The Pennsylvania State University
The Graduate School

PREScribing Pregnancy Loss:
Women Physicians and the Changing Boundaries of Fetal Life in
nineteenth-century America

A Dissertation in
History and Women’s, Gender, and Sexuality Studies

by

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Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Doctor of Philosophy

August 2021
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Abstract

My dissertation examines the role the first cohorts of women physicians in the United States played in shaping the medical subfields of obstetrics and gynecology. Women were trained largely to provide clinical care for women patients in the mid- to late- nineteenth century, yet they entered the profession in a moment of profound ambiguity regarding pregnancy loss that could compromise their professional status. In the early nineteenth century, common law in the United States permitted pregnancy termination before quickening, or the moment of fetal movement. By mid-century, states began clarifying the common law doctrine of quickening and criminalizing termination at any point in pregnancy without providing clarification for instances in which termination may be clinically necessary. It was not uncommon for women to require pregnancy termination to save their life in instances of health complications like cancer or because a fetus was too large to pass through the birth canal before cesarean sections were widely practiced. These procedures would be tacitly illegal under the new laws. Legal ambiguity surrounding pregnancy termination was met with equally opaque guidance from the medical community and municipal authorities increasingly interested in tracking vital statistics. Medical and state definitions of pregnancy loss, including stillbirth, miscarriage, and abortion, were unaligned and made it difficult for these fields to track information in concert with one another. These fissures also created potentially dangerous situations for women physicians when questions regarding pregnancy loss were arbitrated in a court setting. Despite the role pregnancy loss played in the educational and clinical experiences of women medical students and physicians and how their experiences with the subject can redefine how we understand their role in the professionalization of nineteenth-century medicine, this subject has received little scholarly attention beyond noting women’s public-facing denunciations of pregnancy termination.

By centering women physicians’ experiences of pregnancy loss and termination within individual educational and clinical settings, Prescribing Pregnancy Loss complicates the notion that the first cohorts of women physicians practiced on the margins of the regular medical profession. While women physicians publicly capitulated to mainstream views of pregnancy termination asserted by the American Medical Association to protect their professional reputation and gain purchase in mainstream medicine, in community settings they rendered clarity from the ambiguity of legal, medical, and state-sponsored definitions of pregnancy loss. Within the confines of private educational institutions, women physicians and medical students trained to protect themselves in courtroom settings, authored medical texts clarifying the morbid anatomy of pregnancy loss, and confronted it face-to-face while caring for women patients. I contend that in grappling with pregnancy loss in their medical education and clinical practice, women physicians helped shape the future of the nascent medical subfields of obstetrics and gynecology.
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Acknowledgements

Community makes the PhD journey humane, and I am profoundly lucky to be surrounded by people who have helped me through this process in ways both big and small. Chief amongst them is Lori Ginzberg, my advisor, who supported me and this project from its inception and never doubted (at least to me) that it is a story worth telling. She forced me to ask big, vital questions in my research and taught me how to write well. Through the complexities of life and graduate school, she was a tireless advocate on my behalf and continued to take my scholarship seriously. She taught me how to be a good scholar, though perhaps more importantly, she showed me how to be an exceptional mentor. Her teachings, both about the academy and life, will stay with me always.

I am deeply grateful, as well, to my committee members for their insightful comments and mentorship. Joan Landes developed my interest in the history of the body and helped me focus many of the questions at the core of my dissertation research. Through her own scholarship, Crystal Sanders pushed me to examine the intent of nineteenth-century medical education for women. Erin Heidt-Forsythe helped me clarify some early, unclear thoughts on my dissertation topic and continued to offer guidance throughout my project. While she joined my committee near the end of my writing, I’m grateful to Bernice L. Hausman for introducing me to the field of medical humanities and for engaging deeply with my work.

The Penn State community, particularly the Departments of History and Woman’s Gender, and Sexuality Studies, were formative for me, both professionally and personally. I’m grateful to David Atwill, and later Kate Merkel-Hess for guiding me through the ins and outs of graduate school. To Michael Kulikowski for teaching me how to read theory as a new graduate student, and to Amy Greenberg for asking me to consider what size canvas I needed for my study. Bill Blair taught me to appreciate the Civil War and I am deeply grateful to him and the Richards Center for funding portions of my graduate education and research, even though nineteenth-century women physicians didn’t always jibe with Civil War history. To Matt Isham for conversations both scholarly and not, and Barby Singer for making the Richards Center a welcoming place for everyone. I’m indebted, as well, to the many faculty members who expanded my thinking throughout my time at Penn State, particularly Susan Squier, who introduced me to feminist science studies and Jonathan Marks for his warm welcome to the Bioethics Colloquium. Nan Woodruff’s and Tony Kaye’s seminars were deeply influential in my intellectual development.

My friendships with fellow graduate students were, without doubt, the highlight of graduate school, and Kathryn Falvo, Chris Hayashida-Knight, and Lauran Golder were model colleagues and friends from the start. My fellow Pond Lab residents, Sean Trainor, Bill Cossen, Paul Matzko, Antwain Hunter, and Evan Rothera, and later Tyler Sperrazza, Mallory Huard, ShaVonte’ Mills, and Cecily Zander infused my days with intellect, humor, and comradesy. To Rachel Moran, thank you for modeling for me how to be a superb colleague and friend. And to Aisling McIntyre, Alex Feldman, André de Avillez, Rebekah Martin, Derek Olsen, and Laurent Cases – thank you for your friendship.
Archivists and librarians make the work of historians possible, and if you’re very lucky, fun. I’m grateful to the archivists of the Drexel College of Medicine’s Legacy Center Special Archives and Special Collections - Joanne Murrey, Margaret Graham, and especially Matt Herbison - for introducing me to Woman’s Medical College of Pennsylvania and my dissertation topic. My project would not exist had it not been for their patient assistance and mentorship. I benefitted as well from Beth Lander’s deep knowledge of the collections of the College of Physicians of Philadelphia, as well as from the assistance of Jill Rawnsley at the Philadelphia City Archives. Thank you to Steve Peitzman for showing me Woman’s Med, then and now.

A cadre of friends, family, and mentors have buoyed me through this process. I’m indebted to Melissa Plotkin for inspiring this project, Leigh Senderowicz for championing it and me always, Cathy Stouch and Allison Meckely for their friendship and tireless advocacy for women, Ryan Sauder for his mentorship and friendship, and to Katie Langley for seeing me through the last and most difficult leg of this journey with incredible patience, love, and gentle advice. Megan stood with me through the whole thing. Phil Avillo and Peter Levy taught me to love history, and I’m grateful for their guidance early my journey. To my mother, Joan Klinke, and father, Scott Seitz, thank you for supporting me even when my “paper” dragged on for longer than anyone had hoped. And to my brother, Adam Seitz, and my sister-in-law, Faith Ryan, thank you for being there from the beginning. Sandy and Davey Keller, thank you for your support, baby-sitting, and company on early research trips. My late grandparents, Mildred Seitz and Richard Brothers, gave me the love and intellectual curiosity that sustained me through this project.

It feels beyond inadequate to thank Mathew Moore for all he has done and sacrificed so that I could pursue my intellectual work. Thank you, Mat, for the things you do, both visible and not, so that I can be a scholar, mother, friend, and partner. You are my reason, always. And to my children, Isla, Benjamin, and Nathaniel Seitz Moore, thank you for living with this project your entire lives. I’m looking forward to starting our next chapter.
To Mat, always,

and

Isla, Benjamin, and Nathaniel, the joys of my life
**Introduction**

**113 Years of Ambiguity**

In the years leading up to the 1973 Supreme Court decision *Roe v. Wade* that legalized abortion in the United States, doctors at Magee-Women’s Hospital in Pittsburgh, Pennsylvania used the ambiguity of a nineteenth-century state statute on abortion to provide their patients with the procedure. The 1860 statute both prevented “unlawful” abortions and failed to define the terms of an “unlawful” procedure.¹ Over one hundred years later, physicians at Magee-Women’s Hospital interpreted the statute to provide ‘lawful’ abortions to women whose mental or physical health would be negatively affected by continuing the pregnancy. One physician who worked at the Hospital described the attitude as “libertarian” - some physicians chose to provide the procedure and record the evaluation “in a normal, medical manner” to “cover [their] tracks,” while others chose not to provide the procedure at all. A nursing assistant in the Hospital’s emergency department described a bleak situation for women before the *Roe* decision, noting that patients would regularly present to the Department after having undergone an “unlawful” abortion, now suffering the complications and in dire need of medical care. Many of these women, she noted, were afraid to seek medical care even though they were gravely ill. Their fear was legitimate - the nursing assistant noted, as well, that detectives would “hammer” the women to find out who provided their abortion.²

¹ The first statute criminalizing abortion in Pennsylvania was passed by the legislature in 1860. The law criminalized “unlawful” procedures as felonies, punishable by a fine of up to five hundred dollars and imprisonment for up to three years. Purdon, John, Esq. *A Digest of the Laws of Pennsylvania, from the Year One Thousand Seven Hundred to the Tenth Day of July, One Thousand Eight Hundred and Seventy-Two.* Tenth Edition Vol. 2. Philadelphia, 1873. 2 vols. *The Making of Modern Law: Primary Sources.* Web. 1 April 2019, 341.

While *Roe v. Wade* removed the ambiguity of the Pennsylvania state statute and those like it across the country, scenarios like those experienced by the clinicians and patients at Magee-Women's Hospital in Pittsburgh had antecedents well into the nineteenth century. In the vacuum created by ambiguous legislation in Pennsylvania, medical men, municipal authorities, and coroners attempted to define the terms of a “legal” and “illegal” procedure. In doing so, they dramatically altered previously established boundaries of fetal life - in some instances intentionally, at other moments unwittingly - and shaped the nascent medical subfields of obstetrics and gynecology.

While men’s motives and interests are important to understand, this dissertation examines how the first cohorts of women physicians in the United States grappled with the ambiguity of fetal life. Women were overwhelmingly trained to provide clinical care for women patients in the mid- to late-nineteenth century, yet they entered the profession in a moment of profound ambiguity regarding pregnancy loss that could compromise their professional status.3 It was not uncommon for women patients to require pregnancy termination to save their life in instances of health complications like cancer or because a fetus was too large for birth before cesarean sections were widely practiced, and miscarriage was a common occurrence in women’s reproductive lives. Pregnancy loss and termination were central to the educational and clinical experiences of women medical students and physicians, yet this subject has received little scholarly attention beyond noting medical women’s public-facing denunciations of criminal abortion.4

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3Rachel L. Bodley, *Valedictory Address to the Twenty-Ninth Graduating Class of the Woman’s Medical College of Pennsylvania* (Philadelphia: Grant, Faires & Rodgers, 1881), 4-5. In her 1881 speech to the graduating class of Woman’s Medical College, Dean Rachel Bodley, reported that 66% of the College’s graduates pursued careers in obstetrics and gynecology. See also Regina Markell Morantz, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985).

By centering women physicians’ experiences of pregnancy loss and termination within individual educational and clinical settings, *Prescribing Pregnancy Loss* complicates the notion that the first cohorts of women physicians practiced on the margins of the regular medical profession. While women physicians publicly capitulated to mainstream views prohibiting pregnancy termination to protect their professional reputation and gain purchase in mainstream medicine, in community settings they rendered clarity from the ambiguity of legal, medical, and state-sponsored definitions of pregnancy loss. Within the confines of private educational institutions, women physicians and medical students trained to protect themselves in courtroom settings, authored medical texts clarifying the morbid anatomy of pregnancy loss, and confronted it face-to-face while caring for women patients. In grappling with pregnancy loss in their medical education and clinical practice, women physicians also helped shape the future of the nascent medical subfields of obstetrics and gynecology.

The interest of the groups classifying fetal life was not always directly related to opposing or supporting abortion. Municipal authorities, for instance, would unknowingly influence this debate through their interest in quantifying and making sense of their citizenry’s public health data in the late nineteenth century. A project meant to illustrate the modernity of modern cities and create public policy, municipal authorities turned their eye to tallying infant mortality.

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and maternal mortality rates. In doing so, they were forced to confront an important question: at what point was a fetus considered a living child who had protection under the law? While municipal authorities asked these questions in the late nineteenth century, other groups were forced to grapple with them decades before. Coroners, for instance, were required to investigate and report cases that may have involved foul play, bringing them before a coroner’s jury for adjudication. In doing so, they too confronted the ambiguity of the legal code in their attempts to complete their work under their profession’s own standards.

Physicians were the physical conduits between the state and their patients’ bodies, and the very nature of their work placed them at the center of these questions. As the regular medical profession consolidated professional authority and power in the second half of the nineteenth century, physicians increasingly found their work intersecting with government authorities as they reported vital statistics to city officials or delivered the bodies of the dead to coroners alongside stories that corroborated their own findings and reports.6 Physicians held power in their ability to adjudicate life and death in the absence of legal oversight. Alongside this power, however, came a vulnerability: in the absence of broad policy or protocol, individual physicians were left open to investigation and litigation if their actions were questioned.

Women entered the medical field just as pregnancy and birth became increasingly scrutinized. They faced significant challenges, perhaps the most pernicious being the construction of women as delicate, sickly, and often irrational beings for whom a profession as serious and rational as medicine was outside of reach.7 While women entered a variety of

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7 Edward H. Clarke’s 1873 book, *Sex Education: A Fair Chance for Girls*, is perhaps one of the best known and refuted tracts illustrating the medical field’s commitment to pathologizing femininity. Clarke mystified menstruation and argued that higher education of any type would deform a woman’s reproductive organs, leaving
professions in the nineteenth century, the medical field was particularly hostile to their presence. Women physicians, perhaps more so than teachers or even nurses, were forced to grapple with how far their work fell from early Victorian gender stereotypes that fashioned women as keepers of nineteenth-century morality and domesticity. Elizabeth Blackwell, the first woman in the United States to earn a medical degree, argued that “the purpose of the woman’s medical movement is for occupying positions which men can not fully occupy and exercising an influence which men can not wield at all.”

Medicine in the mid-century, however, was often brutal. In the age before the wide-spread acceptance of antisepsis and germ theory, women physicians were expected to employ heroic treatments and were exposed to the naked bodies of their patients. This work fell well outside the bounds of the morality and propriety they were charged to uphold.

Women also faced significant barriers as they trained for and entered the medical profession. Medical schools barred their admittance, spurring those sympathetic to their cause to open separate institutions to train women for the field. Upon entrance to the profession, women faced further discrimination. Local, regional, and national medical societies refused their

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entrance, forcing an effort that created parallel institutions for women physicians. Any woman lucky enough to practice medicine in the late-nineteenth century faced tremendous societal and professional barriers.

Central to the effort to oust women from the medical field was the issue of abortion. By the mid-nineteenth century, the mainstream, “regular” medical community, assisted by the American Medical Association, prohibited abortion. The reasons for this prohibition were varied: some physicians objected to the procedure on moral grounds, arguing for the novel view that fetal life began at the point of conception. Others felt abortion endangered the health and life of their women patients. Women’s entrance into the medical field was also a catalyst for the Association’s position. Women physicians were overwhelmingly trained to care for the medical needs of women, and thus pursued the medical subfields of obstetrics and gynecology. As the field of midwifery declined in the late nineteenth century, childbirth came to represent a lucrative business for men physicians and they had no interest in sharing it with their women colleagues. Linking women doctors with abortionists and discredited midwives was an easy way to drive down competition.

The link with abortion presented a serious challenge for women doctors, who were expected to provide medical care to women at all stages of their reproductive life within the context of a legal and ethical environment dominated by ambiguity and a profession hostile to their very presence. It was not uncommon for women to require termination to save their life in

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10 Reagan, *When Abortion was a Crime*, 57, 80, 82-3.
11 Hugh Lennox Hodge, the Chair of Obstetrics and Diseases of Women and Children at the University of Pennsylvania, was an early and visible proponent of the notion that fetal life began at conception. Hodge delivered a lecture titled “On Criminal Abortion” to the students of the University of Pennsylvania in 1839 that upended the common law doctrine of quickening that marked the point of fetal life, arguing instead that life began at the moment of conception. Hugh L. Hodge, *Introductory Lecture to the Course on Obstetrics and the Diseases of Women and Children, Delivered at the University of Pennsylvania, November 7, 1838* (Philadelphia: J. G. Auner, 1838). Chapter Three further explores his life and work.
instances of pregnancy complications; similarly, spontaneous pregnancy loss was common in the
nineteenth century. These procedures became tacitly illegal and pregnancy loss in general,
suspect, under the newly codified laws and professional codes. Legal and medical ambiguity
surrounding pregnancy termination was met with equally opaque guidance from municipal
authorities interested in tracking vital statistics. Legal, medical, and state definitions of
pregnancy loss, including stillbirth, miscarriage, and abortion, were unaligned and made it
difficult for these fields to track information in concert with one another. These fissures also
created potentially dangerous situations for women physicians when questions regarding
pregnancy loss were arbitrated in a court setting.

This project builds on a central line of scholarship on women in medicine that explores
the space between the therapeutic behavior of women and men physicians. Women physicians
believed their practice to be different than their male counterparts, and early historians of their
experience did as well.13 Though women physicians publicly appealed to their stereotypical
feminine qualities to justify their existence in the profession, there is little evidence that they
practiced medicine differently than their male colleagues.14 Later scholarship probed beyond
women physicians’ statements and showed little difference in the clinical care provided by men
and women.15 What was different, however, was what Regina Markell Morantz calls a “degree

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13 Historians of obstetrics and gynecology framed the professionalization of both medical subfields as part of the
broader narrative of the medicalization of childbirth that pushed midwives from the field and firmly placed birth in
the hands of regular (male) physicians. Women physicians represented the antidote to what many characterized as
the misogyny of male physicians, though this view is too simplistic and reductive to capture the complexities of
women physicians’ experiences. See, for example, G. J. Barker-Benfield, The Horrors of a Half-Known Life: Male
Attitudes toward Women and Sexuality in Nineteenth-Century America, second edition (New York: Routledge
14 On women physicians’ special role in medicine, see Regina Markell Morantz, Sympathy and Science: Women
15 Regina Markell Morantz and Sue Zschoche, “Professionalism, Feminism, and Gender Roles: A Comparative
Markell Morantz, Sympathy and Science, 6.
of control” in institutions run by women.16 Women’s medical schools and hospitals were largely
controlled by women boards of corporators and staffed by women professors and physicians.
Unlike large hospitals often associated with the nation’s prominent medical schools or run by
cities or states, women’s hospitals had a degree of shared feminist ideology that in turn created
staff cohesion that could have positive medical outcomes.17

Building on this line of inquiry, my dissertation interrogates the space between women’s
public statements on abortion to better understand how they actually approached the subject in
their medical education and clinical care.18 Previous studies argue that women, occupying a
more precarious place in the field, had to distance themselves from abortion.19 Women were
overwhelmingly trained to be obstetricians and gynecologists, however, and it would be
impossible for them to avoid pregnancy termination and loss in their practice. Just as medical
men publicly denounced abortion and privately provided abortion care, women physicians’
public statements deviated from their private practice.

Historiography

Centering women physicians’ experiences with pregnancy termination is made possible
by three bodies of scholarship: studies on nineteenth-century women’s roles in medicine;
historical and contemporary research on abortion in the United States; and, more recently,
scholarship that elucidates the legal, historical, and cultural constructions of the fetus. Early

16 Morantz and Zschoche, “Professionalism, Feminism, and Gender Roles,” 415.
17 Morantz Sanchez and Zschoche’s comparative study between Boston Lying-In Hospital and the all-women staffed
New England Hospital show that in the case of puerperal fever outbreaks, the New England was better able to
control infection because of a centralized authority based on a shared feminist ideology that both allowed the
Hospital’s administrator to make bold decisions for patient care and a fundraising strategy that was aligned with the
mission and vision of a hospital for women to care for women.
18 Morantz and Zschoche urged future historians of women in medicine to take this line of inquiry seriously.
Morantz and Zschoche, “Professionalism, Feminism, and Gender Roles,” 415.
19 Reagan, When Abortion was a Crime, 57; Markell Morantz, Sympathy and Science, 220; James C. Mohr, Abortion
161; Mary Roth Walsh, “Doctors Wanted: No Woman Need Apply”: Sexual Barriers in the Medical Profession,
studies of women’s entrance into the medical field focused on the challenges faced by women as they trained for and entered a field dominated by men in a historical moment when women’s roles were legally and culturally constricted. Regina Morantz-Sanchez’s influential body of scholarship illuminates the hurdles women faced in order to craft a successful medical career, focusing largely on the experiences of middling white women who comprised the first cohorts of women physicians. The challenges were both structural and institutional. Women faced significant barriers in pursuing professional work outside of the home. If they managed to buck the cultural norm that circumscribed their work to the domestic sphere, they were met with further challenges as they trained for a career in medicine. Medical schools in the United States refused to accept women, leading to gender segregated medical schooling. Several institutions were created - either by women themselves, or groups supportive of women’s rights - with the specific mission of training women to become physicians. As their graduates entered the profession, they met with continued resistance. The field itself was openly hostile to women physicians and excluded them from membership in national, regional, and local medical societies.  

And yet women persevered, establishing successful medical careers in cities and rural locations across the United States. Familiar names like Elizabeth and Emily Blackwell, as well as the less familiar, like Anna Broomall and Marie Formad who will be featured in this study, emerged from scholarship on women in medicine. In some respects their experiences were uniform in that they faced significant discrimination in their chosen profession, and most would go on to pursue careers treating women and children as obstetricians, gynecologists, and pediatricians. Like the Blackwell sisters, many would remain unmarried. Some would become

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20 Morantz-Sanchez, *Sympathy and Science*, 179. While the American Medical Association seated Dr. Sarah Hackett Stevenson in 1876, women were not formally accepted until 1915.
wives and mothers and continue their career, while others would leave their chosen profession to pursue domestic life. Most—though not all—of them were middling white women who had the means to pursue education. Some, though not all, were feminists involved in the nineteenth-century campaign for women’s rights.

Alongside scholarship focusing on the individual experiences of women in medicine, historians also produced institutional histories of the medical colleges that trained women physicians. Out of necessity, these institutions were founded to train women for the profession when mainstream medical colleges refused women entrance. Founded by women and groups that supported women’s professional education more broadly, women’s medical colleges attempted to offer their students the same level of education as their male colleagues, including the clinical experience necessary to be a successful physician. Significant emphasis was placed on the “special role” of women in medicine, or the idea that women physicians were especially suited to treat women patients. Because of this, women’s medical colleges excelled at training their students for future careers in obstetrics and gynecology, and as in the case of Woman’s Medical College in Philadelphia, actually provided their students with clinical obstetrical experience superior to the training at mainstream medical colleges like Johns Hopkins or the University of Pennsylvania.

It was early scholarship on women in medicine that initially piqued my interest in how women physicians handled abortion and allowed me to ask how, if women were trained to care for other women, they were able to place such ideological boundaries around the very gray and ambiguous events that are pregnancy loss and birth. This led me to Drexel University’s College of Medicine’s Legacy Center, the home of the archival records of Woman’s Medical College of

Pennsylvania (WMCP, Woman’s Med).Founded by Philadelphia Quakers, Woman’s Med was the first medical college in the United States to educate women for careers in medicine. In their archives I found the first inkling that women physicians did indeed confront pregnancy loss and termination in their medical education and clinical practice.

The first studies of abortion in early American life were driven by the desire to understand the dimensions of the demographic turn of the mid- to late-nineteenth century, and centered on the technological developments of fertility control and the legal system’s response to these emergent technologies. Key questions emerged from this period, such as whether emerging technologies or changing notions of morality and perceptions of the family drove down fertility rates, and how state and federal legislation responded to these changes. Abortion took center stage in each of these “conversations” in the sense that many believed it was a significant driver in the country’s declining fertility rates. The physician Horatio Robinson Storer, perhaps the most vocal voice in this debate, believed that as many as one in five women were aborting their pregnancies in the mid- to late- nineteenth century, and those terminating their pregnancies were overwhelmingly married, white, native, middling- and upper-class women.22 Through the work of Storer and others, the issue of abortion reform was yoked with the nativistic goal of increasing the birth rate of married, white, middling, Protestant women.23

By mid-century, regular physicians, arm-in-arm with the American Medical Association and the court system, mounted a powerful campaign to criminalize abortion in the United States.

Their reasons were complex and overlapping. First, the medical field felt that the moment of ‘quickening,’ or the point at which the pregnant person felt fetal movement, was an arbitrary marker of fetal life and any interruption of gestation from the point of conception was criminal. Second, regular physicians’ ideological worldviews constructed their role in medicine as the ultimate protectors of life through, amongst other things, their pledge to uphold the Hippocratic Oath, and they extended this view to fetal life in the mid- to late-nineteenth century. The medical field, as James Mohr argues, was nativistic and committed to upholding nineteenth-century gender ideology, and the anti-abortion legislation they championed was a reflection of the conservativeness of their field. Finally, their anti-abortion crusade centered on economic self-interest. It served them to push out those who presented competition in a complex medical marketplace - midwives, commercial abortionists, alternative medical practitioners, and - importantly - women physicians, who they took to comparing to “dirty” and “dangerous” midwives.

Feminist scholarship expanded this analysis, turning the focus from the regular physician community and their legal campaign to the experiences of individual women who both lived through and died from abortion procedures. Leslie Reagan’s scholarship centers these stories, showing how women’s private interactions with their physicians - held in women’s homes and bedrooms, where their doctors provided their care - shaped abortion policy in the decades leading up to the *Roe v. Wade* Supreme Court decision. Reagan’s influential study complicates the notion that the regular physician community was united in their opposition to abortion, finding instead that physicians’ public-facing opinions failed to align with the clinical care they provided women patients in private. Put another way, when confronted with the reality of

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women seeking abortion care, physicians provided abortions and care for “botched” procedures out of understanding for the challenges patients faced on an individual level. Importantly, physicians’ private experiences with their individual patients led them to act, and as a group physicians became a vital arm of the social movement to decriminalize abortion in the mid- to late-twentieth-century.

Reagan’s scholarship raises several questions that inform this study. The most important, perhaps, is that physicians’ private clinical practices regarding pregnancy termination did not align with their public-facing rhetoric. While the American Medical Association and local medical societies condemned the practice and barred members who were publicly exposed for providing the procedure, in private physicians provided their patients with abortions. Reagan’s insight regarding male physicians raises questions regarding their women counterparts, especially because women physicians of this period revealed that their patients regularly asked them about abortions.25

Other early, key studies focused on complicating the idea that nineteenth-century Americans desired to limit their fertility as a direct result of the changing social values that altered the roles of women and children within the family unit, and the idea that this could be accomplished only through abstinence.26 Janet Farrell Brodie’s scholarship introduced the notion that nineteenth-century Americans had access to vast amounts of information on contraception and abortion, and thus various options for controlling their fertility. The advent of the printing press helped make information on fertility control widely available through advice

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25 Reagan, *When Abortion was a Crime*, 57, 73. Catherine Macfarlane, *Dr. Kitty Mac*, unpublished manuscript, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 36. It is important to note that Reagan does highlight the story of a few women physician-abortionists, though her study does not treat their experiences in-depth. See, for instance, her description of the Dr. Josephine Gabler Clinic, 149-151.

manuals and pamphlets on reproductive control, catalogues that advertised devices and potions, and sex manuals that underwent several printings. Brody argues that this information was so widely available that it diffused beyond the elite to middling, poor, and rural communities in a “web...that twisted, knotted, and folded back upon itself.”

Ultimately, her argument centers on how populations interact with new technologies. Rather than changing notions of morality, Brody argues that access to new forms of limiting fertility drove the declining fertility rate.

Helen Lefkowitz Horowitz’s scholarship builds on Brody’s study and argues that the nineteenth century was the period in which Americans learned to talk about sex in public. Information on sex and reproduction was plentiful for nineteenth-century Americans, and as this information permeated the public consciousness, Americans were forced to learn both how to think and talk about sex with others. She identifies four competing frameworks Americans used to understand sexuality, noting that individuals most certainly drew from several: American vernacular sexual culture, evangelical Christianity, reform physiology, and “a new sensibility that placed sex at the center of life.” Horowitz envisions these four competing and overlapping frameworks not as direct links between prescription and action, but rather one in which there’s a gap that allows for people’s actions to contradict their public-facing beliefs. The gap between belief and practice, also explored by Reagan, is a common leitmotiv in medical history that I find

27 Brodie, Abortion and Contraception in Nineteenth-Century America, xi.
28 Brodie builds on the research of Norman Himes, whose work argued that technology access drove down the Country’s fertility rate. She also challenges Linda Gordon’s argument that the desire to limit fertility is timeless and could only be accomplished through abstinence, found in “Why Nineteenth-Century Feminists Did Not Support Birth Control and Twentieth-Century Feminists Do: Feminism, Reproduction and the Family,” Rethinking the Family: Some Feminist Questions, ed. Barrie Thorne (New York: Longman, 1982).
30 Horowitz, Rereading Sex, 4-5.
valuable for exploring women medical students’ and physicians’ relationship with pregnancy loss and termination.

Farrell, Brodie and Horowitz remind us that the desire to classify the nineteenth-century United States’ morality as monolithic and repressed is inaccurate. Regular physicians were forced to contend with a complex medical marketplace that offered women multiple medical and commercial options for controlling fertility and terminating pregnancy. The experiences of women medical students and physicians must be understood within this complicated medical milieu that in some cases empowered their work, and in others posed direct threats to their position in the medical field.

The most recent scholarship on pregnancy loss and termination centers historical experiences of miscarriage and the cultural, medical, and legal construction of the fetus. A pernicious and often unexplored outcome of politicizing abortion is the silencing of people’s experiences with unexpected pregnancy loss. Contemporary personal accounts from women tell us that miscarriage is far more common than we are led to believe, and this was no different in the nineteenth-century United States. Though abortion is currently legal in the United States, we live with the legacy of criminalization in our culture’s deep stigmatization of miscarriage.

Sara Dubow’s groundbreaking work is at the center of this scholarship, and argues that the fetus has always been a reflection of a society’s values and anxieties. She traces the fetus across the nineteenth- and twentieth-century United States, illuminating the ways the state constructs the fetal citizen at different moments through statutory policies, state and federal laws,


and judicial rulings. The core intervention of Dubow’s scholarship, the notion that the fetal body’s meaning is historically situated and dynamic, is vital to the premise of my dissertation. The fetal body was constructed by siloed professions in the years between 1850 and 1900, and for a variety of reasons. The fetus constructed by the medical field was not the same as the fetus constructed by statutory and judicial law, and neither the medical or legal fetus corresponded to that developed by municipal authorities. Medical men could navigate the ambiguity of these competing fetal bodies, though I am most interested in how their more vulnerable sister physicians navigated fetal ambiguity.

Equally influential to my research is Shannon Withycombe’s recent study, *Lost: Miscarriage in Nineteenth-Century America*, which provides an antidote to the paucity of scholarship on the history of miscarriage.33 Withycombe mined women’s personal correspondences to discern how they perceived pregnancy and miscarriage in a historical moment that included the professionalization of obstetrics, a shift in medical theory from one that understood pregnancy in terms of preformation, the idea that humans simply grew in the womb from miniature versions of their adult bodies, to one based in epigenesis, the theory that an organism develops sequentially from an egg cell, and the emergence of legislation that restricted women’s reproductive control. Withycombe’s findings are both deeply important and yet rather unsurprising: some women celebrated their miscarriages while others felt a deep sadness at their loss, and many felt both joy and grief within the context of a reproductive life that could span decades.

Specifically, Withycombe’s study presents several concepts I’ve found useful to my study. First, and perhaps most importantly, the notion that women’s responses to pregnancy and

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miscarriage depended upon the context in which they lived – both their personal circumstances and the social and medical worlds that more broadly defined their choices. For instance, Withycombe found that some nineteenth-century women described their miscarriages as ‘joyful’ occurrences, while others were devastated by pregnancy loss. The disparate reactions had everything to do with where a woman found herself in her reproductive life, the material circumstances of her family, and the number of children already under her care. This study takes this contextuality - pulled also from Dubow’s scholarship - and applies it to the experiences of women medical students and physicians regarding abortion care. Women physicians’ response to voluntary pregnancy termination was not monolithic because it couldn’t be. It depended upon the practicing physician’s context - her patients, the institution in which she practiced, and her clinical and educational experience.

Alongside her complex analysis of women’s personal reactions to pregnancy and miscarriage, Withycombe’s research highlights a significant shift in the medical management of miscarriage that played out over the course of the nineteenth-century. This shift is integral to understanding that women physicians were not able to avoid caring for women experiencing pregnancy loss in their clinical practice, and this would, inevitably, put them at significant professional and personal risk in a historical moment in which every pregnancy loss could be suspect. Management of miscarriage was changing in the nineteenth century from something once seen as a natural part of a woman’s reproductive life to a medical event in need of physician oversight. This shift in thinking parallels the nineteenth-century’s changing views on pregnancy as an event once overseen by experienced women and midwives to one best managed by a physician.
In the case of miscarriage, Withycombe argues that the shift was rooted in two important changes in medical theory and treatment for pregnancy. First, the theoretical shift from preformation to epigenesis that moved human development from a mysterious and unknowable process to one that could be observed and known. Miscarriage could easily be construed as a natural and unconcerning aspect of one’s reproductive life within a medical worldview that saw fetal specimens as mysterious and something other than human. As physicians and scientists began to study and know the fetus, however, miscarriage became an unnatural and dangerous medical event in need of physician management. As one can imagine, women patients initially had no interest in physicians overseeing their miscarriages. In large part this was because physicians had almost no tools to treat pregnancy loss, and according to domestic medical manuals written by doctors, everything seemed to cause miscarriage. If it was unavoidable and untreatable, women reasoned, then what was the use in inviting a physician to manage the process?

Women’s views on the medical management of miscarriage changed, however, as physicians began attending births, an experience largely reserved for the wealthy and the poor. While patients who could afford it gave birth under a physician’s watchful eye in their own homes, working class and poor patients began giving birth in institutions like lying-in and teaching hospitals that were often attached to women’s medical colleges interested in providing their students with clinical medical experience. The Hospital of Woman’s Medical College of Pennsylvania was one such institution. The power dynamics of the home were different than those in institutional settings in which young women were often away from their extended family support systems and at the mercy of their attending physicians. It was on the bodies of these women, according to Withycombe, that physicians felt comfortable practicing new, more active
forms of treating miscarriage that would ultimately alter the protocol for treating pregnancy loss more generally. Notably, women themselves desired these treatments for miscarriage and became active co-constituents of the medicalization of miscarriage largely accepted as the model by 1880. What was once considered a natural event centered on the bodily knowledge of women had become an unnatural occurrence in need of professional medical intervention.

**Methodology, Sources, and Key Terms**

**Methodology and Sources**

Writing about women medical students’ and physicians’ experiences with pregnancy loss and termination, both in terms of what they learned and how they practiced, is highly contextual. It was relatively easy for medical women to speak out against the ills of intentional pregnancy termination; it was much more difficult, however, for them to learn about and treat pregnancy loss and termination. It required they stretch beyond the polarity of the field’s mainstream views, and it was dangerous work. For the historian, this means information on pregnancy loss and termination is often difficult to find in the historical record. Further, laws on criminal abortion and vital health tracking in the mid to late nineteenth century varied at the municipal and state level. For this reason, I constructed my dissertation research around a single institution. This allowed me to contextualize women medical students’ and physicians’ experiences with pregnancy loss and termination within the broader context of municipal and state policies governing their work. Drawing on Regina Markell Morantz Sanchez’s research showing that women’s medical institutions had what she calls a “degree of control” over operations by means of a shared feminist ideology, I centered my research on the archives of Woman’s Medical College of Pennsylvania (Woman’s Med, WMCP).
Woman’s Medical College of Pennsylvania was the first medical college in the United States to train women. Known as the “Medical Capital of the World” for both its role in advancing the nation’s medical field and its numerous and distinguished hospitals and medical colleges, Philadelphia was particularly hostile to women in medicine. In reaction, a small group of Quaker businessmen and physicians founded Woman’s Med, as it was called, with the primary aim to provide women with medical education equivalent to what their male counterparts received at the medical schools associated with University of Pennsylvania and Thomas Jefferson University. Through the rise and fall of gender-segregated education, Woman’s Med remained stalwart in its mission to provide medical education to women through classroom and clinical training, closing its doors finally in 1973 when it merged with Allegheny Health Systems. It was, by and large, considered the best of the schools that trained women for a career in the medical profession. Through its goal of providing care “for women, by women,” WMCP became renowned for its gynecological and obstetrical training, and its graduates were known to have far superior experience to their male counterparts in both medical subfields. This was due to, in large part, to the clinical experiences women medical students had through their work in the hospital and various out-patient clinics affiliated with the College. Students left their medical training having delivered multiple babies, while it was common for men graduating from Philadelphia’s other medical institutions to have no experience in attending pregnant women.

The records of Woman’s Medical College, its faculty, students, and clinical facilities are held by Drexel University’s College of Medicine’s Legacy Center Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

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34 Though created by boosters, the 1930 book Philadelphia: World’s Medical Centre profiles the 63 hospitals and medical schools in the city. James M. Anders, M.D. Philadelphia: World’s Medical Centre, publisher unknown, 1930, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
Collections. This dissertation makes use of the Legacy Center’s rich collections, including the institutional records of the clinics associated with the College. The annual reports, minutes of the boards of corporators, and various other institutional publications included information at a variety of levels of importance to the College and its supporters, from annual budgets, faculty names and appointments, sources of philanthropic support, and new initiatives and partnerships undertaken by the institution. Through these documents, I was able to make sense of the world in which women led, taught, learned, and cared for their patients.

The writings of women medical students and physicians on abortion and pregnancy termination, both public facing and personal, are equally important to this study. They show us that women physicians’ views on pregnancy termination were situational and directly related to the position they occupied within their institution, and more broadly, the medical profession. Publicly, women medical students bemoaned what they perceived to be the increasing rates of abortion in the United States, and believed as women physicians they had a specific duty to disabuse women of the notion that pregnancy termination before the point of quickening, or the moment at which a woman felt fetal movement, was legal and moral. In their private writings, women physicians reveal a more clinical tone, describing abortion care as a part-and-parcel of caring for pregnant women.

Lectures and pedagogical exercises from both Woman’s Medical College and its all-male competitor, the University of Pennsylvania, provide equally important insight into what women physicians and their male counterparts were taught with regard to abortion and pregnancy termination. Overwhelmingly, men were taught that it was their duty as protectors of women and children to stamp out the notion that pregnancy termination at any stage was moral or legal.
Women, on the other hand, were taught how to legally protect themselves in the event that their medical practice was called into question by the courts.

Neither women nor men medical students, however, were offered clear guidance with regard to protocol for patients presenting in need of abortion care. Their course lectures focused on morality and legal protection, and the prominent medical texts used by Woman’s Med and the all-male medical colleges of Philadelphia offered no substantial guidance on the subject. The “dearth of information” eventually led Marie Formad, a WMC student and later prominent faculty member, to write her senior thesis on the morbid anatomy of criminal abortion so that physicians could use it to identify the signs of criminal abortion in their own practice. Despite the usefulness of her study, Formad’s framing meant her research allowed physicians and others to identify criminal intent and provided no guidance with regard to how a physician would care for a patient who had attempted to self-abort.

While medicine struggled to define the boundaries of fetal life, other facets of society began the work of defining pregnancy loss and intentional termination, albeit for different reasons. Municipal entities, including the City of Philadelphia, began tracking its citizenry in the second half of the nineteenth century in an effort to keep pace with Europe’s sophisticated methods for tracking its populations’ health. Philadelphia’s Board of Health took a sudden and keen interest in maternal and infant mortality, as a low rate of both was considered a marker of a population’s modernity. An interest in infant mortality necessitated an interest in miscarriage and pregnancy loss, which further necessitated an interest in when, exactly, a person was considered a person. This, in turn, raised an important question that would have ramifications far beyond population health: municipal authorities were forced to consider when a fetus became a person they were legally required to count as a part of their population tracking.
Coroners were equally interested in defining the boundaries of pregnancy loss by mid-century, for many - though not all - of the same reasons. As municipal governments became interested in tracking the deaths of their citizenry, they enlisted those who confronted it on a regular basis in their professional lives: doctors, midwives, police officers, and coroners. Coroners were required by law to hold inquests over ‘violent deaths,’ and by 1854 the Coroner of the City of Philadelphia, Joseph Delavau, began holding inquests over stillbirths. A stillbirth was and continues to be a relatively common occurrence in pregnancy and does not necessarily indicate violence. While some of the miscarriage cases in Delavau’s book clearly involved foul play, others seemed to be the result of routine pregnancies. As laws and morality regarding pregnancy termination changed over the course of the mid- to late-nineteenth century, stillbirths were becoming something that piqued suspicion and required a coroner’s adjudication on behalf of the state.

**Key Terms**

I use the term ‘abortion care’ throughout this dissertation in an effort to clearly articulate what women physicians at Woman’s Medical College likely confronted on a regular basis. I saw no evidence in the historical record of women physicians providing abortions for patients who asked for the procedure; instead, what I found was women patients seeking care for pregnancy loss and termination. Whether or not the abortions were spontaneous or intentional does not necessarily matter in this case, as both could be suspect and implicitly illegal. In some instances, I could guess that a woman had intentionally tried to abort her pregnancy through turns of phrase or her particular life circumstances, though this was not often something I could confirm in the historical document. ‘Abortion care’ allows me to accurately describe the medical care provided after pregnancy loss, regardless of whether it was intentional or accidental.
The further I delved into the history of pregnancy loss, the more confused I became by the interchangeable use of the terms ‘miscarriage,’ ‘abortion,’ ‘stillbirth,’ ‘premature labor,’ ‘spontaneous abortion,’ and ‘infanticide’ in historical texts. The flexibility of these terms in a period when law, statistics, and medical care drastically changed the boundaries of pregnancy and birth is not surprising. Words matter, and in some instances the terminology could be intentional and political, as when Dr. Hugh Hodge labeled all intentional pregnancy termination after conception infanticide. Sometimes, though, clumsy terminology seemed to be a result of confusion regarding the meaning of a term at time when definitions were fungible. The confluence of obstetrics as a developing profession, the emergent interest in tracking vital statistics, and legal ambiguity regarding the boundaries of life made it possible for a coroner to pronounce a several-week-old, deceased infant a “stillborn.” Pennsylvania law added further complexity as it clarified the legality of abortion at midcentury. The 1850 Commonwealth v. J. Gibbons Mills decision muddied definitions by equating the terms “abortion” and miscarriage” and an 1860 statute criminalized “unlawful” abortions at any stage of pregnancy without clarifying what constituted a “lawful” procedure.

The ambiguity and evolution of these terms over the second half of the nineteenth century was not something women physicians could ignore. Ambiguity leaves room for interpretation, and women physicians were both autonomous actors who could use this fungibility to leverage access for both themselves and their patients as well as subjects upon which others used this flexibility to restrict. A central aim of this research is untangling the meaning of these terms and how they changed over time, as well as who had the power to determine which terms were used. With this in mind, the following chapters use terms to describe pregnancy loss and termination.
intentionally. Though these terms may still be in use today, they often are not reflective of nineteenth-century American’s understanding of a clinical diagnosis or criminal act.

**Chapter Outlines**

To access a core argument in this dissertation - the idea that women physicians were trained primarily as obstetricians and gynecologists who were unable to avoid abortion care - requires an exploration of the field of nineteenth-century medicine in the United States, as well as women’s roles in it. Chapter One, “Womanhood of the Noblest Type”: The First Medical Training for Women,” examines the field of nineteenth-century medicine writ large. Nineteenth-century Americans could choose a variety of options from a complex medical marketplace to manage their health, including care from a “regular” physician whose practice centered on evidence-based medicine and heroic measures. In a period when regular, known also as orthodox, physicians could often do little to heal their patients, and often only exacerbated their illness, many nineteenth-century Americans turned to other options.

One of those options was sectarian medicine. Broadly, sectarian medical practitioners objected to the heroic practices of regular medicine and believed instrumental, surgical, and pharmacological interventions to be unnecessary and unnatural. Homeopaths, for instance, posited that a very small amount of prescribed medicine could balance the humors of the body and heal a patient. For many nineteenth-century patients, techniques like homeopathy were a welcomed reprieve from what could be a dangerous encounter with a regular physician, even if they were not efficacious. Commercial cures, advertised in newspapers and hawked on street corners, offered nineteenth-century Americans yet another option for medical care. Like all aspects of the medical profession at mid-century, commercialized medicine was unregulated and potentially dangerous to a patient’s health.
Regular physicians actively worked to marginalize sectarian and commercial medicine in the later part of the nineteenth century in an effort to establish professional dominance. They were largely successful by the end of the nineteenth century. Women practitioners and self-proclaimed healers were common in sectarian and commercialized medicine, and the regular profession’s success meant that opportunities for women in healing professions were circumscribed. Institutions dedicated to training women physicians emerged by mid-century, and those focused on training nurses a decade later. Both fields provided women a path by which they could join the ranks of the newly professionalized field of medicine.

Woman’s Medical College in Philadelphia was the first of five institutions founded to train women physicians for a career in medicine. Woman’s Med, as it was known by its alumnae, was founded by Philadelphia Quakers who recognized the hostility of the City’s medical community toward women joining their ranks. Women traveled from around the country and globe to receive an education at Woman’s Med, often returning to their homes to practice medicine after graduation. Four other institutions sprang up in Chicago, Baltimore, Boston, and New York State with the mission to train women for medical careers. Together, these five institutions produced the first cohorts of women physicians who would largely focus their careers on caring for women and children as obstetricians, gynecologists, and pediatricians.

Johns Hopkins was the first of the country’s prestigious medical schools to integrate their student body toward the end of the nineteenth century, and other medical schools eventually followed suit. As they opened their doors to women, four of the five schools dedicated to women’s education closed theirs because their boards and staff felt their mission had been successful. In their eyes, women were now fully integrated into the profession. Woman’s Medical College in Philadelphia was the only school to continue its mission of educating women
for careers in medicine. Philadelphia, known as the “Medical Capital of the World” since the early days of the Republic, was deeply hostile to women in medicine. The City’s medical colleges continued to bar women’s entrance, and the leadership of Woman’s Med recognized a continued need for the institution.

As the longest-running medical school dedicated to training women in medicine, Women’s Medical College provides a case study for understanding how future women physicians created their professional identity. This chapter uses Woman’s Med to explore the ideology women used to justify their place in medicine when the field was particularly hostile to their presence. Woman’s Med constructed for its students an ideology of women’s special role in the medical field based on nineteenth-century gender constructs that encouraged domesticity. Put another way, women belonged in the field because their “caring nature” provided a necessary foil to the detached, rational male physician. An emphasis on women’s caring nature circumscribed them to the medical subfields of obstetrics and gynecology, while men were encouraged to pursue fields like surgery that required the equally-gendered qualities of strength, cunning, and logic.

Women physicians were also needed to treat women patients in a moment when a majority of the population would consider it scandalous for a man to provide obstetrical and gynecological care to a woman. “Care for women, by women” became a theme central to the argument Woman’s Med made for the necessity of producing its graduates and building its facilities. Its hospital, outpatient and maternity clinics primarily served the women of Philadelphia who could not afford to hire a private physician. The board of corporators of the College and clinical facilities believed these women deserved to be cared for by women physicians.
Chapter Two, “Anna Broomall and the Clinical Obstetrical Training at Woman’s Medical College of Philadelphia,” argues that from the earliest moments of their medical education, women medical students were taught in sex-segregated colleges, groomed to justify their role in medicine through their “special,” womanly virtues, and trained in the best obstetrical and gynecological programs in the United States. In a period when women physicians were taught that they could provide the best care to women patients, it would be impossible for them to avoid patients in need of abortion care in their clinical practices. To make this argument, the chapter explores clinical training at Woman’s Med through the lens of Dr. Anna Broomall, one of the College’s most accomplished professors and alumnae.

Dr. Broomall, the Chair of the Obstetrics Department, built a premier clinical obstetrical and gynecological training program for her students that included the oversight of eight to ten births before graduation at a time when most male medical students graduated without ever attending a birth. Broomall wanted her students to leave Woman’s Med with deep clinical knowledge and experience. To that end, she was dissatisfied with the traditional mechanisms for gathering clinical experience - amphitheater clinics and ward walks. Instead, she spearheaded the creation of the Maternity Clinic for the Woman’s Hospital of Philadelphia, as well as an Out-Practice Maternity Clinic that provided what is often cited as the first pre- and post-natal care protocol in the United States. The in-patient Clinic provided students the opportunity to attend births in a hospital setting, while the Out-Practice Clinic ensured experience attending home births.

These Clinics were not only for women medical students’ clinical development. They also provided an opportunity for poor and working-class women to be attended in birth by a woman physician. The Maternity Clinic at Woman’s Hospital of Philadelphia provided the
women of Philadelphia an alternative to Blockley Hospital, the medical facility serving those who could not afford other means of medical care. Blockley was not, as Dr. Broomall noted in her early justification for the Maternity Clinic, very popular with Philadelphia residents. The Maternity and Out-Patient Clinics were advertised as places where women patients could receive world-class care from women physicians.

Woman’s Med promoted its clinical care for women, by women and its exceptional practical obstetrics and gynecology program as a means to attract patients and students, as well as distinguish itself from all-male - and later, co-educational - medical schools. After thirty years of operation, Dean Rachel Bodley sent out a survey to the College’s alumnae. Bodley hoped to use the data to make that case that women belonged in medicine. The medical field, and the Philadelphia medical community in particular, remained hostile to women physicians and Bodley wanted to leverage the experiences of her alumnae and argue that women could have successful careers in medicine while concurrently having happy home lives and maintaining their physical health. Amongst the many interesting things she found through alumnae responses was that 66% of the women she surveyed worked as obstetricians and gynecologists. Women students were listening to the implicit and explicit messages they received from Woman’s Med and the broader medical community and charting career paths in a “woman’s” field.

Chapter Three, “Guardians of the Rights of Infants”: Physicians, Municipal Records, and the Changing Boundaries of Life,” argues that the legal ambiguity of mid-century Pennsylvania Supreme Court decisions and statutory legislation regarding abortion had profound ramifications for patients and the physicians who treated them, as well as the emerging field of obstetrics and gynecology. This chapter also situates the ethical milieu in which women medical students and physicians worked, including the legal, governmental, professional, and cultural factors that
shaped their views on pregnancy loss and abortion. By de-constructing goals and motives, this chapter aims to lay bare the political, religious, and cultural influences on the nascent field of obstetrics and the role of statistical tracking in defining the boundaries of life. The writings of Dr. Hugh Hodge, perhaps the most prominent obstetrician in mid-century Philadelphia, begin this chapter. In an introductory lecture to the 1839 University of Pennsylvania medical class, Hodge elided centuries of common law precedent and social custom by arguing that abortion at any point in pregnancy was akin to murder. His influential opinion reverberated throughout Philadelphia and the country, published over and over as written text of the lecture and in his seminal obstetrical text used in medical schools across the United States.

By mid-century, states were indeed clarifying the legality of abortion, almost exclusively through statutory regulations that criminalized abortion at any stage of pregnancy. Pennsylvania, however, followed a different route to criminalization when its Supreme Court considered *Commonwealth v. J. Gibbons Mills* in 1850. The *Mills* decision rejected the doctrine of quickening and criminalized abortion at any stage of pregnancy at common law, a path many states considered interventionist. The *Mills* opinion also explicitly equated the terms “abortion” and “miscarriage” and failed to offer guidance regarding the legality of medically necessary abortion. Ten years later, the Pennsylvania legislature followed suit and passed statutory legislation criminalizing “unlawful” abortion in Pennsylvania, again with no guidance regarding what constituted an “unlawful” or “lawful” procedure.

Vague abortion legislation led medical men and women, the courts, and public officials to use their platforms to construct fetal life in the absence of legal guidance of what constituted a stillbirth, miscarriage, and an unlawful and lawful abortion. The reports of Joseph Delavau, the Coroner of the City of Philadelphia, show an increased surveillance of stillbirths by mid-century.
Stillbirths were common in the nineteenth-century: according to reports from the Philadelphia Board of Health, one in five pregnancies ended in stillbirth. While some stillbirths in the inquest record clearly required investigation, others showed no evidence of criminal intent. The ambiguity of the Mills case created a legal environment in which all stillbirths were suspect. In turn, Joseph Delavaux chose to investigate routine stillbirths.

By 1860, the City of Philadelphia was legally required to track its citizens through collecting population health and vital statistics. City officials looked to the professions that managed birth, marriage, and death to help them in their efforts. Physicians, midwives, coroners, and sextons were asked to provide vital statistics to City officials, including confirmation of births and deaths. Pregnancy loss, in particular, presented a unique challenge both in terms of oversight and quantification. Suddenly it mattered what term was used to describe pregnancy loss, and municipal authorities struggled to classify early life and its loss without any clear consensus from legal or medical experts.

Equally important was who could report pregnancy loss to municipal officials. Both the Mills decision and the 1860 statute criminalizing “unlawful” abortion meant that reporting any type of pregnancy loss to City officials could be a dangerous proposition for a midwife. The number of births attended by midwives in Philadelphia dwindled between 1860 and 1875, in part because it was increasingly difficult for midwives to comply with the reporting requirements of the City. The combination of City reporting requirements and the professional authority necessary to report complicated pregnancies championed the newly professionalizing field of obstetrics while pushing midwives from the field. Pregnancy loss had to be quantified, and in the process, it became medicalized.
Chapter Four, “Public Statements and Private Practices: Medical Women Confront Pregnancy Loss and Termination,” turns the narrative back to women physicians and their responses to the medical and legal ambiguity around abortion and pregnancy loss. In the years directly preceding and following the 1873 Comstock Act that prohibited the mailing of contraceptives and abortifacients and information describing them through the U.S. Postal Service, six Woman’s Med students wrote their senior theses on abortion, infanticide, and feticide. All six framed their opposition to intentional pregnancy termination through the lens of morality and argued for the central role of women physicians in educating women patients that abortion at any stage of pregnancy was akin to murder and represented a significant risk to the health and wellbeing of the woman. All six students also leveraged religious arguments against abortion before quickening, and like the 1860 Pennsylvania statute preventing “unlawful” abortions, refused to consider cases of medical necessity.

Annual Reports from the Dispensary of the Alumnae of Woman’s Medical College, a clinic operated by Woman’s Medical College, show that the students and physicians staffing the Dispensary would not be afforded the luxury of ignoring cases of medical necessity. Patients were seen for abortion care at the Dispensary from its first year in operation. Initially listed only as “abortion” in the Dispensary’s first annual report, the procedure was broken out into subcategories in subsequent years, listing both “incomplete” and “threatened” abortions and providing additional insight into the care happening in the clinic. “Threatened” abortions referred to potential pregnancy loss, while “incomplete” abortions could be the result of what was called a “spontaneous abortion,” or miscarriage. Incomplete, however, could also refer to an intentional abortion that was not entirely successful. Women medical students treating women patients for “incomplete” abortions - whether the abortion was spontaneous or not - was a
dangerous prospect. The onus fell to the physician to justify their medical care, and women medical students and physicians were in a particularly vulnerable position.

Clinical records from the Obstetrics Department and the Dispensary of the Alumnae of Woman’s Medical College between 1890 and 1900 show that women medical students and physicians treated patients suffering from complications of pregnancy loss and termination. Together, the records probe beyond women’s public polemical writings and elicit greater insight into how women physicians understood and managed pregnancy loss and termination within their clinical practice. Women physicians and medical students saw pregnancy loss and termination as an important aspect in their patient’s medical history and described cases of loss using clinical terms, even when encounters included intentional termination. They understood the emerging field of embryology, identifying the approximate age of the miscarried embryo or fetus even while grappling with labeling the cause of its premature expulsion. Students were a part of almost every clinical encounter, and before they left Woman’s Med women would likely treat at least one case of pregnancy loss under the guidance of a physician.

Dr. Anna Broomall, the head of the Obstetrics and Gynecology Department at Woman’s Medical College, knew her women students would encounter dangerous situations as future obstetricians and gynecologists. As a part of her lectures on infanticide, Dr. Broomall arranged a mock trial experience for her students in which they played the parts of the attending and assistant physicians and experts, coroner, and jury. The case featured a young domestic worker who was charged with infanticide, and prominent Philadelphia attorneys and members of Woman’s Medical College Board of Corporators lent their time to play the part of the judge, the counsel for the defense, and the prosecution. At its core, Anna Broomall’s mock trial illustrates her own complex understanding of abortion and infanticide. Rather than teaching her students to
refuse engagement with pregnancy loss and termination, she taught them how to navigate challenging legal and medical dynamics. Taken together, the theses, Annual Reports from the Dispensary, clinical cases, and mock trial provide nuanced understanding of women medical students’ and physicians’ reactions to the ambiguity of pregnancy termination beyond their public-facing writings.

Chapter Five, “Learning from the Dead: Defining the Morbid Anatomy of Criminal Abortion in Late 19th-Century Philadelphia,” tells the story of Dr. Marie Formad and her brother, Dr. Henry Formad. Both Formads emigrated from Russia, Henry arriving first to practice medicine. After establishing himself, he sent for Marie and the rest of their family, who joined him in Philadelphia. Marie enrolled in Woman’s Medical College at Henry’s suggestion, and she, along with Anna Broomall and Rachel Bodley became three of the school’s most influential alumnae and professors. Henry Formad held faculty positions at both the University of Pennsylvania’s Medical School and Woman’s Medical College. He also served as the Coroner for the City of Philadelphia until his accidental death from poisoning in 1899.35

Henry Formad encountered women who died as a result of criminal abortion in his work as City coroner regularly enough that he asked Marie to write her senior thesis on its morbid anatomy. Both Henry and Marie acknowledged a paucity in the medical literature, and a morbid anatomical study that established similarities in the bodies of women who died from illegal abortion would help both Formads in their work. The death certificates of women who died from complications of criminal abortion rarely listed their actual cause of death, leaving Henry to rely on observation when he encountered a questionable case. As a future gynecologist and obstetrician, Marie would undoubtedly see cases of criminal abortion in her practice.

Marie Formad’s thesis provides a grim glimpse into the world of criminal abortion through her analysis of six coroner’s reports, three of the autopsies she personally attended with Henry. Women uniformly died from septicemia, or blood poisoning, and Marie’s study established common markers physicians and coroners could use to identify it in the bodies of dead women. Marie was interested in identifying criminal abortion post-mortem rather than establishing a protocol of abortion care in a clinical setting so physicians and coroners could protect their interests when they were asked to preside over such a case.

The six case studies reveal important details of about the lives of the women who died from criminal abortion and allow a glimpse into the space these women occupied in their communities, their health and reproductive histories, how they died, and in some cases, why they may have sought an abortion. While Formad wrote for a medical audience, her case studies, when read for contextual clues about women’s lives, can provide additional details when criminal trial transcripts, coroner’s reports, and medical records fall short. The case studies also trouble the nineteenth-century belief that married, middling white women fueled the nation’s abortion epidemic in an effort to limit their family size. At least two of the women were single, two of them already had families of three children, and one woman’s nationality was listed as “German.” All of them died in their prime childbearing years, between the ages of twenty-three and thirty. At least three of the women were almost certainly not from the middling

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36 In writing about the experience of Black women criminals in Reconstruction Philadelphia, for which she has found little historical evidence beyond criminal records, Kali N. Gross argues that historians “must exploit new types of evidence” (6). For Gross, this meant analyzing women’s crimes “not simply as evidence of illegal behavior but as texts possessing a palpable voice…that effectively speaks of values, ambitions, and frustrations…and black women’s past experiences of trauma” (6). I deploy Marie Formad’s morbid anatomical case studies in much the same fashion, attempting to glean from their autopsy reports personal information about the women who died from criminal abortion. See Kali M. Gross, Colored Amazons: Crime, Violence, and Black Women in the City of Brotherly Love, 1880-1910 (Durham: Duke University Press, 2006).
classes. Every one of them died a painful death as a result of blood poisoning that may have been avoided had they sought medical care.

The final section of this chapter considers prominent medical texts’ treatment of forced abortion to argue that Marie Formad’s thesis was vital for women medical students in a moment when they were offered either unclear or unrealistic guidance regarding medical protocol for treating forced abortions. Two required obstetrical texts on Woman’s Medical College’s reading list were Pierre Cazeau’s *A theoretical and practical treatise on midwifery: including the diseases of pregnancy and parturition* and William Thompson Lusk’s *Science and Art of Midwifery*. Cazeau simply refused to treat the issue of forced abortion, citing moral reasons for his omission. Lusk, however, offered a plan for abortion care in a hospital setting based on cutting-edge understandings of germ theory. It was provocative in its disregard for legal ramifications, especially for women physicians who were vulnerable both in terms of their position within professional medical communities and their association with commercial abortionists. Marie Formad’s thesis filled a void in the medical literature and offered physicians, particularly women doctors, a practical and concrete analysis of criminal abortion’s morbid anatomy and methods for legally proving criminal abortion at the autopsy.

At its core, this dissertation is about language: who has the power to determine its meaning in a medical context, and how it affects those who are both in control of and subject to a dominant narrative. Women physicians entered the medical field at a critical moment: the obstetrical subfield for which they were overwhelmingly trained was rapidly codifying and creating standardized protocols, states were beginning to clarify the legality of abortion, and municipalities were increasingly interested in tracking the health and vital statistics of its
citizens. Women who provided obstetrical care to women patients did not have the luxury of ignoring the rapidly changing landscape on the legality of pregnancy loss.

The women of color and foreign women who trained at Woman’s Medical College had even less leeway than their white peers. Rebecca Cole, the second Black woman in the United States to receive a medical degree, graduated from Woman’s Med in 1867. By 1906, Woman’s Medical College of Pennsylvania had graduated twelve Black women. All of these women were taught by Dr. Broomall, and at least one of them - Halle Dillon-Johnson - would have known of or participated in Broomall’s mock trial in 1892. Eliza Grier graduated from Woman’s Med the same year abortions were listed as a medical procedure in the Annual Report. Susan Piccotte, the first American Indian to receive a medical degree in 1889, was also trained by Broomall, as were women who traveled during the same period from India, Syria, and Japan. Cole, Dillon-Johnson, Grier, Piccotte, and others experienced first-hand the ambiguity of pregnancy loss and termination through their education and clinical experience at Woman’s Med and likely realized the danger public scrutiny of their clinical practice would present to their professional reputation. Eliza Grier, for instance, was the subject of a *North American Medical Review* article when she applied to practice in her home state of Georgia after graduating from Woman’s Med in 1897. Even more so than their white peers, women of color and foreign women had to understand how to protect themselves in this period of fetal ambiguity.

In the context of Woman’s Medical College of Pennsylvania, women medical students and physicians came to terms with pregnancy loss’ ambiguity in a variety of ways. Women physicians taught their students how to successfully navigate challenging legal and medical

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37“Coal Black Woman Doctor,” *North American Review*, 1898, Woman’s Medical College of Pennsylvania Public Relations Office Records (ACC-133), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
dynamics associated with the ambiguity of fetal life. Within the confines of Woman’s Medical College clinics, students and physicians treated patients suffering from the complications of pregnancy loss and termination, describing their work in rational, clinical terms. Recognizing the paucity of information on pregnancy termination, they even created protocol other women physicians could use to protect themselves from potential prosecution. The following chapters voice their stories.
Chapter One
“Womanhood of the Noblest Type”: Early Medical Training for Women

The Distinguished Career of Dr. Marie Formad

In 1882 Marie Formad, along with her mother and younger brother, began the long journey from Russia to the United States. The Formads traveled at the behest of Henry Formad, Marie’s brother, who had been living and working in Philadelphia for the past decade. Henry was a well-respected and notable pathologist who taught in the University of Pennsylvania’s medical school and the program at the Woman’s Medical College of Philadelphia. Alongside his teaching positions, he also served as the Coroner’s Physician for the City of Philadelphia. It was uncommon to find a talented professor at the University of Pennsylvania who took interest in women’s medical education, though perhaps the personal experience of having a sister influenced Henry’s perspective. After his family arrived in the City, Henry urged Marie to enroll in ‘Woman’s Med’ to receive a formal medical education, and she matriculated as part of the Class of 1883.  

Marie excelled in her coursework and built a long and distinguished career as a gynecological surgeon. So much so, in fact, that she became a notable figure at Woman’s Med and in the broader profession, even if her influence was occasionally underappreciated. WMCP Dean Martha Tracey provided a brief update in her 1934 letter to alumna Kate Campbell Mead’s inquiry on Formad, noting while Marie never quite attained the “public acclaim that her brother had,” she was, nevertheless, “a good surgeon.” Dean Tracey’s tidy summary of Formad’s career was an understatement: upon her graduation from WMC in 1886 at the age of 21, Marie

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38 *Medical Women’s Journal*, Volume XLIII, No. 5, May 1936, 132, from Marie Formad’s Deceased Alumna File, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
39 Letter from Dean Martha Tracey to Kate Campbell Hurd-Mead, Feb 20, 1934, from Marie Formad’s Deceased Alumna File, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
Formad began work in the gynecological clinic at the Woman’s Hospital of Philadelphia, the institution initially built to provide the students of Woman’s Med with clinical experience at a time when they were unwelcome in the City’s clinics. She worked in what was colloquially referred to as the “Gyn Clinic” while simultaneously maintaining a private gynecological practice until her retirement as the Clinic’s Chief in Gynecology in 1938. Over the span of her fifty-two-year medical career, Formad saw over 30,000 patients, served as the assistant to two Clinic Chiefs, and in 1903 assumed the Chief position herself and led the division for thirty-five years. Her colleague, Catherine MacFarlane, a distinguished surgeon in her own right, noted that Formad was born for surgery: she had “long slender hands and tapering fingers…[and] she would rather operate than eat.”

Marie Formad’s willingness to relocate to an unfamiliar country and city and her illustrious medical career suggest she, like her brother, was not one to shrink from personal or professional challenges. While Marie had many professional interests, including a penchant for pathology inspired by Henry, she was first and foremost a surgeon. This was an unusual medical subfield for women in the late nineteenth-century, and Formad was skilled at her craft. Upon the founding of the Philadelphia College of Surgeons in 1913, she was named as one of the few women members of the founding class. When the Woman’s Hospital and the West Philadelphia Hospital for Women – the two most prominent medical institutions serving women patients in Philadelphia – merged in 1932, Dr. Formad performed the first surgery in the new building on April 13, 1932. Formad again defied boundaries in 1918 when she set out for France with the Women’s Overseas Unit in the last months of World War I. She served with the Unit

40“Dr. Kitty Mac,” 52.
41 Marie Formad was nominated alongside her Woman’s Med colleagues, Drs. Catherine MacFarlane and Carline Purnell. “Dr. Kitty Mac,” 47.
for fourteen months, caring for wounded soldiers and refugees. Marie Formad’s medical education and distinguished career were made possible by Woman’s Medical College of Pennsylvania, from its Quaker founders and initial supporters and teachers, all of whom were men, to the powerful women who Marie would join in the project of managing and leading the first institution in the United States dedicated to training women physicians and caring for women patients. WMCP’s reputation drew students from across the country and around the world, and Marie joined the ranks of peers who hailed from as far away as India, Syria, and Japan.42

Marie Formad and Woman’s Medical College of Pennsylvania are intimately intertwined within the broader history of women students’ and physicians’ experiences with pregnancy loss and termination. While Marie Formad’s distinguished career is in many instances exceptional, her path as a nineteenth-century women physician was typical and reveals vital details regarding how women medical students and physicians reckoned with pregnancy loss and termination in their education and professional lives. As a woman gynecological surgeon and sister to the Coroner’s Physician of Philadelphia, Marie Formad could not afford to ignore the shifting medical and legal definitions of fetal life and the attendant medical risks to her patients and professional risks for herself and her brother. At Henry Formad’s urging, and in an attempt to make sense of the procedure’s medical and legal ambiguity, Formad dedicated her senior thesis at Woman’s Medical College of Pennsylvania to defining the morbid anatomy of criminal

42 Steven J. Peitzman, *A New and Untried Course: Woman’s Medical College and Medical College of Pennsylvania, 1850-1998* (New Brunswick, N.J.: Rutgers University Press, 2000), 65-68. Peitzman notes the presence of foreign students was directly connected to the College’s overseas missionary work. As many as 230 WMC graduates went into the field, often funded by Sarah Josepha Hale, the editor of *Godey’s Lady’s Book*. Hale founded the Ladies Medical Missionary Society of Philadelphia in part to pay for women’s medical education with the expectation that they would then go overseas to practice. The missionary women of WMC, argues Peitzman, contributed to the international reputation of the College at a time when most medical schools had no name recognition outside of the United States.
abortion. Both she and Henry Formad noted the medical literature on the subject was woefully incomplete, and her research made use of six autopsy cases from Henry’s practice to define the physical features of criminal abortion. Her work provides a glimpse into how women physicians attempted to make sense of abortion in their clinical practice and will be explored further in later chapters. The focus of this chapter is Formad’s alma mater, Woman’s Medical College of Pennsylvania, and the medical training she and her peers received there. Specifically, this chapter uses the example of Woman’s Medical College and the experiences of its medical students, faculty, and alumna to explain how and why women’s medical training pushed future women physicians to pursue the medical subfields of gynecology and obstetrics and why this created a difficult double bind with regard to pregnancy loss and termination.

Women physicians, including exceptionally talented ones like Marie Formad, were expected to provide clinical care for women and that meant training to be a gynecologist and obstetrician. They used their “uniquely caring nature” to justify their place in the medical profession and nursing women and children, which was work male physicians were often not particularly interested in pursuing. The historiography has long characterized women physicians as monolithically opposed to abortion for a variety of reasons, most notably because they wanted acceptance within the male-dominated medical profession and the American Medical Association. Marie Formad’s experience, however, raises an important question that challenges the notion that all women physicians were opposed to abortion: how did women

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physicians reconcile the fact that as obstetricians and gynecologists it would be impossible to avoid abortion in their clinical practices?

This question is central to this study, which explores how women medical students and physicians made sense of abortion at a moment when the medical field in general, and obstetrics and gynecology in particular, were professionalizing. Coupled with dynamic changes in medical and legal thinking on abortion, women physicians took it upon themselves to make sense of the ambiguity that could have profound effects on one’s life and career: they wrote polemics urging women physicians to avoid the procedure at all costs, trained their medical students to provide testimony in court, developed protocol to identify the morbid anatomy of the criminal procedure, and nursed women patients who presented in need of abortion care. This chapter lays the initial foundation required to answer these questions through exploring the challenges and benefits of sex-segregated medical education, the ideology women called upon to justify their entrance into the medical profession, and the career paths of women physicians. Ultimately the majority of women physicians would spend their professional life caring for women as gynecologists and obstetricians. The constant reminder of their “special” role in medicine would begin from the moment they entered medical school, to which this chapter now turns.

**Sex-segregated Medical Schooling: A Case Study in the Medical Capital of the World**

Marie Formad and her peers faced a difficult journey in their quest to become physicians, for few nineteenth-century Americans were as supportive of women in medicine as Marie’s brother, Henry. The nation’s first medical schools were not places friendly to advancing women’s education: by the end of the nineteenth century, there were 105 regular medical schools in the United States and only 37 of them admitted women students.44 The medical historian

Regina Morantz Sanchez points out that a majority of the schools accepting women were land-grant state universities founded after the Civil War, and required by their charters to provide coeducation.\textsuperscript{45} Philadelphia’s prestigious medical schools were no exception: the University of Pennsylvania’s School of Medicine – the first in the country – opened its doors in 1765 and did not graduate a woman from its School of Medicine until 1917. Similarly, Thomas Jefferson University, established in 1824 as Jefferson Medical College, did not admit women students until 1960.

While women saw increased medical opportunities in the reform and alternative medicine movements of the nineteenth century, regular medicine remained hostile to their presence and most early women physicians travelled to Europe for medical training.\textsuperscript{46} Medicine in the nineteenth-century United States was a complex arena: regular physicians, or those who identified as practitioners of evidence-based medicine and heroic measures, were professionalizing and attempting to wrest the medical market from practitioners of alternate (or sectarian) and reform medicine, as well as commercialized medicine. They struggled against the deregulation of medical practice and the anti-elitism that accompanied Jacksonian Democracy in the early to mid-parts of the nineteenth century. Part of the project of professionalization included establishing the American Medical Association, a national organization that would create and monitor educational, care, and ethical standards in the field in a moment when the country lacked political will to establish legal standards of practice. Incorporated in Philadelphia

\textsuperscript{45}Morantz-Sanchez, \textit{Sympathy and Science}, 65.
\textsuperscript{46}“Dr. Kitty Mac,” 23. For example, Dr. Anna Broomall and her mentee, Dr. Mary W. Griscom, both studied at the Vienna Frauenklinkik. In her autobiography, Dr. Catherine Macfarlane notes Broomall had to work as a midwife, “mopping floors, washing babies, [and] making beds.” Macfarlane herself borrowed money from her insurance policy to pursue graduate work in obstetrics with Dr. Ernst Bumm, Professor of Obstetrics and Gynecology at the University of Berlin. “Dr. Kitty Mac,” 53-54.
in 1846, the American Medical Association did not formally accept women members until 1915.47

Sectarian movements, conversely, often welcomed women’s presence and influence, and provided a track for women interested in obtaining a medical degree. Broadly, sectarian medical practitioners objected to the heroic practices of regular medicine and believed instrumental, surgical, and pharmacological interventions to be unnecessary and ‘unnatural.’ For instance, homeopaths posited that a very small amount of prescribed medicine could balance the humors of the body and heal a patient. Hydropaths, as their name suggests, used only water internally and externally to remedy a patient’s afflictions. Practitioners of the Thompsonian system used herbs and steam baths to ‘naturally’ purge toxins from a patient’s body.

Sectarian and regular medicine competed for authority and legitimacy in a period when the methods of regular practitioners often seemed excessive and dangerous to patients. While germ theory, or the idea that infection was spread through the proliferation of microorganisms, was becoming the common medical paradigm for disease in Europe, the United States was slow to accept a shift away from the ancient theory of miasma, or the idea that disease was caused by polluted air. Some faculty members quickly embraced germ theory and taught it to their students. Catherine MacFarlane attended Woman’s Med from 1893 to 1896 and noted with interest Dr. John B. Roberts’ interest in antisepsis. During MacFarlane’s third year clinical experience at the adjoining Woman’s Hospital of Philadelphia, the Professor of Surgery “meticulously scrub[bed] his hands for ten minutes while lecturing [the class] on the germ theory of surgical infections.”48

47 Morantz-Sanchez, *Sympathy and Science*, 179. While the American Medical Association seated Dr. Sarah Hackett Stevenson in 1876, women were not formally accepted until 1915.
48 “Dr. Kitty Mac,” 21.
There was, however, an uneven embrace of germ theory within the institution that mirrored the slow paradigm-shift amongst physicians throughout the United States. MacFarlane noted that Dr. Hannah T. Croasdale, the head of the Gynecology Department, was known for dabbing her nose during surgeries with the tiny lace-bordered handkerchief she kept tucked in the upper pocket of her operating gown. Her delicate touch somehow miraculously prevented her patients from falling ill. Many physicians’ touch was not so delicate, and patients often found themselves significantly sicker after their visit to a regular physician than had they visited a sectarian physician whose cures often did nothing, but at least did not further harm the patient. Out of this moment of medical deregulation and patient ambivalence to regular medicine, commercialized “cures” also developed into a booming industry and a formidable competitor to both regular and sectarian therapies. Many commercialized medicines were what nineteenth-century Americans called “quackery,” though they presented, along with sectarian medicine, an alternate option to patients who were rightly frightened by the treatments of orthodox physicians.

Health reform movements were also often friendly to women and provided an outlet for those interested in medical education and leadership, as well as patients interested in exploring the principles of health outside of regular medicine. While sectarian medicine provided women with opportunities for formal medical education, health reform movements provided women with informal opportunities to learn about topics like dress, dietary, and hygiene reform. They were united by a core ideology holding health was a matter of personal responsibility. Middle-class mothers, in particular, were called upon in these movements to take responsibility for the health of their families in a culture that gave them control of their domestic spheres. Health reform movements gave women clear-cut information on how to care for their families, and by virtue of

49 “Dr. Kitty Mac,” 22.
their leadership role in this charge they learned about physiology, diet, and hygiene – topics usually reserved for physicians. Further, leadership roles developed for women who were interested in joining the lecture circuit to spread this information to other women.

The hostility of regular medicine and the American Medical Association to women, coupled with the openness with which women were received by sectarian medicine and health reform movements, created a complex and often difficult path for women interested in a regular medical education in the nineteenth century. Like Elizabeth Blackwell, the first woman to receive a medical degree in the United States, they could fight to gain entrance into one of the many all-male regular medical colleges and continue to struggle as a young doctor discounted by potential patients because of her sex. They could give up the idea of attending a regular medical institution and follow the path of Lydia Folger Fowler, the second woman to receive a medical degree, and attend a (then all-male) sectarian medical college. While they would be accepted in sectarian medicine, regular physicians would use this as an opportunity to discount their medical training. They could feel disillusioned by the entire prospect of receiving a regular education and choose instead to pursue a leadership role in health reform, like Mary Gove Nichols. Few regular physicians would take their training seriously after association with what they believed to be a political movement. No matter the path they pursued, women would be maligned by the regular medical community who was simultaneously interested in pushing sectarians and health reformers out of their sphere of professionalization and preventing women from entering all-male medical colleges. This hostility would lead women and allied men to take an entirely different path by establishing medical colleges specifically to educate women interested in becoming regular physicians.50

50Many early women physicians were against single-sex institutions, preferring instead coeducational opportunities because they believed it to be better for women. Even as she established a medical school linked to the New York
Philadelphia provides an important lens through which to examine the establishment of single-sex regular medical education for women. Alongside being the home to the University of Pennsylvania’s and Thomas Jefferson’s Medical Colleges, the early republic’s leading physician and founding father, Benjamin Rush, practiced medicine in Philadelphia. The nation’s first hospital, The Pennsylvania Hospital, was also founded in the City in 1751 by Benjamin Franklin and Dr. Thomas Bond, and the American Medical Association was founded in the City. Though the male medical establishment certainly did not have it in mind when they coined the moniker, Philadelphia was also home to Woman’s Medical College, the most prestigious and longest running medical college for women, and several prominent hospitals that specialized in the care of women, by women.\(^{51}\)

These institutions existed because the Philadelphia regular medical community was exceptionally hostile to women physicians broadly, and Woman’s Medical College in particular. The state medical society refused to recognize the College’s graduates until 1871 because of an 1860 resolution barring society members from professionally associating with the School’s faculty or alumnae, and the first woman was admitted into the College of Physicians of Philadelphia, the primary professional organization in the City, in 1932. Clinical experiences for women physicians were also limited, thus the need for associated teaching hospitals.\(^{52}\) Coupled

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\(^{51}\) There is evidence that male medical students reacted negatively when women were admitted to clinical lectures. For instance, when Woman’s Medical College Students attended a clinical lecture at the Pennsylvania Hospital in October of 1869, some of the male students “caused a scene of considerable disorder both during and after the lecture.” While the Board of the Pennsylvania Hospital resolved in a special meeting to censure the students who participated in the incident and ensure it never happened again, the scene provides context for how women medical students and physicians could be received by their male peers. Thomas G. Morton, M.D., *The History of the Pennsylvania Hospital, 1751-1895* (Philadelphia: Times Printing House, 1895), 464-5.
with the College’s limited resources and meager salaries for faculty, it was exceptionally difficult to find distinguished physicians like Henry Formad who were willing to publicly associate themselves with the School.\textsuperscript{53}

Alongside its reputation as the medical capital of the world, Philadelphia was also known as the “Quaker City” for its large and prominent communities of Quaker residents. A small portion of the Quaker community embraced, amongst others, the ideals of the abolitionist and feminist movements. Motivated by a relative commitment to gender equality and disturbed by the lack of opportunities for women to receive a medical education in the City’s premiere medical colleges, a small group of Quakers founded an institution whose primary goal was to provide women with medical education equivalent to that their male counterparts received at Penn and Jefferson.

The doors of the Female Medical College, as Woman’s Med was first known, opened in 1850 at 229 Arch Street, and from its inception the institution embraced emerging ideals connected with the nineteenth-century feminist movement, including advocating for women’s access to medical education, gender equity, and marriage reform.\textsuperscript{54} In her 1881 address to the graduating class, Dean Rachel Bodley made the connection between the College’s work and its relationship to feminist principles clear when she rebuked the notion that women’s bodies and minds were too weak and irrational for medical education. “Womanhood of the noblest type can rise to the full possession of all its powers, and yet lose nothing in sweet grace or womanly dignity,” she argued, and “...an earnest purpose in life transforms invalids into healthy women.” She went even further, advocating that medical education could free women from oppressive marriages: “[a medical education and career] renders that unholy thing, a marriage of

\textsuperscript{53} Morantz Sanchez, \textit{Sympathy and Science}, 76.
\textsuperscript{54} Peitzman, \textit{A New and Untried Course}, 13.
convenience, inexcusable, and leaves every woman free to enter the estate of matrimony from the purest motives only.” In the same paragraph, Bodley acknowledged the long-time support of the abolitionist and women’s rights activist Lucretia Mott, who sat on the graduation platform with faculty and students “during successive years when friends were few and commencement audiences small and critical.”

Though not always as explicit, the leadership of Woman’s Medical College, as it would later be known, certainly saw their work as part of the broader project of the nineteenth-century’s reform movements.

Woman’s Medical College attracted women from across the country and world who wanted to receive a medical education. While the first cohorts of students were predominantly from white families with middling or wealthy backgrounds, Woman’s Med soon accepted Black and American Indian women, as well as women from outside of the United States. Rebecca Cole, the second Black woman in the United States to receive a medical degree, graduated from Woman’s Medical College in 1867. Born in Philadelphia, Cole attended the Institute for Colored Youth, now Cheyney University of Pennsylvania, before applying for her medical degree. She would go on to practice medicine for over fifty years, first as a “sanitary visitor” at the Blackwells’ New York Infirmary for Women and Children, then in South Carolina.

She returned to Philadelphia in 1894 to open the Physician Woman’s Directory, an organization that offered an alternative to establishing a foundling hospital in Philadelphia by providing education and support to single mothers so they could keep their children in the home.

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55 Rachel L. Bodley, *Valedictory Address to the Twenty-Ninth Graduating Class of the Woman’s Medical College of Pennsylvania* (Philadelphia: Grant, Faires & Rodgers, 1881), 16.
Washington, DC in 1899 to lead a home run by the Association for the Relief of Destitute Colored Women and Children, where she would end her distinguished career.  

By 1906, Woman’s Medical College of Pennsylvania had graduated twelve Black women. The College’s work even attracted the interest of W. E. B. Du Bois as he planned the Eleventh Conference for the Study of Negro Problems at Atlanta University in May 1906, an event focusing on the role of social factors on health. Du Bois wrote to Dean Clara Marshall early in 1906, inquiring as to the number and names of the Black women graduates of the College. Dean Marshall responded, listing the names of twelve Black women who had recently graduated from Woman’s Med. The College continued to educate and graduate Black women throughout the twentieth century, listing 34 women by 1962.

Throughout the late nineteenth and early twentieth centuries, Woman’s Med welcomed women from across the United States and world for whom it was their only option to receive a medical education. Alongside Rebecca Cole, Susan La Flesche Picotte became the first American Indian to receive a medical degree in the United States when she graduated from Woman’s Medical College of Pennsylvania in 1889. A member of the Omaha Tribe, La Flesche Picotte practiced medicine on the Omaha Reservation until her death in 1915. La Flesche Picotte was motivated to practice medicine because members of the Omaha Tribe had few

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58 Rebecca Cole practiced medicine for over 50 years, though unfortunately there is little in the way of archival records of her life and work. The Drexel Medical College’s Legacy Center Archives and Special Collections holds her senior thesis, *The Eye and Its Appendages*, and she is mentioned in the correspondences of W. E. B. Du Bois and Dean Clara Marshall. The Legacy Center is beginning a “Black Women Physicians Project” that collates the records of WMC’s Black graduates. This will be a helpful resource for learning more about the experiences of Black women in medicine.


60 Negro Graduates, 1867-1962, July 26, 1962, Black Women Physicians Project (ACC-178), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

61 Susan La Flesche Picotte, undated photograph with short biography, Woman’s Medical College of Pennsylvania Photograph Collection (ACC-AHC1), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
options for medical care. Anandibai Joshi, the first Indian woman to receive a medical degree in the West, cited similar reasons for pursuing medical education. At only nineteen years of age, Joshi traveled to the United States to enroll at Woman’s Med. In her application letter, she cited her reasoning for application: “The want of female physicians in India is keenly felt in every quarter, [and] [l]adies both European and Native are naturally averse to expose themselves in cases of emergency to treatment by doctors of the other sex.” Joshi mentions the presence of a few “female doctors” in India from Europe and America, though they “[had] not been of such use to our women as they might” because the cultural barriers were too high.  

It would not be long until other institutions opened to train women for medical careers. Alongside the Female Medical College, four additional regular medical colleges were established in New York City, Chicago, Boston, and Baltimore between 1850 and 1900. Elizabeth Blackwell, the first woman to earn a medical degree in the United States from Geneva Medical College in New York, would found with her sister, Emily, the New York Infirmary for Women and Children in 1857 and later the Woman’s Medical College of the New York Infirmary in 1868. The New York Infirmary’s Medical College set a high bar for women’s medical education the other women’s medical schools would strive to meet.

Blackwell, however, did not begin her medical career with the goal of educating future generations of regular women physicians. Though she was able to attain a medical degree in 1849, she struggled to find professional respect amongst the medical community of New York City. She initially established a medical practice and gave it up when few patients employed her services. While Blackwell was a strong proponent for medical coeducation, when she realized it

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62 Caroline Wells Healey Dall, *The Life of Dr. Anandabai Joshee: A Kinswoman of the Pundita Ramabai* (Boston: Roberts Brothers, 1888) 83-4. Joshi’s class at Woman’s Med also included Sabat Islambouli, a student from Syria and Keiko Okami, from Japan.
was not an option she founded the Infirmary, and later the Medical College, to provide women with better prospects in the field than she experienced. To do this, Blackwell knew her students must meet the highest professional standards. The curriculum of the Infirmary’s Medical College cleaved closely to the recommended American Medical Association standards – closer, in fact, than almost all of the medical male-only medical schools – and offered the longest training period of any medical College in the United States.

While the Blackwells’ New York Infirmary was well regarded for the medical education it provided its students, the New England Female Medical College was the only one of the five initial women’s medical colleges to be noted for the opposite. Chartered by the state of Massachusetts in 1856, the initial institution was founded in 1848 by Samuel Gregory, a Yale-educated health reformer, to train women in the practice of midwifery. Gregory strongly opposed the mid nineteenth-century trend of male midwifery, arguing that it was immodest for women to be attended in birth by a man. In reaction, he united a small group of Boston community leaders and founded a school to produce women midwives.

In 1856 the New England Female Medical College opened its doors with the mission of training women physicians and maintaining a strong connection to the health-reform and feminist movements. Early in the School’s career, the Board of Lady Managers recruited Marie Zakrzewska, a young and promising physician working with the Blackwells at the New York Infirmary, to be the Professor of Obstetrics and Diseases of Women and Children at the College in 1859. Zakrzewska would leave the New England three years later, unhappy with the School’s standards for medical education and Samuel Gregory’s leadership. Samuel Gregory’s
leadership, in fact, ultimately led to the School’s usurpation by Boston University following his
death in 1873 – a moment celebrated by the community of regular women physicians.⁶⁴

Alongside Woman’s Med, the New York Infirmary, and the New England, two additional
“orthodox” medical schools would open their doors in the late nineteenth century. Woman’s
Hospital Medical College was founded in 1870 in reaction to Chicago medical colleges’ hostility
to women students and was supported by several prominent male physicians who taught on the
faculty of the College. Like Woman’s Medical College of Philadelphia, Woman’s Hospital
Medical College had little money to support its mission; however, it was well regarded for the
medical education it provided to its students. Again, similarly to Woman’s Med in Philadelphia,
its graduates took on leadership roles within the institution until its merger with Northwestern
University in 1892.⁶⁵

In 1882, the Woman’s Medical College of Baltimore was founded by a group of women
philanthropists to provide women students with a medical education equal to that of their male
counterparts. Like its sister schools in Philadelphia, Chicago, and New York, the College strived
to meet the training and curriculum standards of the American Medical Association, and an
evaluation of the School in the 1909 Flexner Report notes that Flexner believed the school to be
doing the “best possible [job] with meager resources.”⁶⁶ Unlike the four other orthodox
Colleges, however, women graduates never managed to secure leadership positions within the
institution upon graduation.

⁶⁴ Morantz Sanchez points out Mary Putnam Jacobi’s particular delight in the closing of the New England, Sympathy
and Science, 84. See Morantz Sanchez, Sympathy and Science, 81-84 for a detailed history of the New England
Hospital.
⁶⁵ For additional information on Woman’s Hospital Medical College, see Sympathy and Science, 79-80.
⁶⁶ Quoted in Morantz Sanchez, Sympathy and Science, 81.
In her groundbreaking study of women in medicine, Regina Morantz-Sanchez notes that by 1880, women medical students largely received the same medical education as men in their separate institutions. This golden age of sex-segregated medical education for women would not last much longer, as four of the five orthodox Colleges closed their doors following the opening of the Johns Hopkins Medical School. The agreement of Johns Hopkins’ Board of Trustees to accept women into its program represented for women physicians the ultimate goal of sex-segregated education: coeducation that would ultimately provide women with equal status in the profession. In the minds of some women physicians, the need for sex-segregated education was now a thing of the past. Unfortunately, statistics suggest otherwise: enrollment declined as women faced significant gender discrimination in co-educational institutions.

Amidst the closing of its four sister schools, Woman’s Medical College of Pennsylvania remained steadfast in its mission to provide women with a regular medical education. While the institution’s endowment never matched its co-educational counterparts and made for periods of rockiness, Woman’s Med survived and thrived through the transition period from sex-segregated to co-educational medical training and ultimately trained thousands of women physicians over its 120-year tenure as a woman’s only institution. Women travelled from across the nation and world to study at Woman’s Med, renowned for its gynecological and obstetrical training.

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68 Ultimately the Board of Trustees of The Johns Hopkins Hospital and Medical College admitted women because they had to in order to open the Medical School. The Hospital opened in 1889, though the School of Medicine was approximately $100,000 short of the funds needed for its completion. Four women stepped in to raise the remaining support, including the noted advocate for women’s higher education M. Carey Thomas, and required as a stipulation of the gift that women be allowed admittance in the Medical School. The Board of Trustees agreed, and women entered The Johns Hopkins Medical School in October, 1893. Alan M. Chesney, *The Johns Hopkins Hospital and The Johns Hopkins University School of Medicine, A Chronicle, Vol. I, 1867-1893* (Baltimore: The Johns Hopkins University Press, 1943), 193-221.
70 Woman’s Medical College admitted its first co-educational class in 1970 under its new name, Medical College of Pennsylvania.
Like the founders of the institution, the leaders of Woman’s Med believed separate medical education for women was a positive asset even amidst the push toward co-education, largely due to the Philadelphia medical community’s continued hostility to women in the profession. The institution’s leading role in women’s medical education, its continued commitment to sex-segregated schooling, and the faculty’s commitment to providing the highest quality clinical training in obstetrics and gynecology provide an ideal lens through which to understand how women were molded to pursue careers in obstetrics and gynecology. As women entered a profession often hostile to their presence, they called on conservative gender ideology to justify their “special place” in medicine.

**Gender and Women’s “Special Place” in Medicine**

Most people believed medicine was no place for a woman in the nineteenth century, objecting to both her work in a profession associated with men as well as believing that a medical education that required deep knowledge of anatomy would corrupt a woman’s purity. In part, these objections were rooted in medical women’s defiance of dominant middle-class gender ideology of the period that constructed separate ‘spheres’ of influence for both men and women. Men exercised control of the ‘public’ sphere, engaging in business, holding a job, and exercising political franchise. ‘True’ women, conversely, oversaw the home and its associated domestic realm: caring for children, attending to her husband’s needs, and managing household affairs. The cult of domesticity left little room for women interested in entering medicine, and male physicians used gender ideology as a tool to push medical women from the profession.

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Medicine, according to their argument, would ‘de-sex’ women who would be forced from the home to examine and treat the bodies of men.

More than three decades of feminist historical scholarship has troubled this binary of domestic and public life while also identifying the women it ignores. Early feminist historical scholarship showed how women’s domestic work propped up the nascent market economy of the early Republic and also blurred the boundary between home and work by showing that many women undertook commercial labor in the home in the form of “outwork.” Other women used their leadership positions in benevolent and mutual-aid societies to participate in public life. Those that needed to support their families or themselves in the Early Republic often worked as factory operatives or domestics. And still others worked as midwives, attending to birthing women alongside family members. Thousands of enslaved women had no choice but to toil in the fields and homes of their masters for a majority of the century.

Like all higher education, medicine as a profession was initially a career path for middling to upper-class white women. The first classes of Woman’s Medical College of Pennsylvania matriculants mainly included women who had the cultural capital and financial

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74 See Blewett, *Women, Men, and Work.*


support to pursue an education that was both expensive and placed them firmly outside the bounds of women’s traditional propriety. Anna Broomall, for example, was the daughter of a prominent Quaker family for whom the town of Broomall, Pennsylvania, is named. Descended from a long line of lawyers, Broomall was barred from pursuing a legal career for being a woman and instead chose medicine. Before the establishment of training hospitals that accepted them, women medical students travelled to Europe for clinical experience. Broomall was no exception, and travelled to Vienna and Paris to gain midwifery experience before returning to take over faculty duties at Woman’s Med. Tuition and travel for clinical experience would be considered too costly for many women and their families.77

Despite the exclusivity of medical education, some women sought employment outside of their medical school curriculum to support their studies. Eliza Grier, a formerly enslaved woman, worked alongside taking courses at Woman’s Med and graduated in 1898 after a seven-year course of study. Grier was motivated to pursue medicine because she saw obstetrics, and birth in particular, as an economic opportunity. A quote from the North American Medical Review notes Grier’s irritation that white male physicians made a lot of money attending the births of Black women despite the fact that the woman’s friends often did most of the work associated with the birth. In response, Grier planned to return to her hometown of Atlanta after graduation to practice obstetrics.78

Education provided a path for women interested in a profession before medicine emerged as a viable career path. An informed electorate was vital to the success of the United States’

77 “Anna Broomall,” and “A Beloved Physician, 1847-1931,” from Marie Formad’s Deceased Alumna File, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
78 “Coal Black Woman Doctor,” North American Review, 1898, Woman’s Medical College of Pennsylvania Public Relations Office Records (ACC-133), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
experiment in democracy and schools, both private and public, sprang up across the country in the antebellum period. Women overwhelmingly took positions teaching at these institutions, and by 1860 they occupied between sixty-five and eighty percent of the positions.\(^79\) The records of Woman’s Medical College suggest a trend in women coming to medicine after careers in education. Eliza Grier, for instance, enrolled in Woman’s Med after completing an Advanced Normal course at Fisk University in the 1880s.

Adjacent to and occasionally concurrent with teaching, women pursued careers as writers and editors in the mid- to late-nineteenth century. While women could not participate in formal electoral politics, they used their public perch to influence opinion on a variety of topics. Catharine Beecher is perhaps one of the most notable examples. Beecher established the Hartford Female Seminary in 1823 as well as several other institutions dedicated to women’s education throughout the century. Alongside her work, she authored countless tracts, articles, textbooks, and tomes espousing her views on everything from abolition to the role of women as mothers and teachers. Sarah Josepha Hale, the editor of *Godey’s Lady’s Book*, likewise made a career from her writing and editing. Both women emphasized women’s primary role in maintaining and advancing a morality intent on creating a racial hierarchy through evangelism with the attributes of what Godey referred to as “the Anglo-Saxon” at its pinnacle.\(^80\) Their writing was bolstered by the work of benevolent societies firmly under the control of women, who were seen as the keepers of antebellum morality. Emerging professions for women, including those in medicine, would be equally shaped by the construction of women as keepers of the nation’s morality.


The profession of nursing, for instance, emphasized both morality and discipline in its membership as it professionalized in the last quarter of the nineteenth century. Before the establishment of training schools for nurses, nursing was loosely organized and done by untrained attendants from the urban working class. It was also not uncommon for long-term convalescent patients to nurse others. As training schools emerged in the mid 1870s, these workers were pushed from the field and replaced with a professionalizing nursing core composed largely of middle-class white women. Nurse training programs typically attracted well-educated women to their student bodies, suggesting many women saw nursing as a more viable career path than doctoring. Nursing also presented an opportunity for women who wanted to make an independent living, particularly from rural areas.

Nursing students spent four years in training, and usually lived in nurses’ homes on hospital grounds. Their rigid schedule, usually overseen by a nurse superintendent, reflected the fixed role of nurses in the hierarchy of medical care. Nurses existed to enact the orders of a physician, who always had final authority over patient care. Just as women physicians were largely encouraged to enter subfields focused on caring for other women and children, nurses were first used in medical care in the women’s floors of hospitals because their presence in men’s wards was considered too controversial. There is evidence by the end of the nineteenth century, however, that women were largely accepted as nursing staff on both men’s and women’s hospital wards. Their presence on both floors, however, underscored the field’s

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82 Tomes, “Little World of Our Own,” 473. Many women came to nurse training schools with a high school diploma. Men with the same qualifications would easily gain admittance to medical school, and until 1910 only two medical schools required a high school diploma for entrance.
83 Tomes, “A Little World of Our Own,” 468.
emphasis on morality and discipline. The women nursing in men’s wards had to be of the highest moral character to resist the temptation of corruption.

For all the ways women advanced into professional careers and civil society in the mid-to late-nineteenth century, their presence was more often than not tied to the traditional gender traits of morality, care, and an emotive nature. Women physicians were no exception. As a group, they clung to traditional gender values to justify their existence in the profession.\textsuperscript{84} Women patients required chastity in their medical examinations, and women physicians could ensure their modesty during physical examinations. Women’s hospitals and clinics emerged simultaneously with women physicians entering the medical profession, and their institutional missions reflected the need for women to care for women. The 1861 Act incorporating the Woman’s Hospital of Philadelphia confirms the trend of women physicians justifying their professional existence through their unique abilities to treat women patients. One of three central tenets of the institution’s mission included “establish[ing] in the City of Philadelphia a Hospital for the treatment of diseases of women and children and for obstetrical cases,” noting as well that the chief resident physician must be a woman.\textsuperscript{85} Women patients, even those who could not afford to pay for treatment, deserved to be cared for by women physicians.\textsuperscript{86} There was significant evidence to suggest women patients were interested in being cared for by a woman physician: a 1900 report of the Woman’s Hospital of Philadelphia cited 15,449 patients

\textsuperscript{84} Regina Markell Morantz and Sue Zschoche, “Professionalism, Feminism, and Gender Roles: A Comparative Study of Nineteenth-Century Medical Therapeutics,” Journal of American History, 67 (Dec., 1980), 568-588. The authors argue that women, more so than men, physicians clung to traditional values in their practice, likely because of their link in Victorian culture to the moral guardians of society.

\textsuperscript{85} Board of Managers Regular and Special Meeting Minutes, 1861-1865, Woman’s Hospital of Philadelphia Records (Series One, Box One), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 15.

\textsuperscript{86} The Woman’s Hospital By Laws established that patients not able to pay for medical care would be treated free of charge. Those who could afford treatment would pay an agreed-upon rate. Board of Managers Regular and Special Meeting Minutes, 6.
cared for from the Hospital’s opening in 1861 to January 1, 1900. This included 30,575 home visits, 173,997 Dispensary visits, and 3,771 infants born in the Maternity Clinic.\footnote{“Scope of Work,” in The Annual Report of the Woman’s Hospital of Philadelphia (1900), Woman’s Hospital of Philadelphia Records (Series Three, Box 11), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine; \textit{Historical, Illustrative, and Descriptive Book of Woman’s Hospital of Philadelphia}, Woman’s Hospital of Philadelphia Records (Series Three, Box Eleven), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.}

The need for women physicians to care for women patients was compelling; however, women doctors additionally had to confront the notion that medicine in the mid- to late-nineteenth century was centered on heroic interventions associated with the masculine. Medical women responded by crafting a special niche for themselves within the profession that emphasized feminine characteristics valued by middle-class gender ideology: a caring, emotive, and nurturing nature. The “special” role of women in medicine was in opposition to the rational, cold, and heroic nature of regular medicine practiced by medical men. The profession, medical women argued, was in need of a woman’s caring touch.

As women’s medical colleges opened their doors to students in the 1850s, 60s, and 70s and produced the first classes of trained regular physicians, women graduates soon replaced the initial male educators. Regina Morantz Sanchez’s foundational research on women medical students and physicians in the United States makes clear this link between women’s medical education and medical women’s special role in medicine. Beyond providing their students with an exceptional medical education based in clinical experience, women educators had two central goals for their students: first, to ensure their women students adhered to the highest professional standards, and second, to mold their students into physicians who could blend their unique skills as women with medical training.\footnote{Morantz Sanchez, \textit{Sympathy and Science}, 85.} Put another way, women physicians managed to leverage
middle class gender ideology that was meant to circumscribe their role to the domestic sphere to justify their presence in the profession.

This balancing act of blending one’s professional and “womanly” self was not easy to maintain and required significant coaching on the part of the faculty. A pedagogical exercise run by Dr. Anna Broomall, the head of the Gynecology and Obstetrics Department at Woman’s Med, presents a notable example of the difficulties women medical students faced as they attempted to fashion themselves into physicians capable of practicing medicine and providing care and sympathy for their patients. Learning to speak forcefully and with confidence regarding one’s professional expertise, especially within a courtroom, was central to the professionalization of women physicians and formed the core goal of Broomall’s pedagogical exercise: a mock trial in which students filled nearly every role required in the “courtroom,” from the attending and assistant physicians and experts, to the coroner and the jury. The irony of women medical students playing jury members at a time when Pennsylvania women could not sit on juries was likely not lost on a group of women who had already broken with significant cultural norms to attend medical college.

*The Commonwealth of Pennsylvania v. Susan Jones* featured a young domestic worker accused of infanticide, and prominent Philadelphia attorneys played the part of the judge, the counsel for the defense, and the prosecution. Women medical students were called to testify as

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90 “Mock Trial at the Woman’s Medical College of Pennsylvania,” Records of W/MCP Medical Students 1850-1981 (ACC-072), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
expert medical witnesses for both the prosecution and defense, and Dr. Broomall’s brother, John M. Broomall, played a particularly biting defense attorney who grilled the women as to their expertise. A prominent Philadelphia lawyer, Broomall directly questioned the six expert witnesses for the prosecution, asking whether they considered themselves experts in their field as he cross-examined them. Each of the six future women physicians responded in self-effacing language, using phrases like “I have been so considered” and “I am so called.” In a particularly interesting incident, Broomall asked Dr. Mary A. Johnson if she was considered an expert, to which she replied, “You ask me whether I am considered an expert. I think any physician would hesitate to make such an assertion in regard to herself.”

Broomall retorted by asking whether “the learned judge has noticed many times the diffidence of a physician to call herself an expert,” to which the Judge replied:

Very great modesty. Modesty is generally commendable, but I think I must say for the benefit of those assembled here that, when they have had years of experience and have studied any particular branches and are called upon to say, they should not let their modesty get the better of them, but should say they were experts. All that is necessary to make a person an expert is that he shall have had special opportunities of becoming acquainted with the subject, although he may not know all about it. If they have had special opportunities of fitting themselves to testify on that particular matter, they are experts.

Even after this powerful lesson to the women students engaged in the mock trial exercise, Dr. Johnson demurred and refused to call herself an expert when questioned again by Broomall, instead replying that “I have had unusual opportunities for investigating cases of infanticide.”

Navigating the line between expert, commanding physician and Victorian woman prized for her meek and deferential nature often proved an impossible task for Dr. Johnson and her peers.

91 “Mock Trial,” 24 and 30 (respectively).
92 “Mock Trial,” 29.
93 “Mock Trial,” 29.
Justifying their presence in the field by emphasizing their caring nature had two notable outcomes for women physicians: first, it circumscribed their presence to medical subfields where a caring nature was considered vital: namely, obstetrics, gynecology, and pediatrics. It also simultaneously limited their ability to pursue subfields like surgery that were thought to require stereotypically male characteristics like strength, reason, and a quick intellect – a gendered dynamic that would persist in medical education throughout the twentieth and twenty first centuries. Secondly, and of significant importance to this study, women patients interested in a sympathetic physician flocked to the practices of women physicians. Women physicians, they reasoned, were better able to understand their needs both as a patient and women, and many women physicians registered surprise at the number of patients who asked them for an abortion. The phenomenon was so common, in fact, that Catherine MacFarlane, an 1898 graduate of Woman’s Medical College, noted in her autobiography that she expected amongst the first patients of her newly established medical practice to be a “girl with painful periods…or it would be a woman with an incomplete abortion,” both of which Dr. MacFarlane expressed familiarity and comfort in treating.  

Dr. MacFarlane and her peers at Woman’s Med were taught to embrace their special role in medicine by the faculty of the College. Emphasizing professional women’s stereotypically feminine attributes as an asset to a particular field was not unique to medicine; however, it did have the tangible outcome of funneling women into medical subfields like obstetrics and gynecology, and later pediatrics. In these fields they could exercise their special attributes and avoid the scandal of encountering naked male bodies and the heroic, bloody fields like surgery that were reserved for medical men. Dr. Anna Broomall and her colleagues built a superior

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94 “Dr. Kitty Mac,” 36. Dr. MacFarlane opened her practice in Germantown, a suburb of Philadelphia, in 1900.
obstetrical and gynecological training program that prepared her graduates with clinical experience far beyond the men graduating from the nation’s prestigious medical schools, in turn creating an internationally recognized program for the College. The next chapter, “Anna Broomall and Clinical Obstetrical Training at the Woman’s Medical College of Pennsylvania,” examines in deeper detail Woman’s Medical College of Pennsylvania’s obstetrical and gynecological clinical training program.
Chapter Two

Anna Broomall and Clinical Obstetrical Training at the Woman’s Medical College of Pennsylvania

Dr. Anna Broomall was at the center of Woman’s Medical College’s exceptional obstetrics and gynecology program. Her thirty-five-year tenure with the College began in 1868 as a student and ended with her retirement as Chair of the Obstetrics Department in 1903, and her career was marked by exceptional dedication to her students’ education and her patients’ care, an unwavering interest in adopting clinical advances in obstetrics, and a skilled surgical practice. Upon her graduation from Woman’s Med in 1871, Broomall served as an intern at Woman’s Hospital of Pennsylvania before following the trajectory of most women regular physicians in pursuing post-graduate training in Europe. She travelled with two women who were recent graduates of the University of Michigan’s Medical School, first to a small village near Hanover, Germany, to learn the language. There Broomall fell ill with typhoid fever, and was forced to join her travel companions in Vienna where they had already begun advanced clinics on the ear, nose, and throat. Her second surprise of the trip arrived in the form of a letter from Emmeline Cleveland, Professor of Obstetrics at Woman’s Med, informing Broomall of her terminal illness and asking if she’d consider specializing in obstetrics and returning to Woman’s Med to take her position.

Broomall adjusted her course of study and began attending Karl and Gustave Braun’s midwifery course at the Frauenklinik of the Vienna Hospital at a time when a requirement of attendance included giving birth to a baby of one’s own. While she would become one of the

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95 Mary W. Griscom, “A Beloved Physician, 1847-1931,” from Anna Broomall’s Deceased Alumna File, Deceased Alumnae Files from the Women’s Medical College of Pennsylvania, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 2, 6.
96 Griscom, “Pioneering Medical Women,” 2.
97 Griscom, “Pioneering Medical Women,” 2.
98 Griscom, “Pioneering Medical Women,” 3.
most noted obstetricians of her time, Broomall never married or bore children. She was able to subvert the Brauns’ requirement by making herself useful around the Hospital while observing the workings of the maternity clinic. After finishing her studies in Vienna, Broomall travelled to Paris to further her education before returning home to nurse Dr. Cleveland and succeed her as the Professor of Obstetrics at Woman’s Med.

The Resolution from Woman’s Medical College of Pennsylvania’s Faculty and Board of Corporators upon Anna Broomall’s death in 1931 is a testament to her influence on women in medicine: “Dr. Broomall’s life was an inspiration to hundreds of graduates of the Woman’s Medical College of Pennsylvania in this and other lands; her death marks the closing of an epoch in the history of women in medicine; her achievements are a challenge to the medical women of the future.” Her students knew her as a diligent and supportive professor – a “genius…teacher, [and] a strict martinet” who routinely synthesized material from French, Italian, German, and American medical journals for her lectures. She was the first physician to perform and routinely recommend episiotomies in the country and was unafraid of professional change, continually adopting updated medical innovations and discoveries in her obstetrical practice and teachings. Catherine MacFarlane recalled that she spent a majority of her intern year at Woman’s Hospital “attending Dr. Broomall’s lectures in order to keep up with her ever changing ideas.”

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99 “Dr. Kitty Mac,” 23.
100 Griscom, “Pioneering Medical Women,” 3.
101 Resolution from WMCP on May 1, 1931 in appreciation of Dr. Broomall’s service to the College, from Anna Broomall’s Deceased Alumna File, Deceased Alumnae Files from the Women’s Medical College of Pennsylvania, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
102 “Dr. Kitty Mac,” 28 and Griscom, “Pioneering Medical Women,” 5 (respectively).
103 “Dr. Kitty Mac,” 23 and 32.
104 “Dr. Kitty Mac,” 32.
Amongst her most important “ever changing ideas” was her plan to provide Woman’s Med students with clinical obstetrical experience. Clinical training for late nineteenth-century medical students was rare, and only the most prestigious medical schools offered some level of experience in their students’ final year of schooling.\textsuperscript{105} The paucity of clinical training was largely due to hospitals’ lukewarm reception to medical students, who they saw as liabilities to their mission. Hospitals serving the working poor saw medical students as costly and counter to the efficiencies a successful charity hospital needed to run well. Conversely, institutions with a wealthier clientele could damage their reputation by allowing medical students to practice on patients paying for – and expecting – the highest level of medical care. Instead of allowing access to patients, hospitals typically provided amphitheater experience to medical students, who could observe medical procedures from their seats in the audience. Finding clinical experience was difficult for all medical students, and women medical students faced a particularly difficult

challenge in that many hospitals refused their entrance as students, interns, and physicians. The Woman’s Hospital of Philadelphia was incorporated in April 1861, partly to provide clinical training for Woman’s Medical College Students who were unwelcome at the City’s prestigious clinics. Eventually, the faculty of Woman’s Med developed demonstration relationships with Blockley Hospital, the Pennsylvania Hospital, and the German Hospital for their third year students.

Illustration Two: Woman’s Hospital of Pennsylvania (undated). Woman’s Hospital of Pennsylvania was founded, in large part, to provide clinical instruction to the students of Woman’s Medical College of Pennsylvania in a moment when the clinics of Philadelphia were closed to women. The WHP’s mission also included establishing a hospital to care for women and children and train practical nurses. The Hospital’s finances and administration were managed solely by women.

Broomall was not satisfied with amphitheater clinics and ward walks for her students. In the 1880s she founded both the Maternity Clinic for the Woman’s Hospital of Philadelphia and an Out-Practice Maternity Clinic to provide women medical students with hands-on obstetrical experience and patients with what’s often cited as the first opportunity for prenatal care in the country. The Maternity Clinic of the Woman’s Hospital of Philadelphia was founded by

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106 “Board of Managers Regular and Special Meeting Minutes, 1861-1865,” Woman’s Hospital of Philadelphia Records (WHP, Series One, Box 1), 1.
107 Regina Morantz Sanchez believes Anna Broomall’s clinic provided the first prenatal care in the United States, followed by the New York Infirmary. Morantz Sanchez, Sympathy and Science, 78-9.
Broomall and supported by wealthy patients and friends to provide the women of Philadelphia with the opportunity for a hospital birth in a setting other than Blockley, the main maternity hospital for the working poor, which was “not very popular.” Broomall believed women required hospital care in childbirth, and the Woman’s Hospital offered both private rooms for patients who could pay for care, as well as a ward for those who couldn’t afford a room.

Illustration Three: “Exterior Maternity Building.” Pictured is the exterior edifice of Woman’s Hospital of Pennsylvania’s Maternity Clinic, founded by Dr. Anna Broomall.

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108 “Memorial Meeting for Dr. Anna E. Broomall held by the Delaware County Historical Society on M, April 4, 1932,” from Anna Broomall’s Deceased Alumna File, Deceased Alumnae Files from the Women’s Medical College of Pennsylvania, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
The Maternity Clinic primarily provided clinical experience for interns – women who had just completed their medical degree and who sought specialized post-graduate education. Dr. MacFarlane, a Woman’s Hospital intern from 1898-99, recorded her experience with Dr. Broomall in her autobiography and noted Broomall’s dedication to the Maternity Ward and her patients. She personally conducted rounds with student interns at 7:30 every morning and kept in close contact with the interns and faculty caring for patients when she could not be there. At first, communication was accomplished through a servant used to ferry messages between her private practice on what was known as “Sawbones Row” to the interns several times a day, and later, by way of a telephone installed in the main Hospital building that Broomall expected her students use to make regular patient reports.109

109 “Dr. Kitty Mac,” 29. Dr. Broomall’s practice was located at 1411 Walnut Street in Philadelphia. She opened it in 1883, feeling strongly that a woman needed to have a presence amongst the practices of other noted male physicians on Walnut Street. Griscom, “Pioneering Women Physicians,” 3.

Illustration Six: “Nursery, Maternity Building.” Pictured is the Nursery of the Woman’s Hospital of Pennsylvania. Dr. Anna Broomall believed childbirth was safest in a hospital setting.

Broomall also wanted her students to be skilled at attending patients in home births alongside hospital births, and she opened the Out-Practice Maternity Department of the College in 1887 to provide women medical students with practice in midwifery.\textsuperscript{110} Initially located at

\textsuperscript{110} “Memorial Meeting,” 8, Griscom, “Pioneering Women Physicians,” 3.
10th and Reed Streets in South Philadelphia, Broomall quickly moved the location to 335 Washington Avenue to be closer to the growing immigrant communities who lived along the banks of the Delaware River, and who primarily made up the practice’s patients. Like the Maternity Clinic at Woman’s Hospital, the Out-Practice Maternity Department was funded entirely by Dr. Broomall’s “devoted friends and patients,” as well as “apron [and] cake sales.” Only the Assistant’s salary of $50 per year came from the College treasury.\footnote{Griscom, “Pioneering Women Physicians,” 4.}

Dr. Broomall’s Out-Practice Clinic was likely the first of its kind to provide prenatal care in the country, and its staff emphasized pre- and post-natal care for the mother far before standard protocols were established by the obstetrical field.\footnote{On Broomall’s Clinic as the first in the country to provide prenatal care, see “Memorial Meeting for Dr. Anna E. Broomall,” 8. Morantz-Sanchez, \textit{Sympathy and Science}, 78-9. Peitzman, \textit{A New and Untried Course}, 79. On pre- and postnatal maternity care, see “Dr. Kitty Mac,” 28. Dr. MacFarlane noted, amongst other new protocols, that Dr. Broomall required “the baby’s head to be delivered under a continuous stream of carbolic acid” to ensure sterility during birth. She also required the administration of douches every three hours post-birth for the same reason, and confined a patient to bed “until the fundus of her uterus was on a level with the pubic symphysis.”} The New York Infirmary soon instituted a similar program so its students could gain practical experience with childbirth, and most schools eventually followed suit.\footnote{Peitzman, \textit{New and Untried Course}, 79-80.} Women medical students were assigned individual cases and made home visits for patients’ prenatal care. They delivered women in their homes or at the Clinic, and the staff physician and intern only intervened if there was a significant problem.\footnote{“Dr. Kitty Mac,” 32. Dr. MacFarlane describes her experience serving as the intern of the Out-Practice Maternity Clinic in 1898-9, noting that she would assist medical students with slow and/or challenging births. If the birth was “too much” for her, she would call Dr. Griscom, the staff physician, to apply forceps and perform version. See also: Griscom, “Pioneering Women Physicians,” 3-4 and Peitzman, \textit{New and Untried Course}, 79.}

At a time when most male physicians graduated from the country’s most prestigious medical schools having never delivered a baby, the students of Women’s Medical College were responsible for independently managing up to ten maternity cases in their junior year of clinical
In her memorial essay documenting Dr. Broomall’s career, her mentee, Dr. Mary W. Griscom, recalled the Clinic’s first year attendance was a fairly meager 30 patients. Upon relocating the operation to the growing immigrant communities along the Delaware, however, patient numbers grew to between five and six hundred a year, allowing each student to manage between eight and ten maternity cases. Beyond the invaluable experience of attending maternity cases, students learned bedside manner that would be an important element of their work. Broomall was known to remind her students that a good doctor “never let[s] the patient see [they] are worried.” Doubts and fears were best kept to oneself and her colleagues.

Students wrote often about their experiences at the “South Pole,” the name they gave to the Out-Practice Clinic in South Philadelphia that was a significant physical and cultural distance from the College in North Philadelphia, especially for students who came to study at WMC from rural areas of the United States. Students lived at the Out-Practice Clinic for a portion of their third year, and for many of the upper-middle class, white, Protestant students of Woman’s Med, the experience was a moment of reckoning with poverty and difference. The neighborhoods surrounding the Clinic were home to recent migrants from Southern and Eastern Europe and Black families. Students noted the poverty and cultural difference of the women and families they served with a level of judgment. “At the waterfront,” wrote Catherine MacFarlane, “the strange foreign people fascinated me. Some were so poor they had nothing to wrap the baby in. The thrifty Italians wrapped the baby tightly in a wide muslin bandage, binding fast arms and legs, as we looked on astonished.” She noted, as well, the religious differences of those she

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117 “Dr. Kitty Mac,” 23.
118 Peitzman, *New and Untried Course*, 142. The College was located on N. College Avenue in Philadelphia.
served: “The Jews, when the baby was a boy, invited us to the circumcision party and offered us wine and cakes.”

On the Philadelphia Streets of South Fourth, Fitzwater, and Catherine, students delivered babies and found they were treated with respect by the patients and the families they served. Dr. MacFarlane, for instance, wrote that if a woman went into labor at night, “the husband called for the doctor and carried her obstetrical bag,” and walked her back to the clinic after the baby was delivered. The medical historian Steven Peitzman notes women in the Washington Avenue neighborhood were likely quick to embrace the work of WMC medical students because they were familiar with the practice of delivering with a midwife. The patient numbers of the Clinic indicate women of the neighborhood accepted the women physicians, and Peitzman’s observation is interesting when considered within the complex milieu of the professionalizing obstetrical field. Women physicians worked hard to distinguish themselves from practitioners of midwifery to gain professional traction with the male-dominated medical community and to differentiate themselves from practitioners who were known to perform abortions: midwives and ‘female physicians,’ or professional abortionists. In some ways, association with midwifery was a dangerous prospect for young women physicians and their careers. And yet, women were encouraged to pursue the very type of work the Out-Practice Clinic provided: obstetrical and gynecological care, especially for marginalized patients, providing yet another double bind women physicians had to negotiate.

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119 “Dr. Kitty Mac,” 34-5.
120 “Dr. Kitty Mac,” 32.
Work at the Out-Practice Clinic could also be a danger to students’ health. During a typhoid outbreak in the neighborhood, Catherine MacFarlane and two of the medical students contracted the fever and were confined to the ward of the Woman’s Hospital of Pennsylvania to recover. MacFarlane had a relatively minor case; however, her two colleagues were not as lucky. One died from the infection, and the other nearly lost her life. In a testament to her deep commitment to her students, Dr. Broomall visited the women regularly in the hospital.122

The Maternity Ward at Woman’s Hospital and Out-Practice Clinic of the College provided Woman’s Medical College students and recent graduates with practical obstetrical experience unrivaled by even the most prestigious all-male medical schools. The College’s graduates would begin their career with significant practical knowledge of pre- and post-natal care, and the ability to deliver women in the sanitary wards of a hospital or the confines of her family home. They would know how to interact with patients in the stressful moments of birth because they practiced and honed their skills under the guidance of women physicians invested in their success. Put another way, women would leave the College fully prepared for careers in obstetrics and gynecology. While the Out-Practice Clinic changed over time to accommodate the needs of the students, Woman’s Med continued to grow and promote its exceptional practical obstetrical program as a means to attract students and distinguish itself from co-educational and all-male medical colleges.123

While their experience in obstetrics and gynecology was the most robust, women graduates had access to clinical training in other medical subfields.124 The College opened the

122 “Dr. Kitty Mac,” 23.
123 Regina Morantz Sanchez notes that the obstetrical program at WMC required almost double the amount of clinical obstetrical and gynecological experience as schools like Cornell, the University of Michigan, and the University of Illinois. Morantz Sanchez, Sympathy and Science, 272-3. Peitzman notes that the home delivery service ended around 1948. Peitzman, New and Untried Course, footnote 98, 290.
124 Peitzman argues that Woman’s Medical College students’ clinical education in other medical specialties was comparable to other medical schools. Peitzman, New and Untried Course, 80.
Hospital and Dispensary of the Alumnae of the Woman’s Medical College of Pennsylvania at 1212 South Third Street in 1895 to provide students with additional clinical experience. The Dispensary had a threefold mission, and justified its existence largely upon the grounds of women’s “special role” in medicine. Staff and board felt it important “to give the poor of this district [South Philadelphia] the privilege of applying to women physicians for medical advice; To furnish opportunities for the graduates of the Woman’s Medical College to continue their studies in general and special medicine; [and] To increase the facilities for clinical instruction in the Woman’s Medical College.”¹²⁵

Illustration Seven: “Consulting Room, Alumnae Dispensary”

According to the first annual report, the Dispensary provided students with clinical experience in general medicine and surgery, obstetrics and gynecology, ‘paediatrics,’ ophthalmology, laryngology and rhinology, otology, dermatology, neurology, and diseases of the

¹²⁵ “First Report of the Hospital and Dispensary of the Alumnae of the Woman’s Medical College of Pennsylvania,” Reports of the Hospital of the Woman’s Medical College of Pennsylvania, 1896-1912, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 8
lungs and chest. Woman’s Med students in their third year attended the clinics and could occasionally shadow an intern to gain additional experience, though they did not have the same level of patient responsibility as in Broomall’s Out-Practice Clinic, where each student was assigned several maternity cases to manage on their own.

The Woman’s Hospital of Philadelphia maintained a similar Dispensary in the Hospital’s ‘Clinic Hall’ to provide the surrounding neighborhoods with medical care and students with clinical experience. Dispensary clinics were organized in rooms surrounding the central teaching Amphitheatre, and provided patients with routine medical and surgical, gynecological, eye, ear, nose and throat, children’s, dental and ‘electrical’ medical care. Woman’s Medical College students were invited to attend ‘practical instruction’ in the Dispensary’s morning clinics, and witness surgeries in the Hospital’s Amphitheatre in groups of four. While the Dispensary provided an additional venue for clinical training in medical subfields outside of obstetrics and gynecology, students were not able to directly care for patients as they did in Dr. Broomall’s clinic. Further, the relationship between Woman’s Medical College and Woman’s Hospital of Philadelphia was often tenuous, and dissolved completely in 1903. Dr. Broomall’s clinic remained the longest-running and most successful clinical program of the College.

128 Historical, Illustrative, and Descriptive Book of Woman’s Hospital of Philadelphia, Woman’s Hospital of Philadelphia Records (Series Three, Box Eleven).
129 Historical, Illustrative, and Descriptive Book of Woman’s Hospital of Philadelphia, Woman’s Hospital of Philadelphia Records (Series Three, Box Eleven).
130 Peitzman, New and Untried Course, 125-6.
Illustration Eight: “Clinic Hall.” Pictured is the front edifice of the Woman’s Hospital of Philadelphia’s Clinic Hall, where students attended clinical (amphitheater) lectures and bedside instruction.

Illustration Nine, “Amphitheatre, Clinic Hall.” Pictured is the Woman’s Hospital of Pennsylvania’s teaching amphitheater. Found within Clinic Hall, the amphitheater was used by medical students to observe surgical procedures.
Illustration Ten, “The Dispensary.” Located in rooms surrounding the Amphitheatre in Clinic Hall, the Dispensary Clinics of Woman’s Hospital of Pennsylvania served the residents of the surrounding neighborhood.

WMCP students’ training in the Dispensary and Out-Practice Maternity Clinic of the College was entirely focused on women and children, and a restricted gift to the Woman’s Hospital of Philadelphia prevented the Board of Managers from accepting male patients in both the Hospital and its clinics. Students could access co-ed clinical training in the City’s other clinics, though most remained unaccepting of women in medicine until the turn of the century. As a result, WMCP graduates were largely unprepared to treat the male body in their medical practice, further encouraging women physicians to specialize in obstetrics and gynecology.

131 “Dr. Kitty Mac,” 27. A notable exception to the Hospital’s policy of admitting only women and children occurred in 1898, when the government asked the Hospital to care for sick soldiers who had been fighting in the Spanish-American War. The Hospital staff cared for 97 men, and nursed all but two of them to full health. Historical, Illustrative, and Descriptive Book of Woman’s Hospital of Philadelphia, Woman’s Hospital of Philadelphia Records (Series Three, Box Eleven). In her biography, Catherine MacFarlane described caring for the men who had been evacuated from camps in Cuba and Puerto Rico due to cold weather. Women patients were evacuated from the fourth floor of the Hospital, and soldiers sick with typhoid fever and malaria were moved into the wards. She found the “boys from many states of the Union...an interesting study medically and sociologically.” “Dr. Kitty Mac,” 27-8. Interestingly, the Hospital’s 1861 Act of Incorporation barred the admittance of patients with contagious diseases.
Dr. Broomall and the faculty of Woman’s Medical College of Pennsylvania were at the forefront of crafting a “special” place for women in medicine that melded their medical expertise with the type of work considered appropriate for a woman given the middle class ideology of domesticity. They did so through offering their students exceptional, hands-on clinical opportunities in obstetrics and gynecology that far exceeded any provided by the country’s most prestigious medical schools under the guise of charity work amongst the poorest communities in Philadelphia. In doing so, they taught their students that their professional place was in the medical subfields where they could care for women and children: obstetrics, gynecology, and pediatrics, because women deserved the “privilege of applying to women physicians for medical advice.” Women physicians overwhelmingly practiced obstetrics and gynecology, a fact confirmed by Dean Rachel Bodley’s WMC alumna survey, to which this chapter now turns.

‘Womanhood of the Noblest Type’: Dean Rachel Bodley’s Alumnae Survey

On March 17, 1881 Dean Rachel L. Bodley addressed the twenty-ninth graduating class of Woman’s Medical College of Pennsylvania at their commencement. Bodley, a professor of chemistry and toxicology alongside her deanship, admitted in her speech that she labored over the parting lesson to give the young graduates as they made their way into their professional lives, and finally decided to “show these young graduates the work accomplished by Alma Mater in the person of her daughters throughout the thirty years gone.” A meticulous scientist uninterested in anecdotal evidence, Bodley decided to systematically survey every alumna of the “grand social and educational reform” known as Woman’s Medical College.

On February 16, 1881, Bodley mailed surveys to each of the 244 living WMC alumna, asking for their prompt response to eight questions “designed to cover the whole ground of life

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132 Rachel Bodley, *Valedictory Address to the Twenty-Ninth Graduating Class of the Woman’s Medical College of Pennsylvania*, Philadelphia: Grant, Faires & Rodgers, 1881, 3.
work, as to its professional character, its pecuniary rewards, social status, teaching work, membership in medical societies, and last but by no means least, the influence of the study and practice of medicine upon woman’s holiest relations, as wife and mother.\textsuperscript{133} Alumnae response to Bodley’s survey was exceptional and underscored WMCP’s graduates’ fealty to an institution at the fore of women’s access to medical education. Bodley’s worries that no one would respond to her inquiry were unfounded: by the date of the Commencement address, 189 alumna had responded to her survey from as far away as California, Utah, and Manitoba. Of the 55 alumna who declined response, 25 reported back to Bodley either in person or through letter so that Bodley could include them in some form in her tabulations. Only 27 alumna failed to respond in any way.\textsuperscript{134}

Dean Bodley learned a tremendous amount regarding her previous students’ professional and personal lives, including the type of medicine they practiced, how their communities received their work, their salaries, and the influence of their professional life on their personal relationships. Their responses confirm the central argument of this chapter: women physicians primarily practiced obstetrics and gynecology and justified their professional existence through the dominant middle class gender ideology. Women’s survey responses, however, reveal texture and nuance to easy generalizations, and illuminate the personal struggle of a diverse group of women attempting to forge successful careers. For instance, married physicians struggled to meet the demands of medicine and family, while single physicians balked at Bodley’s focus on the successful marriage of career and domestic life in an attempt to quell critics of women’s medical education.

\textsuperscript{133} Bodley, \textit{Valedictory Address}, 4.
\textsuperscript{134} Bodley’s survey received an 89\% response rate. Bodley, \textit{Valedictory Address}, 4.
Dean Bodley’s first three questions inquired as to whether women were engaged in active medical practice, what type of medicine they practiced, and how their communities received their work. Of the 269 who responded to the first question, only 23 were no longer practicing medicine. 8 women cited domestic duties, 1 cited philanthropic work, 6 were in ill health, 3 were retired, and 5 declined to provide a reason. 166 women responded to Bodley’s second question regarding the type of medicine they practiced, and of them only 57 were not engaged in obstetrical or gynecological work. Put another way, 66 percent of women physicians entered the medical specialties of gynecology and obstetrics. 33 of the respondents – or 20% - were general practitioners, while 20 respondents, or 12% of the population, reported their specialties as ‘medical, ‘surgical,’ or ‘surgical/medical.’ Somewhat surprisingly, women physicians were overwhelmingly received well by the communities in which they worked. 157 women responded to the question, and of them 150 “report cordial social recognition,” and their answers were “often emphasized and frequently accompanied by testimonials in proof thereof.”

Through her next series of questions, Bodley inquired as to the institutions in which women physicians worked, the group’s average salary, and the nature of their teaching engagements. Of the 159 respondents, 60 were employed in some type of charitable institution, whether it be a hospital, asylum, or as a physician in a college or school for girls. The response rate to Bodley’s salary question received the second to least number of responses, and 76 alumnae reported an average income of $2,907.30 per year. Most women physicians reported earning between $1,000 and $3,000 per year.

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135 Bodley, Valedictory Address, 5.
136 Bodley, Valedictory Address, 5-6.
137 Bodley, Valedictory Address, 6.
138 Bodley, Valedictory Address, 7.
Question six asked its respondents to designate whether they taught medicine, either formally at a college or informally to “popular audiences of women.” The responses again confirm both the prominent role of Woman’s Medical College of Pennsylvania in producing the next generation of women physician-educators, as well as the “special role” of the woman physician in educating their women patients. Of the 55 alumna who replied affirmatively to the question, 7 were professors at either the New York Infirmary or Woman’s Medical College of Pennsylvania, and 14 were instructors and lecturers at either the Woman’s Medical College of Pennsylvania or Chicago. Beyond formal education, women physicians revealed their work lecturing on medical subjects for women in a variety of venues, from “large audiences in cities” to “talks in my audience, with patients,” to “lectures on physiology and hygiene in girls’ schools” to “private letters.” Women physicians believed they had a special role to play in educating women regarding their physical health, as one alumna practicing on the Western prairies noted: “I am daily thankful for the privilege of teaching women (in their homes) how to take care of themselves and how to preserve the health of their children.”

While women physicians reported overwhelming acceptance in the communities in which they worked, Bodley’s survey revealed the medical profession at large was not as accepting. To understand the professional status of women in medicine, Bodley inquired as to the medical societies within which the alumnae were active. The survey responses were both heartening and troubling: while 68 women replied that they were indeed members of a local, state, or national medical society, the American Medical Association, the primary professional organization of the medical field, had only eight women amongst its ranks. Five of them were graduates of

139 Bodley, Valedictory Address, 7.
140 Bodley, Valedictory Address, 7.
141 Bodley, Valedictory Address, 8.
Woman’s Medical College of Pennsylvania. Bodley wrote that the City of Philadelphia also remained unfriendly to women in the profession, noting that while 15 women were admitted to the Pennsylvania state medical society, “the membership in regular Medical Societies in the County of Philadelphia is far from satisfactory. The papers have come in from all our Philadelphia Alumnae (30 in number) with the brief answer, “No.”

Women physicians continued to deal with significant criticism in 1881, and Bodley’s final survey question was an effort in quelling the critics of women in medicine. In an attempt to prove women could balance professional and domestic life, Bodley asked her alumnae to report upon the influence of the study and practice of medicine upon their domestic relations as wives and mothers. The response rate for this question was the lowest of the entire survey, with 61 women replying to the inquiry. Bodley interpreted the responses as a significant success for women’s ability to balance both home and career and thus a counter to the critics of women in medicine; however, the responses reveal the difficulties faced by women – married and unmarried – who justified their existence in a profession based upon their adherence to a middle class gender ideology.

Fifty-two married women responded to the survey, and 45 reported the influence of their career upon their home life to be ‘favorable.’ Six noted that it was ‘somewhat unfavorable, and only 1 woman noted that medicine proved an unfavorable influence in her home life.’ While an overwhelming majority of women reported medicine’s positive influence upon their domestic life, many respondents simultaneously acknowledged guilt or fatigue regarding their domestic duties. For instance, a mother of three noted “the study of medicine is of great benefit, but the

142 Bodley, Valedictory Address, 8-9.
143 Bodley, Valedictory Address, 9-10.
144 Bodley, Valedictory Address, 9.
practice often interferes with my duty to my family.”

Another respondent replied similarly: “I keep house, and care for husband and three children as I would if not in practice; perhaps not quite as well, however.” Even the strongest of statements were followed by an acknowledgement of the difficulties attendant with managing career and family: “I have not been less a wife or mother. My duties as such have never been neglected. At times I may have been more taxed than if I had not these duties to attend to.”

Dean Bodley referred to the responses as “a few discordant notes, but such as a master might throw in to enhance the harmonies of his strain.” These small, though significant notes were a testament to the difficulties women physicians faced as they built careers anchored on their “special role” in medicine, amidst a field dominated by men.

An even more salient example of women struggling against the expectations of domesticity and professional medical practice can be found in the survey responses of single women. Eleven unmarried women responded to Dean Bodley’s survey, and many of them understandably struck out the line “wife and mother” from the question’s initial wording.

Four women were explicit in addressing the tensions between career and domesticity: three of them noted that their career prevented marriage, and a fourth reported that she “remained single for reasons entirely distinct from her profession.” Two alumnae attempted to brook their single status with the dominant justification for their presence in the profession: one reported that while she never married, “[she] found time and means to care for several orphan nephews and nieces.”

Another alumna linked the traits of a good domestic wife with her medical education, hoping that she was “more patient and persevering” because she studied medicine. Bodley was

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146 Bodley, *Valedictory Address*, 9.
147 Bodley, *Valedictory Address*, 9.
particularly interested in arguing for women’s place in medicine, and these survey responses revealed the difficulty in grounding women’s place in the profession within an ideology that left many women physicians frustrated in their ability to justify their place in the field.

Dean Bodley used the statistics she gathered from the survey to refute two of the most pernicious criticisms used to prevent women from entering the medical field: that the physicality of medicine would be detrimental to a woman’s health, and that women would surely quit the profession after they married and started families. Bodley proudly noted the unusually low mortality rate for women physicians: only 32 alumnae had died over past 30 years.149 Similarly, she pointed out the “small number of women who have failed to devote themselves to the practice of medicine after graduating.” Only five have stopped practicing after marriage – proof, for her, that women physicians viewed medicine as a life calling, not simply something to occupy their time before marriage.150

Bodley ended her commencement address to the class of 1881 by reaffirming the relationship between domesticity and the profession, and ultimately the fact that women could pursue medicine without compromising their personal relationships. “Womanhood of the noblest type” can arise from medical education and practice, she argued, “and yet [one loses] nothing in sweet grace or womanly dignity…nothing in love of husband or children, or of friends, friends worthy of the name of friend.”151 In fact, she believed medical practice could “transform invalids into healthy women” by preventing marriages of convenience and leaving “every woman free to enter the estate of matrimony from the purest motives only.” Bodley’s tangled argument for women in the profession was based in both feminist and domestic

149 Bodley, Valedictory Address, 10-11.
150 Bodley, Valedictory Address, 11-12.
151 Bodley, Valedictory Address, 16.
ideologies, and it placed women physicians in a difficult position when they unknowingly or knowingly violated its behavioral code. Her study confirmed that while women physicians made great professional headway in the later part of the nineteenth century, they continued to be ghettoized into obstetrics and gynecology, struggled to make sense of their ‘special’ role in medicine, and were often excluded from professional medical societies and communities.

Dean Bodley’s alumnae survey confirms that a majority of women physicians practiced obstetrics and gynecology. From the earliest moments of their medical education, women medical students were taught in sex-segregated colleges, groomed to justify their role in medicine through their “special,” womanly virtues, and trained in the best obstetrical and gynecological programs in the country. Only women physicians could provide the best care to women patients, and it would be impossible for them to avoid patients suffering from the complications of pregnancy loss and termination in their clinical care.

And yet nineteenth-century women physicians practiced medicine at a time when the legal, medical, and state-defined fetuses were rapidly evolving. Pennsylvania judicial decisions and statutory law crafted an ambiguous fetal body that barely resembled that created by medical texts or municipal authorities. Women medical students and physicians were put in vulnerable positions as they cared for their patients experiencing the effects of pregnancy loss and termination. The following chapters explore medical, law, and state influences in creating the late nineteenth-century fetal body, as well as how women medical students and physicians made sense of pregnancy loss and termination in this moment of fetal ambiguity.
Chapter Three
“Guardians of the Rights of Infants”: Physicians, Municipal Records, and the Changing Boundaries of Life

Published two years before the landmark Supreme Court case *Roe v. Wade*, *The Effect of Changes in the State Abortion Laws* issued by the U.S Department of Health, Education, and Welfare’s Division of Research for the Maternal and Child Health Service surveyed abortion legislation across the country and its impact on maternal mortality. As part of the analysis, the report’s author, Edward Duffy, sorted each state into three categories based on the restrictiveness of their laws: ‘more restrictive,’ ‘less restrictive,’ and ‘least restrictive.’ Amongst the thirty-one ‘most restrictive’ states that allowed abortion only to protect the life of the pregnant woman, Duffy noted the particular difficulty presented by the ambiguous legislation in Massachusetts and Pennsylvania that earned each state a place in the most severe classification. In Pennsylvania, the 1860 statute still stood and prohibited ‘unlawful’ abortions, however, according to Duffy, “at the present, ‘unlawful has not been defined either by the courts or by the legislature.” Ambiguity, after all, could be used to restrict, and for over 100 years the Commonwealth of Pennsylvania had refused to define “unlawful” within legal or medical bounds.

The Pennsylvania State Legislature’s reticence to define unlawful abortion in 1860 did not prevent others from drawing their own boundaries of life that would have profound ramifications for Pennsylvanians until the 1973 *Roe* decision. This chapter puts in conversation the cacophony of voices attempting to define and refine the boundaries of fetal life through

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152 Edward A. Duffy, “The Effect of Changes in the State Abortion Laws,” Rockville, MD (U.S. Maternal and Child Health Service), 1971, College of Physicians of Philadelphia (COP 6V 250 no.2165). Of note: Only eleven states followed the model Penal Code the American Law Institute created in 1962, stating “a licensed physician is justified in terminating a pregnancy if he believes that there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or that the pregnancy resulted from rape, incest or other felonious intercourse.” Only Oregon’s law followed the American College of Obstetricians and Gynecologists’ recommendation and included the language alongside the American Law Institute’s model code: “In determining whether or not there is substantial risk…account may be taken of the mother’s total environment, actual or reasonably foreseeable.” (3)
considering medical texts and treatises, state-level and national legislation and court decisions, coroners reports, and municipal health data. In doing so, it lays bare the social and religious influences on the newly codifying field of obstetrics. Beginning two decades before the 1860 Pennsylvania statute, medical men, the courts, and public officials used their platforms to construct fetal life in the absence of legal guidance of what constituted a stillbirth, miscarriage, and an unlawful and lawful abortion. Each group was motivated by different circumstances, and their interests both overlapped and ignored one-another. Together, however, their interests created an ambiguity around pregnancy loss that could have significant effects on the women physicians beginning to enter the profession. Women, who were overwhelmingly trained to provide care for other women in the mid- to late-nineteenth century, would have no way to avoid pregnancy loss in their clinical practice.

**A Break from Tradition: Hugh L. Hodge on Criminal Abortion**

In 1839, Hugh L. Hodge delivered an introductory lecture to his course on obstetrics and the diseases of women and children at the University of Pennsylvania’s Medical School. Titled ‘On Criminal Abortion,’ Hodge offered his young students a medical lesson that would expand their medical authority beyond its customary realm. Hodge spoke of their vital role in not only preserving their patients’ health, but of preventing disease and death – put another way, the discipline of hygiene. A focus on the physician’s role in hygiene expanded the domain of medicine in two important ways: first, it gave the physician license to provide guidance on their patient’s health decisions – for instance, their cleanliness, diet choices, and exercise regimes. Importantly, it named the physician the “guardian of the health and lives of the community” they served. Much like the police officer or the elected official, the physician’s world was expanded

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to “everything which by possibility may injure health or life, becomes the subject of [the physician’s] reflections, and enables him to proffer advice beneficial to society.”\textsuperscript{154}

Hodge believed childbirth was dangerous business. So much so, in fact, that he named pregnancy the most dangerous function of a woman’s reproductive life.\textsuperscript{155} The physician’s focus on hygiene and prevention brought pregnancy and parturition squarely under the physician’s purview for this reason, as well as the fact that both represented an ethical situation unique to what would become obstetric medicine: the need to care for the wellbeing of the bodies of both the pregnant woman and her child.\textsuperscript{156} Physicians, according to Hodge, were the “physical guardian[s] of women and their offspring,” and he charged them with doing everything in their power to protect the life of both woman and infant during pregnancy and birth. In doing so, Hodge crafted for his students an argument that emphasized their role in overseeing a woman’s birthing process, representing a stark break in the management of birth in the past.

In a similar break with social, legal, and medical custom, Hodge also rejected the notion that fetal life began at the moment of quickening, or when the mother first noticed fetal movement. Asking his students to consider “what…have the sensations of the mother to do with the vitality of the child?,” he proposed that life began at conception, based upon his theory that the mother and father contributed their moral, intellectual, spiritual, and physical existence to the child at the moment of conception, so that the fertilized egg was immediately endowed with a “moral nature; a conscience…high intellectual and moral aspirations.”\textsuperscript{157} In this scenario the

\textsuperscript{154} Hodge, \textit{On Criminal Abortion}, 7.
\textsuperscript{155} Hodge, \textit{On Criminal Abortion}, 7.
\textsuperscript{156} Prior to the establishment of pediatrics as a professional subfield of medicine in the late-nineteenth century, obstetricians often cared for infants during and directly after birth. See Richard A. Meckel, \textit{Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929} (Baltimore: The Johns Hopkins University Press, 1990) for an analysis of health reform’s interest in infant mortality and the emergence of pediatrics as a medical subfield.
\textsuperscript{157} Hodge, \textit{On Criminal Abortion}, 11.
mother contributed no more than the father to the growing and nurturing of the embryo and fetus through their connection via her uterus. To use Hodge’s own analogy to explicate the relationship between the mother and the embryo: the mother is doing nothing more than providing the favorable conditions needed for an acorn to grow.

Implicit in Hodge’s argument for the increased role of male physicians in pregnancy and parturition was the stripping of women’s bodily and professional agency within both realms. Through a focus on hygiene, Hodge expanded physicians’ role to include guiding patients through the moral choices they made regarding their own health and fashioned birth as a life-threatening process in need of physician oversight to protect the life of woman and child. Needless to say, the physician Hodge envisioned was a man. More importantly, Hodge stripped pregnant women’s autonomy by devaluing quickening and arguing for their limited role in conception and pregnancy. Hodge envisioned women’s bodies as merely the conduit for pregnancy and life and the physicians’ role was to ensure he protected life from conception through birth.

Hugh Lenox Hodge was a giant amongst the country’s first obstetricians. He was the Chair of Obstetrics and Diseases of Women and Children at the University of Pennsylvania, a position he was initially unprepared to take. Hodge was thirty-nine when he assumed the coveted chair from William DeWees, who resigned for health reasons after a short tenure. As DeWees’s health declined, he urged Hodge - then a trained surgeon and fellow professor - to begin practicing and teaching obstetrics with the hope that he would succeed him. Hodge was elected his successor in 1835, and thus began a new career teaching generations of physicians how to care for women and children.158

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Hodge was the child of a Philadelphia physician who, along with his wife, Maria, raised their two sons in a deeply devout Presbyterian family. Hugh L. Hodge’s father, also named Hugh Hodge, died from yellow fever in 1798 when his son was just two years old.159 Maria Hodge continued raising her sons in a devout home. Charles, Hugh’s brother, would go on to become a professor of theology at Princeton University. At fourteen, Hugh was shipped off to Princeton for undergraduate studies. Two years later he entered medical school at the University of Pennsylvania, receiving his doctorate of medicine in 1818 while also studying with Caspar Wistar, Philadelphia’s noted anatomist.160

Religion was central to Hodge’s personal and professional life. His writings were imbued with religious references, and he built his medical theories on religious thought. While writing his introductory lecture on abortion in 1839, Hodge turned to his brother, Charles, for theological grounding regarding the beginnings of life. In his response, Charles admitted, “I do not know of any speculation on the subject. I suspect we all know just nothing.”161 Ultimately Hugh Hodge chose to ignore his brother’s thoughts and break with long-standing common law custom in the United States to craft a religious argument for ensoulment at conception.

Hodge was well-known in the medical community for upending traditional thought and clinical practice in favor of his own experiences and theories, and his writings on criminal abortion were no exception.162 In his widely-circulated 1839 lecture, Hodge leveraged the language of medicine and science in a moral argument for ensoulment at conception. His

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162 Penrose, *A Discourse Commemorative*, 17, 21. Penrose noted that Hodge himself acknowledged in his own book introduction that his opinion was “often in opposition to the most admired authors. “In his book’s introduction, Hodge notes himself that he is “often in opposition to the most admired authors” (21).
theories completely elided decades of legal, medical, and social custom and practice – as well as the advice of this theologian brother - surrounding the beginning of life, pregnancy, and birth. Hodge occupied perhaps the most coveted chair of obstetrics and diseases of women and children in the country, and his theories and teachings influenced the first generations of obstetricians in the United States.

The subfield of obstetrics and gynecology in the United States was in its early years of professionalization, lagging behind the European medical community’s far more sophisticated knowledge and teachings on pregnancy and childbirth. Many U.S. physicians traveled to Europe to supplement their education, including Dr. Anna Broomall, Chair of the Obstetrics Department at Woman’s Medical College. Hugh Hodge himself planned to travel to Europe following his degree at the University of Pennsylvania, though found himself without funds to pay for the travel. Instead, he signed himself up to be the surgeon of a vessel bound for India, hoping to make enough money for his European studies. While he failed to save enough through his work as the ship’s surgeon to realize his plans, he became expert at treating cholera, a disease then fairly uncommon in Europe and North America. He became a central figure in treating those afflicted with the disease in Philadelphia’s 1832 epidemic, and was presented with a silver pitcher by city officials as a token of thanks for his work.

As the U.S. subfield professionalized behind its European counterparts, obstetrics and gynecology in the United States was shaped by a select group of medical men who occupied prominent positions in educational institutions and medical societies. Hodge was one of these men, and his theories and clinical practices reverberated through generations of medical students.

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163 Mary W. Griscom, “A Beloved Physician, 1847-1931,” from Anna Broomall’s Deceased Alumnae Files from the Women’s Medical College of Pennsylvania, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

164 Penrose, A Discourse Commemorative, 10.
and physicians. In his twenty-eight year tenure at the University of Pennsylvania, Hodge taught thousands of medical students. He authored several widely published and reprinted introductory lectures on obstetrics, culminating in his 1863 text, *Principles and Practice of Obstetrics*.\(^{165}\) His work legitimized a medical subfield considered beneath the study of mainstream medical men because of its association with midwives and childbirth. Though Hodge likely never envisioned his text used by medical women, Woman’s Medical College of Pennsylvania recommended their students buy and keep a copy of Hodge’s text for reference. Hodge’s work remained on the College’s reading list through the turn of the twentieth century.

Hodge felt so strongly that abortion was akin to murder that he petitioned the Pennsylvania attorney general and the Philadelphia grand jury to initiate legislation criminalizing it.\(^{166}\) At the time Hodge accepted his Chairship at the University of Pennsylvania, abortion before quickening was legal in Pennsylvania according to U.S. common law. Common law in the United States was inherited from England at the time of independence and Pennsylvania had no statutory provisions in the state’s penal code further explicating the legality of abortion.

States began clarifying the legality of abortion by mid-century, almost entirely through statutory regulations that criminalized abortion at any stage of pregnancy rather than through altering common law principles.\(^{167}\) Pennsylvania followed a different track, however, when its Supreme Court criminalized abortion at any stage of pregnancy in 1850 through adding to the common law. In the case of *Mills v. Commonwealth*, both the lower and Supreme Court of Pennsylvania rejected the quickening doctrine and ruled to criminalize abortion at any stage of pregnancy.

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\(^{165}\) Penrose, *A Discourse Commemorative*, 20. Hodge was compelled to publish his book in 1864 while in retirement because it had been nearly 38 years since DeWees published his book on midwifery and Hodge felt the field needed an updated text.

\(^{166}\) Joseph, “The “Pennsylvania Model,”” 299.

\(^{167}\) The fact that abortion before quickening was permitted at common law was one facet of the argument made in *Roe v. Wade* for abortion as a constitutional right. *Roe v. Wade*, 410 U.S. 113 (1973).
pregnancy. Jonathan Gibbons Mills, a dentist, was charged with providing Mary Elizabeth Lutz drugs to procure the “birth and destruction of the said child, of which the said Mary Elizabeth Lutz was then and there big and pregnant.”

The Mills case received significant press in Harrisburg, and the Dauphin County judge who initially tried the case attempted to frame the Mills decision in common law terms based in the language of “public wrong,” or any “act of an evil public tendency leading to the destruction of public morals, injury to the public health, [or] destroying or endangering human life.”

Judge Pearson’s opinion used three key arguments to frame abortion as a public wrong. First, Pearson believed abortion threatened to completely degrade women’s virtue by removing the element of shame from non-marital sex. Without regulation, Pearson argued, abortion would become “of [an] almost daily occurrence” as women attempted to abort pregnancies before quickening. Communities would see a degradation in “female virtue” - a public wrong in need of righting through the regulation of pre-quickened abortions.

Secondly, Pearson asserted that abortion was a public health risk in that it was impossible to perform surgically without “greatly endangering” the life of the mother. When examined against the backdrop of the professionalization of obstetrics, Pearson’s argument seems both flimsy and naive to the complexities faced by obstetricians in their day-to-day practice. Though his public-facing writings left little room to explore the ambiguities of birth, Hugh Hodge himself recognized that pregnancy termination was part of clinical practice as an obstetrician. Hodge dedicated part of his time to developing obstetrical instruments he and others could use in

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clinical practice, including those for terminating a pregnancy in the event of complications that endangered the woman’s life. Judge Pearson’s opinion on the safety of surgical abortion was likely influenced by the circumstances of the Mills case that highlighted the potential dangers of abortion when performed without sterile equipment or medical care. His ruling left no room for thought regarding the safety of abortions performed by trained medical professionals, nor reasons why abortion may be medically necessary. Finally, Pearson’s opinion looked to recent medical scholarship - perhaps that of Hodge - to argue for fetal life beginning at conception:

> It is now well settled by writers of the highest celebrity on physiology that life commences at a much earlier period than the time of quickening, and we hold that it is the duty of the law to protect the embryo future citizen as fully as though it was then in active existence.

Judge Coulter of the Pennsylvania Supreme Court, however, chose a different tack in crafting his opinion of the Mills case. In a much shorter opinion, Coulter used the language of common law to argue that abortion was a “crime against nature that obstructs the fountain of life.” Coulter’s opinion established three new and important points. First, abortion at any stage of pregnancy was now a common law crime in Pennsylvania. Second, the crime of abortion, according to Coulter, was technically committed against the mother rather than the fetus. However, he affirmed the civil rights of an infant in ventre sa mere, or in utero, at all periods after conception. Put another way, if the crime was perpetrated against the mother and an “infant” was imbued with civil rights from conception, a court would not need to prove a woman was quick with child to charge a defendant with the crime of abortion. Finally, Coulter explicitly equated the terms abortion and miscarriage in his opinion. Both terms, he argued,

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171 Penrose, A Discourse Commemorative, 16. These instruments included compressores cranii and craniotomy scissors, as well as a one-piece lever and crochet for abortion procedures and pessary removal.
174 The term “infant” is Coulter’s.
were synonymous “in law and philology...[and meant] the bringing forth of the foetus before it is perfectly formed and capable of living.” While now formally linked in Pennsylvania state law, these terms were far from synonymous in medical theory and practice. Justice Coulter’s opinion offered no further guidance regarding the legality of medically necessary abortion and miscarriage, making all pregnancy loss implicitly suspect.

The Supreme Courts of New Jersey and Massachusetts considered similar cases at the same time, each ruling to uphold the quickening doctrine struck down by Pennsylvania’s high court. The Courts’ commitment to upholding the quickening doctrine was influenced by two factors: first, each state’s legislature had recently considered and passed anti-abortion statutes criminalizing abortion at any stage of pregnancy. In both cases, the Courts chose not to expand the body of common law crimes because common law itself discouraged the creation of felonies by judicial decision. Pennsylvania, however, had no pending law criminalizing abortion, thus the judiciary chose the more active route of overturning the quickening doctrine in 1850.

The Pennsylvania legislature did not include a statute on abortion until 1860, at which point it criminalized “unlawful” procedures as felonies, punishable by a fine of up to five hundred dollars and imprisonment for up to three years. The law encompassed all types of abortion, including those completed by instrument and drugs, and used the terms “abortion” and “miscarriage” interchangeably. Just as in the Mills decision, it was a crime to abort a woman at any stage of pregnancy regardless of whether the fetus had quickened. Also in the same vein as the Mills decision was a paucity of information regarding what constituted an “unlawful”

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175 Mills v. Commonwealth.
abortion. This disjuncture between legal and medical language created ambiguity that would be used to restrict the procedure. It also placed a majority of women physicians in treacherous waters as they cared for their patients while negotiating the clinical and legal opaqueness around pregnancy loss.

**Common Law, Quickening, and the Boundaries of Fetal Life Before 1850**

Hugh L. Hodge’s belief that ensoulment occurred at conception was not entirely new; he derived several of his theory’s core tenets from ancient Greek and early modern writings on reproduction. The journey from Ancient Greek and early modern theories to Hodge’s 1839 University of Pennsylvania lecture hall was not linear, however, and Hodge’s theory represented a stark break from common law that permitted abortion before fetal movement, or quickening. Though unprecedented in its argument, Hodge’s introductory lecture foretold an impending change in the legal and medical interpretation of fetal life and the role of physicians in managing pregnancy and childbirth that would be felt for well over a century.

Hodge’s theory of ensoulment at conception was evidence that ancient and early modern theories of reproduction continued to find purchase well into the nineteenth and twentieth centuries in the form of scientific thought, with authors appropriating bits and pieces to explain concepts not yet fully understood. The notion that a fertilized egg was endowed completely with an “intellectual and moral nature” and everything it needed to grow and thrive within the empty vessel of its mother’s uterus, for instance, closely paralleled the concept of preformation, or the idea that humans simply grew in the womb from miniature versions of their adult bodies. Similarly, the idea that the mother’s body offered nothing more than a home for the fully-endowed egg to grow reflected back to Pythagoras’ theory of sex-separated roles in reproduction that emphasized the father’s primary role in creating life while de-emphasizing the influence of
the mother on her offspring to the point where she was nothing but an empty vessel. Hodge believed that men and women contributed equally to the ensoulment of the fertilized egg at the moment of conception and that the mother’s body had “little more influence upon the child in utero than the parent bird has upon its offspring in the egg.” In revising the terms of conception and pregnancy to include men’s equal role in ensoulment and deemphasizing women’s influence on the fetus in utero, Hodge opened the door to delegitimizing women’s roles in pregnancy and childbirth, including their legal right under common law to terminate pregnancies before the moment of quickening.

The United States constructed its legal code upon English common law, which had a long tradition of recognizing fetal life at the moment of quickening. Doing so allowed women significant leeway in both identifying the moment of quickening and terminating their pregnancies before the moment they felt fetal movement. Defining life by the moment when the woman felt fetal movement resulted, to Hodge’s dismay, in a lack of legislation before 1850 preventing abortion before the moment of quickening – an act he equated with murder. While the Mills decision and Pennsylvania’s 1860 legislation predicated the crime of abortion upon the woman, Hodge extended the interpretation of murder to include the unborn fetus. “Every act of procuring abortion,” he believed, “is murder, whether the person perpetrating such act intended to kill the woman, or merely feloniously to destroy the fruits of her womb.”

In rare cases, states like New York closely regulated abortion by permitting the charge of manslaughter in the second degree if the procedure occurred after quickening. Most states, including Pennsylvania, considered the crime a misdemeanor punishable by a substantial fine and prison sentence.

178 See Thomas Laqueur, Making Sex: Body and Gender from the Greeks to Freud (Boston: Harvard University Press, 1992) for a broad-sweeping analysis on historical theories of reproduction.

179 Hodge, On Criminal Abortion, 13.

180 Hodge, On Criminal Abortion, 15.
Pregnancy and birth across racial and class lines was largely a female realm before the mid-nineteenth century. Midwives and women relatives attended laboring women in a historical moment when obstetrics had not yet formed itself as a medical discipline, there was no established prenatal care, and little available formal training on attending women in birth. Even the most prestigious medical schools of the early republic included little or no training on childbirth because it was considered beneath the time and study of medical men. Midwives rarely had formal medical training, though their experience delivering women often gave them more practical knowledge than their physician counterparts.

As the subfield of obstetrics formed over the mid-to-late nineteenth century, the increasingly powerful mainstream medical profession attempted to link midwives with professional abortionists in an attempt to push them from the field. Birth was becoming a lucrative medical “business” and it behooved physicians to remove their primary competition. Statistical reports maintained by the Philadelphia Board of Health attest to midwives’ declining role in the birthing chamber. By 1873, only 3,525 of the 18,702 babies delivered in the city were attended by what the Report called “female accoucheurs.” The remaining 81% of births were attended by “male practitioners.”

Professional abortionists also worked alongside “regular” physicians and midwives in the complex medical marketplace that was nineteenth-century medicine. Prior to the 1850 Mills

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181 In his memorial lecture on the life and work of Dr. Hodge, Dr. William Goodell maligned the field of midwifery, noting its domination by elderly women “whose pretensions were only equaled by their ignorance.” The negative image of midwifery was so pervasive that medical schools often had little to no offerings on midwifery and students interested in the field were forced to travel to England or France. Even when medical men were able to study the practice, women were not quick to employ their skill and, according to him, “midwifery existed almost universally as an art; the aged and imbecile nurse was preferred to the physician.” Dr. Hodge’s mentor, Dr. DeWees, was at the vanguard of transitioning midwifery to the purview of medical men codifying the field of obstetrics within the medical profession. William Goodell, Biographical Memoir: Hugh L. Hodge, M.D. (Philadelphia: Collins, 1874), 9-10, College of Physicians of Philadelphia (Flick Pam, Vol 17, Pam 32).

decision in Pennsylvania, professional abortionists advertised their services in newspaper classified sections and sent information freely through the U.S. Postal Service. How publicly they advertised their services depended upon the rapidly changing legal environment in which they worked. Their advertisements boldly levied critiques of physicians, who could often do little to care for patients in an age before germ theory was understood and embraced.

“Madame Demain,” for instance, whose given name was Ann Ford, advertised her services to women in 1845 through the Public Ledger, a popular daily newspaper in Philadelphia. The ad “caution[ed] the Ladies against placing themselves in the hands of the various female and male “quacks” occasionally appearing and disappearing” who referred to themselves as “Female Physicians,” “Doctors,” &c., &c., and who advertise their knowledge of diseases.”183 She promised her customers that she would “give her whole attention to the treatment of female periodic irregularities” and “her long standing and successful practice in this city are of course sufficient evidence to satisfy the most skeptical that they will receive the benefit they desire.” Ford listed her address in the ad as No. 4 Powell Street, Philadelphia. Her McElroy’s entry is also under her pseudonym of Madame Demain and lists her profession as “doctress.”184

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184 McElroy’s Philadelphia City Directory (Philadelphia: A. McElroy & Co., 1845), pg. 86
Illustration Eleven: Public Ledger Advertisement for Madame Demain’s services. Demain cautioned her reader to beware of “Female Physicians” and “Doctors” “who advertise their knowledge of disease.” A female physician, in this instance, referred to a woman abortionist. The term “Physician” could have referred to a man who practiced abortion or it could be in reference to a member of the “regular” medical community, both of whom represented competition for Madame Demain’s services.

Ford was arrested by city officials in May 1845, at which point her advertisements in The Ledger disappeared. Similarly, she was no longer listed in McElroy’s Directory after 1846. She was tried and convicted in the Court of Oyer and Terminer and Quarter Sessions of the Peace in and for the city and County of Philadelphia in May 1845 for a “violent assault” of Susannah Schoch, who consented to the abortion, as well as killing Schoch’s “female child,” and conspiracy to commit the abortion.185 Ford appealed the decision for a variety of issues, the most important of which was the fact that the prosecution had not charged that Schoch was quick with child - a charge necessary if she were to be convicted of killing the fetus. An appeal was heard before the Pennsylvania State Supreme Court in February of 1846, and Ford was acquitted by the jury. The legal definition of quickening was beginning to change, and the Demain case was amongst the first warnings to abortionists - and anyone overseeing the care of pregnant women - that their work was under increased scrutiny.

Hodge’s 1839 lecture was at the beginning of a movement in medicine and law that would shift the boundaries of fetal life, limit women’s autonomy in pregnancy and birth, and bring childbirth firmly under the purview of the newly codified field of obstetrics. Physicians were at the forefront of advocating for and enacting these changes, inspired by their expanded responsibility for the population’s health and wellbeing and what Hodge saw as their duty to influence legislators, public opinion, and, importantly, pregnant women as to the ‘value of the embryo and foetus, and the high responsibility which rests on the parents of every unborn infant.”

In the absence of legal sanctions, Hodge believed it was the duty of medical men to both protect infant life and educate the general public – particularly pregnant women – “that [they] are responsible to [their] Creator for the life of the being within [them].” Hodge’s widely-circulated and influential lecture marked the beginning of changes to legal and medical thinking on abortion that ultimately explained why Edward Duffy classified Pennsylvania’s abortion policy as ‘more restrictive’ in 1971. But Hodge was not the only voice signaling a sea change regarding the classification of fetal life. By mid-century, the Philadelphia coroner had begun holding inquests, an event normally reserved for the investigation of violent deaths, for routine stillbirths.

Mid-Century Coroner’s Reports and Questionable Stillbirths

Joseph Delavau served as the Coroner for the city of Philadelphia from 1854-1857, and the surviving records of his time in office provide a salient example of the changing boundaries of fetal life foretold in Hodge’s lectures and writings. While the records are patchwork and incomplete, Delavau’s entire casebook for the fiscal year of 1854-5 is preserved in its entirety and its ten inquests involving stillbirth that year offer a glimpse into his struggle to document and

186 Hodge, On Criminal Abortion, 19.
classify stillborn births. The mere fact that he documented many of the stillborn births he attended is curious. An 1845 Pennsylvania law required Philadelphia coroners to be discerning in the number of inquests they held throughout the year, threatening to withhold compensation unless the deceased person died a ‘violent death.’ A stillbirth was a relatively common occurrence in nineteenth-century pregnancy and does not necessarily indicate any level of violence. While some of the cases in Delavau’s book clearly required investigation, others seemed to be the result of routine pregnancies. As later Board of Health records for the city attest, stillbirth was not uncommon in this period.

Delavau’s casebook illustrates four important points: first, that stillbirth piqued suspicion and required state oversight. The authority of a coroner was needed to adjudicate pregnancy loss in a moment when the boundaries of miscarriage, abortion, and stillbirth were blurry. Second, given the number of stillbirths reported by Philadelphia’s Health Department, Delavau’s casebook indicates that women rarely reported them. Third, the cases illustrate that Black women’s stillbirths were more suspicious than those of their white counterparts. Lastly, Delavau’s notes show that the term “still born” was contested and did not correspond to nineteenth-century medical terminology.

It was within the legal context of the Mills decision that Joseph Delavau began his work. At this historical moment stillbirth had indeed become an event worth questioning because Mills v. Commonwealth required some level of state-sponsored oversight in parsing stillbirths from abortions and miscarriages. Joseph Delavau took up this task as coroner of the city of Philadelphia. To him, stillbirth warranted an investigation normally reserved for violent deaths.

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In one year, Delavau investigated ten stillbirths. Half of these cases included a violent death and a very clear reason for opening an inquest; the remaining five record no clear motive for investigation. Given that Delavau noted the presence of violence to either the mother or the fetus or child in half of the cases, it is unlikely that Delavau failed to include reason for suspicion in the other five cases. Their presence in the Delavau casebook indicate the increased surveillance of stillbirth at a time when the legal environment began restricting abortion.

Yet if the Philadelphia Health Department statistics were correct, one in twenty pregnancies ended in miscarriage.\textsuperscript{188} The ten cases in Delavau’s book for the fiscal year 1854-5 would not come close to recording the number of miscarriages in the city. There are several reasons for this paucity of cases, the most important of which is that many women still ascribed to a social and medical milieu that permitted abortion before quickening and viewed early pregnancy loss as a natural part of their reproductive life.\textsuperscript{189} Women also knew that medicine in this period could do very little to prevent miscarriage, and thus avoided calling a physician to assist them. The medical management of miscarriage would shift significantly over the course of the nineteenth century, as highlighted by recent scholarship from Shannon Withycombe. Seen initially as a natural event, physicians and the women they treated played active roles in reframing pregnancy loss as a dangerous condition in need of oversight by a physician. This shift, Withycombe argues, was rooted in two important changes in medical theory and treatment

\textsuperscript{188} Philadelphia Board of Health Report,” Second Annual Message of William S. Stokley, Mayor (1873), Annual Messages of William S. Stokely, Mayor (1873-1876), City Archives of Philadelphia, 317.

\textsuperscript{189} Shannon Withycombe’s recent book, Lost: Miscarriage in Nineteenth-Century America, provides a beautiful and complex look into nineteenth-century women’s views on pregnancy loss. At the core of her study is the notion that women’s responses to pregnancy and miscarriage depended upon the context in which they lived - both their personal circumstances and the social and medical worlds that more broadly defined their choices. Some women welcomed their pregnancy with joy by personifying and naming their fetus, even writing letters to family members in their future child’s voice. These women felt feelings of devastation when they lost their pregnancies. Yet other women felt relief at their pregnancy loss, especially as laws banning abortion and restricting information on fertility control passed in states across the county, limiting women’s ability to control their reproductive lives. For these women, pregnancy loss was seen as an unexpected and welcomed reprieve from childbirth and the economic burden a child could represent to a financially strained family.
for pregnancy loss. First, the theoretical shift from preformation to epigenesis that moved human development from a mysterious and unknowable process to one that could be observed and known. Miscarriage could easily be construed as a natural and unconcerning aspect of one’s reproductive life within a medical worldview that saw fetal specimens as mysterious and something other than human. As physicians and scientists began to study and know the fetus, however, treatment for miscarriage also changed. What was once considered a natural occurrence was reframed as an unnatural and dangerous medical event in need of physician management. As one can imagine, women patients initially had no interest in physicians overseeing their miscarriages, since physicians had almost no tools to treat pregnancy loss, and according to domestic medical manuals written by doctors, everything seemed to cause miscarriage. If it was unavoidable and untreated, women reasoned, there would be little point to calling a physician to manage the process.¹⁹⁰

On the other hand, women were also likely reticent to report their miscarriages to authorities for fear of legal and social retribution. The act of reporting this intimate, personal experience to a public authority was not only a novel idea at a period in time when public health statistics were just beginning to be tracked, it could easily feel like a violation of privacy or the first step in ‘proving’ one’s pregnancy loss was “lawful.” After all, an inquest suggests investigation to prove there was no wrongdoing, and the legal and medical climate in Pennsylvania was beginning to understand the boundaries of life in new and different ways. This would particularly be the case for Black women, whose bodies and sexuality were closely surveilled. Given the ubiquitousness of stillbirths, how did one determine whether a stillbirth was intentional or the result of natural causes? Delavau’s records, unfortunately, do not reveal

his interactions with the accused; however, they do provide vital information regarding who he targeted for investigation.

Joseph Delavau performed ten inquests for cases of stillbirth over the course of the year. In three cases, the mother’s identity was unknown and the cause for opening an inquest was clear: infant remains were found in vacant lots and cemeteries throughout the city. In these circumstances it was safe to presume a suspicious or violent death. The mothers’ identity was known in the remaining seven cases recorded in Delavau’s casebook, and only two cases describe the violence that ultimately led to a stillbirth and initiated Delavau’s inquest. In the case of Christina Sentz’s stillborn child, Delavau determined the cause of stillbirth to be “injuries received by its mother from her husband, John Sentz.” In the January 8th, 1855, case of Harriett Wheeler, Delavau found a male child lying dead and the jury rendered it a case of stillbirth from injuries received by its mother.

Delavau provided no standard interpretation of the term “still born” in his cases. According to the inquest juries, a still born “child” could be preterm, 10 days, or two months old. Take, for instance, an October 24, 1854, case in which Delavau investigated the remains of a male child found in a lot near the corner of 10th and Thompson Streets. The body of the deceased was thought to be no more than ten days old, and the jury returned a verdict of “supposed murder at hands of those unknown.” This decision corresponds to medical and legal precedents that considered the intentional death of a child after it was fully born and separated from the maternal body as infanticide. And yet several months later Delavau investigated the case of Catherine Ann Masterson, a two-month-old found deceased in a home on the corner of 7th Street and Shippen. At two months Masterson was significantly older than ten

192 Coroner Case Records, October 24.
days, yet the jury returned a verdict of ‘still born.’ According to Delavau’s juries, a stillborn ‘child’ could be both preterm and a newborn.

The November 20th case of the male ‘child’ buried before it reached its full term was the only case that corresponded to nineteenth-century medical definitions of still birth. William Thompson Lusk’s popular work *The Science and Art of Midwifery* described still born children as those born without breath or heartbeat. In some cases, they could be resuscitated, and he provided instructions for how to do so in his chapter on the pathology of labor. Pierre Cazeaux’s *Obstetrics* also classified stillborn children as those born without vital signs, as did Hugh L. Hodge’s *Principles and Practice of Obstetrics*. None of these obstetrical texts described still-born children as living through or beyond birth. The inquest jury’s understanding of pregnancy, its termination, and fetal life did not correspond to legal precedent or medical practice.

Delavau’s records illustrate the disparity of understanding between law, medicine, and the general population regarding pregnancy and birth, as well as reveal the valuation of some pregnancies as more suspicious than others. Six of the ten cases of still-birth examined by Delavau justify opening a death inquest. Either a deceased body was found abandoned, a child died, or the still birth resulted from physical abuse. The other four cases, however, list no suspicious cause of death – only that a still birth took place. As noted in late nineteenth-century

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193 Coroner Case Records, December 9.
194 Coroner Case Records, November 20.
Philadelphia Board of Health records indicate, stillbirth was a common experience in the reproductive lives of many women.

The common denominator in each of the four cases was a Black mother, indicating that some pregnancies – and their termination – were more suspicious than others. Delavau’s inquest notes are sparse and tend to list only necessary information: the location of the inquest, presence of violence, the name and race of the mother, and the age of the fetus or child. Yet his records, when examined alongside one another, reveal details regarding how pregnancies under suspicion were tracked. For instance, Delavau knew the names of each of the Black mothers in his casebook. He knew the names of only two of the five white women. His records suggest Delavau knew the names of the white women because the inquests happened in their homes – an obvious way to connect those involved in the case. However, only one of the five cases involving a Black mother took place in her home at No. 67 Monroe Street. The other four cases were either adjudicated by Delavau and the jury in the street or in ward station houses.

In general, Black women’s bodies were more publicly scrutinized than those of white women and Delavau’s casebook reflects this fact. Though Philadelphia was home to a vibrant free-Black community, in 1854 slavery had not yet been abolished in the United States. Generally, it was more common for Black women to work outside of the home than it was for white, middle class women whose primary focus was maintaining a domestic space and caring for children. Traveling to and from a job, working outside the home, and engaging in a professional relationship with an employer put Black women quite literally in a place where they could not hide a pregnancy or its termination.

Delavau noted in each case when violence was involved in a verdict of stillbirth, and only one case involving a Black woman listed a verdict of stillbirth as a result of “injuries received by
its mother.” While it did not list violence, the case of December 8th provided sufficient reason for inquest. The entry described the scene: “in Erens Court running south from Shippen above 7th upon the body of a male child of Arm Parish there lying dead, the verdict of the jury “still born.” There is little information in Delavau’s casebook regarding what triggered the remaining three inquests. Two were held at a ward station house and one at the woman’s residence, and none of the entries list evidence of violence – information relatively easily obtained since the women’s identities were known.

One likely reason Elizabeth Shorts, Catherine Sharpless, and Sarah Seamans’s stillbirths were subject to a coroner’s jury was because as Black women they were less likely to hire a physician to attend their birth or provide care for pregnancy loss. A physician could attest to the legitimacy of their pregnancy loss; however, their services were expensive. In addition, racial and gender power imbalances made white male physicians potentially dangerous to Black women. Instead, Black women often called on midwives or older women to aid them in birth. Together with the increased surveillance of Black women’s bodies, the absence of a physician to sign a death certificate made them more vulnerable to a coroner’s inquest. It would be remiss, as well, not to mention the pain and danger associated with this sort of public jury. Birth, no matter the circumstances, is an intensely vulnerable period in a woman’s life. To be subject to a public coroner’s jury in a ward station house must have been excruciating for Elizabeth and Catherine. Beyond emotionally taxing, a public jury could be ruinous for a Black woman. Had she fled bondage, it provided a path for a master to track her whereabouts. If she was free and employed, it could be cause for an employer to fire her.

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197 Coroner Case Records, January 8th.
The Power of Statistics

The story of the gradual move from births attended by midwives and women relatives to an experience overseen by a male physician is a narrative familiar to both historians of medicine and gender as well as the broader public. As medicine professionalized and sought avenues for its new-found authority, the birthing chamber was identified as a place in need of the oversight of a male physician rather than a community’s midwife. To be clear, medical advances – antisepsis, for instance - toward the end of the century were saving women’s lives. Yet there was little mainstream effort to teach these principles to midwives or other members of the medical marketplace, who were often characterized as dirty, careless practitioners of quackery. What is often overlooked, however, is the role municipal authorities interested in tracking a city’s vital statistics played in championing the authority of the newly professionalizing field of obstetrics, pushing midwives from the field, and codifying the boundaries of birth and death.

Shannon Withycombe’s recent scholarship on pregnancy loss complicates the well-known narrative and illustrates a significant shift in the medical management of miscarriage that played out over the course of the nineteenth-century. Once seen as a natural part of a woman’s reproductive life, physicians and the women they treated played active roles in reframing pregnancy loss as a dangerous condition in need of oversight by a physician. This shift, Withycombe argues, was rooted in two important changes in medical theory and treatment for pregnancy loss. First, the theoretical shift from preformation to epigenesis that moved human development from a mysterious and unknowable process to one that could be observed and known. As physicians and scientists began to study and know the fetus, treatment for

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miscarriage also changed. What was once considered a natural and common occurrence was reframed as an unnatural and dangerous medical event in need of physician management. As one can imagine, women patients initially had no interest in physicians overseeing their miscarriages. In large part this was because physicians had almost no tools to treat pregnancy loss, and according to domestic medical manuals written by doctors, everything seemed to cause miscarriage. If it was unavoidable and untreatable, women reasoned, there would be no reason to invite a physician to manage the process.

This dissertation builds on Withycombe’s work by arguing for an additional reason for the shift in medical management of miscarriage in the nineteenth century. The late nineteenth-century saw an increasing interest in collecting population statistics, especially in the major urban areas of the United States. These statistics were used by city and state officials to guide public health policy, and miscarriage rates were amongst the data public officials became increasingly interested in quantifying. The final part of this chapter explores the role of physicians and city officials from the Philadelphia Board of Health in medicalizing pregnancy loss in an effort to track the vital statistics of the city’s residents.

The Philadelphia Board of Health had significant power in defining life and death as part of an effort to track Philadelphia’s citizenry. Left with very little guidance from national and state laws, city officials were forced to make decisions regarding when life began and ended in order to track Philadelphians’ vital statistics. To do this, they needed a cadre of allies to adjudicate cases; they found their answer in the newly professionalized physicians of Philadelphia. This portion of the chapter traces a straight line from Hugh Hodge’s 1839 lecture at the University of Pennsylvania through Joseph Delavau’s interest in overseeing the city’s stillbirths all the way to state legislation in 1860 that criminalized ‘unlawful’ abortions all the
while providing little guidance as to what characterized unlawfulness. Importantly, a Philadelphia municipal act of 1860 required the city to begin tracking vital statistics – in this case, births, deaths, and marriages. By then, European cities had decades of vital statistics to draw on as they crafted policy to benefit their citizenry. Cities like Boston, New York, and Philadelphia were only beginning to track vital statistics, and began the project with zeal to not seem unmodern. In a moment of profound legal and medical ambiguity with regard to when life began, their efforts shaped Philadelphians’ understanding of birth and life.

By 1854, Joseph Delavau had already started identifying the need to adjudicate suspicious pregnancies. There was no law requiring him to report stillbirths to state authorities; however, his work foretold the March 8, 1860, municipal act that required the city’s physicians, midwives, undertakers, cemetery sextons, and clergy to register their names and place of residence with the health officer, who also required them to track Philadelphia’s births, deaths, and marriages and report the information on a yearly basis. The Act paid special attention to the tracking of deaths and births, and the role of physicians, midwives, coroners, and sextons in both events. Physicians, specifically, were deputized by the Act to witness deaths by submitting a certificate to the undertaker superintending the burial within forty-eight hours of a person’s passing. This duty fell to the “physician who attended during [the deceased] last sickness.” In the event a physician could or would not sign the certificate or if the case came under his purview, a coroner was charged with completing this task.

Death was now entirely under the purview of the state, as the Act prohibited any corpse from being interred or moved beyond the limits of the city without a death certificate signed by

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201 Purdon’s Law Review, 1873.
an attending physician or coroner. The certificate was required to report the deceased’s “full name, sex, color, age and condition (whether married or single)…and the cause of death.” Once the certificate was in the hands of the undertaker or “person having charge of the body,” they were required to add the following information to the document: “occupation of the deceased, the place of birth, the ward, street, and number of the house in which the death occurred, the place and date of interment, and, where the deceased is a minor, the full names of the parents.” And if a person should die without the attendance of a physician or if the physician in attendance refused or neglected to furnish a certificate, the onus was on the undertaker or “any other person acquainted with the facts” to report the case to the health officer, who was authorized to issue a certificate of death as long as there was no need for the coroner’s involvement in the case.

Sextons were required to submit the certificates to the health officer on a weekly basis so that the returns could be published. And there was incentive for physicians and coroners to issue death certificates included in the Act – to neglect to do so would cost them $25 for each offense. In modern terms, this would be equivalent to about $750.

The Act contained a separate section regulating the city’s midwives, anticipating that they would face challenges reporting the statistics the health officer demanded to modernize the city’s public health policies. The text made no mention of the duties of physicians attending the city’s births, and instead addressed the section requiring the tracking of birth statistics only to midwives. Presumably, physicians were already correctly tracking births in the city. Not only were midwives required to register their place of residence with the city, but they were also required to keep ledgers reporting “the full name of each child [they assisted in delivery], its sex, color, the full name and occupation of its parent or parents, [and] the day and place of its

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birth.” This information would be turned over to the city’s health officer each month. While the Act’s aim was to provide city officials with the demographic information they needed to track their citizenry, it presented two distinct problems for Philadelphia’s midwives that would significantly decrease their work over the course of the following decade.

Leslie Reagan’s scholarship reminds us that most midwives served immigrant, Black, and working-class communities, of which they themselves were members.203 Midwives, almost entirely women, were less likely than their physician colleagues to be able to read and write, making this type of tracking difficult for them. Physicians, conversely, were becoming an increasingly authoritative group as medicine professionalized in the later part of the nineteenth century. This is an important distinction when one considers who has authority to oversee birth – a messy, unclear, and often ambiguous journey of two bodies that does not lend itself well to rigid categorization. The city’s incomplete birth records indicate there were approximately 1,000 stillbirths each year.204 In a moment when “unlawful” pregnancy termination was ill-defined, midwives were placed at risk by reporting a pregnancy that could not be defined by the limited scope of the health officer’s required reports.

The Philadelphia Mayor’s Office began issuing annual reports in 1872, and included summaries from each municipal arm of the city, including the Board of Health. In the Second Annual Message of Mayor William S. Stokley, the Board of Health of Philadelphia reported that births attended by midwives paled in comparison with those attended by physicians. Of the 18,702 babies delivered in the city that year, only 3,525 were delivered by “female accoucheurs.” “Male practitioners” delivered 15,165 babies, while parents reported delivering the remaining

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In the thirteen years since the passage of the 1860 Act tracking Philadelphia’s births, deaths, and marriages, births attended by midwives amounted to only nineteen percent.

The shift from midwife to physician-attended births in the late nineteenth-century cities of the United States has been well documented in scholarship. Philadelphia’s story, in many ways, is similar: state regulations made it increasingly difficult for those without a degree from a certified medical college to practice medicine. An Act of March 31, 1870, prohibited “any person to commence or continue the practice of medicine or surgery” in almost every county in Pennsylvania, including Philadelphia, “who has not graduated with the degree of doctor of medicine, and received a diploma from a chartered medical school or other institution authorized to grant medical diplomas.” The law excluded those who had been in practice for over ten continuous years, as well as students working and studying under the direction of a preceptor, as long as they did not operate outside of their preceptor’s office. Violation of the law was a misdemeanor, carrying the penalty of up to six months imprisonment or a fine of $200-$500. The Act included no mention of how one could go about proving to authorities the tenure of their practice.

Later iterations of the law became increasingly specific, requiring standards for practitioners of “medicine, surgery, or obstetrics…namely: a good moral character, a thorough elementary education, a comprehensive knowledge of human anatomy, human physiology, pathology, chemistry, materia medica, obstetrics, and practice of medicine and surgery and public hygiene.” Put another way, as physicians professionalized and obstetrics codified itself as a medical subfield, midwives were pushed from the medical marketplace. Further legislation

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206 PA Law Digest, 1873. Under subheading “Physician.”
207 A March 24, 1877 addition to the act made standards universal across the Commonwealth.
in the early 1890s would make it nearly impossible to operate a midwifery practice: an Act of 1893 established a medical council of Pennsylvania, consisting of the lieutenant-governor, the attorney-general, the secretary of internal affairs, the superintendent of public instruction, the president of the state board of health and vital statistics, and the presidents of the three state boards of medical examiners, whose purpose was the licensing of Commonwealth physicians. In 1894, Pennsylvania passed an Act requiring physicians who received their medical degrees after July 1, 1894, to have at least three years of medical school, and those receiving their degree after the same date in 1895 to have at least four years. Medical education in Pennsylvania and across the country wasprofessionalizing, and it was strengthened by Pennsylvania’s legal code. The state needed physicians to oversee the project of collecting and managing the vital statistics of its citizenry, and midwives simply were not equipped with the training or professional authority to carry forward the task.

The notion that midwives were the crux of underreported births was first iterated in the 1873 Report of the Board of Health of Philadelphia. In a subsection titled “Births,” the Health Office provided an in-depth analysis of Philadelphia’s birth rate and compared it with contemporary and historical data from the United Kingdom.208 The main purpose for the report and comparison centered on the idea that Philadelphia’s infant mortality rates looked extremely high because, city officials argued, births were going unreported. High infant mortality rates were incongruent with a modern municipality, and Philadelphia officials went to great lengths to prove ‘careless’ midwives were one of the main sources of the false reporting. City officials knew, in general terms, that Philadelphia’s population was increasing. Yet the statistics reporting births and the number of deaths of children under one year of age reported an

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extremely high rate of infant mortality: approximately one in every 3.65 births would end in death. Instead, city officials looked to England for more accurate statistical data on infant mortality. The “accurately prepared tables” of the Registrar-General reported an infant mortality rate of about 20%, or about one in every five births ended in death. Philadelphia city officials used this information to surmise that a significant amount of the city’s births were going unreported. But why?

The report referenced two causes for underreported births: “ordinary midwives [and] nurses, who, through carelessness, ignorance of the law, or the want of a proper appreciation of its obligations, fail to report cases coming under their care” as well as others who “have no professional attendance in their confinement” and who never report the birth of their child to authorities. Not even the medical profession escaped the critique of the Health Office. The Report argued the only way to overcome this hurdle was to create a cadre of “properly qualified officers” who could periodically visit every family in the city until such time as the “community, including the profession of medicine, shall properly appreciate the value to society and to the State, of full and accurate birth records.”

The Board of Health was motivated to count its citizenry for three physical, legal, and political reasons: first, tracking deaths “aid[ed] in the disclosing of disease.” This was the era when germ theory and antisepsis were beginning to take root in medical practice, and health officials now had tools to prevent the spread of major outbreaks. Tracking vital statistics was also a legal endeavor, and “provid[ed] the means of tracing descent and proving personal identity” for the citizenry of Philadelphia. Finally, vital statistics were an important tool for the government of the city, giving officials the ability to “[arrive] at correct conclusions with regard

to measures of internal economy, taxation, employment, and commerce.” In short, tracking vital statistics was a modernization project for Philadelphia that allowed its citizens to avoid the spread of disease, prove their personal identity, and build a legitimate tax base. Tracking these vital statistics required a shared perspective of life and death that was not yet legislated by the Commonwealth or codified by the medical profession. In the absence of legal and medical guidance, city officials wrestled with these questions over a several year period.

One of the first questions when tracking births and deaths was who was technically alive and dead. While it seems a relatively concrete answer, nineteenth-century Americans wrestled with this question nearly as much as their contemporaries do when considering life-saving medical interventions at birth and death. A central question emerged in the first years of the Board of Health’s reports to the public: would stillbirths be classified as a birth, a death, or both?

The Board of Health’s report for 1873 lays bare the health officer’s struggle to classify the city’s stillborn babies, even in light of the 1860 law requiring city officials to track births, deaths, and marriages. In an effort to comply with the 1860 Act, the Health Office began tracking stillborn children and their sex in 1861. In an effort to ease tracking, the health officer created a liminal state of life that was alive and never died. Statistics on stillborn children were reported separately in subsections on ‘Birth’ and ‘Death,’ and while their numbers were included in the city’s total births, they were not reported amongst the city’s deaths. According to the city’s vital statistics, these children technically never died. They served as a reminder that the messiness of life never fits the orderly lines of statistics and its reporting: while they were

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211 Each statistic reported by the Board of Health was accompanied by a detailed narrative describing its meaning and broader impact for the city’s citizenry. Statistics reporting stillbirths were treated only minimally, and the discussion was entirely taken up by the rates of male versus female stillbirths, as well as how these rates compare to other states in the Union. See “Philadelphia Board of Health Report (1874),” 398 and 400.
reported amongst those born in the city, their physical remains were a reminder that a death occurred in spite of city officials’ inability to classify it.

To further confound matters, the Board of Health unofficially tallied stillborn children amongst the city’s infant mortality statistics in the Report for 1873, counting them amongst the number of children who died before the age of one.212 This method had its basis in statistical uniformity rather than any sort of legal or medical theory. “Stillbirths were included [in the infant mortality records]” not because municipal officials were trying to take a moral or political stance on the existence of life, but rather so “that the records may harmonize with those of other years in which they have been retained.”213 In other words, the records were included because it was the way the Office had always collected the statistics. To change the process would have skewed the data’s interpretation long-term. Equally confusing was the fact that the official number of deaths for the city in 1873 did not include the city’s stillbirths. The Report asserts stillbirths make the total number of deaths in the city rise to 16,736, which is higher than the 15,224 – “the actual number chargeable to the city.”214 The city’s vital statistics created a category of life for stillbirths that was at once alive in the form of an infant that also existed in a liminal state between life and death. The Board of Health was caught between maintaining a semblance of standard reporting as legal and medical boundaries of life changed in their midst, as well as the desire of the city’s officials to more clearly track its citizenry. Arguably, their solution was the best they could do with very little guidance from medical and legal authorities who were also struggling to categorize stillborn life.

212 “Philadelphia Board of Health Report (1873),” 432.
213 “Philadelphia Board of Health Report (1873),” 432.
214 “Philadelphia Board of Health Report (1873),” 432.
The Board of Health’s Report for 1874 did very little to clarify the status of stillborn life. Like the year before, the Health Office included stillborn rates in the birth statistics and did not include them in the death statistics for the city. Interestingly, however, the health officer took steps to remove stillbirths from statistics on infant mortality, citing them as a “separate and distinct record” whose inclusion in the infant mortality statistics “misrepresents these statistics and impairs their value.” To rectify this misrepresentation, the Health Office constructed tables on infant mortality rates for children under one, five, and ten years of age without stillbirth rates, and took “considerable pains in reconstructing similar tables that have appeared in previous reports.” Removing stillbirths from the infant mortality records had the happy effect of significantly lowering the infant and childhood mortality rates for Philadelphia – a definitive marker of progress for the city. The eternally living stillborn child created through the tracking of vital statistics was now truly an eternal being despite often having coroners reports attached to its name. Its death was neither tracked through the city’s infant mortality or death statistics.

The Health Department’s concern regarding tracking stillbirth rates amongst infant mortality numbers reflected a broader, national interest in prenatal and infant care that coincided with the organization of obstetrics and pediatrics as medical subfields. Whereas infants previously died from common illnesses like diarrhea or malnutrition, physicians trained specifically to care for women and children were beginning to better understand preventative measures that significantly lowered mortality rates in the earliest stages of life. At stake now was educating Philadelphia’s mothers as to the proper methods of infant care, feeding, and

216 “Philadelphia Board of Health Report (1874),” 895.
217 “Philadelphia Board of Health Report (1874),” 432, 894.
218 Meckel, *Save the Babies*, 11-91.
sanitation and regulating midwives – a project that brought the period of infancy into the field of interest for both the medical field and the city.\textsuperscript{219}

Beginning in 1873, the Obstetrical Society of Philadelphia created rules for caring for infants in the summertime, the season responsible for the most infant deaths, with the goal of distributing the instructions to “a very large proportion of the families of the city.”\textsuperscript{220} While removing stillbirth statistics from infant mortality rates for children under one significantly lowered the figures, the statistics were still high enough that the Health Office report from 1875 lamented their statistical reports were not detailed enough as to allow them to break out deaths by age for this period. Including the deaths from children under one had the effect of obscuring the statistics for the city.\textsuperscript{221} Most importantly, the Health Department created distinct boundaries between infancy and stillbirth through an intensified focus on the infant body. A body that could now be saved through advances in medicine and who’s saving ultimately represented a modern, orderly city.

Philadelphia’s municipal authorities were placed in a difficult position with the passing of the 1860 Act requiring the city to track the vital statistics of its population. In the absence of legal and medical guidance on the subject, the Health Office worked with physicians, coroners, sextons, and midwives to register and oversee the city’s births and deaths. But birth and death often defy the neat boundaries of statistical analysis. Among other scenarios, babies are born still, perish in the process of birth, or die shortly thereafter from prematurity or complications from birth. The issue at the center of this work was that city officials were required to track

\textsuperscript{219} The Health Report of 1873 noted that lowering the infant mortality rate of the city required both “improved hygiene” and “improved law” in the form of instructions on how to feed, nurse, cloth, and care for infants and the “regulated education of midwives.” “Philadelphia Board of Health Report (1873),” 440.
\textsuperscript{220} “Philadelphia Board of Health Report (1873),” 440.
information that was not yet agreed upon by city, state, or federal law or medicine. In the absence of consensus, Philadelphia’s Board of Health deputized physicians to oversee births and deaths, thereby pushing midwives, who did not have the training or professional authority to comply with the Office’s regulations, from the medical marketplace. Overseeing and reporting complex births required an individual with professional and social authority. In this particular situation, a community’s midwife was no match for a white, male physician trained in a certified medical college.

Simultaneously, the Board of Health wrestled with how to report complex birth statistics, particularly stillborn births. In the earliest years of the Board’s Report, stillbirths were included in deaths of children under one, though they were not included in the city’s overall total deaths. As the infant body became of interest to both physicians (who could save it) and statisticians (who could track a city’s modernity through infant mortality rates), the delineation between stillbirth and infancy was drawn in sharper contrast. Stillbirth statistics were removed from both infant and overall mortality rates of the city, thereby creating a separate and unique classification for stillborn babies that placed them in an inherently suspicious category requiring the oversight of a physician or coroner.

As Edward Duffy noted in 1971, ambiguity was in fact restrictive, and the unspoken and unlegislated nature of who could oversee the beginnings of life had real consequences for midwives, pregnant women, and physicians that would last for well over a century. It is within this context that students at Woman’s Medical College of Philadelphia trained as future physicians who would care for women throughout their reproductive lives. The next chapter turns to their interactions with pregnancy loss and termination, analyzing the distance between
their public-facing statements and clinical encounters as the city and their profession required increased surveillance and reporting for pregnancy loss.
Chapter Four

Public Statements and Private Practices: Medical Women Confront Pregnancy Loss and Termination

In order to holistically understand the experience of nineteenth-century women physicians, we must probe beyond their public-facing statements on pregnancy loss and termination and ask how they grappled with the rapidly changing and unevenly understood boundaries of fetal life. In the classrooms and clinics of Woman’s Medical College of Pennsylvania, medical students and physicians encountered pregnancy termination and loss in pedagogical exercises and clinical practice. Their public-facing writings cleave closely to the mainstream medical community’s changing views on abortion, driven primarily by prominent physicians like Hugh Hodge and the American Medical Association. Their educational experience and clinical practices, however, offer a more nuanced understanding of how they rendered clarity from ambiguous legislation and their field’s polemical stance on abortion. Taken together, these sources track the distance between women medical students’ and physicians’ public statements and private practices.

In the years preceding and following the 1873 Comstock Act, the federal legislation criminalizing the act of sending information on abortion and birth control, amongst other things, through the United States Postal Service, several women authored senior theses on abortion, feticide, and infanticide at Woman’s Medical College of Pennsylvania. Each of the students framed her opposition to intentional pregnancy termination through the lens of morality and argued for the central role of women physicians in educating women patients that abortion at any

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stage of pregnancy was akin to murder and dangerous to the health and wellbeing of the woman. All of the students also leveraged religious arguments against abortion before quickening, and like the 1860 Pennsylvania statute preventing “unlawful” abortions, largely refused to consider cases of medical necessity.

Annual Reports from the Dispensary of the Alumnae of Woman’s Medical College, a clinic operated by Woman’s Medical College, offer a more complex lens through which to view women medical students’ and physicians’ interactions with pregnancy loss and termination. Patients were seen for abortion care at the Dispensary from its first year in operation. Initially listed only as “abortion” in the Dispensary’s first annual report, the procedure was broken out into subcategories in subsequent years, listing both “incomplete” and “threatened” abortions and providing additional insight into the care happening in the clinic. “Threatened” abortions referred to potential pregnancy loss, while “incomplete” abortions could be the result of what was called a “spontaneous abortion,” or miscarriage. Incomplete, however, could also refer to an intentional abortion that was not entirely successful. Women medical students treating women patients for “incomplete” abortions - whether the abortion was spontaneous or not - was a dangerous prospect. The onus fell to the physician to justify their medical care, and women medical students and physicians were in a particularly vulnerable position.

Within the confines of clinics managed and staffed by women, Woman’s Medical College students learned how to treat pregnancy loss and termination. Clinical case books from the Obstetrics Department and the Dispensary of the Alumnae of Woman’s Medical College between the years of 1890 and 1900 list multiple cases of pregnancy loss and termination, including case notes and patient histories that offer tremendous insight into how women physicians understood and managed pregnancy loss and termination with the clinical context.
Dr. Anna Broomall, the head of the Obstetrics and Gynecology Department at Woman’s Medical College, knew her women students would encounter difficult cases as future obstetricians and gynecologists. As a part of her lectures on infanticide in 1892, Dr. Broomall arranged a mock trial experience in which students played the parts of the attending and assistant physicians and experts, coroner, and jury. The case featured a young domestic worker who was charged with infanticide, and prominent Philadelphia attorneys and members of Woman’s Medical College Board of Corporators lent their time to play the part of the judge, the counsel for the defense, and the prosecution. At its core, Broomall’s mock trial was a pedagogical experience meant to teach her students how to successfully navigate challenging legal and medical dynamics; the case also reveals the close link between abortion and infanticide in the nineteenth century.

**Senior Theses**

The power dynamic between physician, patient, and fetus was part of a new medical paradigm that pathologized childbirth. Physicians, rather than midwives or experienced women family members, were now key to the medical management of birth. Concurrently, legislation criminalizing “unlawful” abortion at any stage of pregnancy while failing to articulate “lawful” procedures made any type of pregnancy loss implicitly suspect. In the same moment, municipal authorities expressed increasing interest in tracking births and deaths. Within this milieu, women medical students articulated a new understanding of fetal life that was very different from the common law doctrine of quickening governing the earlier part of the century. Annetta Kratz, for instance, argued “that the foetus is from the very outset a living and distinct being, hence induced abortion is a crime second to none.”

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223 Annetta Kratz, “Criminal Abortion,” unpublished thesis, WMCP Theses, 1851-1895 (ACC-72), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel College of Medicine, 12.
life within the context of religious morality. Charlotte Ross, for instance, saw abortion as a “crime in the sight of God as heinous early as later,” and Sarah Hall believed intentional pregnancy termination was the “crime of taking a life and robbing an immortal soul of its possibilities for development.” Mary Mitchell, who wrote her senior thesis on the importance of abolishing infanticide, connected the crimes of infanticide and abortion as those indicative of a less sophisticated and inhumane culture. The antidote for both, according to Mitchell, was “stricter laws...that [argue] human life, from its first to its last hour, is sacred, and whoever willfully puts an end to it is a murderer.”

The similarity of the women medical students’ theses to Hugh Hodge’s 1839 lecture on feticide and criminal abortion is striking. Hodge understood his duty as the “guardian of the rights of infants” through his own religious experience and he imbued his lecture and later teachings and writings with morality based in his Presbyterian faith. Hall, Kratz, Ross, and Mitchell could have used other lenses through which to oppose intentional pregnancy termination, including the position of the women’s rights movement. Nineteenth-century feminists predominantly opposed intentional abortion because they believed women should be allowed to determine the spacing of their pregnancies in marriage, and thus the timing of sexual acts. Abortion was construed as a way for men to shirk their familial duties, and it also placed the burden of unwanted pregnancies squarely on women. Another option was referring back

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to the 1860 statute or 1850 Mills decision to justify their position. Both the judicial decision and statute were based in natural law theories that could be construed as religious; however, the texts of both contained very little theological language. The women’s preference for arguments grounded in theology indicate Hugh Hodge’s power in shaping medical theories on pregnancy termination in the nineteenth century.

Most of the women felt that abortion and infanticide were epidemics of national proportion in the late nineteenth century. “The subject...is one of frequent occurrence, the number of mothers passing through the childbearing epoch without aborting once or more is small,” wrote Charlotte Ross.227 Sarah Hall agreed, and believed the topic should be of “national interest.” 228 These future women physicians were worried that their women colleagues would be particularly vulnerable to continuous requests from women seeking to terminate their pregnancies. Hall, for instance, expressed concern that women physicians would be especially tempted to act upon the “common sympathy [with] which one should have for the sufferings of our sex.” The only solution, however “[was] to be deaf to all entreaties of this nature, from whatever source.” 229 Professional physicians did not provide abortions. That role was left to “meddlesome midwives” and “unprincipled practitioners who [were] covertly bartering life for gold, and making the ratio of miscarriages startling.” 230

Whatever its prevalence, where abortion had occurred was difficult to ascertain with confidence. The terms “miscarriage” and “abortion” were used almost interchangeably in medical records, tracts, and educational materials. This was more than mere sloppiness, for an

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intentionally induced abortion could often resemble a miscarriage, or spontaneous abortion.\textsuperscript{231} It was also quite easy, according to Sarah Hall, to confuse an abortion in early pregnancy with stopped menses, “as many of the symptoms are similar.”\textsuperscript{232} Hall believed the two ways to make a more definitive diagnosis included knowing the patient’s menstrual history and performing a digital exam of the patient.\textsuperscript{233} Charlotte Ross agreed, writing that it was easy to confuse an abortion with ordinary menstruation, and that a potential way to distinguish between the two was a digital exam.\textsuperscript{234} As a means to deter women from the procedure, Ross stressed that modern obstetricians believed abortion to be significantly more dangerous to a woman’s health and life than normal, at-term labor and delivery.\textsuperscript{235}

Despite the fact that Pennsylvania laws punished those who provided abortions, each of the women supported legislation that punished those who sought abortions as well. Annetta Kratz, for instance, argued that only legislation intended to punish those who sought abortion could end the problem. Indeed, she even foresaw a role for physicians very similar to what was evolving in Philadelphia’s municipal system. Kratz believed doctors had the expertise to identify forced procedures, and their testimony could be used to capture abortionists.\textsuperscript{236} Mary Mitchell also identified the Pennsylvania legal statute’s interest in protecting maternal rather than fetal life and argued for laws offering fuller protection for the fetus and infant.\textsuperscript{237}

Yet they felt it was their moral imperative as women physicians to educate their patients that life began at conception and any intentional attempt to terminate a pregnancy from

\textsuperscript{231} Hall, “The Physical and Moral Effects,” 1.
\textsuperscript{232} Hall, “The Physical and Moral Effects,” 7.
\textsuperscript{233} Hall, “The Physical and Moral Effects,” 7.
\textsuperscript{234} Ross, “Abortion,” 23-4.
\textsuperscript{235} Ross, Abortion,” 25.
\textsuperscript{236} Kratz, “Criminal Abortion,” 15.
\textsuperscript{237} Mitchell, “Infanticide,” 4-5.
conception forward was illegal. Charlotte Ross believed that it was women physicians’ duty to “teach our daughters and our future mothers the duty they owe to themselves, society, and their Maker in this respect, and then only will you have this wicked and degrading practice abolished.” Women physicians “taught” through a blend of moral suasion and directive. Maria Mitchell noted that “very often must all the eloquence and all the authority of the practitioner be employed; the woman physician especially will be called upon to stir up the conscience of her weak and erring patient and let her know, in language not to be misunderstood, that she is responsible to her Creator for the life of the being within her.” If that failed to work, she urged women physicians to find a religious teacher who could convey the message. Mitchell also cleaved closely to Hugh Hodge’s argument that physicians were protectors of infants. “Physicians must be regarded as the guardians of...children,” she wrote. While Mitchell spared her reader the empty vessel metaphors Hodge used to explain women’s role in conception and pregnancy to his readers, both she and Hodge were concerned with fetal and infant life at the expense of the mother’s.

Perhaps the polemical language of the three future physicians reflected fears regarding their vulnerable place in late nineteenth-century medicine. It was most certainly an easier choice to adopt the mainstream stance on pregnancy termination championed by the AMA. It would also be easy to assume their stances were borne from a clinical naivete regarding the complexity of pregnancy and birth. This, however, was not necessarily the case. Mary Mitchell, for instance, recognized what she called the “many risks [of childbirth]...especially in abnormal labors.” In addition, each of the women who authored theses trained at Woman’s Medical

238 Women physicians spoke out on this point, too. Dr. Josephine Peavey felt it was the duty of women physicians to educate their patients and women in general that “abortion however produced, except therapeutically, is criminal.” Josephine Peavey, “Criminal Abortion,” *The Woman’s Medical Journal* Vol. 8 1899, 209-216.
College, an institution committed to serving the poorest Philadelphians who could not afford a private physician. Woman’s Med students were intimately acquainted with the living conditions of their patients. They provided home visits while rotating through Broomall’s Outpatient Maternity Clinic, and even lived in the community during other rotational posts. They had experience with the myriad reasons women patients might want to terminate pregnancies.

**Infanticide on Trial**

On March 23, 1892, Dr. Anna Broomall, the head of the Gynecology and Obstetrics Department at Woman’s Med, assembled her students in the east lecture room of the College to participate in a mock trial meant to augment her winter term course lectures on infanticide. Women medical students from the class of ’93 filled nearly every role required in the “courtroom,” from the attending and assistant physicians and experts, to the coroner and the jury. *The Commonwealth of Pennsylvania versus Susan Jones* featured an unmarried domestic worker accused of infanticide, and prominent Philadelphia attorneys and members of WMCP Board of Corporators lent their time to play the part of the judge, the counsel for the defense, and the prosecution.^[240]

The mock trial turned on a salacious and fictitious story of infanticide meant to mimic those easily found in the newspapers of Philadelphia and other major metropolitan areas. The inspiration for the mock trial is unknown; however, the events and circumstances closely resemble the case of seventeen-year-old Ida Reed, who stood trial in August of 1891 for suspected infanticide. Her baby was found in the basement with marks about its dislocated neck and an ante-mortem hemorrhage of the brain. Dr. Henry Formad, a highly regarded pathologist,

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[^240]: “Mock Trial at the Woman’s Medical College of Pennsylvania,” Records of W/MCP Medical Students 1850-1981 (ACC-072), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
professor at the University of Pennsylvania, and instructor at Woman’s Medical College, testified in the case. His examination indicated the scratches had occurred after death, and that the injuries were likely sustained during birth. Ultimately his testimony exonerated Reed and the jury pronounced her not guilty. While Formad was connected to WMCP as an instructor, he was more notably the brother of Marie Formad, a professor at Woman’s Med and celebrated gynecologist, surgeon, and pathologist in her own right, and a pillar of the WMCP community. It is likely that Anna Broomall learned of Ida Reed’s case from the Formads and structured the mock trial around Reed’s circumstances.241

At the center of Anna Broomall’s mock trial exercise was the character of Susan Jones, a young domestic who, like Reed, was accused of murdering her infant shortly after birth and hiding the child’s body. The District Attorney, a role played by Philadelphia lawyer Rebekah Roberts, reminded the jury of the prevalence of the crime in her opening remarks: “Shocking as it may appear, the time of the courts is largely taken up with trials of cases of infanticide, and I feel that I cannot dwell too strongly on the evil resulting from the great and well-known reluctance of juries to convict a mother of this crime.”242 She attributed the “universality of the crime” and reluctance of juries to convict the mother to the idea that the “birth is almost always in secret, and therefore conviction for the crime from proof of the crime is extremely difficult.”243

242 “Mock Trial,” 4. Roberts’ statement regarding the prevalence of infanticide is confirmed by the Philadelphia Coroner (and later Mayor of the City) Samuel H. Ashbridge, who favored the creation of a “Foundling House” in Philadelphia to stem the rates of the crime. Additionally, he called for greater regulation of private lying-in houses and homes for infants as part of this initiative. See “The Foundlings’ Home,” The North American (Philadelphia, Pennsylvania, Wednesday, September 28, 1892).
243 “Mock Trial,” 4.
Again mimicking the real-life trial of Ida Reed, *The Commonwealth of Pennsylvania vs. Susan Jones* featured just such a secret birth. The District Attorney’s opening remarks and the testimony of Mary Smith, a witness, gave insight into the details of the case. In the early morning hours of May 19, 1890, Smith, a domestic working in the same home as Jones, woke to begin her duties. As she began her morning rounds, she stopped by the room of Susan Jones and called her to wake. Hearing no response, she entered the room and found Jones hemorrhaging in her bed. Smith’s testimony reported that she was so terrified by the scene that she said nothing to Jones and immediately fled the house to find a doctor.

Mary Smith was able to locate Dr. Gertrude Walker nearby, and Walker accompanied her back to the house on Warnock Street. Dr. Walker quickly assessed the situation and sent Smith to summon her partner, Dr. May, for assistance. Meanwhile, Walker examined Jones, and alongside the hemorrhaging found “conclusive evidence, in her opinion, of recent confinement.” When Dr. May arrived, Walker asked her to find rags to stem Jones’ hemorrhaging. Dr. May opened a trunk in the corner of the room in search of cloth, and she found the body of a dead infant. Upon examination by both physicians, they found that “life was extinct” and sent word for the coroner to come to the home. Susan Jones refused to answer any of the physicians’ questions and “denied all knowledge of the child, [and] how it came there.” As a result, she was charged with murder and placed on trial.

The opening of the trial transcript relays Dr. Broomall’s intention for the exercise: “to emphasize the important points of the lecture, give practice in medical testimony, enable the student to convey scientific knowledge to the minds of the jury, and to face with composure that

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244*Mock Trial,* 5.
245*Mock Trial,* 4.
246*Mock Trial,* 4.
ordeal of all physicians – the witness stand.”  The mock trial, however, was just one aspect of Broomall’s 1892 winter term courses on infanticide, a topic part of the late nineteenth-century’s moral zeitgeist. It made sense that Broomall chose infanticide as the lens through which to teach her students how to provide expert testimony. In her senior thesis, Mary Mitchell believed infanticide to be common in Philadelphia, though relatively undetected and unpunished because the criminals were rarely found with the body of the child. Based in Philadelphia, The North American ran four prominent articles on infanticide in the city between December 1887 and August 1891, one of which likely provided the basis of Broomall’s 1892 mock trial exercise.

Infanticide and abortion were closely linked crimes throughout the nineteenth century because the terms were often conflated in medicine and law. Hugh Hodge himself conflated the nineteenth-century term for infanticide, known as foeticide, with criminal abortion in the title of his influential 1839 lecture, “Foeticide or Criminal Abortion.” His terminology stuck, and in an 1899 study on criminal abortion in The Woman’s Medical Journal, Dr. Josephine Peavey also conflated the terms in her definition of criminal abortion. Quoting the Century Dictionary to argue that criminal abortion was “premeditated or intentional abortion, procured at any period of pregnancy, by artificial means and solely for the purpose of preventing the birth of a living child - foeticide.” Mary Mitchell believed many found abortion less criminal, and she cautioned her reader that it was “but a step” from “the destruction of life to the prevention of it.”

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247 “Mock Trial,” 2.
Beyond conflated terminology, the crimes of abortion and infanticide could be separated by mere seconds. Mary Mitchell explored this in her thesis, and took exception with how Pennsylvania laws distinguished between infanticide and abortion. Infanticide was the crime of killing a child born alive and was punished as murder; however, the child had to be fully born, with no part retained in its mother. If a living child was killed while partially born, the act would likely be considered criminal abortion. Mitchell notes the law’s construction to protect the interests of physicians overseeing complicated labors, though she felt it allowed physicians and others overseeing birth far too much power. In many instances, a physician would be the only person able to attest to when the baby had been fully born. Mitchell recognized this power, and implored her colleagues to be the guardians of children.

This controversy was at the core of Broomall’s mock trial, and the prosecution and defense sparred over whether Susan Jones’ child had been born alive and then murdered or died before or during birth. In the absence of testimony from direct witnesses to the crime, the prosecution examined the child’s body for eight signs of life. The physical indicators included the condition of the eyes, tongue, hair, heart, and brain, as well as the position of the mouth, the color of the umbilical cord, lung crepitation, and the rigidity of the child’s body. There was little agreement over whether the physical signs were in fact reliable markers of life, and what emerged through expert testimony was the notion that some believed life commenced with breath, while others believed it was upon completion of birth.

Dr. Walker, the physician summoned to Susan Jones’ bedside by Mary Smith, was the first witness called to the stand by the prosecution. She believed Susan Jones had murdered her

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255 Mock Trial,” 20. Crepitation was a term physicians used to describe “a particular feeling that one gets under the finger in feeling of a lung tissue in which there is air” (21).
child by strangling it to death after its birth, and her testimony revealed that the markers of fetal life were anything but conclusive. Her colleague, Dr. May, discovered the infant’s body in a clothing trunk in the corner of Jones’ room as she searched for rags. Both doctors examined the body, finding a cold, though not rigid, body with no pulse. They “noticed that the eyes were opened and bulged some, and that the mouth was also open.” The district attorney, keen to prove the child had been born alive, questioned the physician further on these physical markers. Her questioning led Dr. Walker to testify that had the child been born dead, the body would be rigid upon her examination, though this physical indicator was “not at all a positive proof” of a live birth. Alongside rigidity, the prosecution questioned Dr. Walker’s opinion on the marks about the infant’s neck. The witness testified that the marks were likely made before the death of the child, as those made after death “would remain more firmly on the flesh of the child.” These marks “simply resembled bruises and the flesh was not indented to any extent.” Next she asked Walker if the child’s tongue was protruding from its open mouth – according to the district attorney, a sure sign of violent death. Walker had not noticed a protruding tongue. The district attorney closed the questioning by asking Walker about the condition of the child’s eyes. Walker testified that “the eyes were half open and bulged somewhat,” and that under no circumstances could this be the case if the child had died naturally.

Dr. Walker’s cross-examination by the counsel for the defense likely stoked some doubt amongst the jury with regard to physical signs like rigidity, eye bulging, and the condition of the infant’s hair. For example, Henry Broomall questioned Walker as to additional medical causes of eye bulging, and eventually pushed her to admit that disease could also be a sign of the

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256 “Mock Trial,” 6.
257 “Mock Trial,” 7.
258 “Mock Trial,” 7-8.
259 “Mock Trial,” 8.
condition and “not a certain evidence of injury.” Walker also spent a significant amount of the cross-examination explaining that the condition of the child’s hair was an important diagnostic point used to determine a live or stillbirth. She explained to the jury, “if the child has lived, the hair stands out slightly from the head and is dry.” However, if the child is stillborn, the hair “would lie flat upon the head.” Broomall asked her if it would be possible that certain treatment of the stillborn child could also ruff the hair in the same way, to which Walker replied that “It would loosen it, but would not dry it, and would not make it stand out in just the same way, as I would like to explain. Each individual hair stands out.” When pushed, Broomall was again able to get Walker to admit that this evidence could not conclusively prove that the child was born alive and killed after birth.

Broomall continued his line of questioning and pushed Dr. Walker to admit that closed eyes and mouth, as well as a swollen tongue, could also not be considered conclusive evidence. He followed this by asking her if she had seen anything about the child that could conclusively prove it had been born alive. Dr. Walker replied that the cord [umbilical cord] could be used as a diagnostic feature if examined a few hours after birth. If the child had not lived after birth, the cord would present “a more or less dulled appearance.” In the Jones case the umbilical cord was still attached to the afterbirth, both of which were with the dead child. Dr. Walker did not mention whether the cord was dull or shiny before Broomall turned the line of questioning elsewhere.

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260 "Mock Trial,” 9.
261 "Mock Trial,” 9.
262 "Mock Trial,” 10.
263 "Mock Trial,” 10.
264 "Mock Trial,” 10.
The next witness called to the stand was Dr. Sarah R. May, Dr. Walker’s assistant. Dr. May discovered the body of the dead child while searching for rags to stifle Susan Jones’ bleeding. In her examination by the district attorney, May admitted to only touching the child’s body to feel that it was cold and had no heartbeat. While she made no further examination of the body, she did notice “marks on the throat…but that was all.”\textsuperscript{265} The district attorney pushed her further, and asked her whether, “insofar as [she] could tell,” the child had died from a violent or natural death.\textsuperscript{266} Dr. May said the marks about the child’s throat made her think it was a violent death, a statement immediately protested by Mr. Broomall. The Court responded by asking May to describe the marks about the infant’s neck, to which she replied, “they looked as if they might have been done by the fingers – finger marks.”\textsuperscript{267} She added that the child’s eyes and mouth were partly open, and the district attorney asked her if these conditions indicate a violent death. Again, Mr. Broomall protested, citing the pertinence of the question. The Court allowed the questions, and Dr. May answered that only the bulging of the eyes indicated a violent death – “nothing further than that.”\textsuperscript{268}

Mr. Broomall began his cross-examination of the witness by asking whether the child’s eye bulging could be indicative of disease. He pushed Dr. May to admit that she had not examined the infant’s body for any indication of disease, and thus eye bulging was not a conclusive indication of a violent death.\textsuperscript{269} Other than noting that the infant’s mouth was partly open, Dr. May had no additional comment and she was excused from the stand.

\textsuperscript{265}“Mock Trial,” 12.
\textsuperscript{266}“Mock Trial,” 12.
\textsuperscript{267}“Mock Trial,” 13.
\textsuperscript{268}“Mock Trial,” 13.
\textsuperscript{269}“Mock Trial,” 14.
Dr. Harriette O. McCalmont, the coroner, was the next witness called to the stand. Alongside describing the scene in Susan Jones’ quarters as she witnessed it, she gave record of the coroner’s inquest:

The trunk was found to contain nothing but clothing, which had evidently been moved, and the body of a child, the cord and the after-birth. The child was still. It was not yet stiff, and the face was purplish. The eyes were slightly protruding, the mouth was open and the tongue was slightly out; and there were other marks on the neck, one on the right side and two or three, I am not positive which, on the left side.\textsuperscript{270}

The only thing Mr. Broomall asked the witness was whether she was a practicing physician, to which she relied “No.”

Broomall wanted to distinguish the coroner, McCalmont, from the coroner’s physician, Dr. Louise M. Harvey, who was next called to the stand. Dr. Harvey performed the post mortem on the dead infant’s body, and provided perhaps the most damaging testimony against the defense. Her post mortem also highlighted discrepancies in the way Harvey and her colleagues determined fetal life and death. With the permission of the Court, she read from her examination notes:

Male child, no rigor mortis, no putrefaction. Color, white; cord not cut, dull throughout the entire length, slight redness around the navel, eyes open and eyeballs protruding, mouth open and tongue slightly protruding, a frothy bloody serum escaping from the mouth and lungs, the face was dark, the ears stood out from the head, the hair dry and clean, a birth tumor on the crown containing glutinous bloody serum, on the throat well-marked spots, one on the right, one-half an inch from the median line and midway between the chin and collar bone, resembling the imprint of the thumb, three distinct marks on the left side, one-eighth inch from the median line, extending down on the wind pipe. The tissue around the bruises infiltrated with coagulated blood. Thorax had expanded.\textsuperscript{271}

\textsuperscript{270}“Mock Trial,” 17.
\textsuperscript{271}“Mock Trial,” 18.
Her notes also recorded the measurements of the child’s body, which indicated it had been born at full term. There were no fractures of the bones of the skull, the windpipe was open, the large veins of the neck were filled with dark blood, as was the right side of the heart. A frothy serum exuded from the lungs when cut, and the coroner’s physician reported that they floated in 60 degree water “with great delay,” indicating the child breathed before death.\(^{272}\) She found “no signs of inflammation or disease,” and testified “the child was born alive and came to its death by strangulation.”\(^{273}\)

The Court called the District Attorney’s first expert witness, Dr. Mary A. Johnson, to the stand next. Like Dr. Harvey, Johnson believed Susan Jones had killed her newborn child, and she stated it plainly at the beginning of her testimony. The prosecution reiterated the physical condition of the child’s body: dry hair, lungs that floated in hydrostatic testing, the positioning and color of the umbilical cord, the condition of the chest cavity, and the rigidity of the child’s body, and Johnson testified that these factors clearly indicated the child was born at-term, and alive. The prosecution then described the physical appearances that indicated a violent death: a protruding tongue, open mouth, half-open and bulging eyes, to which Johnson replied with confirmation.\(^{274}\)

Of particular note in this line of questioning is the discussion on the rigidity of a child’s body as an indicator of live birth. Aside from the condition of the hair, this is the only external

\(^{272}\) Dr. Harvey used a technique called hydrostatic testing, (also known as the lung float test), to determine whether the child had breathed before its death. The test traces its roots back to distinctions in fetal and infant lungs observed by Aelius Galenus in 200 A.D., and it was first practiced by German physician Johannes Schreyer in 1681. Essentially, the child’s lung is placed in water: a floating lung indicates that the child breathed, while a sinking lung indicates stillbirth. Hydrostatic testing is still used in medicolegal autopsies of newborns and potential stillborns today, particularly in Germany, though the practice remains controversial because a false-positive can have significant legal ramifications. A 2012 German study finds the test was 98% correct, though the study’s authors maintain it cannot be the sole arbiter of life. In the case of the mock trial, the fact that the child’s lungs floated “with great delay” injects doubt into the accuracy of the test. See Anna-Lena Grosse Ostendorf, Markus A. Rothschild, Annette M. Muller, and Sibylle Banaschak, “Is the lung floating test a valuable tool or obsolete? A prospective autopsy study,” \textit{International Journal of Legal Medicine} (2013) 127: 447-451.

\(^{273}\) “Mock Trial,” 19.

\(^{274}\) “Mock Trial,” 24.
physical indicator mentioned by physicians that could potentially indicate life. The prosecution asked Johnson if a stillborn child would be born rigid, and she replied “it would depend upon the length of time that had elapsed between the death of the child and the birth. The rigidity might occur and it might not.” In other words, if a child was born rigid, it likely died before birth. If it became rigid shortly after birth, it likely died before birth. If it was not rigid for some time after birth, it likely died after birth. The prosecution concluded Johnson’s examination by asking her whether it “would be possible to tell from the [external] appearance of the body whether it had died before birth or after?” She noted “one might have an opinion in the case, but one could hardly say positively. Hair and rigidity could be used as indicators, though they could not be used as proof positive evidence as to whether the child was born alive or still.

Dr. Johnson’s response set off a strand of doubt quickly picked up in her cross-examination by the Counsel for the Defense. For the first time in the trial, Broomall raised the idea that the marks about the infant’s neck could have been made by the mother for reasons other than killing the child, or that they may have been made after the child’s death. Broomall’s questioning sparked an interesting exchange with Dr. Johnson regarding how women “naturally” carry their young when Broomall suggested the marks could have been caused after the child’s death and by the mother carrying the dead child across the room to place it in the trunk. In suggesting this, Broomall was attempting to instill doubt in the jury by raising the ideas that the child had been stillborn or accidentally killed by the mother during a difficult birth—two theories he presented in his closing arguments to the Court. The mother would have hidden the body, according to Broomall, out of fear. Dr. Johnson’s response to Broomall was telling. To the suggestion that the woman carried

275 “Mock Trial,” 24.
276 “Mock Trial,” 25.
277 “Mock Trial,” 25.
the child by its neck, she replied: “that is how a cat carries its young, but hardly a woman.”

Broomall’s response was equally intriguing: “Can you expect a woman under all circumstances to act entirely rationally? Would she not be more likely to act like an animal than a woman [in this instance]?”

In returning to Dr. Johnson’s mock testimony, Broomall was able to push Johnson to admit two things that significantly damaged the prosecution’s case. First, it was nearly impossible to tell from external examination whether the child had been born alive or stillborn. The physical indicators of live birth used by the medical community and court, including the condition of the child’s hair and the rigidity of its body, were not proof positive evidence that the child lived after birth. Secondly, after a long back-and-forth regarding the “naturalness” of how women carry their young, Dr. Johnson finally relented Broomall’s point and testified that the marks about the infant’s neck could have been made for reasons other than the mother attempting to kill the child. Dr. Johnson did not indicate under what circumstances this could be possible, and Mr. Broomall did not push the witness.

The final expert called by the prosecution was Dr. Beulah M. Prindle. The District Attorney asked her many of the same questions as the previous witnesses, though one, in particular, stands out for its ability to encapsulate the ambiguity of fetal life in this moment. When speaking of the cause of the slight redness above the child’s navel, Dr. Prindle was asked whether it “would…indicate too that the child had lived after birth or before birth.” Broomall questioned the district attorney’s statement and the Court responded by reframing the question to eliminate

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278**Mock Trial,” 26.
279**Mock Trial,” 26.
280**Mock Trial,” 26.
281**Mock Trial,” 26.
282**Mock Trial,” 27.
283**Mock Trial,” 29.
the language of living before birth. The next witness called to the stand provided deeper insight into the two arbiters of fetal life employed by the prosecution and defense.

Dr. Mary Brewster was the first expert witness called for the defense. Her testimony highlights the conflicting views of fetal life employed by the defense and prosecution. While the district attorney believed breath was synonymous with life, Dr. Brewster’s testimony indicated that birth was the arbiter of life. The testimony also gives insight into the idea of breathing before birth, as Brewster confirmed that it was possible for the child to breathe before birth if only the head was expelled.283 For Brewster, it seemed that technically a child was not considered alive until it breathed after birth. Logic would follow that a child could breathe before birth and not be considered alive, according to Dr. Brewster. The next expert witness, Dr. Mary Greenwald, also confirmed that it was possible for a child to breathe before it was completely delivered.284

Dr. Greenwald’s testimony also revealed her understanding of birth as a potentially dangerous process in that she raised the point that it was possible that the marks about the child’s neck were made by the mother before the child was born, or perhaps the child died by asphyxiation from the umbilical cord during birth.285 Also of note in her testimony is a statement she made regarding the child’s lungs: she explained that the condition of the lungs could be the same whether the child breathed before or after birth, thus essentially making the autopsy and attending hydrostatic test null and void.286 Further in her testimony, important questions regarding the definition of a stillborn child and the act of being born were raised by the District Attorney, who defined a stillborn child as one who “died before birth even though it died during the process of

283 Mock Trial,” 32.
284 Mock Trial,” 33.
285 Mock Trial,” 33.
286 Mock Trial,” 34.
birth.” Dr. Greenwald testified in response that she had “never seen any statement to that effect,” leaving the future women physicians in the room to wonder if life was synonymous with full delivery, and ultimately what they would do if placed in this impossible situation.

The final two expert witnesses echoed the belief of Drs. Brewster and Greenwald that there was no conclusive proof that the mother killed the child after birth. Their belief was based on the idea that it was possible that the mother clutched the baby around its neck to either save its life by extracting it or to relieve her own pain, or that the umbilical cord strangled the child during the delivery process. The final witness for the defense again testified that it was possible for the child to breathe before its birth, especially in the case of a protracted labor like the one in question. The question remained: could a child live before birth, as the DA implied, or was the period of birth a liminal space of life, as indicated by the last remaining expert witnesses? Put another way, was breath the arbiter of life, or was birth?

The District Attorney’s closing statements reiterated her view that breath indicated life. Her final argument to the jury was based firmly in the premise that there was significant physical evidence – from the condition of the infant’s hair, lungs, heart, brain, skin, and condition of the umbilical cord – that indicated breath, and that breath was an arbiter of life. While she asserted “a child might live without breathing,” she concluded that “it cannot breathe without being alive.”

How could a child live without breathing? And how did the District Attorney’s assertion that a child who breathed was living square with the expert witness’ belief that a child must be completely born to be considered alive? The two sides of this case possessed completely different worldviews regarding the beginning of life that reflected the broader ambiguities of nineteenth-

287*“Mock Trial,” 35.
288*“Mock Trial,” 36-39.
289*“Mock Trial,” 39.
290*“Mock Trial,” 40.
century medicine and law. Women physicians were placed squarely at the nexus of this confusion, and at stake was their livelihood and safety.

Henry Broomall’s closing remarks for the defense must have been equally confusing to the students, though for different reasons. Broomall drew on the very same ideology that equated femininity with maternity employed by the prosecution to dehumanize Susan Jones. “When women come to be upon juries [in Pennsylvania]…I have not a question but that a woman juror, knowing herself, and therefore knowing other women, knowing the fondness of a woman for her child, that a woman juror would hesitate to convict any woman of willfully killing her child. I have never been willing to prosecute a woman for killing her child.”

No woman in her “sober senses,” according to Broomall, would ever kill her own child. By asserting these two arguments – that a woman would never kill her child, and if she did, she was not sane – Broomall was able to instill doubt in the jury while simultaneously providing a reason to acquit Jones if they believed she had killed her child. Logic would follow that if she killed her child, she was insane and thus not able to be convicted of a crime.

This argument is directly connected to that of the expert witness for the prosecution who claimed only animals carry their young by the head. Both of these arguments turned on an ideology that equated women with maternity and ultimately left little room for the complexities of women’s lives or the process of childbirth. Women are maternal, and thus women don’t kill their children or carry them in any way other than lovingly, in one’s arms. Women are maternal, and birth is natural, so women are never in a situation where they accidentally – or purposefully – kill their children. This argument could be used simultaneously to justify Susan Jones’ actions, or to condemn them. Broomall leveraged this argument for the benefit of Jones’ case, and interestingly,

291“Mock Trial,” 42.
the final remarks of the case from District Attorney, Rebekah Roberts, took Broomall to task for generalizing about women and ignoring the facts of the trial. Unlike Broomall, Roberts believed that when women became jurors, they would see past the sympathy of all-male juries to the facts of the case and would convict women for killing their children. The ideology that equated women with maternity allowed for little complexity, but widespread manipulation. As the example of Susan Jones shows well, it could be used to prove a woman’s unfitness from any angle.

While Broomall’s initial argument turned on a dangerous ideology of maternity, the remainder of his argument indicated a more complex understanding of Susan Jones’ circumstances. He acknowledged that Susan Jones hid the body of her dead infant and explained that did so out of shame – either from its illegitimacy or because it was stillborn. Broomall acknowledged that Jones “was a woman who had to get her living by her own hands,” and this was why she hid the child. He went as far as to argue that “there [was] not a woman in the country who would not do that, situated like her.” Alongside these comments, Broomall argued that a woman who accidentally killed her child during labor in an effort to relieve her pain was not guilty of infanticide. Broomall’s arguments indicated a class awareness not exhibited by the prosecution. Not all women had access to the obstetrical care that could prevent them from being in a position to defend themselves against the charges of infanticide.

Class mattered with regard to whom could “witness” birth. Poor women like Susan Jones could not attest to their own miscarriage and be believed that the child was, in fact, born dead. Perhaps this is why Susan Jones chose to hide her dead child in a trunk, even though she knew it would surely be found. Whereas women were once the arbiters of human life by virtue of the doctrine of quickening and the practice of midwifery, physicians were beginning to take their

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292 “Mock Trial,” 43.
293 “Mock Trial,” 43.
place. A woman was safe from legal ramifications if a physician was present for her birth, and she was most safe if that physician was a man. Women like Susan Jones who were either too scared or poor to engage a doctor gave birth alone and were not able to seek the medical help they needed. Susan likely would have died from a hemorrhage if Mary Smith did not call on Dr. Walker to treat her.

Dr. Broomall and her brother, Henry, anticipated this difficult reality for the students of Woman’s Medical College, and pushed them to articulate their expertise in the mock courtroom. Alongside anatomy, physiology, and the like, women physicians would also need to know how to defend themselves against the charges of infanticide in front of a court. In his cross-examination of Dr. Johnson, Broomall noted to the judge, “I supposed the learned judge has noticed many times the diffidence of a physician to call herself an expert.”

The judge responded with a brief lecture on modesty and expertise, noting “I think I must say for the benefit of those assembled here that, when they have had years of experience and have studied any particular branches and are called upon to say, they should not let their modesty get the better of them, but should say they were experts.” It must have been frustrating for the future women physicians sitting in the courtroom when in the very next breath the judge referred to experts in the male form: “all that is necessary to make a person an expert is that he shall have had special opportunities of becoming acquainted with the subject, although he may not know all about it.”

Though the lesson may have been lost on the judge, Dr. Broomall and her brother, Henry, believed the best way to prepare women physicians for this dangerous ambiguity was to train them as confident, self-possessed experts who could defend themselves in the courtroom.

294 “Mock Trial,” 28
295 “Mock Trial,” 28.
296 “Mock Trial,” 28.
While the ambiguities of law and medicine were dangerous for women physicians, it also created a potentially fatal and legally dangerous situation for women patients in need of medical care. Women knew they were at risk for legal retribution, and they acted either by specifically seeking out women physicians who might take pity on their condition or by simply not seeking care. Though arguing for Susan Jones’ conviction, the closing remarks from Rebekah Roberts, the District Attorney, indicate how the ambiguities of the law could affect both women physicians and their patients. Roberts argued that the jury “must take into consideration that this woman had not investigated all the authorities. She [Susan Jones] did not know just how far she could kill the child, nor under just what circumstances she could kill it and be considered innocent. We must always consider that while experts are up on these subjects, this woman was nothing of the kind.” Testimony from expert witnesses for both the prosecution and defense indicated that even experts were not “up on these subjects.” There was no medical agreement with regard to when a fetus was considered alive, and this ambiguity placed women physicians and their women patients in danger.

The contentious debate regarding markers of life in the mock trial ultimately reflected broader anxieties regarding the ambiguity of fetal life. While Susan Jones was acquitted in the mock exercise, the expert witnesses and attorneys in her legal case were far from consensus on when, exactly, a fetal body was imbued with rights under the law. Mary Mitchell touched on the implications for this in her thesis, highlighting Pennsylvania’s criminal abortion laws that framed the crime as against the maternal, rather than fetal, body. The exact moment a fetus became a newborn mattered for a variety of reasons, one amongst them being that the rights bestowed to the fetal and infant bodies were different. Yet no one in the mock trial could quite agree on when that

297 “Mock Trial,” 45. Emphasis mine.
moment occurred. As Mitchell noted, the Pennsylvania law requiring complete separation from the maternal body to mark infant life was framed to protect physicians attending “abnormal labors.” From abortion to infanticide, she noted, “was but a step.”

Aside from teaching her students how to testify in court, Anna Broomall’s mock trial illustrated her own complex understanding of abortion and infanticide. Rather than teaching her students to refuse engagement with pregnancy loss and termination, she taught them how to successfully navigate challenging legal and medical dynamics. Their roles in the mock trial gave them front row seats to the challenge of navigating the ambiguities of fetal life, including how these arguments could play out in a courtroom setting around physical markers like breath and birth, hair and eyes. The women in her 1892 winter lectures also learned about Susan Jones’ life and why she might have been afraid to seek assistance from a physician. From this they may also have implicitly gleaned the structural reasons why a woman in Jones’ position may want to terminate a pregnancy. In reality, women physicians trained as future obstetricians and gynecologists had no choice but to treat pregnancy loss, as the records from Woman’s Medical College attest.

**Pregnancy Termination Hiding in Plain Sight**

Records from the Dispensary of the Alumnae of Woman’s Medical College confirm that women medical students would reckon with the complexities of pregnancy loss and termination before they even left their medical program. The Dispensary opened at 1212 S. Third Street in Philadelphia in October of 1895 with a mission to serve the working class and immigrant communities of South Philadelphia. The Junior Class of WMC regularly attended the clinics

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299 “First Report of the Hospital and Dispensary of the Alumnae of the Woman’s Medical College of Pennsylvania,” Reports of the Hospital of the Woman’s Medical College of Pennsylvania, 1896-1912, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
at the Dispensary, and other WMC students often joined as a supplement to their clinical education.\textsuperscript{300} The Dispensary, along with Anna Broomall’s Maternity Hospital on Washington Avenue, provided students with the clinical experience increasingly required of medical schools by state and federal regulations and students often helped treat patients. Hiding in plain sight, within the Dispensary’s annual reports, were statistics showing the clinical staff at the Dispensary provided care for women experiencing pregnancy loss and termination. The Annual Report for the clinic’s first year of operation reveals two abortion procedures.\textsuperscript{301} The following fiscal year, ending in 1897, lists 17 abortions.\textsuperscript{302} Fiscal Year 1897-1898 breaks the procedure into subcategories, listing 13 incomplete abortions and 6 threatened abortions.\textsuperscript{303} Fiscal Year 1898-9 lists 24 incomplete abortions and 11 threatened abortions, while Fiscal Year 1899-1900 lists 21 incomplete and 6 threatened abortions.\textsuperscript{304}

A “threatened abortion” indicated a pregnancy at risk of miscarriage, and therapeutic treatment focused on quelling early labor. The term “incomplete abortion,” however, had several potential meanings. It could be used to describe the diagnosis of someone presenting in need of care after a spontaneous abortion, someone in need of care after attempting to self-abort, or a woman currently experiencing miscarriage. Treatment included dilation and curettage, a procedure that removed fetal tissue from the uterus. Regardless of whether the abortion was

\begin{footnotesize}
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\item \textsuperscript{300} “First Report,” 7.
\item \textsuperscript{301} “First Report,” 14.
\item \textsuperscript{302} “Second Report of the Hospital and Dispensary of the Alumnae of the Woman’s Medical College of Pennsylvania,” Reports of the Hospital of the Woman’s Medical College of Pennsylvania, 1896-1912, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 10.
\item \textsuperscript{303} “Third Report of the Hospital and Dispensary of the Alumnae of the Woman’s Medical College of Pennsylvania,” Reports of the Hospital of the Woman’s Medical College of Pennsylvania, 1896-1912, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 12.
\item \textsuperscript{304} “Fourth Report of the Hospital and Dispensary of the Alumnae of the Woman’s Medical College of Pennsylvania,” Reports of the Hospital of the Woman’s Medical College of Pennsylvania, 1896-1912, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 13; “Fifth Report of the Hospital and Dispensary of the Alumnae of the Woman’s Medical College of Pennsylvania,” Reports of the Hospital of the Woman’s Medical College of Pennsylvania, 1896-1912, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 14.
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spontaneous or intentional, it was tacitly suspect and potentially illegal depending upon the case’s circumstances. The mere presence of abortion in the records offers a more complex lens through which to explore women medical students’ and physicians’ relationship to pregnancy termination and loss. Despite women medical students’ and physicians’ public-facing polemics denouncing intentional pregnancy termination, they confronted it within the clinical context of perhaps the most prominent teaching hospital for women medical students in the United States. Woman’s Med trained over sixty percent of its students for careers in obstetrics and gynecology, and their alumnae occupied positions across the country and world. Women may have practiced on the margins of the Philadelphia medical community, but they did not practice on the margins of obstetrics and gynecology. What women medical students learned at Woman’s Med mattered, both for the future of the profession and the patients these women cared for.

Clinical records from the Woman’s Medical College Hospital and Alumnae Dispensary show that women medical students and physicians treated patients suffering from complications of pregnancy loss and termination. Each page of the case books contains the record of a clinical encounter, and multiple physicians and students recorded cases within the same book over the course of a year or two. Together, the records probe beyond women’s public polemical writings and elicit even greater insight into how women physicians understood and managed pregnancy loss and termination within their clinical practice. Women physicians and medical students saw pregnancy loss and termination as an important aspect in their patient’s medical history and described cases of loss using clinical terms, even when encounters included intentional termination. They understood the emerging field of embryology, identifying the approximate age of the miscarried embryo or fetus while grappling with labeling the cause of its premature expulsion. Students were a part of almost every clinical encounter, though evidence suggests
they were excluded from particularly difficult cases. Before they left Woman’s Med, students would likely treat at least one case of pregnancy loss under the guidance of a physician.

Women students and physicians continued to conflate the terms “abortion” and “miscarriage” in the clinical records as late as 1900. Sometimes this happened within the same record, as was the case with a clinical encounter dated August 13, 1897. The physician noted in the patient’s history that she had “two abortions previous to this one.” In her later remarks, however, the physician described the event as “a 4½ mo. miscarriage.”\(^{305}\) The records suggest deviation in terminology was dependent upon physicians. For instance, Dr. MacFarlane recorded a patient’s history with miscarriage by noting her “first labor [was] normal, second [resulted in] miscarriage at five months.”\(^{306}\) With the same intent, her colleague, Mary Heibsen, recorded a separate patient’s history by substituting the term “abortion” for “miscarriage.”\(^{307}\) In a clinical setting, women physicians often used the terms interchangeably.

While terminology was still fungible, women physicians believed information on pregnancy loss and termination was valuable to their clinical practice and they tracked it with clinical precision in their patients’ histories. Their descriptions of patients’ history with loss and termination were noted in language devoid of moralism, even in cases of intentional termination. For instance, Dr. Rosalie Blitz Stein recorded her patient’s reproductive history, noting “[her labors [were] normal; three miscarriages since her last child which she brought on herself.”\(^{308}\) Intentional termination was not always so easy to identify, though it could be inferred from a

\(^{305}\) “August 13, 1897” Obstetrical Department Book VII, 1897-1899, Clinic Case Books (ACC-77, Box 3), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

\(^{306}\) “February 15, 1898,” Obstetrical Department Book VII, 1897-1899, Clinic Case Books (ACC-77, Box 3), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

\(^{307}\) “August 23, 1897,” Obstetrical Department Book VII, 1897-1899, Clinic Case Books (ACC-77, Box 3), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

\(^{308}\) “September 3, 1898,” Obstetrical Department Book VII, 1897-1899, Clinic Case Books (ACC-77, Box 3), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
clinical history. In a record dated May 1, 1891, the doctor noted that although her patient had easy labors, she also suffered three miscarriages “due to lifting a heavy tub, falling down stairs, and chopping wood. All at 3 ½ months.” It was not uncommon for women to attempt pregnancy termination through physical exertion. At three months, a woman would likely begin to physically appear pregnant.

Women physicians and medical students likely also used patient histories with pregnancy loss and termination as a way to legitimize their clinical practice. For instance, in a particularly difficult case dated March 13, 1900, Drs. Griscom, MacFarlane, and Beaver treated a woman for an abortion. Almost all patients were attended by students, though they were excluded from this case. The patient expelled, on her own, an embryo measuring 4 ½ centimeters and weighing 2 ½ grams on March 12. She called for a doctor the next day, and was found with membranes still retained, “in great pain but bleeding very little.” On March 14, physicians completed a dilation and curettage to remove the membranes and put the patient on a 2 ½ month course of treatment. The patient’s reproductive history mentions four previous miscarriages and her March 12 record makes no mention of intentionality. It was problematic, however, that no one directly witnessed her abortion. Her four miscarriages, however, contextualize her abortion and lent credibility to her attending physicians. Anyone examining the clinical record could see that despite the questionable circumstances, this was a patient with a history of pregnancy loss.

While not the case with this patient, some of the women treated at Woman’s Medical College

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309 “May 1, 1891,” Obstetrical Department Book II, 1890-1892, Clinic Case Books (ACC-77, Box 3), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.

310 “March 12, 1900,” Obstetrical Department Book II, 1890-1892, Clinic Case Books (ACC-77, Box 3), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.
Clinics were transferred to other larger facilities in the city where their records would be scrutinized by physicians outside of the institution.311

Women physicians and medical students distinguished between embryonic and fetal life in their clinical records despite their struggle to consistently label the cause of its premature expulsion. Franklin P. Mall, the noted anatomist and embryologist, was just beginning his work in the last decade of the nineteenth century and women physicians’ clinical documentation cleaved to early understandings of embryological development.312 Physicians used the term “embryo” for miscarriage remnants from pregnancies lasting 6 to 10 weeks, and “fetus” for those lasting three months or longer.313 Women medical students and physicians weighed and measured the remains, including the placenta and umbilical cord. Like noting a patient’s medical history, classifying and measuring remains was a way for women physicians and students to rationalize an ambiguous and potentially dangerous clinical encounter. The act of classification and measurement made miscarriage and abortion remnants medical material, not the remains of a child.

Within the confines of a medical school and clinical facilities run by women directors and staffed by some of the nation’s preeminent women physicians, the students of Woman’s Medical College wrote theses articulating a vision of fetal life based in religious morality quite different from the common law doctrine of quickening governing the earlier part of the century. In their

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311 “January 20, 1897,” Hospital and Dispensary of the Alumnae of Woman’s Medical College, Out Practice, 1896-1897, Clinic Case Books (ACC-77, Box 3), Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine. In this particular entry, the patient was transferred to the Pennsylvania Hospital on January 23, 1897 after receiving treatment for a miscarriage at Woman’s Medical College’s Alumnae Dispensary.

312 Lynn Morgan’s Icons of Life: A Cultural History of Human Embryos provides a thorough overview of embryology and Mall’s central role in the field’s development. Amongst other interventions, Morgan focuses her study on how the medicalization of childbirth and miscarriage was critical to early embryologists’ pipeline of fetal specimens. See also Shannon Withycomb’s recent book, Lost: Miscarriage in Nineteenth-Century America, especially 129-130.

313 “April 19, 1900”; “January 25, 1899”; “April 16, 1899”; “May 4, 1899”; “June 17, 1899”; “February 28, 1900.”
classrooms and clinical education, however, they learned how to treat women suffering from complications of pregnancy loss and termination. The distance between their public statements and private practices was significant. In her mock trial exercise, Dr. Broomall taught her students how to successfully navigate the challenging legal and medical dynamics of pregnancy loss and termination. Within the Obstetrical Department and Alumnae Dispensary, women students treated cases of miscarriage and abortion, learned how to contextualize and support their clinical decisions, and described their work in rational, precise language. As the next generation of obstetricians and gynecologists, they shaped their fields as they took this information back to their communities and practices across the United States and around the world.
Chapter Five
Learning from the Dead: Defining the Morbid Anatomy of Criminal Abortion

In 1883 the noted Philadelphia pathologist Henry Formad mailed a letter to his younger sister, Marie, in Moscow. He urged her to relocate to Pennsylvania for medical training and later that year Marie, along with her mother and younger brother, arrived in Philadelphia. After helping her family settle, she enrolled in coursework at Woman’s Medical College of Philadelphia (WMCP), the only medical school open to women in the City.\(^{314}\) Henry Formad was quite familiar with Woman’s Med, as well as the conservative nature of the Philadelphia medical community. At a moment when many male physicians resisted the presence of women in the field, Henry encouraged his sister Marie to emigrate from Moscow and enroll in courses at Woman’s Medical College. Henry taught pathology to the women students of the College, as well as to the men of the University of Pennsylvania’s medical school. Alongside his teaching duties, he served as a coroner’s physician for the City of Philadelphia.

Formad’s work as a coroner’s physician allowed him unique access to the bodies of those unfortunate City residents who died from suspicious or unusual causes. The City’s coroner often called on him to analyze cases of death by disease, infection, or crime. His work with the coroner’s office was quite different from his teaching at Penn and Woman’s Med, and was not for the faint of heart. Formad exhumed buried bodies and performed autopsies in cemeteries to ascertain criminal intent, and ultimately met his demise through this work. Henry Formad died in 1899, a result of poison absorbed through his skin after examining a body of a murder victim.\(^{315}\)

\(^{314}\) *Medical Women’s Journal*, Volume XLIII, No. 5, May 1936, 132, from Marie Formad’s Deceased Alumna File, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine.  

Formad exhumed the bodies of women who died from criminal abortion and performed postmortem examinations, employing his knowledge of morbid anatomy, or the study of diseased tissues, to search their remains for infection, disease, or indications of the illegal procedure. He scanned exhumed remains for signs of pregnancy, peritonitis, inflammation of the uterus, cervix, or fallopian tubes, fetal or placental remains, and punctures of the internal or external os. Criminal abortion could be difficult to identify, because women who died from infection as a result of the procedure were rarely buried with doctor’s certificates that listed their actual cause of death. The only way the coroner and Henry Formad could find these bodies was if a witness – perhaps a doctor who cared for the woman before her death, a spouse, or an abortionist with a guilty conscience – came forward.

We know about these investigations because Marie Formad wrote her senior thesis at Woman’s Medical College of Philadelphia in 1886 on the topic of criminal abortion. Most Woman’s Medical College students chose to write research papers on particular diseases or treatment techniques. Marie, however, decided to feature case studies of women who died from complications of criminal abortion because she believed the literature on the morbid anatomy to be incomplete, and in her view “not much [could be] gained from its perusal.” The introduction to her thesis confirms that Henry felt similarly, and urged Marie to investigate further the causes of spontaneous abortions so that he could distinguish it from criminal abortion in his work as coroner’s physician. Identifying cases of criminal abortion and infanticide were central to a coroner’s work, and Henry was interested in distancing himself from the archetype of

317 Formad, “Some Notes.”
318 Formad, “Some Notes.”
the corrupt coroner embraced by many regular physicians and reified by an 1875 article in the *Boston Medical and Surgical Journal* highlighting a Boston coroner convicted of performing criminal abortions.\(^{320}\)

Marie Formad’s thesis spoke to Henry Formad’s initial question and described the clinical differences between “spontaneous” and “forced” abortions and the means women used to produce a forced, or illegal, abortion. While she presented statistics showing that most women would encounter pregnancy loss at some point in their childbearing years, whether forced or spontaneous, Marie Formad’s thesis did not address clinical treatment for women suffering spontaneous pregnancy loss. Her interest in identifying criminal abortion lay in protecting physicians and tracking down criminal abortionists. She centered her work on six case studies of criminal abortion drawn from coroner’s reports, three of which she attended personally. She described general similarities among these cases, and codified her findings into a morbid anatomy of criminal abortion that other practitioners could use to identify cases of the procedure in living patients and autopsy investigations of corpses.

Alongside this morbid anatomy, Marie Formad’s thesis and the six case studies within it leave us valuable information regarding the experiences of women who died attempting to terminate their pregnancies. 19\(^{th}\)-century physicians – men and women alike – diagnosed middle class white women as the purveyors of an abortion epidemic of epic proportions.\(^{321}\) White women were selfish, too involved in fashion, overly committed to children they already had, or afraid of childbirth. Women’s reluctant motherhood, they believed, resulted in a declining


population of the white, middling Protestant class the country needed to thrive. Implicit within their narrative of population decline was a fear of increased immigration. Groups of the American public, including physicians and social purity reformers, expressed considerable concern over the increased immigration of the late-nineteenth century. The declining fertility of middle class white women became one outlet for its expression. The women behind Marie Formad’s case studies, however, offer complexity regarding who sought abortions in the late nineteenth century.

To fully understand the paucity of literature on criminal abortion referenced by both of the Formads, this chapter puts in conversation Marie Formad’s thesis with two widely read texts Formad used to learn the craft of obstetrics at Woman’s Medical College. Formad relied on her own clinical observations and chose not to quote the obstetrical texts assigned by her instructor, Dr. Anna Broomall, because they included little practical information on how to distinguish forced from spontaneous abortion. The works of William Lusk and Pierre Cazeaux treated minimally the topic of criminal abortion, though both authors agreed with Formad regarding the ubiquitousness and danger of the procedure. But medical literature treated the issue of forced abortion in ways that were of little practical help to medical students and practitioners. Cazeaux refused to tackle the subject because of moral objection, and Lusk offered a radical proposal for treating women who suffered from the effects of criminal abortion that failed to consider the ways the procedure had become politicized. Further, both texts refused to acknowledge the recent changes in abortion law that made both spontaneous and forced abortions a medical issue.

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322 Woman’s Medical College issued Annual Announcements listing, amongst other things, required and suggested readings on each medical subfield. The works of William Lusk and Pierre Cazeaux are listed in the 36th Annual Report that corresponds to Marie’s time at Woman’s Med. “36th Annual Announcement of Woman’s Medical College of Pennsylvania, WMCP Annual Announcements, Archives and Special Collections on Women in Medicine and Homeopathy, Drexel University College of Medicine, 18.
with profound legal implications for physicians, coroners, and patients. Marie Formad’s thesis filled this void, and offered physicians a practical, concrete, and timely analysis of the morbid anatomy of criminal abortion, methods for legally proving criminal abortion at the autopsy, and the latest state and national legislation on the topic.

Using Marie Formad’s six case studies, this chapter additionally uses autopsy records to argue that women dying from criminal abortions in late nineteenth-century Philadelphia defied the description of classist, anti-immigration rhetoric. These women did not fit the image of the middle-class, Protestant mother. Some were married and others single, some native and others foreign born, some had children, and still others were childless. Some sought medical care before they died, while others suffered without it because they were afraid of legal ramifications. Only one of them had had multiple abortions. Many of them had little or no financial resources, and some struggled to feed themselves. All of them died an incredibly painful death from septicemia, or blood poisoning. This chapter voices their stories.

**Defining the Morbid Anatomy of [Criminal] Abortion**

Marie Formad relied on her own clinical encounters with the bodies of women who died from criminal abortion to define the morbid anatomy of the procedure because the texts assigned to her by Dr. Anna Broomall in her coursework in obstetrics and gynecology at Woman’s Medical College provided little guidance. Examining two widely circulated obstetrical texts assigned to Marie Formad in her time at Woman’s Medical College provides a glimpse into how the newly professionalizing field of obstetrics handled the diagnosis, prognosis, and treatment of abortion and why the Formads felt it was incomplete and ambiguous. William Thompson Lusk’s *The Science and Art of Midwifery* and Pierre Cazeaux’s *A theoretical and practical treatise on midwifery: including the diseases of pregnancy and parturition* dedicated little space to
exploring criminal abortion or its morbid anatomy, perhaps inspiring Marie Formad’s comment regarding the “meager” nature of the literature on the subject. Both wrote of abortion within the context of prevention, or the methods by which the termination of the pregnancy could be halted. The lack of information on the morbid anatomy of criminal abortion made it difficult for the Formads to identify the difference between spontaneous and forced instances. Similarly, framing the diagnosis, prognosis, and treatment of abortion through the lens of prevention also made it difficult for physicians to know the best way to clinically treat women who presented in need of medical care after a forced procedure.

Physicians were forced to read between the lines when caring for patients who suffered from the effects of forced abortion, turning instead to the treatment for conditions like puerperal fever or spontaneous abortions. When criminal abortion was addressed at length in a later edition of Cazeaux’s text, it was within the context of medical jurisprudence that focused on establishing criminal intent through autopsy examinations rather than the clinical treatment of patients presenting in need of care. Unlike any other medical procedure, the legality of abortion lay only in intent, which was often extremely difficult to prove. An emphasis on intent shifted the ways medical texts discussed abortion, moving away from treatment and toward establishing criminal intent, particularly through autopsy examinations. This also had tangible ramifications for women patients, who chose not to seek medical assistance because they were afraid of legal retribution.

William Thompson Lusk, a former Assistant Adjutant General in the Union Army, studied obstetrics and gynecology with Europe’s elite upon leaving the Army in 1893. Upon his return to the United States, he became a professor of physiology and microscopical anatomy at the Long Island College Hospital, and later the Bellevue Hospital Medical College, where in
1890 he became President of the institution, which would later merge with the New York University Medical College. In his influential work, *The Science and Art of Midwifery*, Lusk recognized the rate by which women died from criminal abortion, believing abortion, rather than puerperal fever contracted in childbirth, to be the leading cause of death in women of childbearing age. Lusk conjectured that more women died by hemorrhage or puerperal fever as a result of abortion than did women who died from puerperal fever in childbirth – a theory that ran counter to the period’s mainstream medical belief that puerperal – or childbed – fever was the leading cause of death in women of childbearing age.

In the new and professionalizing field of obstetrics, Lusk was considered an authority and his texts on obstetrics and gynecology were influential, respected, and well read. *The Art and Science of Midwifery*, published initially in 1881, went through four editions, including one substantial revision, and was published in both Spanish and French. Lusk was in the midst of rewriting his fifth addition upon his death in 1897. Speaking to the influence of the book, an 1882 review in the *Supplement to the American Journal of Obstetrics* referred to the text as “By far the most learned and most complete exposition of the science and art of obstetrics written in the English language.”

Alongside his text, Lusk was also well known amongst his obstetrical colleagues for his writings on the causes of puerperal fever. His provocative article on the causes of the infection challenged the theories (and sensibilities) of several members of the obstetrical elite and

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324 “Death of Mr. WM. T. Lusk,” *New York Times*, June 13, 1897, 2. Amongst his many accomplishments, Lusk’s obituary mentions his posts at the President of the Bellevue Hospital Medical College and Vice President of the New York Obstetrical Society. He was also one of only a few physicians at the time of his death to have successfully performed several cesarean operations.
326 Reamy, “In Memoriam,” 469.
informed Lusk’s own ideas on how best to treat criminal abortion. Known colloquially as childbed fever, puerperal fever was a condition that occurred when a patient was exposed to bacteria through an open wound. The resulting blood infection almost always proved fatal, and was the leading cause of maternal mortality in the nineteenth-century United States. Puerperal fever, however, was a political and controversial disease in the medical literature and practice of the nineteenth century. Early theories of puerperal fever offered by the ancient Greek physician, Galen, and later embraced by the influential Scottish obstetrician William Smellie, inventor of the Smellie forceps that revolutionized childbirth, remained recalcitrant amid clinical experiences that proved otherwise. The cause of puerperal fever was based in Galen’s theory of bodily humors, and held that the fever was the result of suppressed lochia, or the remnants of childbirth, in the postpartum woman’s body.

An 1843 treatise by the American physician Dr. Oliver Wendell Holmes countered the theory and argued that childbed fever was spread by physicians and midwives who used unclean hands and instruments to examine and assist women in childbirth. In other words, it was contagion and not the suppression of bodily humors that caused the disease. There was considerable outcry from regular physicians, especially two of the most notable obstetricians in the country, Hugh L. Hodge and Charles Meigs, both of Philadelphia. The idea that a physician-gentleman could unknowingly spread, rather than cure, disease through his own uncleanliness was unthinkable. Underlying what they viewed as an assault on the dignity of their profession

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was uncertainty and resistance to emerging theories of contagion, known otherwise as germ theory, amongst regular physicians who felt unable to “form any clear idea” on the subject.328

Charles Meigs and Hugh Hodge were the first generation of obstetrical elite in the United States. Both were professors of obstetrics in Philadelphia’s most prestigious medical colleges – Meigs at Jefferson Medical College, and Hodge at the University of Pennsylvania. William Thompson Lusk, a part of the next generation of obstetrical elite in New York City, countered their belief that a physician could not transmit disease to the very patient he was attempting to help in his controversial 1876 article, “Causes and Prevention of Puerperal Fever,” presented at the International Congress at Philadelphia, and in several chapters of the book Marie Formad was assigned for her course with Dr. Anna Broomall at Woman’s Medical College of Pennsylvania. In both pieces of writing, Lusk used germ theory to argue that puerperal fever was caused by microscopic organisms and was indeed spread by physicians and midwives. He dedicated a subsection of his chapter on ‘Diseases of Childbed’ to refuting Hodge and Meigs and spoke directly to their assertion that doctors could not carry disease: “The ordinary carriers of infection are unquestionably the unclean hands, instruments, utensils, clothing, wash material, and the like which are brought into contact, during or after labor, with the genitals of the female.”329

Lusk’s provocative writings on puerperal fever and antisepsis directly informed his equally provocative suggestion regarding treating cases of criminal abortion. While Lusk believed that women who aborted spontaneously and in the care of a medical professional were “devoid of danger,” those who aborted criminally – and without medical care – were likely to die

328 Lusk, The Science and Art of Midwifery, 683-4. See also page 661, where Lusk discusses the progression of the theories of puerperal fever in more detail, including those advanced by French obstetrician Nicolas Puzos and embraced by late-seventeenth-century French obstetricians.
from infection. At a time when most texts refused to even treat the subject of criminal abortion for fear of legal retribution, Lusk proposed that the best way to treat cases of criminal abortion was in hospital settings where women could receive sterile medical care. While the details of Lusk’s examples remain sparse, he cites both the Rotunda Hospital in Dublin, and his own institution, Bellevue Hospital in New York City, as evidence that hospitalization reduced the number of women dying from either sepsis or hemorrhage as a result of an incomplete abortion procedure.

Lusk’s solution was surprising in that regular physicians remained staunchly opposed to abortion in the late nineteenth-century, largely a result of the American Medical Association’s mid-century campaign to criminalize the procedure and distinguish themselves from midwives, alternative practitioners of medicine, and abortionists. Hugh Hodge himself had long ago lectured on the dangers, both moral and medical, of criminal abortion. At the request of the Medical Class of 1854, Hodge revised the lecture for publication, citing its “practical importance to the moral character of the community” and “under the hope that it may, in some degree, rectify erroneous and prevalent views, as to the value of the life of the “foetus in utero.” Hodge’s tract was widely circulated and cited amongst the medical community, and reflected regular physicians’ attitudes toward criminal abortion. In this way, Lusk’s suggestion that women in need of post-criminal abortion medical care should and would seek it from a regular physician in a hospital setting was exceptionally provocative. Marie Formad’s case studies both confirm the need for such care, as well as women’s reticence to seek medical help after a

332 Hodge, On Criminal Abortion, 2.
criminal abortion. Only three of the six women called a regular physician to attend to them when they began experiencing symptoms of puerperal fever for fear of legal retribution.

While Lusk’s text explores in great detail “threatened,” “inevitable,” “neglected,” and “artificial” abortion within a chapter titled “Premature Expulsion of the Ovum,” he writes little more about criminal abortion beyond linking the procedure to puerperal fever and offering a proposal for lowering mortality rates through hospitalizing women in need of post-abortion care.333 Like most medical texts, Lusk focused on prevention and the “arrest of [the] threatened abortion,” though a practitioner interested in learning how to treat a patient in need of care post-criminal abortion could extrapolate a course of action from the sections describing treatment of inevitable, neglected, incomplete, or artificial abortions.334 These sections detailed methods for removing the contents of the uterus to prevent sepsis and the use of carbolized water for sterilization – a method unique to Lusk, who embraced germ theory and antisepsis well before the mainstream medical profession.

Unlike his colleagues, Lusk’s text treated criminal abortion as a medical procedure rather than a matter of medical jurisprudence. He thus proposed a plan – albeit sparse in detail - for treatment that included cutting edge methods of antisepsis delivered within a hospital setting to save women’s lives. In this way, Lusk obviated the social, medical, and legal milieu that pushed other physicians to focus on identifying criminal intent in their writings on abortion. In other words, Lusk was interested in treating the live bodies of women rather identifying signs of the procedure in women who died from infection as a result of criminal abortion so that criminal abortionists could be prosecuted. This meant that Lusk spent little time differentiating between

forced and spontaneous abortions. The legal system had no role in treating criminal abortion, which he saw as a medical issue with a medical solution.

As a result, Marie Formad would find very little regarding the morbid anatomy of criminal abortion in Lusk’s *Science and Art of Midwifery*. If she consulted Pierre Cazeaux’s *A theoretical and practical treatise on midwifery: including the diseases of pregnancy and parturition*, a text Dr. Broomall also assigned to her obstetrics and gynecology students, she would be doubly disappointed. 335 Though Cazeaux - a French physician and member of the Imperial Academy of Medicine in Paris - died in 1863, his text continued to be added to, amended, and published in the United States well beyond his death. 336 By 1884, Cazeaux’s text was renamed *Obstetrics: the theory and practice: including the diseases of pregnancy and parturition, obstetrical operations, etc.* The 1884 edition of *Obstetrics* treated the subject of criminal abortion only insofar that Cazeaux mentioned the procedure, which he called “provoked” abortion, and declined to treat it further for reasons of propriety. 337 His text included a section on the causes, symptoms, and treatments of spontaneous and accidental abortions that focused on prevention, as well as a section on when to rely upon premature delivery and abortion to protect the life of the mother. While Cazeaux refused to treat criminal abortion in his manual, he believed abortion was justified as an obstetrical operation when a woman’s pelvis was too narrow for the fetus to pass through. In this case, the only options would be an embryotomy, caesarian section, or abortion. Further, he believed it was completely justified to sacrifice the life of the child to save that of the mother.

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336 By 1886, Cazeaux’s text was in its eighth U.S. edition and listed Dr. S. Tarnier, Professor of Obstetrics and Diseases of Women and Children in the Faculty of Medicine in Paris, as the one who “remodeled and rearranged” the text in French. In the United States, the text was edited and revised by Dr. Robert J. Hess, Physician to the Northern Dispensary in Philadelphia.
Marie Formad and the Matter of Intent

Marie Formad dedicated her thesis to parsing these questions of spontaneous and forced, legal and illegal, so that physicians could use her research as a guide in their own practice. In doing so, she recognized both the paucity of literature on criminal abortion, as well as the need to distinguish between forced and spontaneous abortion for those who encountered it in their work – specifically, women physicians pushed to pursue obstetrics and gynecology, as well as coroners charged with identifying cause of death. Formad moved beyond the abstract definitions and theories of abortion articulated in prominent obstetrical texts and used her own experience examining the bodies of women who died as a result of criminal abortion to establish a morbid anatomy of the procedure. For practitioners who encountered abortion regularly in their work, the lines between criminality and legality drawn by Lusk, Cazeaux, and the broader obstetrical field were too blurry.

According to obstetrical texts, the difference between an abortion that was forced and one that was spontaneous – or an abortion that was illegal or legal - lay only in intent: if one willfully terminated a pregnancy that did not endanger the life of the mother, it was considered criminal. If the termination was the result of medical anomaly, accident, or medical necessity to save the life of the mother, it was considered legal. The value placed on intent gave physicians an exceptional amount of power while overseeing birth and loss, yet prominent obstetrical texts failed to acknowledge the ways abortion was becoming increasingly surveilled by the legal system and offered no practical guidance regarding how to both distinguish between spontaneous and forced abortions and provide care to women who presented after attempting to self-abort.

Lusk provided a solution for treating women suffering from criminal abortion that included hospitalization, and Cazeaux simply refused to treat the subject in his text. As
prominent members of the obstetrical elite, both authors could skirt the issue in ways not possible for Marie Formad and her colleagues at Woman’s Medical College. Women physicians were new members of the profession, and they occupied a precarious position within the medical community. For them, presiding over an abortion, whether it be to save the life of a mother or treat a woman who presented in need of care after an attempted self-abortion, presented a considerable risk to their professional reputation. Women medical students and physicians were placed in a difficult position. They were required to treat patients who presented in need of care, yet the major obstetrical texts of the period refused to provide concrete ways to distinguish the legality of the procedure. Further, the concept of “intent” was slippery. Physicians were placed in a position to determine when a woman’s life was in danger, and a marginal member of the medical community’s actions could easily be called into question and prosecuted by established members of the field looking to push away competition.

Formad navigated the politics and ambiguity of criminal abortion by providing concrete information to medical practitioners, and in so doing provided her sister physicians with a road-map for protecting themselves. Unlike Lusk, Formad did not use her analysis to suggest novel and innovative treatments for women suffering from the effects of criminal abortion because her position within the medical community would not allow it. Women physicians attempting to forge a place within mainstream regular medicine could not operate above the law. To comply with it, however, they required the concrete information Formad included in her thesis, including the morbid anatomy of criminal abortion, methods for establishing cases of criminal abortion at an autopsy, and the new abortion laws for Pennsylvania. Formad’s thesis knitted together the medical and legal aspects of the procedure in practical, concrete ways ignored by the foremost
obstetrical texts of the time and provided women physicians with a meaningful guide for navigating abortion in their own medical practices.

In the same year Marie Formad wrote her thesis and graduated from Woman’s Medical College of Philadelphia, the eighth American edition of Cazeaux’s text was released posthumously. It included an Appendix written by Dr. Paul F. Munde, a Professor of Gynecology at the New York Polyclinic and at Dartmouth College, and Vice President of the American Gynecological Society. Titled “Obstetric and Gynecic Jurisprudence,” the introduction to the Appendix promised the section would cover “some of the most important subjects” that would be of “full interest and value to every physician.” At the request of the publisher, Munde structured the Appendix to “include a number of subjects which have been omitted or but lightly touched upon in [Cazeaux’s] work itself, or which appear especially interesting and useful to the profession at this time.” Criminal abortion, alongside issues of the physician/patient relationship, paternity and legitimacy, pregnancy, live- and stillbirth, infanticide, were the central foci of the chapter.

Like Formad’s thesis, Munde’s writing on criminal abortion was unique in that it contextualized abortion within both the medical and legal systems, a field known as medical jurisprudence, and offered physicians a guide for navigating circumstances in which medical knowledge was used to establish criminal intent. Similarly, Munde was not concerned with providing guidelines for the treatment of criminal abortion or potential solutions for lowering the mortality rate. Instead, he focused his text on offering medical practitioners a guide for differentiating between spontaneous and criminal abortions, a process he believed was “generally

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easy.” He provided his readers with several points to consider as they examined the living or dead body of the mother, the products of conception, and any drugs or instruments involved in the case. Munde did not create these lists from his own clinical observations, however, and drew this section of his Appendix from the works of Dr. Charles Meymott Tidy, an English physician noted for his groundbreaking work in legal medicine. In doing so, however, he supported Marie Formad’s insight concerning the incomplete literature on criminal abortion. This is made visible when Munde’s text is held in relief to Formad’s thesis. Formad’s writings were based on her own clinical case studies, and offered her readers detailed insight on the morbid anatomy of criminal abortion based on cutting-edge understandings of sepsis, steps for proving criminal abortion in autopsy cases, and an overview of the most current abortion laws. Munde’s text, however, provided only vague methods and suggestions for differentiating between spontaneous and criminal abortions in examining live and dead bodies, the products of conception, and any instruments or medicines associated with the case, and occasionally these suggestions were contradictory. For instance, in considering the products of conception, Munde instructed his reader to “determine whether a [fetus] be born alive; its probable age, and the cause of its death.” Only a few pages before, Munde suggested that the “only conditions which would afford certain proof of ante-natal death, would be those of intra-uterine putrefaction or maceration [of the fetus], making it nearly impossible to determine whether a fetus be born alive or dead.

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The contradictory and ambiguous treatment of abortion in the foremost obstetrical texts of the late nineteenth-century compromised the professional reputations of women physicians and those like Henry Formad who would routinely encounter the procedure in their medical practice. In response, Marie Formad used her thesis to contextualize abortion within the medical and legal systems, providing her readers with detailed morbid anatomy of criminal abortion based on clinical case studies she attended in person, legal steps for establishing criminal abortion at the autopsy procedure, and finally the most current legislation on criminal abortion. In doing so, Formad worked within the system to protect the interests of women physicians.

“A.K., age 25, White, Single, First Pregnancy”: Reading Autopsy Records for Personal Histories

In some respects, Marie Formad’s autopsy records leave us only vague details of the women who died from complications of abortion. Writing for a medical audience, Formad took pains to anonymize each woman’s story, assigning numbers to each case and listing only the woman’s first and last initials. Of import to her and her audience was establishing the morbid anatomy of criminal abortion, and her case studies used medical histories of the body to identify commonalities other practitioners could use to prove evidence of the procedure. When one looks for details about women’s lives, however, these records tell a rich story, both individually and collectively, and allow a glimpse into the space these women occupied in their communities, their health histories, how they died, and in some cases, why they may have sought an abortion.

The health histories Marie Formad included in each patient’s case reveal facts about women’s social and reproductive lives that countered physicians and social purity reformers who placed married, middle class white women at the center of the nation’s abortion epidemic. All of the women died in their prime childbearing years, between the ages of twenty-three and thirty.
C.J.S. was 23, A.B. was 24, both J.G. and A.K. were 25, L.S. was 26, and S.L. was 30. Three of the women were married and two of them were single, and five of the six were described as ‘White.’ Only J.G. was listed as “German,” a term used to circumscribe her membership from the native, middling class. Most of the women had living children. Both A.K. and C.J.S. were childless, while A.B. had one child, J.G. and S.L. were mothers to three children, and L.S. had children, though the exact number is unknown. At least two of the women were single and two of them already had families of three children.

These women were likely not from the middling classes. At least two of them – A.K. and J.G. – called on a professional abortionist, or “operator,” to perform their procedure. It is likely that S.L., C.J.S., and A.B. also used professional abortionists based upon contextual clues in their case files. Marie Formad noted that all three cases were reported to the coroner because the women called on a regular physician to treat their complications before their death. Using a professional abortionist and seeking care for complications from the procedure with a regular physician was a common practice, and also the method by which many cases of criminal abortion were discovered by authorities. It was equally common, however, for women to die rather than seek medical care, for fear of legal retribution or shame. Notably, Formad’s description does not completely rule out the possibility of the women patients obtaining an abortion from a regular physician.

Middle- and upper-class white women often sought abortions from physicians rather than from what Marie Formad referred to as “operators,” or professional abortionists. Though not necessarily safer than seeking the procedure from a professional abortionist, a physician-

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344 Marie Formad did not list the marital status of Case III, a woman called ‘S.L.’ Based on my reading, I take this to mean S.L. was unmarried, though I cannot know this for certain.
345 Formad wrote of the woman L.S., “Has had children and is said to have aborted before but this is not definitely established.” Formad, “Some Notes,” 19.
performed abortion was advantageous to women who could afford it. First, it provided a level of privacy. Women who could obtain abortions from their physicians never had to risk being seen using the services of an operator. Secondly, and of most import, it was accessible. Professional abortionists were largely located in urban areas, often leaving women who lived in rural areas without any other option.

There are additional clues in Formad’s case histories that suggest the women who died from criminal abortion were not of the middling classes. As a part of her post-mortem exam, Marie Formad described the condition of each of the women’s bodies, paying particular attention to details that revealed how each woman lived. While Formad described three of the six bodies using terms like ‘well nourished,’ ‘healthy,’ and ‘well built,’ the remaining three bodies were malnourished. C.J.S.’s body was described as “that of a small sized lean young woman.”

Similarly, she wrote of S.L.’s body that it was “that of a small, lean, but otherwise healthy looking woman.” A.B.’s body revealed the most pronounced markers of poverty. Formad noted in her case study that A.B. was once a “[m]iddle sized woman, muscular but ill nourished, [with] signs of pregnancy well marked.” At least two of these women’s bodies were ‘lean’ and ‘small,’ and one was ‘ill nourished.’ C.J.S., S.L., and A.B. did not fit the description of the middling, healthy, married women of anti-abortion rhetoricians’ nightmares.

Alongside an understanding of the social space the women of her reports occupied within the Philadelphia community, Marie Formad’s case notes offer possible explanations as to why women sought the procedure that would eventually take their life. It is difficult to discern a reason for the two women who were mothers to three children. ‘J.G.’ was a married twenty-five-

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year-old German woman already caring for three children in a new and foreign country. Similarly, ‘S.L.’ was a thirty-year-old woman with three children, and it is not possible to know from Formad’s records whether she was married. Perhaps these women felt their families were complete with three children. It is also possible both women were frightened of childbirth, which remained a perilous prospect for both mothers and children in the late-nineteenth-century. Formad’s medical records leave us no way to tell; however, it is possible to understand why the three remaining women sought abortion procedures.

C.J.S.’s case record is particularly heart wrenching. She died on December 2, 1885, about six weeks after her wedding. An autopsy revealed that her “uterus showed evidences of pregnancy of about the fourth month” at the time of her death, and Marie Formad’s case notes make the connection between the timing of her marriage, pregnancy, and abortion procedure explicit. Formad wrote, “Abortion performed eleven days previously with consent of her husband in order to avoid confinement before the elapse of the legitimate time after marriage.” Her case was reported to the coroner by a regular physician called upon to care for C.J.S. in the eleven days between her abortion procedure and her death. Ultimately the regular physician could do nothing to save her life, and she died from peritonitis and pyaemia, or blood poisoning, as a result of her abortion procedure.

C.J.S. had an abortion to avoid the social stigma of pregnancy before marriage, and ultimately died as a result of blood poisoning. Her husband consented to the procedure, presumably because he also wanted to avoid the stigma associated with non-marital sex. The records of two other women – A.K. and L.S. – indicate that they, too, had abortions because they

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351 Formad noted in her thesis that married women seek abortion to avoid bearing children, while single women abort to hide the shame and sin association with childbearing out of marriage. Formad, “Some Notes,” 7.
were unmarried and pregnant and hoping to avoid the stigma of premarital sex as well as the difficulties of raising a child as a single woman. According to Marie Formad’s autopsy report, A.K. was a twenty-five-year-old single woman who had no children prior to her death. Ultimately, the coroner learned of A.K.’s death because she confessed her abortion to a source undisclosed in her autopsy report. The unknown source reported A.K.’s criminal abortion to the coroner, who exhumed the body five days after A.K.’s death. The operator was arrested after A.K.’s confession, and sentenced to seven years imprisonment.\footnote{Formad, “Some Notes,” 12.}

L.S.’s personal history was strikingly similar to A.K.’s. She was a twenty-six-year-old single woman who sought an abortion because she was unmarried and pregnant. Her medical record indicated that she, too, was in good health prior to her death. In her autopsy report, Formad noted “[her] body was that of a middle sized well built woman, of evident good health during life.”\footnote{Formad, “Some Notes,” 19.} Like A.K., L.S. died ten days after her abortion procedure, of septicemia, or blood poisoning. Unlike A.K., however, the autopsy report did not reveal from whom she received an abortion, nor how the coroner learned of her death. L.S. did not receive care from a regular physician as she began to show signs of blood poisoning, which was how many cases of criminal abortion came to the attention of the coroner. Three of the six women featured in Formad’s thesis refused to call a physician to attend them as they suffered from the effects of blood poisoning.

The decision of whether to engage medical assistance after an abortion depended on the legitimacy of a woman’s pregnancy. Marie Formad’s case studies indicate that the women who called a physician to care for them post-procedure – S.L., C.J.S., A.B., and potentially J.G. – were the women whose pregnancies fell within the boundaries of respectability by nineteenth-
century society. In other words, every woman who was married called a physician to care for her in the period between her procedure and death. The women who refused to call a physician, and who ultimately died as a result, were single, pregnant women who most likely sought abortions to hide the shame of pregnancy out of wedlock, or because they could not afford to care for a child. Similarly, single women had no male partner who could offer potential protection from a suspicious physician or police officer.

There was no record of L.S.’ confession, even though her autopsy report records that her body was disinterred by the coroner and an autopsy performed seven days after her death. Unlike the other women, L.S.’s record indicated that she “has had children and is said to have aborted before but this is not definitely established.” Perhaps this knowledge led the coroner to L.S.’ body – Henry Formad may have been able to connect the dots between the death of a healthy twenty-six-year-old woman who was known to have aborted. In a moment when social purity reformers and regular physicians decried an abortion epidemic of epic proportions, L.S. was the only one of the six women Marie Formad wrote about who had likely had more than one abortion procedure during her lifetime. For the remaining five women – A.K., J.G., S.L., C.J.S., and A.B. – their first abortion would take their lives.

The bodies of women who died from criminal abortions were often buried with death certificates that listed the cause of death as something other than the procedure to protect the reputation and identity of anyone involved in the act. The coroner and coroner’s physician usually learned of deaths from criminal abortion through physicians who treated a woman for symptoms associated infection from the procedure prior to her death, the death-bed confession of the woman, or the confession of a witness, such as the abortionist or a spouse. Both the families

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of the women who died and the person who performed her procedure valued privacy for a variety of reasons, including preserving professional reputations, avoiding legal ramifications like jail time, and the social stigma of non-marital sex, pregnancy, and abortion. While three of the six autopsy reports Marie Formad included in her thesis listed sepsis as a result of criminal abortion as the woman’s initial cause of death, the other three listed causes meant to hide the woman’s criminal abortion. Both A.K. and L.S. were buried with a doctor’s certificate of gastritis, and J.G.’s cause of death was recorded as heart disease.

Using a doctor’s certificate to hide criminal abortion did little to protect women beyond preserving their memory and reputation. Listing the cause of death as gastritis or heart disease did, however, protect the person who performed the woman’s abortion and any witnesses involved, such as her spouse or partner by throwing off the trail the coroner and coroner’s physician. Marie Formad’s autopsy records indicate there was good reason to do so. A.K.’s body was buried with a doctor’s certificate listing her cause of death as gastritis, though the coroner’s physician disinterred her body five days after she died because A.K. confessed her criminal abortion to an unknown source before her death. Perhaps it was a physician, as her autopsy report mentions that she had been treated for peritonitis before her death, though her abdominal cavity was “completely filled with a purulent exudate” at the time of her post-mortem. After the coroner established A.K.’s actual cause of death as peritonitis from criminal abortion, the operator who performed her abortion procedure was sentenced to seven years imprisonment.

The coroner’s reports also allow for a deeper understanding of when in their pregnancies women typically aborted, as well as how long they lived afterward. This knowledge would be

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extremely helpful to Formad’s readers interested in identifying criminal abortion and potentially protecting themselves from legal liability. Three of the six autopsy reports included a note describing how far along the woman was in her pregnancy when she sought an abortion. S.L., C.J.S., and A.K. were all approximately five months pregnant when they terminated their pregnancies with an operator. Most women show visible signs of pregnancy in the early to mid-second trimester, which coincided with the moment these women chose to end their pregnancies.

Three of the women were early in their second trimester when they aborted, and they lived an average of eleven days after they terminated their pregnancy. S.L. died only eight days after her abortion procedure – the shortest period between an abortion and death for any of the six women. A.B., however, lived for fourteen days after she terminated her pregnancy, the longest amount of time of any of the six women. While A.K.’s initial doctor’s certificate listed gastritis as her cause of death, the autopsy report listed “peritonitis from criminal abortion” as the true cause. J.G.’s certificate listed a cause related to peritonitis: “septicaemia due to endometritis.” The remaining four women’s causes of death mirrored the first two: S.L. died from “peritonitis,” L.S. and A.B. from “septicaecemia,” and C.J.S. from “peritonitis and pyaemia.”

Marie Formad’s 1886 thesis on criminal abortion offers a rich and complex lens through which to examine criminal abortion in the late nineteenth-century United States. In one sense, her writings were an act of professional service to women in medicine who would be forced to confront abortion – both criminal and spontaneous – in their own medical practices. Formad laid bare the morbid anatomy of criminal abortion, basing her observations on her personal experience. In doing so, she created a detailed and practical guide physicians could use to identify both the medical and legal practice of criminal abortion and protect themselves from

legal ramifications. The foremost obstetrical writings of the late nineteenth-century either refused to treat the subject of criminal abortion, or offered broad, theoretical commentary with solutions based in prevention, and often excerpted from other medical texts rather than culled from clinical experience. Formad’s thesis responded to this void and acknowledged the prevalence of the procedure, distinguished it from spontaneous abortion, and offered concrete medical and legal guidance to physicians who would encounter the procedure at some point in their medical careers. As the future head of the Gynecological Clinic of the Woman’s Hospital of Philadelphia, Marie Formad would carry her knowledge of criminal abortion forward in her work training future cohorts of women physicians.

For all of her interest in identifying the legal and medical forms of criminal abortion to protect the interest of physicians, Marie Formad remained unconcerned with offering a treatment for women suffering from the effects of the procedure. As a woman medical student, she occupied a precarious place in the medical field and offering a course of treatment for women suffering from criminal abortion in a public-facing document like her senior thesis was simply impossible. Formad instead chose to focus her clinical work on the bodies of women who had died as a result of criminal abortion. Alongside the morbid anatomy she developed through her study, Formad also included case notes for each of the six autopsies. This valuable information allows a glimpse into the lives of women dying from criminal abortion in late nineteenth-century Philadelphia and show that middle-class white women were not at the center of the abortion epidemic. The women Formad exhumed and examined were married and single, native and foreign born, mothers and childless. Almost all of them had limited means, and all of them died from septicemia.
Formad’s thesis held in an uncomfortable tension her dual interests of aiding women physicians and her need to distance herself from treating patients in need of abortion care. This tension was not unique to Formad, as this dissertation argues, but rather a systemic issue women practitioners would be forced to confront in a male-dominated medical community that classified abortion care as a professional liability. The irony, of course, is that women patients were also vying for survival in a world constrained by the very same gender ideologies that both criminalized abortion and made childbearing a medical and economic risk for poor and unmarried women. These same ideologies placed men like William Lusk in a position to offer radical theories for the treatment of criminal abortion while delimiting women physicians’ public thinking and writing on the subject. Yet, within this complex milieu Marie Formad’s thesis offered a concrete and practical guide based on clinical observation and up-to-date medical and legal thinking physicians and coroners could use in their everyday work.

Probing beyond women physicians’ public-facing denunciations of pregnancy loss and termination matters because it allows for a more holistic understanding of how most nineteenth-century women physicians actually practiced their craft. Without the context of Woman’s Medical College, Marie Formad’s thesis can be read only as an implicit denunciation of pregnancy termination. Understood alongside pedagogical exercises like Anna Broomall’s mock trial and the extensive clinical obstetrical experiences women medical students received as a part of their education, however, Formad’s research can be seen in the nuanced light in which it was intended. As Woman’s Medical College of Pennsylvania graduates entered their clinical practices across the country and globe, they would be well equipped to navigate the complexities of pregnancy termination and loss, in turn shaping the nascent fields of obstetrics and gynecology in the United States.
Conclusion

The Case of Purvi Patel

The case of Purvi Patel was splashed across national news headlines when I began writing this dissertation. Patel, an Indiana woman who ingested an abortifacient purchased online from Hong Kong, was accused of feticide and child neglect after delivering a 25-30 week-old fetus she claimed had been born dead. The lower court judge found her guilty of both counts in 2015 and her appeal captured national headlines in 2016, just as I wrote the chapter on Dr. Anna Broomall’s mock trial exercise with her obstetrics and gynecology students at Woman’s Medical College. The Patel case had a profound influence on how I approached my research for this dissertation. I was perplexed by the idea that one could be accused of both feticide, or the death of a fetus, and child neglect. The distinction between fetus and child was disregarded and used to convict Patel of neglecting a 25-30 week-old fetus. It was a stark reminder to me - at that moment, 3 months pregnant with my first child - that the ambiguity surrounding fetal life in the late nineteenth century continued into the present and had material, often terrible, consequences for pregnant women.

Though Broomall’s mock trial and Patel’s appeal case were 124 years apart, it was impossible to ignore their similarities. Central to the case was a woman - in the case of Patel, a second generation Indian-American - who chose to terminate her pregnancy on her own, without medical oversight. To someone unfamiliar with the history of abortion legality and access in the United States, this may seem a foolish move. But when one learns more about the ways in which the field committed violence on the bodies of Black, brown, and poor women over the course of the nineteenth century, it is clearer why a woman would try to take her health into her own

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hands.\textsuperscript{358} The legacy of racism looms large in the history of obstetrics and gynecology in the United States, from James Marion Simms’ experimentation on the bodies of enslaved women in the nineteenth century to the population control schemes of national and international reproductive health organizations in the twentieth century that target long-acting reversible contraceptives (LARC) like intrauterine devices (IUD) to Black and brown communities and then refuse women’s requests for removal.

Physicians had significant power and influence in the Jones and Patel cases. Physicians both reported Susan Jones’ case to authorities and testified for the prosecution and as expert witnesses. While Patel terminated her pregnancy at home, without the care of a medical professional, she drove herself to a nearby medical center because she was bleeding continuously. According to her appeal transcript, she told the doctors at St. Joseph she was ten to twelve weeks pregnant, though based on the size of the umbilical cord still attached to Patel they estimated the fetus was closer to 25 or 30 weeks old. Drs. Kelly McGuire and Tracy Byrne left the hospital after examining Patel to search the dumpster where Patel had deposited the body, estimating it could still be living. After locating the dead baby sometime later, Dr. McGuire examined the body, believing it had been viable “[d]espite the fact that it was not born in a hospital setting.”\textsuperscript{359} A forensic examination of the baby’s body revealed no external or internal abnormalities, and the pathologist believed the baby had breathed after it was born. Its body showed no signs of tissue breakdown that would occur after death in utero.

\textsuperscript{358} On this vital topic, I am influenced by the recent scholarship of Deidre Cooper Owens, who through her recent scholarship demonstrates that experimentation on Black women’s bodies was central to the development of American gynecology. Deidre Cooper Owens, \textit{Medical Bondage: Race, Gender, and the Origins of American Gynecology} (Athens: University of Georgia Press, 2017). Also the works of Dorothy Roberts, especially \textit{Killing the Black Body: Race, Reproduction, and the Meaning of Liberty} (New York: Random House, 1997).
\textsuperscript{359} Purvi Patel v. State of Indiana, 10.
It seems odd that two obstetricians would leave their shift at a regional medical center to search a dumpster when paramedics and police were doing the same. But Dr. Kelly McGuire was proving a point: he was in charge of deciding when life began. McGuire’s profile on OB/GYN Associates of Northern Indiana lists his membership in the American Association of Pro-Life Obstetricians and Gynecologists.\textsuperscript{360} Dr. McGuire was not neutral in the Patel case, and his statement testifying to the fetus’ viability is not only of questionable veracity, but also reveals why Patel may have been hesitant to seek medical care in the first place.

The hydrostatic lung test was also used in both historical and contemporary cases to determine whether the fetus had breathed at birth, in both cases seen as a marker of life. Now largely discredited, the test requires lungs to be observed in water. If they float, it’s likely the child breathed at birth because the lung will have enough air within to buoy it in water. The test’s accuracy is contested, and amici briefs filed on behalf of Patel by the Innocence Project and Dr. Gregory J. Davis highlight the test’s contested nature.\textsuperscript{361} The pathologist testified that he used the test in concert with other data points that together pointed to the likelihood the fetus was born alive. Ultimately the amici briefs were dismissed because Patel admitted that the fetus was born alive.

Dr. Joseph Prahlow, the pathologist who performed the autopsy on Patel’s fetus, provided a report to the Court that was striking in its similarity to the mock trial. It also revealed cracks in the idea that “breath” is the arbiter by which we must judge life and urges us to consider that language really does matter. Prahlow examined the body and umbilical cord for external and internal abnormalities, and the fetus’s body for signs of maceration, or the breaking down of


\textsuperscript{361} Purvi Patel v. State of Indiana, 12. See note 12 for a synopsis of the amicus brief filed on behalf of Patel by The Innocence Network and Dr. Gregory J. Davis.
tissue in utero after death. He testified that the fetus died by homicide, likely because of what he called

“extreme prematurity” coupled with a lack of essential medical care, hypothermia or hyperthermia due to the baby’s inability to regulate its body temperature, loss of blood due to the severed umbilical cord, or asphyxia from being placed in a plastic bag or from items inside the bag that could cover its mouth and nose.362

Just as nineteenth-century legislation, medicine, and statistical tracking asks us to consider what was “unlawful” and who was able to make this decision, Prahlow’s testimony shows us that we’re still asking these questions. What is “extreme prematurity”? Prahlow believed it was incompatible with life, and yet breath was still present. How are we to make sense of this? Who gets to make these decisions? And perhaps more importantly, who suffers as a result?

It cannot be ignored, as well, that at the time of the Patel case and appeal, Indiana had proposed and ratified some of the most restrictive reproductive health legislation in the United States. As a congressional representative, Mike Pence initiated the Pence Amendment that proposed to cut all federal funding from Planned Parenthood, a move that would ultimately cease millions of dollars in funding for preventative screenings for those unable to pay. As Governor of Indiana, Pence continued to cut funding for Planned Parenthood, the largest women’s health safety net provider in the state.

At the time of Anna Broomall’s mock trial, Pennsylvania’s legal landscape had also recently become restrictive to pregnancy termination, having changed rapidly over the course of a ten year period. Pennsylvania is distinguished as the first and one of only a few states that criminalized abortion at any point of pregnancy at common law through a Supreme Court decision in 1850. An 1860 statute followed, criminalizing “unlawful” abortion at any point in

pregnancy with no clarification of what constituted a lawful and unlawful procedure. As the Duffy pamphlet published by the U.S. Department of Health, Education, and Welfare’s Division of Research for the Maternal and Child Health Service noted in 1971, legal ambiguity was most often used to restrict and the language of the 1860 statute landed Pennsylvania in the “most restrictive” category of Duffy’s analysis.363

The 1860 statute outlawing “unlawful” abortions remained in effect until nullified by Roe v. Wade in 1973. In that 113 year interim, women and their physicians were forced to navigate ambiguous legislation around fetal life and pregnancy termination. The similarities between the experiences of late nineteenth-century Woman’s Med physicians and patients in this study and the physicians and patients of Magee-Women’s Hospital in Pittsburgh, Pennsylvania, who opened this dissertation in the years leading up to Roe v. Wade are striking. Ambiguous legislation around the procedure effectively made it illegal and drove women to seek abortions from non-medical providers or attempt to self-abort their pregnancies. Women patients would seek care in the Clinics of Woman’s Medical College and the Emergency Department of Magee-Women’s Hospital, where clinicians would treat them.

The public-facing anti-abortion rhetoric of nineteenth-century women medical students and physicians should be taken seriously. And yet, it is not the full story. There is no evidence in historical documents I used for this study to suggest that women physicians entertained “gender sympathy” on a collective level and provided abortions to their women patients out of understanding for their individual situations. Even feminist circles refused to embrace abortion. Instead, women interested in a modicum of control over their sexual and reproductive lives embraced abstinence as constructed through the ideology of passionlessness. A passionless


Even if women medical students and physicians were sympathetic to their patients seeking abortion care, they faced significant challenges from moral reformers and the regular, male-dominated medical field. Early and prominent obstetricians like Hugh Hodge worked with the American Medical Association to criminalize abortion across the United States and attempted to link women physicians with “dirty” midwives and professional abortionists as a way to drive them from the medical field. Women physicians and the institutions that trained them responded by articulating their “special place” in medicine caring for other women, and overwhelmingly prepared their students for careers in obstetrics and gynecology.

It is not enough to assume, as the historiography does, that women physicians were diametrically opposed to abortion and therefore never confronted it in their own obstetrical practice. Exploring their educational and clinical relationship with pregnancy loss and termination allows us to holistically understand the experience of a majority of nineteenth-century women physicians. Public health data from mid-to-late nineteenth-century Philadelphia confirms that pregnancy loss, including miscarriage, stillbirth, and abortion, both spontaneous and intentional, was a common occurrence in women’s reproductive lives. Pregnancy loss and termination was unavoidable for women and the women physicians who cared for them. We need the stories of Anna Broomall, Marie Formad, and the students and physicians of Woman’s Med. They ask us to push beyond public-facing polemics to examine how women physicians,
both individually and collectively, operationalized ambiguous legal and medical guidance to care for their patients and used what little power that was theirs to protect the position of women in medicine.

In the mid to late nineteenth century, women physicians occupied a new and vulnerable position within the medical profession and were without a powerful perch to critique the field’s stance on abortion or demand protocol for complex or ambiguous cases of pregnancy loss. Ambiguous legislation outlawing “unlawful” abortions offered no guidance, and the premier obstetrical and gynecological texts of the period were of little help. Many addressed abortion in terms of prevention, articulating how to prevent spontaneous abortions from permanently terminating the pregnancy. Some texts refused to event treat the subject, while others framed ‘forced’ abortions through the lens of medical jurisprudence and offered advice for how physicians could best protect themselves from legal risk.

Only one text read by Woman’s Med students framed “forced” abortion in medical terms with a medical solution. William Thompson Lusk believed puerperal fever contracted through an abortion procedure to be the leading cause of death in women of childbearing age. This belief ran counter to the profession’s view that puerperal fever in childbirth was the leading cause of death for the demographic. Moral reformers, as well, viewed abortion as exponentially more dangerous than childbirth. Because of this, Lusk advocated for abortions to be completed in a hospital setting as a means to reduce mortality rates. Unlike Hodge, Storer, and the collective regular profession, Lusk treated criminal abortion as a medical procedure rather than a matter of medical jurisprudence and proposed a plan, albeit sparse, to use cutting edge methods of antisepsis in a hospital setting to save women’s lives.
None of this helped women physicians, who needed guidance that spoke to their vulnerable position within the field. Women medical students and physicians created pedagogical exercises and conducted their own research to remove ambiguity and establish protocols in an effort to protect themselves from legal liability. Dr. Anna Broomall, the Chair of Obstetrics and Gynecology at Woman’s Med, went so far as to walk her students through a mock trial exercise in their course lectures on infanticide with the intent of arming them with the skills to successfully navigate the legal and medical ambiguity of fetal life. Dr. Marie Formad, similarly, conducted her own study with her brother, Dr. Henry Formad, to establish the morbid anatomy of criminal abortion so that she and her sister physicians could use the information to protect themselves in their clinical practices. Meanwhile students and physicians cared for women suffering from complications of pregnancy loss and termination in the clinics of Woman’s Medical College where they documented their work in rational, clinical language.

Woman’s Medical College students and physicians working to remove ambiguity on behalf of other women in the profession was an act of solidarity that acknowledged the hostile legal and professional climates in which they worked. It was deeply pragmatic in the sense that it was meant to protect the role of women within the medical field while also providing the medical care their patients required. Through Broomall’s mock trial, Marie Formad’s thesis, and clinical obstetrical experience, students learned how to navigate medical care that could raise the interest of legal authorities within the safety of a medical environment that was run by women, for women. This was not a political statement on behalf of Woman’s Med or individual faculty or students, nor was it inherently feminist. It was borne of necessity: women physicians were trained to treat women patients and abortion care was absolutely unavoidable.
While students’ training at Woman’s Med helped them navigate the legal and medical ambiguities of fetal life, it also reified mainstream regular medicine’s punitive view of criminal abortion and precluded the opportunity to frame the procedure in terms of medical care rather than through the lens of medical jurisprudence. While annual reports and clinical records from Woman’s Med clinics confirm that women physicians and students cared for patients suffering with the effects of pregnancy loss and termination, Dr. Formad’s thesis shows that many more women refused to seek medical care for complications after their abortion. Women patients were afraid to seek medical care because they understood that physicians could be pathways to legal and state involvement. Many women chose to suffer and ultimately die when faced with the challenge of discerning which physician they could trust to provide them with medical care without reporting their case to the police.

Over one hundred years later, the physicians of Magee-Women’s Hospital in Pittsburgh, Pennsylvania navigated the ambiguity of Pennsylvania’s 1860 statute in a way strikingly similar to the women of Woman’s Med. In the years directly before Roe v. Wade, physicians at Magee-Women’s Hospital interpreted the statute to provide “lawful” abortions to women whose mental or physical health would be negatively affected by continuing the pregnancy. Some physicians chose not to provide the procedure at all, while some did and charted the procedure in a normal, medical manner. Women were afraid to seek medical care, often presenting at the Emergency Department doors gravely ill after having undergone an “unlawful” abortion. Their fear was legitimate, because detectives were known to aggressively question women to find out who provided their abortion.

A little over forty years later, Purvi Patel walked into the Emergency Room at St. Joseph Hospital in Mishawaka, Indiana, for medical care after her self-induced abortion and found a
physician who publicly identified as a member of a national pro-life group. Dr. Kelly McGuire believed Patel to be between 25 and 30 weeks pregnant and far enough in gestation for the fetus to be born alive. He reported her case to law enforcement and he left the emergency room that night with another physician to search for the body. Patel would later be convicted of both feticide and child abuse by an Indiana court, though her case was later overturned on appeal. If charged, however, she would have been the first woman to go to prison for the crime of feticide in the United States – a crime historically reserved for perpetrators of domestic violence. Her case was a warning to other women across the United States who found themselves in need of abortion care. Doctors are not apolitical and neutral, and hospitals are public spaces where women in need of medical care can be met with questions from law enforcement.

The United States’ infatuation with the fetus makes it nearly impossible to shift the frame of reference to maternal health. This comes at great expense to women, as maternal mortality rates in the United States, especially for Black and brown women, routinely rank amongst the highest in the developed world. Within the field of maternal-fetal medicine, physicians are beginning to acknowledge the limitations of a paradigm that values the fetal body over the maternal, as well as the ways in which societal influences have shaped this limiting frame. As

366 In 2017, NPR and ProPublica ran a special series examining the United States’ high maternal mortality rates. They found that more women died from pregnancy-related complications than any other developed country, and that only in the United States has the rate of women who die been rising. Black women, the study found, were at the center of the country’s maternal mortality crisis. This investigation, alongside the rise of Black Lives Matter, played a key part in connecting Black maternal mortality with structural racism for the mainstream medical community. “Lost Mothers: Maternal Mortality in the U.S.,” NPR, https://www.npr.org/series/543928389/lost-mothers.
the medical field attempts to refocus its energies onto the maternal body, historical research on the development and professionalization of medical subfields like obstetrics, gynecology, pediatrics, and maternal-fetal health and how each has been influenced by our uniquely American focus on the fetus will be helpful. While these subfields emerged in concert with and occasionally counter to one another, they are united by the U.S. abortion debate. It is impossible to ignore the correlation between a myopic focus on the fetus in maternal-fetal health and the presence of a strong anti-choice voice in the United States. How the latter influenced the development of the former is an important topic for future historical scholarship.

This dissertation takes language seriously in the sense that it shapes the liminal and ambiguous space of fetal life. It is important to know who gets to name life and what effect it has on the lives and careers of those involved. Of greater importance to my study, however, is the distance between public statements and private practices, for within this space we can truly understand how the more vulnerable members of the medical profession grappled with and made sense of fetal ambiguity while also providing care for their women patients. The medical students and physicians of Woman’s Med, the doctors of Magee-Women’s Hospital, and the physicians of St. Joseph are united across centuries. They were often the first person a woman in need of abortion care turned to when she feared for her life. We need these historical and modern day stories to fully appreciate how physicians navigated clinical care for a politicized medical procedure within the power structures in which they worked. Medicine does not happen in a vacuum, nor are physicians apolitical. To believe the field is neutral imperils the lives of the very patients physicians are by oath bound to save.

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procedures were encouraged by health care systems and hostile malpractice environments. See Jacqueline H. Wolf, *Cesarian Section: An American History of Risk, Technology, and Consequence* (Baltimore: Johns Hopkins University Press, 2018).
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