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Abstract

Obstetrics and Gynecology (OB/GYN) is a medical subspecialty primarily concerned with birth care, reproduction, and gynecological health. OB/GYN practice plays a historically significant role in the treatment of infertility and reproductive disorders as cultural ideologies of fertility and motherhood have been co-constructed alongside the development of OB/GYN medical practice and knowledge. These constructs inform obstetric practice and serve as a framework for contemporary reproductive care. Modern birth care in the medical setting often reinforces a myriad of issues including stigmatization of birthing people’s bodies, over-medicalization of birth, obstetric racism, and obstetric violence. This paper focuses on the evolution of particular facets of obstetric thinking related to pain, stigma, harm, and power. These thematic domains serve as scaffolding for many of the persistent issues in OB/GYN medicine. There is substantial literature investigating contemporary issues of abuse and discrimination in obstetrics as well as qualitative work exploring the institutional framework of power which promotes these practices. However, there is less scholarship offering thematic analyses of the historical conditions which gave rise to crucial ideologies underlying institutional practices. To address this, I conducted a thematic analysis of literature published in the New England Journal of Medicine between 1935 and 1969. These decades encompass the beginning of infertility medicine’s rise to prominence up until the paradigm shift in the late 1960s as birth control became a focal point within reproductive medicine. The findings of this analysis indicate a thematic landscape of de-emphasizing women’s pain, stigmatizing conditions related to infertility, and utilizing authority to inflict dangerous and harmful “treatment”. These findings have implications for current OB/GYN practice as meaningful precursors to modern-day stigma, invalidation of pain, and harmful treatment.
Acknowledgements

I’d like to thank, first and foremost, my readers Dr. Ijeoma Opara and Dr. Nicola Hawley for helping me make this project what I’d hoped it would be. I’d also like to thank those Yale faculty and librarians who offered their time and expertise – who answered all my questions and helped me find direction. Lastly, I’d like to thank my friends and the aptly named emotions committee - Anna Stouffer, Maggie Weber, and Gillian Weeks - who’ve walked alongside me all this time.
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Introduction

OB/GYN practice in the United States is a medical subspecialty focused on the reproductive health of women and/or birthing people. Within the scope of reproductive health, infertility treatment is sought out by roughly 12.7% of reproductive-aged women in the U.S. (Carson, 2021). This realm of medicine has undergone rapid technological advancement over the course of the twentieth and twenty-first centuries. Since 2018, roughly 80,000 babies are born each year in the U.S. using assisted reproduction techniques (CDC, 2023). Among the most common infertility-related disorders are Endometriosis and Polycystic Ovarian Syndrome (PCOS). It is well-established that these disorders alone account for 40% of all female infertility cases in the United States (Unuane, 2011).

Importantly, infertility disorders such as endometriosis and PCOS are not only chronic physical conditions but also hold socially constructed meaning surrounding motherhood and womanhood (Young, 2018). Women and birthing people who deal with fertility issues such as these experience a greater risk of depression and anxiety (Rooney, 2018). Furthermore, both internal and societal stigma often accompany infertility as women are often blamed for issues surrounding conception (Taebi, 2021). Elements of blame, failure, and stigmatization persist both within and beyond the medical practice of obstetrics and gynecology (Whiteford, 1995). They are entangled with issues related to gender expectations, authoritative and medicalized knowledge, and mistreatment of women’s bodies. There is a complex social positionality which accompanies the experience of chronic pain associated with these disorders and infertility for women (Young, 2018).

This paper aims to examine the ways in which the socially constructed characterizations of the infertile female body in early obstetrics can be meaningfully mapped
onto contemporary obstetric praxis and treatment of infertility-related disorders in medical settings. By explicating the relationship between early constructions of the birthing body and contemporary obstetric praxis, enduring beliefs and norms rooted in twentieth century obstetrics which frame the ways in which we define infertility in relation to the birthing body can be better understood. Using The New England Journal of Medicine archives as a primary source, this investigation aims to shed light on ways in which early obstetrics gave rise to expectations of reproductive normativity through language and how these constructs endure to shape reproductive medicine in the present day. A greater understanding of these factors may point toward avenues for improved OB/GYN-related treatment and a reduction in persistent racial and ethnic disparities in this area.

**Background & Literature Review**

**Endometriosis & PCOS**

Endometriosis occurs when endometrial tissue grows outside the uterus and creates lesions in and around the pelvis (Young, 2018). It is an inflammatory disease with largely unknown causal pathways, however, current research is being conducted in order to identify etiology factors which may include genetic, hormonal, and/or immunologic components (Horne, 2022). The association between Endometriosis and infertility is meaningful but not ubiquitous; 30-50% of women with endometriosis have infertility (Macer, 2012). The mechanisms by which endometriosis leads to infertility are complex and not wholly understood, however, the pelvic adhesions characteristic of endometriosis demonstrate a mechanical interruption of oocyte release which inhibits ovulation (Macer, 2012).
This condition is characterized not only by infertility but also chronic, sometimes debilitating, pelvic pain (Fedele, 2024). Additional symptoms include pain during sex, painful menstruation, and bowel and bladder symptoms (Macer, 2012). It is a chronic disease with no clinical cure and is primarily approached with pain-management treatments in clinical settings (Parasar, 2017).

PCOS has a similarly complex etiology and may cause potentially debilitating levels of pain in addition to infertility (Zehra, 2018). This disorder is characterized by progressive growth of cysts on one or both ovaries as well as the onset of hormonal imbalances (Zehra, 2018). These cysts are often the source of chronic pelvic pain. Unlike Endometriosis, PCOS also adversely affects hormonal processes related to sleep, hair growth, metabolic function, fatigue, and skin conditions (Zehra, 2018). These hormonal imbalances – namely the overproduction of androgens and insulin and underproduction of follicle-stimulating hormones – disrupt the ovulation cycle (Dennett, 2015). PCOS is the most common cause of anovulatory infertility (lack of ovulation through hormonal pathways) (Dennett, 2015).

Within the U.S. medical system, pain associated with both endometriosis and PCOS has always been acknowledged, to varying degrees (Benagiano, 2014).

One domain of chronic pain which may go untreated is vaginal, pelvic, and back pain after childbirth, which 35% of women experience 8 months to a year after birth (Molin, 2024). Postpartum birth care rarely includes pain counseling or pain assessment (Molin, 2024). Other forms of chronic pain amongst women which are often de-legitimized by physicians are dyspareunia (pain during sex), fibromyalgia, and severe menstrual pain (Braksmajer, 2017; Wilson, 2006; Molin, 2024).
Disparities in Obstetric Care

In contemporary OB/GYN care spaces, there are marked racial and ethnic disparities in successful diagnosis and effective treatment of reproductive disorders such as endometriosis and PCOS. Historically thought to be a ‘white woman’s disease’ in early American medical settings, endometriosis affects roughly 10% of the world’s population (Westwood, 2023). Twentieth century OB/GYNs treated almost exclusively upper-class white women for reproductive disorders and it was not until the latter part of the twentieth century that treatment of these chronic diseases was extended beyond this group (Jacoby, 2015). In modern day OB/GYN care there remains an epidemic of undiagnosed endometriosis, particularly among black women (Bougie, 2022). The phenomenon of under-diagnosis is related to persistent cultural perceptions around black women as less susceptible to endometriosis as well as marked omissions by medical textbooks and teachers who fail to represent infertility patients as anyone other than white women (Bougie, 2022).

Racial and ethnic disparities in infertility care are not isolated to missed diagnoses, they also affect modality and quality of treatment (Westwood, 2023). White women are more likely than black women to receive minimally invasive treatments for endometriosis and are less likely to experience complications as a result of their endometriosis-related surgeries (Westwood, 2023).

The significance of these phenomena is not ahistorical nor unique to modern medicine. Rather, they demonstrate the reality that at its inception - obstetric care was meant to improve the health and fertility of white women at the expense of black women (Nuriddin, 2020).
**Stigma**

Infertility disorders cut across both physical and psychological symptomatology with sometimes severe mental health consequences (Rooney, 2018). Beyond the scope of emotional distress related to pain, stigmatization related to infertility is often a heavy burden for women whether or not they are actively trying to conceive (Rooney, 2018). This stigma exists in multiple levels of the social-ecological framework (Whiteford, 1995). Firstly, internalized stigma may arise as women engage in patterns of thinking related to self-blame and shame (Taebi, 2021). These perceptions may also be projected upon women by their family or community as motherhood is often perceived as a critical pillar of womanhood. Secondly, there is stigmatization expressed through the communication and behavior of providers. This form of stigma may arise due to discomfort, lack of knowledge, or internal biases on the part of the provider (Klitzman, 2018). Finally, the form of stigma which this paper concerns itself with is that of the structural stigma perpetuated by clinical medicine and its practitioners (Whiteford, 1995). The assertion that all women, particularly those who are married, should and must reproduce is woven into many aspects of American culture, government and medicine (Whiteford, 1995; Bell, 2016). In a top-down manner, these cultural projections may infiltrate community and familial dynamics as well as fueling negative self-perceptions (Taebi, 2021).

**Power and Authority**

A key mechanism for the internalization of socially constructed norms and stigma surrounding fertility-related issues among birthing people involves the use of power and authority among medical professionals. Authoritative knowledge production is the process by which validity, authority, and rigor are socially constructed by and for powerful social groups
(Jordan, 1997; Bonaparte, 2014). This knowledge is positioned as both natural and irrefutable; it is a tool which assigns value to knowledge depending upon who produces it (Jordan, 1997). Hierarchically ‘superior’ groups, doctors among them, use this socially sanctioned authoritative knowledge in a myriad of ways; not all of them scientifically justified (Aries, 2003). In obstetrics, power and authority are deployed in service of the perpetuation of gender dynamics, institutional power, and white supremacy (Perrotte, 2020). Medicine and its actors are situated as gatekeepers of knowledge and hold the authority to diagnose and treat the general population. Their power, however, extends beyond simple diagnoses; practitioners also hold the authority to determine the validity of pain or discomfort. They often have final say over who gets treatment, when, and why. They hold the power to definitively declare who is healthy and who is not. In obstetrics, issues of medical misogyny and sexism in combination with racism and colorism influence patient/provider dynamics and intensify the pre-existing power of authority physicians hold (Shabot, 2021).

Eugenics and Racism

The misuse of power and authority within the medical professional has been at times related to the promotion of white supremacy. For example, The origins of obstetric medicine are inextricably linked to eugenics (Byrd, 2001; Nnoli, 2023). While early twentieth-century physicians sought to cure ‘sterility’ in certain women, they campaigned to inflict it upon others. Forced sterilization of black women was practiced by OB/GYNs from the late nineteenth century into the late twentieth century and was legally sanctioned beginning in the 1920s (Swanson, 2021). Experimental surgeries were carried out upon the bodies of black women without anesthesia and without consent (Swanson, 2021). The echoes and reproduction of these practices
are what Dr. Dána-Ain Davis has termed ‘the afterlife of slavery’. That is, the continuation of abuse of black women particularly in medical obstetric spaces rooted in ideologies and practices which began during the period of American chattel slavery.

Ultimately, a prominent goal among twentieth century obstetricians was to describe, diagnose, ponder, and attempt to fix infertility (Campbell, 2013). Issues related to infertility carried profound consequences in the minds of obstetricians who identified chronic disease not only as a physical pathology but an embodiment of failure (Ulfelder, 1956). Twentieth century social values were prominently featured in obstetric medicine as clinicians described the negative impacts infertility had on marital dynamics and psychological health (Fallon, 1946).

The historical evidence of their work and knowledge production exists but is not unique to the archives of the New England Journal of Medicine. This journal documents more than just the science of the time; it demonstrates the sociocultural constructions of the birthing body through language and the ways in which cultural beliefs serve as the scaffolding of medicine. Most importantly, the evolution of obstetric thinking and its impact on contemporary OB/GYN practice may be better understood through the writings of those early obstetricians (Podolsky, 2012).

An Historical Perspective on Obstetric Medicine

In the twenty-first century, formalized obstetric care primarily takes place in hospital and clinic settings and is more often than not conducted by physicians in brick-and-mortar medical facilities. In 2020 a recorded 98.4% of all births in the United States took place in hospital settings; a stark departure from the typical home birthing environment of the past (National
Academies of Sciences, Engineering, and Medicine, 2020). However, these spaces were not always the primary setting for birth care.

The institution of obstetric medicine has undergone iterative changes across the twentieth century; this evolution informs present day obstetric practice and praxis. Historically, all birth care in the United States was overseen by midwives with specialized knowledge acquired through experiential and community learning (Leavitt, 1996).

Across the mid-to-late twentieth century, Obstetric and Gynecology practice (OB/GYN) gradually began to encompass more than just the birth event; prenatal care, infertility treatment, postnatal care, and reproductive disorders all became subjects of interest to physicians (Drife, 2002).

Prototypical evidence-based obstetric medicine in the United States may be traced to the early twentieth century as reproductive care shifted away from the domain of midwives and into professional medical spaces (Drife, 2002). This novel shift inspired fundamental change within the field; physicians began developing new obstetric tools, procedures, and theoretical paradigms (Drife, 2002). The twentieth century marks the induction of obstetrics into medical schools and its re-imagining as a medical science rather than an at-home practice (Drife, 2002). Physicians sought to imbue obstetrics with systematic and predictable practices under the authority of specialists (Leavitt, 1996). By 1943 hospital births made up 72% of all births - a rapid transformation from the centuries-long practice of home births under the care of midwives (Leavitt, 1996).

It is during this time that the birthing body transformed - reproduction and fertility became medical phenomena and accompanying reproductive pathologies were investigated. In 1935 PCOS, a chronic disease associated with infertility, was described for the first time.
PCOS and Endometriosis are now understood to be the most common endocrine condition among women of reproductive age (Rasquin, 2022). During the early to mid twentieth century, interest in PCOS and endometriosis was driven by increasing concern surrounding women’s responsibility to bear children (Cook, 2004).

Through their investigations of infertility-related chronic disease, early obstetric medicine began to define the birthing body as one that either works or does not (Al-Gailani, 2014). This literature created its narratives through language - physicians described the female body that is unable to give birth as ‘alien’ or ‘invalid’ within the most prominent medical journals of the time (Ulfelder, 1956). This language, couched within an assumed framework of scientific objectivity, formed a definitional divide between the normal and abnormal female body (Jordan, 1999).

The history of obstetric, fertility, and reproductive medicine is scattered and complex. It is a domain with a tumultuous history entwined with and sometimes defined by the harm it has caused. The inception of obstetrics brought with it the conceptual solidification of a normative birthing body and, consequently, that of an abnormal body as well (Cahill, 2008).

The state of twentieth century obstetric medicine is inextricably linked to the cultural, political, and technological advancements of its time. These components of the American social fabric contextualized the beliefs and practices of twentieth century obstetricians. As previously stated, PCOS was first described in medical literature in 1935. Both PCOS and Endometriosis became subjects of clinical interest and were frequently discussed in publications.

Simultaneously, hospital wards were quickly transforming into the primary spaces in which women gave birth (Walzer, 2016). By the turn of the twentieth century, roughly half of all births were overseen by physicians (Walzer, 2016). Despite this phenomenon, physicians often received little to no obstetric training during their education (Walzer, 2016). Although physicians
took over birth care in rapid succession, their maternal morbidity and mortality rates saw no improvement as compared to home births (Walzer, 2016). Furthermore, the sterile and impersonable environment of hospital birth wards was met with strong condemnation by those women who experienced the shift (Walzer, 2016). Several historical accounts detail the “cruelty of maternity wards” as women who gave birth in these spaces described the loss of autonomy and dignity they endured as a “nightmare” (Walzer, 2016).

Obstetricians concerned themselves with delivering babies as a central focus of their work. As they endeavored to reach this goal, physicians developed technologies meant to expedite and systematize the birth process (Drife, 2002). Forceps, although a dangerous tool for both mother and fetus, were standard practice (Drife, 2002). The presumed benefit of extracting a fetus via forceps was speed (Drife, 2002). Additional birth technologies were created and refined in the interest of scientifically mediated birth - anesthesia was often administered in order to render women unconscious prior to forceps delivery (Walzer, 2016).

The explosion of birth wards and obstetric tools during this time served to reframe birth as a scientific endeavor (Campbell, 2013). The assumption was that, under the care of physicians, pathologies related to birth complications and issues of fertility could be fixed (Campbell, 2013).

The 1930s and 1940s were dominated by anecdotal clinical cases as the subject of journal publication (King, 2005). Beginning in the 1950s, however, the clinical trial began to permeate obstetric medicine (King, 2005). Therapies were developed and tested in order to assess their efficacy in treating infertility as well as preventing miscarriages (King, 2005). These trials took no precautions to minimize bias through randomization, double blinding, or placebo controls (King, 2005). As a result, many of these therapies did more harm than good (King, 2005). By
1955, ninety-five percent of births took place in hospital settings (Walzer, 2016). This also marks the time period during which, for the first time, physician-mediated birth became safer and maternal mortality decreased (Walzer, 2016). This phenomenon may be attributed to the development of new medical capabilities such as blood transfusion (Walzer, 2016).

This decrease in child and maternal mortality brought with it new clinical and political concerns. By the 1960s the U.S. population was rapidly increasing and political as well as medical actors began to invest in means of population control (Faúndes, 1995). The birth control movement arose in the 1960s as a reaction, in part, to economic concerns. The rapid population increase was predicted to overburden the U.S. economy and increase expenditures down the line (Faúndes, 1995).

Ultimately, solving infertility and ensuring women can and do give birth was a defining characteristic of obstetrics between the 1930s and early 1960s. The epistemological shift towards limiting births as opposed to maintaining them represents a confluence of political, technological, and cultural contexts. This paper aims to investigate the time period within which the discovery of major infertility-related chronic diseases occurred and prior to the paradigm shift in the 1960s.

**Objectives**

Utilizing the NEJM archives as a primary source, this paper aims to investigate and address the following research questions;

1. How does early obstetrics create and enforce a thematic landscape of reproductive normativity through language?
2. How is the female body conceptualized when expectations of reproductive normativity are not met?

3. How do these constructs endure and inform reproductive medicine across the 20th century?

4. How might these themes impact present-day reproductive medicine?

**Theoretical Framework**

The theoretical framework which informs this investigation is one that conceptualizes practices related to birth as a human right. The Reproductive Justice Framework operates under the assertion that birthing people have the right to dignified fertility management as well as an unwavering entitlement to choose whether to give birth or not (Solinger, 2019). Birthing people have the right to respectful fertility management and birth - free of coercion and with explicit consent in their care. Furthermore, birthing people have the right to autonomy and choice without stigma.

Throughout the data analysis and interpretation phase of this research project, obstetric practices described within historical literature will be evaluated through the lens of reproductive justice and human rights.

**Hypotheses**

At the outset of this paper hypotheses are as follows -

1. The language within primary sources will conflate infertility with abnormality and inadequacy.
2. The language within primary sources will construct the female body according to cultural perceptions surrounding birth as a pillar of successful womanhood.

3. Authoritative knowledge will be deployed in order to substantiate cultural constructs of the birthing body as factual.

Methods

Data Collection

The New England Journal of Medicine archive was systematically searched between the years of 1935 and 1969. This journal was selected because of its prestige and prominence throughout the nineteenth, twentieth and twenty-first centuries. The New England Journal of Medicine, established in 1812, represents a microcosm of medical thinking, culture and discourse at the highest level of perceived academic rigor. For these reasons, I determined that it would provide meaningful historical content well-suited for the investigative aims of this research.

The search terms used in the collection phase of this project were; Endometriosis, Polycystic Ovarian Syndrome, Infertility, Sterility, and Stein–Leventhal syndrome. The terms ‘sterility’ and ‘Stein–Leventhal syndrome’, while no longer common in the medical lexicon, yielded relevant literature because of their frequent usage in medical scholarship during the 1930s-1950s. Given the subject matter this thesis is focused on, all search terms and chosen articles explored lines of inquiry related to infertility diagnosis and treatment. This methodology was selected in order to maintain consistency throughout the analysis phase and compare content
within and across articles that were in conversation with one another. This depth rather than breadth approach allowed for more focused and consistent analyses.

These search terms typically returned twenty to thirty articles within each decade. Articles were either included or excluded on the basis of relevance. The articles selected for inclusion met the following criteria:

1. An original study or case report
2. Authorship by a medical doctor
3. A primary focus on infertility or sterility in women as a result of either Endometriosis or PCOS (Stein–Leventhal syndrome)

Articles were typically excluded when they were authored by anyone other than a medical doctor (such as nurses or non-medical doctors). This criteria was chosen in accordance with the aims of this project; to evaluate the written work of physicians who treated patients.

Furthermore, articles that constituted a book review rather than an original analysis, and/or mentioned infertility only in passing with a greater emphasis on other domains of medicine were excluded.

In total, forty-one articles were included in the analysis with a relatively even distribution across the four decades of interest.

Data Analysis

These data were analyzed using the qualitative analysis software Taguette. Each article was reviewed and coded using an inductive approach. The inductive approach involves observational analysis through the iterative emergence of codes related to the phenomenon of interest – infertility (Bingham, 2021). Themes are then identified based on saturation of codes
grounded in the data (Butler, 2020). Each article published within the decades of interest that included any of the selected search terms was read and evaluated for inclusion on the basis of the criteria described above. Child codes were produced according to their prominence within and across the literature. Phrases and descriptions that appeared frequently in the selected articles were identified as important signifiers of larger concepts being presented by multiple physicians across the literature. Fifty-six child codes arose and were subsequently grouped into parent codes. Examples of child codes include: ‘frigidity’, ‘infantile’, ‘faulty’, ‘defective’, and ‘abnormal’. These codes were organized into the parent code: ‘degrading language’ because of their definitional overlap in relation to overall disrespectful and degrading language.

Parent codes were produced by collecting interrelated child codes. Based on meaningful similarities, child codes were gathered in order to support larger concepts (parent codes) which were prevalent in the data. Examples of parent codes include ‘infertility & psychological factors’, ‘infertility & morality’, and ‘policing women’s behavior’. These codes ultimately yielded ‘Stigma and Blame’ as a core theme represented in the data.

**Results**

Five themes arose during the analysis phase: 1) Stigma and Blame, 2) Emphasizing Conception; De-emphasizing Pain, 3) Authority and Power 4) Treatment through Mistreatment, 5) What goes unseen; Eugenics and Racism. Each of these themes are described below.

**Stigma and Blame**

Stigma and Blame occurred frequently in the literature. This theme describes an ethos of individualized responsibility and blame associated with infertility. The authors of this literature describe the bodies of their patients using negative and degrading language. This serves to stigmatize infertility, describing it as a confluence of personal failures and inherently dysfunctional bodies.

Utilizing objectifying, alienating, and degrading language to describe the bodies of patients, these physicians' linguistic choices evoked both implicit and explicit patriarchal ideologies as they contemplated the ‘faulty’ women they treated.

Physicians frequently cited their patients’ weight, intelligence, libido, behavior and habits, personal hygiene, and psychological ‘disturbances’ as potential causes of their infertility.

In an article published in 1944 entitled ‘Therapy with Female Sex Hormones’ one physician wrote;

“strained social relations, absence of healthful routines, shocking episodes, poor emotional adjustment, psychic disturbance, ill-suited occupation, bad habits and so forth are often obviously, and apparently causally, associated with all sorts of functional disturbances of the various bodily systems.” (Smith, 1944).

Similarly, in an article entitled ‘Therapeutic Limitations of Female Sex Hormones in Gynecologic Conditions’ an obstetrician wrote of one of his infertile patients “[her] sexual
frigidity may have such a complex back-ground that a definite place for hormones in its treatment is difficult to determine.” (Smith, 1940).

These sentiments are important to contextualize within a larger phenomenon of problematizing women’s bodies and behaviors. While many actors (including patients themselves) undoubtedly contributed to this problematization; doctors are ultimately the bridge between those perceived problems and the actions taken to resolve them.

As the earliest obstetricians set out to cure infertility, their focus often wandered outside the medical domain and into arguments of personal accountability and blame - stigmatizing a range of behaviors associated with weight gain, ‘psychic neuroses’, ‘emotional instability’, ‘ill-suited occupation’, ‘marital problems’, ‘frigidity’ and ‘poor hygiene’. (Greenblatt, 1965; Fallon, 1946; Smith, 1940; Scheffey, 1947).

In addition to the individual blame physicians placed on their patients, they also revealed in their writings a negative stigma associated with the body parts themselves. Using phraseology such as; “the presence of a defective ovum”, as was written in an article entitled ‘The Control of Abortion’ in 1937 (Taussig, 1937).

Similarly, an article published in the NEJM in 1939 entitled ‘Report on Medical Progress – Gynecology’ includes the sentence: “[an] underdeveloped uterus with a normal endometrial cycle is due to a primary deficiency of the uterus itself.” (Meigs, 1939).

The significance of this language is in its assumptions and associations. Describing body parts, which cannot be inherently right or wrong, as ‘defective’, ‘deficient’, ‘faulty’ or ‘infantile’, paints a picture of the female reproductive system as something that can be broken or wrong. And, by extension, a picture in which women themselves can be broken or wrong. Throughout
the literature, infertility - whether resulting from a ‘defective ova’ or ‘frigidity’ - is attributed either to a failure of conduct or a failure of the body.

*Emphasizing Conception; De-emphasizing Pain*

While obstetricians recognized pain as a symptom of both endometriosis and PCOS (Stein–Leventhal syndrome), it was often described as a secondary or non-serious concern in comparison to the issues these conditions caused related to fertility and conception. This is evidenced by published statements like the following; “*pain* may be sharply localized, or it may radiate to the sacrum or thigh. The nature and location of the pain are not important. *What is significant is its relation to menstruation.*” (Fallon, 1946).

Despite patients’ experiences of pain (which were often described but rarely addressed), physicians made clear that their primary role was as a facilitator of successful pregnancy. They seemed to conceptualize pain not only as secondary but oftentimes a natural piece of womanhood. These attitudes are exemplified by blatant assertions such as; “*patients who recognize irregularity as pathologic but who accept periodic pain as woman's normal lot*” (Hardy, 1945).

As demonstrated above, physicians were not particularly concerned with pain. However, they were deeply concerned with ensuring married women had babies. One obstetrician wrote of a married woman who came to see him with severe pelvic pain during menstruation. The physician notes that her ovary was enlarged and covered in cysts. After performing a surgery on her, he writes; “*This patient was urged to try for pregnancy soon after her discharge from the hospital*”. (Levi, 1948).
This quote encapsulates the predominant thinking among obstetricians at the time; a patient complaining of pain underwent surgery in an effort to resolve that pain. Despite the patients’ experience of physical discomfort, this doctor prescribed sex soon after surgery in order to solve the issue that most concerned him; her ability to become pregnant.

Through my analysis of these historical data I encountered several doctors who presented the argument that conception would somehow resolve endometriosis. Re-conceptualizing birth as a treatment in and of itself; “Endometriosis” as one doctor explained “is an antivenereal disease — that is, it is associated with sexual unfulfillment. The prophylaxis seems to be early marriage and a child every few years.” (Fallon, 1946).

Later this physician repeated his hypothesis that; “Marriage at the age of seventeen and a child every three years would probably abolish endometriosis.”

These sentiments describe a solutions-oriented perspective which hopes to position birth itself as the remedy to any and all reproductive issues. It is through this tunnel-vision that women’s pain becomes invariably left behind in favor of her fertility.

Authority and Power

Themes related to authority and power among medical professionals emerged in the data as evidenced by implicit beliefs that physicians both maintained and deserved authority over their patients. They used the power conferred upon them in order to assign worth to the bodies and lives of the women they treated. Just as these women had no choice but to ask for the help of men when they were ill or in pain, they had no choice but to accept degradation, mistreatment, or harm by those who held the authority to both fix and hurt their bodies.
In 1935 an obstetrician wrote into the NEJM and made this value-based determination of one of his patients: “Certainly she never has been worthy physically or mentally for motherhood”. (Sutherland, 1935). This language meaningfully indicates that this physician believes it is within his scope of authority to determine his patients’ physical and mental worth.

“In addition to the usual careful physical checkup certain special examinations are demanded by every intelligent patient” (Fremont-Smith, 1953). This quote points to another mode by which obstetricians at this time exercised their power - to offer a higher standard of care to those they deem more valuable. By this token, obstetricians reserve the authority to provide or withhold treatment and care depending on their assessment of their patients' worth. This authority also gives obstetricians the power to administer treatments that may be harmful, painful, or dangerous.

Treatment through Mistreatment

The fourth theme that arose over the course of this research was a willing mistreatment of women’s bodies for medical purposes. In the pursuit of their clinical aims (to treat infertility disorders), obstetricians conceived of, tested, recorded, and recommended a myriad of erroneous, dangerous and painful treatments. While erroneous and dangerous treatment was not unique to obstetric medicine during this time, the particular methods of mistreatment employed by early obstetricians is an important indicator of the ways in which practitioners viewed the female body on the whole.

In 1939 one obstetrician wrote into the NEJM; “In old women, unmarried women, the La Fort operation is popular...This operation partially closes the vagina and prevents satisfactory
intercourse.” (Meigs, 1939). This operation was proposed by the author as a surgical measure to correct uterine prolapse.

Other doctors advocated radiating ovaries to treat endometriosis and PCOS as well as vinegar douches, lactic acid douches, prolonged hot saline douches, snake venom, and introducing rubber bags filled with mercury into women’s vaginas. These treatments predated the development of acceptable standards of evidence based medicine and often had little or no scientific backing (Johnson, 2013). In 1946 one doctor wrote that “it was mechanically practicable to remove [endometrial lesions], combined with temporary castration by a small dose of radium.” (Fallon, 1946).

These treatments may be more accurately termed ‘mistreatments’ as they are both ineffective and likely painful. While science and medicine necessarily progresses and improves over time, these treatments represent more than just ‘bad science’. In the pursuit of fixing, obstetricians readily looked to abrasive and harmful substances to prescribe to women without rigorous scientific evidence of efficacy (Johnson, 2013). Within the pages of the New England Journal of Medicine, these physicians regularly discussed their experimentation with novel surgeries and therapies in order to treat ‘female sterility’.

This phenomenon encapsulates these obstetricians’ willingness to subject their female patients to all manner of mistreatments in order to fix their ailments, namely, their inability to have children.

What goes unseen; Eugenics and Racism

Eugenics and racism were evident in the data examined related to early obstetric practice. This was observed in practices and communication designed to promote reproduction amongst
those who are deemed “valuable” members of society while eradicating those who are believed to be less valuable on the basis of race. Although this belief system was implicit across obstetrics, it is not acknowledged in the New England Journal of Medicine between 1935 and 1969. However, these omissions are meaningful in and of themselves. In these historical documents physicians recounted experiences with the women they considered patients. Those they were trying to, from their perspective, help. This is likely the reason black women and other BIPOC birthing people are not included in the literature - they were not considered patients.

Despite these omissions, the philosophies and thought-patterns of eugenicists arose throughout the literature, whether or not the term was used outright.

One obstetrician wrote into the NEJM in 1952 claiming; “Since professional women tend to marry professional men, they are likely to have children with intelligence above the average...many of them post-pone starting a family and then restrict the total number of children to an extent that ensures a decline in this valuable population.” (Baird, 1952)

This quote proposes that ‘professional’ groups of people within the population have intelligent children and that this group is valuable. Dr. Baird then arrives at the conclusion that this group should be having more, not fewer children.

This sentiment is reiterated again and again in the literature - physicians pull from eugenics thinking in order to assess the value of women and the relative importance of their ability to reproduce.

In my analysis of the data, I found one outright reference to eugenics. In 1946 an obstetrician wrote about endometriosis; “It should be remembered that the disease itself, not eugenics, ethics or even common sense, is under consideration.” (Fallon, 1946).
This casual reference signifies the implicit presence of eugenics within the minds of these medical practitioners as they write seemingly unrelated scholarship. Even more noteworthy is this authors’ grouping of eugenics with ethics and common sense. What this statement makes clear is that, in this moment, eugenics is simply another intellectual consideration; one that is as ubiquitous and natural as ‘common sense’.

Ultimately, each of these examples of language and practice exemplify an attitude of depersonalized and de-humanized patient care pervasive across these written works. The obstetricians whose words have made it into this archive demonstrate an exertion of their socially sanctioned power in order to both enact physical mistreatment and project negative stigmas upon their female patients whose pain and pathology they seek to treat. Furthermore, the subtext of much of their writings communicate eugenics ideologies through their assessments of patient intelligence, value and right to reproduce.

Discussion

The findings presented in this paper suggest a relationship between early obstetric praxis and practice and that of contemporary OB/GYN reproductive healthcare. Surgical methods, drug treatments, and aspects of patient care have undergone meaningful and tangible improvement (Sternke, 2014). However, the framework of thinking - in many ways - persists.

Within the U.S. medical system, pain associated with both endometriosis and PCOS has always been acknowledged, to varying degrees (Benagiano, 2014). In this review of early-to-mid twentieth century literature, both infertility and pain have been documented by practicing obstetricians. However, the degree to which the authors of this literature understood, empathized with, or aimed to alleviate pain through efficacious treatment was not always consistent. The
literature analyzed for this thesis revealed a complex picture of clinical thinking with regard to female infertility, reproduction, and experiences of pain. These historical pieces of literature reveal a common attitude among early obstetricians whose efforts ultimately favored solving infertility over management of pain (Davis, 1935; Smith, 1940; Fallon, 1946; Ulfelder, 1956). This issue is reflected in contemporary OB/GYN practice as infertility medicine has yet to identify an effective cure or even definitive pain management treatment for endometriosis and PCOS (Parasar, 2017). The historical literature included in this paper demonstrates a poor understanding of women’s health and infertility-disorder disease etiologies. While the etiologies, symptoms, and biological pathways are now understood in greater detail and scope, there is still an element of scientific perplexity in modern day literature (Hudson, 2022). We now have the ability to more effectively treat endometrial lesions and remove ovarian cysts (Zehra, 2018; Unuane, 2011). However, the chronic nature of these diseases mean that lesions and cysts reappear and continue to cause pain and impact fertility (Parasar, 2017). Thus, even modern treatment falls short of treating women’s pain in the long-term.

Eugenics is a major component of early-to-mid 20th century obstetric medicine (Byrd, 2001). These practices go un-published in the New England Journal of Medicine, whose contributors describe every facet of their female patients from their weight to their perceived ‘intelligence’ but without any mention of race or ethnicity which not only indicates systematic exclusion but also impedes any treatment generalizability. This reflects the general structure of medicine during this time period, whose services were reserved primarily for white women and men (Swanson, 2021).

To the author's knowledge, there have been no published resources in the New England Journal of Medicine indicating that physicians were writing about non-white women between
1935 and 1969. This is not surprising, however, as those doctors interested in solving infertility or addressing chronic pain were not concerned with the reproductive health of black women (Westwood, 2023). Rather, they were steeped within a medical space whose co-existing aims were to promote the fertility of white married women and to actively subjugate and cause harm to black women (Nuriddin, 2020).

This is deeply relevant to contemporary racial and ethnic disparities among those black and brown patients who seek out diagnosis and treatment for their reproductive health issues (Howell, 2023). Gendered racism in OB/GYN care affects the way BIPOC women are able to navigate healthcare systems as well as the quality of treatment they receive (Howell, 2023). There is a national under-diagnosis crisis among black and brown women with regards to both endometriosis and PCOS (Bougie, 2022). There are multiple intersecting causal factors including medical mistrust, perceptions of “black” vs. “white” diseases, obstacles in access to specialists, and biases related to the dismissal of black women’s health concerns (Bougie, 2022). This gets at the fundamental question of who infertility medicine was meant for.

It is apparent from historical literature that the patient population which obstetricians built their practice around were primarily upper-class married white women (Westwood, 2023). This is the population whose reproductive capacities obstetricians were most interested in optimizing. Given this context, the medical system’s continued failure to serve black, indigenous, and people of color transforms from an ahistorical phenomenon to one that is in fact the intention of those who invented and populated the subspecialty.

The findings within this paper related to power and authority as well as stigma and blame are necessarily interrelated. Stigma is heightened when it is weaponized by members of society with both perceived and real power (Cook, 2014). Physicians’ role as the keepers of authoritative
knowledge add weight and credibility to their words and actions (Jordan, 1997). This is as true today as it was at the inception of obstetric and gynecology disciplines (Cahill, 2008).

The power and authority to make decisions about women’s bodies was taken away from midwives and conferred upon obstetricians at the inception of OB/GYN medical practice (Bonaparte, 2014). Despite a very poor understanding of infertility disorders, these doctors exercised a great deal of authority as they described not only the physical maladies of women but their psychological, moral, and behavioral failings as well (Angel, 2010).

In my analysis of physicians’ writings at the outset of medicalized obstetric practice, this stigma and subtle condemnation of the inability to conceive, particularly among married women, is almost ubiquitously present.

Contemporary literature continues to investigate the pervasiveness and consequences of stigma and blame in reproductive health, saddling women with personal accountability for their illness (Hudson, 2022). This stigma has tangible consequences; it affects mental health, depression, and anxiety as well as self-perception and social positionality (Sims, 2021). Current scholarship has also investigated tertiary consequences such as motivation and productivity, familial relationships, and physical comorbidities (Sims, 2021). Qualitative research has revealed rich data related to women’s experiences with depersonalized and alienating care in the medical system (Assaysh-Öberg, 2023). Often these experiences are accompanied by feelings of dismissal and blame (Taebi, 2021). Particularly in instances of chronic pain, women often find it difficult to be believed. Women deal with persistent frustration as they advocate for themselves in an attempt to have their pain recognized (Werner, 2003).

This echoes many of the obstetricians’ assessments of their patients in the historical literature, who often noted complaints of pain but offered little more than a medical description.
The attitude pervasive across this scholarship is that pain is “women’s lot”. This exemplifies a down-playing of the legitimate ongoing pain experienced by their patients.

Ultimately, each of these issues (stigma, blame, power, authority, racism, and pain) are reflected in the historical medical literature. While much of the language and treatments utilized have changed, many of the underlying issues have endured. Women and birthing people are no longer described as exhibiting “low intelligence”, “poor hygiene” or “neuroses”, however, the experience of personal accountability and blame is still felt. Similarly, while eugenics is resoundingly recognized as racist white-supremacist pseudo-science, the institutional ethos which placed white women at its center continues to perpetuate disparities in infertility-disorder diagnoses. Authoritative knowledge still operates in the realm of medicine and allows for the de-legitimizing of pain as well as the heightening of stigma.

**Implications**

The importance of these findings, alongside other historical analyses, are in their ability to elucidate the problematic thinking that scaffolds OB/GYN practice, infertility medicine, and reproductive healthcare. It is crucial to position present issues in these fields not simply as “add-on” problems but components that are woven into their fabric. When operating within a theoretical framework which posits that birthing people have an inherent right to dignity, choice, respect, and consent; then OB/GYN practice does not always succeed in meeting these standards. Stigma, blame, authority, power, racism, and mistreatment should be seen not as isolated phenomena or disparate incidences of harmful practice but as a collective project engineered at the outset of this discipline.
This context can and should be applied at the institutional level; within medical school teaching and clinical practice. While medical training often includes at least one elective course that reviews the history of medicine, this curriculum does not anchor current health equity issues in historical patterns (Shedlock, 2012). Rather, these curricula are often broad overviews of noteworthy figures in medicine as well as benchmark technological or methodological developments (Ludmerer, 2015). This learning, while technically an overview of the history of the field, does not often leverage the field’s problematic history in order to understand contemporary issues in medicine and improve best practices (Ludmerer, 2015).

The usefulness of re-conceptualization medicine’s history is that it allows both researchers and practitioners to evaluate the whole of these issues, rather than their parts. Un-checked authority begets stigma which begets mistreatment. A historically-informed understanding of contemporary issues may allow OB/GYN practitioners to look inwards at who they believe to be their patient population; is it married white women? And what happens when it isn’t? What internal biases lead a practitioner to make a determination about the legitimacy of someone’s pain? Midwifery practice may offer some insights.

This thesis has given an overview of the historical development of formalized medicalized obstetrics and the simultaneous cultural departure from midwifery as a legitimate and valuable source of knowledge. Midwifery and doula practices, which currently exist on the margins of mainstream OB/GYN practice, may be an important intervention to re-integrate into birth care (Mottl-Santiago, 2023). Many of the historical issues related to mistreatment, authority, and power were solidified and intensified as male-dominated OB/GYN medicine arose (Campbell, 2013). Midwives and doulas have a historically distinct practice which exists outside of standard obstetric practice (Leavitt, 1996). This form of birth care is typically less medicalized
and more community oriented – midwives and patients often come out of similar communities and remain connected to those communities (Davis, 2020). In a modern context, midwives and doulas practice advocacy for birthing people, de-medicalization of birth, and the upholding of birthing people’s rights on the basis of reproductive justice (Davis, 2020).

As an example; Radical black birth workers, who are often doulas or midwives, position themselves as advocates for black birthing people with a specific historically informed approach (Davis, 2020). These birth workers utilize their understanding of modern birth inequities as historically grounded in racist medicine in order to close the gap of adverse birth outcomes among black birthing people (Davis, 2020). This model of birth care deconstructs the authority and power exercised by the medical industrial complex and its actors in order to center black birthing people’s rights (Davis, 2020).

Midwives and radical birth workers operate with an informed understanding that birthing people may need an advocate in order to have their concerns, including pain, taken seriously (Mottl-Santiago, 2023). These radical birth workers’ model of practice has a great deal of value – their historically contextualized and advocacy-centered knowledge would likely benefit obstetric practice on the whole. This knowledge should be drawn upon not only to address inequities but also to better platform women’s experiences. This may look like, for example, the integration and normalization of midwifery in hospital settings or the inclusion of trainings taught specifically by midwives.

Furthermore, as many of these domains fall into the scope of public health research, it remains important to anchor research questions and findings in a holistic context to ensure foundational historical patterns in obstetrics are not repeated. When asking how chronic infertility disorders are so poorly understood or why the associated stigma is so distressing, there
is a legacy worth considering. One that may point to potential answers as well as inform potential solutions.

**Limitations**

This is a subjective project as the author is the sole analyst of these data. It is imperative that this subjectivity be acknowledged; particularly with regards to the authors’ positionality as a white woman who has never given birth or been diagnosed with a chronic infertility-related disorder.

Furthermore, these data were collected from one prominent medical journal and analyzed in order to gain insights regarding the state of OB/GYN discourse. The NEJM was chosen for this investigation because it provides literature that represents the historical period in which the OB/GYN profession was solidifying and therefore contained data that was essential to the aims of this paper. Additionally, this journal is widely considered to be a top-tier medical journal and sets a standard for high-quality findings in the field. However, a singular focus on this journal introduces several limitations to the findings presented.

First, this analysis does not encompass the larger scope of medical literature that was being published across a multitude of journals between 1935 and 1969. It is possible that other relevant journal publications during the time examined in this study may present alternative or contradictory themes to those described here. For example, there may have been contexts in which birthing people received effective or empowering care related to the disorders identified in this study. Additionally, the NEJM is not exclusively focused on obstetrics, women’s health, or infertility. In a larger sense; this journal cannot offer concrete insights into broader cultural perceptions of infertility as it was (and still is) primarily accessible only to those who work in
medical spaces. As a result, this journal is both written and read by a small subset of the population which impacts this project's generalizability. Therefore, findings presented in this study should be interpreted with caution.

Finally, this project includes only the provider perspective without first-hand accounts from any patients. In the absence of patient voices, this project cannot speak to the lived experiences of the women under these providers’ care. Nor can patients’ own perceptions of their bodies, motherhood, and/or child-bearing be examined.

**Conclusion**

The findings presented in this paper describe a process by which the female body and infertility are constructed using degrading language which serves to stigmatize women’s bodies and place blame. Through their written work, obstetricians in the early-to-mid twentieth century describe their patients’ bodies with language such as “abnormal”, “faulty”, “defective”, and “deficient”. They place blame on their patients’ intelligence, behaviors, hygiene, choice of occupation, weight, and sex lives. Their assessments of these women are legitimized through their socially sanctioned roles as gatekeepers of knowledge and authority. These doctors inflict harmful treatments upon their patients in the interest of promoting their fertility and reproductive capacities, at the expense of their patients’ chronic physical pain. Furthermore, their interest in solving infertility is filtered through ideologies rooted in eugenics as they seek to promote reproduction primarily amongst the segments of the population they deem valuable. Namely, upper-class white women.

Ultimately, OB/GYN and infertility practice face issues related to stigma, blame, racism, and mistreatment. Many of these issues are either heightened or facilitated by authority and
power. These issues are not ahistorical but rather echo early twentieth century attitudes and practices. Utilizing a reproductive justice framework, it is important to contextualize these issues as inherent violations of reproductive rights whose consequences are historically ingrained and intergenerationally felt. To deconstruct these foundational issues – it would be important to re-integrate the unique expertise of midwives into birth care and include historically informed equity-focused learning in medical education.
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