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## Medical treatment and care of hospitalized Maine women, 1874-1882

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**THE MEDICAL TREATMENT AND CARE  
OF HOSPITALIZED MAINE WOMEN, 1874-1882**

by  
Jenny Higgins

Submitted in Partial Fulfillment of the Requirements  
of the Senior Scholar's Program

COLBY COLLEGE

1997

## ABSTRACT

The construction of the ideal Victorian woman as an invalid, weak, delicate, and perpetually prone to illness could not have been maintained without the support of the medical profession. Late nineteenth-century medical ideas embodied and incorporated, explicitly or implicitly, social ideas about women—their nature, role, abilities, and limitations. The medical profession was persuasive and powerful in shaping women's roles, and this influence took on a wide variety of forms. This paper examines one of these forms—the treatment of women in a hospital setting, and how this treatment both reflected and perpetuated existing social understandings of Victorian femininity and gender roles. I achieve this investigation through the content analysis of 400 hospital records from Maine General Hospital in Portland, Maine at the height of the Victorian Era (1874-1882). The main issues I examine include: the history and rise of Maine General Hospital, physicians' roles and approaches, class differences in Victorian health constructions, hysteria, and uterine disease.

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## INTRODUCTION

In the nineteenth century, women's roles changed dramatically. With the industrialization of society came the removal of production from the home and the emergence of an associated conceptual distinction between "public" and "private" spheres. Men, who ran and maintained the world of industry, were seen as the primary occupants of this new public sphere, while women were the moral guardians of the private sphere. Thorstein Veblen, in the *Theory of the Leisure Class*, published in 1899, pointed to the burden placed upon women by the struggle to create and meet standards of "decency" imposed to bring order to the transient social structure typical of a highly industrialized community. Decency demanded that a wife remain at home as an emblem of her husband's earning power (Veblen, 1899, quoted in Duffin, 1976:26).

The ideal Victorian woman, then, was mistress of the private sphere—a lady of delicacy, grace, and leisure. This idealized role gave her no purposeful activity, but instead rendered her progressively less and less productive. It was her lack of productivity that led to the belief that she was incapable and ultimately disabled such that she must be protected and prohibited from serious participation in society.

The image of the ideal woman became, in time, the image of the disabled woman, the female invalid. In the mid- and late-nineteenth century, a curious epidemic swept through the middle and upper-class female population in both the United States and England. Diaries and journals from the time give us hundreds of examples of women slipping into hopeless invalidism. This explosion of female disease in the second half of the nineteenth century is reflected not only in these



writings, but also in the in the art, popular novels, and countless medical writings of the time. Catherine Beecher, a well-known suffragist who was traveling around the country at the time and visiting many women, called it "an epidemic of female invalidism."

Doctors found a variety of diagnostic labels for the wave of invalidism gripping the female population: "neurasthenia," "nervous prostration," "cardiac inadequacy," "dyspepsia," "rheumatism," and "hysteria".<sup>1</sup> The symptoms included headaches, muscular aches, weakness, depression, menstrual difficulties, indigestion, and often a general debility requiring constant rest. And while certainly no woman wished to be suffering or debilitated, there was a certain element of fashion to being femininely weak or sickly. In fact, some upper class "ladies" ate bits of arsenic so that they would appear pale and anemic.

The image of woman as an invalid, as weak, delicate and perpetually prone to illness, could not have been maintained without the support of the medical profession. It was and is, after all, doctors who make judgments as to who is physically (and often mentally) fit and who is not, and these judgments carry with them implications for particular tasks and activities. The central role of medicine in defining the lives of men and women rests on the fact that it deals with the human body. Wherever social theories are constructed which discriminate between men and women, they are made to rest ultimately on the most conspicuous difference between the sexes—their anatomy (Duffin, 1978:26). Medical knowledge thus functions as a social force helping to shape the options and roles available to members of a social setting and, thus, plays a crucial role in ideas about sexual differentiation, discrimination, and disability.

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<sup>1</sup> For clarification on these or other medical terms that arise, please refer to Appendix B (on page 98) which contains a glossary of selected terms.

In the nineteenth century, medical theory mirrored the emerging features of industrial civilization and the changing roles of men and women within this new social order. Medical ideas embodied and incorporated, explicitly or implicitly, social ideas about women—their nature, role, abilities, and limitations. Throughout the nineteenth century, science, in general, and medicine, in particular, were invoked to justify the social inequalities and limitations imposed by sex—as well as by class and race. After the mid-century, religious arguments on these matters declined in strength, but the moral righteousness which had once been the prerogative of the clergy was taken up by the physicians. In a changing society, physicians saw themselves (and, eventually, came to be viewed by society) as moral as well as physical guardians of women. They used their ever-increasing professional authority over a wide range of questions, and not the least in response to the demands made by women for greater freedom and opportunities.

Historian Juliet Mitchell has argued that four basic axes define women's place in our society—production, reproduction, sexuality and socialization of children (Mitchell, 1976). Stress or tension in one of these dimensions is accompanied by change in one or more of the others. In the nineteenth century, women's attempts to enter the world of production, or more generally the world outside the home, produced a reaction which emphasized their role in reproduction and the importance of their reproductive systems. Women's biological function was in turn extended into a social and cultural vocation in the home, particularly related to the socialization of children.

There were many ways in which medical theory played an active role in the struggle of the sexes in the nineteenth century. The medical profession was persuasive and powerful in shaping women's roles, and this influence took on a wide variety of forms in the classification of female disease, the treatment given to women, and opposition to their entrance into the medical profession. This paper

looks particularly at the treatment of women in a hospital setting, and how this treatment both reflected and perpetuated existing social understandings of femininity and gender roles. I achieve this analysis through the use of a data set of 400 hospital records from the height of the Victorian Era, 1874-1882.

Before doing so, however, it is important to outline briefly some of the changing conditions which shaped the historical context surrounding female invalidism. These specific changes were all taking place within the larger context of industrialism and its attendant uncertainties. For example, by the second half of the nineteenth century, women were seriously challenging the traditional sexual divisions of society. They were doing what they had been assured they could not do—enter the so-called public sphere, or man's world. They were demanding the right to vote, rights to property and children, higher education and professional careers. Medical theory was invoked, therefore, in response to these changes to justify social control (Duffin, 1978:28). It was called on to supply the evidence needed to reinforce the social prescription of "appropriate" behavior for women. As already alluded to, this period saw the transformation of a group of medical practitioners into a profession with its accompanying autonomy and high status. Especially since they were seeking greater professional status, physicians were more than happy to step into this role of supplying evidence for social prescriptions of gender.

However, the "evidence" the medical profession had to offer was, in many ways, extremely limited. Conceptions of the body—biological functions, the acquisition and embodiment of disease, germ theory, and so forth—were still very far removed from our twentieth century understandings of these concepts. Thus, at the same time that they were coming up with new medical theory, physicians were also depending on social understandings to take over where their medical knowledge ended. In order to fill in the gaps in their medical knowledge, doctors

sometimes relied on social understandings and perceptions to influence their medical theory and practice. The institution of health care is thus based, in some ways, on the social construction of gender roles, racism, classism, and other phenomena. Health and illness, in this sense, were (and are) clearly shaped by social *perceptions* of health and illness—who is deemed physically and mentally able, and who is not. In turn, the medical profession influences societal views on health; a dialectical relationship exists between the culture and medical profession.

### *Introduction to Class Issues*

In his widely read *L'Amour*, French historian Jules Michelet declared that each century had its own malady—leprosy in the thirteenth century, plague in the fourteenth, and syphilis in the sixteenth (however, as we will see, syphilis was hardly a thing of the past in the nineteenth century). Writing in 1968, Michelet characterized the nineteenth century as "the age of the womb"—an observation borne out by the century's pervasive concern with women's health (Michelet, 1968:1). The popular medical literature of the period portrayed women as the victims of a host of female complaints (Stage, 1979:64). An emphasis on the morbid and melodramatic—fallen wombs, hysteria, venereal excess—typified the style of medical writers and social commentators. Women were viewed as being victims of their own bodies, debilitated by their reproductive organs.

However, the distinctions between the public sphere and the "Gilded Cage" of the private sphere—the social pressures keeping women restrained to their domestic arena, and, most important to this paper's analysis, the explosion of female invalidism—were almost entirely functions of the middle and upper classes. After all, only women who were not required to work out of financial need could afford to remain idle and, in many cases, sickly, in the domestic sphere. What about

working-class women, for whom the public/private distinction had little bearing? A "woman of leisure" could afford to be fashionably ill; if her husband or father was earning the family income, she did not have to be concerned with illness taking her away from work and depleting part of the family income. While these upper class "ladies" spent months debilitated by hysteria and uterine complaints, working class women could simply not *afford* to be sick. Their families depended on them either to supply part of the income or be available to raise children, since a nanny or governess was financially out of the question. While the Victorian Era's constructions of health and illness pervaded all class levels of society, we can and must assume that there were important class differences in how these constructions were enacted.

An extensive amount of research exists on Victorian constructions of health and illness, particularly in relationship to this epidemic of female invalidism. Countless scholars, researchers, and writers have informed us that, perhaps more than at any other time in history, it was fashionable for Victorian women to be sick. This research is extremely important in conveying the ways in which our health is influenced by social institutions and understanding. However, it leaves much to be desired in terms of working-class appropriations of Victorian Era health rhetoric. My analysis of hospital records from this time period is, in large part, an attempt to provide a more thorough examination of these working-class interpretations. It is also an invitation to other scholars and researchers to do the same. We need to increase the amount of scholarship on working class perceptions and embodiments of health and illness.

### *How My Interest in the Project Developed*

Several years ago, I took a course on Victorian constructions of sexuality, and began learning about the nineteenth-century interpretations of womanhood, which were very much linked to constructions of health and illness. For the research paper assigned for the course, I looked at the rise of gynecology within the nineteenth-century medical profession. To find some research materials, I went to the library at the Maine Medical Center in Portland, Maine. I was directed to the library archives, where the archivist pulled four large, leather-bound record books out of their acid-free paper and presented them to me on the table. These books contained patient records from the hospital's first days—when it was Maine General Hospital (MGH) instead of Maine Medical Center, and served an average of 150 patients a year instead of the 20,000 a year it serves today. In their beautiful script and florid language, the records were truly captivating; as I poured over them, concepts of Victorian health and illness seemed to leap off the paper. It was an incredible experience to flip through the pages and see the ideas we had been discussing in class come to life in the form of actual Maine women: hysteria, uterine disease, forceps-related injuries, and vague "female complaints," with even more vague diagnoses and treatments. I promised myself that I would revisit the records someday.

This project is a revisiting of these records. Over the course of this academic year, I entered 400 of these hospital patient accounts into a data base, the records covering a time at the height of the Victorian Era, 1874-1882. Since hospitals then mainly provided care to members of the working class, the case study of these records provides a rare and valuable entree into the medical profession's constructions of working class health and treatment care. We now think of hospitals as the most visible embodiment of medical care in its technically most sophisticated form, but before the last one hundred years, hospitals and medical practice actually had little to do with each other. In the middle of the nineteenth

century, hospitals were not a desirable place in which to receive care; they mostly treated low income and poor people who could not afford private physicians. As one can imagine, the environment was less than optimal.

### *Historical Background of Hospitals*

In general, doctors' services at hospitals were rendered free of charge; physicians made their money by treating wealthy patients (especially wealthy *women* patients) outside of the hospital (Rosenberg, 1987:252). It was very typical, then, for a hospital physician both to work at the hospital and also to run a private practice which provided him with financial means. Why would hospital doctors provide such philanthropy? Most used it as an opportunity to gain the experience with surgery offered by a hospital situation. This was especially true for young men who had only recently completed or were still in medical school. Indeed, hospitals usually were operated in conjunction with medical schools. One of the reforms advanced by medicine's scientific elite was that recent medical school graduates or advanced students should acquire experience not only with laboratories and lectures but, also, with living patients. However, which patients would offer themselves to such examination and treatment? Given the choice, most people would want to avoid being an object of practice for inexperienced medical students. Certainly, no decent woman in 1900 would want her delivery witnessed by any unnecessary young males (Stage, 1979:75). The only choice was the people who had the least choice—the poor. And so the medical schools, the most advanced ones anyway, began to attach themselves parasitically to the nearest "charity" hospital. In an arrangement which has flourished ever since, the medical school offered its medical trainees and recent graduates as staff for the hospital; the hospital, in turn, provided the raw "material" for medical education—the bodies and minds of the sickly poor.

The moral ambiguities in this situation were easily rationalized away by the leaders of scientific medicine. As a doctor on the staff of Cornell Medical College put it:

There are heroes of war, who give up their lives on the field of battle for country and for principle, and medical heroes of peace, who brave the dangers and horrors of pestilence to save life, but the homeless, friendless, degraded, and possible criminal sick poor in the wards of a charity hospital, receiving aid and comfort in their extremity and contributing each one his modest share to the advancement of medical science, render even greater service to humanity (Flint, 1898, quoted in Rosenberg, 1987:331).

Doctors at MGH hospital did not work in conjunction with a medical school (although MGH did try, unsuccessfully, to raise the funds for "Maine Medical School" in 1877). However, the attitudes of eager experimentation and exploration on live subjects seemed to exist at MGH, as evidenced in the glorification of new surgical techniques and procedures in the written Annual Reports. Also, like their counterparts at other hospitals, MGH physicians did not receive pay of any kind. This fact is reiterated in the Annual Reports on multiple occasions. Judging from the space and time devoted to it in the Reports, it seemed very important for the MGH directors to correct any misconceptions Maine people might have had about the salaries of the hospital physicians.

Even without pay, community hospital physicians derived significant benefits from their voluntary efforts. In hospitals, both elite urban and small-town practitioners gained greater exposure to other young doctors, obtained increased respect within the profession, and had direct experience with surgical procedures. Rural physicians had always spent a substantial portion of their time in travel, and the hospital offered the great advantage of bringing the patient or patients to the physician. This was particularly advantageous when patients had serious illnesses which would have demanded daily visits to scattered homes.



The hospital is perhaps distinctive among social organizations in having first been built primarily for the poor, and only later entered in significant numbers and an entirely different state of mind by those in the more respectable classes (Starr, 1987: 143). As its functions were transformed, the hospital emerged from the underlife of society to a position of an accepted experience, still an occasion for anxiety, perhaps, but not of the horror previously associated with hospitalization. The moral assimilation of the hospital came at the end of the nineteenth century with its scientific redefinition and incorporation into medicine. Roughly between 1870 and 1910, hospitals moved from the periphery to the center of medical education and medical practice. The MGH records in my data set fall into this time period (1874-1882).

### *History of Maine General Hospital*

In 1870, no public institution existed within the state of Maine to which a sick person could turn unless he were a seaman, lunatic, or a pauper. This was explained in the 1872 MGH "Sketch" a pamphlet intended to convince the people of Maine (particularly the wealthy ones, from whom donations were needed) of the need for a hospital. *If [one] is a sailor, he can be admitted to the United States Marine Hospital; if he is demented, the needed help will be afforded him in the State Asylum for the Insane at Augusta; if he is reduced to beggary, he will receive such attention as is to be had in the so-called hospital connected with every almshouse* (Sketch, 1872:5). Thus, for a state with a population between six- and seven-hundred thousand, affordable public health care was extremely limited: the expensive luxury of a private physician was available to very few. As a result, a group of entrepreneurs, physicians, and public figures began rallying for the funds to put together a state hospital.

This plea to build up Maine's health care services did not fall on deaf ears. The state government, as well as a number of private parties, donated the amount necessary to build a first section of what was planned to grow into a larger complex. While they had hoped to have the hospital completed before it officially opened, the hospital directors decided to admit patients with only the first wing completed (the final sections were not finished until 1892). Maine General Hospital opened on October 22, 1874, serving an average of 14 patients at once (a figure which grew over the years) with a staff of 15 (this number excludes the 12 people who served as trustees and directors to the hospital). A photograph of what is referred to as the "1870 wing" (this first phase) can be found on page iv.

MGH staff was comprised of five consulting physicians (including one man who served as both physician and superintendent), four visiting physicians, three visiting surgeons, one pathologist, and two house pupils. While it is not exactly clear what "house pupils" were, it seems probable they were men planning to go into the medical profession—today's equivalent of the medical intern or resident. I also surmise that house pupils were responsible for the actual writing of the medical records. Since the physicians were always referred to in third person in the records (as in, "today Dr. Small performed a hysterectomy"), it is probable that the doctors themselves were not writing the records. However, the people who did enter them, the "writers," seemed to have an excellent grasp of medical terminology. All told, based on variations in the handwriting, seven different persons recorded these patients' case histories. Also, there were no nurses when the hospital opened (and it is not noted when they are introduced to the hospital, although we they are present in 1890 and 1892 photographs of the hospital on pages v and vi).

### *The Economic Status of Patients at MGH*

The Annual Reports of the hospital give much more information than simply the number of people who worked at MGH. For example, the Reports indicate that the majority of MGH patients were members of the working or lower class. An excerpt from the 1872 "Sketch" conveys the socioeconomic orientation of the hospital: *It is needed for those engaged in the industrial pursuits of life who, with limited means and without permanent homes, could receive its manifold benefits, at a comparatively small cost, and without any sacrifice of their independence or self respect.* The last issue, the implication of protecting the pride of its care recipients, had to do with the fact that the alms-house previously had been the only place to which a poor person could resort if she were sick but could not afford a private physician. There is also a constant appeal in the Reports for "free beds," large contributions which covered the cost of one patient for an entire year (including food, medicines, and other treatment fees). The following passage, a maudlin appeal to upper class persons to be generous toward those in the lower income classes, not an uncommon approach, is from the 1876 Annual Report:

*Four more free beds have been added this year, but more are desperately needed. Frequent applications for admission on the free list are made from persons without pecuniary means, who are the unfortunate victims of severe and protracted suffering, and require, for their restoration or relief, not only skillful surgery but also subsequent hospital treatment.*

The Reports also sought such donations by voicing the claim that working class patients needed to be restored to health so they could get back to work in the state's factories, farms, and stores. For example, following is a passage from the 1878 Annual Report, in a section discussing all of the patients who benefited from the free beds: *Happily, we are able to say that a large portion of them returned to their families, and in due time to their business pursuits, with greatly improved medical health* (emphasis mine). The good health of the members of the working class was

essential to the smooth and successful running of the state's economy, and this was pointed out to wealthy philanthropists.

However, working class people were not the *only* patients at the hospital, particularly as time passed. Even at the very beginning of MGH, one of the arguments used to secure support for the opening of a hospital was to suggest that wealthy people would benefit, in particular, from the advantages of surgery which MGH had to offer. Also, as medical historian Charles Rosenberg pointed out, nowhere was the upper-class patient's role more prominent than in the expanding numbers of community hospitals which appeared some three decades before America entered the First World War. "Some [hospitals] were proprietary, some industrial, a greater number nonprofit, but almost all shared the common dependence on dollars of the upper class and the desire of the local physicians to integrate the hospital into their routine practice" (Rosenberg, 1987:248). Touting themselves as medically advanced surgical institutions was one of the methods hospitals used to secure these upper class dollars. What private physicians could not provide for members of the middle and upper classes on house visits, the equipment and services at the hospital could. The advantages worked both ways: not only did middle and upper class people benefit from the surgery available at the hospital, but also the hospital was more likely to receive financial contributions from these members of society if they were receiving care at the hospital. Indeed, as MGH grew—both medically and surgically, a gradual but steady influx of middle and upper class patients occurred, as can be seen in both the Annual Reports and patient records. Another indication of the changing hospital population is the rates the hospital charged over time. MGH, like most hospitals of its day, had a sliding pay scale; the more money a patient had to offer, the higher was her cost per week for a bed and treatment. (Information on a patient's pay rate was never included in the actual record, however. The only figures available are the broad numbers in the

Annual Reports.) Around 75 percent of the patients in the records paid at the base payment level of \$7.00 a week. However, with each Annual Report, the number of people paying at higher levels rises. The Reports show the following:

- In 1878 (the first time the pay scale is provided in the reports), 110 patients total:

- 1 patient at \$42/week
  - 1 at \$30
  - 1 at \$28
  - 1 at \$20
  - 1 at \$19.25
  - 23 at \$14
  - and 82 at \$7

Thus, 75% are paying at \$7, 21% paying at \$14, and 4% paying a higher levels.

- In 1882, 257 patients total:

- 1 at \$35/week
  - 36 at \$28
  - 54 at \$14
  - 2 at \$10
  - 164 at \$7

Thus, 63% paying at \$7, 22% at \$10 or \$14, and 15% paying at higher levels.

Thus, the percentage of patients who were paying at the base level or \$7.00 a week decreased from 75 to 63 percent between 1878 and 1882. Also, the percentage of patients paying rates higher than \$14.00 a week rose from four to 15 percent. These changes are particularly significant given that the inflation of hospital costs did not play a role in this rise. In fact, as the hospital increased in size, the net cost of the hospital for each patient per week *decreased* slightly (in 1875, with 114 patients, the net cost per patient per week was \$11.00; in 1881, with 298 patients, the net cost was \$10.40). The increased percentage of patients paying at higher pay rates over time

indicates that middle and upper class patients were entering MGH in greater numbers.

Other ways in which this upper-class influx is seen are more subtle. For example, in the 1880 Annual Report, quite a significant amount of space was given to convincing its readers of the following idea: *A Hospital, fulfilling its true mission, is at once and at the same time a house of mercy for the helpless and a school of science on which even the richest are dependent.* Once again, the portrayal paints the hospital as being necessary for the privileged members of society, and not just the working class who the hospital had served previously.

### ***Surgical Unit Compared to the Medical Unit of MGH***

Surgery was one of the main reasons that middle and upper patients were first attracted to the hospital setting, and MGH was no exception. The hospital was divided into two main camps: surgical and medical, with the surgical unit being more prominent initially, as was the case nationally. Charles Rosenberg (1987:249) has written that community hospitals were even more overwhelmingly surgical than urban hospitals, "a factor that made institutional treatment seem both necessary and proper." Especially in its very first years, MGH was more of a surgical than a medical institution. For example, in the hospital's first year, 70 percent of its patients were surgical while only 30 percent were medical, and this prevalence of patients on the surgical side continued for many years. The 1879 Annual Report stated: *Surgical cases largely predominate in our wards—in a ratio of nearly three to one, as compared with the medical department.* However, the gap between the medical and the surgical began to lessen gradually. The 1881 Annual Report noted: *Surgical cases, as usual, predominate, but the number received in the medial department has largely increased, and, we have reason to believe, will be constantly*

*increasing in the future.* By this point, the hospital had established itself as a respectable medical institution, and MGH no longer needed to use surgery to attract new patients as much as it had previously.

Surgical patients at MGH were generally in the hospital for a much shorter period of time than the average medical patient. Surgical cases were largely straightforward and easily treated or "cured"; the patient came in with a specific, clear-cut complaint (for example, a perineum torn from childbirth, a lacerated leg muscle, or an ovarian cyst), which would (hopefully) be remedied with a unequivocal surgical operation. The patient then stayed on at the hospital for as long as it took the incision to heal. Medical patients, on the other hand, often had much more vague complaints, symptoms, and cures; they could stay indefinitely at the hospital, even with no real cure in sight. The medical unit, then, was home to most of the records in which I was particularly interested, the cases of vague "female complaints."

Women tended to dominate the medical care side of the hospital and men the surgical side. In 1875, when the Hospital first opened, women made up only 40 percent of the total patients. By 1879, women make up 45 percent, and by 1881, 51 percent. With respect to surgical patients, there were far more men than women. For example, in the first year (1875), there were 80 surgical patients and 53, or two-thirds, were men and 27, or one-third, women. However, the numbers of women surgical patients increased slowly, so that by 1880 they comprised 49 percent. This trend is visible in Table I (and will be discussed in greater length in the section on uterine disease).

Table I.

Medical/Surgical and Men/Women Patient Ratios

- 1875: 114 patients total  
68 men, 46 women  
34 medical patients (15 men, 19 women)  
80 surgical patients (53 men, 27 women)
- 1876: 157 patients total  
89 men, 68 women  
52 medical patients (28 men, 24 women)  
105 surgical patients (62 men, 43 females)
- 1877: 158 patients total  
99 men, 59 women  
40 medical patients (19 men, 21 women)  
118 surgical patients (80 men, 38 women)
- 1878: 156 patients total  
90 men, 66 women  
38 medical patients (20 men, 18 women)  
118 surgical patients (70 men, 48 women)
- 1879: 176 patients total  
96 men, 80 women  
37 medical patients (15 men, 22 women)  
139 surgical patients (81 men, 58 women)
- 1880: 238 patients total  
124 men, 114 women  
65 medical patients (36 men, 29 women)  
173 surgical patients (88 men, 85 women)
- 1881: 298 patients total  
146 men, 152 women  
93 medical patients (40 men, 53 women)  
205 surgical patients (106 men, 99 women)

(The numbers from 1882 were missing from the Archives.)

## *Methodology*

The records from MGH did not survive in their entirety. While all the patient accounts between October 22, 1874 (when the first patient was admitted) and November of 1882 are available, the records end abruptly after this date, and there is



no indication of what happened to the others. Aside from a volume of "eye case" records from 1900-1908, no more records are available until mid-way into this century.

Case records for the time period 1874-1882 number well over 1,000, providing a rich resource. Due to time and other constraints, I eventually decided to use 400 of the records as my data set. More specifically, I selected for analysis 200 cases from the earlier period (1874-77) and 200 from the later (1881-82). Even though, generally, an eight year period might not witness monumental changes in health care and medical practice, it is sufficient time for subtle changes in diagnosis, treatment, and general understanding of various diseases and disorders to take place. Indeed, the changes in numerous categories investigated between the first and second set of records (for example, in the rise of uterine disease patients over time) were quite significant and suggestive.

Although my focus in this analysis is primarily on the women patients, I included both men's and women's records. Inclusion of the men's records provides opportunity for valuable comparison. Allowing the treatment of men to stand in contrast with the treatment of women pinpoints important differences between the two. For example, comparing male venereal disease patients with female uterine disease complaints led to an array of insights. My approach was to enter both men's and women's cases in the order in which they were recorded (that is, I did not take every fifth or twentieth record, but entered them consecutively, one after the other). This technique resulted, just by chance, in similar numbers of each: 197 women and 203 men. This is somewhat remarkable, given that, as the Annual Reports spelled out, there were more men than women patients overall.

Additionally, I did not select medical and surgical records in proportion to their numbers in the actual records (that is, three surgical records for every one medical record). Instead, I selected 200 of each. The medical records were of more

interest to me than the surgical records for several reasons. Not only were women better represented in them, but the medical records tended to be more in-depth and detailed, giving a more complete picture of the patient and the treatment received. Furthermore, vague diagnoses such as "hysteria" and "uterine disease" were rarely, if ever, found on the surgical side. However, the surgical records are also worth examining; not only do they offer insight into the rise of gynecological surgery of the time, but they also—as do the men's records in relation to women's—provide an important comparison and contrast with the medical records.

The records in my data set, then, fall into the following categories:

- Medical Cases 1 (or M1):  
7-8-1875 to 7-8-1878.  
56 men, 44 women.
- Surgical Cases 1 (or S1):  
11-13-1875 to 3-14-1876.  
56 men, 44 women.<sup>2</sup>
- Medical Cases 2 (or M2):  
7-19-1881 to 11-1-1882.  
46 men, 54 women.
- Surgical Cases 2 (or S2):  
8-16-1880 to 2-28-1881.  
45 men, 55 women.<sup>3</sup>

total: 203 men; 197 women

### *The Records*

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<sup>2</sup> Notice how it takes almost three years to cover 100 medical patients, while it takes half that amount of time to cover 100 surgical patients. This speaks to the hospital's primary role as a surgical institution.

<sup>3</sup> By this point, it takes about the same amount of time (a year and a few months) to cover both 100 medical records and 100 surgical records. This points to the fact that the number of medical cases at MGH steadily rose as the years passed.

The records were kept in thick, leather-bound books of approximately 200 lined-pages each. The patient's name and age, as well as the date, were the first pieces of information on every record. Usually the patient's marital status and occupation were included in the patient history as well, but this varied a great deal between patients. Sometimes either or both a patient's occupation or marital status were omitted. These gaps point to some of the limitations of the records as historical documents. I debated, for example, whether the lack of notation of occupation on a woman's record was an indication that she was not employed, or if it was simply omitted information. Another limitation resulted from the variations in records by writer; for instance, some writers never stated a patient's occupation. The sixth writer, for instance, who recorded cases 312 through 371, very rarely indicated the patient's marital status or job status. (A change in handwriting indicates different writers.)

The patient's chief complaint usually came first in the record, and often a patient's health history was included. The initial section of the record often concluded with a background statement of some sort: a general commentary on how healthy the patient is—particularly when the patient was a woman. Also, this kind of information is much more common in the medical records. People did not always come in with specific ailments when entering the medical side of the hospital, and doctors tended to obtain, and record, a sense of the patient's physical, and often mental, stability. However, this also could have been a result of differences in writers' styles. For example, writer "Three", who entered some of the first-period surgical records (S1), almost always included a general health commentary (for example: *patient has never been well since twelve years of age*), whereas writer "Five", who entered some of the second-period medical records (M2), did not. Once again, this speaks to the problem of having more than one

person enter the records. This dilemma of interpreting writers' personal styles is increased seven-fold when there are seven different writers.

The patient's history was followed in the record by a statement noting his or her present condition, then a diagnosis (sometimes), and the treatment prescribed and conducted. After this are dated notes on the patient's progress until the patient was either discharged or, in a few cases, died.

### *Content Analysis*

Content analysis is the research method appropriate for studying historical documents. Units of communication, such as words, paragraphs, case records, and books, are the usual units of analysis in content analysis (Babbie, 1995:335). Content analyses involves the study of a set of objects, that is, cultural artifacts, or events by counting them systematically or interpreting the themes contained therein. Those utilizing the method of content analysis—including, sociologists, historians, literary analysts, anthropologists and archeologists, among others—are interested in cultural artifacts as human products. These products stem from every aspect of human life, including relatively private worlds, "high" culture, popular culture, and organizational life. One of the distinctive properties of cultural artifacts is that they possess a naturalistic "found" quality because they are not created for the purpose of study. Second, they are non-interactive; that is, they do not require questioning respondents or observing active social behaviors (Reinhartz, 1992:147). At the same time, historical documents present certain research disadvantages. For example, the artifacts can contain gaps or lead to questions that the researcher may never be able to answer completely.

Two levels of analysis occur with respect to analysis and interpretation of written records. Analysis at the manifest content level refers to the directly visible,

objectively identifiable characteristics of a communication, such as the specific words in a book, the medical treatments conveyed in medical records, and so forth. Latent content refers to analysis at the level of meanings contained within communications. The determination of latent content, especially, requires judgments on the part of the researcher. Data are coded with attention to both levels of analysis, manifest and content. Coding is the process of transforming raw data—either manifest or latent content—into standardized, quantitative form. Schemes of analysis and classification are constructed, based on the categories which emerge from careful, systematic, and thorough study of the documents (e.g., newspapers, journals, letters, or medical records). The conceptual model for coding is that of the grounded theory method of data analysis (Strauss and Corbin, 1990). Further, content analysis utilizes quantitative or qualitative approaches, or both. Computer programs that count word frequency, for example, can reveal hidden patterns embedded in large set of documents, as well as offer openings for determination of implicit meanings contained within the documents. As part of my project, I devised a computer entry program which allowed me to examine the documents (medical records) in this way.

My analysis of the MGH case records involves the examination of both manifest and latent content, through both quantitative and qualitative analysis. For example, with my data set, I can count the number of times "hysteria" appears in the patient records—this is a manifest, quantitative measure. The analysis of the physicians' construction of hysteria in the records (through their description of the patient and her symptoms, the treatment offered, and so on) is a qualitative measure of latent content. Quantitative measures and techniques were very important to this project, as a great deal of my analysis, particularly in the earlier phases, entailed the tallying and comparing of numbers and frequencies—for example, examining and comparing the numbers of uterine disease patients in

period one and period two of the medical records. However, qualitative analysis is at least as important in this research project: it involves, for example, the interpretation of meaning which leads us to explanations of the numerical changes in patient conditions and treatments. Only the qualitative approach can offer answers to the question "What is going on here?"

My study, more specifically, entails a *feminist* content analysis. That is, I bring to this research a gender perspective: a belief that society is, and was, organized along gender lines and in accordance with an ideological system which posits difference on the basis of sex (Reinhartz, 1992). A feminist content analysis, then, attends to the presence and influences of gender arrangements and beliefs. Feminist researchers use quantitative content analysis to identify patterns in authorship, subject matter, methods, and interpretation. As feminist researcher Shulamit Reinhartz explains, "contemporary feminist scholars of cultural texts are likely to see meaning as mediated" (Reinhartz, 1992:145). Findings from studies are then used to generate or test presuppositions relevant to feminist theory and concerns, or to press for social change.

### *Analyses at Work in the Project*

Analyses occur at several levels in this project. One entails a comparison of medical to surgical records: how and why the cases were different, and when and why significant gender asymmetry occurred. I also examine changes in the records over time—set one (mainly 1874-77) and set two (1880-82)—for both surgical and medical. Lastly, to some extent, I parallel my findings in the records with pre-existing research on these issues.<sup>4</sup>

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<sup>4</sup> As a case study, this project deals primarily with the records themselves and much less with outside resources. I have chosen to give the least amount of attention to this category. As far as the hysteria issue alone is concerned, I could have easily written an entire 100-page project on

The issues I examine are also diverse. These include the history and rise of Maine General Hospital, the MGH physicians' roles and approaches, hysteria, uterine disease, venereal disease, patients who were portrayed as making up symptoms, class issues, nervousness, and depression, among others. In the analysis of the records, I gleaned more than twenty different categories, which I eventually compressed into twelve. (See Appendix A.) For the most part, however, I look most closely at hysteria and uterine disease in this analysis. These two disorders were not only the most common "female complaints" of the Victorian Era, but they also lend themselves easily to the incorporation and analysis of some of the other identified categories. There is a great deal of interplay and overlap between these classifications: a woman who was hysterical very often had some sort of uterine problem, for example, and also had a high probability of exhibiting nervousness, depression, or, perhaps, insanity.

### *Life on the Ward*

Reports and records provide few clues about what everyday life was like on the hospital ward. What little we know comes from photographs, pieces of information in the Annual Reports and records, and a few miscellaneous sources (see below).

According to information in the Annual Reports, MGH physicians were frequently on the premises, even though they had their own practices elsewhere. This is indicated, for example, in the 1879 Annual Report:

*Each physician and surgeon make at least one daily visit, and as many more as the necessities of the patients may require. In all important cases a full consultation is uniformly held, and no surgical operations are resorted to without the concurrence, and unless unavoidably prevented, the presence of*

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the cases I found in the MGH records in conjunction with outside sources on the subject. However, I have chosen to direct the majority of my focus to the primary sources themselves: the records.

*the entire staff. Sometime, and not infrequently, three or four consecutive operations are performed, occupying several of the most important working hours of the day.*

(Why a case was designated as important cannot be known for certain.)

One of these few historical documents which gives us a clearer picture of life in the hospital is a letter written from a patient to a friend in 1899. (This is the only letter available in the archives, at least for the 1800s.) While this was written several years after the case records (1874-1882) themselves, its contents are relevant and revealing.

Feb 7 1899

Portland General Hospital

Dear Friend,

*I cannot tell you how pleased I have been to git a letter from you today I have been in Surgical ward three weeks Thursday have been able to git out of bed this morning for a few minutes am now lying on my back in bed I teased the Doc. to let me git up on my feet so Sunday I slid out of bed on my feet and got in the chair but had to be lifted back but today I got along some better and I feel some better*

*I wish you could look in this ward There is 20 beds 10 on a side very small ones pure white it is a pretty site Troin come up to see it he has been quite sick since he went back he was better last I heard from him I am sufforing about the same with my side as when I came here they have done nothing at all for it and cannot unless they can reach it with Medream? there is not one here who can tell what the matter is when I get so I can walk around that is if I ever git to that I shall try to come home but I don't know when that will be I though soon whale I should have to say goodbye to the whale wounld but I am improving now and I am thankful indeed We had a sad death in here Saturday night a young woman was burnt almost to death in the city and braught her in here her crys of distress would break the hardest heart all in the ward suffered to hear her ageny she died near morning and I saw them carry her out There is so many dreadful sights and sounds here too much for*



*my nerves but I will try to be content a while longer I expected to hear something new from Mrs Fran Davis but time will tell when I git home I will tell you about the picture now I am not takeing your time for care please try to comfort Mrs Sudwig I have not forgot her so it is hard work to write laying on my back do please write again it is good to hear from home I look for a letter from Mis Barter this week it is about dinner time so good by for a while I know you can find this out so tell my friends I am still alive.*

This letter offers an idea of the physical set-up of the wards: *20 beds 10 on a side very small ones*. This is supported by the photographs on pages v and vi, which indicate a similar arrangement—Ward A was a long, rectangular room with small beds against the wall on each side. No dividers separated the patients; thus, everyone's business was visible to everyone else. This can be seen in the letter, as well: *We had a sad death in here Saturday night a young woman was burnt almost to death in the city and braught her in here her crys of distress would break the hardest heart all in the ward suffered to hear her agony she died near morning and I saw them carry her out*. Clearly death and sickness were not private affairs in the wards—unless one had a separate room, which only the wealthiest patients could afford. The woman's concluding comment is also fascinating (and a subject to be explored later): *There is so many dreadful sights and sounds here to much for my nerves but I will try to be content a while longer*. The passage illustrates the often-unpleasant nature of being a hospital patient in late nineteenth-century.

## HYSTERIA

### *Historical-Medical Background of Hysteria*

By the mid-nineteenth century, doctors and the culture at large had established that women were ill, that sickness was innate, and that this sickness stemmed from the very possession of a uterus and ovaries. Thus, they had eliminated the duality of "sickness" and "health" for the female sex; there was only the constant struggle a woman had with her reproductive organs and functions. At the same time, however, doctors *were* expected to cure. The development of commercial medicine, with its aggressive, instrumental approach to healing, required some public faith that doctors could *do something*, that they could fix things.

It took a specific syndrome to force confrontation with the ambiguities in the doctor-patient relationship, and to finally clinch the medical world's hold on women and the female psyche. This syndrome was hysteria (Ehrenreich and English, 1978:137). In many ways, hysteria epitomized the cult of female invalidism. It affected middle- and upper-class women almost exclusively. Medical writings of the time focused almost entirely on hysteria as a fashionable woman's disease. Hysteria had no discernible organic basis, and was often totally resistant to medical treatment. However, unlike the more common pattern of invalidism, hysteria was episodic. It came and went in unpredictable, and frequently violent, fits. According to descriptions of the time, as well as the records of the women who suffered from hysteria at MGH, the victim of hysteria might either faint or throw her limbs about

uncontrollably. Her back might arch, with her entire body becoming rigid, or she might beat her chest, tear her hair or attempt to bite herself and others. Aside from fits and fainting, the disease took a variety of forms: hysterical loss of voice, loss of appetite, hysterical coughing or sneezing, and, of course, hysterical screaming, laughing, and crying. The disease spread wildly, not only throughout the United States, but also in England and throughout Europe (Russet, 1989:115).

Doctors became obsessed with this "most confusing, mysterious and rebellious of diseases." In some ways, it was the ideal disease for the doctors: it was never fatal, and it required almost an endless amount of medical attention (which meant more money and prestige for the physicians). However, it was also a strike against a medical world which could not come up with a cure for a disorder so debilitating to thousands of women. Furthermore, physicians working in the hospital setting had a different take on the issue than did private physicians. While women with incurable, ongoing illnesses provided private physicians with financial support, they were another matter entirely to the hospital physician who, unpaid, worked at the hospital mainly for exposure to surgery (Rosenberg, 1987:316).

Because most hysteria patients were upper-middle class women who, until the late nineteenth and early twentieth century at any rate, usually sought private care rather than hospitalized care, the condition did not pose too great a problem for the unpaid community hospital practitioners. While most working class women had neither the time or financial situation to be ill indefinitely, there were cases of poorer women trying allegedly to emulate these "fashionable" illnesses of privileged women. At least, this was the perception of some of the physicians who treated them. However, there *were* working class women who suffered from hysteria, as we see in the passages below. (The italics in the following passages are all mine.)

*Hysteria is often seen amongst seamstresses, lace-workers and others of the female populations of large towns, confined for many hours daily at sedentary employments, or in heated manufactories; and who, from associating in numbers, excite each other's passions (Laycock [1840], cited in Jalland and Hooper, 1985:96).*

*There exists a peculiar disease, more common among females than males, which medical writers recognize by the name of hysteria. It resides in great cities, and visits, though impartially, all classes of the community. It attaches itself particularly to the noble and opulent, it is well-known among the bourgeoisie; and not infrequently, though far more rarely, it associates with the industrial poor (Johnson [1850], cited in Jalland and Hooper, 1985:99).*

*This sad condition [hysteria] is of more or less frequent occurrence among well-to-do female population of all countries living an indolent life, with no especial occupation, excepting that health-damaging one a continual round of gaiety and amusement, turning night into day and day into night, forgetting all the rules of health. . . . On the other hand, the females of our lower, middle, and poorer classes . . . are seldom found sufferers from these nervous disorders, and thus are spared one of the worst affections of the period of a woman's existence. Healthful occupation of the body, and consequently of the mind, is one of the great preventatives of this deplorable condition of ill-health (Weatherly [1882], cited in Jalland and Hooper, 1985:105).*

This last passage is particularly interesting in its discussion of working class women as being "spared" from hysteria. We do see some working class women displaying hysterical symptoms in the MGH records. Indeed, in the MGH records, the most severe and, to the physicians, seemingly exasperating cases of hysteria were those of working class women. The question then becomes, were hysterical lower class women viewed and/or treated differently by the physicians?

### ***Hysteria in the MGH Records—Overview***

Among the 200 women's records were 17 cases of hysteria; no men were diagnosed with hysteria, of course. My criterion for including a case in the hysteria group was if the word "hysteria" or "hysterical attack" was mentioned somewhere in the record. However, in some ways this is a difficult standard with which to

work. It excludes the cases which described very similar medical scenario but in which the word "hysteria" was not mentioned. These kind of symptoms were especially prevalent in the uterine disease cases—a category which clearly had much overlap with hysteria. However, there were also serious hysteria connections with cases involving made-up symptoms, nervousness, wildness, insanity, or a combination of all these things (I discuss these in more detail below). The quantitative breakdown of hysteria cases is:

hysteria:

- 10 cases of hysteria in M1  
Thus, out of 44 women (the number of women patients in M1), roughly 20%, or 1 in 5 women, were diagnosed with hysteria.
- 0 cases in S1
- 7 cases in M2  
Out of 54 women (the number of women patients in M2), roughly 13% of women were diagnosed with hysteria.
- 0 cases in S2

Perhaps the first thing to note is that there were no cases of hysteria in the surgical records. This is understandable: by the late-nineteenth century, the medical world considered hysteria an emotional-neurological imbalance, not a cause for surgery. It points, once again, to an important difference between medical records and surgical records: medical patients were much more likely to have vague, emotion-based psychosomatic illnesses than surgical patients. And while the surgical records were dominated by men, women—clearly deemed to be the more emotionally unbalanced gender—made up the majority of medical cases.

As the above numbers portray, in M1 there were nine patient cases in which hysteria was mentioned. Thus, nine out of 44 records on women (there were 44 women in M1) mentioned "hysteria"—basically 20 percent, or one in five women. In M2, there were seven cases of hysteria. That is, seven out of 54 women were

diagnosed with it in M2—about 13 percent of women. Hysteria, then, was mentioned more often in the earlier records. This is, at first glance, surprising: with the influx of more middle and upper class women into the hospital in later years, one would expect there to be more cases of hysteria in M2. However, there is a significant increase in the amount of uterine disease between M1 and M2 (also S1 and S2), as well as a large increase in the number of pessaries, hot water injections, and glycerine packs used to treat these patients (these issues will be discussed more fully in the uterine disease section). I believe this indicates that, while the word "hysteria" was not being used with as much frequency in the second segment of records, a shift had occurred; physicians were describing the same sort of debilitated physical and mental health scenarios in a different arena—as uterine complications. There was also a rise between M1 and M2 in the number of women described as "nervous" (a category I viewed as separate from "hysteria" in my coding process). Here, too, is another possible overlap category; it is likely that women who would have been described as "hysterical" in M1 were simply falling into different categories in M2. The distinction between hysteria, uterine disease, and nervousness was often arbitrary, and in many cases, the three overlapped. In fact, the category of hysteria is significant because, according to the MGH records, these cases are representative of a host of related health issues experienced by women patients, including those from the working class.

Hysteria was manifested in the patient accounts in a multitude of ways. In fact, given the cultural themes, it is curious that **more** women in the records were not diagnosed with it. Some of the more frequently occurring hysterical motifs were patients who made up symptoms, fever, nervousness, debilitation, wildness, and of course, attacks. Also, frequent connections were made between outbreaks of hysteria and times of menstruation. Attentiveness to these relationships strengthens the interpretation of the records.

### *Convergence of Hysteria and Patients who Invented Symptoms*

One of the most interesting categories of hysteria patients in the MGH records are the women who were described as inventing or making-up symptoms. I did not find a reported connection between hysteria and deception in any of the then-current outside research or medical descriptions. The descriptions in these sources, dealing almost entirely with upper-class women, focus mostly on the emotional, attack-like nature of hysteria. However, five of the 17 hysteria patients in the MGH records (30 percent)—all of whom were lower income, working women—were seen as deceiving doctors. The particular records do not suggest that these women were falsifying the hysteria; rather, hysteria was equated with making-up symptoms more generally. This idea both challenges and preserves class boundaries.

The quantitative breakdown of the patients in the entire record sample who fall into this category (not just the hysteria patients):

patients perceived as inventing or fabricating symptoms:

- 8 cases in M1  
    1 man, 7 women
- 0 cases from S1
- 7 cases from M2  
    1 man, 6 women
- 0 cases from S2

Thus, out of 15 cases of patients perceived as making-up symptoms, two were men (13 percent) and 13 were women (87 percent). Women were portrayed as "falsifying" symptoms much more often than were men. In terms of overlap with hysteria patients, then, three of the ten hysteria cases in M1 also involved women reportedly making-up symptoms. In M2, this was true of two of the seven cases. So, indeed, there was a great deal of convergence between the two categories.

A strong example of the convergence between hysteria and fabrication of symptoms is patient Mary LaRose, a 24 year-old, single dressmaker from Rockland who was admitted in December of 1875, for a 28 day stay. Her record began:

*Patient affirms she had a tumor of the abdomen 8 years ago but cannot tell where or how much fluid was taken away. She is indifferent about answering questions. Says she has not menstruated for a year. Present condition: medium size, muscular, not confined to her bed. Complains of great pain on the left side of her abdomen. Pulse 70 or 80, and the pulse is not accelerated when she (pretends) suffers severe pain. There is no enlargement about the abdomen and nothing abnormal is found in vaginal examination. Diagnosis: Hysteria.*

Immediately, it is clear how the writer established the patient's intention as being one to deceive. First of all, she was described as being *muscular and not confined to her bed*—a healthy condition the opposite of those of most women with female complaints, who were described as pale, anemic, in pain, and so forth. The writer's most remarkable indication of the woman's deception was his notation that her pulse did not accelerate *when she (pretends) suffers severe pain*. This type of editorializing comment was extremely rare in most of the records. (In fact, this type of comment is found, understandably, in the hysteria section more often than anywhere else.) What was the diagnosis that they gave to this woman who, in their minds, was clearly making-up symptoms? It was *hysteria*. Thus, in this case, hysteria was equated not with attacks, fever, or convulsions, but with inventing illness.

The physicians attempted to treat LaRose for her "disease:" her treatment included *opiates, hypnotics, and nourishing diet*. However, after a month of this treatment, the doctors gave up any hope of curing her. The following note was made on 1-12:

*It became very evident that her object was to deceive and that her complaints had no real foundation. Accordingly Dr. Graves made a prescription for*



*"hard work" upon which she has improved rapidly and is discharged, able to execute the above recommendation.*

It is fascinating that Dr. Graves believed the only treatment which would cure LaRose of her disorder was *hard work*. This conclusion was inextricably linked to class; these kinds of comments simply do not appear in records of women of higher status. In fact, with upper class women, the "rest cure"—not hard work—was what was commonly prescribed, evident not so much in the MGH records but in popular nineteenth century portrayals of hysteria, such as Charlotte Perkins Gilman's "The Yellow Wallpaper." LaRose's record is a physician's interpretations of hysteria among working class women. In this case, hard work, not bed rest or uterine treatments, was the best treatment to get the patient back to dress-making.

The harsh tone used by the MGH staff with LaRose was not taken with all hysteria patients, however. Not all hysteria patients allegedly made up symptoms, some simply could not help themselves. These women were treated with more sympathy. One such woman was Laura North, a 26 year-old single domestic who was admitted in October of 1876, for 183 days, or a little over six months (!). Her records began:

*Mother died of cholera, father of consumption. Has always been delicate and unable to stand fatigue like other girls, but has never had any prolonged sickness until 5 years ago when she had rheumatism around the heart, and was confined to the house about 6 months. Had considerable pain in heart region. Complains of much pain and distress in left side through her loins.*

A stark contrast can be noted between this patient description and the one of LaRose, above. Instead of being described as being *muscular* and *not confined to bed*, North *has always been delicate and unable to stand fatigue like other girls*. Furthermore, this feminine description came after the writer had established that the young woman was an orphan. The sympathetic tone here is impossible to miss.

As the weeks passed, North fluctuated in health. She continued to have pain in her left lung, as well as *violent headaches* and a flushed face. In January, three months after admittance, the patient, at last, received a vague diagnosis from Dr. Small: he thought the problem was cardiac, not lung, that there was insufficiency of the valves, hence the headache and flushed face. He also thought her *extremely hysterical*. On what did he base this judgment?

*Since the 14 of January she has had a great variety of symptoms in RAPID SUCCESSION very easily influenced by surroundings. For instance, a case of cystitis in the ward has produced like symptoms with her but on examination of bladder and womb nothing abnormal in either is found.*

Here, again, is an example of hysteria being equated with a patient's tendency to make-up or imagine various symptoms of illness. However, the doctors did not take the frustrated attitude that they did with LaRose; instead, they exhibited sympathy. The record continued: *She is evidently an honest girl. Has had a hard time in life thus far. Has been overworked and is somewhat anemic, therefore gave her iron pills. The doctor has decided to continue this, watch her kindly and watch the effect.* Here, too, the sympathetic condescension is hard to ignore. The physicians seemed to be saying, "She is a poor, overworked domestic. She can't help it if she is hysterical." Some of the notes that followed are:

3-3: *Finds her suffering with almost any symptom we choose to suggest.*

3-21: *SAYS she doesn't retain anything in stomach, vomits all her drink, even.*<sup>5</sup>

4-5: *The nausea continued until she was tired of lying in bed. By great effort she has occasionally vomited, rather poor success, though: no doubt she has been misrepresented in regards to vomiting.*<sup>6</sup>

4-15: *For several days has kept out of the way of the attending physician. Is advised by him to leave the hospital as prospects of her recovery with the present surroundings are doubtful. Discharged 4-17.*

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<sup>5</sup> They decide to observe her and see if she is really vomiting.

<sup>6</sup> Emphasis mine. Clearly they believed that she had been lying to them about the vomiting.

The sympathy the doctors exhibited towards North, at least as recorded in the beginning of her case record, was rarely exhibited in connection with other working-class hysteria patients. However, as the months wore on and North did not seem to respond to the doctors' treatment, their sympathy for her wore thin.

### *Convergence of Hysteria with "Attacks"*

Not all hysteria patients were viewed as guilty of making up symptoms. In fact, hysteria was most often portrayed as some sort of attacks or convulsions—and very "real" ones at that. Dr. Robert Barrens (1873), discussed these attacks in *The Lancet*, England's primary medical journal. He wrote, "Under either of these conditions [either "exalted nervous action" of hysteria or "excess of irritation" of hysteria], a fit of epilepsy or of hysteria, according to the constitution of the patient, may explode." It is not far-fetched to compare a hysterical attack to an epileptic seizure: the comparison is common in many medical texts from the time as well.

Both kinds of hysterical attacks were described in the MGH records. For example, Julia Synder, a 32-year old single woman, came into MGH with *dysmenorrhea at times and a very disagreeable feeling in the head*. At the time she checked in to the hospital, she was *suffering from an attack of dysmenorrhea* (painful periods) *with an occasionally hysterical convulsion*. Of particular interest here is the frequently-drawn parallel between menstruation and hysteria.

Another example of a patient with hysterical "attacks" is Delia Sprague, a 37-year-old married woman who came in to MGH complaining of irregular menstruation and painful defecation. Her diagnosis was *hysteria with torpor of bowels*. At this point in the record, there had been no previous mention of hysteria. It was as if the mention of irregular menstruation was enough to warrant the hysteria diagnosis. There was also no more mention of hysteria in the record—that

is, until mid-record, when the following note was made: *she had a hysterical convulsion during the afternoon, characterized by muscular contraction.*

One case of an hysterical patient with "attacks" was a woman who was a recovering opium addict, or *opium eater*. This case makes an interesting link between hysteria and recovering from addiction. Elizabeth Lincoln, a married woman whose age was not noted, was admitted on June 22, 1876, for about two months. *History is that of an opium eater.*<sup>7</sup> When Lincoln was admitted to the hospital, she reported using 16 grams of morphine a day, as she had for several years. The hospital staff ordered her potassium bromide (a drug often used to assuage nervousness or "melancholia"), but they refused to give her morphine, hoping she would overcome the addiction. The patient, understandably, showed symptoms of withdrawal. But to what did the physicians attribute these withdrawal symptoms but to hysterical attacks? Parts of her record read (emphasis mine):

*6-27: Is very nervous and shows signs of hysteria. Morphine is ordered—to be reduced gradually.*

*7-3: She secured the custody of her morphine and took its contents (about 4 grams) and seems to be partially narcotized. The pupils are widely dilated. She cannot be aroused to talk but keeps up an incoherent muttering.*

*7-9: Not much change since last note. Dr. Kenneston called in for consultation and after a careful examination it was concluded that it was a case of hysteria and at present time there is no immediate danger of approaching dissolution.*

*7-14: She still lies in the same condition.*

*7-21: Morphine now reduced to a very small amount each day.*

*8-2: She has improved rapidly within a few days in her mental condition. Walks around with some help, converses intelligently. Discharged on 8-16 cured.*

It is interesting to note, particularly on the July 9 record, that an indication of an overdose was interpreted as a clear-cut case of a hysterical attack. Furthermore,

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<sup>7</sup> Lincoln is one of the few female examples of a substance addict in the MGH records. In fact, "addiction to substances" and "venereal disease" were the only two male-dominated categories of the more than twenty assessed. The breakdown for "addiction to substances" ("substances" included alcohol, morphine, and opium) was 26 cases total, 6 of which were women (23 percent) and 20 of which were men (77 percent).

in the line *it was concluded that it was a case of hysteria and at present time there is no immediate danger of approaching dissolution*, we see how the "fact" that the patient was hysterical was used to relieve the MGH staff. After all, hysteria was in no way believed to be life threatening or a cause for immediate medical intervention. No man suffering from withdrawal to a substance or an overdose would be, or was, called hysterical, yet the physicians seemed more than willing to make this diagnosis with respect to women. In fact, out of the four cases of women patients with addictions in M1, two also fit within the hysteria category.

Another "attack" example is May Westhaver, a 16-year old who was admitted on September 24, 1876, and remained there for nearly four months. She was admitted the first time on account of fever. Her chills passed on and off, but she broke the fever and convalesced until December 6, when she was discharged. She returned to hospital three weeks later, *the reason given by her parents for her return was that she had been very sick. But upon examination and questioning the patient, it was decided that she had frequently hysterical attacks which caused the alarm.* She was treated with various medicines and was discharged on February 6, 1877. Here, again, if the writer's notations are accurate, the physicians assigned the label of "hysterical attacks" to the girl's otherwise undiagnosed sickness.

One of the more interesting cases of a hysterical woman with "attacks" was Lizzie Smith, a 22 year-old single woman admitted in July 1882, for a period of two-and-a-half months. Smith's attacks were portrayed as her way of dealing with pain, nervousness, and, in some cases, a need for attention. Her case is also a good example of a hysteria patient having definitively specified uterine disease. When admitted, she had a *tender spine and is hysterical*. About one year previous, her circumflex nerve had been injured when she fell from a carriage. *From this tender point on the shoulder the pain seems to radiate down back and extremities. At times this pain becomes almost intolerable and ushers in a typical hysterical attack.*

*These attacks come on each week or oftener.* Here the connection between her pain and hysterical attacks is made evident. However, the physician did not deem pain alone to precipitate an attack, but attributed that to dysfunction of her reproductive organs.

Indeed, immediately after his remark about the frequency of her attacks, the physician gave her a pelvic examination: *found uterus sharply anteverted. Cervix eroded for a space as large as a silver dollar from friction against posterior vaginal wall. Dr. Jones introduced a vaginal pack saturated with rodoform [an astringent containing iodine] and water. Ordered 4 medicines, dry cups over shoulder and back twice daily.* Here is a theme that appears repeatedly in the records—the physician looking for some sort of reproductive-organ related problem in order to explain a woman's hysteria, nervousness, or vague physical maladies.

At first, Smith did not appear to benefit from the treatment. *7-24: No change in conditions. Has hysterical attack once daily or more. Pain in back pretty severe all the time.* They continued religiously with her uterine applications, as before. After all, they perceived that she would not stop having attacks until her uterine dysfunction was cured. Towards August, the physicians began to experiment with pessaries. By this time, the focus of the record was entirely removed from the patient's tender spine pain, addressing instead the hysteria.

*8-8: Managed to place a small-sized pessary today this PM had a slight attack of hysteria. Gave ammonia valerate [a sedative] and applied hot water bag to feet. Lasted for one half hour. She said it was caused by the pessary.*

The pessary appears to have led finally to Smith's improvement; on August 10, the following note was made: *Patient feels better—the pessary holds the uterus on position and prevents friction of os on posterior wall.* With the pessary in place and apparently working, marked convalescence can then be seen in Smith's record:

*8-12: Patient says she feels less nervous than for a long time.*

8-22: Slow but gradual improvement is noticeable.

8-28: Gradual improvement but pain in back till persists. Erosion on os nearly all healed.

9-1: Improvement still evident. Color good and eats well.

9-5: A slight hysterical attack, the first in a number of days. Lasted only a few moments.

9-8: pessary replaced today. Ulceration of uteri entirely healed. Went out of doors today. Slight hysterical attack in the PM for a short time only.

9-18: Ulcerated uteri entirely healed. Hysterical attacks at long intervals. Sent patient home on the 18th.

It is evident that the intent here was to simply reduce the frequency of the hysterical attacks by spreading them out over time. The most notable aspect of this patient's course of treatment and recovery, however, was the improvement of her hysteria with the "fixing" of the position of her uterus.

### ***Convergence of Hysteria with Fever***

Fever was another way in which hysteria could be discerned in patients at MGH, according to the records. Like the convergence of hysteria and fabricating symptoms, fever was another form of hysteria evident in the records, but not in the formal textual descriptions of the disorder from the period. Perhaps, again, this was because working class women diagnosed with hysteria were viewed as being different from their counterparts in the more well-to-do classes.

For example, Jennie Meymouth, a 20 year-old, single table girl was admitted on July 27, 1875, for 30 days. She had been sick for about one week when admitted. Her present condition was described as *anemic with more or less fever*. Her diagnosis was *chlorosis with some hysterical symptoms*. (Chlorosis was a disorder especially common during the nineteenth century, disappearing abruptly soon thereafter and believed to be associated with iron deficiency and anemia. It generally affected adolescent females [Dorland, 1985:257].) Unfortunately, there was



no explanation of what those "hysterical symptoms" were. In fact, hysteria or hysterical symptoms were not mentioned again for the entire record—the only reference to hysteria in her case was with the notation of fever. This reinforces the theme already discussed: in several cases, the word hysteria was mentioned only once or twice, leaving us unclear about what the term means. (Of course, MGH writers and physicians were not writing with twentieth-century historians in mind.)

A final example of a hysterical patient with fever is Laurel Brown, a 38 year-old, single seamstress admitted on August 31, 1875, for a whopping ten-and-a-half months (and her record ends abruptly after at this point, so it is unknown how long she was actually at MGH). (Her case is examined in greater detail in another section below.) At the very end of her record, on July 14, 1876, the following was written: *Has caught the hysterical fever which is raging at the present time.* This is the only mention of hysteria in this patient's entire record. Of particular interest with this case is the seeming contagious nature of the *hysterical fever*; interestingly, Brown was described as having *caught* it. The convergence of hysteria with the making-up of symptoms reported with respect to other patients also suggests the belief that women could, or would, take on the symptoms of others in the ward. In these cases, as well, the seeming "contagious" nature of hysteria appears to be a distinctive characteristic of lower-class women. The notion that women could "pass off" hysteria or other ailments to others carries important ramifications, particularly if the view was held widely by MGH staff. Could a woman have become hysterical just by being around another woman? Since this is the only mention made in the records of hysteria being like a contagious disease, the answer to this question is left to speculation.

### *Convergence of Hysteria with Nervousness or Melancholia*



Laurel Brown's case also provides insights into another common embodiment of hysteria in the records: hysteria patients as nervous or depressed. Brown was described immediately as a weak, sickly woman:

*Medium size, black hair, delicate, has been subject to headaches, swelling of the legs and feet so that shoes could not be worn, constipation and pain in the bowels and back. Father and sister died of consumption, mother died of cancer, and another sister of typhoid fever.*

This description represents another theme which is seen so often in the records (and already has been seen)—a sad and debilitating history, both physically and otherwise. This history of vague "female complaints" led the physicians to perform a vaginal exam.

*Present condition: heart and lungs normal. Nothing abnormal discovered about the abdomen, uterus, or vagina. Appears melancholy. Sits all day without conversing with those around her or noticing what is said. Answers questions slowly but intelligently. Treatment: pills of Iodide of Iron after each meal.*

This passage contains the physicians' and/or writer's interesting portrayal of Brown's anxiety or depression: *appears melancholy. Sits all day without conversing with those around her or noticing what has been said.* The ways they remark upon her improvement are also notable; they comment on her state of cheerfulness or nervousness:

*9-17: Does not appear any more cheerful.*

*10-8: Appears more cheerful and laughs every once in a while—general health also very much improved.*

*12-7: Had a restless night, talking incoherently all the time and this morning she answers negatively to all ailments—but says oh dear, oh dear, and moans.*

*12-9: Been hallowing furiously, has a wild stare. Pupils contract and relax without change of light. She is controlled by Bromide of Potassium.*

*7-14: Has caught the hysterical fever which is raging at the present time. She laughs and cries alternately. Says she is in severe pain. Cold baths are ordered.*

The phrase *she is controlled by bromide potassium* sheds a great deal of light on the physicians' attitudes toward women with emotional disorders. Here Brown's case also illustrates the wild or delirious embodiment of hysteria (explored more below).

Another example of a "nervous" hysteria patient is Sarah Ulrich, a 38 year-old dressmaker admitted on April 25, 1878, for about three months. As in Brown's case, Ulrich's nervousness and hysteria—as well as the condition of her uterus—were viewed as the causes of her debilitated health:

*She has had frequent attacks of what she calls colic—severe abdominal pain with headache and vomiting. Present condition: she sits up a little each day. appetite poor. Has headache, severe at times. Very nervous, and inclined to be hysterical. Complains of some pain when passing urine. A vaginal exam shows profuse mucous discharge. The uterus is about of normal length and position, but very sensitive, the use of the sound being followed by considerable hemorrhage. Treatment: various medicines, iodine applied to uterus, glycerine pack.*

This record is a good example of a case in which uterine disease, hysteria, and nervousness overlap.

Hysteria records were not the only cases in which nervousness was exhibited by the patients. In general, nervousness was demonstrated far more frequently by female than male patients. My criterion for including a record in the nervousness category was if the word "nervous" was mentioned anywhere within the record. The quantitative breakdown of MGH patients exhibiting nervousness is:

nervousness:

- 8 cases of nervousness in M1: 2 men, 6 women
- 0 cases of nervousness in S1
- 12 cases of nervousness in M2: 3 men, 9 women
- 4 cases of nervousness in S2: all women

Thus, out of 24 cases of nervousness, 19 were women (79 percent) and five were men (21 percent). The gender asymmetry of this category supports existing Victorian ideology of women being much more emotionally and neurologically unbalanced than men.

This gender imbalance is not exhibited nearly as much in the category of depression or "melancholia," although there were fewer cases of this disorder than nervousness. Once again, my criterion for including a record in this category was if one of the words "depression," "melancholy," or "neurasthenia" was mentioned in the record. The quantitative breakdown is as follows:

depression or "melancholia:"

- 3 cases in M1: 2 men, 1 woman
- 0 cases in S1
- 4 cases in M2: 1 man, 3 women
- 1 case in S2: 1 man

Thus, out of eight cases of depression or melancholia, four were male patients and four were female patients. One would expect more gender asymmetry in this category; as women were (and are today as well) perceived as being more emotional than men, it would follow that female patients would be diagnosed with depression or "melancholia" much more than males. However, it must be remembered that there are many other woman-specific diagnoses (i.e., "hysteria," "uterine disease," "nervousness") which allow room for displays emotion. Men clearly are never diagnosed as being hysterical, and they are thought of as being nervous much less regularly than women (remember: only 21 percent of the nervousness cases were male patients.) If we think of "nervousness" and "melancholia" as the only two diagnoses for men which allow for displays of emotion, then clearly, the men in the MGH records are not considered to be an emotional group—it means there were only five nervous men and four depressed men out of 200!

### *Convergence of Hysteria with Wildness, Delirium, or Insanity*

The last embodiment of hysteria in the MGH records which I want to discuss is the conjunction of hysteria and wildness, delirium, or insanity. These hysteria patients were perhaps as "out of control" as a patient could get at MGH; the frustration and the physicians exhibit for such patients is evident in the latent content of the records.

Take, for example, Abby Bowden, a 44 year-old married woman admitted on August 31, 1881, for a 51 days. Her diagnosis was *exhausted in nervous energy with hysteria to some degree. At present she is suffering from Locomotor Ataxia* (failure of muscular coordination; irregularity of muscular action) *to some extent. Bowels constipated. Appetite poor. Severe pains in loins and thighs are nearly constant. Headache is often present and severe.* Several medicines were ordered, and she seemed to get better. However, after a few weeks, she began to deteriorate. This deterioration was portrayed in the losing of her mental faculties, which was first hinted at when she mentioned she was experiencing a *sense of suffocation*;

*9-20: She feels comfortable and has lost less blood than before. All throughout she has sore throat, a "sense of suffocation," etc. Medicines given.*

*9-30: Since the above she has been improving day by day. The application per atomizer gives much relief and the catarrhal condition of the pharynx is much improved.*

*10-21: For the past few nights she has been more deranged mentally, necessitating the administration of Ammonia Valerate. On the night of the 18th she got out of bed and had to be put back. Fancies all against her. Discharged unimproved.*

This case of a woman diagnosed with *nervous energy with hysteria to some degree* ends with the discharge of the patient being even more *deranged mentally* than at the time of her admittance.

Another example of a hysteria patient portrayed as having mental health problems is Constance Osborne, a 52 year-old single woman admitted on August 20, 1877, for four days. This woman was also an example of a hysteria patient who was perceived (at first, at least) as fabricating her symptoms. She is, in some ways, the ultimate case of hysteria—she became increasingly unstable and out of control, until she was at last sent to the insane asylum (!). At the very beginning of her record, however, the physicians did not consider her insane—only deceptive and disagreeable:

*At time of admission, she appeared very hysterical—was unruly and seemed to be practicing deception, for she readily understood what was being done but would not admit to it except in unguarded moments. Had a very DISAGREEABLE way of pulling hair, etc.*

This passage indicates that Osborne was clearly a source of annoyance and frustration to the physicians—an example of a hysterical woman who was taking up the physicians' valuable time. However, she proceeded to become even more disagreeable, even uncontrollable: on the afternoon of August 22, *she acted wildly* and the physicians gave her sedatives of some sort. This wild behavior continued:

*8-23: Condition not improved—will not take nourishment.*

*8-24: Awoke quite rational but complained of nervousness and strange sights upon closing her eyes.*

*8-25: Potassium Bromide administered every 3 hours during the day. Slept until midnight, when she awoke tearing the sheets. During the day she broke down gas fixtures and broke the furniture. At 5:30 PM she was sent to the Asylum in Augusta.*

It is interesting that this woman's insanity (at least, what was *perceived* as her insanity) was at first recognized and portrayed as hysteria. While Osborne was the only hysteria patient who was transferred to the insane asylum, her case speaks to the slippery slope in the physicians' minds between hysteria, wildness, and,

ultimately, complete insanity. In some ways, the hysteria in Osborne's case served as a "warning sign" for insanity.

Hysteria patients were not the only women who exhibited signs of wildness or delirium. However, women, in general, were much more likely to exhibit these symptoms than men in the MGH records. The quantitative breakdown of these patients is:

wildness or delirium

- M1: 5 cases; 1 man, 4 women
- S1: 1 case; 1 woman
- M2: 8 cases; 4 men, 4 women
- S2: 0 cases

13 cases; 30 percent men, 70 percent women

This MGH trend, too, is consistent with the Victorian Era's portrayal of women as being far more emotionally unstable and as having less control over their bodies and minds than men.

## *Conclusion*

We have seen that hysteria took on an amazing variety of forms in the medical records: attacks, inventing symptoms, fever, nervousness, depression, or even insanity. A common theme ran through all of the hysteria, cases, however: each women was perceived as being somehow emotionally and neurologically unbalanced, which was thought to contribute greatly to their poor health. Another common thread that runs through many of the cases, as we have seen, is the connection to uterine disease. Hysteria and uterine disease are clearly closely linked in the records. In this sense, the categorical distinction can be somewhat arbitrary—

the absence of the word "hysteria" in a woman's record does not necessarily indicate that the patient's illness is thought to be very much connected to her nerves. In fact, there are a number of cases which, aside from the fact that the word "hysteria" does not appear in the record, are virtually identical to the hysteria records in their descriptions of women's neurological-related sicknesses.

## UTERINE DISEASE

### *Introduction*

On May 3, 1882, Wendy Lund, a single, 29 year-old woman was admitted to the medical unit at MGH. Her patient history reads as follows:

*Patient was born of healthy parents and was herself perfectly healthy until she reached the age of 16 and began to menstruate. At this time she had much local pain and great disturbance of the nervous system. Has never been well since. Little strength. Easily fatigued. Weak digestion. Always very nervous. She says, more than anything, she wants to be well.*

Her present condition: *muddy skin, coated tongue, constipated. Becomes tired easily. Slight causes make her very nervous. Does not sleep soundly. Feels all "nerved up" most of the time.* What was the first step the doctor made after assessing this woman's health history? He gave her a vaginal exam because, after all, what *else* could possibly be the cause of her nervous and debilitating symptoms but some sort of uterine-related problem? The record continues:

*Vaginal exam made by Dr. Perry. Vagina normal. Typical virgin cervix. Uterus, however, is retroflexed and slightly drawn to left side. Marked tenderness of both ovaries particularly by the left. Patient says pain at menstrual periods is largely at location of ovaries. Dr. Perry thinks the condition of the uterus and ovaries bears a causative relation to her troubles. He thinks the congested and irritable ovaries have produced and kept up the symptoms listed above.*

Indeed, a direct link is made here between her symptoms of nervousness, weakness, and general invalidism with the dysfunction of her reproductive organs. Dr. Perry treated her for this uterine disease with a glycerine pack in the vagina,



copious hot water injections, iodine painted over ovaries at night. Eventually, leeches were placed over ovaries to get rid of excess blood. And how did Lund respond to this treatment? Three months after her admittance to the hospital, the following note was made:

*Patient has gained in weight and strength. Shows almost none of the hysterical tendencies which were so conspicuous when admitted. Sleeps well. Is not nervous. Her periods have gotten much shorter and less debilitating. Today she completed the only comfortable menstrual period she ever knew. Upon examination, uterus is found in normal position. Excellent spirits. Discharged "cured" on July 29.*

What we see in this hospital record is a history of poor, if not debilitating, health—nervousness, fatigue, weak digestion, painful periods—all beginning and continuing indefinitely with the onset of menstruation. The assigned cause of the poor health was the malfunctioning reproductive organs. The almost 180-degree turn around from invalidism to wellness was attributed to the application of glycerine packs and iodine. All of these things constitute an excellent representative sample of the uterine disease patient in nineteenth-century America, the kind of patient I encountered time and time again in the MGH records.

### ***Medical Background on Uterine Disease—MGH and Beyond***

Women came into MGH with more complaints regarding their reproductive organs than any others. For example, in the records there were 70 cases involving uterine disease compared to 17 of hysteria. The women's laments, of course, took on a myriad of forms, such as: "cervical laceration," "periuterine inflammation," "congested, tender uterus," "tumor of the ovary," as well as some more vague titles such as "nervous prostration," "cardiac inadequacy," "dyspepsia," and "rheumatism." They were extremely varied but shared a number of common

symptoms—nervousness, pain through back and loins, weakness, poor digestion, painful periods, leucorrhea, and, sometimes, being unable to walk at all. For the purposes of compression, I have placed all these reproductive-organ-related complaints into the category "uterine disease," as did the physicians in one way or another. Take, for example, the following excerpt from record 237, a medical patient admitted on January 2, 1882:

*Disease: Uterine. Duration of disease: 9 years. Symptoms: painful and difficult urination. Leucorrheal discharge. Plains of a bearing-down nature through the pelvis and thighs. Bowels irregular. Appetite poor. Much difficulty in walking. Can not stand up without causing pain. Disorder of the menstrual functions.*

These complaints were typical of those made by women during the time period: long lasting, all-encompassing, and gripping multiple parts of the body. And *so many* women seemed to have it. One medical paper wrote (emphasis mine):

The fact that *more than one half* of the females of the present day are suffering from Prolapsed Uteri and its concomitant difficulties, is a startling one—one which has an important welfare of the Mothers and Daughters of our country, and through them the well-being of our race. The evil is a progressive one, and the question, are there no measures which may be adopted to remedy, the remove an evil which is producing so great physical deterioration of the sex?—is to the Pathologist and Physician one of the deepest interest (Greene, 1856:1).

Other writings—both popular and medical—quoted similar figures in terms of the number of women suffering from uterine disease during the period. Of course, some scholars might write that this portrayal was insincere—physicians were *not* as concerned with curing women from these ailments as this passage suggested. As previously noted, Victorian ideology saw women as being inherently ill, and physicians could not help but be influenced by this ideology. While certainly they wanted women to get better (particularly, perhaps, hospital physicians, who did

not have as much time or energy to spare with such patients), they were not alarmed with the extremely high numbers of cases of uterine disease. Victorian women were *supposed* to be sick, even, although to a lesser extent, working class women. And whether it was 25 or 75 percent of women who actually suffered from "female complaints" (we will never know for sure), what is certain is that a enormous part of the female population was debilitated from uterine complications.

### *Women's Reproductive Functions as Being Pathological*

On a more specifically medical level, one of the reasons that "uterine disease" was so incredibly common among women was that the medical world understood women's reproductive functions as being entirely pathological. Women's reproductive organs, in general, were thought of as being the source of both great physical and mental stress, turmoil, and illness. Puberty was viewed as a period of stress and crisis; the entire female organism was thrown into a turmoil. Menstruation or its lack were treated equally as dysfunctional. Furthermore, the "affliction" of menstruation was not confined to a short period but continued throughout most of a woman's life. Menstruation and ovulation were thought to occur at the same time. Dr. King, writing in the *American Journal of Obstetrics*, in 1878, produced an extraordinary argument based on this belief. He argued that conception was most likely during menstruation. However, intercourse was not "permitted" at the time of menstruation since the menstrual blood was also considered to be a source of male gonorrhea. Menstruation stood in the way of fruitful coitus and could not have been ordained, therefore, by nature. Thus, it was unnatural, that is to say, pathological (King, 1878, quoted in Duffin, 1978:33).

Similarly, a pregnant woman was ill. The more time she spent lying immobile and inactive in bed, the better. By removing pregnancy and childbirth

from the sphere of the normal into the sphere of illness, doctors also removed its control and management from both the women themselves and female midwives, and placed it in the hands of the male medical practitioners (Duffin, 1978:30). Simply put: something was inherently "wrong" or malfunctioning about the female reproductive system..

### *Other Alleged Causes of Uterine Disease*

Lest we give no or too little credit to the medical world, there were certain outside agents or extra-biological causes viewed by physicians as being responsible for many of the uterine complaints given by so many women. Clearly, not all, even if most, medical personnel took the simple view that women's reproductive functions were inherently pathological. Chief among the other possible sources of uterine disease was the dress of the period: corsets, heavy skirts and dresses placing up to twenty pounds of weight on the constricted waist of a woman. One medical handbook strictly advised against this "tight lacing:"

Corsets hinder wholesome exercise and prevent the free play of internal organs. The muscles waste away and become feeble and are unable to do their proper work. They permit the bowels to gravitate out of their normal position and these become pendulous. The mechanical pressure created by the lacing presses the contents of the abdomen toward the pelvis, and the pelvic contents are crowded down to below their natural position. This is the cause of the "pot bellied" appearance of many fashionable women (Danelson, 1874:605).

Other doctors and medical writings echoed this sensible sentiment. A medical document from the category of more-enlightened physicians and medical thinkers and writers which particularly caught my attention was the medical school thesis of one of the first female medical school graduates in the country, Cordelia Agnes Greene. In the mid- to late-nineteenth century, medical school students, in

order to graduate, were required to write a thesis about a particular health-related topic (the criteria were open-ended at the time). Greene, who graduated in 1856, wrote a thesis titled "Prolapsed Uteri, and Other Malpositions of the Abdominal and Pelvic Viscera." While the thesis was written several years before the records from MGH begin, her ideas are relevant to our discussion—after all, the topics about which medical students of the late 1850s were writing became the medical theories of late-nineteenth century health care.

Dr. Greene was ahead of her time in terms of her thoughts on uterine disease. She refused to believe that the "endemic" of uterine disease was an unavoidable aspect of women's biology (although she *did* portray women as creatures of weakness and suffering).

To think that a less degree of health and happiness was designed for woman than for man—that she must find the office of Maternity a source of Misery and anguish—or by virtue of her peculiar organization, become subject to a double share of life's sufferings, and drag out a miserable existence—would be libelous to the character of our All Wise Father (Greene, 1856:1).

Here Greene questioned the popular notions of women's biology as being inherently pathological by calling God into the question. She argued: would God create inherently malfunctioning or unhealthy beings? She went on to state that there were many outside factors that produced prolapsed uteri and its accompanying symptoms (or "difficulties," as she wrote). "Improper modes of dress" was one of the first causes she cited. Her description of the process, which echoes the above passage from the medical textbook, is insightful:

Our present mode of dress is bad, very bad—a process of slow compression upon the upper portion of the abdominal parities, and viscera, forces them downward, so that we find the form in *at least eight cases in ten of our females*. Permanent atonic condition is the result [of the clothes]—the contents of the abdomen so far as permitted, follow the law of gravitation, pressing downward by their superimposed weight the pelvic organs—the perineum soon fails under performance of double duty and a diaphragm with

the thoracic viscera above, becomes also in no inconsiderable degree implicated in the general mal arrangement (Greene, 1856:3).

In addition to improper dress, Greene also faulted "sedentary habits" (which keep a woman from the exercise she needs to keep healthy), "laborious parturition" (or difficult childbirth), "miscarriages," and "hereditary tendencies" (such as cancer) as other possible causes of uterine disease. Thus, these sensible explanations indicate that not *all* members of the medical profession were completely influenced by social perceptions of Victorian women's health, perceptions which blamed either women's dysfunctional biology or their nerves and state of mental health for dramatically altering their physical health. Dr. Greene's writings, with others, indicated that there *were* very real, logical causes to women's uterine complaints recognized by at least some medical care providers at the end of the nineteenth century.

Unfortunately, however, very few, if any, physicians were able to break free entirely of the social constructions of women's health. Even enlightened, sincerely concerned doctors, such as Cordelia Greene, subscribed to the connection between women's health and cultural notions of women's role and characteristics. For example, one of the other causes of prolapsed uteri listed by her was "licentious excesses, within or without the pale of marriage." Thus, too much sexual activity—whether or not it occurred within the acceptable boundaries of marriage—was never healthy for women (this, of course, ties in with a key element of Victorian gender roles—the suppression of women's sexuality). "Masturbation, that evil of all evils" was another of her proposed causes of uterine disease. In fact, she portrayed both masturbation and an excess of sexual activity with a partner as having "fearful wages paid in untold sufferings" (Greene, 1856:6). This linkage between excessive sexuality and women's disease is reflected in almost all other medical texts of the period. Excess sexuality of any kind—masturbation in particular—was viewed as

being one of the primary causes of physical ailments in women, particularly hysteria. For example, a popular medical handbook attributed the causes of uterine disease, in addition to "improper dress," to "masturbation, and excessive coitus" (Danelson, 1874:604).

However, the single largest cause of uterine disease—at least as it was perceived by nineteenth-century physicians and medical writers such as Dr. Greene—was mental influences. Greene credited this as the leading cause of prolapsed uteri.

Mental influences are fruitful yet almost unnoticed sources of female diseases. The active, ardent, versatile nature of woman, is one which greatly needs the ballast of a purpose, a life work to do—in far too many instances has the early culture of our young females developed little else than a sickly sentimentality, and a nervous irritable, hysterical habit which is truly deplorable. We find this condition much aggravated in cases of those females who have unfortunately become victims of disappointment in marriage, of masturbation, or whose early associate influences or self culture have developed the passions unnaturally.

The excited imagination, left to prey upon itself, produces disordered functional action of the Nervous centers, and through them a weakened and debilitated condition of the sexual organs. Hysteria, though properly regarded as a disease of the cerebro spinal system, may be produced by reflex action (Greene, 1856:9).

### *Symptoms of Uterine Disease*

While there were wide variations, the symptoms of uterine disease were described consistent in most medical texts of the time. Symptoms were not restricted to pain and/or complications in the region of the reproductive organs—uterine disease could clearly affect the entire body. Once again, Greene's thesis provides the best available summary, especially because its language is consistent with that used in the MGH records.



Feelings of general languor and debility, with considerable nervous disturbance—obstruction of circulation, primarily of portal systems, Dyspepsia, Constipation and various biliary derangements, cold hands and feet—congestions of various organs such as the brain, liver, or uterus.

Prolapsed ani, hemorrhoids, frequent painful or profuse menstruation, extreme nervous irritability and depression of spirits, Irritability or curvature of the spine, spasms, dyspnoea, loss of voice, and not infrequently, a functional disturbance of almost every organ in the body, some of which, at a period more or less remote may result in fatal organic lesions. It is no uncommon thing to see patients confined to their beds for years (suffering under the name of Spinal disease, Decline, Consumption, etc.) from the causes we have been considering, until, from some secondarily induced disease, death comes to relieve them from the grievous burden of existence (Greene, 1856:12).

The symptoms of uterine disease were so varied that, basically, any physical malady experienced by a woman patient could be deemed uterine disease. It is no wonder so many women had it. In the MGH records, pelvic exams were given readily and routinely—even when a woman's complaints had little to do with her reproductive organs.

### *MGH Patients with Uterine Disease*

In the MGH records, how many women were diagnosed with uterine disease, either explicitly or implicitly by reference to reproductive dysfunction and/or a gynecological exam? At first glance there are not as many cases as one might expect—at least judging from the above medical descriptions of the disease. One would expect literally *all* female patients to be diagnosed with uterine disease if we followed the symptoms included in these writings. Yet, the number of cases of uterine disease in the records (70 cases total) is significant when positioned in the MGH context.

uterine disease:



- 14 cases of uterine disease (UD) in M1  
Thus, out of 44 women (the number of women patients in M1), roughly 32%, or 1 in 3 women were diagnosed with UD.
- 11 cases of UD in S1  
Out of 44 women (the number of women patients in S1 as well), that is exactly 25%, or 1 in 4 women.
- 21 cases of UD in M2  
Out of 54 women (the number of women patients in M2), that is roughly 40%, or 2 in 5 women.
- 24 cases of UD in S2  
Out of 55 women (the number of women patients in S2), that is roughly 44%.

A sizable number of cases in the MGH records, then, involved uterine disease. Between one-third and almost one-half of all women admitted to MGH were somehow diagnosed with uterine disease.

By the 1880s, more middle- and upper-class women were entering hospitals and MGH, more specifically. More prevalent in these classes were both hysteria and uterine disease. Reflected in both the MGH Annual Reports and materials on hospitals, at large, in the United States during this time, hospitals were being transformed from institutions serving the lower classes and poor to one serving the privileged.

One of the ways this can be seen in the MGH records is by the high number of references in M2 and S2 to patients who have previously consulted private physicians. These references are an indication of two things. First of all, if a patient had visited a private physician, chances are she was middle/upper class—otherwise, it is unlikely she (or her family) could have afforded the high costs associated with private health care. Second, these references indicate that more and more private physicians were viewing the hospital as a center not only of adequate but of superior health care. Otherwise, they would not send their patients to MGH. Examples from the case records are as follows. Each of these points to the rising expert reputation of

MGH within the Maine and greater Portland community. Private physicians were either sending patients they could not cure to MGH, or patients who could not find relief from private health care providers were turning to MGH.

- *Clara Davidson, a 21 year-old single woman admitted on February 28, 1878, for 28 days. General poor health—had pain in right iliac region and a "bearing down" feeling when standing. Has been treated by Dr. Pelstrom of Dixfield—wore a pessary for two weeks. A uterine exam reveals much tenderness in the cervix. Treatment: a glycerine pack on the vagina. Discharged April 11, fully cured.*
- *Melissa Kimball, a married woman from Lewiston, was admitted on March 21, 1878, for 56 days. Five years ago when drawing herself up by the hands and climbing into a loft, "felt something give way" in the pelvic region. Has had "bearing down," backache, and a burning sensation while urinating ever since. A doctor inserted pessaries for a while, but they did not relieve back pain. For several weeks she has had a cough and hemorrhages as often as every three weeks, spells which leave her "weak and trembling." Has been confined to the house for 2 years, not being able to walk during that time. She has consulted several physicians, some thinking spine affliction, others thinking the uterus and the kidneys. Is up only to have the bed made. She is treated with various medicines and glycerine packs. Also, the lining of the uterus is scraped with a curette to remove growths and promote heavy action. She is discharged improved with instructions to continue treatment at her sister's.*
- *Lucy Bracken, 41, married, admitted on October 24, 1881, for 25 days. Been sick 3 years since she miscarried. Since then, she has been habitually constipated. Frequent micturition [urination]. Pain in back especially when standing. Bearing down pains in loins. Has lost flesh. Examination reveals complete retroversion of the uterus. Her former medical attendant diagnosed her trouble ovarian tumor. [However, the idea of a tumor does not come up again in the record; the physicians treated her solely for a retroverted uterus—and, apparently, with great success.] 11-8: The uterus is held in place by a pessary and she shows rapid improvement. 11-21: She has shown wonderful improvement and begins to show flesh. She is also gaining in strength. Can stand on her feet—the first time she could walk in years. She has shown the results of medical treatment to a wonderful degree, being in fact a different person than when admitted. Discharged 11-18.*

As can be seen in this case excerpt, the MGH physicians took an entirely different treatment approach than did the patient's prior private health care

provider. The following is a case in which a private physician worked in conjunction with the hospital:

*Florence Hunting, 25, admitted on June 6, 1882, for 60 days. Was married 4 years ago. Her first child was born 11 months ago. She had a very long and precipitate labor and the cervix uteri was torn up to the cervico-vaginal junction on the left side. Soon after her delivery she had quite a severe attack of pelvic cellulitis and has had several minor attacks since. The uterus is now slightly retroflexed and enlarged. Her physician sent her here with the idea of restoring the lacerated cervix as soon as she is suitably prepared.*

*5-6: Medicines are ordered, hot injections twice daily, glycerine packs.*

*7-26: The local condition is much improved—there is almost complete absence of tenderness in pelvis, uterus is freely moveable.*

*8-5: Turned over to the surgical side to have her lacerated cervix repaired. Here a case of private physician working in conjunction with the hospital.*

The case of Eliza Blackman is a last example I provide here of a woman referred to the Hospital by a private physician, for treatment of uterine disease.

*Eliza Blackman, 20, from Castine, admitted on December 29, 1880 for 5 days. Was injured two years ago by a fall, she striking the tip of the coccyx. There were no immediate bad effects but soon she began to have much pain and tenderness along the spine. The points most tender are now in the lumber region and especially in the cervical region. She also has much pain through the abdomen extending up into the chest. Her attending physician thought there was a tumor in the pelvis. 12-30: Dr. Martin examined her but found no evidence of a pelvic tumor. [He disagrees with private physician] There is a derangement of menstruation, it being prolonged and very painful.*

*1-2: Dr. Briggs's service. Another examination was made but there were no signs of a tumor. Following a prescription, ordered a large quantity of medicines.*

*1-4: As there was no tumor, no evidence of an organic lesion of the spinal cord, her suffering due to a disordered treatment of the nervous system, Dr. Briggs decided that she was not a patient for surgical treatment. Transferred to the medical side.*

### **Medical Uterine Disease Cases—Vague Complaints**

"Uterine disease," as discussed and detailed in the medical records, involves vague sorts of complaints and treatments. The surgical records, in contrast, while

less descriptive, offer a view into the rise of surgical gynecology at the end of the nineteenth century. Uterine disease complaints were similar in the records: a bearing down pain in the back and loins, nervous prostration, weakness, pain in walking, leucorrheal discharge, painful menstruation, and so forth. Another common pattern was for a woman to come in with back pain, shoulder pain, or some other complaint, and be given a vaginal exam, apparently as standard procedure. Faced with a physical malady for which they might have no specific other diagnosis or treatment, doctors looked to some sort of reproductive imbalance or dysfunction. They then could follow the route of treating uterine disease as they had so often before with hot water injections, pessaries, and glycerine packs.

Perhaps the most startling reduction of a patient to her reproductive organs is found in the case of Ada Day, a 25 year-old who was admitted on October 29, 1880, for a 28 day stay. Her record began:

*Came in with eyes heavily bandaged, saying she was unable to bear the least bit of light and requested that a dark curtain be hung up in the window. Has been very nervous and feeble for the past 6 or 7 months. Dr. Briggs ordered the bandage to be taken from her eyes and the curtain to be removed. There is no inflammation of the eyes though there may have been and there is but little photophobia. Eyes are weak from long disuse. On examination Dr. Martin found a laceration of the cervix uteri.*

This patient came in with pain in her eyes. However, the physician evidently did not believe her and immediately had the bandage taken from her eyes. Instead of treating her for eye pain, he gave her a pelvic exam, as if some sort of uterine examination would lead to the source of her *actual* troubles—being *nervous and feeble*. We are left to speculate somewhat as to what is left out of the record. For example, Day may have indicated that she had been having pain in the uterine region. However, it is unlikely that this kind of uterine complaint would be omitted from the record if it had been reported by the patient. The woman's eyes

were not mentioned anywhere else in the record. Instead, the medical staff operated on the lacerated cervix with apparent "success"—*she heals nicely*.

Another example of a woman being diagnosed with some form of uterine disease after arriving at MGH with other complaints is Emma Lucas. She was a 25 year-old woman, admitted on May 9, 1877, for a month-long stay.

*For about one year she has had asthma which has been growing steadily worse and for a few months has been accompanied by a severe and painful cough. She is very much emaciated and weak—needs help sitting up. On examination the uterus is found to be four times its normal size, hard, light-colored, tipping slightly to right side. Diagnosis: subinvolution of the uterus.*

Lucas came in complaining of asthma trouble and received a diagnosis of uterine disease. It was as if the physicians assigned the cause of her asthma to her reproductive organ problems.

#### *Comparison of (Female) Uterine Disease Patients to (Male) Venereal Disease Patients*

The tendency to consider women's reproductive organs to be the cause of their physical problems was very common in the uterine disease cases. This pattern is particularly remarkable when the records of men in somewhat equivalent situations are examined. Venereal disease was the only circumstance in which men's health had the potential to be reduced to their reproductive organs in a way similar to the way women's ailments were defined as uterine disease.

#### *Venereal Disease: Historical Background*

The statistics on venereal disease in the nineteenth century reveal alarming rates of the illness. The city of Cincinnati, which instituted a system of medical

licensing and regular physician examinations in 1893, reported that half of the 625 licensed prostitutes were infected at least once during the year. Frederick R. Sturgis, reading a paper before the American Public Health Association in 1874, estimated that one out of every 18.5 persons in New York City was suffering from syphilis. In another paper read before the American Medical Association meeting in Detroit, a doctor claimed that one out of every 22 persons in the United States was syphilitic. Statistics drawn up by the Army and Navy were no less encouraging (Haller and Haller, 1974:258).

It was noted all over the country that men were not particularly healthy, and that there was an extremely high incidence of venereal disease (VD), particularly among enlisted men. By the 1850s, the incidence had grown alarmingly—in the Army, one-third of medical cases were related to VD. While the armed forces tried to constrain men's sexual urges by diverting their attention with "sports clubs," extra drilling, and the like, the numbers continued to rise and cause concern. The Army did not want to lose man-hours to sexually-transmitted diseases. Aside from just man-hours lost, however, Victorians, in general, were alarmed by the idea of sexuality running rampant. One can imagine that venereal disease would be as concerning as were issues of women's sexuality.

During this era, the rise in VD cases led to "social hygiene" campaigns in both the United States and England. Prostitutes were often targeted as the primary carriers of venereal diseases. As "fallen women," prostitutes would never achieve the ideal of Victorian Womanhood. Some opponents of the social hygiene campaigns, often feminist reformers, criticized the sexual double standard: targeting prostitutes allowed men to sidestep their responsibility in the rampant spread of VD. However, what about "regular" Victorian women—the wives of some of these men? Were they considered to be vulnerable to or infected by venereal diseases?

Both popular and medical literature portrayed VD almost entirely as a male disease. This was, in part, because until late in the nineteenth century, physicians had no clear understanding of the nature and/or cause of gonorrhea. Doctors often confused symptoms of minor infections with those of gonorrhea, they were slow to recognize that the disease was in fact venereal. One physician insisted that there were two kinds of gonorrhea—one venereal and one not dependent on sexual intercourse (Stage, 1978:82). Medical writers from the ancients through much of the nineteenth century attributed the less virulent forms of venereal disease to such phenomena as gout, rheumatism, bladder stones, exposure to dampness, the overuse of snuff, Spanish flies, uncleanness, and even the cutting of a tooth. Physicians throughout most of the Victorian Era held that gonorrhea could be contracted from sexual relations between previously uninfected partners, even between married couples who remained monogamous. It was thought by some that intercourse during menstruation could lead to the severest form of gonorrhea. For example, Danelson (1872:72), in his medical guide written for general households, wrote:

In the majority of cases, [gonorrhea] follows connection [euphemism for sexual intercourse] with one so affected, but not invariably. The exceptions occur when the urethra is uncommonly sensitive and arises from mechanical injury from the use of catheter, from intercourse during the menstrual period and acrid leucorrheal discharge.

#### *Physicians' Connection to Venereal Disease*

From the fifteenth through most of the nineteenth centuries, much of the odium connected with venereal disease extended even to the medical men who treated it. "As a consequence," wrote one doctor in 1895: "This department of medicine was largely relegated to the charlatan, who, under the control of ignorance and avarice, contributed to the exaggeration and confusion which still cloud the



minds of many when they consider the subject" (Hyde and Montgomery, 1895:18). Statistics on venereal disease during the nineteenth century were sometimes grossly inaccurate since they did not take into account the fact that most public institutions, except those which made a specialty of dealing with the "private disease," held it to be a disgrace to treat venereal patients (Rosenberg, 1987:23). For example, many hospitals in New York and elsewhere had rules prohibiting the treatment of gonorrhea or syphilis. There is no way to know whether or not MGH treated VD patients as if they were afflicted with a disgraceful condition but the records indicate that men admitted to the hospital were infected with venereal disease.

The "pox doctors" who treated men for gonorrhea and syphilis often conspired with their patients to keep the nature of the illness from the men's wives and fiancées. Secrecy was the stock-in-trade of these physicians, who all too often came from the seamy underworld of medicine (Haller and Haller, 1974:263). But honest physicians, too, participated in the conspiracy of silence. A course of treatment usually lasted for two or three months, during which time the initial symptoms disappeared. The doctor then declared his patient cured, free to marry or to resume sexual relations with his wife. Believing, as they did, that gonorrhea could be effectively cured, they had no reason to suspect that a man still could infect a woman.

Until 1879, when the gonococcus was identified as the infecting agent, physicians did not diagnosis gonorrhea with any accuracy. In 1876, German émigré Emil Noeggerath had angered members of the newly formed American Gynecological Society by insisting that ninety percent of sterile women suffered from gonorrhea they had contracted from husbands who often had been treated for the disease and pronounced cured by their physicians. Since women often presented no symptoms in the early stages of the disease, the infection passed unchecked through the womb to the Fallopian tubes and peritoneal cavity.



Noeggerath tried to convince American physicians that gonorrhea presented a "latent" period in men, during which they were asymptomatic but still able to infect their wives. This period of latency, he argued, explained why so many healthy, blooming young women began to suffer with female complaints shortly after they married and why so many wives remained childless.<sup>8</sup>

Many doctors, however, believed gonorrhea to be a relatively trivial problem among women. The leading figures in American gynecology proved neither ready nor willing to accept the implications of Noeggerath's research. In the remarks that followed his address, physicians sought to avoid the burden of male responsibility by insisting that gonorrheal infections resulted not only from contact with a diseased partner, but also from crowded city conditions, excessive masturbation, or exposure to the cold. However, Noeggerath's claims were soon given stronger backing. In 1879, the German physician Albert Neisser succeeded in identifying the gonococcus under the microscope. Doctors soon learned to recognize and diagnose gonorrhea which, as Noeggerath had predicted, retained its infective power long after its acute symptoms had passed (Stage, 1979:82).

### *Medical Constructions of Venereal Disease*

While studying and recording the MGH records, I saw that only men were diagnosed with venereal disease and surmised, for a time, that the doctors had not understood that women could contract venereal disease. However, when I reached record 392 (out of the total of 400), I found a woman patient who *was* diagnosed with syphilis (explored further below). This pointed to developments in the medical

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<sup>8</sup> In *For Her Own Good*, Barbara Ehrenreich and Deirdre English (1979:134) discussed how the American birth rate, at least for whites, shrank by half from 1800 to 1900. While this decrease was certainly not due entirely to VD-induced sterility in women, there was certainly a connection.

world and, in particular, among the staff at MGH: the understandings of VD had shifted and venereal disease was understood as affecting women, not only men. Also, as I later discovered, medical texts, while listing the disease under men's disorders, indicated in subtle ways also that women could be afflicted. For example, in *Dr. Danelson's Counselor*, venereal diseases were listed under the heading "Genetic Diseases of Men"—which included "Emissions, Continence, Spermatorrhea, Impotence, Inflamed testicle/swelled testicles, Varicocele, Clap/gonorrhea, Stricture of the Urethra, Circumcision, and Pox/syphilis." But there was reference, as well, to women's vulnerability (emphasis mine):

CLAP—Blenorrhea, Gonorrhea, Bubo

This is an infectious disease, consisting of a catarrh of the urethra (the discharge pipe of the urine) *in either sex* attending an inflammation of the mucous membrane lining the canal. *It affects also the prepuce in the male and the vagina in the female.* In the majority of cases it follows connection with one so affected, but not invariably. The exceptions occur when the urethra is uncommonly sensitive and arise from mechanical injuries from the use of a catheter, from intercourse during the menstrual period and acrid leucorrheal discharges (Danelson, 1874:74).

Danelson (1874:75) also described one of the tertiary symptoms of syphilis as "loss of virility, abortion—if gestation occurs—and transmission of the disease in all its vigor, if offspring is born alive." ("Abortion" in this sense referred to both spontaneous and induced, and was synonymous, therefore, with "miscarriage" and "premature labor.") Even though it had become medically accepted that women were capable of acquiring and showing its signs, physicians seemed to resist connecting venereal disease with women. For example, in Danelson's section, "Genetic Diseases of Women," gonorrhea or syphilis were not mentioned, whereas they had been under this category with respect to men. The titles, or "diseases," cited under the heading of "Genetic Disease of Women" (each of which had its own accompanying section) provide an interesting glimpse into constructions of Victorian women's health, even as they overlooked venereal disease:

Love, Puberty, Chastity, Wedding Journey, Objections to Maternity Considered, Maternity, Signs of Pregnancy, Diseases of Pregnancy, Labor (Parturition), Abortion-Miscarriage-Premature Labor, Childbed Fever—Puerperal Fever, Puerperal Convulsions, Amenorrhea (Suppression of the Menstrual Flow), Painful menstruation—Dysmenorrhea, Vulvitis (Danelson, 1876:2).

#### *MGH Patients with Venereal Disease*

venereal disease:

- 3 cases in M1; 3 men  
1 case of gonorrhea, 2 cases syphilis
- 6 cases from S1; 6 men  
4 cases of gonorrhea, 2 cases of syphilis
- 6 cases from M2; 6 men  
1 case of gonorrhea, 5 cases of syphilis
- 3 cases from S2; 2 men, 1 woman  
1 case of gonorrhea, 2 of syphilis

18 cases total; 17 men (94%), 1 woman (16%)

Indicated in these data is the fact that there was no major change in the number of venereal cases between the early and later records. The proportion of patients diagnosed with VD remained consistent over time.

Seventeen cases of venereal disease out of the 200 male case records, or one in twelve men, puts the percentage at 8.5. This is even higher than the figures offered by Sturgis in 1874: that one out of every 18.5 persons (5.4 percent) in New York City was suffering from syphilis or, as suggested by another doctor, one out of every 22 persons (4.5 percent) in the United States (Haller and Haller, 1974:258). Also, 17 cases of venereal disease among this sample of men patients at MGH is probably an underestimate. For example, several men came into MGH with stricture of the urethra, perhaps a sign of gonorrhea or secondary and tertiary syphilis which was

not diagnosed as such. We have no way to know if the hospital turned away venereal disease patients. Clearly, unlike New York Hospital, MGH did not have a blanket rule which prohibited the admittance of any patient with a VD. But men with severe cases of VD may have been turned away because late-nineteenth century physicians were still unclear on issues such as the contagion of venereal disease. Thus, it is likely that MGH staff members were concerned about patients severely affected with venereal disease passing it on to the other patients. With respect to the extensiveness of the disease state-wide, these figures are probably underestimates. Middle and upper class people suffering from venereal disease were likely to seek medical treatment from private physicians, not from those in a public institution, and so were less likely to show up in official public health figures.

Furthermore, what is perhaps more important to note than the number of cases is the comparison of men and women diagnosed with venereal disease. These figures represent a ratio of *seventeen to one*—this is the largest discrepancy between sexes of any category examined in the records. (Of course, no men were diagnosed with uterine disease or hysteria, but that's because these disorders were purely "women's diseases".) Also, the medical approach taken to assess and treat the VD cases, compared to the approach to uterine disease cases, needs consideration. As we have already seen with hysteria and uterine disease patients, a woman often did not have to make any sort of complaint about her reproductive organs in order to receive a vaginal exam. In fact, it was extremely rare that a female patient with some sort of vague neurological complaint *did not* receive an exam of her reproductive organs. Furthermore, when a female patient *did* express specific uterine complaints, attention to her reproductive organs was almost constant. Doctors experimented with different-sized pessaries, glycerine packs, and iodine on the cervix, as well as made continuous notes regarding the woman's point in the menstrual cycle, the position of her uterus, and so forth.

One would imagine that venereal patients, though fewer in number than uterine disease and hysteria patients, would have received a similar approach from the physicians, seeing as how the disease was contracted through and often manifested itself in the sexual organs. However, this was not the case in the MGH cases—nor in the medical world, at large. For example, in the Army and Navy, even though large numbers of men were out of commission with venereal disease, military medical staff did not examine soldiers' genitals—this, after all, was considered a robbing of their manhood. This also appears to have been the attitude of doctors at MGH, based on notations in the records. Sometimes men who mentioned that they had a venereal disease never even received a genital exam—at least, no genital exam was recorded (while vaginal exams, on the other hand, were always noted).

Patient Charles Marshall is one example. He was a 31-year-old seaman from New Jersey who was admitted on July 20, 1875, for a 27-day stay. While bathing in the water, Marshall felt his body growing cold and numb. Several hours later, he was unable to move about without support. Upon admittance to MGH, he could *not bear the least weight on his feet*. According to his case history, Marshall informed the physician that *he has been a healthy man but has had gonorrhea about 20 times*. One would think this information supplied by the patient immediately would have warranted a genital exam. However, nothing of the sort was mentioned, nor is there further mention of the gonorrhea in the record. His treatment was Floral extract of ergot, to be given every four hours. He was discharged after 27 days (once his knees gained in strength).

Another example of a male patient having mentioned a history of venereal disease but apparently not receiving treatment is Timothy Cohen. He was a sea captain (age and marital status not noted) who was admitted on August 16, 1881, for *acute rheumatism*. Far down in his case record the following note was made: *Ten*

*years ago he had syphilis followed by secondary symptoms. For the past two years he has been troubled more or less with pain in limbs which has been promptly removed by Iodide of Potassium.* No mention was made of a genital exam, and syphilis was not mentioned again. Cohen improved and was discharged after 35 days.

Two issues are of particular interest in this record. First of all, secondary syphilis is often marked by joint pain, which is also a sign of rheumatism, according to twentieth-century medical knowledge. Thus, we now know that there was a very good chance that this man's rheumatism was actually a secondary symptom of the syphilis. Secondly, the venereal disease was mentioned about three-quarters of the way into the record, as if it had only a casual connection to his sickness and convalescence. There are several records like Cohen's among the venereal disease patients, more or less ignoring the venereal disease condition and reports. This simply would be unimaginable in a case of a woman complaining of a uterine problem, or even a non-uterine problem: she, as the records indicate happened time and again, would have received a vaginal exam immediately. Whereas a woman's ill health was seen as stemming from malfunction of the reproductive organs, men's sickness—even when related to venereal disease—was seen as completely separate from his reproductive organs.

In the 392nd (out of 400) records I examined, a woman was finally diagnosed with venereal disease. This suggests that by 1881 the medical world, in general, and the MGH staff, in particular, were finally beginning to acknowledge that women could acquire the disease. The patient, Gloria Dowd, a 32 year-old married woman, was admitted on February 10, 1881, for a two day period. Of particular interest in her record is that it reads like a standard case of uterine disease until the very last line; particularly noteworthy is the syntax of the patient history: *Duration of the disease 6 years. Married 13 years. Has four children.* By indicating that Dowd contracted

syphilis seven years into her marriage, the writer was likely implying that her husband was responsible for giving her the disease. Also, by then mentioning that they had four children, the writer may have been indicating that the children may have suffered negative consequences from their father's actions as well. Perhaps of even greater interest in the record is the fact that, unlike her male counterparts who were diagnosed with venereal disease, Dowd's reproductive organs were both examined and treated. In fact, the physicians treated her by treating her reproductive organs. Her record reads:

*Began to have pain in head and circumscribed bunches appeared on forehead and on limbs—but did not suppurate.<sup>9</sup> Has been much troubled by sore throat. For some time was confined to her bed but now is feeling better. Has had some inflammation of vagina and now complains of displacement. 2-11: Dr. Greene examined the patient. Uterine examination discovers a retroversion of the uterus with evidence of periuterine inflammation. Introduced a retroversion pessary and advised her physician to follow an antisyphilitic course of Iodide of Potassium.*

The most concerning aspect of this record is how the physicians portrayed the syphilis as taking form in her reproductive organs: displacement of the womb, retroversion of the uterus, and periuterine inflammation. These symptoms are suspiciously similar to many of the cases of uterine disease.

### ***Women in the MGH Records who may have had Venereal Disease but were not Diagnosed as Such***

Florence Spaulding was a 25-year old married woman admitted to MGH on June 6, 1882, and diagnosed with a *severe case of pelvic cellulitis. The uterus is now slightly retroflexed and enlarged. Uterus is now moveable but she has considerable*

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<sup>9</sup> "Bunches" or growths such as this, which suppurate, or drain with pus, are often a symptom of syphilis (Higgins, 1997).



*periuterine inflammation*. While this description is almost identical to the symptoms suffered by the above female syphilis patient, venereal disease was not mentioned anywhere in Ms. Spaulding's record. Several other cases of women whose uterine disease was described in very similar terms are seen among the sample of records, as well. It is more than likely that such women were actually suffering from venereal disease but were not diagnosed with it.

Another possible indication of women in the MGH records having venereal disease is the syntax in records connecting marriage with the onset of uterine disease. Other researchers have noted how often Victorian women's health seemed begin deteriorating upon marriage; much of this dilapidation, they believed, had to do with the fact that new wives caught venereal disease from their husbands. Indeed, in 1876, Noeggerath argued that ninety percent of sterile women suffered from gonorrhea contracted from husbands who often had been treated for the disease and pronounced cured by their physicians. Latent gonorrhea in men, he held, explained why so many healthy, blooming young women began to suffer with female complains shortly after they were married and why so many wives remained childless. An interesting statement appears in some of the medical uterine disease records—a statement linking the women's time of marriage with the onset of their uterine disease symptoms. A sampling follows:

- Vera Brown, a 29 year-old married woman was admitted on August 21, 1877 with a tumor on the left side of her uterus. One of the first lines on her record reads: *Patient has always been well up to the time of her marriage.*
- Maggie Harding, a 28 year-old married woman, was admitted on September 8, 1881 with *leucorrhea* and an os that was found *enormously hyperlapsed and hypertrophied*. Her patient history reads: *Duration of illness seven years. Been married eight years. No children and no miscarriages.*
- Lizzie Fairbrother, a 24 year-old married woman, was admitted on June 17, 1882 with *pain in pelvic, back, and limbs, some leucorrhea, and rather painful menstruation*. Her history reads: *Married for five years. Before that her health was good. Had a miscarriage four years ago when three months*



*advanced and then followed the symptoms of uterine disease which have continued up until the present time.*

It is impossible to say whether or not the onset of these women's illnesses was actually a direct result of the women acquiring venereal disease from their new husbands. For example, in Lizzie Fairbrother's case, the writer's comments lead us to believe that the miscarriage was what caused Ms. Fairbrother's uterine disease—not sexual intercourse within the marriage. (Nonetheless, the syntax of her patient history is hard to ignore: *Married for five years. Before that her health was good.* Furthermore, in Maggie Harding's case, both childbirth and miscarriages were clearly discounted as potential causes of her illness.) Even though the association between marriage and venereal disease is impossible to trace directly in the records, the occurrence of marriage and its possible role in these women's states of health is an interesting one to consider. And whether or not women's sickness was directly connected to marriage, experts hold that uterine disease was often a misdiagnosis of women who were likely to have actually had venereal disease. For example, Stage (1979:8) argued that many of the medical problems surrounding women's reproductive organs were actually venereal-based but not recognized as such:

The diseased ovary and suppurating fallopian tube were all too familiar to surgeons who treated women's diseases. But they did not, as so many doctors claimed, result from late hours, unnatural habits, brain work, or sexual excess. They resulted from venereal disease. Gonorrhea accounted for many of the commonest complaints that brought women to the gynecologist—vaginal discharge, backache, painful menstruation, abnormal uterine bleeding, incapacitating pelvic pain, and barrenness.

Indeed, leucorrhea, "bearing down" pains in back and loins, painful periods, and debilitating pelvic pain are symptoms that appeared repeatedly in the MGH uterine disease records.

Venereal disease in women spreads quickly from the vagina up into the uterus and the fallopian tubes and into the peritoneal cavity, potentially causing

chronic pelvic pain, painful menstruation, heavy bleeding, and sterility (Higgins, 1997). In the nineteenth century, surgical gynecological procedures such as hysterectomy, ovariectomy, and salpingectomy (removal of the fallopian tubes) were the only treatments for these unending cycle of illness and acute pelvic pain (Stage, 1979:8). Surgery succeeded where all else failed, removing the site of infection. Effective medical, non-surgical treatment came with the advent of sulfa drugs in the 1930s. Roy (1990:191) explains that surgery to reposition the uterus remained one of the most frequently performed gynecological procedures throughout the nineteenth century. "Unfortunately," however, she writes, "physicians did not realize many of these symptoms resulted from the effects of sexually transmitted disease, especially gonorrhea." By the turn of the century, medical research revealed the serious cost of venereal disease to women, resulting in infertility and chronic invalidism; gynecological surgery offered these women the chance to return to a normal life.

How many cases of uterine disease in the MGH records were actually misdiagnosed venereal disease is a question we cannot answer. However, it is probable that a significant portion of uterine disease cases were actually venereal-disease-related. At least four of the male venereal disease patients married (and for another three VD patients, marital status not noted). One can assume with some confidence that these men's wives also had the disease and would thus need to seek treatment. Also, the descriptions of uterine disease patients' complaints and symptoms seem far too similar to descriptions of venereal disease to discount this possibility. Furthermore, the rise of uterine-related surgery in the records over time may be an indication of venereal disease conditions as women sought relief from symptoms.

The rise of gynecological surgery was not related only to venereal disease, however. Surgery was one of the keystone ways in which gynecology gained

momentum and prestige as a medical specialty. In fact, surgery led, in many ways, to the founding of gynecology.

### *Historical Background of Surgical Gynecology*

Gynecology was born in 1809, when Dr. Ephram McDowell performed surgery on a woman and successfully removed a fifteen-pound ovarian cyst. Word of this amazing feat spread, and speculation arose as to what other surgery was possible on women's reproductive organs. The next major boost to gynecological surgery came in 1852. At this time, one of the most painful conditions that a woman could experience was a vesico-vaginal or recto-vaginal fistula, which involved a tract between the vagina and the rectum or bladder. The fistula was caused by a tear between the vagina and bladder or rectum during long or difficult labor, and was a common childbirth outcome. Women so afflicted endured lifelong incontinence; the constant drip of urine from the vaginal opening resulted in tremendous pain, severe skin irritations, odor, and, social ostracism (Higgins, 1997). The physician considered to be the "father of gynecology" (Roy, 1991:174), Marion Sims, sought a surgical technique to successfully close this fistula. In 1840, a slave owner with a slave-woman suffering from a vesico-vaginal fistula approached Dr. Sims. Soon thereafter, Sims had "collected" four other slave women with the same disorder. He experimented with his "cure" on these women, keeping them housed in a small building (which he called his "hospital") in his backyard and operating on them repeatedly over the course of four years. He operated upwards of thirty times on one slave alone. Eventually, Sims devised the procedure of using "silver sutures" to close the fistula and, as they did not cause secondary infections, concluded this approach was highly successful. In publishing the results of this surgery, Sims was positioned at the forefront of a new medical specialty called "gynecology." His

newly acquired prestige led him to open the "Women's Hospital" in New York City, and his interventionist experimental attitude followed him into the hospital setting. His hospital served mostly Irish women who were poor and treated at no cost if they consented to being experimental patients. One patient, Mary Smith, underwent thirty surgical procedures in thirty years.

Sims's attitude toward surgical subjugation of women was also reflected in the world of medicine as a whole. The development of surgical gynecology introduced a new approach to health care for women. Beginning in the mid- to late-nineteenth century, certain physicians proposed surgical procedures to investigate and cure pathological conditions of the female reproductive organs. As long as these organs remained hidden from view inside the body, both normal and abnormal functions elicited speculative and sometimes fanciful explanations (Roy, 1991:178).<sup>10</sup> According to accepted nineteenth-century medical theory, the female generative system affected all other parts of the body through its contact with the sympathetic nervous system. Thus, headaches, nervous complaints, and dyspepsia could be caused by menstrual difficulties or a retroverted uterus. Gynecologists urged women to consult them for any illness since, as "specialists", they possessed expertise in treating the organs ultimately responsible for the symptoms (Ricci, 1945:3). This focus on surgery as a way to combat women's neurological imbalances became particularly common by the end of the nineteenth century. In fact, Ricci (1945:3) discussed the "rapid increase in surgery during the 1870s and 1880s as an era of 'pelvic surgery gone wild'."

Initially, practitioners of the new specialty referred to themselves as "woman's doctors," in order to differentiate their field from obstetrics. By the 1870s, however, both the physicians and their patients used the more "scientific" term

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<sup>10</sup> The Greeks, for example, attributed certain female illnesses to hysteria—or as it meant originally, "traveling womb."

*gynecologist*. Over the next fifty years, the new "woman's doctors" extended the range of their operations from the repair of childbirth lacerations to uterine displacements and menstrual irregularities and, ultimately, to the "capital" operations of ovariectomy and hysterectomy. Gynecology thus thoroughly adopted a specific medical technique, surgery, to attack specific functions of the female reproductive system, reinforcing the surgical interventionist approaches taken towards female patients by doctors and in hospitals such as Sims's.

This surgical, gynecological manipulation of women is seen more often in accounts such as Dr. Sims' than in the MGH records. Nonetheless, reviewing the history of gynecology points to the impulse at work behind the rise of uterine-related surgery in the late 1900s. The staff at MGH probably could not have helped but be influenced by these prevailing surgical attitudes. Indeed, there is a significant rise in gynecological surgery during this time in the MGH records as well.

### ***MGH Surgical Records and Uterine Disease***

In the MGH records, there were not staggering numbers of hysterectomies, salpinxectomies, ovariectomies, or other drastic operations that marked some of its counterpart hospitals of the time (Rosenberg, 1987). The most commonly performed procedures were low-scale-intervention operations, such as perineorrhaphy (suture of the perineum, performed for the repair of a usually childbirth-caused laceration), and the suture of pelvic abscesses. However, the rise of gynecological surgery is nonetheless evident in the records. This increase had to do with several factors. First of all, there was the influx of middle and upper class women into MGH over time, and part of this influx was a result of the surgical procedures offered by the hospital. The hospital was becoming both the most fashionable and most medically-advanced treatment center for an upper-class

woman with uterine disorders—especially if those disorders were operable. The inflation of uterine-related surgery at MGH also reflects national trends of the time. Uterine disease cases in S1 and S2 fell into the following categories:

- 11 cases of UD-related surgery in S1  
Out of 44 women (the number of women patients in S1), that is 25%, or 1 in 4 women.
- 24 cases of UD-related surgery in S2  
Out of 55 women (the number of women patients in S2), that is roughly 44%.

The increase from 25 percent to 44 percent represents a change of nearly 20 percent. In the medical cases of uterine disease, there was not nearly as much of an increase over time (from 32 to 40 percent). The above numbers indicate that, in 1880-82, almost half of all female patients on the surgical side had gynecological-related surgery. Much of this information is available in the Annual Reports as well. For example, the 1875 Annual Report indicates that 19 out of the 54 surgical operations on women (35 percent) were uterine-related. In 1880, that figure rose to 27 out of 70 (39 percent), and in 1881, to 50 out of 99 (51 percent).

Not only do the number of cases increase, but the types of surgery intensify as well: far more radical surgical operations are noted in the later records. The Annual Reports provide the number and types of gynecological surgery for most years. Those during the period of 1875 to 1881 were:

- 1875—19 cases total:  
2 cases of lacerated cervixes, 2 cases of ovarian tumors, 9 cases perineorrhaphies, 3 cases of polyps of the uterus, 1 case of polyps of the urethra, and 2 cases of womb-related tumors.
- 1881—50 cases total:  
9 recto-vesico fistulae, 3 vesico-vaginal fistulae, 10 cases of lacerated cervixes, 7 perineorrhaphies, 5 cases of uterine cancer (in which growths were removed), 1 case of vulva cancer (growth removed), 3 cases of uterine fibroids, 2 *hysterectomies*, 1 *removal of uterus and ovaries*, and 8 *ovariotomies* (emphasis mine).

No operations to remove entire reproductive organs occurred in 1875, but in 1881 there was a total of two hysterectomies, one total hysterectomy (removal of uterus and ovaries), and *eight* ovariectomies. Clearly, then, gynecological surgery was on the rise—both in terms of numbers and degree—within the MGH setting, at the same time that such surgery was sweeping hospitals and private practices across the country.

MGH hardly seemed concerned with this inflation of gynecological surgery. In fact, based on the Annual Reports, it appears as if the hospital was proud of its ability to introduce and utilize new surgical techniques and procedures. Surgery was considered a far more prestigious and glamorous practice for the hospital physician than the administering of care, for example, for rheumatism or dysmenorrhea sufferers in the medical unit. As the public generally shared this pro-surgery view, the rise of surgery, in general, was used to gain outside philanthropic support for the hospital. In the early Annual Reports of the hospital, which were published in part as a fundraising effort, one of the highlights was the outlining of surgical activities, titled *The More Important Surgical Operations Performed at the Maine General Hospital During the Year*. Another possible reason that MGH took such pride in its surgical practice was that, for the most part, surgical operations were successful. And while there were also success stories within the medical unit, there were many medical patients (a large majority of whom were uterine disease patients) who left the hospital only slightly improved, if at all.

### ***Differences Between Medical and Surgical Uterine Disease Records***

In almost all of the surgical uterine disease cases, there was no way for the patients to make up, imagine, or exaggerate their ailments. Maladies such as

tumors, torn perineums, and pelvic abscesses are all tangible ailments which cannot be created out of will or be exaggerated by a condition such as nervousness. In fact, there was little, if any, mention of nervousness (and, as we have seen, *no* mention of hysteria) in the surgical records. In S1, nervousness was not mentioned at all; in S2, it was mentioned in four of the 55 women's cases; in contrast, there were six cases of nervousness in M1 (out of 44 women) and nine cases in M2 (out of 54 women). Furthermore, when these vague nervous complaints or symptoms did come into the a surgical record, the record seemed out of place among the others. Surgical patients who were not rapidly "cured" by surgery also appeared out of place among the others. In some of these cases, the patient was transferred over to the medical unit, especially once the person exhibited signs of nervousness or other neurological disorders.

Patient Clara Stimford was a 20 year-old who was admitted on December 12, 1880, for a five day stay. She had been injured two years previous by *a fall*, striking her tailbone. Although there had been no immediate negative effects, soon *she began to have much pain and tenderness along the spine*. She also experienced much pain through the abdomen, extending up into the chest. As her former private physician had surmised that there was a tumor in her pelvis, Stimford was assigned to the surgical unit and the physicians looked to the tumor as the source of her troubles. However, on December 30, the doctor found no evidence of a pelvic tumor in his examination of her. Yet there *was a derangement of menstruation, it being prolonged and very painful*. Another examination was made but there was again no sign of a tumor—and thus, nothing on which to operate. Then on January 4, the following note was made:

*As there was no tumor, no evidence of an organic lesion of the spinal cord, her suffering due to a disordered temperament of the nervous system, Dr. Briggs decided that she was not a patient for surgical treatment. Transferred to the medical side.*



Once it was determined that the patient's trouble was caused not by an operable tumor but by a *disordered temperament of the nervous system*, Ms. Stimford was transferred to the medical unit. This record illustrates the MGH staff's perception of which uterine disease patients were "appropriate" for surgery and which were not.

A final illustration of the medical/surgical uterine disease distinction is Abbie Browning, a 43 year-old woman admitted on October 19, 1880, for four-and-a-half months. Browning suffered from *continuous menstrual flowing caused by fungus growths in the uterus*. *Often-times the bleeding is quite profuse*. In her record, there were descriptions of weakness and debilitation; such notations were a rare occurrence in the surgical records. She also showed symptoms of nervousness—even after the uterine growths had been surgically removed with a curette. For example:

*11-12: She has kept to her bed the larger part of the time and is gaining strength daily. As she does not sleep well nights, ordered Potassium Bromide.*

*11-26: Is much troubled with palpitations of the heart. Another medicine given.*

*11-30: She has a very nervous spree this evening. Gave her Potassium Bromide and repeated in 2 hours, which finally quieted her.*

Some of the diction in this passage is particularly notable: potassium bromide finally *quieted her*. Generally, the use of potassium bromide was quite rare in the surgical records. In December, Browning had an operation to remove the uterine growths yet again. However, her symptoms of nervousness and debilitation continued and she became worse:

*1-19: She is now in a very weak, anemic condition. She has so little strength that she can scarcely cross the ward without her cane. Her nervous system is in poor condition, she being easily excited and troubled greatly with insomnia.*

The physicians tried one more time to remove the growths and, thus, her nervousness. They also introduced a glycerine pack to her vagina. However, the repeated surgery and new treatment were of no avail. The note on March 11 read:

*During the past 2-3 weeks there has been considerable nervous disturbance manifested by loss of memory and lack of coordination of muscles. Patient walks with an unstable gait. Inability to talk plainly or express ideas. Transferred to the medical side.*

These two cases illustrate that patients who showed either signs of nervousness or lack of improvement were not considered suitable for the surgical side; patients were almost always "cured" in this unit. In fact, the only situations in which surgical UD patients left MGH "uncured" was if they had some sort of malignant disorder—or, as above, if they were transferred to the medical unit. After all, it was the medical side where women with vague complaints and lack of medical improvement belonged.

### ***Medical Uterine Disease Cases: The Success/Failure Distinction***

However, not all medical cases of uterine disease were unsuccessful. In fact, there were several medical uterine disease patients who had amazingly rapid recoveries. For example, take Rebecca Rhodes, a 41 year-old married woman who was admitted on October 24, 1881, for 25 days. *Been sick three years since the time she miscarried. Since then, pain in back especially when standing, bearing down pains in loins, and lost flesh.* As usual, the doctors turned to her uterus to explain these typical "female complaints": *Examination reveals complete retroversion of the uterus.* She was given a retroversion pessary, which immediately gave her great relief.

*11-8: The uterus is held in place by the pessary and she shows wonderful improvement. Can stand on her feet—the first time she could walk in years. She has shown the results of medical treatment to a wonderful degree, being in fact an entirely different person than when admitted.*

Another example is Sarah Gerring, a 22 year-old single woman, admitted on May 22, 1882, for only three days. Ms. Gerring had *had uterine sickness for two years. Has headaches, backaches, pelvic pain, and dragging. Rather profuse leucorrhea.* She also exhibited the common debilitation symptoms that led to a vaginal exam.

*Vaginal examination shows marked anteversion of the uterus. Introduced a Thomas retroversion pessary and patient affirmed she had immediate relief. 5-25: Patient says she feels like a new person. Went home to continue treatment.*

Ms. Gerring was there for only three days, yet she "feels like a new person."

There is a likely chance that treatments such as pessaries and glycerine packs actually worked with many women. However, the speed with which some of the women moved from complete invalidism to perfect health gives reason for pause. The possibility needs to be considered that such women were perhaps dependent on the male-dominated medical field to convince them of their own cure or health.

Far more concerning than rapid-success cases, however, are the uterine disease patients whose health failed to improve. Take, for example, Viola Harding, a 21 year-old single woman admitted on January 13, 1876, for almost ten months. Her record at first sounds very similar to the above women's: a poor health history which led to a vaginal exam and a diagnosis of uterine complication. The record indicates that:

*Her health has been impaired for the last 18 months. Part of the time she has been obliged to keep in bed. The disease is referred to the uterus and upon examination Dr. Hatch finds that organ is congested.*

She was ordered to take medicine at night and have a glycerine pack applied to the womb daily. However, the treatment did not appear to work. A sampling of the case notes follows:

*4-29: A vaginal exam is made today and the uterus is found to be prolapsed. The parts are found very much congested and are tender to the touch. Cervical endometriosis is found to exist and the os is closed so a sound cannot be passed into the uterus. She suffers much pain all the time, in the back and abdomen.*

*6-1: Is kept in a recumbent position most of the time. Suffers greatly.*

Over the months, the notes were made at increasingly longer intervals. Harding stayed on at the hospital throughout the entire summer and into the fall with no significant improvement. On November 4, the following note was made: *Patient is discharged today, not well but improved in general condition.*

A final example of a uterine disease patient who failed to improve under MGH's care is Jennie McLeod, a 37 year-old married woman who was admitted on March 15, 1876, for about three months. Her vague uterine complaints were: *pains in loins, severe pain in the back and left side. Bowels constipated. On examination the vagina and uterus are found to be congested and very tender to the touch.* She was treated with a cotton pessary moistened with glycerine, and twice daily vaginal injections of warm water. However, these treatments led to little improvement:

*4-29: There has been little change in her condition—only the symptoms are less severe. On examination the organs feel a bit healthier.*

*5-10: A pessary is introduced but offers no relief.*

*6-10: She says she suffers from pain nearly all the time but no cause for it can be found and no treatment appears to be of avail. Discharged today.*

These three women, all of whom the MGH staff appeared to give up on with respect to medical treatment, are a far cry from the other cases in which the insertion of a pessary brought on immediate relief. The contrast between these two kinds of records is fascinating. While the patients exhibited the same complaints

and received same treatments, some recovered admirably while others left MGH after a months of experiencing no improvement.

This contrast illustrates the paradox discussed in the introductory section—sometimes, physicians could "cure" women of their female complaints through the use of glycerine packs, hot water injections, pessaries; other times, they could **not** cure women of a disorder which, in many ways, the medical world itself had helped to create.

## CONCLUSION

The romantic ideal of femininity, which medicine had worked so hard to help construct, contained a basic contradiction. Medicine had insisted that woman was sick and that her life centered on the reproductive function. Doctors had wanted women to be sick, but now they found themselves in a dilemma: was the illness a construction of the medical world, a figment of the patient's imagination, or something "real" which, nevertheless, eluded the medical efforts of medical science? What, after all, was behind the "hysteria" and "uterine disease" labels attached to female invalidism?

The medical establishment insisted that women required professional medical intervention in order to get better. That is, recovery was possible but necessitated relying upon the appropriate medical channels. One of the ways the medical establishment secured women's dependence was by convincing them that they were weak and suffering. This, which is made clear in the MGH records, had powerfully negative, debilitating effects on women.

We take for granted the conception of health today—that the body is, for the most part, healthy and self-regulating. Even though modern women's health care is still strongly influenced and regulated by sexist social understandings, for the most part, our conception of the body is that it is not diseased unless an outside agent of some sort (for example, bacteria, a hereditary gene which carries cancer, too much exposure to cold resulting in frostbite) acts upon the body and inflicts sickness, disorder, or disease. Nineteenth century women hardly had this affirmative ideology underpinning their health assessments. Their biology, instead, was defined as inherently dysfunctional and pathological. They were destined to a life of unhealth.

In many ways, it is tempting to look upon these records—as well as the countless medical writings of the time—with an air of late-twentieth-century medical smugness. After all, we like to believe that medical care providers possess a clear conception of the body, anatomy, illness and disease, and treatments. Certainly we acknowledge the reality of presently incurable maladies such as cancer and AIDS, but each day we bolster our unshaken faith in Western medicine by contending that, indeed, steady progress in understanding will inexorably lead to cure.

However, this smugness is premature and, in some ways, risky. Lest we become too sanctimonious, let us remember that our health and bodies are very much influenced, if not constructed, by social institutions and perceptions. We need to remember the legacy of the Victorian constructions of women's invalidism: the physical is dramatically influenced by the social. And we must recall that medicine, like any other social institution, both reflects and perpetuates society's conceptions of things such as race, age, and, in particular, gender. Thus, it is helpful to examine these medical records from the late nineteenth century as a way to see how far we have progressed in terms of our conceptions of women's health and wellness. However, at the same time they are a reminder of our condition: pushing

the boundaries of knowledge is an ongoing human enterprise. The MGH case records offer us a view of that process in action.

**APPENDIX A:**  
**Coding Category Breakdown**

- **M1:** 7-8-1875 to 7-8-78.  
56 men, 44 women
- **S1:** 11-13-1875 to 3-14-76.  
56 men, 44 women.
- **M2:** 7-19-81 to 11-1-82.  
46 men, 54 women.
- **S2:** 8-16-80 to 2-28-81.  
45 men, 55 women.

totals: 203 men, 197 women

- hysteria (all women)
  - M1: 10 cases
  - S1: 0 cases
  - M2: 7 cases
  - S2: 0 cases
- uterine disease (all women)
  - M1: 14 cases (32%)
  - S1: 11 cases (25%)
  - M2: 21 cases (40%)
  - S2: 24 cases (44%)
- glycerine pack (all women)
  - M1: 7 cases
  - S2: 3 cases
  - M2: 10 cases
  - S2: 3 cases
- hot water injections (all women)
  - M1: 4 cases
  - S1: 0 cases
  - M2: 14 cases
  - S2: 10 cases



- pessaries (all women)
  - M1: 1 case
  - S1: 0 cases
  - M2: 12 cases
  - M2: 4 cases
- nervousness
  - M1: 8 cases; 2 men, 6 women
  - S1: 0 cases
  - M2: 12 cases; 3 men, 9 women
  - S2: 4 cases; all women
  - 24 cases total; 21% men, 79% women
- depression or "melancholia"
  - M1: 3 cases; 2 men, 1 woman
  - S1: 0 cases
  - M2: 4 cases; 1 man, 3 women
  - S2: 1 case; 1 man
  - 8 cases total; 50% men, 50% women
- insanity
  - M1: 8 cases; 7 men, 1 woman
  - S1: 0 cases
  - M2: 7 cases; 1 man, 6 women
  - S2: 0 cases
  - 15 cases total; 53% men, 47% women
- wildness or delirium
  - M1: 5 cases; 1 man, 4 women
  - S1: 1 case; 1 woman
  - M2: 8 cases; 4 men, 4 women
  - S2: 0 cases
  - 13 cases; 30% men, 70% women
- patients making up or "imagining" symptoms
  - M1: 8 cases; 1 man, 7 women
  - S1: 0 cases
  - M2: 8 cases; 2 men, 6 women
  - S2: 1 case; 1 woman
  - 17 cases total; 18% men, 82% women
- venereal disease
  - M1: 3 cases; 3 men
  - S1: 6 cases; all men
  - M2: 7 cases; 6 men, 1 woman

S2: 2 cases; 2 men

18 cases total; 94% men, 6% women

- addiction to substances (alcohol, morphine, opium)

M1: 12 cases; 10 men, 2 women

S1: 1 case; 1 man

M2: 12 cases; 8 men, 4 women

S1: 1 case; 1 man

26 cases total; 77% men; 23% women

## APPENDIX B:

### Glossary of Selected Medical Terms<sup>11</sup>

**ammonia valerate:** a sedative

**catarrh:** inflammation of a mucous membrane with a free discharge; especially such inflammation of the air passages of the head and throat.

**cellulitis:** inflammation of the flesh or skin due to infection. *Several women in the MGH records were diagnosed with "periuterine cellulitis" or "pelvic cellulitis."*

**cystocele:** hernial protrusion of the urinary bladder through the vaginal wall—an outpouching of the bladder.

**dysmenorrhea:** painful menstruation.

**dyspepsia:** impairment of the power or function of digestion. In nineteenth century usage, it was often thought to stem from general nervousness.

**endometriosis:** the presence and growth of uterine lining tissue in places other than the uterus that often results in severe pain and infertility.

**fistula:** an abnormal tract, usually between two internal organs.

**hemorrhoids:** large blood vessels at the anus which bleed.

**leucorrhea:** a whitish, viscid discharge from the vagina and uterine cavity. According to one medical text, "one of the most common of female complaints" (Danelson, 1872:615).

**locomotor ataxia:** failure of muscular coordination; irregularity of muscular action.

**neurasthenia:** a generalized term for people with vague complaints such as weakness, nervousness, fatigue, depression, and anxiety.

**os:** the opening to the uterus.

**ovariotomy:** surgical removal of an ovary or the ovaries.

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<sup>11</sup> Definitions compiled from: Dorland's Medical Dictionary and consultation with Dr. Higgins, unless otherwise noted.

**perineorrhaphy:** suturation of the perineum, performed for the repair of a laceration.

**pessary:** an instrument placed in the vagina to support the uterus or rectum (*see attached pictures*).

**polyps:** protruding growths from a mucous membrane. Cervical polyps vary widely in size and may produce irregular vaginal bleeding.

**potassium bromide (KBr) :** a sedative. Used occasionally for grand mal seizures. In the MGH records and other nineteenth-century medial arenas, was often administered to patients exhibiting "nervous" symptoms.

**recto-vaginal fistula:** a fistula between the rectum and the vagina.

**rheumatism:** any variety of disorders marked by inflammation, degeneration, or derangement of the connective tissue structures of the body, especially in the joint and related structures. Pain, stiffness, or limitation of movement of these parts. Rheumatism of the joints—arthritis.

**suppurate:** to discharge with pus.

**vesico-vaginal fistula:** a fistula between the vagina and the bladder.

## WORKS CITED

- Apple, Rima D. 1990. Women, Health, and Medicine in America. New York: Garland Publishing, Inc.
- Babbie, Earl. 1995. The Practice of Social Research. 7th ed. Belmont, California: Wadsworth Publishing Co.
- Barrens, Robert. 1873. "Lumleian Lectures on the Convulsive Diseases of Women." The Lancet. 26 April 1873, pp. 586-8.
- Danelson, Edwin J., M.D. 1880. Dr. Danelson's Counselor with Recipes: A Practical and Trusty Guide for the Family and Suggested Handbook for the Physician. New York: A. L. Burt Publishers.
- Delamont, Sarah and Duffin, Lorna, ed. 1978. The Nineteenth Century Woman. New York: Harper and Row Publishers, Inc.
- Dorland's Illustrated Medical Dictionary. 1985. 26th ed. Philadelphia: W. B. Saunders Co.
- Ehrenreich, Barbara and Deirdre English. 1978. For Her Own Good: 150 Years of the Experts' Advice to Women. New York: Doubleday Dell Publishing Group.
- Gilman, Charlotte Perkins. 1995. The Yellow Wallpaper and Other Stories. New York: Oxford University Press.
- Greene, Cordelia Agnes. 1856. "Prolapsed Uteri and Other Malpositions of the Abdominal and Pelvic Viscera." Case Western Reserve Archives.
- Haller, John S. and Robin M. Haller. 1974. The Physician and Sexuality in Victorian America. Chicago: University of Illinois Press.
- Herndl, Diane Price. 1993. Invalid Women: Figuring Feminine Illness in American Fiction and Culture, 1840-1940. Chapel Hill: The University of North Carolina Press.
- Higgins, George L., M.D. 1997. Personal correspondence. Portland, Maine.
- Hooper, John and Pat Jalland, eds. 1985. Women from Birth to Death: The Female Life Cycle in Britain, 1830-1914. Atlantic Highlands, New Jersey: Humanities Press International.

- Hyde, James N. and Frank H. Montgomery. 1895. A Manual of Syphilis and the Venereal Diseases. Philadelphia, Pennsylvania.
- Jordanova, Ludmilla. 1989. Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries. Madison, Wisconsin: The University of Wisconsin Press.
- Maine Medical Center Library, Archives Section. Portland, Maine.
- Martin, Emily. 1989. The Woman in the Body: A Cultural Analysis of Reproduction. Boston: Beacon Press.
- Michelet, Jules. 1868. L'Amour. Trans. from 4th Paris ed. by J. W. Palmer, M.D. New York: Carleton Publishers.
- Mitchell, Julie. 1976. "Four Structures in a Complex Unity," in Liberating Women's History, edited by Bernice E. Carroll. Chicago: University of Illinois Press.
- Morantz-Sanchez, Regina Markell. 1985. Sympathy and Science: Women in American Medicine. New York: Oxford University Press.
- Reinhartz, Shulamit. 1992. Feminist Methods in Social Research. New York: Oxford University Press.
- Ricci, James. 1945. One Hundred Years of Gynecology, 1800-1900. Philadelphia: The Blakiston Co.
- Rosenberg, Charles E. 1987. The Care of Strangers: The Rise of America's Hospital System. New York: Basic Books, Inc.
- Roy, Judith. 1990. "Surgical Gynecology," in Women, Health, and Medicine in America, edited by Rima D. Apple. New York: Garland Publishing, Inc.
- Russett, Cynthia Eagle. 1989. Sexual Science: The Victorian Construction of Womanhood. Cambridge: Harvard University Press.
- Shorter, Edward. 1991. Women's Bodies: A Social History of Women's Encounter with Health, Ill-Health, and Medicine. New Brunswick, New Jersey: Transaction Publishers.
- Skolow, Jayme A. 1983. Eros and Modernization. Cranbury, New Jersey: Fairleigh Dickinson University Press.
- Stage, Sarah. 1979. Female Complaints. New York: W. W. Norton and Company.

- Starr, Paul. 1982. The Social Transformation of American Medicine. New York: Basic Books, Inc.
- Strauss, Anslem and Juliet Corbin. 1990. Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park: Sage Publications.
- Veblen, Thorstein. 1974. The Theory of the Leisure Class quoted in Feminism: The Essential Historical Writings, edited by M. Schneir. New York: Random House.