-in hospitals in Cody 2004, 309–348. See also for example Report on the Comparative Mortality of Maternities and Domiciliary Lying-In Charities. The *BMJ*, April 20, 1867, 463–464; May 4, 1867, 517–518. See also Lying-In Hospitals. The *BMJ*, July 3, 1880, 20–21; Lying-In Hospitals. The *BMJ*, July 24, 1880, 151–152.

1273 Granshaw 1996, 197–218. See also Porter 2001, 92–93.

1274 Lewis 1986, 156–160.

Many nineteenth-century medical writers noted how the ideals and practices of birth varied in different countries. Britain was its own social-cultural region and some customs were notably characteristic of the British way of giving birth, even if some traditions had also changed in England/Britain over the course of past couple of centuries. As Henry Thomas Scott described in the 1870s, "the preparations for this event, among Europeans, varies slightly. Some are delivered upon a chair; others are seated on the lap of a female friend."[1275] Giving birth in a birth chair or a stool – these chairs were different in style and design, as the historian Amanda Carson Banks has shown in her study – had a long history. In childbirth, the labouring woman was seated at the front of a stool, and she was supported and held by another woman standing behind her, while the midwife was kneeling before the woman. Some women gave birth in sitting or squatting postures, or on all fours. However, the custom of using a stool or a chair largely disappeared around the mid-1700s.[1276] I have found only few mentions of birth stools in the *BMJ*.[1277]

In nineteenth-century medical texts, women usually gave birth in their beds, even if Henry Thomas Scott, for example, noted that practices varied also within the British Empire: "[s]ome women use a little bed kept for the purpose; and others are delivered in the bed on which they usually sleep. This last, for many reasons, is the best and the most proper practice".[1278] The position, lying on the left side on the bed, was recommended both in professional and popular medical literature throughout the whole sixty-year period of time I have examined in this study.[1279] As many writers acknowledged, the position on the left side was medico-culturally defined; it was sometimes called the "British left-sided position" and "established English obstetric position".[1280] According to Florence Stacpoole

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1275 Scott 1870 [?], 45. See also Banks 1999, 21–22.

1276 Banks 1999, 5–9, 12–20. Birth stools had three and birth chairs four legs, some decorated with engravings and other personalisation. The woman giving birth sat on the chair, while she could push, grip or pull the handholds during contractions, or she could lean against the chair. The attendants could massage or support the woman otherwise. Moreover, the midwife had easy access to the birth canal. In her study, Banks was not particularly objective when she wrote the history of birth chairs, describing "a long, glorious history" of non-interference labour. See p. xxi. See also Wilson 1995, 36–38; Wilson 2013, 158–159.

1277 See for example The Birth Stool. The *BMJ*, September 1, 1888, 521. In this letter, the writer described the use of the birth stool in the early nineteenth century and the benefits of the sitting position in complicated labours. As the writer noticed, the stool "is not by any means so frequently used as it ought to be".

1278 Scott 1870 [?], 46.

1279 See for example Fox 1834, 72; Conquest 1849, 44; Walker 1893, 100; Swayne 1893, 14. Compare to Denman & Ryan 1836, 38; Ryan 1837, 276. The position was not often mentioned in the patient records, usually only if something dramatic and unexpected happened; see for example the case in which the woman died after the physician had used "great force" in delivery. The woman was lying on her left side, as the journal described the fatal case. See the *BMJ*, March 6, 1858, 192; See also Gentles, T. Lawrie, Case of Rupture of Female Bladder Associated with Abortion. The *BMJ*, January 6, 1883, 8: "I found a well made woman of 36 lying on her left side". Also Nurse Baker recommended the left side in her 1850s manual, see Baker 1856, 27.

1280 Drummond MacDonald, A., The Straight-Bodied Position in Labour. The *BMJ*, December 2, 1882, 1091. See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 262–263.

and William Hamilton Kittoe, in America and in most parts of the Continent, women delivered in beds but lay on their backs, in the so-called lithotomy position.[1281] In British obstetrics, the ideal was that the woman was placed on the "left side, the body curved as much as possible, the knees drawn up, and, perhaps separated by a pillow placed between them", as Henry Thomas Scott described British midwifery practice in his manual.[1282] The only one to criticise the left side custom was the physician-author Michael Ryan who argued in the 1830s that "too much stress" was laid on the necessity of the side position.[1283]

Indeed, all accounts show that the nineteenth-century medical profession agreed quite unanimously that medically the most correct position for delivery was the side position.[1284] Some historians have suggested that this was mainly due to issues of the doctors' own convenience; the idea was that the position eased the working conditions of the medical practitioner himself.[1285] However, this argument understates the fact that the side position was actually rather comfortable for the parturient woman, who could save her energy while resting on the bed between the contractions. Moreover, the position was "much pleasanter for them [women], and does not cause nearly so much exposure of the person", as Florence Stacpoole described, noticing also the meaning of decorum in childbirth.[1286] Four decades earlier, in 1858, the members of the *Obstetrical Society of London* discussed a "special position" in labour, noticing that basically the parturient woman could choose between "standing, reclining on the back, prone and horizontal postures".[1287] However, as many reports demonstrated, giving birth in other positions was considered medically dangerous and risky; for example in 1889, one doctor found his patient "in the middle of the bed on her hands and knees", asking her to get into the "proper position".[1288] Another writer noted in

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1281 Stacpoole 1894, 116; Kittoe 1845, 178.

1282 Scott 1870 [?], 53.

1283 Ryan 1841, 171. See also MacDonald, A. Drummond, The Straight-Bodied Position in Labour. The *BMJ*, December 2, 1882, 1090–1091.

1284 See for example Bull 1837, 131; Hills 1841, 9; Conquest 1849, 41–42; Black 1888, 53–54; Allbutt 1890, 19. See also Playfair 1893a, 354–355. See also Reports of Societies. Obstetrical Society of London. The *BMJ*, March 17, 1860, 213. See also Lewis 1986, 176–178.

1285 Banks 1999, 47, 62: "the use of recumbent delivery was based on physician's comfort, preference, and ideology". See also Gélis 1991, 130–131. See also Donnison 1999, 44–45.

1286 Stacpoole 1894, 116. See also Surgeon & Accoucheur [anonym.] 1900–1909 [?], 262–263. See also Playfair 1893a, 354.

1287 See Hardey, Robert, On special Position and the Obstetrical Binder as Aids in the Treatment of Impeded Parturition. The *BMJ*, March 17, 1860, 213. One writer described "the sedentary posture on or between two chairs" to be resorted to in complicated cases: the patient was placed between two chairs put together, her knees "firmly pressed against the side of the bed, her chest fixed by holding on to the foot-post of the bed, and her feet placed firmly on the floor". The doctor was sitting or kneeling behind the patient. After fixing the problem, the patient was removed to bed and delivery was finished "in the ordinary position", meaning the left side. On different positions in the history of childbirth, see Gélis 1991, 121–132.

1288 Thomas, D. E., A Case of Triplets. The *BMJ*, January 5, 1889, 16. See also Skinner, Thomas, Retroversion of the Gravid Uterus: The Best Position during Its Reduction. The *BMJ*, January 4, 1862, 7; Rupture of the Uterus. Birmingham Pathological Society. The *PMSJ*, September 11, 1844, 372–373. See also Ryan 1837, 276.

1854 that his patient, who later suffered from puerperal mania and eventually died, was delivered kneeling, which was "a very favourite position with the lower class" in the patient's neighbourhood; the writer himself did not consider the position proper.[1289]

Moreover, some historians have argued that it was pain relief and anaesthesia which led to horizontal deliveries, and consequently, birth was transferred to the bed, the "location of sickness", as Amanda Carson Banks has described this medico-cultural transformation that took place around the late eighteenth and early nineteenth centuries.[1290] Some historians have argued that the recumbent position implied "weakness, inferiority, and submission" of *the patient*, and a loss of control and of women's own agency in childbirth.[1291] However, the critics seem to forget that the bed was a very ordinary place of nightly rest and sleep, and moreover, the marital bed was the common place for sex where the majority of conceptions most likely occurred. Hence, the bed was the location of life as well as it was a place of sickness – and, more rarely, also death. Indeed, Michel Foucault has pointed out that "the natural locus of disease is the natural locus of life".[1292] Even if Foucault did not specifically mean childbirth – he referred to the family as "gentle, spontaneous care, expressive of love and a common desire for a cure" – this was true also of delivery and lying-in.

Indeed, in the birthing room, the most important single item of furniture was the bed; the baby was born there and the mother spent the first days and weeks of her convalescence time mainly in a horizontal position in the same place. In popular health manuals, the birthing bed described was usually a normal double bed, occupied by the parturient woman and her husband. There is evidence that some aristocratic women had a special bed for birth, designed specifically for the occasion, but it is clear that only few could afford to re-arrange their bedroom furniture expressly for the labour and the lying-in period. This special birthing bed was narrower than the ordinary double bed, making the parturient patient easier to access by the doctor and nurse.[1293] For example, in 1902, Ralph Vincent, whose readers were clearly wealthy upper-class women, included a picture of the medically ideal bed in his manual; the single bed was made of iron and it had wheels, making it easy to move about. Vincent also stressed that the narrow bed was practical for the doctor also to administer chloroform; this, however, was not a commonly shared view in nineteenth-century midwifery.[1294]

1289 West, R. U., Fatal and Other Cases of Puerperal Mania. The *Association Medical Journal*, August 11, 1854, 716–717. See also Rupture of the Uterus. Birmingham Pathological Society. The *PMSJ*, September 11, 1844, 372–373. On puerperal mania and maternal mortality, see for example Loudon 1992, 143–146.

1290 Banks 1999, 65.

1291 Tew 1998, 143.

1292 Foucault 2005, 19. On beds as material objects in history, see Cavallo 2015, 143–148. See also Lewis 1986, 161. See also Handley 2016, 121.

1293 Lewis 1986, 161. Women within the same family could share this birthing bed, thus making the custom a female bonding experience rather than an economic necessity. See also the letter of Queen Victoria to her eldest daughter Victoria, the Crown Princess of Prussia. April 8, 1863. *Dearest Mama* 1968, 192–193.

1294 Vincent 1902, 43–44. See also Black 1888, 52. Compare to Chavasse 1866, 142–143; Chavasse & An American Medical Writer 1871, 246.

During the first stage of labour, when the cervix was opening, the woman was usually free to move about in the birthing room or elsewhere in the house. The "cramped, uncomfortable position", as described by John Tricker Conquest, only tended to tire the woman and create unnecessary complications and protracted labours.[1295] During the first stage, staying in bed was not usually recommended: "[l]et her move about, walk, stand, or sit, as she pleases; kneel or lie on the bed or a sofa, as she fancies most refreshing and agreeable", as encouraged also by Conquest.[1296] Thus, the images we have of parturient Victorian women confined to beds in childbirth do not represent these medical ideals. As the nineteenth-century medical writers often stressed, staying in bed only added to the risks of complications, "unnecessary weaning and weakening the patient", causing unpleasant cramps.[1297] Actually, the only demand the doctors usually had concerning pre-labour conduct was that the woman was not to over tire herself by walking about too much. For example, the women studied by Pat Jalland spend their time walking and reading while waiting for their labours to proceed.[1298] The only doctor who ordered the woman to go straight to bed was Ralph Vincent, who noted that women were often advised to walk about so as to stimulate labour. Vincent argued that "[t]his is the worst possible advice, and she [the parturient woman] cannot do better than lie quietly in bed, taking up any position which gives the most comfort."[1299] According to Vincent, irritation caused by walking hardened the dilating neck of the womb and made the labour last longer.

Considering the importance of the bed in childbirth, it is hardly any surprise that most writers concentrated on their advice and practical hints on it and especially on how the bed was to be arranged. First, the bed, preferably containing a hard and healthy horsehair mattress, was covered with a leather, India-rubber, canvas, or mackintosh protection sheet, or a piece of oiled silk, or, if nothing else was available and the family was short of means, sheets of brown paper smeared with pitch or oil-cloth.[1300] At the end of the nineteenth century, Jane H. Walker

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1295 Conquest 1849, 45. See also Bull 1837, 136–137; Hills 1841, 9; Allbutt 1890, 19; Scott 1870 [?], 53; Chavasse 1866, 129, 139–145. Chavasse encouraged women to go outside of the birthing room, when they were waiting for the cervix to dilate. The woman was even encouraged "to be attending to her household duties", if she was feeling strong enough. Moreover, the ventilation of the room was easier to arrange if the woman moved between the rooms. See also Walker 1893, 101.

1296 Conquest 1849, 45. See also Bull 1837, 136–137; Bull 1865, 184–186; Hills 1841, 9; Davies 1852, 35–36; Bakewell 1859, 121–122; Chavasse 1866, 129, 131; Scott 1870 [?], 53; Weatherly 1882, 63; Stacpoole 1894, 117. See also Herman 1891, 71; Swayne 1893, 12–13; Playfair 1893a, 353. See also Allison 1996, 83–84. See also Lewis 1986, 174.

1297 Bull 1837, 137. In fact, Thomas Bull noticed that the woman herself was the best person to decide this, and not the doctor.

1298 Jalland 1986, 144.

1299 Vincent 1902, 46. See also Philothalos 1860, 50–51: "she ought to lie down in bed immediately; or if she be unable to do so, still she ought to lie down, even on the floor, if no more convenient places be available, as the standing or sitting posture may expose her to danger".

1300 See for example Fox 1834, 70; Bull 1837, 131–132; Bull 1865, 175, 178; Hills 1841, 9; Kittoe 1845, 177; Conquest 1849, 41; Davies 1852, 33–34; Bakewell 1859, 121–122; Chavasse 1866, 142; Scott 1870 [?], 45–46; Weatherly 1882, 62; Allbutt 1890, 20; *Doctor at Home* 1891, 466; Drew 1891, 38; Walker 1893, 99; Stacpoole 1894, 107–108, 115–116;

recommended tarred paper, "antiseptic" cheap material that could be burnt after use.[1301] The mattress and its protection were covered with blankets and sheets, folded two or four times, and easily removed after the baby was born and the placenta was removed.[1302] First of all, this arrangement was practical: the bed and mattress were saved from staining and wetting, and after the delivery was finally over, the leather, blankets and sheets were easily removed without causing too much trouble to the patient who spent the following days in the recumbent position in bed rest.

The material requirements of the birthing room had both practical and symbolic functions. According to cultural ideals, the urban middle-class home was organised by different functions and its different spaces were gendered and divided by age, wealth, and social status of the family, but in reality, especially many urban houses were quite small, and thus rooms could be chaotic and used for many purposes during the day by different family members.[1303] Moreover, the boundaries between public and private in the house were "permeable and frequently transgressed", as the historian Jane Hamlett has pointed out.[1304] The birthing room, even if it was solely occupied by a female parturient, was not a specifically feminine territory; rather, it was closely associated with the routines of the sickbed and sickroom, breaking the routines and disturbing the normal rhythm of the house.[1305] The ideal was that the future mother-to-be was free from her normal household duties and social obligations during the lying-in period, which directly affected the daily routines and the dynamics of the family and the whole household.

According to the medical ideals, the birthing room was often the master bedroom of the house – it was a private and secluded space accessible only to a few carefully selected attendants. As Jane Hamlett has argued, the bedroom was also "the heart of marital intimacy in the house"; many writers hinted that the

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Herman 1891, 68. As Dr Douglas Fox advised, the protection was about a yard square, kept in its place by tapes "sewed to the corners and tied to the posts, or to the sides of the bed." The horsehair mattress was more convenient and healthier than the feather bed, which was described as too hot and in every respect inconvenient. See for example Bull 1837, 131. See also Allison 1996, 79–82.

1301 Walker 1893, 89, 99.

1302 Baker 1856, 24. On the practical advice on how the bed was made, see Bull 1837, 131–132; Hills 1841, 9; Davies 1852, 33–34; Baker 1856, 24; Chavasse 1866, 144–145.

1303 Hamlett 2010, 3–5, 40–43, 73. The family, including the husband, wife, their children, and the servants, whose number varied considerably according to the wealth of the family, occupied the house. Family members had to constantly negotiate the use of different rooms of the house, such as the drawing room, study, and the nursery. The rooms manifested contemporary hierarchies of power between the husband and wife, the parents and their children, and the masters and their servants. Different rooms and spaces both ensured privacy and brought the family members and guests together. See also Branca 1975, 50–57; Leavitt 1986, 56; Tosh 1999, 11–26; Davidoff & Hall 1988, 357–369, 375–388.

1304 Hamlett 2010, 31. On gendered spaces and the middle-class home, see also Hamlett 2009, 576–589. For more about the ideals of middle-class masculinity at home, see Tosh 1999, 17–26, 30–39. Compared to Adams 1996, 75–81.

1305 See for example Tosh 1999, 56. On changing sickbed methods in early modern England, see also Smith 2007, 218. Compare to the manual of Robert Hall Bakewell (Bakewell 1857), see especially advice concerning cleanliness, quietness, temperature, and ventilation of the sickroom, pp. 9–14, 39–41.

marital bed was a double bed and that normally, the married couple shared the same bed.[1306] During childbirth, this ideal of marital intimacy was temporarily changed as the husband moved away from the bedroom, usually into the adjoining room, next to the bedroom.[1307] Childbirth and the lying-in period meant that all marital sexual activities temporarily ceased. An alternative option for the special purpose was a drawing room, or at least a room on the drawing-room floor; the best room of the house was also the "healthiest, most airy" space, as explained by the English physician and gynaecologist Robert Barnes in the 1880s.[1308] According to the nineteenth-century medical ideals, the pregnant woman occupied the birthing room at the time of her confinement, preferably some days before labour and spent her lying-in period in the same room.

Medical ideals show that the patient's physical and mental well-being was the first priority of the birthing room. The room was meant to be no torture chamber but a comfortable and familiar environment for the critical time period.[1309] Some of the preparations for the birthing room echoed those traditions of the previous centuries; the ideal nineteenth-century birthing room was a separate space, excluding the parturient woman from the daily routines and activities of the house and her family. However, in early modern ideals, the birthing room has often been described as a womb-like space, with closed windows, warm temperature, and little light.[1310] Unlike this space occupied by the parturient in previous centuries, the ideal Victorian birthing room was large, airy, and full of light – "as bright and cheerful as possible", as Gordon Stables described it.[1311] The perfect room was easily ventilated, with large windows, a fireplace, and light furniture, containing the bed, possible a sofa and a few other indispensable pieces of furniture. The worst possible birthing and lying-in room was in the basement of

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1306 Hamlett 2010, 97, 99. One notable exception was Gordon Stables who recommended that the couple should occupy the same room but sleep in "two narrow beds instead of one very wide one". This was more hygienic: "the rest at night is all-important". He did not discuss marital sexuality more specifically. See Stables 1894, 183. On silence in primary sources concerning marital sexuality, see also Tosh 1999, 59. See also Handley 2016, 124.

1307 Hamlett 2010, 97, 99. This smaller room was usually the dressing room, containing a single bed. Hamlett has suggested that the room represented the culture of abstinence, not necessarily always associated with childbirth, even if this marital abstinence directly affected the number of children. See also Tosh 1999, 156. For an example of the husband having his own small bed in the birthing room, see Woodhouse, R. T., Case of Puerperal Convulsions. The *Association Medical Journal*, May 17, 1856, 405–406. See also Lewis 1986, 160–163.

1308 Barnes, Robert, On the Causes, Internal and External, of Puerperal Fever. The *BMJ*, November 12, 1887, 1040. Barnes referred to his older colleague who had advised converting the best drawing room temporarily into the lying-in room: "I have never forgotten his teaching, and have often turned it to profitable account".

1309 Occasionally, extremely risky operations were performed in very demanding circumstances, see for example a case of a Caesarean section performed by candle-light in a farmer's house, Muillot, F. Albert, A Successful Case of Caesarean Section. The *BMJ*, June 28, 1890, 1482.

1310 See for example French 2016, 131–132; Gélis 1991, 96–98; Wilson, A. 2002, 134.

1311 Stables 1894, 213. For descriptions of the ideal birthing room, see for example in Conquest 1849, 44–47; Bull 1867, 173–177; Black 1888, 50–51; Walker 1893, 98–99; Stables 1894, 213–214; Vincent 1902, 42–44.

the house or in damp cellars; these were the places where poor women gave birth.[1312]

All medical writers described the material requirements of the birthing room at least to some extent. Gordon Stables was the most specific and detailed in his advice to his readers; nothing was too insignificant for his attention. The ideal birthing room was "home-like", containing beautiful objects, including pictures and flowers – Stables even observed that the window blind should be red – which was "cheerful", unlike green, which was a "gloomy and depressing" colour.[1313] The ideal birthing room was a combination of beauty, cosiness, practicality, and – what was probably the most important aspect – also hygiene. This included removing all curtains and valances from around the bed, in order to assist the free play of air, easier access to the bed, and general hygiene of the room. "It is wonderful how refreshing [--] a well-ventilated room is to a lying-in patient", noted also Pye Henry Chavasse.[1314] Traditionally, the curtains and canopies had protected the bed and the sleeper from cold, draughts, noises, and light, and they also provided much needed privacy.[1315] In nineteenth-century medical discourse, these arrangements were declared unhygienic and dangerous, and their removal from the room was usually requested.

As doctors often advised their readers, the pregnant woman was urged to "not to put everything off to the last"; all arrangements were made in time, so that everything was ready when the labour finally started – sometimes quite unexpectedly.[1316] However, baby clothes and linen, such as caps, gowns, pillows, covers, and blankets, were not just material everyday necessities, with only a practical function. Rather, the material arrangements were a socially important sign of an established and announced pregnancy; in the case of unexpected neonatal death, material preparations could demonstrate that the intention had not been to hide pregnancy and destroy the child. For example, in one case dated to 1851, a pregnant woman had used the night chair, suddenly noticing that her stillborn, full-grown child was lying in the vessel. The doctor described how the woman and her husband had "expressed great anxiety respecting the birth of the child, and every usual preparation had been made for its reception".[1317] Thus, there had been no reason to conceal the birth and to suspect foul play of any kind.

1312 Barnes, Robert, On the Causes, Internal and External, of Puerperal Fever. The *BMJ*, November 12, 1887, 1039–1040. On fevers and ventilation, see Barker, T. Herbert, The treatment of Fevers: With Special Reference to Ventilation. The *Association Medical Journal*, November 8, 1856, 955–957; November 15, 1856, 972–977. See also Bull 1865, 175–176.

1313 Stables 1894, 213–214. See also Stacpoole 1894, 113–119. On good and bad smells in medicine, see Palmer 2004, 66–67.

1314 Chavasse 1866, 145. On the bed curtains, see for example Conquest 1849, 44; Chavasse 1866, 144; Walker 1893, 98; Chavasse 1902, 42. See also Bakewell 1857, 10, 40. See also Playfair 1893a, 247. See also Kidd, George H., Address in Obstetric Medicine. The *BMJ*, August 2, 1884, 221.

1315 See for example Cavallo 2015, 146–147; Handley 2016, 115–118, 147.

1316 Chavasse 1866, 143; Conquest 1849, 41; Philothalos 1860, 35–37.

1317 Gregson Harrison, John, On Quick Childbirth, as Connected with Criminal Courts of Law. The *PMSJ*, February 5, 1851, 79–80. On material requirements for the baby, see especially Walker 1893, 93–96. See also Holloway 2018, 159. See also Kilday 2013, 42–43. See also Scott 1870 [?], 121–122. On infanticides, see Mann 1893, 130–164.

Moreover, baby clothes and objects specially selected for the birthing room were also important material demonstrations of emotions and family relations; love, affection, hope, and anticipation.[1318] However, preparing for birth was not always only a pleasant task for the mother-to-be, as it also reminded her of the reality of childbirth and the fear of forthcoming pain and uncertainties. For example, Queen Victoria wrote to her eldest daughter, who was preparing for her second labour in 1860: "[t]he arrangements, you mention are indeed too horrid – and quite like an execution."[1319] This was the Queen's sarcastic humour, but no doubt, some women found it true.

Royal mothers could always rely on their servants, but usually the woman herself was in charge of making sure everything needed was at hand: clothing of the mother and the soon to be born baby, a flannel receiver and nappies for the child, waterproof protection for the bed, sheets and blankets, binders and bandages for the mother, and a bed-pan.[1320] For the doctor and the vaginal examinations he performed during delivery, the following ought to be at hand: Vaseline, unsalted lard, cold cream, pomatum, or (olive) oil, as well as castor-oil, soap and sponges, sharp scissors, syringes and tubes, a douche-can, and strong thread to tie the umbilical cord when the baby was born.[1321] At the end of the nineteenth century, women were also advised to obtain some disinfectants, for example diluted carbolic acid or antiseptic soap or powders.[1322] Safety pins were another novelty after the second half of the nineteenth century.[1323] Otherwise, the list of

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1318 On maternal emotions and objects, see Holloway 2018, 154–171. On material culture, emotions, and the social meanings of objects, see for example Downes, Holloway & Randles 2018, 8–23. On objects and emotional relations between women, see for example French 20016, 132. On material preparation for birth in early modern England, see Mann 2005, 137–157; on the material culture of childbirth in Medieval London, see French 2016, 126–140. See also Brown, Chas. R., An Obstetric Incident. The *BMJ*, February 15, 1879, 257; Philothalos 1860, 35–37.

1319 Queen Victoria to her eldest daughter Victoria, the Princess Royal, June 11, 1860. *Dearest Child* 1964, 265. The daughter Victoria had previously written to her mother: "I shall arrange my rooms and make all final preparations the same as a person does that is going to have her head cut off." Ibid.

1320 The binder, made of calico or flannel, was often recommended for the parturient woman, see the instructions in Bakewell 1859, 112–113; Walker 1893, 92–93. Especially guidebooks written for use by working-class women stressed the importance of sewing, see for example Philothalos 1860, 8. See also Dr. Murphy's Obstetrical Binder. The *BMJ*, October 15, 1887, 865; A New Obstetrical Binder. The *BMJ*, January 30, 1897, 276. On material requirements in early modern childbirth, see Gélis 1991, 112–114.

1321 On material preparations, see for example Hills 1841, 9; Kittoe 1845, 179; Davies 1852, 29–35; Conquest 1849, 41–46, 67–72; Bakewell 1859, 112–116; Chavasse 1866, 134–150; Scott 1870 [?], 46–48; Weatherly 1882, 61–62; Black 1888, 52; Allbutt, 1890, 18; Walker 1893, 89–96; Stacpoole 1894, 105–112; Stables 1894, 214–215. See also "A Baby Box". The *BMJ*, April 25, 1896, 1042. On Vaseline, see Liston, Henry, Vaseline vs. Lysol in Midwifery. The *BMJ*, October, 15, 1898, 1207. See also Playfair, W. S., Introduction to a Discussion on the Prevention of Puerperal Fever. The *BMJ*, November 12, 1887, 1034–1036. See also Herman 1891, 66–68; Swayne 1893, 1–2.

1322 See for example Walker 1893, 93, 95. Jane H. Walker advised her readers how the make disinfectants. Condy's fluid was one recommended solution. See also Allbutt 1890, 18, 23. On the use of antiseptic lubricants, see Cullingworth, Charles, An Introductory Address on Puerperal Fever, a Preventable Disease: A Plea for the More General Adoption of Antiseptic in Midwifery Practice. The *BMJ*, October 6, 1888, 746.

1323 Allbutt 1890, 18; Stables 1894, 215.

requirements remained relatively unaltered during the whole Victorian era. For example, in the 1850s, Nurse Baker advised her female peers to supply the necessary things: *sal volatile*, brandy, feeding-cups, spoons, glasses, hot and cold water, linen, the receiver, scissors and thread, bandages, and a small pillow to be placed between the knees of the parturient woman.[1324] This pillow was found also in the manuals of doctors; it was both practical and comfortable for the woman who spent the second stage of childbirth lying in the side position.[1325]

When the doctor finally arrived at the birthing room, he brought his bag with him. In 1894, Gordon Stables advised his readers to inform the doctor about the nature of the case, pointing out that the practitioner could not bring "all his tools, bottles, and bandages unless he called on his patients in a caravan".[1326] Occasionally, the contents of the bag were listed in the medical periodicals; for example, in the 1840s, the bag contained female catheters, lancets for venesection, midwifery and craniotomy forceps, lever, hooks and perforators, some morphine or opium, and a pair of scissors.[1327] The content remained relatively unaltered but there were also some additions, the foremost being chloroform and ether, after their introduction in the late 1840s. Based on the advertisements published in the *BMJ* between 1870 and 1894, the ideal midwifery bag consisted of various instruments, such as midwifery and vectis forceps, hooks, crochets, and perforators, a stethoscope, ergot of rye, turpentine, and syringes.[1328] The bag itself was also designed according to the modern necessities; at the end of the nineteenth century, when cycling had become more popular also amongst the medical profession, new kinds of practical midwifery bags were designed to be used together with a bicycle.[1329] At the end of the nineteenth century, also specific models of antiseptic

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1324 Baker 1856, 23–24. See also Cullingworth 1884, 26–27; Drew 1891, 37–38; A London Physician [anonym.] 1891, 294–295.

1325 See for example Bull 1837, 131; Conquest 1849, 42; Scott 1870 [?], 53; Black 1888, 52; Walker 1893, 100. See also Brown, Chas. R., An Obstetric Incident. The *BMJ*, February 15, 1879, 257.

1326 Stables 1894, 198–199.

1327 See for example Ryan 1841, 168–169.

1328 See for example Coxeter's Obstetrics Vade-Mecum. Reports and Analysis, and Descriptions of New Inventions. The *BMJ*, May 31, 1884, 1050. In this particular bag, as the journal noted, there was no "instruments of destructive character [craniotomy forceps and hooks]", which were "so seldom needed, and scarcely ever urgently required". See also An Improved Compact Midwifery Bag. The *BMJ*, April 27, 1895, 933; this bag contained the midwifery forceps, craniotomy forceps and perforator, hooks, and crotchets; "useful drugs", such as ergotine, antipyrin and choral hydrate [both analgesic], opium and chloroform; and tubes of lano-creoline and hazeline cream for vaginal examination. See also Arnold and Sons' Obstetric Bag. The *BMJ*, April 23, 1870, 412; The New Gynaecological Bag (Registered). The *BMJ*, June 8, 1872, 612; Dr. Barnes's Obstetrical Bag. The *BMJ*, October 31, 1874, 560; Belfield, C. W., Treatment of *Post Partum* Haemorrhage. The *BMJ*, October 22, 1881, 666. See also Swayne 1893, 1–2. See also Playfair 1893a, 346–348.

1329 See for example A Midwifery Satchel for the Saddle. The *BMJ*, August 29, 1896, 511. This bag contained a bottle of chloroform, ergot and chloral, morphine, a pair of frenum scissors, needles, syringe, catheter, and a pair of Simpson's long forceps, originally designed by James Young Simpson. See also A Cycle Midwifery Bag. The *BMJ*, July 24, 1897, 223. This bag was light, made of waterproof canvas bound with leather, containing "all the usual obstetric instruments". See also Macintosh, George D., A Midwifery Satchel for the Saddle. The *BMJ*, July 17, 1886, 112. On bicycling and doctors, see Digby 1999, 144–151.

midwifery bags were advertised in the *BMJ*; they followed the new bacteriological ideals of the time with washable and replaceable upholstery fabrics.[1330] However, as William S. Playfair reminded his medical peers in his manual, not everyone could afford these expensive luxuries; one could always make them oneself.[1331]

Even if demands for hygiene and general cleanliness were found in the popular medical writings throughout the whole period of sixty years, at the end of the nineteenth century, the idea of antiseptic midwifery was commonly presented in popular health manuals, and also the readers were constantly advised to pay close attention to the rules of "surgical cleanliness" in the birthing room. As Gordon Stables reminded his lay readers in 1894: "cleanliness first, and disinfection in the second place, are two of your greatest friends".[1332] Women were advised to have some antiseptic, such as corrosive sublimate, carbolic acid, or *Condy's Fluid*, meaning permanganate potash, ready for their deliveries, and doctors constantly stressed the preventative responsibility of an individual woman when she was pre-organising her confinement. For example, Florence Stacpoole stressed in 1894 that women themselves had "*personal* responsibility" to ensure that good hygiene was taken care of during childbirth and lying-in. Passivity and ignorance were no excuses.[1333] At the turn of the twentieth century, Ralph Vincent discussed the "surgical cleanliness" of the birthing room, recommending that right before the labour commenced, the woman should scrub herself thoroughly with soap and water, "in order to ensure that she is free from all traces of dirt, which might be a source of infection".[1334] It was equally necessary that the bowels should be emptied with castor oil or by an enema, as soon as the woman noticed that her delivery had started; however, this advice was as relevant in the 1840s as it was at the turn of the century.[1335]

Indeed, even if the discourse of scientific hygiene and increasing demands for antiseptics were converted into the language used in health manuals, "perfect cleanliness" was an ongoing, continuing discourse. "Cleanliness is next to godliness" was a slogan often repeated – it was a luxury free to all, but it was particularly important during childbirth and lying-in.[1336] In practice, this meant that no strong smells were allowed in the birthing room, or "anything to render the air offensive and impure".[1337] In nineteenth-century obstetrics, childbed fever was

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1330 See for example Antiseptic Midwifery Bag. The *BMJ*, December 1, 1894, 1246. See also Antiseptic Midwifery Forceps. The *BMJ*, December 15, 1894, 1374.

1331 Playfair 1893a, 347. Playfair included in his bag for example chloroform, ether, laudanum, ergot, syringes, catheters, and "a good pair of forceps".

1332 Stables 1894, 215.

1333 Stacpoole 1894, 81–85, 110–111. See also Discussion on Antiseptic Midwifery. The International Medical Congress. The *BMJ*, September 3, 1881, 401. See also Scott 1870 [?], 121; Black 1888, 69; Allbutt 1890, 18; Herman 1891, 168–175; Swayne 1893, viii–xiii; Walker 1893, 93; Stables 1894, 215. See also Leavitt 1986, 169–170. See also Loudon 2000, 132–135.

1334 Vincent 1902, 40, 45, see also pp. 69–70. See also Playfair 1893a, 348–350. See also for example Jardine, Robert, Aseptic Midwifery. The *BMJ*, September 17, 1898, 782–784.

1335 See for example Chavasse 1866, 143. See also Chapter 4.2.

1336 Harvey 1863, 8; Stables 1894, 42. See also Obstetric Aphorisms. The *BMJ,* November 26, 1881, 884.

1337 Conquest 1849, 44.

closely associated with sewage fumes, coming from the poorly organised sanitation system of the house.[1338] Moreover, the cleanliness of the birthing room included a good ventilation system and sunlight, both considered efficient disinfectants.[1339] Very important immaterial hygienic qualities of the room were also a low temperature and general quietness; 60 degrees Fahrenheit (16 degrees) was a sufficient temperature inside the room. In order to remove the dampness of the room, a fire in an open fireplace was often recommended. No street noises or the sounds of the house itself should have disturbed the patient when she was in labour or lying-in. This quietness also included the conversation in the room: no loud talk was allowed, no gossiping or reminiscences of old cases.[1340] Horror stories and rumours only made the patient nervous, afraid, and anxious, thus, creating unnecessary complications and protracted labours. As George Black noted in 1888, "[e]very fear in the young female should be, as far as possible, allayed"; he advised the attendants to constantly remind the parturient woman that the process was "a natural one".[1341] Indeed, the woman was encouraged to look forward to "the satisfactory termination of her sufferings" in every possible way.[1342]

The dress worn in labour was also worth great consideration. While medical journals and patient reports contained only few direct references to dress, medical manuals gave many practical hints to their readers on the choice of suitable garments in childbirth.[1343] As Henry Thomas Scott noted in the 1870s, in childbirth, there was no need for keeping up appearances: "[c]ertainly, she will be *en deshabille* [partially clothed] – a warm flannel night-gown, or any convenient,

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1338 See for example Playfair 1893b, 359–364. See also William S. Playfair quoted in Stacpoole 1894, 85–92, 85–90; see the examples in medical periodicals; Ferrier, John C., Sewer-Gas and Puerperal Septicaemia. The *BMJ*, April 8, 1882, 497; Ground, Edwd., Puerperal Fever: Defective Drainage. The *BMJ*, June 20, 1891, 1333. In the latter case, the doctor had his patient removed from the house lacking water closets and with bad drainage. Interestingly, taking care of sanitation was gender-based; some writers stressed in their popular medical manuals that it was the responsibility of the husband to make sure the sewage system functioned properly in the house, see for example in Stables 1894, 183; Vincent 1902, 152–160. See also Weatherly 1882, 23–25. See also Steeves, G. Walter, Midwifery and Sanitation. The *BMJ*, March 14, 1896, 697. See also Palmer 2004, 61–68; Worboys 2000, 110–113; Bashford 1998, 73–75.

1339 See for example Barnes, Robert, On the Causes, Internal and External, of Puerperal Fever. The *BMJ*, November 12, 1887, 1042: "We cannot make the sun shine, but we may extract much more good from the sun than is commonly supposed. In the first place, let the lying-in room face south; so when the sun condescends to shine you can open the window; and when he does not, there is still a very important advantage gained in a south aspect; it is always lighter and drier." See also Barnes, Robert, Discussion on Puerperal Septicaemia. The *BMJ*, September 16, 1893, 626; The Air of Bedrooms; The *BMJ*, September 27, 1890, 746. See also *Doctor at Home* 1891, 256–257. The description of the unsuitable birthing room, see Woodhouse, R. T., Case of Tetanus Occurring Ten Day after Parturition. The *Association Medical Journal*, February 9, 1855, 120–121. See also Smith 2007, 218, 222–223, 297–302; Loudon 2000, 78–81.

1340 Conquest 1849, 46; Bull 1865, 175–176; Vincent 1902, 42. The temperature of the room, see Conquest 1849, 44; Davies 1852, 32–33; Black 1888, 51; Stables 1894, 213.

1341 Black 1888, 50. See also Drew 1891, 38.

1342 Black 1888, 50. In fact, Black discussed the "character of the pains" but did not mention chloroform at all, see Black 1888, 56–57. See also Chapter 5.4.

1343 See for example the case described in *The Lancet*: On a Case of Caesarean Section, Hard Cancer of Os and Cervix Uteri; Six Days' Labour; No Dilation; Abdominal Hysterotomy; Mother Convalescent, and Child Living. *The Lancet*, January 5, 1861, 4–5.

loose apparel, will suffice."[1344] Usually, the dress recommended was a practical and comfortable two-piece outfit, consisting of a chemise, shorter bed-gown, or a longer nightgown, worn together with a strapless flannel petticoat.[1345] There is also evidence that some aristocratic women had a special garment only for childbirth; considering the economic background of these women in question, this was a demonstration of a strong emotional bond inside of a family rather than a practical or economic necessity.[1346] If the weather was cold, it was advisable to wear a morning-gown, wrapper, or a shawl in addition.

When the second stage of labour was at hand, both the nightgown and petticoat were simply rolled up to the waist, and, after the baby was born and the afterbirths expelled, the soiled and wetted petticoat was removed and a longer nightgown was drawn back down, until, after a short rest, it was time to change it for a clean one.[1347] This was both practical and convenient; the woman felt that she was properly dressed, while the doctor could perform necessary examinations during the different stages of labour. Thus, clothes provided both material and symbolic protection of privacy and decorum.[1348] Moreover, more valuable day dresses remained clean and unsoiled; these clothes were often considered dirty and impractical in many ways.[1349] According to doctors, some women allegedly believed that the corset gave them some kind of physical support, but usually it was recommended to remove the stays altogether and instead to use a roller or a broad bandage, made of flannel or calico.[1350]

5.3 Husbands, Mothers, Friends: Who Attended Labour?

In nineteenth-century medical writings, the birthing room was supposed to be relatively uncrowded, at least if the policy was compared to the previous centuries and the presence of the all-female entourage, *the gossip,* in early modern deliveries. According to medical ideals, the most important people in the room were the parturient woman, the doctor, the female nurse/midwife, and possibly one female friend of the soon-to-be mother. The limitations on those attending were based on both hygienic aspects and psychology: "[a] greater number contaminate

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1344 Scott 1870 [?], 46. See also Fox 1834, 70 –71.

1345 See for example Denman & Ryan 1836, 33–34; Bull 1837, 132; Bull 1865, 178–179; Hill 1841, 9; Kittoe 1845, 178–179; Conquest 1849, 42; Baker 1856, 25; Chavasse 1866, 144; Weatherly 1882, 62; Black 1888, 52–53; Allbutt 1890, 20; *Doctor at Home* 1891, 467; Walker 1893, 99–100; Vincent 1902, 45. See also Gélis 1991, 119–120.

1346 See for example Lewis 1986, 161. See also Queen Victoria to her eldest daughter Victoria, the Crown Princess of Prussia, April 8, 1863. *Dearest Mama* 1968, 192–193.

1347 Conquest 1849, 42; Davies 1852, 34; Stacpoole 1894, 116; Chavasse 1866, 144; Black 1888, 52–53; Drew 1891, 42. See also Lying-In Night-Dress. Obstetrical Society of London. The *BMJ*, April 25, 1874, 547.

1348 On clothes, nakedness, sleeping, and decency, see also Elias 1978, 163–168. See also Gélis 1991, 120.

1349 See for example Weatherly 1882, 62; Allbutt 1890, 20.

1350 See for example Bull 1837, 132; Bull 1865, 179; Hills 1841, 10; Conquest 1849, 42; Davies 1852, 32; Scott 1870 [?] 46–47; Black 1888, 53; Allbutt 1890, 23; Herman 1891, 68; Swayne 1893, 31–32.

the atmosphere, and by their conversation disturb the patient", as Henry Thomas Scott noted in his manual in the 1870s.[1351] For example, Hilary Marland has argued that male doctors "stripped away a source of emotional and practical support", after banishing the gossip as "outmoded and potentially dangerous".[1352] However, as I discuss in this subchapter, nineteenth-century medical writings constantly emphasised the importance of the presence of a female friend: she was an emotional supporter, carrying out some of the traditional functions of the gossip. Moreover, the ideal birthing room was a quiet, peaceful place; the parturient woman was able to concentrate solely on her delivery, while she was not disturbed by any noise or reminiscences of previous confinements and the horror stories about the cases gone wrong. Indeed, it can be said that the emotions played an important role in nineteenth-century birthing rooms.[1353]

Considering the constant need to emphasise their professional competence, scientific capability and the sense of educational superiority, less surprisingly, doctors represented themselves as the most important persons in the birthing room. As all writers assured, the doctor was "the firmest" or "the best" friend of the parturient woman, a supreme guardian of female health and the women's reproductive future.[1354] A parturient woman was advised to trust her doctor completely and to follow his advice in every respect. As well as being an expert on practical medicine, the doctor's role was also psychological; it was the doctor who consoled his patients and inspired them with confidence and hope.[1355] Many authors emphasised that the presence of the accoucheur would radiate "confidence, afford relief, and expedite delivery without the necessity of any manual operation whatever".[1356] In fact, "an intelligent confidence" between the parturient patient and doctor and the doctor's "industrious attention" banished much of "the terrors of the lying-in room".[1357] In this sense, the doctor's role was indispensable, as Henry Arthur Allbutt promoted his peers collectively in his guidebook: "she [the patient] should place herself entirely in his hands, looking upon him as her best friend for the time being".[1358]

Even if the doctors constantly stressed their own importance, manuals intended for use by women emphasised that the *constant* presence of the doctor in the birthing room was not in fact necessary. The doctor was the one who supervised the whole event, made vaginal examinations to observe the dilation of the cervix, determined the child's position and the progression of labour, but his time was valuable and he was also needed elsewhere. "Doctors do not like to be sent

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1351 Scott 1870 [?], 47. See also Hills 1841, 9; Chavasse 1866, 145–147; Back 1888, 49–50.
1352 Marland 2004, 23; Marland 2006, 57. See also Digby 1994, 270.
1353 See for example Simpson 1871, 3–4. See also Oakley 1993, 67. On emotions in medicine, see for example Alberti 2014.
1354 Stables 1894, 237. See also Allbutt 1890, 19. See also Bull 1865, 189: "the medical man enters the lying-in chamber, everything ought to be guided by his judgement, and under his unlimited control." On paradoxes of friendliness and friendship in doctor-patient relationship, see for example Gerlander 2003, 53–63.
1355 Conquest 1849, 41. See also Kittoe 1845, 173–174; Obstetric Aphorisms. The *BMJ*, November 26, 1882, 884; Swayne 1893, 44.
1356 Kittoe 1845, 173.
1357 Obstetric Aphorisms. The *BMJ*, November 26, 1881, 884.
1358 Allbutt 1890, 19. See also Stables 1894, 237. See also Peterson 1978, 131–132.

too soon", Nurse Baker also noted in her manual written in the 1850s.[1359] Hence, calling the doctor was a matter of great consideration; false alarms were frustrating, but based only on the message sent to the doctor in haste, it was difficult, if not impossible, to decide if and when the need for medical help was real and urgent. For example, the manual aimed at midwifery students, *First Lines in Midwifery* (1891), stressed that "[w]hen sent, *go at once*".[1360] Usually, women were advised to engage the doctor forehand; this required its own special medical-economic etiquette, as the abundance of enquiries made in the *BMJ* revealed.[1361] On the other hand, manuals also stressed the pregnant woman's own responsibility in distinguishing real labour pains from false; especially the appearance of the "show", meaning the small amount of blood and mucus, was considered a reliable sign that the delivery had started.[1362]

Interestingly, some manuals also included a separate section of advice in case the doctor for some reason was absent or unable to get there in time.[1363] As many writers noted, occasionally confinements could be extremely rapid, and especially in the countryside, the doctor was not necessarily available, especially in cases of emergency; the distances could be great, or the practitioner could be engaged elsewhere. Hence, manuals gave instructions also for lay persons, family members and friends, who were collectively advised "what to do, and what NOT to do" in labour, as Pye Henry Chavasse emphasised this self-midwifery policy.[1364] The most crucial thing was that the lay attendant stayed calm and composed, not alarming the parturient woman. During childbirth, the attendant supported the head of the child, while he/she placed his/her hand upon the belly of the woman and grasped the womb in order to prevent flooding. It was also the duty of the attendant to check that the umbilical cord was not around the baby's neck and there was no mucus in the baby's mouth; the writers also explained how to revive an apparently lifeless child with a warm bath, by rubbing it or by artificial respiration. Moreover, lay attendants were advised how to tie the umbilical cord after the baby had breathed for the first time, using scissors and

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1359 Baker 1856, 28.

1360 Herman 1891, 64. See also for example Stables 1894, 198–199. See also Loudon 1999, 117.

1361 See for example Burges, Robert, Midwifery Engagements. The *BMJ*, April 27, 1878, 634; Sheen, Alfred, Midwifery Engagements. The *BMJ*, May 4, 1878, 670; J. L. D. [anonym.] Midwifery Fees. The *BMJ*, October 9, 1880, 610; Obstetric Etiquette. The *BMJ*, September 19, 1885, 571; Midwifery Contracts. The *BMJ*, March 22, 1902, 752; Midwifery Engagements. The *BMJ*, April 5, 1902, 870.

1362 See for example Bakewell 1859, 116; Scott 1870 [?], 44–45; Chavasse 1866, 111–112, 127; Chavasse & An American Medical Writer 1871, 234; Black 1888, 46, 57–58; Allbutt 1890, 17; Walker 1893, 100–101; Stacpoole 1894, 114; Stables 1894, 222; Vincent 1902, 46, 47; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 246–248. See also Herman 1891, 69–70; Playfair 1893a, 320–321. See also Swayne 1893, 1–3: "When sent for to a labour, obey the call immediately; for then, if you are too early, you can return home until wanted; and if you are too late, it is not your fault"; see also pp. 10–11.

1363 This section was included in Fox 1834, 72–77; Davies 1852, 37; Philothalos 1860, 50–51; Bull 1865, 192–194, 221–226; Chavasse 1866, 154–159; Chavasse & An American Medical Writer 1871, 256–259; Scott 1870 [?], 54–56; Black 1888, 57–61; Stacpoole 1894, 118–121; Stables 1894, 226–227; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 267–272.

1364 Chavasse 1866, 154.

strong thread. Any traces of after-births, however scarce, were to be kept safe until the doctor inspected them. All these pieces of advice suggested that in the minds of the medical profession, the presence of a doctor was a rule and his absence was an abnormality; a medical practitioner was the only one capable of ensuring that everything was proceeding well. "[T]hus it will be seen how important it is that the doctor should be present", as Florence Stacpoole pointed out in her manual in 1894.[1365] However, in reality, doctors did not attend all deliveries, and as some writers acknowledged, thousands of women gave birth without professional medical assistance.

Historians have paid a considerable amount of attention to the question of whether husbands attended their wives' confinements or not.[1366] Current practices in childbirth, meaning British men attending the births of their children, new viewpoints in gender history, and an obvious need to make men visible also in the history of the family, have turned the historical gaze to those roles that men had or were given also in nineteenth-century childbirth. For example, John Tosh has argued that by the 1840s, British husbands *were* present in the delivery room, and, in fact, "it had become commonplace for husbands to be in attendance during the birth itself".[1367] However, the primary sources studied for my research neither confirm nor dispute the Tosh's argument; in fact, it is somewhat difficult to argue with absolute certainty if this really was the common practice in every social class and in every family.

The fact is that many popular health manuals failed to mention husbands at all, and likewise, medical periodicals rarely noticed soon-to-be fathers or their presence in the lying-in room. Usually, the husband was the one to call the doctor and he provided the necessary information that the labour had started, but otherwise he remained largely invisible.[1368] Husbands clearly observed the reproductional health of their wives and were sometimes able to inform about any

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1365 Stacpoole 1894, 119. See also Chavasse 1866, 155, 159.

1366 The American sociologist Jill Suitor has used the terms *participation*, *presence,* and *attendance* in reference "to non-medical individuals' presence during labour and birth". Suitor herself preferred the term "participation" when she discussed men attending childbirth because she wanted to stress that husbands provided emotional and sometimes physical support during labour. I use all terms interchangeably in this research. See Suitor 1981, 278; see also King 2016, 5. On men in early modern childbirth, see Gélis 1991, 101–103; on fatherhood, see also Gillis 1996, 179–200; Tosh 1999, 79–101.

1367 Tosh 1999, 82. See also Jalland 1986, 144–145; Gélis 1991, 102; Gillis 1996, 168–169, 190–192. On working-class fathers, see Strange 2015; Strange did not discuss childbirth directly but presented working-class fathers in everyday interactions with their children. On American fathers and childbirth, see Leavitt 2009, 156. Leavitt argued that fathers did not participate childbirth prior the twentieth century. On nineteenth-century law and fathers, see Broughton & Rogers 2007, 8–12. On the twentieth-century customs in Britain, see King 2016, 1–19. See also King 2015.

1368 See for example Hodgson, G. F., A Case of Inversion of the Uterus. The *BMJ*, August 24, 1867, 149; Gentles, T. Lawrie, Case of Rupture of Female Bladder Associated with Abortion. The *BMJ*, January 6, 1883, 8. See some of the manuals which did not mention the presence of men at all, Black 1888; Vincent 1902. Jane H. Walker did not make any references to a husband in labour but she mentioned that during lying-in, no one, except the husband, doctor, and the nurse, should admitted to the room occupied by the parturient woman. See Walker 1893, 110. Compare to Suitor 1981, 283–285.

abnormalities in the menstrual cycle or in their wives' reproductive bodies, and thus, doctors acknowledged that husbands could occasionally be a very valuable source of information.[1369] Some men noticed certain familiar symptoms and signs with particular confidence, as described by one doctor in 1878. When the pregnant wife of a soldier had had a sudden and violent fit of convulsions, greatly alarming the doctor, the husband remarked only, "[a]ll right doctor; she'll have a child in three days".[1370] As the doctor noticed, the husband "knew the sign" and was apparently right in his prognosis. However, sometimes this lay diagnosis was less successful; men could misread some of the symptoms their wives suffered from as confirmatory signs of pregnancy – even if that was not the case.[1371]

Historians have often referred to a famous and much quoted discussion, dated to the early 1840s. In their letters sent to *The Lancet,* medical men discussed the presence of husbands in nineteenth-century birthing rooms. Between 1840 and 1857, Prince Albert had famously attended the births of all his nine children; in fact, the birth of the royal couple's first child in November 1840 was the starting point for the discussion in the journal. Indeed, in royal circles and in elite families, husbands were often present in the birthing rooms, holding their wives' hand and supporting them when their children were born, and some of them continued to nurse their wives after childbirth.[1372] For example, when Queen Victoria's youngest daughter, Princess Beatrice's first confinement took place at Windsor Castle in 1886, it was both Beatrice's mother and her husband, Prince Henry of Battenberg, who attended the labour, as the Queen herself described: "Dear Liko [Prince Henry] was very helpful & was there continually excepting when he took a little rest while I remained".[1373] This custom was practised also in other European courts. However, it was not only about emotional bonds within the royal and imperial families but a presentation of power, dynastic traditions, and lines, enforcing especially the

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1369 See for example Denton, E. R., A Case of Spontaneous Rupture of the Uterus during Labour. The *BMJ*, August 20, 1870, 187–188; Habgood, Henry, Case of Interstitial Tubo-Gestation. The *BMJ*, February 10, 1883, 250–251; Carwardine, Thomas, A Clinical Lecture on Early Extrauterine Pregnancy. The *BMJ*, January 11, 1902, 67. In Henry Arthur Allbutt's manual, the husband was in fact the one who sent for the doctor. Allbutt 1890, 18.

1370 Hypodermic Injection of Chloral in Puerperal Eclampsia. Obstetrical Society of Dublin. The *BMJ*, July 20, 1878, 123. See also Montgomery 1837, 255.

1371 See for example the case of a woman who had a large tumour, alongside a foetus in cavity of the uterus. The doctor notices that: "[N]either the patient nor her husband had noticed any enlargement until shortly after menstruation had ceased in March; and they then thought it was to be attributed to pregnancy." Savage, T., A Case of Porro's' Operation: Recovery. The *BMJ*, September 2, 1882, 423.

1372 See for example Jalland 1986, 144–146; Lewis 1986, 171–173; Calvert 2017, 23–31. See also Snow 2008, 80–82. See also Gélis 1991, 102.

1373 Queen Victoria to Victoria of Battenberg, November 23, 1886. Hough (ed.) 1975, 84–85. Princess Beatrice was the Queen's youngest child. See also the description of the first delivery of Princess Alice, the Queen's second eldest daughter in 1863 in Victoria's letter, Queen Victoria to her daughter Victoria, the Crown Princess of Prussia, April 8, 1863. *Dearest Mama* 1968, 192–193.

legitimacy of a new heir.[1374] Moreover, as Judith Schneid Lewis has stressed, women (and men) coming from royal circles and the aristocracy did not usually represent anyone than themselves.[1375] Thus, the presence of royal fathers at childbirth did not imply the attendance of *all* men.

Indeed, not everyone agreed with this practice of men attending childbirth. In the first letter sent to *The Lancet* in December 1840, the conduct of the young Queen and her German-born husband was condemned as the "fashionable '*London practice of midwifery*'", suggesting that the husband's presence at childbirth had been uncommon prior to 1840.[1376] However, this letter faced criticism in subsequent issues of the journal.[1377] Some correspondents called especially for empathy and understanding, as did one particular anonymous writer: "I do think that when the wife is suffering the pains of labour, and the fear and dread which are attendant upon that moment of severe trial, it is unnatural not to allow her partner in life to enter the room, and whisper words of comfort and solace."[1378] This was especially beneficial in the case of the patients "of a desponding nature".[1379] The letter demonstrated that Victorian men were expected to be attentive husbands, as John Tosh has pointed out in his studies.[1380] It seems, however, that in medical thinking men were firstly husbands and only secondly fathers: it was acknowledged that the husband was worried about the well-being of his wife, and that the wife, especially "at the climax of her suffering", could benefit from the presence of the loving and caring husband. The men's role as fathers seemed less important; at least it was not discussed in medical literature in connection of childbirth.[1381]

1374 For example, in 1868 when the future Tsar Nicholas II was born, present in the birthing room were the father of the baby, Tsarevich Alexander (the future Tsar Alexander III) and also the baby's paternal grandparents, Tsar Alexander II and Empress Maria Alexandrovna. See Hall, C. 2001, 51–52.

1375 See Lewis 1986, 7.

1376 "Country Doctor" [anonym.], Husbands in Bed-Rooms during Parturition. *The Lancet*, December 11, 1841, 391. The anonymous doctor with decades of experience wanted to bring the question before his colleagues in order to raise "some discussion". In this, he was certainly very successful. See also Gélis 1991, 101.

1377 See for example John Chatto, Husbands at Childbirth. *The Lancet*, December 18, 1841, 421. The writer expressed his wish that the practice would spread "even into the most remote provincial districts". See also Bryant, John, Husbands at Accouchements. *The Lancet*, December 18, 1841, 421.

1378 "B. H. W. H." [anonym.], To the Editor of The Lancet. *The Lancet*, December 18, 1841, 421–422.

1379 "B. H. W. H." [anonym.], To the Editor of The Lancet. *The Lancet*, December 18, 1841, 421–422. This writer even doubted whether the "Country Doctor" was a married man himself – actually wanting to know "whether, if his lady were many hours or days in suffering, he would like to be forbidden to see her on the score of delicacy."

1380 Tosh 1999. On the other hand, the presence of men was a class-related question. As Laura King has shown, in nineteenth-century working-class families men did not attend childbirth; the reason was connected to "norms of masculinity". Childbirth was not a "man's place" because it was not considered "manly". Nevertheless, men could be very emotional when their children were born. King 2015, 108, 175–177; King 2016, 1.

1381 Interestingly, one non-medical correspondent who took part in the discussion, noticed that men did not want to be treated like children, kept at a distance and not knowing what was happening to their wives and children "F." [anonym.], Husband at accouchements. *The Lancet,* February 26, 1842, 759–760. This second non-medical

In addition, the topic of decency and the question of gender roles came up. One correspondent, another anonymous doctor, argued that the husband "can do no good in the room [--] if the case were going on well, I think his presence would be indecent, unbecoming, and unnecessary."[1382] It seems that when it was a question of husbands, gender became an important legitimising function – but in a very different way than when male doctors were discussed. As one non-medical reader, taking part in the conversation in the journal, asked if it was indecent for the husband to be in the lying-in room, why was it appropriate that a man-midwife, *a man*, should be there – "on the score of decency".[1383] The writer, who was not "altogether inexperienced on the subject" – clarifying that he was a family man himself – considered the profession of man-midwife "very mal-appropriate employment" for men.[1384] It is hardly any surprise that the medical profession did not share this opinion.[1385]

Secondly, the idea was that husbands, as *lay men*, lacked personal and natural *female* experience of giving birth and thus, they could not relate to what was going on in childbirth, only making themselves and the parturient women nervous – always risky and potentially creating unnecessary complications in delivery. In his manual, Gordon Stables noticed that for some time before the actual labour, husbands and "will-be" fathers were actually more nervous than women, who, according to Stables, were often "really remarkable brave".[1386] Some men bore this nervousness well, but, occasionally, there are mentions of fathers fainting when seeing their wives in childbirth or in a lying-in bed.[1387] Hence, emotions and the close marital bond could became an obstacle: men cared too much for their wives and were terrified of seeing women in pain, frightened by the uncommon sounds of the birthing room and seeing the blood and other secretions of the parturient body. As I discuss further in this chapter, according to the nine-

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reader of the journal taking part in the discussion – who had been present at the birth of two of his children – remarked that is was awkward that the doctor could be a total stranger to the woman in labour and yet "a father and a husband is forbid by delicacy to be present at the birth of his own child". On Chavasse and fatherhood, see Chavasse 1872, 51–54.

1382 "W. K." [anonym.], Husbands in Lying-In Rooms. *The Lancet*, January 15, 1842, 551–552. In fact, the writer was somewhat surprised when he found that three letters printed in *The Lancet* encouraged the system of the husbands being present in the lying-in room. The custom was "a great dislike" to him. He even stated that in most cases, women did not want their husbands to participate "*till it is all over*".

1383 "H. B." [anonym.] Attendance at Accouchements. *The Lancet*, February 5, 1842, 562.

1384 "H. B." [anonym.] Attendance at Accouchements. *The Lancet*, February 5, 1842, 562.

1385 Kirkby, T. W. B., Midwives and Midwifery. *The Lancet*, February 26, 1842, 761–762. See also "A Subscriber" [anonym.] Incompetency of Female Accoucheurs. *The Lancet*, February 26, 1842, 760–761.

1386 Stables 1894, 212.

1387 See for example Woodhouse, R. T., Case of Puerperal Convulsions. The *Association Medical Journal*, May 17, 1856, 406. In this particular case, the husband saw his wife having puerperal convulsions a day after delivery: "He, either overcome by his feelings, or alarm at the appalling sight, fainted and fell on the floor". The husband himself was a doctor. See also "B. H. W. H.", To the Editor of The Lancet. *The Lancet*, December 18, 1841, 421–422. On the companionship in labour in twentieth-century America, see Leavitt 2009, 176, 183–188.

teenth-century medical ideals, a "sister-woman" was considered a better attendant in the birthing room because she possessed the necessary personal experience of childbirth.[1388] In this sense, female experience, albeit always lay knowledge, was superior to emotional marital closeness between husbands and wives.

More generally, popular medical manuals did not usually encourage husbands to enter the birthing rooms, not until the delivery was provably over – the only exception being the guidebook of William Hamilton Kittoe, written in the 1840s.[1389] This did not mean that doctors did not understand the close emotional bond and intimacy between the married couple. Indeed, Pye Henry Chavasse, for example, replied with a somewhat sharpish tone when answering his own question as to whether the husband should be present during the labour; "[c]ertainly not".[1390] But even Chavasse, like many of his peers, acknowledged that husbands were emotionally attached to their wives, even if the medically right place for a man was always *outside* of the room. Thus, doctors clearly understood that husbands were anxious to know what was going on and that they waited for the result impatiently. "[B]ut as soon as the labour is over, and all the soiled clothes have been put out of the way, let him instantly see his wife, for a few minutes, to whisper in her ear words of affection, of gratitude, and consolation", as Chavasse described in his manual.[1391]

Regarding the history of the family, the historian Julie-Marie Strange has justifiably pointed out that a *husband* was not the same as a *father*, and, hence, the relations between wives and husbands were not analogical to those of men and their children.[1392] Moreover, the family dynamic could change within one family over time and be complex due to various things. Thus, presumably some women did not necessarily want their husbands in the birthing room and some men did not want to be there, even if they had had a chance to do this.[1393] Due to this fact, some medical writers stressed that the choice was ultimately made by the parturient woman, and not by the doctor – unless it was a case of emergency.[1394] The historian Judith Walzer Leavitt has discussed the emotional changes taking place within the marital relations during the last couple of centuries; how women

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1388 "H. B." [anonym.], Attendance at Accouchements. *The Lancet*, February 5, 1842, 652. The writer stated that the profession of man-midwife was "an importation, and not a very ancient one". Ibid.

1389 Kittoe 1845, 175: "There can never be the slightest reason why the husband should be interdicted at this period; on the contrary, it may not only tend to calm the irritability of the patient, but will at once disabuse the former of any prejudice he might have before entertained on the subject."

1390 Chavasse 1866, 136. See also A London Physician [anonym.] 1891, 262.

1391 Chavasse 1866, 136. See also Allbutt 1890, 19: "The woman's husband and neighbours must be kept out of the lying-in room". On emotional support and marital intimacy, see for example Jalland 1986, 145.

1392 Strange 2015, 3. See also Gillis 1996, 12.

1393 See for example Jardine, Robert, Hysterical Aphonia in a Young Man. The *BMJ*, April 7, 1900, 888. See also Bryant, John, Husband at Accouchements. *The Lancet*, January 29, 1842, 630.

1394 Playfair 1893a, 348. See also "W. K." [anonym.], Husbands in Lying-In Rooms. *The Lancet*, January 15, 1842, 551–552. See also Suitor 1981, 284–285; Gillis 1996, 191; Tosh 1999, 82.

wanted to share their intimacies with their husbands rather than the female cycle of gossip and how husbands were growingly eager to participate in their wives' pregnancies and deliveries.[1395] However, this notion does not take into account the fact that also in the early modern world, men were very much involved with their wives' reproductional health, even if they were not welcomed to the birthing chamber in person.[1396]

On the other hand, as the historian Laura King has illustrated, in practice, "being present" for birth could mean a number of things: sometimes this included being present during the whole delivery, and sometimes witnessing only some parts of it.[1397] In nineteenth-century birthing rooms, with birth taking place in a homely environment, fathers certainly had easier access to childbirth than in the next century when hospital birth became the norm and happened on the terms of the hospital rather than of the family in question. Nineteenth-century homes were often small, and, thus, in some families, family members could not always withdraw themselves from what was going on in childbirth – even if they had wished to do so. In their own homes, men also had more authority – especially if they were socially privileged upper-class husbands with wealth and a prestigious family name. Indeed, in the twentieth century, when birth was finally moved to hospitals, a husband's role was eventually to be merely that of a visitor.[1398]

Many accounts showed, nevertheless, that husbands nursed their wives during labour and lying-in, playing active practical and supportive roles in these important and emotionally meaningful family events. For example, in 1879, the *BMJ* mentioned a clergyman, who was the husband of a pregnant woman suffering from headache and "depression of spirits"; he was described as "a most excellent nurse" by the doctor reporting the case.[1399] Patient reports show that some husbands actively participated in the treatment of their wives, supporting them, and giving practical help during the different stages of labour and lying-in. For example, in 1850, in the case of a woman suffering from puerperal convulsions, the husband held his wife down when she was having the seizures. However, after the attack was over, he was asked to leave the room by the doctor – which he did "with very great reluctance".[1400] Two women, who were also present in

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1395 Leavitt 2009, 47–48.

1396 See for example Gélis 1991, 101–102; Gillis 1996, 184–185; Evans & Read 2015.

1397 King 2016, 5.

1398 For example, in 1954, 63.7 percent of British births took place in hospital and in 1972, already 91.4 percent. See for example King 2015, 3–17. See also Leavitt 1986, 87–89.

1399 Bird, Valentine, Induction of Labour and Delivery by Forceps in Puerperal Mania. The *BMJ*, April 12, 1879, 544–545. Also Prince Albert lifted his wife from bed to the sofa when the Queen was not allowed to walk, and kept her company when she was staying in her rooms during lying-in. See for example Woodham-Smith 1972, 217. See also Calvert 2017, 24–31.

1400 King, George, Remarks on Epilepsy or Puerperal Fever. The *PMSJ*, March 6, 1850, 116–117. The parturient woman was suffering from edema; the female neighbour of the woman had called for the doctor. When the delivery started, the woman was lying on her back, while her husband and two other women were holding her down. The baby was stillborn but the woman survived; however, it was only some days later when she "could be made to understand that she had been confined", because she could not remember anything. See also Chapter 5.5.

the birthing room, were allowed to stay. The doctor, reporting on the case, noted that the practical medical work was often difficult, due to "the anxious entreaties of relations, the whispers of friends, as well as the significant insinuations of the nurses and the ignorant by-standers".[1401] As Judith Walzer Leavitt has illustrated, sometimes lay attendants could also expect the doctor to "do something", even if this kind of interference was not necessary or medically justified.[1402] In fact, when discussing complicated births, the *BMJ* stressed that "the anxiety of a patient and her friends [--] is a dangerous guide to treatment".[1403]

These cases confirm that men were usually mentioned only if something unexpected and dramatic happened at some point during pregnancy, childbirth, or lying-in. Men witnessed events and observed what was taking place, but sometimes they just happened to be there, given a very small part in the whole story. For example, in 1876, in the case of a successful Caesarean section, the parturient woman travelled a cab journey in her husband's lap to be operated on in hospital.[1404] In another case, involving a woman who died some hours after she had given birth, the husband had lain next to his wife when she was sleeping; it was the husband who noticed that the woman started to breathe with difficulty and was feeling faint.[1405] It is clear, however, that not all men paid much attention to medical advice and ideals dictating the rules and treatment in childbirth and lying-in. Nurse Baker, for example, described in her manual how one of her patients suffered from the conduct of the husband, who rushed into the lying-in room and agitated the patient with his stories, apparently meant to be "shocking or horrid for her amusement".[1406] The doctor had "no more control over this entertaining husband" than Nurse Baker had had.[1407]

Some accounts revealed that the relationship between a doctor and the husband could also be tense and very unpleasant. In 1855, one doctor described a midwifery case of his which ended in the death of the patient; a "self-willed husband" was constantly interfering in the treatment, after failing to organise a proper lying-in room for his wife.[1408] Usually, the result of the birth and the gen-

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1401 King, George, Remarks on Epilepsy or Puerperal Fever. The *PMSJ*, March 6, 1850, 116–117. As the writer noted, the doctor needed "great presence of mind, much firmness, untiring patience, and great moral courage" to face these disadvantages of his work.

1402 Leavitt 1986, 43, 144, 151. See also The Address in the Section of Obstetrics and Gynaecology. The *BMJ*, September 18, 1897, 726.

1403 The Address in the Section of Obstetrics and Gynaecology. The *BMJ*, September 18, 1897, 726.

1404 Edmunds, James, The Report on a Second Case of Caesarean Section in Which the Mother and Child Recovers. *The Lancet*, December 9, 1876, 819.

1405 Berry, Samuel, Case of Sudden Death Seven Hours after Delivery – Air Found in the Heart. The *PMSJ*, November 27, 1850, 656.

1406 Baker 1856, 17–18. See also "Country Doctor" [anonym.], Husbands in Bed-Rooms during Parturition. *The Lancet*, December 11, 1841, 391.

1407 Baker 1856, 17–18.

1408 Woodhouse, R. T., Case of Tetanus Occurring Ten Days after Delivery. The *Association Medical Journal*, February 9, 1855, 120–122. The husband was a coal-merchant; the parturient woman was spending her lying-in in a filthy room, filled with "the litter of the husband's trade". According to the doctor, the husband had made his wife eat his own specialties, "a good deal of rum in gruel".

eral management of the patient had an impact on how relations gradually developed. For example, in 1889, in the case of a woman who died due to malpractice by the doctor, the practitioner called the husband an "ignorant boy", when he was defending himself in the *BMJ,* shortly after he was charged with manslaughter and eventually found guilty. This particular doctor was clearly indignant that the husband had taken control in the birthing room and confronted the authority of the doctor; the husband "coolly informed me that 'he had to bring in those other two blokes [two other doctors] to finish my job', and that he would not pay my fee".[1409] Unfortunately, the documents failed to mention whether the husband had been present in the birthing room for the whole time. Some reports revealed that men were called into the birthing rooms only to say a last goodbye to their dying wives, indicating that the husbands had not been there during the entire labour and that they were not expected to attend the labour itself.[1410]

Occasionally patient reports revealed that husbands had their strong opinions about the treatment of their wives and children, sometimes confronting the medical authority of the doctor or the nurse. These conflicts made some doctors enquire, for example, whether it was illegal to use medical aids, such as midwifery forceps, in labour without the consent of the patient's husband. In 1885, in the case of a 43-year-old primipara, the husband, six days after confinement, had suddenly demanded an explanation why "those 'devil's instruments'" had been used.[1411] In their answer, the editors of the *BMJ* stressed that the husband's consent was not needed in such cases. However, there is evidence that the husband could forbid the post-mortem examination of his wife, even if the doctor was anxious to know the cause of death in fatal midwifery cases.[1412] Also in cases

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1409 See Verdict of Manslaughter against a Medical Man. The *BMJ*, September 21, 1889, 681–682. The parturient woman, age 23, was described as "strong, healthy, very muscular". Her first labour had been very difficult, being an instrumental one. The second delivery had lasted more than seventy hours when the doctor produced a mortal rupture with his fingers. See also Special Correspondence: Birmingham. The *BMJ*, September 14, 1889, 619.

1410 See for example Thompson, C. M., Post Partum Haemorrhage. The *BMJ*, January 10, 1874, 47. In this particular case, the husband took part in the recovery measures of his wife: "The labour was soon over, but was followed by such fearful flooding that defied all control – so much so, that I [the doctor] called the husband into the room, that he might be present at the death. All at once, I thought my enemy, the frost [it had been a cold morning]. I desired the husband to bring me a handful of ice [--] I thrust a handful of ice into the uterus. Contraction at once took place; my patient was saved".

1411 L. F. P. S. [anonym.], Marital Interference in Obstetric Operations. The *BMJ*, June 6, 1885, 1184. See also Denman & Ryan 1836, 81; Ryan 1841, 255. On authoritative confrontations between the doctor and husband, see also Leavitt 2009, 188.

1412 See for example the case of a woman who had an ovarian tumour complicating the delivery. After the woman had died, the doctor was anxious to do a post-mortem; "the wife having made the husband promise that it should not be done, in case of her death, it was refused me". Edwards, Conway T., Case of Ovarian Tumour Impending Delivery. The *PMJRMS*, July 30, 1842, 329; Ewen, Henry, Extrauterine Pregnancy. The *BMJ*, August 29, 1868, 216. See also Boyle Runnalls, H., Inversion of the Uterus Immediately Following Labour. The *BMJ*, March 13, 1886, 492. See also the report by Pye Henry Chavasse in 1856; the patient made Chavasse promise that the doctors would "open her as soon as she was dead". Chavasse, Pye, H., Case of Extra-Uterine Pregnancy. The *Association Medical Journal*, November 30, 1856, 1071–1072. See also Foscati 2019, 470.

of Caesarean section, the consent of the husband was needed, as I discuss in Chapter 5.5.[1413]

Patient reports published in medical periodicals demonstrated how in dramatic circumstances, husbands were forced, alongside doctors and other family members, to make difficult decisions concerning their wives and children – sometimes, to choose between mother and child. In complicated labours, such men "might be put down either a good husband but a bad father, or a good father but a bad husband", as it was noted by Murdoch Cameron, a Scottish pioneer of an antiseptic Caesarean section, in the *BMJ* in 1891.[1414] Historically, the Emperor Napoleon I of France (1769–1821) was seen as an example of a husband who wanted his wife saved if some kind of choice had to be made. British doctors often referred to the famous story according to which before the birth of his son in 1811 Napoleon had allegedly said: "Treat the Empress [Marie Louise] as you would a shopkeeper's wife in the Rue St. Martin, but, if one life must be lost, by all means save the mother."[1415] The infamous sixteenth-century ruler, Henry VIII of England (1491–1547), on the other hand, was primarily a father and only secondly a husband. In nineteenth-century medicine, Henry VIII was sometimes depicted as a man who let his wife die in order to save his much-anticipated son and heir. Some even believed that Henry had ordered a Caesarean section for his third wife, Jane Seymour, when she was giving birth to the future Edward VI and subsequently dying in childbirth in 1537.[1416] These examples show that the historical anecdotes could be used to legitimise the current medical practices.

However, this was not merely a professional question. In their private lives, many doctors were married men and had families of their own. As for a reply to the question whether the presence of a man at childbirth was indecent and improper, William Hamilton Kittoe noted in his guidebook (1845) that doctors were "generally" husbands and fathers themselves and that their professional and social reputation was constantly "at stake".[1417] Thus, social control and a constant fear of losing both a professional and social reputation protected both male doctors and their parturient patients. Moreover, married doctors with children of

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1413 See for example Tanner 1860, 74: "Legally, the conduct of these men [who refused to allow the operation] was justifiable; morally, they would certainly appear to have been guilty of homicide". See also for example Dowling, Jeremiah, The Caesarean Section. The *BMJ*, January 1, 1876, 32; Hunter, R. H. A., Successful Case of Caesarean Section. The *BMJ*, September 26, 1885, 599.

1414 Cameron, Murdoch, On the Relief of Labour with Impaction by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 509. See also for example Radford, Thomas, A Successful Case of Caesarean Section. The *PMSJ*, August 22, 1849, 456–457.

1415 See for example Cameron, Murdoch, On the Relief of Labour with Impact by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 510; Sheppard, Edgar, On the Relative Value of Maternal and Foetal Life. The *PMSJ*, November 10, 1852, 591. See also Ryan 1841, 261.

1416 See for example Cody 2008, 248. On Henry VIII in nineteenth-century medical texts, see Cameron, Murdoch, On the Relief of Labour with Impact by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 510. See also An Anti-Caesarean Society. The *BMJ*, May 30, 1891, 1192. See also Playfair 1893b, 233. See also O'Dowd & Philipp 2011, 159.

1417 Kittoe 1845, 174. See also Ryan 1841, 168; "He [the doctor], too, most likely, is a husband, a father, and citizen".

their own were often also personally acquainted with the practices of childbirth. In the case of a medical man, he knew, based on his education and professional experience, what was happening, and, thus he was able to act more confidently and calmly in the birthing room than his lay contemporaries.

For example, in 1892, an anonymous penname *Drew* asked in the *BMJ* whether it was "customary and whether it is advisable for a medical man to attend his own wife in her confinement".[1418] The answer of the journal noted that the presence of the doctor-husband in childbirth was acceptable, although "not customary"; seven years later, another answer to the same kind of query noticed that there was "nothing contrary to medical etiquette in a medical man attending his own wife in her confinement", and it was "often done".[1419] It was pointed out, however, that it was usually "wiser" that someone else treated the nearest members of the doctor's own family.[1420] Emotions, primarily worry and fear for someone close, prevented doctors from working rationally. The "husband-accoucheur" could temporarily lose his professional protection when seeing his own wife in pain and agony, thus creating emotional stress which otherwise did not in exist in a more professional and less intimate doctor–patient relationship. Otherwise, it seems that no consensus existed amongst the medical profession itself; some were convinced that the presence of a husband-accoucheur was beneficial in every possible way, and "certainly more soothing to the wife's susceptible feelings", while some considered it inadvisable.[1421] Different roles and responsibilities were renegotiated in the case of the husband-accoucheur.

More generally, most medical writers agreed with Robert Hills, who had no difficulties in limiting the number of those allowed to attend the birthing room: "[n]o person should be admitted in the room except the nurse and one female friend; more only excite, and cause unpleasant feelings."[1422] This opinion was confirmed by many. Moreover, the overcrowded room was polluted by dangerous carbon dioxide – a stuffy hot room with bad ventilation was a constant hygienic danger in nineteenth-century medical discourse.[1423] According to the medical manuals, the best companion in the birthing room was a female friend of the parturient woman, even if at the end of the nineteenth century, she was sometimes replaced by a professional nurse.[1424] This female friend was always married and already a mother herself; her personal experience made her sympathetic to the sufferings of the parturient, encouraged her, and kept both herself and the

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1418 Queries. Letters, Notes, and Answers to Correspondents. The *BMJ*, June 4, 1892, 1235.

1419 Queries. Letters, Notes, and Answers to Correspondents. The *BMJ*, June 4, 1892, 1235. See also Answers. The *BMJ*, January 21, 1899, 190: "we believe, however, that it is wiser for a medical man not to attend any near member of his own family when other competent medical assistance is available". See also Loudon 1999, 106.

1420 See for example Ryan 1836, 39. See also Braxton Hicks, J., Remarks in Which the Whole or Part of the Placenta Was Retained for a Longer Period than Usual after Delivery of the Child. The *BMJ*, July 22, 1882, 124. See also Woodhouse, R. T., Case of Puerperal Convulsions. The *Association Medical Journal*, May 17, 1856, 406.

1421 Husband and Accoucheur. The *BMJ*, June 11, 1892, 1283. See also Answers. The *BMJ*, January 21, 1899, 190.

1422 Hills 1841, 9. See also Bull 1837, 129–130.

1423 See for example Bull 1837, 129; Chavasse 1866, 145.

1424 See for example Allbutt 1890, 19.

parturient woman calm, even if some kind of problem occurred.[1425] She was to "act calmly and lovingly", with understanding and tact, as John Tricker Conquest described the ideal type of attendant in his manual: "a married female of light and easy mind, cheering in her disposition, and acquainted with the routine of the lying-in chamber".[1426]

This ideal of only one participant clearly went against the practice of past centuries and the presence of the *gossip*, a group of female friends, relatives, and neighbours attending delivery. Thus, it has been suggested that the nineteenth-century doctors stripped away a traditional source of emotional and practical female peer support.[1427] However, based on the patient reports and health manuals, doctors clearly appreciated the personal experiences and peer support of women, constantly stressing that the attendant's duty was to keep the atmosphere as light and cheerful as possible. "No conversation of depressing character should for one moment be allowed", noted also Pye Henry Chavasse in the 1860s.[1428] On the other hand, the presence of the third party in the birthing room also guaranteed that nothing improper or morally questionable happened during childbirth. For this reason, unmarried women were not usually welcomed into the birthing room; it was very likely they did not fully understand what was *normal* and what was not, panicking and needlessly alarming the parturient woman.[1429] Indeed, generally, emotions such as "fuss, or flurry, or hurry, or worry", were unwelcomed in childbirth, as was described by Gordon Stables.[1430]

As the historian Judith Schneid Lewis has argued in her study *In the Family Way: Childbearing in the British Aristocracy 1760–1860* (1986), since the 1850s, in British aristocratic families, what she called "emotional energy" was increasingly directed towards the family of the parturient woman. Lewis had noted that women became emotionally more dependent on their own mothers and sisters rather than the members of their husband's family. Thus, in the nineteenth century, childbirth attended by the maternal family members become a norm within the British aristocracy, whereas in the eighteenth century, most children had been born in the presence of their paternal relations.[1431] According to Lewis, this change was connected to the rise of domesticity within a hundred-year period, from 1760 to 1860, and to the new attitude towards motherhood; giving birth to an heir (a son) was no longer a service to the paternal family as much as it was an emotionally significant status of the *mother* herself, emphasising the close

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1425 See for example Chavasse 1866, 146; Black 1888, 49.
1426 Conquest 1849, 41. See also Leavitt 1986, 97–108.
1427 See for example Marland 2006, 57.
1428 Chavasse 1866, 146. See also Davies 1852, 31. Many authors were convinced that both nurses and lay attendants told horror stories and reminisced about bad cases. See for example Denman & Ryan 1836, 34; Kittoe 1845, 177; Black 1888, 50. On the general atmosphere of the sickroom, see also Frawley 2004, 181–182.
1429 Bull 1837, 129. See also Leavitt 1986, 108–110. See also Gélis 1991, 99–101.
1430 Stables 1894, 226.
1431 Lewis 1986, 52–53. However, women studied by Lewis belonged to the British aristocracy who were socially and economically a small homogenous group, and thus, they represented only themselves, not the entire population. See also Wilson 2013, 154–155.

bond between the woman and her children, especially with daughters.[1432] Indeed, childbirth was also emotional bonding between an adult woman and her mother who was now more often attending her own daughter's deliveries. For example, in royal circles Queen Victoria was present at the confinements of her daughters and granddaughters – at least those who lived in Britain or could travel there – alongside the husbands of the women in question.[1433] No doctor certainly had the power to prevent the Queen from showing up in the birthing room.

However, despite these cultural changes and the royal examples, in medical ideals, the mother of the parturient woman was not usually regarded as the best suitable companion in the birthing room. Doctors knew that in the matters of pregnancy and birth, women consulted each other and especially the role of the woman's own mother was often very important; this peer support was unofficial, private, and often invisible, but often much-needed and indispensable for the women themselves.[1434] However, medical authors thought that the mother, seeing her own daughter in pain, made the parturient nervous and depressed the atmosphere out of "her maternal anxiety", as for example Pye Henry Chavasse noted in his guidebook.[1435] However, many writers, like Chavasse, clearly acknowledged that women within the same family were emotionally attached to each other. Hence, even if the presence of the soon-to-be grandmother inside the birthing room was not usually recommended, it was nevertheless argued that she could stay in the *same house*; "the patient [--] derives comfort from the knowledge of her mother being so near at hand", as Chavasse, for example, pointed out.[1436] Thus, doctors acknowledged that childbirth was a socially and emotionally significant family event, concerning a wide circle of family friends and especially female relatives, the mother of the parturient woman being the closest of them.

In the patient reports and letters published in medical periodicals, doctors often referred to lay attendants as "friends", but quite often did not specify who they were – it is unclear if they were really related to the parturient woman and, if they were, how closely, or were "the friends" indeed female friends, not related by blood. According to the patient reports and letters published in medical journals, these "friends" supported the woman emotionally but they also took part in the decision-making concerning the treatment in protracted and complicated

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1432 Lewis 1986, 52–55.

1433 See Queen Victoria describing the deliveries of her daughters Alice and Beatrice: Queen Victoria to her eldest daughter Victoria, Crown Princess of Prussia, April 8, 1863. *Dearest Mama* 1968, 192–193; Queen Victoria to her granddaughter Victoria of Battenberg, November 23, 1886. Hough 1975, 84–85. Moreover, the Queen repeatedly invited her eldest daughter Victoria, who was married to the future emperor of Germany and lived permanently abroad, to come and give birth in Britain but this plan was never realised. See also Lewis 1986, 53.

1434 See for example Leavitt 2009, 23; Leavitt 1986, 88–95; Jalland 1986, 141, 146.

1435 Chavasse 1866, 146. See also Davies 1852, 32: "for although her natural affection might prompt her to undertake the office, yet, as her feelings and anxieties are not unlikely to betray her judgement, and place her in a most painful situation". See also Bull 1865, 170–171; Black 1888, 49.

1436 Chavasse 1866, 146; Scott 1870 [?], 47. See also Black 1888, 49; *Doctor at Home* 1891, 466.

cases, together with husbands and doctors.[1437] For example, in 1882, one parturient woman bled so copiously in her confinement that she collapsed; doctors decided that she needed a blood transfusion to survive. First, the husband offered to supply the necessary blood, but then the mother of the parturient woman "begged that she be the donor".[1438] The parturient woman was already unconscious but soon she was able to recognise "her friends", who, in this case, were her husband and mother. Many similar kinds of reports revealed that in practice, the mothers of parturient women attended the birthing rooms of their daughters. One such case was the wife of a village carpenter and a mother of nine children, who died shortly after she had given birth in 1845. In the court, the female neighbour testified that the mother of the woman had been in the birthing room for the whole time, and later, the mother herself gave her own testimony against the medical practitioner who was charged with (and found guilty of) "gross ignorance" and manslaughter.[1439] In this case, the husband was not mentioned until his wife was dying and he was called in the room to see her for the last time.[1440] The journal, however, did not see anything peculiar in that the mother had been in the same room with her parturient daughter. The mother had witnessed the events and she was also present when her daughter died, giving her evidence "much affected", as the journal reported later.[1441]

1437 See for example Radford, Thomas, Cases in Midwifery. The *PMSJ*, August 6, 1851, 424–427. In the first case reported, the husband and friends of the parturient woman decided together with the doctors that a Caesarean section was necessary; in the second case, the unidentified "friends", "readily consented that we [doctors] should adopt any practice we thought best". In both cases, the parturient woman died soon after they were operated on. Both women had given their consent to the risky operation. See also for example Hodgson, G. F., A Case of Inversion of the Uterus. The *BMJ*, August 24, 1867, 149–150.

1438 Walter, William, A Successful Case of Transfusion of Blood after Severe *Post Partum* Haemorrhage. The *BMJ*, September 2, 1882, 415. The delivery had been a quick one. The patient, who laid "a pool of blood", was given ergot and the doctor introduced the hand, but the haemorrhage continued. Transfusion was no ordinary procedure in childbirth, as doctors noted: "from ten to twelve minutes, all the blood (nearly four ounces) was injected; and the patient's arm being bound up, we anxiously watched the results of the transfusion".

1439 Forcible Removal of the Uterus and a Portion of the Large Intestines in a Parturient Woman: Inquest. The *PMSJ*, March 12, 1845, 168–170. Another case of maternal death took place six months earlier in 1844 when a single woman, "a very diminutive person" died after the craniotomy operation had failed and then a Caesarean section was performed. Both the parturient woman and her mother had been "willing" when the doctor suggested a Caesarean operation; the doctor referred to "friends" but very likely he meant the mother. The woman lived fifty-four hours after the risky operation. See Cox, Frederick, Case of Deformed Pelves – Caesarean Section – Death. The *PMSJ*, September 18, 1844, 382–384. A similar kind of case in which a mother attended her own daughter's delivery ending tragically, see Stanger, G. E., Horrible Case of Malapraxis in Midwifery. The *Association Medical Journal*, March 17, 1854, 253–254. See also Denton, E. R., A Case of Spontaneous Rupture of the Uterus during Labour. The *BMJ*, August 20, 1870, 187–188.

1440 Forcible Removal of the Uterus and a Portion of the Large Intestines in a Parturient Woman: Inquest. The *PMSJ*, March 12, 1845, 168–170.

1441 Forcible Removal of the Uterus and a Portion of the Large Intestines in a Parturient Woman: Inquest. The *PMSJ*, March 12, 1845, 168–170.

This particular case demonstrates that in many cases, women and their closest circle could be terrified of the risks of birth, while the darker shades of reproduction shaped many nineteenth-century marriages and families, affected a larger circle of friends and neighbours, and emotionally, they also had a long-lasting impact on doctors and their work, as I discuss in the next two subchapters, the first one illustrating the question of pain relief in nineteenth-century obstetrics and the latter concentrating on the risks and complications of labour.

5.4 "Robs Labour of Its Dread, Its Pain, and Its Anxiety": Labour Pains and Pain Relief

Pain was a part of a large cultural and medico-ethical discussion in both nineteenth-century society and medicine, very visible also in the popular medical literature analysed in my study. I have examined the changing perceptions of pain in the primary sources – after the 1840s, when the new methods in pain relief had been introduced in medicine, the topic was often discussed also in popular health literature. Traditionally, in Christian theology, pain was often seen as punishment from God or analogously an expression of God's justice or will; thus, pain was inevitably a natural part of all human life and the human's lot was to suffer with patience and fortitude, relying on God's wisdom.[1442] In childbirth, pain was often associated with the Bible and the curse of Eve – the wages of an irreconcilable sin committed by the first woman. However, many historical accounts demonstrated that in practice, attempts were often made to alleviate pain with different kinds of methods.[1443] Various reports and case studies published in medical periodicals show that in the early 1840s, opium, morphine, and laudanum were used at least in the most difficult midwifery cases, and opium and laudanum constituted an important part of self-medication and home doctoring during pregnancy.[1444] As one doctor wrote in 1844 – only some years before the

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1442 Bending 2004, 5–9, 44–45, 47. This is of course a generalisation; as Lucy Bending has noted, no general consensus existed as to the meaning of pain in Christian theology. Arguments were by no means unanimous and flexible perceptions varied according to the theological writer in question. Thus, pain could be seen as a remedy for a sin and "also recognized as a spur to action". See also Leavitt 1986, 28; Porter & Porter 1988, 98–101, 168–179, 235–243; Towler & Bramall 1986, 24, 29; Rey 1995, 53–57, 85–88; Caton 1999, 94–103; Snow 2008, 15; Beier 2002, 122–123. See also Lewis 1986, 59. On inevitability of pain, see also Duden 1991, 87–88.

1443 Herbs and alcohol were used in order to alleviate pain in childbirth; parturient women were also massaged and supported physically. Various charms and religious objects, such as relics, were also an integral part of the experience of childbirth. See also Chapter 3.1. See also Snow 2008, 75–76.

1444 The German pharmacists Friedrich Wilhelm Sertürner isolated morphine from opium at the beginning of the nineteenth century. Opium was already well known in ancient pharmacy and medicine; in the eighteenth century, it became increasingly popular in medicine, not only used as a painkiller and an analgesic, but also as remedy against fever, diarrhoea, and vomiting. On opium in medicine, see Scarborough 1998, 4–18; Maehle 1998, 52; Rey 1995, 148–152; Snow 2008, 7–9. Compare to Caton 1999, 75–76. See also Smith, T. and H., An Improved Form of Laudanum. The *BMJ*,

introduction of chloroform: "[t]hough it be true that the decree has gone forth that the woman in sorrow shall bring forth children, this is no reason why the obstetrician should not resort to the aid of art, guided by science and experience, to alleviate the suffering of his patient."[1445] This was an ideal but not necessarily always practice.

The historian Lucy Bending has argued that the understanding about bodily pain changed dramatically between the 1840s and the 1880s; by the end of the nineteenth century, anaesthesia had become a routine part of surgery and the very idea of pain had transformed according to the new discoveries, taken place in the late 1840s and onwards. Thus, during the nineteenth century, pain began to be seen more and more as an expression of God's *injustice* – it become a medical and scientific problem rather than being a Divine mystery.[1446] As Florence Stacpoole wrote in 1894, it was accepted that "*pain* is *not* good for people", whereas "long ago many really seemed to think it was".[1447] In the late 1840s, new breakthroughs in anaesthesia changed the perceptions of pain; now pain become "something to be avoided at all costs", as Lucy Bending has pointed out.[1448] Concerning childbirth, the question of pain and its injuriousness, however, was not particularly simple. The very essence of labour pains was constantly debated; was pain in childbirth *natural*, some kind of necessity or even somehow beneficial, or could modern science help parturient women, in order to lessen their sufferings or even remove pain altogether.[1449]

In November 1847, the Scottish obstetrician, James Young Simpson, famously introduced chloroform in medicine; he had also administered ether in a midwifery case for the first time earlier in the same year, in January 1847.[1450] Chloroform, an organic compound, was, as John Tricker Conquest described it in his 1849 popular manual, "a fragrant volatile fluid, obtained by the distillation

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May 24, 1884, 1004. See for example Denman & Ryan 1836, 35; Bull 1837, 88–90; Welch 1838, 19–20.

1445 Breen, John, Artificially Dilating the Os Uteri. *The Lancet*, May 11, 1844, 217. See also The Jubilee of Anaesthesia. History of the Discovery. The *BMJ*, October 17, 1896, 1135–1142. See also Philothalos 1860, 44–45. See also Serious Charge against a Surgeon. The *BMJ*, November 14, 1857, 952–953.

1446 Bending 2004, 25–31. See also Caton 1999, 110–121, 124–129. On pain in nineteenth-century medical discourse, see Latham, P. M., General Remarks on the Practice of Medicine. XIV. Pain. The *BMJ*, June 28, 1862, 677–680; July 5, 1862, 1–3. See also Boddice 2019, 152–163.

1447 Stacpoole 1894, 104.

1448 Bending 2004, 69. Stephanie J. Snow has claimed that before the nineteenth century, doctors explained that pain was necessary and functional in surgery; the introduction of anaesthesia gradually eroded this argument. See Snow 2008, xiii.

1449 See for example Bending 2004, 52, 75–81. See also Rey 1995, 91–94; Caton 1999, 15–16; Poovey 1987, 140–141.

1450 James Young Simpson had administered ether in a midwifery case for the first time in January 1847. According to Donald Caton, this was the first known administration of chemical anaesthesia for childbirth. Caton 1999, 3. On the history of anesthesia, see also the nineteenth-century discourse of science and progress in The Jubilee of Anaesthesia; History of the Discover. The *BMJ*, October 17, 1896, 1135–1142. See also Operations Performed under the Influence of Aether. The *PMSJ*, January 11, 1847, 27–28; Simpson, James Young, Discovery of a New Anaesthetic Agent More Efficient than Sulphuric Aether. The *PMSJ*, December 1, 1847, 1, 656–658. See also Simpson 1849, 83–109.

of spirits of wine over powdered Chloride of Lime, the vapour of which, if inspired from a hollow-shaped sponge or pocket-handkerchief [--] produce unconsciousness of some duration".[1451] Ether, equally a colourless and volatile compound, had been presented in the 1840s, first in American dentistry; after some very public and unsuccessful attempts, it was eventually accepted in surgical operations alongside chloroform.[1452] According to Wendy Mitchinson, in Canada, chloroform was the most predominant anaesthetic until the 1870s when ether eventually replaced it.[1453] However, as one of the leading obstetricians of his time, William S. Playfair pointed out in 1893, in Britain, chloroform was the "agent hitherto employed".[1454] Patient records show that both chloroform and ether were administered in obstetrical surgical operations, but the risks of chloroform were more often discussed and reported in medical periodicals.[1455] Popular health manuals I have analysed mentioned only chloroform if their authors discussed the possibility of pain relief in childbirth.[1456] There were also other possible options: the anaesthetic qualities of nitrous oxide had been investigated already in eighteenth-century England; it was used first in dentistry in the 1840s in the United States and since then, occasionally also in childbirth.[1457] However, in nineteenth-century obstetric medicine, it was clearly overshadowed by chloroform and ether.

As the abundance of letters and reports published in medical periodicals show, at first, after its introduction, chloroform was a miracle drug, but very soon

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1451 Conquest 1849, 51. See also Harvey 1863, 109–116.

1452 Snow 2008, 22–45. See also Caton 1999, 4–6. Compare to Rey 1995, 153–166. See for example Pickess, Henry, Case of Delivery under the Influence of Aether. The *PMSJ*, September 22, 1847, 516. See also The Jubilee of Anaesthesia. History of the Discovery. The *BMJ*, October 17, 1896, 1137–1140.

1453 Mitchinson 1991, 41.

1454 Playfair 1893a, 367, see also pp. 368–371. See also Snow 2008, 168. See also Savill, Thomas D., On the Use of Anaesthetics during Labour. The *BMJ*, May 12, 1883, 903–904.

1455 See for example Savill, Thomas D., On the Use of Anaesthetics during Labour. The *BMJ*, May 12, 1883, 903–904; Simpson, Alex. Russell, Case of Caesarean Hystero-Oophorectomy, or Porro's Operation; With Remarks. The *BMJ*, June 11, 1881, 910–911; Barnes, Francourt, Why is Chloroform So Well Borne in Midwifery? The *BMJ*, October 21, 1882, 788; Eastes, George, The Vapours Chiefly Used for Anaesthetic Inhalations, and Their Safe Employment. The *BMJ*, November 29, 1884, 1064–1065; Cameron, Murdoch, Remarks on Caesarean Section, with Notes of a Second Successful Cases. The *BMJ*, March 15, 1890, 583–585; Mouillot, F. Albert, A Successful Case of Caesarean Section. The *BMJ*, June 28, 1890, 1482; Alleged Safety of Chloroform in Parturition. The *BMJ*, January 6, 1900, 35. See also Buxton, Dudley W., Fifty Years of Anaesthetics. The *BMJ*, October 17, 1896, 1143–1148.

1456 See for example Surgeon & Accoucheur [anonym.] 1900–1909 [?], 251–252. The manual of J. T. Conquest briefly mentioned *Chloride of Olefiant Gas*, or *oil of olefiant gas*, *Dutch oil*, or *oil of the Dutch Chemist*, recommended by his colleague. Conquest had heard that it was less dangerous and "equally pleasant, potent, and speedy of action" than chloroform. Conquest 1849, 66. See also Rey 1995, 165–166.

1457 See for example Snow 2008, 9–14, 20–22; Bending 2004, 52–53; Rey 1995, 143–148. See also Nitrous Oxide in Oxygen as an Anaesthetic in Labour. The *BMJ*, November 7, 1885, 866–867: "The patients were generally semi-conscious; so that though they would answer if asked a question, they felt no pain, and were unware when the baby was born". See also Braine, Woodhouse, Anaesthetics, and Their Administration. The *BMJ*, November 29, 1884, 1060–1063. The Jubilee of Anaesthesia. History of the Discovery. The *BMJ*, October 17, 1896, 1137.

it was discovered that patients responded to it in very different ways and it was not safe for everyone who inhaled it. "It has been given thousands without injury; but to others it has been death", noted also Thomas Bull in the 1865 edition of his popular manual.[1458] During the first years, its possible dangers were also associated with a sexual-moral threat; some feared that an unconscious woman, trusting the male medical attendants, would be an easy target for molestation, even for rape.[1459] The bigger and medically more important question was, however, the safety of anaesthesia in medical operations. Many accounts show that nineteenth-century doctors sought a balance between safety and the dangers of anaesthesia; this was an ongoing debate and worry after the turn of the second half of the century.[1460] It was generally accepted that its use was risky; as the historian Stephanie J. Snow has illustrated, in the nineteenth century, doctors were not held responsible even if their patients died due to anaesthesia.[1461] And, as the *BMJ* noted in 1896, when celebrating the golden jubilee of anaesthesia, "the ideal anaesthetic, however, has yet to be discovered".[1462] Indeed, Thomas Bull pointed out in 1865 that the use of chloroform was always "*to a certain extent, an experiment*".[1463] Some reports in the 1850s demonstrated that on some occasions, husbands could give their parturient wives chloroform during delivery, but generally, writers stressed that administering the anaesthetic was always to be left

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1458 Bull 1865, 161. See also Rey 1995, 167–169; Poovey 1987, 137–156.

1459 See for example Rape Perpetrated on a Female while under the Influence of Aether. The *PMSJ*, August 11, 1847, 447–448; The Use of Chloroform for Criminal Purposes. The *Association Medical Journal*, August 4, 1854, 697–698; Conviction of a Dentist for Violating a Patient while under the Influence of Ether Inhalation. The *Association Medical Journal*, May 11, 1855, 439–445. See also Snow 2008, 121–147; Mitchinson 1991, 117–119.

1460 See for example Caton 1999, 28–32; Snow 2008. See the examples of discussion in Snow, John, On the Use of Chloroform in Surgical Operations and Midwifery. The *London Journal of Medicine*, No. i, January 1849, 50–55; Holmes, T., Death Following the Inhalation of Chloroform in Surgical Operation. The *BMJ*, January 24, 1857, 65–68. See also Leavitt 1986, 119–126.

1461 Snow 2008, 40, 169. See also O'Neill, Charles, The Safe Administration of Anaesthetics: With Special Reference to Chloroform and Methylene. The *BMJ*, June 12, 1897, 1465–1466.

1462 The Jubilee of Anaesthesia. The *BMJ*, October 17, 1896, 1150. See also Swayne 1893, 47–49. On the other hand, doctors famously experimented with anaesthetics on themselves; for example, Simpson, together with his assistant James Matthews Duncan, who later became a prestigious obstetrician in his own right, tested chloroform in June 1847, some months before publishing his findings in medical periodicals. Snow 2008, 32, 44–45. See also Rey 1995, 143–144; Poovey 1987, 137. See the paper of James Young Simpson, Discovery of a New Anaesthetic Agent More Efficient than Sulphuric Aether. The *PMSJ*, December 1, 1847, 1, 656–658. See also Schiebinger 2004b, 391.

1463 Bull 1865, 162. Italics in the original source. Compare to Vincent 1902, 52–53. See also for example Copeman, Edward, Remarks on Chloroform. The *BMJ*, August 30, 1862, 237–238.

solely to a doctor.[1464] There were always individual differences in the quantity needed for the individual patient, known only by professional practitioners.[1465]

For a medical practitioner, the administration of chloroform was relatively easy – no inhaler or special instrument was needed, basically a handkerchief was enough, even if special masks were also designed for the purpose.[1466] As James Young Simpson himself explained, chloroform possessed "an agreeable, fragrant, fruit-like odour, and a saccharine taste".[1467] Simpson also claimed that chloroform worked quicker than ether – thus, valuable time was saved in risky operations – and it was cheap and easy to carry with the doctor in his bag.[1468] However, in childbirth, unlike in surgical operations where shock alone could kill the patient, a full loss of consciousness was not necessary.[1469] Indeed, one of the first parturient patients, who had been administered chloroform in 1848, was, according to her doctor, "comfortably asleep, though easily roused"; the patient herself noticed the effect produced by anaesthesia, describing that she had been "in another world".[1470] John Snow (1813–1858), an English physician and one of the pioneers of both anaesthesia and epidemiology, noted in 1849 that chloroform produced five different stages of consciousness, even if the different degrees run into each other gradually.[1471] In the first degree, the patient experienced slighter effects but was able to observe what was going on around him/her. The second

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1464 See for example The Late Accidents from Chloroform. The *Association Medical Journal*, November 4, 1853, 959. In this particular case, taken place in France, the husband had left the handkerchief with chloroform on his wife's face; the woman was saved by mouth-to-mouth resuscitation. The practitioner had been present at childbirth but for some reason, the husband was in charge of anaesthesia. See also especially Dilemma [anonym.], Anaesthesia in Accouchements. The *BMJ*, December 7, 1878, 858. Also Prince Albert had given the Queen some chloroform in 1857. See Snow 2008, 93. On the regulation of drugs in Britain, see Holloway 1998, 77–95. See also Chavasse 1866, 150–151; Stables 1894, 226; Stacpoole 1894, 104–105. See also Mitchinson 1991, 179.

1465 See for example Bull 1865, 162. See also for example Murphy, Edward W., Chloroform in Midwifery. The *Association Medical Journal*, February 2, 1856, 86–88.

1466 See for example Snow, John, The Breathing and the Pulse under the Influence of Chloroform. The *Association Medical Journal*, April 6, 1855, 313–318; Skinner, Thomas, Anaesthesia in Midwifery: With New Apparatus for Its Safer and More Economical Induction by Chloroform. The *BMJ*, August 3, 1862, 108–111; A Modified Chloroform Inhaler. The *BMJ,* November 7, 1896, 1391; An Apparatus for Administering Anaesthetics and Other Volatile Vapours. The *BMJ*, August 7, 1897, 347. See also O'Neill, Charles, The Safe Administration of Anaesthetics: With Special Reference to Chloroform and Methylene. The *BMJ*, June 12, 1897, 1465–1466. See also Harvey 1863, 115; Swayne 1893, 48–49. See also Snow 2008, 49.

1467 Simpson, James Young, Discovery of a New Anesthetic Agent More Efficient than Sulphuric Aether. The *PMSJ*, December 1, 1847, 656.

1468 Simpson, James Young, Discovery of a New Anesthetic Agent More Efficient than Sulphuric Aether. The *PMSJ*, December 1, 1847, 656–657

1469 See this fact explained in Chavasse 1866, 153. See also Caton 1999, xii; Snow 2008, xiii.

1470 Budd, Herbert W., Two Cases of Delivery under the Influence of Chloroform. The *PMSJ*, February 9, 1848, 62. See also Pickess, Henry B., Case of Delivery under the Influence of Ether. The *PMSJ*, September 22, 1847, 516: "the patient recovered herself , but for a time, she was incredulous of what had occurred, and when convinced, manifested equal surprise and delight, repeatedly affirming that she had been unconscious of all that had passed". See also Conquest 1849, 55: "I feel as if I were in heaven!"

1471 On Snow, see Snow 2008, 34–40, 69–74; Caton 1999, 56–69; Bynum 1996, 79–81; Harrison 2004, 103–104.

stage was described as "the dreaming, or wandering state of the mind", being somewhere between unconsciousness and awakeness. In the third degree, the patient was motionless and silent, only involuntary muscular contractions or rigidity were experienced, whereas the fourth stage was "a state of absolute relaxation", perfect for surgical operations. The fifth stage was already very close to death.[1472]

My intention is not to depreciate the experience of pain – it has been real to the sufferer and thus, always extremely personal – but the discourse of pain is very much cultural, historical, and political. Thus, pain has its own language, as the historian Rosely Rey has pointed out.[1473] Pain has been "othered, sidelined, reduced, justified, condoned, condemned and mythologised", to quote historian Rob Boddice's list.[1474] Glorification of pain has also been typical particularly in religious contexts, but in childbirth, sacrificial pain was thought to define woman's true character, especially heroism and self-sacrifice, when she was transforming from a girl into a woman and mother.[1475] Indeed, as Laura Gowing has noted, in early modern England, labour pains were seen as "a measure of virtue and civilisation"; this perception was very visible also in the nineteenth-century cultural-medical discourse. Especially too easy and short births were seen as a "marker of cultural and social inferiority".[1476] Thus, pain, suffering, and sensitivity were hierarchal and deeply polarised culturally: only white Christian and respectfully married women suffered in childbirth, whereas "savage women" and prostitutes reportedly gave birth painlessly. In nineteenth-century medicine, working-class women were often added to the list.[1477] Civilisation and luxurious living conditions were allegedly corrupting the natural female body; it was believed that women living in a less cultivated state of society, "the savage women", suffered less than their better-off contemporaries did.[1478] Indeed, Wendy Mitchinson has argued that this kind of theory of civilisation as a cause of disease provided "doctors with a reason if they failed": a problem was simply too big for them.[1479]

Many accounts show that women themselves clearly were afraid of suffering and agony, produced by uncontrollable pain.[1480] As doctors constantly warned, fear was always a negative emotion in childbirth, increasing the risks of

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1472 Snow, John, On the Use of Chloroform in Surgical Operations and Midwifery. The *London Journal of Medicine*, No. i, January 1849, 50–55. See also Snow, John, On the Administration of Chloroform during Parturition. The *Association Medical Journal*, June 16, 1853, 500–502.

1473 Ray 1993, 4. See also Bending 2004, 82–115; Bourke 2005, 287–290; Duden 88–91: "The language of pain conveys an entire world view." See also Porter 1985, 186–187.

1474 Boddice 2014, 3. See also Boddice 2019, 152–163. See also Rey 1995, 2–9. See also Gélis 1991, 153–154; Duden 1991, 87–89. See also Porter 1985, 186–187.

1475 Lewis 1986, 73–78. See also Gélis 1991, 150–151.

1476 Gowing 2003, 170. See also Wood 2014, 188.

1477 Gowing 2003, 70. See also Bending 2004, 125, 178–183, 203–209. See also Russett 1989, 56. Prostitutes were also believed to be sterile, see for example Drysdale, C. R., Sterility of Prostitutes. The *BMJ*, October 15, 1881, 656. See also Snow 2008, 63–66; Gélis 1991, 154. See also Risse & Warner 1992, 197.

1478 Davies 1852, 34. See also Bending 2004, 6, 123–135. See also Chapter 5.1.

1479 Mitchinson 1991, 75.

1480 See for example Leavitt 1986, 32–33.

complications. Pain, emotions, and the body are closely and complexly interwoven together; pain was associated with emotions, foremost fear and anxiety, and these were correspondingly rooted in the body.[1481] To the women themselves, doctors usually explained that in childbirth, "some degree of suffering" was always connected with the process, even if suffering was eventually unequal in different women, and in the same woman in different labours.[1482] Pain could also be beneficial, even if writers did not explain how exactly.[1483] The focus was mainly on the negative effects of fear: Thomas Bull, for example, noted in the first edition of his manual in 1837 that some women dreaded giving birth; thus, they were afraid of getting pregnant, simply because they feared pain and all the discomfort associated with childbirth.[1484] Bull, like his colleague Henry Davies, claimed that in reality women did not usually suffer as much as they believed in advance; both Bull and Davies also argued that women were encouraged by the argument that labour was "a natural process" and that eventually all pain ceased when the baby was born.[1485] Some writers also explained that the feeling of a child was "the greatest thrill of delight a woman ever experiences in this world", thus, making the moment of birth amnesia of some kind.[1486] Moreover, the parturient woman needed "kind sympathy" and assurance that "all will end well and speedily"; in this sense the role of attendants as emotional supporters became even more important.[1487]

However, if labour was lingering and pains were hard and severe, most writers recommended the administration of chloroform. As Pye Henry Chavasse pointed out, the possibility of pain relief transformed a state "of gloom, despondency and misery" into "cheerfulness, hope and happiness".[1488] As many writers explained, *both* mothers *and* doctors were indebted to James Young Simpson for introducing anaesthesia in childbirth; the discovery had been welcomed with "feelings of thankful joy and wonder".[1489] For example, Pye Henry Chavasse described how "formerly he [the doctor] dreaded a tedious and hard labour: *now* he does not do so".[1490] In the seventh edition of his guidebook (1866) Chavasse included his remarks on chloroform: "the *moderate* use of Chloroform, in *proper* cases, robs labour of its dread, its pain, and its anxiety, and is a real

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1481 Bourke 2005, 8; Boddice 2014, 1–10; Bending 2004, 52–54; Snow 2008, 5; Alberti 2014, 8, 12, 17, 21–29, 31–35, 140–156. See also Kittoe 1845, 258–259.

1482 Bull 1865, 159; Allbutt 1890, 21; Stacpoole 1894, 1.

1483 See for example Bull 1837, 138; Allbutt 1890, 21. In Christian theology, pain was seen as prophylactic or it built up the character, punishing the sufferer. See for example Bending 2004, 37, 44–45, 65–66; Snow 2008, 78–79. See also Leavitt 1986, 117.

1484 Bull 1837, 141.

1485 Bull 1837, 141. See also Davies 1852, 34.

1486 Chavasse 1866, 147. On Chavasse's view on chloroform, see pp. 150–154. See also Black 1888, 50; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 252.

1487 Hills 1841, 8. See also Wood 2014, 189. See also Gélis 1991, 152–153.

1488 Chavasse 1866, 152. See also Snow, John, On the Use of Chloroform in Surgical Operations and Midwifery. The *London Journal of Medicine*, No. i, January 1849, 50–55. See also Swayne 1893, 48; Stables 1894, 226.

1489 Bull 1865, 160. See also Chavasse 1866, 150, 153; Conquest 1849, 53; Stables 1894, 226. See also Poncia, F. T., On Anaesthesia in Labour. The *BMJ*, November 29, 1862, 572–573.

1490 Chavasse 1866, 153.

blessing to the patient, the doctor, and to all concerned!"[1491] Many medical writers did not even try to conceal the fact that also doctors benefited from anaesthesia; now they did not need to see the suffering of their patients and they had means to alleviate pain. In this sense, suffering was seen as inhumane.[1492] As Andrew Wear has noted, the fear of pain has always been a "crucial factor" in the patient–doctor relationship.[1493] In 1899, in discussion on pain relief, it was noted that "the first duty" of the obstetrician was to relieve suffering.[1494] The most pro-chloroform was Ralph Vincent, who in his manual intended for upper-class women (1902) quite openly praised anaesthesia in childbirth.[1495] Vincent noted that the prevention of pain by the use of chloroform was one of the essentials of "a perfect labour". In fact, Vincent was of the opinion that this was "natural labour" in essence: suffering *without* any relief was not natural, and delivery without chloroform was an "inhumane and unscientific proceeding".[1496]

Since the late 1840s, the majority of writers offered some kind of opinion about the use of chloroform in childbirth; for example, Robert Bakewell noted in 1859, that "it may be expected" that he said "a few words" about it in his manual.[1497] He, like many of his peers, opined that in the cases of ordinary labour when all was going on well, chloroform was not necessarily needed.[1498] Nevertheless, as Bakewell himself acknowledged, he would give his patient chloroform if the parturient woman specifically requested it; Bakewell believed that chloroform caused relaxation and hastened delivery.[1499] The historian Mary Poovey has claimed that in medical articles and textbooks, patients were only quoted if they supported the decisions made by the medical profession.[1500] However, the sources show that some women themselves expressly wished for some kind of pain relief, and on the other hand, some doctors mentioned that some of their patients refused to have it.[1501] At the end of the nineteenth century, Henry Arthur

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1491 Chavasse 1866, Preface ix. See also Conquest 1849, 53.

1492 See for example Conquest 1849, 53. See also Simpson, James Young, Discovery of a New Anaesthetic Agent More Efficient than Sulphuric Aether. The *PMSJ*, December 1, 1847, 1, 656–658. See also Swayne 1893, 48. See also Bending 2004, 130–131; Snow 2008, xiii.

1493 Wear 2000, 242.

1494 Relief of Suffering in Obstetric Practice. Reports of Societies. The *BMJ*, January 28, 1899, 215.

1495 Vincent 1902, 52–55. Due to the use of chloroform in labour, Vincent was one of the few who recommended that the parturient woman should stay in bed whereas others noted the woman was allowed to move about in the birthing room during the first stage. See also Chapter 5.2.

1496 Vincent 1902, 52, 55.

1497 Bakewell 1859, 123.

1498 Bakewell 1859, 123. See also Chavasse 1866, 151. Jane H. Walker, on the other hand, noticed that in first confinements, generally acknowledged as more tedious and slower than the subsequent ones, most doctors administered "a little chloroform". See Walker 1893, 103.

1499 Bakewell 1859, 124.

1500 Poovey 1987, 151.

1501 See for example Manners Mann, Robert, Chloroform in Midwifery. The *Association Medical Journal*, November 11, 1853, 1001; Braxton Hicks, J., Remarks in Which the Whole or Part of the Placenta Was Retained for a Longer Period than Usual after Delivery of the Child. The *BMJ*, July 22, 1882, 123. See for example Jalland 1986, 147–148; Leavitt 1986, 117–118, 127.

Allbutt presented chloroform as a necessary evil; in tedious and painful cases, it gave "wonderful relief", but as he argued, sometimes women were reluctant to inhale it.[1502] Some patients refused it "from religious scruples or from fear of danger to life", as Jane H. Walker noted in her popular textbook.[1503]

One of the most interesting manuals regarding chloroform was *Letters to a Mother* by John Tricker Conquest. The third edition of the book was published in 1849, only one year after the famous experiments of James Young Simpson and his students.[1504] Conquest praised "this wonderful agent", describing two of his own patients who were saved by the possibility of effective pain relief; he warmly supported chloroform but noted that it acted differently on different persons.[1505] Some writers, like John Harvey in 1863, assured that anaesthesia was nowhere "more fully prized than in the lying-in room"; he argued that women who once took chloroform always wished for it again.[1506] In instrumental deliveries, used together with midwifery forceps, Harvey administered it "to its full extent", according to his own words, at least. However, it is necessary to remember that anaesthesia and analgesia, meaning the absence of pain by drugs, were not by any means the only medical methods of pain relief, or at least of lessening the tediousness of the second stage in childbirth. In order to help the parturient woman both to push and to bear the pain, female readers were often advised to press their feet against the bedstead and pull a towel fastened around the opposite bedpost.[1507] Also warm baths and massage could help women during the most painful moments in childbirth.[1508] Some also encouraged women to cry out.[1509]

In obstetric surgical operations, such as in Caesarean sections, chloroform and ether were generally welcomed, even if during the first years, their use was

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1502 Allbutt 1890, 22. Allbutt did not recommend it in every case but "[i]f the doctor proposes it, the woman must not demur."

1503 Walker 1893, 103–104. As Walker noted, "nothing can be said" about the religious objections of the patient herself but she assured her readers that chloroform was perfectly safe, and "where advised by the doctor, had better be taken". See also Stacpoole 1894, 102–103.

1504 The second edition of Conquest's manual, with remarks on chloroform, was published in 1848 but, unfortunately, this edition was not available.

1505 Conquest 1849, 51–59.

1506 Harvey 1863, 116. See also Beatty, Thomas Edward, Address in Midwifery, Delivered at the Thirty-Seventh Annual Meeting of the British Medical Association. The *BMJ*, August 7, 1869, 138–139. See also Leavitt 1986, 117–118.

1507 About the towel-aid, see Denman & Ryan 1836, 33; Fox 1834, 70; Bull 1837, 131, 142; Bull 1865, 190; Hills 1841, 9; Kittoe 1845, 178; Conquest 1849, 42; Davies 1852, 34; Scott [1870?], 53; Cullingworth 1884, 28–29; Weatherly 1882, 65; Black 1888, 52; Allbutt 1890, 21; Walker 1893, 99–100; Stacpoole 1894, 116. Brown, Chas. R., An Obstetric Incident. The *BMJ*, February 15, 1879, 257. See also Lewis 1984, 25.

1508 Walker 1893, 101; Fox 1834, 69; Bull 1837, 134; Chavasse 1866, 131; Cullingworth 1884, 32–33.

1509 Chavasse & An American Medical Writer 1871, 245. See also Gélis 1991, 120–121, 150–151, 154. On the other hand, Jacques Gélis claimed that obstetricians "became more severe in their attitudes", arguing that women "must learn to suffer in silence". This, however, was not the case, at least in popular health literature.

not an absolute rule in obstetrical surgery.[1510] For example, in 1849 Thomas Radford, a Manchester pioneer of Caesarean sections, described the case in which the woman, a former servant, was successfully operated on. Radford stated that no chloroform was needed in the operation: anaesthesia was unnecessary because the woman "possessed in such a high degree tranquility, calmness, and resignation of mind", reflecting the traditional Christian ideals of resignation and self-control.[1511] In fact, Radford was of the opinion that "[m]oral courage is superior to anaesthesia"; two years later he discussed "an enduring Christian spirit" of his other patient, after the patient did not make any complaints and expressed herself "as happily relieved" after the risky operation.[1512] However, some twenty years later, Radford was operating on his midwifery patient with chloroform; already in 1851, he had given laudanum at least to one of his patients who was delivered by Caesarean section.[1513] Reports in the 1850s demonstrated that if the patient herself requested chloroform before Caesarean section, she was often given it.[1514] After the operations, women were usually administered opium, laudanum, or morphine.[1515]

As is very well known, the acceptance of chloroform was aided by the most prestigious woman of the whole Empire. As Judith Schneid Lewis has argued, Queen Victoria unwittingly had an important influence on the nineteenth-century ideals and practices of childbirth.[1516] Victoria, a mother of nine children, was given chloroform for the first time in 1853 at the birth of Prince Leopold, and

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1510 See for example Hawkins, James, Successful Case of Caesarean Operation: Mother and Child Saved. The *BMJ*, May 1, 1858, 386–387. On the history surgery and pain, see Wear 2000, 241–255.

1511 Radford, Thomas, A Successful Case of Caesarean Section, with Remarks. The *PMSJ*, August 22, 1849, 459.

1512 Radford, Thomas, Cases in Midwifery. The *PMSJ*, June 11, 1851, 316. In the latter case, the patient was given opium after the operation. The baby survived the operation but it died of diarrhoea before reaching the first full year. The woman died after she aborted her subsequent pregnancy. See also Radford, Thomas, Observation on the Caesarean Section and on Other Obstetric Operations . The *BMJ*, March 18, 1865, 263–265.

1513 Radford, Thomas, Cases in Midwifery. The *PMSJ*, August 6, 1851, 427. It is unclear why this particular patient, a woman aged 39 with eight previous pregnancies, was given laudanum and the others were not. However, it is possible that Radford administered laudanum or opium all his patients but failed to mention it in his reports. The woman died two days after the operation. See also Radford, Thomas, Further Observations on the Caesarean Section. The *BMJ*, April 4, 1868, 321–324.

1514 See for example West, Dr., Midwifery. The *PMSJ*, April 2, 1851, 188: "The Patient was, by her own desire, subjected to the influence of chloroform [--] no difficulty was experienced in its performance".

1515 See for example Gaunt, J. S., Successful Case of Caesarean Operation: Mother and Child Alive. The *BMJ*, August 28, 1869, 240; Dolan, Thomas M., Caesarean Section: A Case and Its Lesson. The *BMJ*, May 23, 1885, 1036–1038. See also Pollock, George, An Address on the Use of Opium as an Aid to Surgery. The *BMJ*, April 26, 1884, 799–802; Cameron, Murdoch, Remarks on Caesarean Section, with Notes of a Second Successful Cases. The *BMJ*, March 15, 1890, 583–585; McGowan, Wm., Case of Caesarean Section for Osteo-Malacic Pelvis. The *BMJ*, March 15, 1890, 589–590.

1516 Lewis 1986, 7, 83–84, 191. See Death of Queen Victoria. The *BMJ*, January 26, 1901, 233–235; The Introduction of Chloroform into Obstetric Practice. The *BMJ*, February 9, 1901, 357. See also Snow 2008, 82–96.

subsequently four years later when the youngest of the Queen's children, Princess Beatrice, was born in May 1857. The Queen detested the role of women were given in childbirth, clearly appreciating the possibility of pain relief, famously calling it "that blessed Chloroform [--] soothing, quieting & delightful beyond measure".[1517] Victoria's own circle was very interested in chloroform, undoubtedly encouraging the Queen to try it.[1518] Consequently, in 1853, John Snow was asked to administer chloroform when Victoria's eighth delivery was approaching; Snow dripped some drops of chloroform into a handkerchief and the royal patient fell into a pleasant sleep while giving birth to her youngest son.[1519] Snow died in 1858 but Charles Locock (1799–1875), the Queens's Physician Accoucheur, was rewarded with a baronetcy in 1857 – some twenty years later, when the royal obstetrician was dying, the Queen visited him for the last time, paying her respects to her personal accoucheur.[1520]

Interestingly, the Queen's example in pain relief was never referred to in the popular medical literature intended for use by women. However, her treatment and example were widely discussed in medical periodicals, especially in the early 1850s, and for the second time in 1901, at the time of her death. When Prince Leopold was born in 1853, the tone in *The Lancet* was highly critical, whereas the predecessor of the *BMJ*, the *Association Medical Journal,* noted only a week after the birth of the new prince that "we chronicle the recent accouchement of Her Majesty as an event of unquestionable medical importance".[1521] In the Queen's case, the discussion was concentrated especially on the medical risks of treatment of the highest person in the country and Empire. The *Association Medical Journal* had a somewhat egalitarian opinion; the journal stressed that in medicine, all human beings were equals, that is to say, all women in childbirth should be treated in the same manner, regardless of their social position and wealth. "If the risk of giving chloroform in midwifery is too great for the Queen, it is too great for her meanest subject [--] The rank and standing must be forgotten, and human being alone remembered".[1522] Victoria herself, however, was praised especially for her courage. Some fifty years later, in 1901, when Victoria died, this example of the Queen in 1853 was generally remembered as a true landmark in

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1517 See for example Longford 1964, 234; Woodham-Smith 1972, 328, 331. See also Her Majesty's Accouchement: Chloroform. *Associated Medical Journal*, April 15, 1853, 318.

1518 Prince Albert was known for his enthusiasm for the latest scientific discoveries and the Queen's close friend and the Mistress of the Robes, Harriet, Duchess of Sutherland gave the Queen the copy of the pamphlet by James Young Simpson in the late 1840s. Snow 2008, 82–96.

1519 Snow 2008, 82–95. See also Her Majesty's Accouchement: Chloroform. The *Association Medical Journal*, April 5, 1853, 318.

1520 See for example The Week. The *BMJ*, April 25, 1857, 347; Sir Charles Locock. Obituary. The *BMJ*, July 31, 1875, 151; The Queen and Her Medical Advisers. British Leaders in Medicine during the Victorian Age. The *BMJ*, June 19, 1897, 1579–1585. See also Lewis 1986, 101.

1521 Her Majesty's Accouchement: Chloroform. *Associated Medical Journal*, April 15, 1853, 318; May 27 5, 1853, 450. See also Snow 2008, 89–90, 94. See also Administration of Chloroform to the Queen. *The Lancet*, May 14, 1853, 453.

1522 The Queen and Chloroform. The *Association Medical Journal*, June 3, 1853, 478. See also Edwards, Conway T., Chloroform in Labour. The *Association Medical Journal*, June 3, 1853, 493.

medicine, as the *BMJ* noted in the obituary of the long-reigning monarch and the matriarch of her constantly expanding family.[1523]

Some fifty years later after the discovery of anesthesia, it had become a generally shared belief that anesthesia had been fiercely opposed in the 1840s, mainly for religious reasons. The Queen's obituary, published in the *BMJ* in 1901, repeated the story that in the late 1840s, chloroform would have commonly been denounced as a "'decoy of Satan', an impious evasion of the curse pronounced by the Almighty on all daughters of Eve".[1524] As some historians have shown, some religious opposition existed but it seems that its amount was later exaggerated.[1525] As I have already discussed in this subchapter, in medicine at least, it was the safety of chloroform that was constantly discussed and debated. People were also reminded that new discoveries were always opposed, sometimes fiercely. For example, in 1856, one writer compared chloroform with gaslight: first, it had faced criticism, but then became generally accepted. The writer predicted the same kind of route for chloroform: now it was "under its trial" but when better understood, it would "ultimately be as indispensable in the lying-in apartment".[1526] On the other hand, to explain and to justify the use of chloroform in childbirth, James Young Simpson himself wrote a little pamphlet, *Answer to the Religious Objections Advanced against the Employment of Anaesthetic Agents in Midwifery and Surgery* (1847), quoting the Bible, using "the same weapon" as his opponents had done. Simpson argued that God had cast Adam into a deep sleep

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1523 "To her, indeed, the general acceptance of that inestimable boon was largely due". Death of Queen Victoria. The *BMJ*, January 26, 1901, 234. See also The Death of the Queen. The *BMJ*, February 2, 1901, 299: "this act rendered a splendid service to suffering ones, and especially to women in their hour of supreme need". However, the use of chloroform was not the only thing the *BMJ* appraised in the Queen's "noble example of her readiness to avail herself of the benefits of well-established scientific discoveries"; also the fact that she had been vaccinated was mentioned and her appreciation of Joseph Lister's findings in antiseptics were noted. In short, as her medical subjects noted, Victoria's long reign had been a period of great scientific victories and advances.

1524 Death of Queen Victoria. The *BMJ*, January 26, 1901, 234. See also The Jubilee of Anaesthesia. The *BMJ*, October 17, 1896, 1149–1150; The Jubilee of Anaesthesia. History of the Discovery. The *BMJ*, October 17, 1896, 1141–1142. See also Lewis 1986, 189.

1525 Bending 2004, 21. See also Farr 1996, 61–79; Rey 1995, 184–190; Caton 1999, 105–106; Snow 2008, 80. See also Leavitt 1986, 117. See also Simpson 1849, 182–189. See also Chloroform in Midwifery. The *BMJ*, December 21, 1878, 927–928: "Every imaginable objection – moral, physiological, therapeutical, and religious – was raised against this innovation." Compare to Donnison 1999, 65–66. See also Harvey 1863, 111–112.

1526 Murphy, Edward W., Chloroform in Midwifery. The *Association Medical Journal*, February 2, 1856, 86–88.

when removing his rib in order to make Eve, marking it as some kind of anaesthesia, first of its kind.[1527] The pamphlet, containing some thirty pages, was very well received by the *Provincial Medical and Surgical Journal*.[1528]

This potential medical or even religious criticism did not affect the Queen in any way; she continued to recommended chloroform to her own daughters and granddaughters when they gave birth to the new generations of European royalty. For example, in 1863, the Queen's granddaughter and namesake Victoria of Battenberg was born at Windsor Castle, in the presence of her maternal grandmother. The Queen described the delivery in her letter to her eldest daughter: "she [Princess Alice, Queen's second eldest daughter] was only ill from ¼ past 9 and the child was born at ¼ to 5 as naturally as possible, and during the last hour and the half chloroform was freely given, especially quite at the last".[1529] Again, some twenty years later, Victoria attended the delivery of her youngest daughter Beatrice, who gave birth to her eldest child in 1886: "[Beatrice] has a gd. deal of chloroform but was very quiet & never entirely unconscious tho' felt little pain [--] I feel so relieved & grateful to God! for having brought dear Auntie [Beatrice] safely thro' her gt. [great] troubles".[1530] Considering these examples, it is somewhat surprising that the pioneering role of the Queen in pain relief and her positive attitude towards chloroform were not familiar to everyone in her own family. One of Victoria's granddaughters, Marie of Edinburgh (1875–1938), later the Queen of Romania, was very much surprised when she learned in the 1890s that her English grandmother regretted having chloroform only in her last two confinements and not in all nine. Marie had expected her grandmother to be a "Spartan", not approving of any kind of meddling – especially when it was a question of childbirth.[1531] It seems that the British medical press was better acquainted with the Queen's pioneering role in medicine than the members of her own family.

1527 The Introduction of Chloroform into Obstetrics. The *BMJ*, February 9, 1901, 357. See a reference to the pamphlet made by Conquest 1849, 62–66. See also Simpson 1847, 21–22. See also Simpson 1849, 110–131. See also Simpson, James Young, The Propriety and Morality of Using Anaesthetics in Instrumental and Natural Parturition. The *Association Medical Journal*, July 8, 1853, 582–589. See also Caton 1999, 103–106; Bending 2004, 21; Snow 2008, 79–80.

1528 Reviews. The *PMSJ*, January 12, 1848, 16: "We would earnestly recommend the perusal of his observations to all who may entertain objections to the employment of anaesthetic agents on religious grounds".

1529 Queen Victoria to her eldest daughter Victoria, the Crown Princess of Prussia, April 8, 1863. *Dearest Mama* 1968, 192–193. See also Pakula 2002, 115–118, 131.

1530 Queen Victoria to her granddaughter Victoria of Battenberg, November 23, 1886. Hough 1975, 84–85.

1531 Marie, Queen of Roumania 1934, 233–234; Pakula 1998, 96–97. Marie of Edinburgh, later the Queen of Romania, was a daughter of Prince Alfred, a second son of Queen Victoria, and his Russian-born wife, Grand Duchess Maria Alexandrovna. When giving birth to her eldest child, Marie herself was attended by her mother's English obstetrician William S. Playfair, who travelled to Romania to attend delivery. This time, Marie was given chloroform. It seems, however, that Marie did not know that Queen Victoria had in fact been given chloroform *twice*, not once, as she claimed in her memoirs.

5.5 "Fear, Fatigue, and Exhaustion": Risks and Complications of Labour

In the nineteenth century, the majority of women survived childbirth and lying-in, but the process of reproduction sometimes contained a great risk for their health and lives, nevertheless. Considering the relationship between mortality in childbirth, women's fears, and potential risks, the general discourse of popular health manuals was complex. In one sense, the tone was optimistic, as William Hamilton Kittoe wrote in 1845: "it rarely happens in the present day that a woman dies in labour, and never from the consequence, without imprudence on her own part or mismanagement on that of her attendants."[1532] Throughout the sixty years studied in my research, it was believed that science and progress were soon about to solve all problems and change the course for the good. Robert Hills, likewise in the 1840s, noted that the parturient women could be "consoled with the cheering remembrance that women in the ordinary and natural way scarcely ever lose their lives in child-bed".[1533] And if they happened to be so unfortunate, the cause was "mismanagement, defects in constitution", or disease.[1534] Thus, even if death, "an unhappy termination", as Robert Hills called it, was a potential threat, it was avoidable if the laws of Nature and medical rules were followed and the idea of prevention was understood, and, moreover, if women trusted in the medical profession and its ability to save their lives.[1535] In addition, women were constantly reminded how "wonderfully" their "organisation" was adapting to pregnancy; this information helped women to calm their fears.[1536] Women were, in other words, designed to give birth, and their natural bodies gave them much needed confidence.

On the other hand, doctors also acknowledged that many women were afraid of childbirth and for some, the process of reproduction, with its different phases and risks, could be cruel and dangerous. The historian Judith Walzer Leavitt has pointed out that the patient had a limited range of choices at the mercy of physical forces; ultimately, the fact was that "neither women nor medicine could control all of the forces of birth".[1537] As many historians have noted, part of nineteenth century women's experience of childbirth was indeed fear – anticipation that they might die or be seriously injured in pregnancy, childbirth, or during lying-in.[1538] There is evidence that some women even wrote their wills

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1532 Kittoe 1845, 170. Compare to Philothalos 1860, 67–68: "All wives are alike exposed to the same danger, and no one may confidently calculate upon a fortunate issue, however promising the condition may seem to be." See also Bull 1865, 158–159.

1533 Hills 1841, 8.

1534 Hills 1841, 8.

1535 Hills 1841, 8.

1536 Bull 1865, 158.

1537 Walzer 1986, 199.

1538 Leavitt 1986, 14, 20–28. See also Beier 2002, 104–105; Wood 2014, 187–198; Read 2013, 158–159. See also Gélis 1991, 66–71. On the cultural history of fear, see Bourke 2005. See also Fox 1834, 65; Ryan 1841, 174; Tilt 1851, 73; Bakewell 1859, 103; Bull 1865, 159–160. Joanne Begiato has discussed "a pervasive sense of apprehension", see Begiato 2017, 14, see also pp. 20–24.

before they went into labour but it is very likely that this procedure was not commonly practised.[1539] What is known and well documented, however, is that throughout the centuries, pregnant women protected themselves from anything symbolical of death and "constantly sought protective measures", such as prayers and vows, gemstones, amulets, girdles, and shrines dedicated to the Virgin Mother, all of which would ease them through pregnancy and labour and protect their future health and happiness.[1540]

However, some historians have also argued that historically, the discourse of fear of childbirth has been greatly exaggerated. For example, Adrian Wilson has noted – not particularly convincingly – that women in the past were not, in fact, "terrorized" by the fear of childbirth. Wilson distinguished "the fear of pain" and "the fear of death", and moreover, the *risk* of death from the *fear* of death, and managed to compare childbirth with the risks of modern motoring: "[w]hile we all know that dozens of people are killed on the roads every week, very few of us (I suggest) set out on our daily car journeys in terror".[1541] It is difficult to see how giving birth and driving a car are somehow analogous. Giving birth certainly is not a normal daily activity but a deeply personal, physical, emotional, and meaningful event. Moreover, many accounts found both in medical periodicals and popular health manuals demonstrated that fear was constantly present during pregnancy and in the birthing rooms; it was both fear and "a strange indefinable dread, as of the unknown and the awful", as Gordon Stables, for example, explained.[1542] Occasionally, doctors described the fears of their patients quite openly.[1543] Removing or at least lessening negative and unnecessary fears was in fact one of the main motivations of the doctors for writing their popular manuals. Ignorance, in this sense, was certainly not bliss.

Many women were afraid of childbirth because of the pain, the "dread of suffering", and the "anxiety of her safety", meaning the feeling of a loss of control, and the possibility of difficult postpartum gynaecological problems, or even the loss of their own life and/or that of the foetus.[1544] There was a risk that during obstructed labour, if the baby's head did not fit through the mother's birth canal and got stuck, the tissues separating the bladder or the rectum from the vagina

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1539 Leavitt 1986, 21; Jalland 1986, 159; Lewis 1986, 74–75.

1540 Gélis 1991, 67–69, 75, 115–118, 146–149; Towler & Bramall 1986, 30–33; Gowing 2003, 167–169; Fissell 2006b, 14–24, 44, 49–51; Powell 2012; Morse 2019.

1541 Wilson 1996, 137–151. Wilson quoted his fellow historian Irvine Loudon when discussing the connection between motoring and childbirth. See p. 138. See also Loudon 1992, 162–165.

1542 Stables 1894, 161.

1543 See for example Bishop, Edwin, Cases of Difficult Parturition. The *PMSJ*, April 23, 1852, 208: "Considering that this poor woman [a mother of eleven children] had passed thorough similar trials, I never met with a case where fear and mental depression were so prominent; kind words and promises of a favourable issue failed to inspire her with hope". See also Herriot, J. V., Case of Induction of Premature Labour. The *PMSJ*, January 13, 1844, 289–290; Copeman, Edward, Rare Cases of Midwifery. The *BMJ*, January 11, 1862, 33–34; Imlach, Francis, On Successful Case of Porro's Operation. The *BMJ*, October 10, 1885, 695. See also Ryan 1841, 174; Conquest 1849, 46–47; Tanner 1860, 416–418; Playfair 1894b, 6.

1544 Bull 1865, 159. See Leavitt 1986, 13–35; Jalland 1986, 159–160; Beier 2002, 104–105.

were "torn and destroyed by pressure", thus leaving the patient with chronic incontinence and the state of constant wetness, pain, and smell.[1545] Vesicovaginal and rectovaginal fistulas, lacerations, and perineal tears could greatly disturb women's later lives, and, at worst, they made normal daily living extremely difficult, usually bringing all married life to an end and isolating the sufferer from society, unable to control her bodily functions.[1546] One such a case was a young woman, who had delivered a stillborn child in a complicated labour in 1833; the physical and psychological damages of difficult childbirth were still very apparent several years later when her case was discussed in *The Lancet*. The woman, who had been a "strong robust girl", had become "emaciated and hysterical", not able to walk in an upright posture, suffering from constant pains, urinary incontinence, repetitive inflammations of the skin, and ulcers. Since her delivery the woman's life had been misery; despite her disability, she had occasionally worked as a cook, yet confessing that she had been "self-destructive" from time to time.[1547] In another similar kind of case, the woman suffering from vesicovaginal fistula "looked forward only to permanent rest in the grave".[1548]

Serious lacerations and fistulas, such as these, were never discussed in popular health manuals intended for use by women, but it is very presumable that many women were terrified by the risks, at least to some extent.[1549] This side of reproduction was in conflict with the general ideal of motherhood, presenting a leaking offensive female body instead of a pictorial image of the all-consuming mother figure. The first steps in the successful development of reconstructive obstetrical surgery took place around the middle of the nineteenth century, but surgery was not available for everyone and some cases were beyond surgical help.

1545 Lawson Tait, An Address on the Surgical Aspect of Impacted Labour. The *BMJ*, March 22, 1890, 658. See also for example Temple, Algernon, Prevention of Laceration of the Perinaeum in Primiparae. The *BMJ*, January 30, 1886, 191. See also Aliquis [anonym.], How Is the Perinaeum Best Guarded during Labour? The *BMJ*, February 18, 1860, 136; See the answers: February 25, 1860, 157; March 10, 1860, 195–197; March 17, 1860, 215–216; March 24, 1860, 234; March 31, 1860, 255–256. See also Graily Hewitt, Supporting the Perinaeum. The *BMJ*, March 30, 1861, 325–326; April 6, 1861, 353–355; April 13, 1861, 379–381; April 27, 1861, 433–435; May 4, 1861, 461–463; May 11, 1861, 587–489. On the prevention of laceration, see Herman 1891, 72–73; Playfair 1893a, 356–361. See also Swayne 1893, 96–97; Drew 1891, 443–44.

1546 See for examples of perforations of the perineum in labour, Boulton, Percy, Vesico-Vaginal Fistulae. The *BMJ*, July 21, 1883, 113–114; Ferguson, James, Perforation of the Perineum during Labour. The *BMJ*, July 21, 1888, 121. See also Denman & Ryan 1836, 41. See also Playfair 1893b, 146–148. See also Leavitt 1986, 28–32; Wall 2018, ix–x, 1–4, 19–44.

1547 Reid, James, On a Palliative Mode of Treatment for Vesico-Vaginal Fissure. *The Lancet*, February 18, 1843, 737–739. The doctor had had a chance to monitor the condition of his patient for several years and his report confirmed that while the situation and the condition of the woman was occasionally better, she had been in "a constant state of suffering and ill health". See also Kinkead, R. J., Obstetrics as a Branch of Education. The *BMJ*, December 14, 1878, 871. See also Wall 2018, 36–37.

1548 See also Harrinson, Isaac, Case of Utero-Vaginal Fistula: Novel Means of Relief. In *PMSJ*, June 11, 1845, 372–373: "Day and night the urine pursued its errant course; – day and night did it continually dribble away [--] Excluded from society-the very atmosphere surrounding her polluted by her presence, she was miserable both morally and physically".

1549 See gynaecological surgery in Bakewell 1859, 134–135. See for example Jalland 1986, 148–149. See Surgeon & Accoucheur [anonym.] 1900–1909 [?], 263.

The most famous doctor associated with obstetrical surgery was J. Marion Sims (1813–1883), a celebrated, yet very controversial American gynaecologist, who developed new surgical techniques of repairing obstetrical fistulas, using silver-wire sutures – and testing his methods on black slave women.[1550] Patient reports revealed that some women suffering from severe lacerations were treated with pessaries and catheters, some operated on surgically, partially or fully cured, while others continued to live in "misery both morally and physically", somewhere on the margins of society.[1551]

Some laceration cases were no doubt associated with an over carefree use of the forceps and other obstetric instruments.[1552] Nineteenth-century doctors' midwifery forceps skills varied greatly; some doctors were perfectly skilled and experienced while some could cause considerable damage with "the artificial hands", as Henry Arthur Allbutt described the forceps to his readers.[1553] On the other hand, some medical practitioners were reluctant to use instruments in time as the *BMJ* noted in 1889; some could apply the forceps "too readily, hardly giving Dame Nature a fair chance, others trusting her too much", meaning that instruments were not used, at least until it was too late.[1554] Medical aids, such as the forceps, could be applied but during the nineteenth century, in the most difficult and complicated cases, childbirth was becoming growingly surgical. British obstetrical culture changed especially in relation to the Caesarean section, "conservative midwifery", as described by the obstetrician-physician Robert Barnes in 1886, and to craniotomy/embryotomy, "sacrificial midwifery", both meaning

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1550 Wall 2018, 89–122. See also Bennet, J. Henry, Notes on Laceration of the Cervix Uteri; Its Causes and Treatment. The *BMJ*, November 26, 1881, 847–849; J. Marion Sims, M. D. Obituary. The *BMJ*, November 17, 1883, 1000–1001. See also Snow 2008, 66; Wertz & Wertz 1977, 100–101.

1551 See for example Harrington, Isaac, Case of Utero-Vaginal Fistula: Novel Means of Relief. The *PMSJ,* June 11, 1845, 372–373; Palmer, Silas, Case of Urethro-Vaginal, Recto-Vaginal Fistulae, and Culculus Vesicae. The *PMSJ*, October 13, 1852, 530; Spencer Wells, T., Vesico-Vaginal and Recto-Vaginal Fistula. The *BMJ*, August 31, 1861, 223–225; September 7, 1861, 250–252; September 14, 1861, 275–277; Boulton, Percy, Vesico-Vaginal Fistulae. The *BMJ*, July 21, 1873, 113–114; Ferguson, James, Perforation of the Perineum during Labour. The *BMJ*, July 21, 1888, 121–122; A Case of Vesico-Vaginal Fistula. Obstetrical Society of London. The *BMJ*, November 16, 1889, 1099; McCann, Frederick, Case of Vesico-Vaginal Fistula, Cured by a Method Believed to Be New. The *BMJ*, May 17, 1902, 1204–1205.

1552 See a very exceptional letter, sent to the *BMJ*: Poulain, V., Old and New Midwifery. The *BMJ*, May 3, 1879, 689: "Now, placing myself in the position of a layman and husband, I feel that I should strongly object to my wife's perinaeum being split up [--] in order to indulge the impatience of the doctor and the parturient. However my great adoration for my 'cara sposa', I would rather that she should accept 'Eve's legacy' with resignation, than have a very important portion of her body suffer damage." See also Gibson and Wife v. Jeffries and Hills. Medico-Legal and Medico-Ethical. The *BMJ*, August 3, 1887, 385; The Forceps and the Perineum. The *BMJ*, February 23, 1889, 453; March 30, 1889, 751; April 6, 1889, 814–815; May 4, 1889, 1039; May 18, 1889, 1155–1156; June 8, 1889, 1301–1302; The Forceps and Rupture of the Perineum: Assilini's Forceps. The *BMJ*, April 6, 1889, 799–800. See also Wall 2018, 49–61; Leavitt 1986, 52–56, 144–151.

1553 Allbutt 1890, 22: "which are to introduce to clasp the child's head and bring it forward, the human hands being too thick to introduce both together".

1554 The Forceps and the Perineum. The *BMJ*, June 8, 1889, 1302.

the destruction of the foetus in order to save the mother's life.[1555] This was, very understandably, considered the most trying part in midwifery.

For example, Cameron Murdoch, a Scottish pioneer of the Caesarean section, wrote in the *BMJ* in the 1890s that it "has been a recognised rule in midwifery that no woman should be allowed to die undelivered without some attempt being made to save her and her offspring".[1556] In most cases, this "recognised rule" meant that in Britain, unlike in Roman Catholic France, obstetrical culture favoured the life of the mother in complicated childbirth, even "at the expense of the child."[1557] This, however, did not mean that British doctors would have given "little or no weight" to the duty of preserving the child when a choice had to be made, as some historians have claimed.[1558] In fact, the ongoing debate in the *BMJ* shows that doctors gave considerable time to discussing the morally challenging medico-ethical aspects of complicated childbirth. As one doctor, after performing both unsuccessful craniotomy and a Caesarean Section on the same patient, wrote in 1844, the responsibility laid upon the medical profession was in fact quite horrible: "I cannot imagine a medical man placed in a more delicate and responsible situation than the one in which he has to determine upon the destruction of a [living] child in utero".[1559] A decade later, in 1853, one colleague

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1555 Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 623–625. See also Meadows, Alfred, An Address Delivered at the Opening of the Section of Obstetrics Medicine at the Annual Meeting of the British Medical Association Held in Brighton. The *BMJ*, August 21, 1886, 356–357.

1556 Cameron, Murdoch, On the Relief of Labour with Impaction by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 509. See also Ryan 1841, 254.

1557 Cameron, Murdoch, On the Relief of Labour with Impaction by Abdominal Section, as a Substitute for the Performance of Craniotomy. *The BMJ*, March 7, 1891, 509. See the policy in early modern Europe in Gélis 1991, 231–232, 234–237; In England, see Wilson 1995, 50–53. See also for example The Caesarean Section in a Theological Aspect. The *BMJ*, June 29, 1878, 940. See also Cox, Frederick, Case of Deformed Pelvis – Caesarean Section – Death. The *PMSJ*, September 18, 1844, 383; Knowles, G. B., Practical Remarks on Cephalotomy and Gastro-Hysterotomy. The *PMSJ*, November 6, 1844, 492–493; Smith, W. Tyler, On the Abolition of Craniotomy from Obstetric Practice. The *BMJ*, February 19, 1859, 154; Cousins, John Ward, Caesarean Section: Recovery. The *BMJ*, May 1, 1897, 1081. See also Denman & Ryan 1836, 144–145. See also Playfair 1893b, 213–251. See also Loudon 1992, 133–135.

1558 Moscucci 1990, 142. See also Loudon 1992, 134: "In the British Isles, there was little hesitation in using craniotomy, even if the baby was alive, if it was essential in order to preserve the life of the mother." See also McLaren 1984, 126–127.

1559 Cox, Frederick, Case of Deformed Pelvis – Caesarean Section – Death. The *PMSJ*, September 18, 1844, 383. See also Craniotomy in Parturition. Remarks by Dr Ramsbotham on the Criticism of Mr. Bloxam. *The Lancet*, November 7, 1840, 223–224; Egan, WM. B. Mc., Mr. Cox's Case of Caesarean Section. The *PMSJ*, October 30, 1844, 480; Knowles, G. B., Practical Remarks on Cephalotomy and Gastro-Hysterotomy. The *PMSJ*, November 6, 1844, 491–492; Simpson, J. Y., Memoir on Turning, as an Alternative for Craniotomy and the Long Forceps, in Deformity of the Brim of the Pelvis, etc. The *PMSJ*, February 23, 1848, 85–89; Greenhalgh, Robert, A Clinical Discussion on the Caesarean Section: And Its Claims as an Operation of Selection. The *BMJ*, November 30, 1867, 489; Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 622–625.

noted similarly how "[w]e have to muster all our moral courage to make up our minds to coolly and deliberately take away the life of a human being".[1560]

In medical periodicals, craniotomy and embryotomy were described as painful and trying operations also for the medical practitioner, who was the very person forced to perform the inevitable act.[1561] In practice, at this point, labour had usually already lasted some days, the practitioner was feeling "jaded and fatigued by long nightly attendance", and his hands were "cramped, benumbed, and paralyzed", as was described in the *BMJ* in 1846.[1562] Reports show that some doctors did everything they could to preserve the child and were disappointed if their efforts were not successful.[1563] This kind of responsibility certainly was no light cross to bear.

Already in the 1840s, some doctors expressed that in their view craniotomy should never be performed; it was "an act with unwonted cruelty", and these opinions only increased within the following years.[1564] Craniotomy, while considered a better option than a Caesarean section, was not particularly safe either; the mortality of women operated on was at least 20 per cent.[1565] The exact number of these destructive operations was not known; in the 1850s, it was estimated that craniotomy was performed in about one in every 340 or 500 deliveries; in 1886, the estimated number was one in 340.[1566] Thus, it was not particularly common, but for some individual women this side of reproduction could be extremely cruel; for example, one woman whose case was reported in the *BMJ* had had eight embryotomies and three induced labours between 1862 and 1875.[1567] Reports

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1560 King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturition. The *Association Medical Journal*, November 4, 1853, 966–967.

1561 See for example King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturition. The *Association Medical Journal*, November 4, 1853, 966–967. See also Radford, Thomas, Observations on the Caesarean Section and Other Obstetric Operations. The *BMJ*, April 15, 1865, 365–367; Lawson Tait, An Address on the Surgical Aspect of Impacted Labour. The *BMJ*, March 22, 1890, 658–660.

1562 Swayne, J. G., Introductory Lecture on Midwifery Delivered at the Bristol Medical School. The *PMSJ*, October 21, 1846, 498–499.

1563 See for example Williams, Edward, Case of the Induction of Premature Labour. The *BMJ*, July 25, 1857, 623.

1564 Egan, WM. B. Mc., Mr. Cox's Case of Caesarean Section. The *PMSJ*, October 30, 1844, 480. See also Radford, Thomas, Remarks on the Caesarean Section, Craniotomy, and on the Induction of Premature Labour. The *PMSJ*, April 2, 1851, 175–178. According to Radford, craniotomy was called "inhumane", "cruel", "barbarous", "bloody", and "murderous". See also Simpson, Dr., Turning as a Substitute for Craniotomy in Labour Delayed by Obstruction at the Brim of the Pelvis. The *London Journal of Medicine*, No. xl, April 1852, 364–365. See also Simpson 1871, 486–488.

1565 Lawson Tait, An Address on the Surgical Aspect of Impacted Labour. The *BMJ*, March 22, 1890, 659.

1566 King, George, The Condition of the Foetal Head at the Full Period of Gestation, and Its Effects on Parturition. The *Association Medical Journal*, November 4, 1853, 969; Smith, W. Tyler, On the Abolition of Craniotomy from Obstetric Practice. The *BMJ*, February 19, 1859, 154; Radford, Thomas, Observations on the Caesarean Section and on Other Obstetric Operations. The *BMJ*, April 8, 1865, 341–344; Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 623; Sinclair, J. G., Address in Obstetric Medicine. The *BMJ*, August 20, 1881, 317. See also Simpson 1871, 460–465.

1567 Cameron, Murdoch, On the Relief of Labour with Impaction by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 510. Murdoch described this statistic as "revolting" and sickening. See also Hunter, R. H. A., Successful Case of Caesarean Section. The *BMJ*, September 26, 1885, 599: "Upon

show that some doctors could refuse to attend these women, as did one medical practitioner in 1843, after performing craniotomy on his parturient patient in a difficult labour: "I then told her [the patient], most positively, if she ever became pregnant again I would not attend her."[1568] The doctor, however, took his words back after "the earnest entreaties of her [the patient's] husband", but the woman died when giving birth to her sixth child. This time the doctor did not know about the pregnancy: in his words, if he had, he would have induced premature labour "in proper time", believing that this procedure would have saved the patient.[1569]

In a complicated situation, various methods and instruments were available, depending on the patient's anatomy and general state of health, the position of the foetus, and the course of events, inter alia. These included the midwifery forceps (there were different models and designs, such as the long midwifery forceps), but also other instruments such as the vectis, the lever and hooks, the turning of the foetus, premature or induced labour, and finally – if no other option was left – craniotomy or embryotomy, or a Caesarean section.[1570] In the 1840s, a Caesarean section was described as "so singularly fatal in this country, that nothing can justify its use, whilst any *possible* mode of delivery remains untried".[1571] It was justly called a "dernier resort", a last chance.[1572] The history of successful sections in Britain was short, gloomy, and somewhat discouraging: in the British Isles, the first successful Caesarean section was performed by an Irish midwife, Mary Donnelly/Donally/Dunally, who saved the life of a parturient woman in 1738. However, not much is known about this operation; even the fate of the child remained obscure.[1573] The first successful doctor-made section was performed in 1793 by James Barlow, a Lancashire surgeon.[1574]

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calling to see her [the patient], she informed me that, of her seven former confinements, six required craniotomy, and one was premature."

1568 Shearman, E. J., Case of Perforation of the Bladder by Mistake during Parturition, *The PMJRMS*, December 30, 1843, 234. See on other obstetric operations, Radford, Thomas, Observations on the Caesarean Section and on Other Obstetric Operations. The *BMJ*, March 25, 1865, 289–292; April 1, 1865, 313–315; April 8, 1865, 341–344; April 15, 1865, 365–367.

1569 Shearman, E. J., Case of Perforation of the Bladder by Mistake during Parturition. The *PMJRMS*, December 30, 1843, 234.

1570 For the operations and the use of instruments explained, see for example Playfair 1893b, 57–89, 156–212. See also Radford, Thomas, Observation on the Caesarean Section and on Other Obstetric Operation. The *BMJ*, March 25, 1865, 289–292.

1571 Cox, Frederick, Case of Deformed Pelvis – Caesarean Section – Death. The *PMSJ*, September 18, 1844, 383. See also Dorrington, Thomas, A Case of Malignant Disease of the Uteri Coexisting with Pregnancy, and Terminating Fatally Half an Hour after Delivery. With Remarks. The *PMJRMS*, October 28, 1843, 66–67; Ingleby, J. T., Clinical Lecture Addressed to the Students of the Midwifery Class at the Royal School of Medicine. *The Lancet*, January 25, 1840, 638. See also Playfair 1893b, 89.

1572 Lawson Tait, An Address on the Surgical Aspect of Impacted Labour. The *BMJ*, March 22, 1890, 659. On Caesarean section and its history, see Wall 2018, 61–84.

1573 For example, the doctor-historian Geoffrey Chamberlain argued in his book, first, that the child survived, and then later, that the child had already died in the womb. Chamberlain 2007, 77, 106. Compare to Donnison 1999, 59 (both mother and child survived); Moscucci 1990, 47 (mother survived but child did not). See also Naqvi 1985, 568; O'Dowd & Philipp 2011, 160; Frampton 2018, 178. See the case mentioned very briefly in Oldham, H., Case of Caesarean Section. Royal Medical & Chirurgical Society. The *PMSJ*, March 19, 1851, 160. See also Denman & Ryan 1836, 105.

1574 Naqvi 1985, 468–472; McLaren 1984, 125.

During the first decades of my research, a Caesarean section was notably rare. It was not considered a realistic choice in complicated cases; in the 1860s, for example, 80 to 90 per cent of women operated on died, due to shock, exhaustion, haemorrhage, peritonitis, and septicaemia.[1575] In obstetrics, the greatest nemeses were indeed "fear, fatigue, and exhaustion", all notably present in Caesarean section cases.[1576] Some members of the medical profession, nevertheless, strongly advocated Caesarean section, such as Thomas Radford (1793–1881) from Manchester, who had already in the 1840s become known as a firm supporter of the abdominal surgical operation.[1577] During the lifetime of Radford, Caesarean sections remained relatively rare but around the time of his death, the tone was slowly changing. For a short period around the 1870s and 1880s, a Porro's operation, which was a "Caesarian section, followed by removal of the uterus, together with its appendages, including the ovaries, leaving only the cervical portion of the uterus", was preferred over the traditional Caesarean section.[1578] The Porro's operation, at this point considered safer than a traditional section, was named after the Italian obstetrician Eduardo Porro (1842–1902), who performed his first successful operation in 1876.[1579] Permanent sterility, an inevitable consequence of the procedure, was sometimes seen as a positive side effect, especially in the cases of women whose pelvises were seriously deformed and who could not give birth vaginally.[1580]

1575 Radford, Thomas, Observations on the Caesarean Section and on the Other Obstetric Operations. The *BMJ*, March 4, 1865, 211–213; March 11, 1865, 237–240; Radford, Thomas, Further Observations on the Caesarean Section. The *BMJ*, March 28, 1868, 295–297; Radford, Thomas, Postscript to "Further Observation on the Caesarean Section". The *BMJ*, May 23, 1868, 503–504; Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 624–625; Kinkead, R. J., Craniotomy and Caesarean Section. The *BMJ*, October 2, 1886, 625–626. See also Solly, Samuel, Case in Which the Caesarean Section Was Performed: With Remarks on the Peculiar Sources of Danger Attendant on the Operation. The *London Journal of Medicine*, No. xxvii, March 1851, 279–280. See also Playfair 1893b, 240–244.

1576 Weatherill, Thomas, Fatal Midwifery. Coroner's Inquest. *The Lancet*, April 10, 1841, 104.

1577 See for example Knowles, G. B., Practical Remarks on Cephalotomy and Gastro-Hysterotomy. The *PMSJ*, November 6, 1844, 492. See the Radford's answer in Radford, Thomas, Dr. Radford on the Operation of Craniotomy. The *PMSJ*, November 13, 1844, 510–511. See also Walter, William, A Case of Caesarean Section, in Which Both the Mother and Child Were Saved. The *BMJ*, January 8, 1881, 46; Dolan, Thomas M., Caesarean Section: A Case of and Its Lesson. The *BMJ*, May 23, 1885, 1038. See also Ryan 1841, 213; Playfair 1893b, 89.

1578 Godson, Clement, Porro's Operation. British Medical Association, Fifty-First Annual Meeting. The *BMJ*, January 26, 1884, 142–159; Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 622–625; Simpson, Alex. Russell, Clinical Lecture on a Case of Caesarean Hystero-Oöphorectomy, or Porro's Operation; With Remarks. The *BMJ*, June 11, 1881, 910–912. See also Playfair 1894b, 32, 249–251.

1579 See for example Eduardo Porro, M. D. Obituary. The *BMJ*, August 2, 1902, 363–364; Godson, Clement, Porro's Operation. British Medical Association, Fifty-First Annual Meeting. The *BMJ*, January 26, 1884, 142–159. See also Dolan, Thomas M., Caesarean Section: A Case and Its Lesson. The *BMJ*, May 23, 1885, 1036–1038; Murphy, James, Two Cases of Amputation of the Uterus during Labour. The *BMJ*, October 10, 1891, 796. On Porro, see Todman 2006; Wall 2018, 76–78.

1580 See for example Berry Hart, D., Case of Successful Caesarean Section (Porro's Modification). The *BMJ*, January 26, 1889, 183–184. Compare to Munro Kerr, John M., Caesarean Section: With Notes of Three Successful Cases. The *BMJ*, October 5, 1901, 949–

However, around the 1880s and 1890s, Porro's operation was eventually replaced by a Caesarean section, and ability and capability to perform surgical operations became seen as an essential qualification in obstetrics. As one writer noted in 1884 in the *BMJ*, if the practitioner could not undertake a Caesarean section in practical work, he was merely a "man-midwife", and not "worthy of the name obstetrician".[1581] In 1902, when presenting the work of prestigious Manchester obstetricians, the *BMJ* noted how during the lifetime of Radford, the maternal mortality rate from Caesarean sections had been 80 per cent or more, whereas the *recovery rate* was now the same.[1582] For some, this development, rather surprisingly, was a return to the "good old days"; in 1889, the *BMJ* rejoiced at the rehabilitation of a Caesarean section, "one of the most ancient of all operations" after the centuries of alleged neglect.[1583] This view, expressed in the journal was, however, merely a fantasy. The history of Caesarean section demonstrated that most women did not survive the operation until the end of the nineteenth century.

Nevertheless, this development was generally welcomed in obstetrical medicine. As a result, in the 1890s, doctors could declare in the *BMJ* that the general obstetrical motto even in the most difficult cases should – and indeed could – be: "We live to save and not to destroy".[1584] This meant that at the end of the nineteenth century, the general tone toward craniotomy had become remarkably

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950. See also Wells, Spencer, Comparison of the Caesarean Section with Porro's Operation. The *BMJ*, October 29, 1887, 928–929. On rickets and contracted pelvis, see Loudon 1992, 130–143. See also the case in which the woman operated on wished for sterility herself, C. Section (Conservative Method). Reports on Medical and Surgical Practice in the Hospitals and Asylums of the British Empire. The *BMJ*, November 2, 1901, 1340. See also Rachitis [anonym.] Pregnancy in Contracted Pelvis. The *BMJ*, December 15, 1900, 1759.

1581 Godson, Clement, An Address Delivered at the Opening of the Section of Obstetric Medicine. The *BMJ*, August 2, 1884, 233. See also The Address in the Section of Obstetrics and Gynaecology. The *BMJ*, September 18, 1897, 726.

1582 Lloyd Roberts, D., Introductory Address Delivered at the Opening of the Section of Obstetrics and Gynaecology at the Annual Meeting of the British Medical Association Held in Manchester. The *BMJ*, August 9, 1902, 379. See also Murphy, James, An Address Delivered at the Opening of the Section of Obstetric Medicine and Gynaecology at the Annual Meeting of the British Medical Association. The *BMJ*, August 26, 1893, 454; Harris, Robert P., The Caesarean Operation in the United Kingdom: With a Continuation of the Statistical Record of Dr. Radford, from 1868 to 1879. The *BMJ*, April 3, 1880, 508–510; Cousins, John Ward, Caesarean Section: Recovery. The *BMJ*, May 1, 1897, 1081. See also Radford, Thomas, Further Observations on the Caesarean Section. The *BMJ*, March 28, 1868, 295–297. See also Playfair 1893b, 235.

1583 Antiquity of Caesarean Section. The *BMJ*, July 20, 1889, 141–142. See also Playfair 1893b, 233. For similar kind of rhetoric concerning the midwifery forceps, see King 2012, 115.

1584 Cameron, Murdoch, On the Relief of Labour with Impaction by Abdominal Section, as a Substitute for the Performance of Craniotomy. The *BMJ*, March 7, 1891, 510. See also for example Knowles, G. B., Practical Remarks on Cephalotomy and Gastro-Hysterotomy. The *PMSJ*, November 6, 1844, 492. See also for example Lloyd Robinson, David, A Discussion on the Modern Indication for Caesarean Section. The *BMJ*, October 11, 1902, 1123–1126.

negative and morally condemning; the operation was now called a "difficult, violent, and murderous proceeding".[1585] For example, the *BMJ* pointed out at the turn of the century that the abolition of craniotomy had been the dream of obstetricians for years.[1586] This process had not been a particularly clear or safe route, with countless lost lives and fatal experiments, but one result was that destructive operations could eventually be replaced by other, morally less controversial alternatives, which usually also saved the child's life. Eventually, the new generation of British practitioners became less familiar with craniotomy. For example in 1891, one younger doctor described how he had only a little experience of destructive obstetric operations; he was "happy to say that in a somewhat extensive consulting midwifery practice of several years' duration" he had never been present at a craniotomy on a living foetus.[1587] Development of antiseptics, anaesthetics, blood transfusion, and improving surgical methods and techniques, including sutures and incisions, made Caesarean section relatively safe, and, consequently made craniotomy largely unnecessary.[1588]

Moreover, the ideological essence the whole obstetric-surgical policy was also slowly changing. As Thomas Radford had pointed out on several occasions, previously surgical operations were in most cases performed too late, as a last resort, when all other courses had been explored and failed, meaning that the labour had already lasted for days, the mother was exhausted and depressed, the doctor was tired and nervous, and the foetus died in the womb.[1589] In 1902, one writer stressed that in the case of Caesarean sections, the general obstetrical

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1585 Cadge, W., Case of Porro-Caesarean Operation. The *BMJ*, July 19, 1890, 140. See also Madden, Thomas More, An Address Delivered at the Opening of the Section of Obstetric Medicine, at the Annual Meeting of the British Medical Association Held in Glasgow, August, 1888. The *BMJ*, August 18, 1888, 344; Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 622; Munro Kerr, John M., Caesarean Section: With Notes of Three Successful Cases. The *BMJ*, October 5, 1901, 949–950. See also Playfair 1893b, 214.

1586 Herman, G. E., Midwifery and Gynaecology in 1800. The *BMJ*, December 29, 1900, 1856. See also Campbell, Colin, A Second Successful Case of Caesarean Hysterectomy. The *BMJ*, January 19, 1901, 143–144; Munro Kerr, John M., Caesarean Section, with Notes of Three Successful Cases. The *BMJ*, October 5, 1901, 949–950.

1587 Murphy, James, Two Cases of Amputation of the Uterus during Labour. The *BMJ*, October 10, 1891, 796. See also Galabin, Alfred Lewis, Inaugural Address on Modern Progress in Obstetrics and Gynaecology. The *BMJ*, March 16, 1889, 577–580; Murphy, James, An Address Delivered at the Opening of the Section of Obstetric Medicine and Gynaecology at the Annual Meeting of the British Medical Association. The *BMJ*, August 26, 1893, 453–459.

1588 See for example Cameron, Murdoch, Remarks on Fifty Cases of Caesarean Section. The *BMJ*, October 11, 1902, 1126–1127. On blood transfusion, see for example Playfair 1893b, 264–278. See also for example Wheatcroft, John, Cases of Uterine Haemorrhage, Treated Successfully by Transfusion. The *BMJ*, April 10, 1858, 290–292; Graily Hewitt, On the Operation of Transfusion in Obstetric Practice. The *BMJ*, August 29, 1863, 232–237; Walter, William, A Successful Case of Transfusion of Blood after Severe *Post Partum* Haemorrhage. The *BMJ*, September 2, 1882, 415. See also Worboys 2000, 192; Bynum 1996, 132–137.

1589 See for example Radford, Thomas, Observations on Caesarean Section and on Other Obstetric Operations. The *BMJ*, March 11, 1865, 237–240; The *BMJ*, March 18, 1865, 263. See also Playfair 1893b, 234–235.

motto should be, "[o]perate early; delay is fatal".[1590] The good basic condition of the patient increased the positive prognosis; this kind of view emphasised, not only the meaning of the non-naturals during pregnancy, but also antenatal monitoring, and "better hygienic" conditions especially for working-class women working in factories – parturient women would be healthier, and the possible complicated cases were prevented altogether or recognised well before a potentially risky labour commenced.[1591] For some, the answer lay in better prenatal control and surveillance.[1592]

It is hardly any surprise that this gloomy side of reproduction was not generally discussed in popular health literature. Henry Arthur Allbutt's *Wife's Handbook*, published for the first time in the 1880s, was the only popular manual to mention craniotomy/embryotomy: "[t]here are women who can never bear living children [--] the consequence being that the child has to be brought away in pieces, or has to be delivered either by turning or by the forceps."[1593] Another manual, likewise aimed at working-class women, *The Wife's Domain* (1860), was one of a few guidebooks to explain a Caesarean section to its lay readers. According to the guidebook, the operation was performed only if the pregnant woman had died during delivery and the baby was still probably alive.[1594] These post-mortem sections were not by any means common but it is possible to find some mentions of them also in the *BMJ*.[1595] For example, in 1902, the journal argued that families often "consent or even urge" Caesarean section if the parturient woman had died undelivered; it was the doctor's professional skill to estimate if

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1590 Smyly, W. J., A Case of Caesarean Section. Royal Academy in Ireland. The *BMJ*, January 25, 1902, 205. See the example of successful Caesarean Section: Granger, R. F., Case of Caesarean Section. The *BMJ*, March 7, 1891, 515. See the example of unsuccessful Caesarean section, Perigal, Arthur, Caesarean Section. The *BMJ*, July 16, 1881, 79–80. See also Simpson, Alex. Russell, Clinical Lecture on a Case of Caesarean Hystero-Oöphorectomy or Porro's Operation; With Remarks. The *BMJ*, June 18, 1881, 957.

1591 See for example Edis, Arthur W., Remarks on the Influence of Obstetric Knowledge on the Mortality of Mothers in Childbed. The *BMJ*, October 5, 1878, 509–511; Barnes, Robert, The Alternatives to Craniotomy. The *BMJ*, October 2, 1886, 622–623. See also Playfair 1893b, 244–245. See also Vincent 1902, 17. On the risks of poverty in childbirth, see Loudon 1992, 45–48.

1592 See for example Vincent 1902, 17.

1593 Allbutt 1890, 46. Some writers discussed the potential risks but usually they concentrated on the lying-in period, see for example Scott 1870 [?], 61–67.

1594 Philothalos 1860, 69–82. In fact, *The Wife's Domain* was exceptionally frank when it discussed some of the complications of childbirth, including childbed fever, flooding, and puerperal convulsions.

1595 Post-Mortem Caesarean Section. The *BMJ*, July 21, 1900, 179. In this case, the woman was operated on within five minutes after she had died; the foetal heart sound was still audible. See also Radford, Thomas, Observation on the Caesarean Section and on Other Obstetric Operations. The *BMJ*, March 4, 1865, 213; Greenhalgh, Robert, A Clinical Discussion on the Caesarean Section: And Its Claims as an Operation of Election. The *BMJ*, December 7, 1867, 517; Successful Caesarean Section after Death. The *BMJ*, November 28, 1896, 1595–1596; Post-Mortem Delivery. The *BMJ*, December 24, 1898, 1892–1893; Post-Mortem Caesarean Section. The *BMJ*, December 27, 1902, 1962. On post-mortem Caesarean Sections in early modern Europe, see Gélis 1991, 235–237. See also Lawson Tait, An Address on the Surgical Aspect of Impacted Labour. The *BMJ*, March 22, 1890, 658–659. See also Playfair 1893b, 238–240.

it was worth it to "violate the sanctity of the death-chamber".[1596] This "urge", however, is somewhat unlikely, as many families refused post-mortem examinations altogether if death had taken place in childbed. There is evidence that some women even made their family members swear that their bodies were to be left untouched if they did not survive pregnancy and childbirth.[1597]

Complicated situations were distressing for all parties, above all for the parturient woman. In the patient reports published in medical periodicals, doctors occasionally noted that women were very anxious to have a living child, despite the fact that their own life was in great danger. For example, in 1893, in the case of a Catholic woman, a patient pregnant with her first child, together with her unidentified friends, asked the doctor to perform a Caesarean section, after it had become obvious that vaginal delivery was not possible. Eventually, the child survived, but the woman herself died of an "epileptic fit" five days after the operation.[1598] Patient reports reveal that doctors negotiated with their patients, and that the husbands, families, and friends were also involved in the decision making, at least in the most trying cases. For example, in 1861, in the case of a young woman whose labour had been complicated by a cancerous tumour obstructing the birthing canal, after consulting her husband and parents, the patient herself choose a Caesarean section, after the doctor made "her fully understand each procedure, with its risks and contingencies"[1599]. The woman survived the operation but died some months later; also the child died before its first birthday. The

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1596 Post-Mortem Caesarean Section. The *BMJ,* December 27, 1902, 1964. Compare to Gélis 1991, 236. See also Removal of a Living Child from a Dying Mother. The *BMJ*, September 13, 1862, 288–289; Buckell, Edward, Case of Caesarean Section Post Mortem: Transposition of Viscera. The *BMJ*, August 4, 1877, 135–136; Delivery of the Moribund, or Post-Mortem Caesarean Section. The *BMJ*, July 12, 1890, 95. See also Foscati 2019, 465–480.

1597 See for example Wraith, Samuel H., Case of Caesarean Operation. The *PMJRMS*, January 21, 1843, 329–330; Garraway, Edward, Intractable Pregnant Sickness, Necessitating Premature Deliver, on Two Occasions, in the Same Patient: Death on the Tenth Day after the Last Operation. The *BMJ*, October 3, 1857, 829; Booth, J. Mackenzie, Two Cases of Placenta Praevia. The *BMJ*, April 28, 1883, 810–811; Campbell, S. George, A Case of Puerperal Arterial Thrombosis. The *BMJ*, July 21, 1888, 124; Dunlop, James, Sudden Death during Labour. The *BMJ*, May 5, 1894, 965. See also The Caesarean Operation: Its Scientific Aspect. The *BMJ*, June 8, 1861, 612–614. See also Gélis 1991, 236–237.

1598 Clair Gray, A Case of Caesarean Section. The *BMJ*, April 22, 1893, 843. See also Smyly, W. J., A Case of Caesarean Section. Royal Academy in Ireland. The *BMJ*, January 25, 1902, 205; Radford, Thomas, Observations on the Caesarean Section and on the Other Obstetric Operations. The *BMJ*, March 4, 1865, 213; Simpson, Alex. Russell, Clinical Lecture on a Case of Caesarean Hystero-Oöphorectomy, or Porro's Operation; With Remarks. The *BMJ*, June 11, 1881, 910–912. See also Blacker, Ernest, Induction of Premature Labour. The *BMJ*, November 18, 1882, 997; Murphy, Edward William, History of a Few Cases Illustrative of the Use of the Forceps in Difficult Labours. The *Association Medical Journal*, March 18, 1853, 229–232. See also Caesarean Section. The *BMJ*, November 27, 1875, 694; the *BMJ*, December 4, 1875, 724.

1599 Edmunds, James, On a Case of Caesarean Section, Hard Cancer of Os and Cervix Uteri; Six Days' Labour; No Dilation; Abdominal Hysterotomy; Mother Convalescent, and Child Living. *The Lancet*, January 5, 1861, 4–5. Edmunds reported forty years later, in 1902, that the patient had died "some months later", in a Cancer Hospital. The baby had died soon after the doctor published his report in January 1861. The mother breastfed the child, but after "it got chilled, a severe attack of aphthae came on, it was unable to suck, and soon sank [died]." Edmunds, James, The Late

same doctor, James Edmunds (1832–1911), reported another similar kind of case in 1876, in which the patient had a Caesarean section after sixty hours of futile trying. In this case, the birth canal was obstructed by a large tumour, but after hearing the foetus's heart beating "vigorously and regularly", it was the doctors who were convinced that they were not "justified in opening the head of a vigorous living infant or in subjecting the mother to the additional risk and anxiety."[1600] In this case, both mother and child survived. In fact, they were both alive and well twenty-six years later when the doctor who had performed the operation sent a letter to the *BMJ*.[1601] Three decades earlier, *The Lancet* had noted optimistically how "[s]uch records raise the fame of obstetric surgery."[1602]

In desperate situations, women also acted themselves. In 1885, the *BMJ* reported the very exceptional case of a Caesarean section performed by the pregnant woman herself, in her own home without any medical assistance. The German woman, already a mother of seven children, had cut her own abdomen on the right side with a razor. She had previously heard about the operation and performed it on herself, after her pains had become agonizing and the movements of the child had ceased; the woman survived the self-made section but the child was stillborn.[1603] Another similar kind of case took place in 1883, this time in Britain, when a farmer's wife, in her ninth labour, had made a vaginal self-examination and ruptured the membranes by herself. The woman's doctors had done so in her previous labours, and she "had been so much helped by it, that she saw no harm in doing it for herself".[1604] While it is clear that these two cases were no doubt rare exceptions, albeit medically extremely interesting, the stories

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Case of Caesarean Section. *The Lancet*, January 12, 1861, 39; Edmunds, James, Caesarean Section. The *BMJ*, October 18, 1902, 1282. See also Radford, Thomas, A Successful Case of Caesarean Section, with Remarks. The *PMSJ*, August 22, 1849, 457; Cox, Frederick, Case of Deformed Pelvis – Caesarean Section – Death. The *PMSJ*, September 18, 1844, 383; Radford, Thomas, A Successful Case of Caesarean Section, with Remarks. The *PMSJ*, August 22, 1849, 456–460; Hunter, R. H. A., Successful Case of Caesarean Section. The *BMJ*, September 26, 1885, 599; McGowan, Wm., Case of Caesarean Section for Osteo-Malacic Pelvis. The *BMJ*, March 15, 1890, 589–590; Lloyd Robinson, David, A Discussion on the Modern Indication for Caesarean Section. The *BMJ*, October 11, 1902, 1123–1126. On medical etiquette concerning surgery, see Snow 2008, 4.

1600 Edmunds, James, Report on a Second Case of Caesarean Section in Which Mother and Child Recovered. *The Lancet*, December 9, 1876, 818–821: "The friend at once concurred, and the patient, on being appealed to, replied that she would submit to anything that we might advise". On tumours and labour, see for example Swayne 1893, 118–119.

1601 Edmunds, James, Caesarean Section. The *BMJ*, October 18, 1902, 1282.

1602 Abdominal and Caesarean Section. *The Lancet*, December 16, 1876, 874–875. See also James Edmunds. Obituary. The *BMJ*, February 28, 1911, 470–471: "He was a man of most varied attainments, and a pioneer in the temperance world and in several other branches of medical and scientific work." See also James Edmunds. Obituary. *The Lancet*, March 4, 1911, 551; Spencer, Herbert R., The Late Dr. James Edmunds and Caesarean Section. *The Lancet*, March 4, 1911, 617.

1603 Case of Caesarean Section Performed by the Patient Herself. The *BMJ*, February 21, 1885, 392–393. Four of the woman's previous children were born without assistance and two with forceps. She had had one craniotomy. Doctors did not see anything suspicious about the case: the woman returned to her work and had been "in perfect health" ever since.

1604 Clarke, Albert B., Self-Help in Labour. The *BMJ*, November 24, 1883, 1053.

demonstrated that these particular women had carefully observed what was done to them by their doctors, and they knew how to act. Women were not just passive patients; their agency was occasionally very prominent in the journals.

However, the difficult medical-moral question in choosing between a Caesarean section and craniotomy/embryotomy was not the only cause of worry as far as labouring women were concerned. Apart from *flooding*, meaning a violent haemorrhage during or after labour, *puerperal convulsions*, or *eclampsia*, was and still is a potentially life-threatening disorder of labouring women, who, had suffered from a headache usually during the last semester of pregnancy, in addition to having a large amount of protein (albuminuria) in the urine and swollenness of the appendages and face.[1605] As the contemporary term *puerperal convulsions* reveals, the disorder led to mental confusion, and violent seizures, subsequently a loss of consciousness and coma – the ultimate consequence of this unexplained, mysterious, and frightful condition was death.[1606] Puerperal convulsions were particularly dramatic scenes, disturbing the quiet atmosphere of the birthing room, as described by one doctor in 1844:

> My fears were confirmed on opening the door, for I heard the lady screaming violently, madly, and found four or five attendants trying, fruitlessly, to keep her in bed; the eyes were glaring and furious, the whole face distorted, the muscular strength immense, breathing loud and stertorous.[1607]

For anyone present, including the doctor, this sudden interruption was indeed terrifying, as one doctor described in 1842: "[i]n a minute more she [the patient] was in violent convulsions [--] the whole presenting the most frightful picture of human distortion I ever beheld".[1608]

Nineteenth-century medical periodicals included numerous cases of pregnant women who suddenly started to complain about a headache, blurred vision, and swellings of their limbs. In most cases, doctors tried to treat their patients by opening a vein in their patients' arms. In fact, venesection remained an important cure of the disorder throughout the whole century until the 1890s, despite many historians having claimed that in medicine, bleeding was used up to about 1750.[1609] In 1868, bleeding was still described as "our sheet-anchor" in midwifery; in 1888, in the *BMJ* venesection was referred to as "an old but now much ne-

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1605 See the example of the cases: Coincidence of Albuminuria and Puerperal Convulsion. The *PMSJ*, February 10, 1844, 364; Oke, W. S., Puerperal Convulsions. The *Association Medical Journal*, May 5, 1854, 386–389. See also Philothalos 1860, 60. See also A London Physician [anonym.] 1891, 230–231; Herman 1891, 155–156; Drew 1891, 56–58; Swayne 1893, 135–139; Playfair 1893a, 238–239, 241–243; Playfair 1893b, 318–330. On urine and puerperal convulsions, see for example Tanner 1860, 425–435; Stables 1894, 200; Vincent 1902, 39. On the terms, see Loudon 1992, 85.

1606 On puerperal convulsions, see Loudon 1992, 85–96. On obstetric haemorrhage, see Loudon 1992, 97–106. See also for example Cullingworth 1884, 45–46.

1607 Cox, Frederick, Treatment of Puerperal Convulsions. The *PMSJ*, May 22, 1844, 109. See also Woodhouse, R. T., Case of Puerperal Convulsions. The *Association Medical Journal*, May 17, 1856, 405–408.

1608 Jeffrery, H., Puerperal Convulsions. *The Lancet*, January 22, 1842, 568.

1609 Gélis 1991, 144.

glected remedy", the writer remarking how the best treatments of puerperal convulsions were bleeding, anaesthetic, and delivery, in the order of their importance.[1610] Apart from venesection, the range of possible treatments was extensive but the results were not particularly encouraging: leeches, poultices, turpentine enemas, fomentations, laxatives, blisters, ice, chloroform, and various drugs, such as opium, laudanum, morphine, henbane, calomel (purgative), and jalap (a cathartic drug, from a South-American medical plant called *Ipomoea purge*).[1611] Patients' heads were also often shaved.[1612] Despite these desperate means, after the violent convulsions, women quite often simply "sank", as doctors described the last moments of their parturient patients.[1613] The condition remained a terrifying mystery in nineteenth-century midwifery.

Maternal mortality was indeed a real and current problem in nineteenth-century obstetrics. In England and Wales, it was estimated that approximately 4 to 9 women per 1,000 births died from maternal causes; the mortality rate remained obstinately high even if it was beginning to fall around the turn of the century.[1614] In 1896, a medical man Robert R. Rentoul referred maternal mortality

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1610 Dyce, Robert, On Puerperal Convulsions. The *BMJ*, April 18, 1868, 372–373; Swayne, Joseph Griffiths, Venesection in Puerperal Convulsions. The *BMJ*, December 22, 1888, 1414–1415. See also Swayne 1893, 139. See also Mason, Frederick, Cases of Puerperal Convulsions. The *BMJ*, June 13, 1857, 499; Pollard, James, Bleeding in Puerperal Convulsions. The *BMJ*, July 12, 1879, 47; Buxton, Edward, Venesection in Post-Partum Eclampsia. The *BMJ*, November 10, 1888, 1044; Galabin, I–A. L., A Discussion on Puerperal Eclampsia. The *BMJ*, September 26, 1891, 679–684; Venesection. The *BMJ*, October 10, 1891, 809; The Revival of Venesection. The *BMJ*, January 31, 1891, 242; Davis, Sandom, Post-Partum Convulsions: Venesection: Recovery. The *BMJ*, May 6, 1899, 1089; See also Leavitt 1986, 43–44. Compare to Caton 1999, 49–50. On surgical treatment, see Caesarean Section for Eclampsia. The *BMJ*, December 9, 1899, 1626. On the use venesection in the popular manual, see for example Bull 1837, 24–26. See also Playfair 1897b, 326–327. See also Prosser, R., Cases of Puerperal Convulsions Treated with and without Bleeding. The *BMJ*, July 25, 1863, 86–87. See also Philothalos 1860, 71.

1611 See for example Storrs, Robert, Observations of the Treatment of Puerperal Convulsions. The *PMSJ*, June 19, 1844, 167–170; Puerperal Convulsions: Their Pathology and Treatment: Explanation of the More Common Occurrence of Reno-Toxic Convulsions in First and Plural Pregnancies. The *Association Medical Journal*, December 8, 1854, 1103; Page, Fred., Puerperal Convulsions Successfully Treated by Chloroform. The *BMJ*, April 13, 1861, 386–387. Compare to treatment of puerperal convulsions in Loudon 1992, 88–92.

1612 See the examples: Gibson, Matthew W., Contributions to Medicine. Puerperal Fever. *The Lancet,* April 23, 1842, 121–127; Fisher, N. B., Malignant Puerperal Fever. A Statement of Five Fatal Cases, Involving the Question of Contagion. The *PMSJ*, November 4, 1843, 83–92; Swayne, J. G., Cases of Puerperal Convulsions, with Remarks on the Use of Blood-Letting. The *BMJ*, April 4, 1863, 346–348; Evans, C. J., Puerperal Convulsions before Delivery: Death: Remarks. The *BMJ*, May 25, 1867, 600; Eaton, J., Bleeding in Puerperal Convulsions. The *BMJ*, September 20, 1879, 450–451. See also Wiggins, B., Leeches in Puerperal Eclampsia. The *BMJ*, March 13, 1897, 653; Barnes Hughes, A., Puerperal Eclampsia: Convulsions of Mother and Child: Recovery of Both. The *BMJ*, February 25, 1899, 469. See also A London Physician [anonym.] 1891, 230–232. See also Playfair 1893b, 325–330.

1613 See for example Pound, George, A Fatal Case of Puerperal Convulsions. The *Association Medical Journal*, June 16, 1854, 532.

1614 See for example Loudon 1992, 19–32, 234–240; Loudon 2000, 6, 152–155; Moscucci 1990, 184–185. The mortality rate was at its highest level in 1874. See also Sinclair, J. G., Address in Obstetric Medicine. The *BMJ*, August 20, 1881, 318. See the figures in nineteenth-century Canada in Mitchinson 1991, 227–229.

rates as "the slaughter-rate among mothers"; Rentoul estimated that between 1871 and 1893, in England and Wales, nearly 100,000 mothers had died in childbed fever alone.[1615] The Scottish obstetrician James Matthew Duncan had calculated that "not fewer than one in every 120 women" died "delivered at or near the full time [--] within the four weeks of childbirth".[1616] The unexpected death of a young woman in the prime of her life was always a shock, "terrible in ways that other mortalities are not", as Irvine Loudon has described the effects maternal mortality had on families, breaking many marriages and homes, leaving children without a mother, and affecting also a larger circle of family members and friends.[1617] Doctors were particularly emotional when they wrote about maternal mortality, both in the *BMJ* and popular health manuals:

> In place of a happy mother beaming of joy at the sight of her offspring, there is but the pallid corpse concealed beneath the sheet; and the father of the helpless orphan, if haply it have survived its tedious and dangerous transit, can but cry to vacant chairs and widowed walls – "My house is left unto me desolate!"[1618]

Moreover, maternal death was particularly frightful and cruel, because it was unpredictable, even if the women themselves and their circle were aware of the risks of reproduction. A death scene in childbirth could be sudden and dramatic, such as in cases of puerperal convulsions, but more often, it was painful and slow, especially if the cause of death was childbed fever, *puerperal fever*, or *puerperal septicaemia*, the most common killer of parturient women in the nineteenth century. Puerperal fever is a bacterial infection following childbirth, at worst causing septicaemia, peritonitis, and death.[1619] Childbed fever was particularly cruel: after what otherwise could have been a perfectly successful and uncomplicated labour, the woman started to suffer from rigour, an intensive shivering attack, had a fever and turned delirious, vomited, and then lingered possibly for days in intolerable pains and with a high fever without recognising anyone around her.[1620]

1615 Rentoul, Robert R., What Is a Natural Labour. The *BMJ*, January 4, 1896, 49.

1616 James Matthew Duncan cited in Cullingworth, Charles J., Introductory Address on Puerperal Fever a Preventable Disease: A Plea for the More General Adaption of Antiseptics in Midwifery Practice. The *BMJ*, October 6, 1888, 743–747. See also, for example, A Young Accoucheur [anonym.], Three Thousand Labours in Seven Years, with the Loss of Only One Mother. The *BMJ*, November 29, 1884, 1109; Beatty, W. J., One Thousand Midwifery Cases without a Maternal Death. The *BMJ*, June 20, 1885, 1244–1245; Ashenden, Charles, Mortality after Childbirth. The *BMJ*, August 29, 1885, 425.

1617 Loudon 1992, 2–3. See also for example Steele, Charles, Case of Puerperal Cardiac Embolism. The *BMJ*, April 7, 1866, 359–361. See also Gélis 1991, 252–253.

1618 Edis, Arthur W., Remarks on the Influence of Obstetric Knowledge on the Mortality of Mothers in Childbed. The *BMJ*, October 5, 1878, 510. See also Philothalos 1860, 67; Warwick, W. R., Cases Occurring in Obstetric Practice. *The Lancet,* September 5, 1840, 856; Carwardine, Thomas, A Clinical Lecture on Early Extrauterine Pregnancy. The *BMJ*, January 11, 1902, 67. See also Loudon 2000, 5.

1619 See for example Loudon 2000, 7–8.

1620 See Loudon 1992, 49–84; Loudon 2000. On the description of the symptoms, see Kittoe 1845, 189–191; Philothalos 1860, 64–65; *Doctor at Home* 1891, 653; Drew 1891, 58–59; Swayne 1893, 145–149; Playfair 1893b, 372–375.

The vaginal discharge, *lochia*, became offensive or ceased altogether. Doctors' reports revealed that some women forgot that they had recently given birth and they had a baby; this was always considered a very bad sign.[1621]

In popular health manuals, the topic of childbed fever was occasionally mentioned, but, as Henry Thomas Scott pointed out in the 1870s, the infection of the uterus and the surrounding tissues was "a disease too formidable a nature to treat in a work like the present".[1622] Partly this silence was an uneasiness about discussing this "melancholic and fearful disease" in popular manuals and thus, only increasing the fear and apprehension of women.[1623] However, more importantly, this obmutescence can be explained by the fact that the nineteenth-century medical profession continued to debate about the true nature and contagiousness of the dreaded postpartum disease, preventive methods, and the best treatment of it.[1624] One particularly painful question was the role doctors eventually played in the spreading of the disease. It is possible to find some descriptions, dated to the 1840s and onwards, of the desperate measures doctors tried to prevent the contagion: changing their clothes and washing their hands in solution of chloride of lime.[1625] Some of them could confess with horror that they believed that they "carried the deadly poison" from one patient to another; however, this kind of confession was possible only in medical journals.[1626] On the other hand, many refused to believe that any respectful practitioner could play any part in

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1621 See for example Gibson, Matthew W., Contributions to Medicine. Puerperal Fever. *The Lancet,* April 23, 1842, 121–127. See also Loudon 2000, 5–6.

1622 Scott 1870 [?], 62–63. See also Kittoe 1845, 189–192; Philothalos 1860, 64–65; Bakewell 1859, 110, 131–134; Harvey 1863, 81–84; Black 1888, 68; Allbutt 1890, 25.

1623 Kittoe 1845, 191. Compare to Stacpoole 1894, 68.

1624 See for example Gooch 1831, 1–37; Playfair 1893b, 346–386. See also Loudon 1992, 57–84; Loudon 2000; Leavitt 1986, 154–155; Worboys 2000, 104–105. See also Cullingworth, Charles J., Introductory Address on Puerperal Fever a Preventable Disease: A Plea for the More General Adaption of Antiseptics in Midwifery Practice. The *BMJ*, October 6, 1888, 743–747; Herman, G. Ernest, The Prevention of Puerperal Fever in Private Practice. The *BMJ*, January 11, 1896, 74–78; Hart, Berry, A discussion on Puerperal Fever in Relation to Notification. The *BMJ*, September 15, 1900, 705–709.

1625 See for example Fisher, N. B., Malignant Puerperal Fever. A Statement of Five Fatal Cases, Involving the Question of Contagion. The *PMSJ*, November 4, 1843, 83–92; Elsdalf, Robinson, On the Identity between the Poison of Erysipelas and That of Puerperal Fever. The *Association Medical Journal*, February 18, 1853, 147–148; Storrs, Robert, Observations on Puerperal Fever; Containing a Series of Evidence Respecting Its Origin, Causes, and Mode of Propagation. The *PMSJ*, December 2, 1843, 164–169. See also Crowfoot, W. Henchman, Inflammation of the Uterus during the Prevalence of Puerperal Fever. The *PMSJ*, May 8, 1844, 76–77; West, R. U., Puerperal Fever; In What Way It May Originate from Erysipelas, and How Communicate. The *PMSJ*, March 8, 1848, 117–119; Huntley, Robt. Elliot, Puerperal Fever. The *BMJ*, August 5, 1865, 116–117. See also Obstetricus [anonym.] Puerperal Infection. The *BMJ*, January 23, 1875, 129; Homicide by Infection. The *BMJ*, February 4, 1882, 164; Byers, John W., The Prevention of Puerperal Fever in Private Practice. The *BMJ*, November 12, 1887, 1042–1044. Cullingworth, Charles J., Introductory Address on Puerperal Fever a Preventable Disease: A Plea for the More General Adaption of Antiseptics in Midwifery Practice. The *BMJ*, October 6, 1888, 743–747. See also Manslaughter by Infection. The *BMJ*, March 6, 1875, 313. See also Bakewell 1859, 131–134; Harvey 1863, 83. See especially Loudon 2000, 80–81; Bashford 1998, 81–82.

1626 See for example Fisher, N. B., Malignant Puerperal Fever. A Statement of Five Fatal Cases, Involving the Question of Contagion. The *PMSJ*, November 4, 1843, 83–92. See also for example Bashford 1998, 68–69, 76.

the spreading of such a horrible disease.[1627] The role of a doctor was to heal and make their patients feel stronger and better, not to put them in great danger or kill them, as quacks allegedly did.

The discussion changed around the late 1870s and 1880s when bacteriologists, foremost the French biologist and chemist Louis Pasteur (1822–1895), were able to show that puerperal fever was due to an organism called *Streptococcus pyogenes*.[1628] As a result, the bodily cleanliness of the practitioner, "surgical cleanliness" as it was often called, came to be "something of a measure of status and credibility", as for example Alison Bashford has argued.[1629] Consequently, especially the discoveries of the Hungarian obstetrician Ignaz Semmelweis (1818–1865), whose theories of the contagiousness of childbed fever had been discussed also in the 1840s British medical press, but who eventually failed to publish his results, were re-evaluated in medicine. In the 1840s, while working at the large lying-in hospital in Vienna, Semmelweis had famously observed that doctors were agents in the contagiousness of the puerperal infections; they attended both labours and post mortem examinations, carrying the poisonous matter, "decomposing animal organic matter", on their hands.[1630] Semmelweis suggested that midwifery students and practitioners should wash their hands with a solution of chloride of lime but eventually this did not solve the problem; sometimes, it is put forward that childbirth fever was defeated simply because nineteenth-century doctors learned to wash their hands, which is not quite the truth.[1631] Semmelweis himself insisted that childbed fever was not an epidemic disease; this might have been one reason why his theories were not commonly accepted in his lifetime, as Irvine Loudon has suggested.[1632]

Interestingly, in 1859, the British health manual *A Popular Manual of Female Diseases*, written by Robert H. Bakewell, noted that practitioners attending post mortems could have female patients dying of puerperal fever – and that the disease was both contagious and epidemical.[1633] Irvine Loudon has argued that British doctors were far more ready to accept that childbed fever was contagious than

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1627 One of the most famous doctors in this sense was the American obstetrician Charles D. Meigs (1792–1869) who rejected the idea that childbed fever was contagious and that the doctor could play any part in transmitting the disease from one patient to another. See for example Loudon 1995a, 57–63; Loudon 1992, 64.

1628 See for example Loudon 1995a; Loudon 2000, 120–125. On the development of germ theories in medicine between 1865 and 1900, see especially Worboys 2000. See also the manual aimed at midwifery students on the dangers of obstetrical engagements and post-mortem examination in Herman 1891, 65–66. See also for example Collingsworth, Charles, Introductory Address on Puerperal Fever a Preventable Disease: A Plea for the More General Adoption of Antiseptics in Midwifery Practice. The *BMJ*, October 6, 1888, 743–747; Smyly, William J., Address in Obstetrics. The *BMJ*, August 11, 1900, 337–340. See also Bashford 1998, 63–83; Leavitt 1986, 155–160; Bynum 1996, 107–109, 127–129.

1629 Bashford 1998, 63.

1630 See for example Loudon 2000, 88–110.

1631 See for example Rich 1997, 155: "Semmelweis's plea for doctors to wash their hands finally became accepted practice [--] Two hundred years of puerperal fever were coming to an end."

1632 Loudon 2000, 90–110. See also Loudon 1992, 65–68.

1633 Bakewell 1859, 131–132.

their Continental peers.[1634] The case of Semmelweis was later discussed also in the manual of Florence Stacpoole (1894), who celebrated the tragic life of the Hungarian obstetrician in the section *What Modern Medicine Has Done to Lessen Danger in Childbirth* of her guidebook.[1635] Semmelweis himself had died forgotten in a mental asylum in 1865, but at the end of the century, he became a renowned, yet overlooked genius in medicine; a mistreated and tragic Mozart-like martyr figure, driven insane by his ignorant contemporaries, a popular cultural type popularised in the Victorian era.[1636] Semmelweis was not the only nineteenth-century doctor to discuss the nature and mechanisms of childbed fever – for example, James Young Simpson and the American physician and poet Oliver Wendell Holmes (1809–1894) were amongst them – but eventually he became the most famous pioneer of antiseptic midwifery and one of the most recognised names in nineteenth-century medicine.[1637]

Fear, distress, and constant worry were common for everyone when it was a matter of childbed fever. As one doctor wrote in the *BMJ* in 1883, "the healthiest, happiest homes are not proof against the invasion of this horrible destroyer, as most of my own cases would show".[1638] Doctors' collective dread and desperation were very visible, but a childbed fever case and loss of a patient were also bad for business and a serious blow to professional credibility. Few practitioners could claim that in their practice, maternal mortality cases were largely missing; in fact, one obstetrical author noted in 1875 how the low mortality in his practice rate was attributed more to his "good fortune" rather than to "any other cause".[1639] Nevertheless, the most common advice given in popular health manuals was that if the parturient woman showed any of the symptoms of a fever, a doctor should be called. The ideal was, of course, that the doctor knew his case and was able to help; occasionally, women actually survived, but in the case of puerperal fever, the medical means were certainly very limited. During the different decades of the Victorian era, puerperal fever was treated with venesection, turpentine, leeches, blisters, poultices, fomentations, enemas, emetics, laxatives,

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1634 Loudon 2000, 106; Loudon 1992, 61.

1635 Stacpoole 1894, 67–92. See also Duka, Theodore, Childbed Fever: Its Causes and Prevention: A Life's History. *The Lancet*, July 31, 1886, 206–208; August 7, 1886, 246–248.

1636 See for example Ignaz Philipp Semmelweis. The *BMJ*, May 9, 1891, 1033–1034. The papers of Semmelweis were discussed for example in the *London Journal of Medicine* in 1850; see Skoda on the Causes of Puerperal Fever – Experiments on Animals. The *London Journal of Medicine*, No. xix, July 1850, 700–703. On Semmelweis and his life, see especially Loudon 2000, 88–110, 146–150; Bashford 1998, 75–76.

1637 On Oliver Wendell Holmes, see Loudon 1992, 62–64. See also Oliver Wendell Holmes. Note of a Conversation with Him, September 13th, 1893. By Ernest Hart. The *BMJ*, October 13, 1894, 833–834; Obituary. Oliver Wendell Holmes. The *BMJ*, October 13, 1894, 839–841. Oliver Wendell Holmes and the Contagiousness of Puerperal Fever. The *BMJ*, October 20, 1894, 885.

1638 Strange, William, The Etiology and Pathology of Sporadic Puerperal Septicaemia. The *BMJ*, December 22, 1883, 1228. On puerperal fever and women, see Jalland 1986, 172–175.

1639 See for example Swayne, J. G., Obstetrical Statistics. The *BMJ*, November 20, 1875, 635–638. The mortality rate in Swayne's practice was five deaths to 1,069 labours, or one in 213. See also Baker 1856, 12–13. See also Loudon 1992, 64.

ice, vaginal douches, calomel, quinine, and opiates, for example.[1640] However, it was not until the introduction of antibiotics in the twentieth century that childbed fever became a curable – and also forgotten – disease.

Maternal death was never a private matter, concerning only individual families. One particular maternal death in childbed, however, caused huge national grief and also traumatised the nineteenth-century medical profession, a tragedy still echoing at the end of the Victorian era. In 1817, the popular and well-loved Princess Charlotte of Wales (1796–1817), the only child of the future King George IV (1762–1830) and next in line for the throne after her father, died of the complications of a difficult and prolonged labour, at the age of twenty-one. The Princess' only child, a large baby boy, was stillborn: the child had died in the womb sometime during labour, which, in total, lasted more than fifty hours. Charlotte herself died only some hours later after the child was born; she complained of sickness and pains in the stomach and was breathing only with great difficulty.[1641] Three months later, the tragedy turned even darker when Charlotte's accoucheur, Sir Richard Croft (1762–1818), a prestigious and well-connected medical man, shot himself, after public opinion blamed him for the deaths of both Charlotte and her unborn child.[1642] Apart from a personal tragedy, Charlotte's unexpected death was also a serious blow to the British monarchy, already suffering from the madness of Charlotte's grandfather, George III (1738–1820) and the growing unpopularity of the King's eldest son, Charlotte's father, the notorious Prince Regent, and the Prince's younger brothers. Consequently, in the 1950s, the British gynaecologist Sir Eardley Holland named the royal case the *triple obstetric tragedy*.[1643]

The tragic deaths of Charlotte, her baby, and Sir Richard Croft were discussed and analysed by the British medical profession on several occasions during the nineteenth century. For example, Hilary Marland has argued that Charlotte's death legitimated and "added urgency to trends" to intervene in childbirth "to speed delivery".[1644] This argument, however, is not at all that simple, as I have already discussed in this chapter. The final cause of the Princess' death remained a mystery and eventually nineteenth-century doctors could not agree on

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1640 See for example Puerperal Fever; Sloughing of the Uterus. Birmingham Pathological Society. The *PMSJ*, July 10, 1844, 222–223; Beck, T. Snow, On Puerperal Fever. The *BMJ*, April 29, 1865, 428–430; Mitchell, T. A., Puerperal Fever: Recovery. The *BMJ*, April 12, 1884, 716; Byers, John W., The Prevention of Puerperal Fever in Private Practice. The *BMJ*, November 12, 1887, 1042–1044; More Madden, T., On the Prevention and Treatment of Puerperal Fever. The *BMJ*, November 12, 1887, 1045; Durno, Leslie, A Case of Puerperal Septicaemia Treated by Antistreptococcus Serum: Recovery. The *BMJ*, October 30, 1897, 1257–1258; The Nature of and Treatment of Puerperal Infection. The *BMJ*, July 14, 1900, 78. See also Loudon 2000. See also Kittoe 1845, 191–192; Bakewell 1859, 134; Swayne 1893, 148–149; Playfair 1893b, 367–385. See also Bakewell 1857, 21–27; Bakewell 1859, 134; *Doctor at Home* 1891, 653; Drew 1891, 59–60. See Porter 2000, 183–188; Gélis 1991, 249–250.

1641 See for example Lewis 1986, 182–188. The whole case is explained in detail in History of the Case of the Princess Charlotte. The *London Journal of Medicine*, No. xii, December 1849, 1138–1141. See also Holland 1951.

1642 On Croft and his professional and family networks, see Lewis 1986, 95–101, 106–109.

1643 Holland 1951.

1644 Marland 2004, 16. See also Lewis 1986, 179, 187–188.

what would have been the best way to save the royal parturient: the use of venesection, the application of forceps, or more attentive antenatal care especially with a more nutritious diet, for example.[1645] What was more important, however, was that the case of Princess Charlotte collectively reminded people that ultimately no woman was safe from the dangers of childbirth, and that the responsibility and reputation of a medical professional were constantly at stake. The royal tragedy showed in a very concrete way that the fear of losing a parturient patient was real and the results could be catastrophic, especially if the patient was "a lady of rank" – in Princess Charlotte's case, literally the most important woman in the whole Empire.[1646] Indeed, some decades later, in 1837, William F. Montgomery, a famous author on midwifery, could still recall the sombre atmosphere following the death the death in the royal childbed: "I believe it is well known that during the years which immediately succeeded the lamented death of the Princess Charlotte, the most gloomy anticipations clouded and depressed the minds of pregnant and parturient women".[1647]

The tragic end of Princess Charlotte was re-evaluated especially in the early 1840s, when Charlotte's young cousin, Queen Victoria, was giving birth to the eldest of her nine children. Victoria herself had been one of the results of the 1817 tragedy; she was born in 1819, only one and a half years after the death of Charlotte.[1648] Therefore, in 1840, many could still remember the unhappy incident. For example, *The Lancet*, when describing Victoria's first confinement in November 1840, recalled how Princess Charlotte had been "perished in this natural trial [--] not through any malformation, inaptitude, or peculiar fragility of frame, but, as the profession felt, either by an inexplicable fatality, or by some error in the hygienic and medical management of the patient".[1649] The journal also noted how the responsibility of the Queen's doctors had indeed been "doubled in this instance".[1650] There was rejoicing that Victoria's confinement had been safe and somewhat short – thanks to the Queen's "calm, agreeable tenor of her exalted

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1645 See for example Perfect, T. W. C., The Accidents of Childbirth. *The Lancet*, October 5, 1839, 67–68; Lee, Robert, Observations on the Cause of Death after Delivery in the Case of Her Royal Highness the Princess Charlotte of Wales. *The Lancet*, April 28, 1849, 450–452; An Old Accoucheur [anonym.], Midwifery Practices and the Princess Charlotte at Claremont. *Medical Times and Gazette*, November 30, 1872, 617; Stokes, Thos., On the Death of the Princess Charlotte of Wales. *Medical Times and Gazette*. December 14, 1872, 668; The Forceps and the Perineum. The *BMJ*, March 9, 1889, 575–576.

1646 See especially Lewis 1986, 116–119. As Judith Schneid Lewis aptly noted about the successful career and prestigious patients, "[s]uccess provided little assistance, for it only gave him [Croft] more to lose". See also Schiebinger 2004b, 393; Cody 2008, 310–311; Marland 2006, 53–54. See also *The Accoucheuse versus the Accoucheur* 1864 [?], 24–25.

1647 Montgomery 1837, 14.

1648 Victoria's parents, Edward, Duke of Kent, who was the fourth son of King III, and Victoria of Saxe-Coburg-Saalfeld, a German Princess and a one-time widow, married in 1818. Their only child, Victoria, was born in May 1819. See for example Longford 1964, 15–22; Woodham-Smith 1972, 3–31.

1649 Delivery of the Queen and the Birth of a Princess. *The Lancet*, November 28, 1840, 347–348. See also Breen, John, Observations on the Practice Artificially Dilating the Os Uteri. *The Lancet*, May 11, 1844, 214.

1650 Delivery of the Queen and the Birth of a Princess. *The Lancet*, November 28, 1840, 348.

life", "hygienic rules" followed during pregnancy, above all, exercise, "progress in medical science", and moreover, "the presence and support of friends, her mother, and her beloved consort [Prince Albert]".[1651] Queen Victoria's personal correspondences showed, however, that the fate of Charlotte and dangers of the childbed were not far from the Queen's mind; in her private letters, Victoria also described the maternal deaths taken place in her inner circle.[1652] In 1860, Victoria was also worried when she found out that her pregnant daughter was given a picture of the memorial of Princess Charlotte and her baby, fearing that the future mother was "hipping" herself "about it".[1653]

Consequently, Princess Charlotte's death had a long-lasting effect on British culture, the medical profession, and obstetrics. Doctors' letters and case reports published in medical journals demonstrated that the British medical profession was traumatised by the incident and that the tragedy was revisited on several occasions during the century.[1654] At the end of the nineteenth century, the royal case was also discussed at length in the popular manual of Florence Stacpoole.[1655] Stacpoole, like the obstetric authority she greatly admired, William S. Playfair, blamed the timid interventional policy of their predecessors and the fear of meddlesome midwifery, "that bugbear", as Playfair called it, of the tragedy:

> One would have thought that this terrible story – the fifty-two hours of suffering – with its calamitous ending [--] bringing universal regret, would have caused a revolution in the midwifery practice of the day, but it was many years before old-fashioned doctrine of the English physicians, "never to use artificial means when nature could effect delivery", which they had faithfully adhered to in their treatment of the unfortunate Princess, came to be recognised as mischievous, dangerous, and absurd.[1656]

1651 Delivery of the Queen and the Birth of a Princess. *The Lancet*, November 28, 1840, 348. The presence of Prince Albert in childbirth is discussed in Chapter 5.3. See also Woodham-Smith 1972, 216–217; Longford 1964, 150, 153. However, historians have not agreed whether Victoria's mother, the Duchess of Kent, was in the same room with her daughter: some mentioned that she was waiting in the next room, together with ministers and other members of court, some have claimed that she was present in the birthing room.

1652 See for example Queen Victoria to her eldest daughter Victoria, the Crown Princess of Prussia, February 7, 1863. *Dearest Mama* 1968; 73–174; Queen Victoria to her granddaughter Victoria of Battenberg, July 4, 1888. Hough 1975, 95–96; Queen Victoria to her uncle Leopold I, King of Belgium, November 6, 1838. Benson & Esher 1908, 130–131.

1653 Queen Victoria to her eldest daughter Victoria, the Princess Royal, May 23, 1860. *Dearest Child* 1964, 256.

1654 See for example Toogood, Jonathan, On the Practice of Midwifery, with Remarks. The *PMSJ*, May 22, 1844, 103–108; Thompson, C. M., Post Partum Haemorrhage. The *BMJ*, January 10, 1874, 47; The Death of the Princess Charlotte. The *BMJ*, July 20, 1878, 128; The Forceps and the Perineum. The *BMJ*, March 9, 1889, 575; March 30, 1889, 751. See also Playfair 1894b, 18–22. See also Playfair quoted in Stacpoole 1894, 95–96.

1655 Stacpoole 1894, 94–101.

1656 Stacpoole 1894, 100–101. See also Playfair, W. S., A Discussion on Modern Methods of Managing Lingering Labour. The *BMJ*, September 27, 1890, 715–717; Playfair, W. S., A Valedictory Lecture on the Progress of Obstetrics and Gynaecology. The *BMJ*, March 19, 1898, 742. See also Playfair, W. S., On the Death of the Princess Charlotte of Wales. *Medical Times and Gazette*, December 7, 1872, 636–637; Playfair 1894b, 18–22.

Both Stacpoole and Playfair clearly believed that the forceps would have saved Charlotte and her child. This was, however, only one opinion amongst others, reflecting the ideals of the obstetrical policy at the end of the nineteenth century – but it was not the universally shared perception of Charlotte's case or even the understanding of meddlesome midwifery in the Victorian era, as I have already illustrated in this work.

5.6 "Still for Another Month of Great Care Will Be Required to Keep Well": Lying-In and the Recovering Body and Mind

Lying-in or puerperium was an integral part of the reproduction process, being both a period of rest and recovery and the transition back to normal life and routines – or, as it often occurred, until a new pregnancy. In this last subchapter of this study, I shortly discuss the medical ideal and practices of lying-in, noticing its indispensable role in childbirth. The family historian John R. Gillis has argued that the period of lying-in was "a ritualized period of up to a month when she [the parturient woman] was in a transition state, betwixt and between, neither fully a wife nor fully a mother".[1657] Lying-in was an interesting and in many ways an exceptional phase in the female life cycle: the woman was secluded from her normal daily routines and social engagements, she lived in social separation from her community, and the routines of her marriage and family life were also temporarily changed. However, this was also a class-related custom: poor women did not have a chance or means to have a full lying-in period with its different phases and medico-cultural rituals and treatments.[1658]

This time period was usually called *lying-in*; another popular term was *puerperal*, which, according to Florence Stacpoole, was taken from "two Latin words, *puer*, 'a boy,' and *pario*, 'to bring forth,' and means simply 'pertaining to childbirth'".[1659] However, as Irvine Loudon has stressed, "puerperal" was often used loosely as meaning "maternal", and not necessary connected directly to the lying-in period.[1660] The precise length of the postnatal period changed but usually, lying-in lasted approximately a month, depending on the social status and wealth

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1657 Gillis 1996, 163. See also Wilson 1995, 26–27; Wilson 2013, 191–200; Astbury 2017a, 500–519; Tosh 1999, 56. For example, Jean Donnison considered nineteenth-century manuals, such as the *Advice to a Wife* by Pye Henry Chavasse, as medicalised examples of injurious customs: Donnison noted that women were advised to lie on their backs for days, "now recognized as positively injurious". Donnison failed to notice, however, that the lying-in period had been ritualised and some of the customs had a longer history. Donnison 1999, 65. On lying-in in medieval England, see Harris-Stoertz 2019.

1658 See especially Philothalos 1860, 83–84; *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 27–28.

1659 Stacpoole 1894, 67.

1660 See Loudon 1995a, xxv. Also the term "puerperium" and "puerperae" were used, sometimes loosely to describe, for example, maternity patients in general.

of the parturient woman and her family.[1661] In nineteenth-century medical ideals, the lying-in period usually lasted four to six weeks after delivery. Traditionally, churching was seen as the end of this period; in the special religious ceremony, the woman was re-integrated back into her community and position, while celebrating also a safe deliverance.[1662] In nineteenth-century medical texts, churching had lost its meaning; I have found only few references to this traditional postnatal ritual. For example, in 1902, one doctor described how his patient "had arranged that she should be 'churched'", but gave no other details.[1663]

Usually the state of the woman's health determined the point when she was ready to return to her normal life, as Henry Davies described in 1852: "[a]t the termination of the third week after her delivery, under ordinary circumstances, a patient may join her family, and gradually afterwards resume her domestic avocations".[1664] Gordon Stables, on the other hand, noted that it took at least six weeks before the womb was back in its normal state; thus, it was physiology alone dictating when recovery was completed.[1665] "Coming downstairs", leaving the lying-in room, was an important mark in re-establishing the normal rhythm and gradually returning back to normal life. The time itself was divided into different phases; first, absolute bed rest, then the carefully managed first uprising when the new mother was allowed to sit up and then walk while staying in her room. Lastly, she was allowed to leave the room, and finally, the house.[1666]

Historically, lying-in was a peculiar combination of worry over health and recovery, and on the other hand, thanksgiving and celebration of a safe delivery and the birth of a baby.[1667] As Henry Arthur Allbutt noticed in his manual; "[a]lthough the pains and the perils of pregnancy and labor are now past, still for another month great care will be required to keep well and to escape other dangers which accompany the lying-in state".[1668] As the historian Leah Astbury has

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1661 As Lucinda McCray Beier has pointed out, only the poorest women could not stay in bed for two weeks after delivery. Beier 2004, 397. See also Lewis 1986, 193. See also Wilson, A. 2002, 138–139. See also Baker 1856, 45–46. See the whole lying-in period described in Playfair 1893b, 297–294. See also *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown].

1662 See for example Gowing 2003, 172–173; Astbury 2017a, 501–502; Gillis 1996, 164–165.

1663 Reuell Atkinson, T., Embolism of the Pulmonary Artery More than Two Months after Delivery: Death. The *BMJ*, January 23, 1897, 203. One of the few references to churching in the nineteenth century was found in the article of Greenhalgh, Robert, A Clinical Discussion on the Caesarean Section: And Its Claims as an Operation of Selection. The *BMJ*, November 30, 1867, 489–491.

1664 Davies 1852, 47. See also Drew 1891, 47–48. See also *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 24–29. On the practices of lying-in in the British political families, see Jalland 1986, 152–153, 156–158.

1665 Stables 1894, 228, 231. See also Stacpoole 1894, 123; Vincent 1902, 61–62, 72–73. See also *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 6–9, 17–22.

1666 On the lying-in period, see for example Bull 1865, 210–212; Chavasse 1866, 171–179; Scott 1870 [?], 59–60; Black 1888, 69–73; Herman 1891, 160–167; Swayne 1893, 37–38. See also Wilson 2013, 170–172; Jalland 1986, 152–153.

1667 See for example Gowing 2003, 172–173; Lewis 1986, 201–202.

1668 Allbutt 1890, 24.

noted, surviving labour was indeed one thing, regaining health another.[1669] Lying-in was also a time of great danger, recovery could be slow and relapses were likely; it was a period of regaining health and returning back to normal routines, but it also determined the future state of health.[1670] Indeed, as Gordon Stables noted in 1894, during pregnancy, the woman was not considered an invalid, but when recovering from labour, she really was one; during lying-in, the new mother had the identity of a *patient*.[1671] According to medical ideals, women, when recovering from delivery, could not rely on their own observations concerning their health. In fact, their bodily signs could be deceptive; women could feel perfectly fine even if their bodies were not. Some doctors reported how their patients protested against the demand for absolute bed rest; for example, in 1865, one lying-in patient told her doctor that "keeping in bed was only a farce."[1672] Acting against medical instructions, the woman could jeopardize her recovery and her future health and happiness.[1673] The longer the rest was, the better.

Jacque Gélis has noted that in the eighteenth century, the precepts of perfect lying-in were silence, stillness, and isolation.[1674] However, the social isolation of the new mother was often a relative matter. As Laura Gowing has pointed out, in early modern England, lying-in was "distinguished as much by sociability as by seclusion": the new mother was visited by midwives, neighbours, friends, and family members who were celebrating the birth of the child and the mother's recovery.[1675] In nineteenth-century ideals, this crowd was no longer welcomed into the lying-in room. Indeed, the essential ideal was that the room occupied by the woman was "cool, well ventilated, and free from visitors".[1676] All medical writers emphasised the importance of quietness during the lying-in period; no visitors and no family members, apart from the short visitations by the husband and the closest members of the woman's circle.[1677] Gordon Stables described how "talkativeness" in the lying-in room left the new mother "excited and feverish, or even greatly depressed".[1678] What the recovering patient needed was quiet and cheerful encouragement; "[a] hopeful state of mind as a most important influence in promoting the return to health", as noted also in the manual of Robert

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1669 Astbury 2017a, 509.
1670 See for example Vincent 1902, 60.
1671 Stables 1894, 228. See also Philothalos 1860, 56–57; Vincent 1902, 62, 71–73.
1672 Beck, T. Snow, On Puerperal Fever. The *BMJ*, April 29, 1865, 428.
1673 See for example Philothalos 1860, 57–58; Chavasse 1866, 171–173; Weatherly 1882, 77–79; Black 1888, 69–71. See also *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 9–11. See also Beier 2008, 275–277.
1674 Gélis 1991, 181.
1675 Gowing 2003, 172–175. See also Gélis 1991, 188–191. See also Bakewell 1857, 13.
1676 Bull 1837, 156. See also Walker 1893, 110–111; Stables 1894, 228–230; Stacpoole 1894, 124–125. See also Banks 1999, 52.
1677 These postpartum customs were based on the class of the patient, as was acknowledged also by George Black: "[a]mongst the lower classes it frequently happens that a confinement is scarcely over than the apartment in which she is lying becomes thronged with neighbours and friends, whose intentions may be good and laudable enough, but whose company she had much better be without". Black 1888, 63.
1678 Stables 1894, 230. See also Welch 1838, 74–75; Bull 1865, 206; Cullingworth 1884, 70–71; Stacpoole 1894, 125.

Bakewell, giving advice on the sickbed in the 1850s.[1679] Hope was indeed the "best medicine in the world".[1680]

Lying-in was an interphase also in marital relations. Sex was forbidden during the first month after delivery; any sexual activity was hurtful for the woman's health and recovering body.[1681] Indeed, during the lying-in period, the female body was expressively a maternal body, not a sexual one. In fact, as Henry Arthur Allbutt stressed, the woman's duty was to refuse any sexual connections whatsoever, even if the husband demanded them; "[o]n this she must strongly insist".[1682] Moreover, the possibility of a new pregnancy was always risky at this point in the reproduction cycle; it harmed the woman's health both physically and mentally, and made the new foetus weak and unfit. Hence, the husband's role was to be merely a visitor in the lying-in room: he was keen to know what was happening, but he, too, should remember and follow the "hygienic rules", dictating the lying-in period.[1683] In fact, Jane H. Walker stressed the example of the women of the "so-called savage nations" who reportedly lived apart from their husbands for three years after the birth of a child. To Walker, this was a way to avoid over-population and save women from "anxiety and carking [causing distress] care".[1684]

Indeed, as the little booklet written for working-class women, *On the Evils Resulting from Rising Too Early after Childbirth,* pointed out, in order to make good convalescence, nothing was so essential "as rest of mind and *body*".[1685] Hence, the idea of prevention also dictated the rules during the lying-in period. For example, Florence Stacpoole listed five essentials for the successful lying-in period, all shared by her peers: rest, quiet, cleanliness, "good and proper food", and "avoidance of draughts and chills".[1686] The writings emphasised the responsibility of the woman herself; the ideal patient understood that rest, meaning staying in absolute bed rest in a horizontal position, was indispensable in every possible way. Directly after labour was over, the petticoat and some of the soiled bedclothes were removed but otherwise the woman was allowed to rest approximately for an hour in a darkened room until she was washed and all her remaining clothes were changed. A binder and bandage made of calico or flannel was placed on "the external parts".[1687] All writers stressed the importance of staying

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1679 Bakewell 1857, 13–14. See also Newton 2017, 117–119.

1680 Stables 1894, 79. See also Digby 1994, 86–87.

1681 On sex during lying-in, see McLaren 1990, 117–118; Wilson 1995, 27, 29; Wilson 2013, 174–175; Gillis 1996, 164–165; Gowing 2003, 173–174. On post-partal women, health, and sex in medieval England, see Harris-Stoertz 2019, 232–233.

1682 Allbutt 1890, 28.

1683 See for example Walker 1893, 110; Baker 1856, 17–18.

1684 Walker 1893, 125.

1685 *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 14–15.

1686 Stacpoole 1894, 122; Stables 1894, 230–231. See also Fox 1834, 78; Philothalos 1860, 61. On convalescence in early modern England, see Newton 2017.

1687 See descriptions for example in Conquest 1849, 83; Bakewell 1859, 125–128; Davies 1852, 38–40; Philothalos 1860, 51–52; Chavasse 1866, 160–163; Weatherly 1882, 67–69; Cullingworth 1884, 61–76; Black 1888, 61–63; Allbutt 1890, 23–24; Drew 1891, 46–47; Herman 1891, 78–79; Walker 1893, 104–106; Vincent 62–66. See also for example Steele, A. B., The Obstetric Binder in Post Partum Haemorrhage. The *BMJ*, December

in bed: "she must neither talk nor move about, and must on no account sit up", as Thomas Arthur Allbutt pointed out in his manual.[1688] Medically, if there was a need to move the woman, it was important that she was lifted so that she could remain in a horizontal position.[1689] Hence, beside the bed, the other furniture needed in the room was a sofa.[1690] Otherwise, the environment of lying-in was the same as in delivery. As the writers noted, the medically ideal room was clean, cheerful, well ventilated, and not too hot.[1691] The right temperature of the room and the abundance of fresh air were medical necessities for a successful lying-in period; a too hot and badly ventilated room was always medically risky.[1692]

Diet was also an important part of lying-in rituals and health care; the medically ideal postnatal diet was light, consisting of tea, gruel, arrowroot, and broths.[1693] Directly after labour, a cup of tea with some milk and bread was enough, or beef tea. Alcohol was not usually recommended, unless it was prescribed as medicine.[1694] Otherwise, during the first couple of days, the diet was for the most part fluid, but gradually the woman was allowed to have more nourishing and solid food, including boiled eggs, arrowroot and sago, light puddings, chicken and white fish. On the third or fourth day, the woman could add some red meat into her diet, such as mutton, a piece of steak, or roast beef. If her general state was improving and she was feeling better, the woman could return to her old diet, albeit preferably in a lighter version.[1695] The best postpartum beverages

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6, 1873, 656; Williams, D. M., Abstract of Two Thousand Five Hundreds Consecutive Cases in Midwifery Practice. The *BMJ*, July 2, 1881, 9–10. See also Playfair 1893a, 365–366; Playfair 1893b, 292–293. See also Gélis 1991, 179–180. On darkness during lying-in, see Lewis 1986, 196–197.

1688 Allbutt 1890, 23. See also Fox 1834, 78–81; Baker 1856, 34; *Doctor at Home* 1891, 545–546. See also Kittoe 1845, 182; Baker 1856, 40; Chavasse 1866, 171–173; Vincent 1902, 71–73. See also Lewis 1986, 199–200.

1689 See for example Braxton Hicks, J., Remarks on Cases in Which the Whole or Part of the Placenta Was Retained for a Longer Period than Usual after Delivery of the Child. The *BMJ*, July 22, 1882, 125. See also *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown].

1690 Baker 1856, 38–39. See also Bull 1837, 158; Bull 1865, 195–196; Chavasse 1866, 172; Scott 1870 [?], 59; Black 1888, 71–72.

1691 See for example Stables 1894, 228–229; Allbutt 1897, 21.

1692 See for example Chavasse 1866, 163–164; Stables 1894, 228–230; Allbutt 1897, 15–23. See also M. D. [anonym.], On the Right Management of the Puerperal State. The *BMJ*, November 14, 1874, 636.

1693 See for examples Baker 1856, 36; Bakewell 1859, 128; Herman 1891, 164; Swayne 1893. 36–37. *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 15–16. See also Gélis 1991, 180–181; Lewis 1986, 208–209. See also Newton 2017, 114.

1694 See for example Black 1888, 74; Allbutt 1890, 29.

1695 See for example Fox 1834, 82–83; Bull 1837, 155–157; Bull 1865, 208–210; Welch 1838, 70–72; Hills 1841, 10; Kittoe 1845, 181–182; Baker 1856, 35–36; Bakewell 1859, 128; Chavasse 1866, 173–176; Scott 1870 [?], 57; Weatherly 1882, 75–76; Black 1888, 62, 73–74; Allbutt 1890, 27–28; Drew 1891, 50–51; Walker 1893, 106–107, 110; Stables 1894, 232; Stacpoole 1894, 125–126; Allbutt 1897, 16; Vincent 1902, 74; Surgeon & Accoucheur [anonym.] 1900–1909 [?], 276–277. See also Bakewell 1857, 15–18. See also Liverpool Medical Institution. The *BMJ*, December 12, 1863, 648–649; Candlish, Henry, Crossman, Edward & Whitmarsh, William Michael, Treatment of Parturient Women. The *BMJ*, November 19, 1864, 589–591; Lowndes, Henry, Remarks on the Diet after Childbirth. The *BMJ*, December 1865, 600–604. See also Playfair 1893b, 291–292. See

were barley water, tea, cold water, toast water, or soda, but no alcoholic drinks.[1696] It is clear that not everyone had the chance or means to follow these precepts, but in royal circles, the medically correct dietary ideals were closely followed, as was confirmed by Queen Victoria when she described her daughter Alice's first delivery in 1863: "Alice [--] is very hungry; she has had to be kept up very much, far more than I was with the elder ones. She had beef tea the same day, fish the next – chicken yesterday and boiled mutton."[1697]

During some weeks after labour, the woman's body produced a vaginal discharge, seen as an important sign of puerperal well-being and health. The *lochia*, or *cleansings*, marked the transition from pregnancy and labour to motherhood; the discharge was a combination of blood, mucus, and tissues of the womb.[1698] Medical writers paid a considerable amount of attention to the lochia; it was an important indicator of puerperal health, even if the writers acknowledged individual differences in the quantities of the discharge. First, the discharge was more copious, being reddish in colour, but gradually it diminished and turned paler. If the lochia suddenly ceased altogether or the discharge had "a disagreeable sickly odour", it was always a warning sign that something was wrong.[1699] Thus, a strange odour or bad smell was an important indicator of puerperal health; in this, a competent doctor was not to trust only his or her sight and hearing but also sense of smell.[1700] On the other hand, too copious a blood loss, *flooding,* was also a life-threatening condition, demanding quick actions.[1701] The lochia was directly linked to the puerperal hygiene and cleanliness of the lying-in period; the lower body of the woman was carefully and regularly washed with tepid water and a sponge, and the vagina was flushed with a syringe.[1702] Good hygiene was

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also Newton 2017, 113–116. On lying-in diet in medieval England, see Harris-Stoertz 2019, 242.

1696 See for example Fox 1834, 83; Hills 1841, 10; Chavasse 1866, 162, 176–178; Black 1888, 74; *Doctor at Home* 1891, 237.

1697 Queen Victoria to her daughter Victoria, the Crown Princess of Prussia, April 8, 1863. *Dearest Mama* 1968, 192–193.

1698 Read 2013, 2, 35–37, 145–170. See also Gélis 1991, 178; Astbury 2017a, 505–506, 510. See for example Davies 1852, 40–41; Bakewell 1859, 129–130; Scott 1870 [?], 57–58.

1699 See for example Conquest 1849, 79–80; Bakewell 1859, 129; Philothalos 1860, 53–54; Bull 1865, 198–201; Chavasse 1866, 170–171; Cullingworth 1884, 64–65, 68–69; Black 1888, 67–68; Drew 1891, 48; Walker 1893, 109; Stables 1894, 230; Allbutt 1890, 25–26; Herman 1891, 162; *Doctor at Home* 1891, 159–160; Vincent 1902, 68–69. *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 13–14. See also Swayne 1893, 36, 92–94. See also Beck, T. Snow, On Puerperal Fever. The *BMJ*, April 29, 1865, 428–429.

1700 See for example George Campbell, S., A Case of Puerperal Arterial Thrombosis. The *BMJ*, July 21, 1888, 124: "A slight lochial discharge still present with normal odour". See also Macleod, Neil, Remarks on Antiseptic Midwifery: Experiments with Lochial Fluid. The *BMJ*, October 14, 1882, 717–718. See also Storrs, Robert, History of Puerperal Fever in Doncaster. The *PMRMS*, April 23, 1842, 45–51. On bad smells in medicine, see Palmer 2004, 61–68.

1701 See for example Allbutt 1890, 29; Fox 1834, 75–76; Philothalos 1860, 58–60. See also *On the Evils Resulting from Rising Too Early after Childbirth* [publication date unknown], 11–14. See especially Playfair 1893b, 111–134.

1702 See for example Bull 1837, 154; Black 1888, 68; Stables 1894, 229. See also for example Braxton Hicks, J., The Use of the Intraunterine Douche after Labour, Where Offensive Lochia Exists, as a Rule of Practice. The *BMJ*, November 13, 1869, 527–528; Macleod,

an ongoing medical discourse, even if at the end of the nineteenth century, bacteriology clearly changed the general tone also in popular health manuals. "Cleanliness now is absolutely necessary to ensure a save recovery, and those who neglect it cause a patient to run a very serious risk", warned also George Black in his manual (1888).[1703]

Apart from childbed fever, already discussed in the previous subchapter, another "very bad result of lying-in" and getting up too soon after delivery was *white leg*, *swelled leg, milk leg,* or *phlegmasia dolens*, the painful thrombosis of the femoral vein in the leg following childbirth.[1704] Its symptoms included a fever and shivering, a headache, a great sense of weight in the leg, throbbing and aching sensations, as it was described, and the general swollenness of the limb: the skin was white, tight, and shining and the leg felt firm and hard, "almost like a piece of marble".[1705] In popular medical literature, this condition was usually seen as a result of getting up too soon after labour: women did not follow medical advice, self-diagnosing themselves as stronger than they actually were.[1706] On the other hand, discussion related to *white leg* and its causes was clearly class-related; working-class women were easily held responsible for their postpartum health problems. In the case of Princess Louise Margaret (1860–1917), Duchess of Connaught and the wife of Queen Victoria's third son, the cause of *white leg* was rather "a form of blood-poisoning arising from the depressing influence of sewer-gas", than the injurious conduct of the new mother herself.[1707] As the *BMJ* reported, the royal patient was able to travel to France to take care of her postnatal health, but usually the condition was treated with bandages and fomentations, leeches, blisters, mild purgatives, and bathing.[1708] In his manual, Henry Arthur Allbutt was the only one to warn women about not having any more children if

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Neil, Antiseptic Midwifery: Experiments with Lochial Fluid. The *BMJ,* October 14, 1882, 717–718.

1703 Black 1888, 68. See also Chavasse 1866, 160–162. See also Vincent 1902, 69.

1704 See for example Evans, C. J., Epileptiform Neuralgia during the Puerperal Period: Epileptic Seizures: Phlegmasia Dolens. The *BMJ*, July 6, 1867, 5; Brittan, F., Remarks on the Pathology of White Leg. The *BMJ*, January 15, 1870, 49–50; On the Common Form of "White Leg" After Confinement. Obstetrical Society of London. The *BMJ*, May 11, 1895, 1038–1040. See also Welch 1838, 74. See also Shorter 1983, 113. See also Swayne 1893, 149–150; Playfair 1893b, 412–421.

1705 Allbutt 1890, 44–45. See also Kittoe 1845, 192–194; Scott 1870 [?], 63; Philothalos 1860, 55–56; Drew 1891, 55–56. See also Johnson, H., Westminster Medical Society. The *PMSJ*, January 15, 1842, 317; Brittan, F., Remarks on the Pathology of White Leg. The *BMJ*, January 15, 1870, 49–50.

1706 Welch 1838, 74; Allbutt 1890, 45. See also Baker 1856, 47–48. Nurse Baker stated in her manual that *white leg* was a rare disease. The treatment consisted of leeching at the groin, fomentations, and counter irritation – an irritation produced in one part of the body that was intended to relieve an irritation in the other part. See also Nevill, W. N., Puerperal Pulmonary Obstruction Followed by Phlegmasia Dolens; Recovery. The *BMJ*, June 11, 1892, 1253: "The condition seems very imperfectly understood as yet."

1707 The Duchess of Connaught. The *BMJ*, February 11, 1882, 201; The *BMJ*, March 4, 1882, 314. The Duchess had given birth to her first child in January 1882, and was treated by William S. Playfair, one of the leading obstetricians of the time. Compare to Philothalos 1860, 55–57.

1708 See for example Kittoe 1845, 194; Scott 1870 [?], 152; Allbutt 1890, 45. Swayne 1893, 150; Playfair 1893b, 418–420.

they had previously suffered from this condition. The woman's life was in danger if the cloth blocking the vein was carried either to the heart or to the lungs.[1709]

However, the lying-in period was not just about physical signs indicating that the woman was regaining her health or that she was still suffering physically from the complications of childbirth. Postnatal mental health was also an indispensable part of the lying-in period, even if the majority of popular writings concerning mental health issues concentrated almost solely on the pregnancy months. For example, the manual by Robert H. Bakewell (1859) also briefly discussed "mania", noticing that generally, the condition was treatable, but the most "troublesome symptom" was the mother's "desire to murder the infant".[1710] As Hilary Marland has illustrated, repeated childbearing, mental excitement involved with the reproduction process, poorly managed deliveries, and general discomfort were taking their toll on the health of many women who were already malnourished and suffering from various gynaecological and other problems with their health.[1711] This aspect was not usually discussed in popular health manuals; women were advised to control their minds against strong emotions, hysterical fits, convulsions, and darker shades of maternal insanity; the strength of the body and regular bowels also protected the mind, with the help of fresh air, rest, diet, and "cheerful company".[1712]

After labour, there was a risk of the new mother starting to act aberrantly; women could be aggressive, unable to sleep and eat, being indifferent or hostile to their newborn child, having hallucinations, making sexual gestures, and otherwise behaving disturbingly. Nineteenth-century doctors generally thought that this erratic behaviour, *puerperal mania,* was far more common than maternal *melancholia*, a state considered more threatening and incurable than mania.[1713] At worst, the results could be tragic. As Marland has noted, infanticide was a "total antithesis of female nature" in nineteenth-century society, "a total rejection of maternal ties, duties and feelings", and the antithesis of the woman's most paramount duty in life, motherhood.[1714] In this sense, puerperal insanity provided a medically reasonable explanation and rationale to describe and define this otherwise incomprehensible deed done by a new mother, who was expected to love

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1709 Allbutt 1890, 45–46. See the examples of the cases in medical periodicals, Bennett, James Risdon, Puerperal Arterial Obstruction. The *Association Medical Journal*, February 17, 1854, 143–144; George Campbell, G., A Case of Puerperal Arterial Thrombosis. The *BMJ*, July 21, 1888, 124. On thrombosis, see Playfair 1893b, 387–407.

1710 Bakewell 1859, 134. The reason why Bakewell's manual discussed also puerperal mania could have been the fact that the book concentrated on female diseases. On puerperal insanity and infanticide, see Marland 2004, 167–200. Puerperal insanity was not only about new mothers murdering their infants; also complete ignorance of the child was one symptom, or handling it roughly. See also Swayne 1893, 153–155.

1711 Marland 2004, 11, 21, 113–116. See also Williams 2011, 80–81. See also Allbutt 1890, 43.

1712 See for example Allbutt 1890, 43; Philothalos 1860, 89. On treatment of puerperal insanity, see Marland 2004, 44–48, 116–122, 132–134.

1713 Marland 2004, 4–5, 35–42; Marland 2006. See also Gooch 1831, 104–169. See for example The Week. The *BMJ*, July 19, 1862, 71–72; Macleod, M. D., An Address on Puerperal Insanity. The *BMJ*, August 7, 1886, 239–242. See also for example Jones, Rupert, Puerperal Insanity. The *BMJ*, March 8, 1902, 579–586; March 15, 1902, 646–651.

1714 Marland 2004, 171, 172–178. See also Kilday 2013.

and protect her child, not to mishandle or try to destroy it.[1715] Ornella Moscucci has argued that infanticide cases demonstrated how women's sexual physiology and pathology affected their behaviour and how these ideas were applied in practice: women were regarded as vulnerable, and therefore, they were not totally responsible for their actions.[1716] However, it was not only the child's life that was in danger; puerperal insanity destroyed, interrupted, or at least complicated marital relations, the very natural bond between the husband and wife, although unmarried mothers were seen as being at greater risk of killing their newborn infants. Postnatal maternal insanity broke the normal cycle of the family life and daily routines of the house. The result, as one doctor described it in 1886, was "distress, anxiety, and sorrow", instead of joy and "bright hopes", otherwise associated with the birth of a child.[1717]

Even if ultimately the cases of puerperal insanity were rare, many women felt a sense of loss of control over their own life and body when their pregnancies followed each other repeatedly in rapid succession. Moreover, traumatic birth experiences could have long-lasting consequences for future motherhood and family life. Personally, many women, such as Queen Victoria for example, knew from their own personal experience that as well as the body, also the mind went through a great change during pregnancy and delivery. In 1859, Victoria described the experiences of her early years of motherhood to her eldest daughter, who had just given birth for the first time. Victoria recalled to her the early years of her own motherhood, having experienced two of her first pregnancies in two years, which had been too much for the young Queen:

> I see a decided progress, and hope each day you will feel stronger and better. Occasional lowness and tendency to cry you must expect. You of all people would be inclined to this and I am quite agreeably surprised to hear from Sir James [the Queen's doctor] how little you suffered with this; for it is what every lady suffers with more or less and what I, during my two first confinements, suffered dreadfully with.[1718]

The Queen's letter demonstrated how in matters related to childbirth women confided in each other; thus, female peer support still continued to play an important role in nineteenth-century birthing and lying-in rooms. Indeed, as I have discussed in this chapter, in childbirth, personal female experience was often considered superior to the emotional closeness between the married couple; most nineteenth-century medical writers did not recommend the husband's attendance at the delivery, even if they acknowledged that husbands were emotionally

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1715 Marland 2004, 172. See also Kilday 2013, 181.

1716 Moscucci 1990, 31, 105.

1717 Macleod, M. D., An Address on Puerperal Insanity. The *BMJ*, August 7, 1886, 242. See also especially Marland 2004, 62–63, 65–94, 129, 158–165; Marland 2006, 67–73. See also Loudon 1992, 143–146.

1718 Queen Victoria to her eldest daughter, Victoria, the Princess Royal. February 23, 1859. *Dearest Child* 1964, 162. See also Queen Victoria to her eldest daughter. June 15, 1859. *Dearest Child* 1964, 195–196. See also Queen Victoria's letter to her uncle, Leopold I of Belgium, December 7, 1841. Benson & Esher 1908, 366–367: "I have likewise been suffering from lowness that it made me quite miserable, and I know how difficult it is to fight against it." See also Lewis 1986, 213–215; Marland 2004, 1–2.

attached to their wives and could occasionally be a very important source of information. Emotions, foremost fear, were constantly discussed in nineteenth-century obstetric medicine; everything in the birthing and lying-in room, including the attendants, material preparations, the topics of conversation and general "cheerfulness", served the parturient woman, keeping her calm and composed during the delivery and lying-in period.

6 CONCLUSION

When conducting research on the history of human reproduction, one comes to agree with the French historian Jacques Gélis, who in his study on the history of childbirth in early modern Europe explained that "nothing is more complex than the creation of new life, and any historian embarking on a study of childbirth quickly realizes the immensity of the task".[1719] Reconstructing the past from scattered fragments is always creating the more or less factitious models and theories of the past; the historian is inevitably left with an incomplete picture of the past, full of black holes "which it is difficult to fill in", as Gélis has noted.[1720] This is the case also in this research; I have studied primary sources created almost solely by the nineteenth-century British medical profession. Thus, the focus has been on doctors and their writings; their constructions of their own role as the authorised experts on pregnancy and childbirth, medical ideals and practices described in their writings, ethical codes and professional expectations, and also some of the realities defining and framing medical work and doctors' position in Victorian Britain. The first-hand experiences of nineteenth-century pregnant/parturient women or the writings of British midwives have not been analysed in this study; I have examined more closely only one manual written by a British midwife, mainly to demonstrate that the doctors' writings were no neutral collections of advice. All manuals are socio-cultural constructions; they do not reflect some kind of independent reality of the world or produce more refined or "better" knowledge of it, even if they are actively involved in the processes of constructing or representing "reality". Nineteenth-century doctors' guidebooks were just one type amongst the flourishing genre of popular manuals.

This thesis has investigated the nineteenth-century medical perceptions of pregnancy and childbirth using two collections of primary sources: first, popular health literature – meaning health manuals intended for use by lay women – and medical journals, particularly the *British Medical Journal*. Thus, both types of primary sources were created by the same party, the nineteenth-century medical

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1719 Gélis 1991, xiv.
1720 Gélis 1991, xiv.

profession; simplified, popular medical manuals included doctors' advice on pregnancy, labour, and lying-in for lay readers, and the medical journals consisted of writings whose implied audience were peers from the different levels of the professional hierarchy. The majority of the *BMJ*'s subscribers were general practitioners to whom the *BMJ* was an important arena of joint communication and discussion, a source of information, and a channel of mutual solidarity and sense of community amongst the medical practitioners living and working in different parts of the British Empire. Longer lectures printed in the periodicals were usually written by the leading medical authorities of the time but also less famous or prestigious medical practitioners could have their voices heard; provincial doctors could send letters to the editor or shorter messages printed at the end of each issue. In this research, I have explored many types of writings published in the *BMJ* – lectures, book reviews, weekly sections, and advertisements – but especially doctors' letters and shorter notifications have been in many ways indispensable and informative. The letters described practical medical work, what doctors thought about their patients and each other, and especially what kinds of problems they faced concerning pregnancy and childbirth in their daily encounters or in those instances when their special expertise was needed. In fact, the correspondence section was the place where the medical profession was allowed to ask for help and to get another opinion, to describe their conflicts and contentions with medical peers, and to comment on and to join the discussion of what was written in the previous issues of the journal.

I have analysed doctors' constructions of their own roles in taking care of women' health during pregnancy and labour. Both types of writings clearly show that the medical profession was actively involved in childbirth, presenting doctors as the legitimate experts on every stage of human reproduction. However, in reality, they were not the only ones providing midwifery services in nineteenth-century Britain. Doctors' writings show that most British women gave birth at home and they were accompanied by one or more attendants, who had some kind of special knowledge and previous experiences of childbirth. Contrary to the ideals fostered by the British medical profession, the attendant in childbirth was not necessary a university-trained doctor but quite often a female midwife whose work and training were not standardised or controlled during the period studied in this research. In Britain – or more precisely, in England and Wales – the first *Midwives Act* was not enacted until 1902. In their writings, British doctors' opinions on midwives were often negative and pejorative; in popular health manuals, midwives were depicted as ignorant, negligent, and reckless, whose work was dictated by outdated traditions rather than scientific medical knowledge, respectability, rational compassion, and deep understanding of "Nature and her laws" – as was the case in the doctors' own ideas of themselves. Hence, popular manuals can be understood as the business cards of the British medical profession, promoting and advertising their services and demonstrating their professional knowledge, competence, and sensitivity in the eyes of their potential female readers.

Moreover, both popular manuals and medical journals demonstrated that nineteenth-century childbirth was a social event; thus, it was controlled by society, from below, even if the traditional female circle attending labours, the *gossip*, had lost its former meaning. As I have shown, the nineteenth-century medical profession did not, however, discard the emotional female peer support in the birthing room; the lay attendant recommended was usually a married female friend who was guided by her own personal experience of giving birth, often considered superior to the emotional support provided by the husbands and mothers of the parturient women. During pregnancy, this female peer guidance was often considered dangerous – inexperienced women heard horror stories from their friends, and consequently, got frightened and scared – but in childbirth, the presence of a female friend was considered in many ways beneficial, primarily because the attendant knew from her own experience what was going on in labour. In the popular medical texts, the attendance of husbands in the birthing room was not usually recommended; lay men had no personal experiences of giving birth and thus, they only made the parturient woman nervous with their own nervousness. The writers clearly acknowledged that men, as husbands, were very much involved emotionally; this demonstrates that childbirth was considered an important family event in which emotions played an indispensable part – for better and worse. However, patient reports published in the medical journals show that even if many writers referred to lay attendants as "friends", quite often these "friends" were in fact family members who also took part in the decision making, at least in the most difficult midwifery cases.

Especially the moment of birth was described in detail. As I have illustrated, according to the nineteenth-century British popular medical literature, parturient women were not confined to their beds, forced to lie down on their backs passively for hours, or possible for days. Actually, the position in childbirth recommended was the left side, knees bent and possibly a small pillow placed between the knees. This was a medico-culturally defined practice; the side position was namely a British custom whereas elsewhere in Europe women gave birth in other positions. Both in journals and guidebooks, doctors explained that lying on the left side was not only medically justified but it also protected women's modesty and respectability during the second stage in labour, together with the necessary garments. During the first stage in labour, when the cervix was dilating, women were usually encouraged to walk about in the birthing room; the only precondition was that they were not to tire themselves. Moreover, an ideal birthing room was arranged to be as cosy as possible; as I have discussed, everything in the room served the parturient woman, creating a comforting and safe atmosphere. Especially fear was the greatest enemy in childbirth; the attendants were encouraged to choose light topics of conversation and cheer up the parturient woman in every possible way. Of course, these descriptions published in the popular medical manuals cannot be understood simply as actual portraits of nineteenth-century birthing rooms. On the other hand, the ideals also demonstrate in their own way that the birthing room was not intended to be a torture chamber and

that the wellbeing – both physical and mental – of the parturient woman played an important part in the doctors' constructions of childbirth.

Moreover, also material requirements for birth had important social, medical, emotional, and practical roles before and during labour, carefully described in doctors' writings. First of all, various objects needed had practical functions; women were advised to have special materials for the bed, primarily bedclothes and protective covers. Hygienic aspects also mattered; at the end of the nineteenth-century, disinfectants and the discourse of "surgical cleanliness" became the precondition for the medically ideal birthing room and its requirements. Throughout the sixty years covered in this research, the ideal room was large, airy, well ventilated, and full of light; hygiene included also the right temperature and the absence of dangerous sewage fumes, the latter associated especially with dreaded childbed fever. However, these material preparations also had an important social function; they were a socially visible sign of an established pregnancy, thus, known by the family and also the larger community of the parturient woman. For example, if the neonatal child died sometime during delivery and there were no witnesses, material preparations could demonstrate that the intention had not been to destroy the foetus soon after its birth. More generally, material preparations, primarily baby clothes and linen, were demonstrations of emotions and family relations; love, affection, hope, and anticipation.

As my study has shown, the concept of "natural" was crucial in nineteenth-century British medical writings; concepts such as "natural labour", "natural", or "Nature"/"nature" were constantly displayed, discussed, and debated both in popular heath manuals and in medical journals. The meaning of nature, however, was far from clear; as doctor Robert R. Rentoul, who also tried without any success to create his own definition of natural labour, noted in 1898 that the "definitions show the absolute state of chaos which exists in our faculty as to what is a natural labour".[1721] As I have demonstrated in this study, in the nineteenth-century obstetrical discourse – following the longer midwifery traditions – natural labour was a technical term to describe the presentation of the foetus, sometimes also including the duration of the labour – usually twelve or twenty-four hours – or the need to use special obstetrical instruments sometime during birth. Thus, the "naturalness" of each labour could only be decided afterwards and not before the woman went into labour. In the primary sources studied in this research, there is no evidence that nineteenth-century women themselves would have decided to give birth somehow "naturally"; thus, the term was used solely in medicine, even if women could be consoled that giving birth was indeed a natural part of the life of every married woman.

In broader terms, as I have discussed, nature and natural were useful categories for the nineteenth-century (male) medical profession, who could claim that they had the most profound understanding of Nature and her laws, unlike their main competitors, female midwives. Moreover, doctors could argue that they were also capable of handling complicated cases, with the help of specific medical aids and methods, including the possibility of pain relief, the midwifery

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1721 Rentoul, Robert, What is a "Natural Labour? The *BMJ*, January 4, 1896, 48.

forceps, antiseptics, and the development of obstetric surgery, foremost the Caesarean section. Medical sources demonstrate that in nineteenth-century medicine, nature was a flexible concept to justify many contradictory ideas and practices; nature was both omnipotent and inadequate, wise and capricious, a teacher and destroyer. Nature could be imitated and learned from, and yet ultimately, nature was mysterious and unexplained. This kind of contradictory and oppositional setting was very suitable for the nineteenth-century medical profession; doctors' constructions of nature and science complemented rather than excluded each other. This shows that "natural" in connection with childbirth has actually quite often been a male-authored concept.

In nineteenth-century medicine, nature was also seen as the opposite of civilisation. As this study has demonstrated, the British nineteenth-century medical profession believed in the theory of the corruptive influence of modernisation or civilisation and that this binary setting between civilisation and nature or natural was employed in obstetric medicine. According to the doctors' thinking "primitive women", who were living more closely to nature, gave birth unassisted and instinctively, they had larger pelvises, and their natural bodies were not corrupted by unnatural and unhealthy life habits, unlike their civilised women-sisters, whose labours were consequently more difficult and painful. In nineteenth-century doctors' constructions, this was indeed one reason why the "civilised" women, usually meaning upper-class parturients, needed the special expertise provided by the medical profession. Moreover, in nineteenth-century science, racial differences were thought to be based on biology: in the case of females, the female pelvis was an important tool of categorisation especially when different races were ordered hierarchically. In this context, a large pelvis could be a sign of inferiority, especially in relation to the size of the head. Thus, an easy and painless delivery could be both a sign of inferiority and paradoxically also an ideal.

In nineteenth-century popular manuals, women could easily have been held responsible for their health problems if they did not follow the laws of Nature, meaning the preventable methods of the six non-naturals, or the principle of self-control in their daily activities. In medical periodicals, however, this kind of moralising element was largely missing; rather, medical journals show – sometimes very concretely – that uncertainty was an indispensable part of medical work. Especially early pregnancy was a time of great uncertainty and bodily ambivalence; doctors' writings show that the individual combination of signs and symptoms of pregnancy were open to many interpretations and sometimes time alone revealed if the woman was indeed pregnant or not. Typically, four main categories were mentioned in this regard; missing menstruation, morning sickness, changes in the body, and lastly, *quickening*, meaning the movements of the foetus felt for the first time by the pregnant woman. Popular health manuals demonstrate that in medical literature, the latter continued to play an important role in self-diagnosing pregnancy, even if the word quickening itself had disappeared for example from the abortion law already in the 1830s. In addition to the

four main categories, doctors also described minor signs and symptoms of pregnancy but it was noted that none of the signs alone was decisive or occurred in every pregnancy.

The most significant figures in doctors' writings were ultimately the doctors themselves. Since the eighteenth century, medical practitioners had claimed that their role was indispensable, as was explained in the *BMJ* in 1864: "[the man-midwife] became an operator of no mean importance; being looked upon, not as he was formerly, the destroyer of human life; but as its preserver".[1722] Based on their constructions of childbirth, the nineteenth-century medical profession could claim that they were in fact the protectors of parturient women and their children. With the help of medicine and science, the processes and laws of Nature were better understood; doctors argued that they both understood Nature and were also able to act if these natural methods failed. In other words, doctors could claim that they were capable of handling both normal and complicated labours, with the help of decorous rationality or rational compassion, their special knowledge and expertise, science, and respectability. Especially the concept of *meddlesome midwifery* played an important part in nineteenth-century obstetrics; it was a very useful category in making the difference between what was considered right and wrong, doing actual harm and the proper treatment, and defining the professional responsibility of an obstetrician. I argue that the popularity of the concept in nineteenth-century obstetrics is meaningful, and thus, it requires more analysis in further studies.

The doctor was the one with the unique kind of responsibility and ultimately he was the one to perform the medical operations with very high risks and moral dilemmas. I argue that this is one major medico-ethical aspect in the professional literature studied in this research. As was generally acknowledged, delivering babies was no easy work; it was time-consuming and badly paid, with heavy responsibilities, low appreciation, and professional rivalry. As discussed in this study, many risks and dangers associated with pregnancy and childbirth, such as the possibility of miscarriage, postpartum haemorrhage, eclampsia or *puerperal convulsions,* as the seizures before, during, or after labour were generally called in nineteenth-century obstetrics, and what was probably the most dreaded complication, *childbed fever*, or *puerperal fever*, were real and current problems in midwifery, defining doctors' writings especially in professional medical literature and medical periodicals. Especially the discussion about the operation called *craniotomy*, which meant the destruction of the foetus in obstructed labours, in order to save the mother's life, and the Caesarean section shows that for nineteenth-century doctors this part of their work was the most difficult. In the British context, doctors usually tried to save the mother's life if the choice had to be made between the parturient woman and the foetus in obstructed midwifery cases; many descriptions show, however, that the destruction of the living foetus was a horrible responsibility for a medical practitioner.

[1722] Murphy, Edward W., Introductory Lecture on the History of Midwifery. The *BMJ*, May 14, 1864, 523–528.

The discussion related to craniotomy and other obstetrical operations was also closely linked to the question of *abortion*, here meaning an intentional termination of pregnancy. During the first six decades of the nineteenth century, abortion legislation in Britain gradually tightened, and in the 1860s, abortion in all circumstances was a criminal act. Craniotomy, in all but name, was a termination of pregnancy but according to the medical ideals, the operation was performed only when other means had failed and the aim was to save the mother's life. In those cases, the medical practitioner needed to be open with his cases and be able to show that the operation was justified. Otherwise, a respectable practitioner had nothing to do with "criminal abortions", as illegal terminations were commonly called in nineteenth-century obstetrics. However, countless reports published in the medical journals show also that in nineteenth-century Britain, many women tried to end their pregnancies themselves using poisonous substances and mechanical means, such as crotchet hooks, knitting needles, and other perfectly ordinary household supplies. In popular manuals, the topic of intentional termination was also very visible; when doctors discussed the *prevention* of miscarriage, they also collectively reminded their female readers that intentional termination was a morally objectionable and criminal procedure, thus describing it in the most condemning and warning terms. At worst, the results very extremely hazardous and in some cases, fatal; the abortion cases reported in the medical press clearly concentrated on the unsuccessful attempts needing medical treatment. These stories are equally an indisputable part of the history of childbirth in the Victorian era, albeit a hidden and very troublesome one.

In doctors' writings, it was constantly emphasised that pregnancy was not a disease and childbirth was a normal part of the life of every married woman. On the other hand, doctors' knowledge and expertise were needed specifically in complicated and obstructed midwifery cases. The writings analysed here in this study demonstrate that during the nineteenth century obstetrics was also becoming more surgical, at least in the most complicated cases. This was a long and not particularly straightforward process; for example, the introduction of anaesthesia at the end of the 1840s did not mean that in obstetrical operations anaesthesia was considered self-evident during the first years. However, at the end of nineteenth-century, many practices had changed. In 1898, the famous Scottish obstetrician William S. Playfair noted in his lecture on the progress of obstetrics and gynaecology how "[t]hings are possible now, and with comparative safety, previously undreamt of."[1723] "Comparative" is a necessary addition to the sentence, otherwise reflecting the typical nineteenth-century perceptions of inevitable progress in medicine and science. Generally, throughout the century doctors believed that a more advanced age was at hand and this new better future was aided by more effective methods, such as anaesthesia and "surgical cleanliness", and constantly improving medical knowledge in both obstetrics and gynaecology.

[1723] Playfair, W. S., A Valedictory Lecture on the Progress of Obstetrics and Gynaecology. The *BMJ*, March 19, 1898, 744. See also Ryan 1836, 122.

All this, however, did not mean that the general ideal would have been that *every* delivery was handled surgically or aided by midwifery forceps, for example. In the medical journals, this question was constructed around what was done in complicated situations. At the end of the nineteenth century, the medical profession could claim that destructive midwifery operations – found morally extremely difficult – had largely been eradicated. Moreover, risky operations could be performed earlier than they had been done before. During the nineteenth century, especially a Caesarean section was gradually becoming a realistic option in complicated labours; during the first decades studied in my research the majority of the operations ended badly, with nearly 90 per cent of women operated on dying. At the end of the nineteenth century, doctors could claim that they specifically delivered *living* children while they could also save the lives of parturient women. Thus, from the medical point of view, the early 1840s was a very different kind of world compared to the 1890s. This development and especially ethical aspects of the discussion require more systematic analysis and international comparison; the history of Caesarean section in the nineteenth century is inevitably transnational because news of medical breakthroughs and new ideas spread to Britain from other countries. In this sense doctors' own descriptions of the operations and their emotional reactions are also a very valuable source.

Especially the example of *maternal impressions* demonstrated that many parallel and contradictory practices and ideas co-existed and prevailed in nineteenth-century British medicine. The controversial theory of maternal impressions was used to explain some of the deformities and physical marks in the foetus formed sometime during the pregnancy months, in tandem with maternal imagination, emotions, and experiences. In previous research, many historians and other scholars have found the theory outdated in the nineteenth-century context, and thus, they have paid very little attention to the doctors' descriptions of the phenomenon; maternal impressions as a theory has uneasily been associated with the ideas of the constantly improving state of science in the nineteenth century. However, as I have shown in my study, the abundance of doctors' letters sent to the *BMJ* – which at that time was the largest medical journal in the whole world – demonstrate that the theory still prevailed amongst the British medical profession. Not every doctor believed in it but still in the 1880s and 1890s, many writers wanted to share their experiences of physical deformities seen in newborn children and requiring some kind of medically adequate explanation. Comparing two different kinds of primary sources, it is possible to produce a more detailed picture of the development of the theory and its popularity; in popular health manuals, the theory was considered outdated whereas in the *BMJ*, it clearly prevailed much longer. This can be explained by the fact that in medical journals discussion and many contradictory points of view were allowed, even expected, whereas medical manuals were more conventional and homologous, creating a more unified picture of doctors' perceptions and ideas.

Indeed, as I have discussed in this study, in reality the nineteenth-century medical profession was not a particularly homogenous group, sharing the same realities in practice. Certain medico-cultural ideas, however, were expected from

the medical practitioners; many accounts found in the primary sources demonstrated that nineteenth-century doctors expressed their sympathy and compassion, and the emotional aspects of their work were constantly displayed in their writings; they were not immune to human sufferings, distress, and pain. Quite the contrary; an ideal doctor was compassionate, sensitive, and supportive, and was capable of radiating confidence and trust to their patients and their circle. A bad doctor was insecure, timid, and nervous, unable to make quick decisions in demanding circumstances. An ideal nineteenth-century doctor was a "true gentleman", a "philanthropist", and "a Christian"; he – the prototype of a doctor was always male – understood the rules of decorum and was familiar with medical etiquette or the *bedside manner*.[1724] As I have illustrated, for an ideal medical practitioner, it was important to behave discreetly, to be trustworthy, and also to know the lay vocabulary for the "female complaints", in order to be successful and credible in the eyes of potential female patients. Medical periodicals reveal, however, that in complicated situations, some of the doctors panicked, some were distressed and felt helpless and disappointed if they were unable to save their midwifery patients.

In practical work, a doctor was protected by medical etiquette, a good reputation, and the discourse of science; these aspects guaranteed that a male medical practitioner, whenever encountering pregnant or parturient patients, could present himself as a compassionate and skillful human machine and not a sexual predator, as he was sometimes portrayed in anti-man-midwifery literature. Touch, the most important sense in obstetrics, was the very base of medical authority; the hands of a (male) obstetrician were represented as the tools of "decorous rationality", discretion, and science, able to save the patient whenever needed, also knowing not to exceed the limit of propriety or meddlesome midwifery, meaning over-treatment and doing actual harm. However, the hands, as actual concrete objects, were rarely discussed in obstetrical literature. Usually, the focus was on the cleanliness of the hands; at the end of the nineteenth century, the discourse of "surgical cleanliness" became one of the most important prerequisites in midwifery, and hence, also the basis of professional competence and the idea of being a good doctor.

One of the greatest differences between doctors' professional writings and popular medical literature was the idea of prevention and the role of the patient herself. The very idea in publishing guidebook literature was that lay women needed guidance and authorised advice during the critical phases of pregnancy and childbirth; the medical profession was very willing to represent themselves as the key element in this process seen as so indispensable for the future of society and the whole British Empire. The patient's first and most important duty was to absorb the idea of prevention, being "a doctor of oneself"; in the case of a pregnant woman, she was responsible both for her own and her child's future health and happiness – and that of the whole nation and race. This also included the narrative of the eugenic discourse of "making better babies" at the end of the

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1724 Swayne, J. G., Introductory Lecture on Midwifery, Delivered at the Bristol Medical School. The *PMSJ*, October 28, 1846, 514.

nineteenth century. Moreover, writers promised that labour would be easier and women's future health would also be secured after the "change of life", meaning the menopause. "Prevention is easier than cure" was indeed the medical slogan in the nineteenth century, which was found in every manual studied in this research – if it was not quoted verbatim, at least the very idea permeated the advice and instructions concerning both the maternal body and mind.

Popular health manuals cultivated the idea of preserving health and preventing diseases with the idea of six non-naturals deriving from the ancient and medieval medical tradition, meaning the preventative methods of diet, rest, exercise, air, excretion, and mental balance, the control of passions and emotions. Hence, popular medical manuals included an abundance of practical instructions and hints on dress, exercise, diet, sleeping, and hygiene, including the state of the bowels and bathing. Especially emotions played an important part in nineteenth-century medicine. In popular health manuals, the mind and the body were intertwined together, as the main title of this research, *The Health and Happiness of the Expectant Mother,* also suggests. In this research, I have understood "health" as a physical state of healthiness, and "happiness" as a steady state of mind. Mental health certainly was no taboo in nineteenth-century obstetrics; in medical writings, especially fear was an unwelcomed emotion during both pregnancy and childbirth, creating prolonged suffering and complicated labours. Fear, frights, and other undesired emotions were also associated with the theory of maternal impressions. Consequently, women were constantly encouraged to exercise self-control, responsibility, and good behaviour.

In fact, many writers could claim that one motive for writing and publishing popular medical literature was to lessen at least some of the negative apprehensions which especially young and unexperienced women tended to have, because of the stories told by the women themselves, cultivating fear and terror in their less experienced friends – or at least this is how the medical profession presented peer female guidance in their writings. The primary sources analysed in this study do not reveal, however, how well this advice worked in real life and how closely women actually followed the instructions they were given. Doctors themselves generally believed that their writings were much appreciated by the lay audience and the books were well read and studied. Book reviews show that amongst the medical profession popular manuals were accepted as necessities; the guidebooks encouraged their readers to actively take care of their health but they also stressed the role of medical practitioners in caring for women's health and happiness during the critical time of pregnancy and childbirth. Importantly, the popular health manuals also revealed the nineteenth-century medical networks; occasionally, guidebooks were dedicated to prestigious medical peers or professional role models of some kind. The writers clearly were also aware that their manuals were read and peer-reviewed by their colleagues, not only by the lay audience.

For the medical profession, thrusting the responsibility on the patient could nevertheless be useful. This idea suggested that the patient could be held responsible for bad health, illnesses and complications, creating a moralising dimension

both in the healing process and in the doctor–patient relationship. A doctor could always claim that the problem was too big for him/her and beyond that help s/he could offer to the patient if the very basics of health care had not been followed. For the patient, this kind of argument, however, could be deeply problematic; it suggested that the patient could be seen partially or wholly to blame for their own condition, because of self-indulgence and lack of self-control and discipline. In nineteenth-century medicine, by following the advice given, there was always the promise that prevention was possible, even likely, whereas disregarding instructions patients submitted themselves to uncontrollable risks, illnesses, and pain. Medical periodicals, especially the patient reports, demonstrated, however, that in practice, the idea of prevention was often only an ideal; the majority of obstetrical complications could not have been prevented by the actions taken by the individual patient. Moreover, patient reports and various enquiries published in medical periodicals demonstrated that the doctor was not that omnipotent, assertive figure he was often portrayed as in popular medical literature. In fact, the role of the medical profession was actually smaller than the doctors themselves would have liked to admit.

However, from the primary sources analysed in this study, one can easily get the idea that the medical profession attempted to get actively involved in the everyday life of their patients. In reality, the services of a doctor were not available to everyone; for many in nineteenth-century Britain, professional medical services were either too expensive, intimidating, or otherwise unattainable. Especially in working-class households, a doctor was a rarely seen figure even if the patient reports published in medical journals clearly distort this fact. Hence, peer support, self-help, home doctoring, and irregulars constituted an important part of the nineteenth-century medical market. As this study has discussed, doctors were very concerned about quackery, an undesirable counterforce in the medical discourse. A quack was a very visible figure in nineteenth-century medicine and in doctors' writings; a quack was presented as a dangerous and depraved self-seeker who only wanted to profit from people's distress and desire to feel better. For the medical profession, a quack was a useful figure; doctors could represent themselves as respectful, skillful, and sensitive – all qualities the quacks clearly did not possess, according to the doctors' writings.

All in all, the popular medical guidebooks analysed in this study cannot be read as demonstrative collections of nineteenth-century medical ideas, of what happened in practical medical work, or how the medical ideas and innovations spread amongst the medical writers and practitioners. As is illustrated, the nature of the popular manuals was in fact conservative, and the writings followed medico-cultural traditions rather than being an arena for the latest inventions and new medical ideas. For example, bacteriology and the discourse of "surgical cleanliness" or "antiseptic midwifery" made their way also into the popular medical writings at the end of the nineteenth century, but on the other hand, the concept of hygiene was constantly displayed and discussed. The nineteenth-century doctors' constructions of hygiene were particularly complex; the concept of hy-

giene included traditions of Galenic-Hippocratic medicine with a new understanding of microscopic science, and from the 1870s on, growing understanding of bacteriology and antisepsis, combined with the contemporary discourse of sanitation and with traditional holistic ideas of the mind and body and their (im)balances causing diseases and ailments. At the end of the nineteenth century, doctors were openly fighting against bacteria, armed with antiseptics and disinfectants – and a firm belief in their effectiveness.

Moreover, it is important to notice that doctors themselves emphasised that the popular health manuals they had written were always meant to be imperfect collections of advice; in fact, some writers could stress that their writings contained very little that was new or interesting in a professional way. Guidebooks included many different kinds of text types, not just medical "facts"; in many instances, short fictional stories, religious texts, poems, and aphorisms were added to the content of the manuals, to educate and entertain their lay readers. However, at least some of the doctors' practical experiences made their way into the writings: doctors had witnessed cases in which women had not recognised the signs and symptoms of pregnancy and went into labour quite unexpectedly. Some doctors could also co-operate with their female patients and that the female experience was not discarded; women had read the draft version and then gave their own hints on the topics discussed in the manuals. No doubt, this was a rhetorical way to convince potential readers of the writer's ability and capacity to deal with his midwifery cases with tact and understanding. In practice, diagnosing pregnancy also required the woman's cooperation and that of her closest circle; husbands, mothers, and friends could be a valuable source of information. However, every practitioner needed to remember that not everything was quite as told; patients could fabricate their symptoms or remain silent; in the case of female patients, the possibility of pregnancy was sometimes denied even if the woman was in fact with child, or correspondingly, some women believed that they were pregnant when they were suffering with symptoms closely resembling pregnancy. The doctor needed to both rely on the patient's story and doubt it at the same time.

The majority of the obstetrical cases reported in the *BMJ* concentrated mainly on the complicated or otherwise special obstetrical cases requiring medical expertise provided by the medical profession. Thus, they cannot be understood as descriptive examples of what took place during average childbirth in nineteenth-century Britain. The medical reports and doctors' letters published in the journals show only what was troubling doctors, revealing those topics doctors themselves or the editors of the journals considered important and necessary to publish and distribute in printed form. As was generally accepted, it was crucial to discuss also failures in medical work; they could be in many ways illuminating and educational. This, however, was often easier said than done. The line between failures, incompetence, and malpractice was not particularly easy to draw; it was obvious that in some cases, doctors could do very little but there was always a considerable risk of losing both professional and social reputation. To the medical profession, the latter cases were extremely difficult; the profession

was bound by peer-to-peer solidarity, internal integrity, and mutually shared codes of respectability. The cases of malpractice published in the medical periodicals demonstrated that the reputation and respectability of the whole profession could be jeopardised. However, this aspect of the medical works requires more research and analysis using other sources, such as court cases and such like.

This study demonstrates that the history of childbirth in nineteenth-century Britain is a story of many uniform medical ideas concerning childbirth but also often of contradictory discourses, medical diversity, loosely defined conceptions, and persistent cultural stereotypes. Traditionally, the history of medicine has been presented as a great victorious story of progress – how the inevitable change for the better took place and how childbirth ultimately became rationalised and in every way safer. This study suggests that the story is actually the history of trial and error, good fortune and even better intentions, complete (and often intentionally forgotten) failures, unexpected strokes of luck, and ongoing testing – inevitably with unlucky patients. It is very tempting to create a consistent and unified story about nineteenth-century medicine; how important ideas and inventions were applied and medicine became a basis of modern life. However, despite this alleged "modern state of medicine" in the nineteenth-century world, especially medical journals demonstrate that ideas spread unevenly and that medical practitioners made very different use of contemporary scientific ideas and discoveries in their daily practices. In practice, for example, the use of the stethoscope – often considered the symbol of nineteenth-century medical competence and authority – could be extremely difficult when a doctor was trying to locate a foetal heartbeat or placental souffle; errors in a diagnosis could be a professional humiliation resulting in the loss of authority and reputation both in the eyes of patients and medical peers.

In the broad sense, the function of both genres – medical manuals and periodicals – was educational. The targeted audiences were different but the very idea was that the implied reader could always learn something from the texts, to be able to educate and improve themselves. A pregnant woman was always a microcosm in one person, defining the future health and happiness of the whole British Empire; according to the doctors' own constructions of childbirth, the medical practitioner was the best guardian of the "expectant mother". Indeed, it is very useful and instructive to read these sources side by side, in order to understand better the limits and gaps in both genres. Together these sources provide a more nuanced picture of what took place in nineteenth-century British midwifery and medicine and how doctors constructed their ideas and practical experiences of childbirth in their writings. Concentrating only on popular manuals or medical periodicals would have produced a very different kind of picture of the doctors' ideas of childbirth; for example, the discussion about the theory of maternal impressions would have remained unrecognised if only popular manuals had been studied in this research. On the other hand, it would be very useful to investigate popular medical health manuals intended for use by lay men side by side with the guidebooks written for women; by concentrating on the whole genre rather than discussing the separate gendered sections of it, the

longer traditions, cultural contexts, and especially language used in the manuals could become better recognised and analysed.

Indeed, occasionally, in the medical writings the contribution of an individual doctor could be extremely small and scientifically insignificant, such as this poem written by a Bolton doctor, "Dr. Johnston", at the end of the nineteenth century. The poem, in its own sentimental way, summarised the peculiar role the medical profession had in people's lives, while it also reflected some of those ideals doctors had about their work. In reality, the nineteenth-century medical profession did not always possess the methods needed for curing their patients or saving their lives, but this does not diminish the fact that through their work doctors witnessed many aspects and events of human life "from the womb to the tomb", including how women gave birth and children were born in nineteenth-century Britain.

Who is entrusted with the lives
Of fathers, husbands, mothers, wives,
And who untiring service gives?
The Doctor.

Who is our best, most trusty friend,
On whose help loyal we depend,
From life's first dawning to its end?
The Doctor.[1725]

[1725] Dr. Johnston [anonym.?], The Doctor. The *BMJ*, February 8, 1896, 384. The original poem contained seven stanzas, based on the same structure as these last two stanzas quoted here.

SUMMARY IN FINNISH

Tutkimuskysymykset, tausta ja metodit

Tässä väitöskirjassa olen tutkinut brittilääkäreiden kirjoituksissa rakentuneita käsityksiä raskausajasta ja synnyttämisestä vuosien 1840–1902 välisellä ajanjaksolla. Työn aikarajaus perustuu löyhästi viktoriaaniseen aikakauteen – 1800-luvulla kuningatar Viktorian (1819–1901) hallitsema Britannia oli yksi johtavista maailmanvalloista. Työssä on tarkasteltu brittilääkäreiden käsityksiä raskausajasta ja synnyttämisestä: miksi mieslääkärit olivat mielestään synnytysten parhaita asiantuntijoita ja miten lääkäreiden aktiivista roolia perusteltiin sekä raskaana oleville/synnyttäville naisille ja heidän lähipiirilleen että laajemmin lääketieteessä. Millaisia ominaisuuksia hyvällä synnytyslääkärillä tuli olla? Miten raskaus todettiin ja miten sitä piti hoitaa, mikäli raskaana oleva nainen halusi seurata 1800-luvun lääketieteen ohjeistuksia? Mihin nämä ohjeet pohjautuivat? Miten synnytykseen piti varautua? Metodeina työssä on käytetty lähilukua ja kontekstuaalista tekstianalyysia.

1800-luvun aikana lääketieteessä tapahtui monia muutoksia, joilla oli suoria vaikutuksia synnytysten hoitoon ja lääkäreiden asemaan. Lääkärikuntaa määriteltiin uudelleen lainsäädännöllisesti, sairauksien hoito eriytyi omiksi erikoisaloikseen ja ammattikunnan koulutusta yhtenäistettiin. Lääketieteessä uudet innovaatiot – erityisesti tehokkaiden anestesiamenetelmien käyttöönotto 1840-luvun lopulla ja antiseptiikan läpimurto 1870-luvulta lähtien – muuttivat monia hoitokäytänteitä ja ajattelutapoja pysyvästi. Esimerkiksi moderni kirurgia kehittyi 1800-luvun jälkimmäisellä puoliskolla, mikä näkyi erityisesti synnytyskomplikaatioiden hoidossa. Käsitys ihmisruumista oli myös muutoksessa ja monien sairauksien syntymekanismeja selitettiin uusista lähtökohdista käsin. Perinteisesti ruumiin oli ajateltu koostuvan erilaisista nesteistä, ja sairauksien syynä oli ruumiin sisäinen epätasapaino. Uusien käsitysten mukaan ihmisruumissa oli elimiä, joilla kaikilla oli oma erityistehtävänsä. Bakteereista tuli ulkoinen uhka, jota vastaan lääketieteessä taisteltiin antiseptiikan avulla – 1800-luvun viimeisillä vuosikymmenillä *kirurginen puhtaus* omaksuttiin myös synnytyslääketieteeseen.

Tutkimus osoittaa kuitenkin, että 1800-luvun lääketieteessä monet perinteet olivat edelleen vahvoja, uudet innovaatiot ja ajattelumallit levisivät ammattikunnassa eriaikaisesti ja lääkärit sovelsivat innovaatioita monenlaisista lähtökohdista käsin. Esimerkiksi *venesektio*, suoneniskentä, säilyi synnytyslääketieteessä hoitomuotona pidempään kuin muualla. Antiikin perinteiden vaikutus näkyi selvästi erityisesti suurelle yleisölle suunnatussa valistuskirjallisuudessa: opaskirjoissa painotettiin ennaltaehkäisyn ja itsekurin merkitystä, ja hoito-ohjeet perustuivat edelleen pitkälti antiikista peräisin oleviin periaatteisiin.

Tutkimistani lääkäreistä valtaosa oli miehiä. Synnytysten hoidossa suurin muutos olikin tapahtunut Britanniassa jo 1700-luvun aikana. Mieslääkärit olivat silloin alkaneet hoitaa myös *normaaleja* synnytyksiä. Synnytyksissä avustaminen oli perinteisesti kuulunut naispuolisille kätilöille: kätilöllä oli kokemukseen pe-

rustuvaa tietoa ja osaamista, he saivat työstään palkkion ja monet olivat yhteisöidensä arvostettuja jäseniä. Ennen 1700-lukua lääkärin läsnäolo oli yleensä ollut huono merkki: synnytyksessä oli vakavia komplikaatioita ja lääkärin tehtävänä oli paloitella sikiö kohtuun ja yrittää pelastaa synnyttävän naisen henki. Nämä toimenpiteet olivat kuitenkin harvinaisia. 1700-luvulla perinteinen asetelma muuttui ja (mies)lääkärin läsnäolosta tuli suunniteltua ja etukäteen järjestettyä. 1840-luvulla lääkäreiden asema oli jo vakiintunut ja synnytysopista oli tullut yhä tiiviimmin osa akateemista lääketiedettä, vaikka suuri osa naisista synnytti Britanniassa yhä edelleen kätilön avustamana.

1800-luvulla lääkäreiden suhde kätilöihin säilyi kireänä koko vuosisadan ajan. Lääkäreiden kirjoituksissa kätilö esitettiin useimmiten epäpätevänä, taitamattomana ja epähygieenisenä hahmona. Taustalla oli paitsi halu korostaa lääkäreiden omaa arvovaltaa ja asemaa, myös taloudellisia intressejä – lääkärit ja kätilöt kilpailivat samoista potilaista ja palkkioista. Ongelmana nähtiin myös, että 1800-luvulla kätilöiden työtä ja alan standardeja ei valvottu lainsäädännöllisesti. Englannissa ja Walesissa ensimmäinen kätilölaki säädettiin vasta vuonna 1902. Tähän vuoteen myös oma tutkimukseni päättyy.

Aineistot: BMJ ja opaskirjat

Tutkimuksen alkuperäislähteinä on käytetty kahta aineistokokonaisuutta: 1) lääkäreiden kirjoittamia yleiskielisiä opaskirjoja sekä 2) lääketieteellistä aikakauslehti *British Medical Journalia* (*BMJ*). Kummankin aineiston funktio oli pohjimmiltaan opetuksellinen, mutta kohdeyleisö oli eri. Populaarit lääketieteelliset opaskirjat oli kirjoitettu nuorille, yleensä vasta-avioituneille naisille, joilla oli lääkäreiden mukaan vähäisesti kokemusta ja tietoa raskausajasta ja synnyttämisestä. Tutkimuksessa on analysoitu kolmekymmentä populaaria opaskirjaa, jotka jakautuvat kahdeksalle vuosikymmenelle 1830-luvulta 1900-luvun alkuun asti. Naisille suunnattujen oppaiden lisäksi olen käynyt läpi myös lääketieteellistä ammattikirjallisuutta: tiettyihin alan auktoriteetteihin (mm. William F. Montgomery, James Young Simpson, William S. Playfair) viitattiin sekä populaareissa opaskirjoissa että aikakauslehtiaineistoissa. Viittaukset ja opaskirjojen omistuskirjoitukset kertovatkin alan sisäisistä verkostoista ja lääkäreiden välisistä ammatillisista suhteista.

Lääketieteellinen aikakauslehti *British Medical Journal* (*BMJ*) alkoi ilmestyä syksyllä 1840. Ensimmäisten vuosikymmenten aikana lehden asema oli epävarma ja se joutui kamppailemaan olemassaolostaan kilpailulla alalla. Vuosisadan loppupuolella *BMJ*:sta oli kuitenkin tullut maailman laajalevikkisin lääketieteellinen julkaisu ja se seurasi tarkasti uutisia sekä lääketieteessä että laajemmin yhteiskunnassa. *BMJ* oli eri puolilla Britanniaa työskenteleville lääkäreille tärkeä keskinäinen keskustelukanava ja tiedonlähde. 1800-luvun lääketieteessä julkaiseminen oli perusta ammatilliselle maineelle ja menestykselle. Aikakauslehtiin saattoivat kuitenkin kirjoittaa myös ne tavalliset lääkärit, jotka eivät koskaan julkaisseet muissa yhteyksissä. Kirjoittajien ei tarvinnut olla samaa mieltä keskenään: lehden sivuilla esiintyivät rinnakkain monet ristiriitaisetkin näkemykset ja tulkinnat, jotka eivät välttämättä edustaneet lehden omaa linjaa. On kuitenkin

otaksuttavaa, että osa lehdelle lähetetyistä kirjeistä hylättiin ja julkaistuja kirjoituksia editoitiin.

Lisääntymisterveyteen ja synnyttämiseen liittyvät kirjoitukset olivat keskeinen osa *BMJ*:n sisältöä heti ensimmäisistä numeroista lähtien. Olen tutkimusta varten analysoinut lehdessä julkaistuja tapauskertomuksia, raportteja, tieteellisiä luentoja, kirja-arvioita, mainoksia ja lääkäreiden kirjeitä. Erityisesti lääkärien kirjeet kuvaavat niitä olosuhteita, joissa lääkärit tekivät työtään, millaisia odotuksia heillä oli hoitojen ja toimenpiteiden onnistumisesta, ja mitä he ajattelivat potilaistaan ja lääketieteen tilasta ja tulevaisuudesta.

Naisille suunnatuissa populaareissa opaskirjoissa korostuivat ennaltaehkäisyn ja itsehoidon periaatteet. Oppaissa julkaistu tieto esitettiin oikeaoppisena ja se myös legitimoi lääkäreiden aseman naisten terveyden asiantuntijoina. Naisten keskinäinen opastus ja kokemusten vaihto esitettiin usein vahingollisena - lääkäreiden mukaan naiset kertoivat tosilleen kauhutarinoita, mikä lisäsi ennakkoluuloja ja tarpeettomia pelkoja. Lääkärit itse pitivät populaareja opaskirjoja tarpeellisina. Kuten kirjoittajat totesivat teostensa esipuheissa, opaskirjojen oli kuitenkin tarkoitus olla epätäydellisiä ohjekokoelmia, eivätkä ne koskaan voineet korvata lääkärin ammattitaitoa. Lukijalla oli silti aina moraalinen velvollisuus pitää huolta omasta terveydentilastaan – raskaana olevan naisen kohdalla tämä oli erityisen tärkeää, sillä nainen ei ollut vastuussa vain omasta, vaan myös syntymättömän lapsensa ja koko kansakunnan tulevaisuudesta. Ongelmatilanteissa paikalle oli aina kutsuttava lääkäri, joka opaskirjojen kuvauksissa esitettiin sensitiivisenä ja osaavana ammattilaisena. Opaskirjoja voikin hyvin pitää lääkäreiden kollektiivisina käyntikortteina.

Opaskirjoissa käsiteltiin sekä ruumiin että mielen terveyttä, jotka vaikuttivat ihmisen kokonaisterveyteen – ”terve sielu terveessä ruumissa”. Olen tässä tutkimuksessa ymmärtänyt käsitteen *health* ruumiillisena, kokonaisvaltaisena terveytenä. Käsite *happiness* viittaa tasaiseen, huolista ja peloista vapaaseen mielenlaatuun, joka oli tavoitteena erityisesti raskaana olevan naisen kohdalla. *Expectant mother* paljastaa, että odottavaa naista pidettiin äitinä jo raskausaikana: 1800-luvun lääkäreiden mielestä nainen saattoi periaatteessa kutsua itseään äidiksi jo heti hedelmöittymisen jälkeen. Äitiys oli 1800-luvun lääkäreille naisen elämän tärkein rooli – se määritti naisten elämää jo ennen raskautta, sen aikana ja myöhemmässä elämässä. Samalla äitien terveys oli pohja koko imperiumin terveydelle ja tulevaisuudelle.

Lääketieteellisissä lehdissä puolestaan korostui ennen muuta lääkärien tarve keskustella niistä tapauksista, joissa ilmeni komplikaatioita tai jotka olivat jollakin muulla tavalla poikkeuksellisia. Normaalisti sujunut synnytys ei ollut ammatillisesti yhtä kiinnostava kuin haastavia toimenpiteitä ja vaikeita moraalisia päätöksiä vaatinut tapaus. Lääketieteessä kaikkein tärkein oppi saatiin juuri kokemuksen kautta – siksi oli tärkeää keskustella tapauksista kollegoiden kanssa, kysyä neuvoa ja kuulla myös muiden lääkäreiden kokemuksista. Toisaalta lehdissä kysymys oli myös yksittäisten lääkärien ammatillisesta maineesta ja kunniallisuudesta sekä koko alan yhtenäisyydestä. Lehdessä julkaistu kuvaus oli aina

yksittäisen lääkärin jälkikäteen kirjoittama versio tapahtumista, ei neutraali raportti siitä, mitä ”todella tapahtui”. Varsinkin suhtautuminen virheisiin oli kompleksista. Yleisellä tasolla tunnustettiin, että virheet ja epävarmuus olivat olennainen osa lääketiedettä ja niistä piti keskustella avoimesti, mutta käytännössä kyse oli myös yksittäisen lääkärin maineesta, koko alan kollektiivisesta kunniallisuudesta ja yhteiskunnassa vallitsevista käsityksistä ja laeista, jotka säätelivät myös lääkärin työtä.

Raskausaika

1800-luvun lääketieteessä oli hyvin tiedossa, että raskauden diagnosointi saattoi toisinaan olla vaikeaa kokeneellekin lääkärille. Raskauden ensimmäiset kuukaudet olivatkin yleensä epävarmuuden aikaa. Tyypillisimmät raskauteen viittaavat merkit jaettiin oppaissa neljään ryhmään: 1) kuukautisten poisjääntі 2) aamupahoinvointi 3) ruumiilliset merkit, erityisesti rinnoissa 4) sikiön ensimmäiset selvästi tunnistettavat liikkeet (*quickening*). Jälkimmäistä oli perinteisesti pidetty tärkeänä taitekohtana, jolloin sikiön ajateltiin tulevan eläväksi olennoksi. Tämä raskaana olevan naisen kokema haptinen, subjektiivinen tuntemus säilyi opaskirjallisuudessa tunnusmerkkinä vielä 1800-luvun lopulle saakka, vaikka sana *quickening* oli kadonnut esimerkiksi aborttilainsäädännöstä jo 1830-luvulla. Neljän pääkohdan lisäksi oli lukuisia muita raskauteen viittaavia merkkejä ja oireita, kuten esimerkiksi närästys, ummetus, turvotus, painajaiset tai muutokset syljenerityksessä. Lääkärit kuitenkin korostivat, että mikään yksittäinen merkki tai oire ei yksin varmentanut raskautta, eivätkä oireet välttämättä toistuneet saman naisen eri raskauksissa. Yksilölliset erot naisten välillä olivat suuria.

Lääkäreillä oli käytössään myös tarkempia keinoja raskauden varmistamiseen. Sisätutkimuksessa voitiin tarkastella muun muassa vaginan väritystä ja koostumusta. Stetoskooppia käytettiin myös raskauden diagnosointiin, mutta sikiön sydänäänten tai istukan paikantaminen ei ollut aina helppoa kokeneellekaan lääkärille.

Raskauden toteamista saattoivat hankaloittaa myös naisten omien kertomusten ristiriitaisuudet ja joskus myös naisten lähipiirin väärät todistukset. Oli hyvin tiedossa, että osa naisista ei tunnistanut raskauden merkkejä ja oireita ruumiissaan, osa tulkitsi ne väärin, osa taas saattoi muunnella kertomustaan tai vaieta tietyistä yksityiskohdista kokonaan. Osa sairauksista saattoi myös aiheuttaa samankaltaisia oireita kuin raskaus. Lääkäreiden piti siis samaan aikaan uskoa potilaan tarinaan ja samalla epäillä sitä. Aikakauslehtiaineistosta paljastuukin raskaana olevien ja synnyttävien naisten toimijuus: esimerkiksi raskauden toteaminen vaati aina yhteistyötä raskaana olevan naisen ja lääkärin välillä. Naisilla saattoi myös olla omat motiivinsa, miksi he salasivat oireitaan tai muuntelivat kertomuksiaan. Kysymys saattoi myös olla vaikeudesta puhua intiimeistä ja arkaluontoisista asioista vieraalle miehelle.

Raskausaikaa varten naisille annettiin oppaissa yksityiskohtaisia neuvoja, kuinka hoitaa ja ylläpitää terveyttä kriittisenä ajanjaksona. Oppaissa esitelty itsehoito perustui antiikista periytyvään *non-naturals* -ohjeistukseen. Jokaisen raskaana olevan naisen piti huolehtia siitä, että hän hengitti raitista ilmaa, liikkui ja

lepäsi riittävästi, sai oikeanlaista ravintoa ja että suolisto oli kunnossa. Hygienia oli raskausaikana tärkeä osa hoito-ohjeita ja reseptejä. 1800-luvun hygienia-käsityksissä yhdistyivät perinteiset uskomukset ympäristön, ruumiinnesteiden (epä)tasapainon ja mielen yhteydestä ihmisten terveyteen sekä uudet käsitykset bakteereista sairauksien aiheuttajina. Hyvä hygienia oli sekä puhdistautumista veden ja saippuan avulla, mutta myös moraalisuutta, kunniallisuutta ja kokonaisvaltaista terveyttä.

Raskaudenaikainen mielenterveys ei ollut tabu 1800-luvun lääketieteessä. Oli tärkeää, että odottavan naisen mieliala pystyi raskausaikana tasaisena ja huolista vapaana. Muuttuva mieliala saattoi olla myös yksi raskauden oireista: osalle naisista raskaus oli ”yhdeksän kuukauden pituinen sairaus”, osa taas voi sen aikana poikkeuksellisen hyvin. Erot naisten välillä olivat suuria.

Mielenterveys ja itsekontrolli liitettiin toisinaan myös kiistanalaiseen *maternal impressions* -teoriaan, jonka mukaan raskaana olevan naisen kokemat ja näkemät asiat saattoivat siirtyä suoraan sikiöön ja näkyä vastasyntyneessä erilaisia fyysisinä epämuodostumina. Vielä 1880-luvullakin lääkärit kuvasivat kirjeissään tapauksia, joissa epämuodostuneen lapsen synnyttäneet naiset olivat oman todistuksensa mukaan nähneet odotusaikana jotain poikkeuksellista (mm. epämuodostuneen ihmisen/eläimen) tai kokeneet suuren järkytyksen. Myös ruokaan liittyvät mielihalut saattoivat teorian mukaan selittää erikoisia piirteitä vastasyntyneen ulkomuodossa. *Maternal impressions* -teorian suosio kertoo ennen muuta traditioiden pitkäikäisyydestä: kiistelty teoria tarjosi omalla tavallaan loogisen selityksen ilmiölle, jolle muuten saattoi olla vaikeaa löytää yksittäistä näkyvää syytä. Toisaalta epämuodostumia selitettiin 1800-luvun loppupuolella myös perinnöllisillä tekijöillä. Degeneraation pelko, huoli kansakunnan tulevaisuudesta ja sosiaalidarvinismi leimasivat varsinkin lääkärien 1800-luvun lopun kirjoituksia.

Oli myös riskinä, että raskaus päättyi keskenmenoon tai ennenaikaiseen synnytykseen. Raskauden keskeytyminen esitettiin aina henkilökohtaisena tragediana: se nähtiin syynä onnettomiin avioliittoihin ja avioeroihin. Lääkärit olivat kuitenkin myös hyvin tietoisia siitä, että kaikille naisille uusi raskaus ei ollut toivottu asia. Ohjeita keskenmenon *ennaltaehkäisyyn* saatettiinkin käyttää toisin kuin ne oli alun perin tarkoitettu: kirjoittaessaan raskausajasta ja keskenmenoista lääkärit viittasivat paheksuvasti *laittomiin abortteihin*, kuten raskaudenkeskeytyksiä kutsuttiin 1800-luvun lääketieteessä. Britannian aborttilainsäädäntö oli 1860-luvulta lähtien Europan tiukin. Oli tilanteita, joissa lääkärit totesivat, että raskaaksi tuleminen muodosti suuren riskin naisen terveydelle. Oppaissa ei kuitenkaan annettu käytännön ohjeita raskaudenehkäisyyn, eikä aiheesta ei keskusteltu myöskään lääketieteellisissä lehdissä.

Synnyttäminen

1800-luvun Britanniassa suurin osa naisista synnytti kotonaan, joten nainen itse oli vastuussa siitä, että kaikki tarvittava oli valmiina synnytystä ja lapsivuodeaikaa varten. Synnytyksen materiaaliset valmistelut kertoivat paitsi käytännönelä-

män välttämättömyyksistä, myös emotionaalisista suhteista perheen ja suvun sisällä ja tulevaan lapseen kohdistuvista odotuksista ja kiintymyksestä. Naisen lähipiirille ja muulle ympäristölle materiaaliset valmistelut olivat näkyvä merkki raskaudesta – jos nainen synnytti yksin ja lapsi kuoli, materiaaliset valmistelut saattoivat todistaa, että tarkoitus ei ollut salata raskautta eikä tuhota sikiötä heti sen syntymän jälkeen. Salassa yksin synnyttäminen oli aina epäilyttävää – se liitettiin laittomiin raskaudenkeskeytyksiin ja lapsenmurhiin. Raskaudenaikaiset ja synnytykseen liittyvät materiaaliset järjestelyt ja sosiaaliset rituaalit siis suojasivat synnyttävää naista ja hänen mainettaan.

Synnyttäminen oli 1800-luvullakin sosiaalinen tapahtuma. Esimodernin ajan synnytyksissä läsnä oli ollut sukulaisista, naapureista ja ystävistä koostunut naisten piiri, *gossip*, jonka tehtävänä oli tukea synnyttäjää, antaa neuvoja, valvoa kätilön toimintaa ja toimia todistajina, mikäli synnytyksen aikana tapahtui jotakin odottamatonta. 1800-luvulla tämä joukko ei ollut enää tervetullut synnytyshuoneeseen. Lääkäreiden kirjoituksissa läsnä olivat synnyttäjän ohella lääkäri, mahdollisesti avustava kätilö/hoitaja sekä usein synnyttävän naisen yksi naispuolinen, naimisissa oleva ystävä. Naispuolisen ystävän tehtävänä oli kannustaa ja tukea synnyttäjää – siksi oli tärkeää, että tukihenkilöllä oli omakohtaista kokemusta raskauksista ja synnyttämisestä. Ylimääräinen todistaja varmisti myös, ettei synnytyksen aikana tapahtunut mitään sopimatonta.

Kirjoitustensa perusteella useimmat lääkärit arvostivat synnytyksissä naisten omakohtaista kokemusta enemmän kuin aviopuolisoiden välistä emotionaalista sidettä. Miesten osallistumisesta synnytyksiin ei ollut yksimielisyyttä: osa kirjoittajista piti aviomiehen läsnäoloa hyödyllisenä, osa taas vastusti sitä. Vastustajien mukaan miehillä ei voinut olla omakohtaista kokemusta synnyttämisestä – he eivät tienneet mikä oli normaalia ja pelkäsivät siksi synnytyshuoneen ääniä, hajuja ja ihmisruumiin eritteitä. Miehet myös hermostuttivat synnyttäjän omalla hermoilullaan. Pelko oli synnytyksissä ehdottoman vahingollinen tunne: pelko hidasti synnytystä ja altisti erilaisille komplikaatioille ja tarpeettomille kivuille. Samasta syystä opaskirjat eivät suositelleet raskaana olevan naisen oman äidin läsnäoloa synnytyshuoneessa: liian läheinen suhde loi synnytykseen haitallisia emotionaalisia jännitteitä. Sama koski myös lääkärin omaa lähipiiriä: oli hyvä, että lääkäri ei hoitanut oman perheensä jäseniä.

Sukulaisiin ja muuhun synnyttäjän lähipiiriin viitattiin lääketieteellisissä lehdissä usein kollektiivisella nimityksellä ”ystävät”. Aviomies tai ”ystävät” kutsuivat paikalle lääkärin ja antoivat tarvittavia taustatietoja tapahtumien kulusta ja synnyttäjän terveydestä, mutta muutoin heidät mainittiin tavallisimmin ohimennen osana tapahtumien laajempaa kuvausta. Vakavissa komplikaatiotilanteissa lähipiiri saattoi kuitenkin joutua tekemään päätöksiä siitä, kenen henki synnytyksessä yritettiin pelastaa. Päätös riskialttiista keisarileikkauksesta saattoi olla lääkärin, synnyttäjän ja tämän lähipiirin yhdessä tekemä ratkaisu.

Synnytyshuoneessa tärkein yksittäinen huonekalu oli sänky, jossa ponnistusvaihe ja lapsen syntymä yleensä tapahtuivat. Britanniassa naiset synnyttivät vasemmalla kyljellään maaten, polvet koukussa. Asentoa pidettiin lääketieteellisesti oikeaoppisena, mutta se säästi synnyttäjän voimia ja suojasi myös tämän

kunniallisuutta yhdessä sopivan vaatetuksen kanssa. Avautumisvaiheen aikana naisia kehotettiin usein liikkumaan vapaasti – ainoa huoli oli, ettei nainen saanut väsyttää itseään tarpeettomasti. Ihanteellinen synnytykseen varattu tila oli hiljainen, valoisa, puhdas ja sopivan viileä. Synnytyksen aikana kaiken oli palveltava synnyttäjää: läsnäolijoiden oli tuettava naista kaikin mahdollisin tavoin, ilmapiirin oli oltava kannustava, eikä vanhoja tapauksia saanut muistella.

Luonnollisuus oli keskeinen käsite 1800-luvun lääketieteessä. *Natural labour* oli brittilääketieteessä tekninen termi, jolla selitettiin sikiön normaalitarjontaa synnytyksessä. 'Luonto' oli lääketieteessä kuitenkin paljon laajempi ja kompleksinen käsite – sen avulla voitiin perustella monia keskenään täysin ristiriitaisiakin asioita. Luonto voitiin nähdä suurena yliluonnollisena voimana, joka ylläpiti kaikkea elämää ja ihmisten terveyttä, mutta samaan aikaan luonto oli pohjimmiltaan arvaamaton ja oikullinen. Synnytyksestään puhuessaan lääkärit viittasivat usein modernisaation vaaroihin: hektinen nykyaika vahingollisine elämäntapoineen oli tuhonnut naisten luonnollisen terveyden. Siksi naiset tarvitsivat avuksi lääkäreitä ja lääketiedettä. Mieslääkärit konstruoivat itsensä luonnon puolestapuhujiksi ja suojelijoiksi, joilla oli samalla kertaa puolellaan niin luoto, lääketiede, tiede kuin edistyskin. Lääkäreiden mukaan he ymmärsivät luontoa ja sen mekanismeja, mutta tarvittaessa heillä oli käytössään tieteen ja edistyksen mahdollistamat keinot, kuten synnytyspihdit, kirurgiset menetelmät ja kirurginen puhtaus. Samalla tieteellinen diskurssi mahdollisti sen, että mieslääkärit saattoivat ylittää sukupuolensa rajat, siinä missä naispuoliset kätilöt leimattiin taitamattomiksi ja vanhanaikaisten ja vaarallisten traditioiden ylläpitäjiksi.

Lääkäreiden vastuu näkyi ennen kaikkea komplikaatiotilanteissa. 1800-luvun lopulla varsinkin keisarileikkauksesta tuli suhteellisen turvallinen operaatio. 1840-luvulla riskialttiit keisarileikkaukset olivat vielä hyvin harvinaisia: tutkimuksen ensimmäisinä vuosikymmeninä 80–90 prosenttia leikatuista naisista kuoli. Vuosisadan loppupuolella sama prosentuaalinen osuus selvisi leikkauksesta hengissä. Keisarileikkauksen läpimurtoon vaikuttivat muun muassa anestesian/kivunlievityksen yleistyminen kirurgiassa (erit. kloroformi), ymmärrys bakteereiden toiminnasta, leikkaustekniikoissa tapahtuneet parannukset ja yleisen hoitomentaliteetin muutos. 1800-luvun loppupuolella leikkauksia voitiin tehdä suunnitelmallisemmin ajoissa. Tutkimuksen ensimmäisinä vuosikymmeninä brittilääkärit olivat joutuneet hätätilanteissa turvautumaan *kraniotomiaan* tai *embryotomiaan* – operaatioissa tarkoitus oli yrittää pelastaa synnyttävän naisen henki leikkaamalla sikiö palasiksi tai puhkaisemalla sen kallo kohdussa. Toimenpide oli 1800-luvun lääkäreille moraalisesti hyvin vaikea: operaatio oli käytännössä raskaudenkeskeytys, vaikkakin lääketieteellisesti perusteltu silloin, kun se tehtiin hätätilanteissa. 1800-luvun lopulla kraniotomia oli pitkälti syrjäytetty. Vuosisadan lopulla lääkärit saattoivatkin perustella, että he auttoivat maailmaan eläviä lapsia ja että he pelastivat myös synnyttävän naisen hengen.

1800-luvun brittilääkäreillä oli käytössään käsite *meddlesome midwifery*. Vaikeasti suomennettavalla termillä tarkoitettiin kiirehtimistä ja liiallista puuttumista normaalisti etenevän synnytyksen kulkuun. Käsitteen soveltamista käytännön työhön 1800-luvun kirjoittajat eivät olleet samaa mieltä, mutta sen avulla

lääkärit saattoivat kuitenkin käydä keskustelua siitä, mikä oli perusteltua hoitoa, miten erilaisia apuvälineitä (mm. synnytyspihdit) saattoi käyttää ja mikä ylipäätään oli lääkärin rooli synnytyksissä. Hyvä lääkäri tiesi milloin operoida ja milloin taas oli viisaampaa olla tekemättä liikaa. Lääkärin ei tarvinnutkaan olla läsnä *koko* synnytyksen ajan – riitti kun hän seurasi synnytyksen edistymistä ja oli paikalla lapsen syntyessä. Osa opaskirjoista sisälsi myös ohjeita niitä tilanteita varten, jos lääkäri ei ehtinyt paikalle ajoissa.

Ideaalilääkäri oli rationaalisesti myötätuntoinen, sensitiivinen ja kärsivällinen. Hyvä maine ja kunniallisuus olivat perusta ammatilliselle menestykselle. Mieslääkärit joutuivat perustelemaan tarkasti varsinkin suhdettaan naispotilaisiin, erityisesti miten potilasta saattoi koskettaa ja katsoa ja miten potilaan kunniallisuus ja moraalinen koskemattomuus säilyivät myös gynekologissa sisätutkimuksissa ja synnytysten aikana. Todellisuudessa synnytyslääketieteen arvostus oli 1800-luvulla alhainen, lääkärin työ vastuullista ja vaikeaa, palkkiot pieniä ja kilpailu potilaista ja toimeentulosta kovaa.

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