

CHAPTER FOUR



IRISH IMMIGRANT WOMEN AND AMERICAN GYNECOLOGY

Oh brave, brave Irish girls,
We well might call you brave
Should the least of all your perils
The Stormy ocean waves.

—James Connally, *Labour in Ireland*

Accordingly it is found, that the patients generally are irregular
and careless in their attendance, and pay but little attention
to direction. The greater part are extremely ignorant.

—William Buell, writing on the behavior of his
poor Irish immigrant patients

THE GYNECOLOGICAL EXPERIENCES OF IRISH IMMIGRANT WOMEN IN America began following the transatlantic voyages they took after they fled Ireland because of a potato famine that left them and their nation hungry and desperate. Their sexual exploitation, however, began before these ships reached their destination. Like African women who were forced to board slave ships for the Americas three centuries earlier, nineteenth-century Irish immigrant women also suffered sexual abuses on “coffin ships,” so named because of the number of people who died during oceanic voyages to America. The thousands of Irish women headed to the United States were young, alone, and unprotected as they traveled aboard these vessels. For those women who were sexually abused, the boats represented floating prisons where they were un-

able to escape the sexual violence inflicted on them. The notes and published writings of ship captains, newspaper reporters, and others who chronicled the Irish immigrant seaboard experience described the collective sufferings that both male and female immigrants endured. While they did not emphasize sexual assaults, they compared the atrocities the Irish experienced with those that West African captives had undergone on slave ships. A March 10, 1847, article published in the *Cork Examiner* detailed conditions aboard the *Medemseh*, a ship carrying Irish passengers to New York City. The author wrote, "It reflects disgrace upon the regulations of the Government that creatures in this condition should be suffered to proceed to sea, with no other dependence against a long and enfeebling voyage than the kindness of persons whose treatment of their passengers, on an average, is hardly less brutal than that experienced from the masters of slave-ships."¹

More broadly, maritime travel was intimately connected to medicine because of the physical examinations passengers underwent when they arrived in the United States. When the ships reached their destinations, doctors examined the surviving passengers' bodies for deformities, diseases, and perceived abnormalities. Before the 1880s, few governmental and social agencies devoted considerable resources to assessing who met the criteria for "unfit immigrants." In addition, women with gynecological disorders might have been able to escape examination because their illnesses were sometimes internal rather than external. Further, the journal articles that doctors wrote about Irish immigrant women, which detailed their medical practices and thoughts, helped to create the foundation for racist laws that colored the Irish as not quite white and sometimes placed them alongside black people as biological models for racial inferiority.² As such, immigration became enmeshed in nineteenth-century systems of social control, just as the institution of slavery concerned discipline, surveillance, and ultimately control. For this reason, the later development of modern American gynecology can no more be disentangled from Irish immigration than it can be separated from its roots in slavery.

One year after the *Cork Examiner* reported on the atrocities committed aboard the *Medemseh*, well-known archbishop John Hughes wrote a passionate letter to Irish American leader Robert Emmet about the number of sexual assaults committed against Irish women aboard these U.S.-bound ships. Cloaked in the restrained Victorian language of the day, Archbishop Hughes commented on the different set of protections that were needed in America for Irish women. Hughes stated, "The protection of a shield" was not necessary in Ireland because Irish women allegedly did not experience this kind of sexual violence at home.³ Yet, for "pure, innocent" Irish women who were supposedly ignorant of the "snares of the world, and the dangers to which poverty

and inexperience would expose them in a foreign land,” a mighty shield was necessary.⁴

As Irish women landed in American port cities, even more “snares” awaited them. They entered the country as members of the largest European immigrant group to live in major cities, and they faced a bleak economic landscape.⁵ Job options were limited, and Irish women worked physically challenging, low-wage jobs such as factory labor, trash collection, and domestic service that were often dangerous and unhealthy. Although the Irish immigrant women were free laborers, historians like Hasia Diner, Alan Kraut, and Kevin Kelly have argued that thousands of these women became enmeshed in an antebellum labor system that was static and reduced them to wage slavery. Without financial stability, Irish women were unable to protect themselves against many of the dangers that urban women faced, including overcrowded and unsanitary housing, violence, and prostitution. Further, until the last half of the century, poor Irish women often stood outside the protective barriers accessible to native-born white women. For example, the protection of white women’s sexuality and reproduction had been a basic feature of early British colonialism, American nationalism, and white supremacy since the seventeenth century, when the first laws evolved that distinguished blackness from whiteness. By the 1800s, a famous article in London’s popular magazine *Punch*, “The Missing Link,” cautioned readers to protect themselves against an Irish “creature manifestly between the Gorilla and the Negro.”⁶ Finally, in 1860, political leaders drafted a congressional act designed “to regulate the carriage of passengers in steamships and other vessels, for the better protection of female passengers.”⁷ This act represented the wide-ranging shield that Archbishop Hughes wanted for Irish victims of sexual violence. While this law stopped neither shipboard rapes nor sexual assaults on land, it did codify whiteness for Irish women who had experienced American anti-Irish discrimination.

The most intimate details of poor Irish immigrant women’s medical and reproductive lives could not escape public discourse, largely because social welfare and reform issues focused on immigrants in the northeastern cities where most of these women lived. Comparable to southern enslaved women whose bodies fueled the advancement of the field, Irish-born women’s bodies helped to create a nascent urban social-welfare system and to a lesser degree, maintained American gynecology as a dynamic branch of medicine.

One group in particular held special interest for men interested in collecting statistical data and gaining a better understanding of sexuality, criminality, behavior, and race: Irish prostitutes. Lacking skills, family support, and opportunities, and having been sexually abused on ship, many Irish women immigrants turned to prostitution to earn a living. Public health officials, Irish

nationalists, Catholic leaders, and government workers were aware of the sustained sexual abuse that Irish women faced at sea and on land. Thus the establishment of hospitals and institutions devoted to Irish women's medical care was an integral component of Irish American community building. More importantly, the institution building that occurred moved Irish-born women closer to middle-class respectability. White northerners, including abolitionists, did not offer free black women who engaged in sex work the kind of brick-and-mortar institutions that were meant to mold them into respectable ladies. Irish immigrant women occupied the bottom rung of the economic ladder alongside black women, yet they still benefited from the existence of an affluent Irish-Catholic community that was concerned about their care. Institutional assistance was especially prominent as the field of gynecology's developed and sex workers, needing medical care, suffered from a number of sexually transmitted infections. It is important to note that not all Irish immigrant women were sex workers or victimized, and some might very well have been sexually liberated in their private lives despite the controlling influence of the church and other charitable institutions.

The notion of owning one's own body loomed large for impoverished Irish immigrant women for many reasons. Many women were forced to sell their bodies to men who claimed possession of them as pimps. Many others worked as little more than wage slaves as domestics, factory workers, and street peddlers, which often meant that their bodies, mobility, and autonomy were at the disposal of their male bosses. Accordingly, Irish women's roles as sex workers (whether assumed to be voluntarily or not) posed a growing social problem for nineteenth-century reformers. Sex work was dangerous, placed women at great risk for contracting sexually transmitted infections, and also marked them as immoral. John Francis Maguire, writing about the entry of the Irish into America, states, "*Innocent and unprotected girls, came consigned to houses of prostitution.*"⁸

Although no comprehensive studies exist that determine how Irish women sex workers contracted sexually transmitted infections (largely because germ theory had not been discovered and infections contracted from sexual contact could be difficult to diagnose), it is likely that many of these infections were caused by sexual violence.

Leading the charge for moral reform was the Catholic Church, which sanctioned the opening of many privately owned hospitals and almshouses. Poor Irish immigrant women used institutions such as New York City's Saint Vincent's Hospital to attend to their spiritual and physical needs. Not only were these institutions medically necessary resources for this immigrant group, but they also served as physical testaments to the desire of Irish people to prove that they were not deviant and, in fact, wanted to improve their condition

in America. For the women who used them, the act of choosing where to be treated medically was one of the ways they claimed ownership of their bodies and medical experiences.

In 1850s New York, the Irish Catholic Sisters of Mercy would “nurse the newly arrived so they would be healthy enough to perform hard labor in a few weeks’ time.”⁹ Catholic groups like the Sisters of Mercy, Sisters of the Good Shepherd Convent, and the Sisters of Charity proved indispensable to thousands of Irish-immigrant women. Historian Jean Richardson points out that northern “antebellum hospitals did not profess to cure illnesses, but rather warehoused the poverty-stricken sick” who were either homeless or lived in unsanitary tenements unfit for recovery.¹⁰ In contrast, the Catholic organizations that devoted themselves to caring for Irish immigrant women made every effort to heal them. The House of the Good Shepherd, the charitable outgrowth of the Sisters of the Good Shepherd, was a controversial charitable antebellum organization because of its focus on aiding Irish prostitutes.¹¹ Prostitutes would use the House of the Good Shepherd when they needed housing and medical attention, “particularly for sexually transmitted diseases.”¹²

In 1857, William Sanger, a well-known medical doctor, researched the history of prostitution and sexually transmitted diseases in the city. He published statistically driven scholarship that illustrated the sheer volume of venereal disease cases reported by a range of professionals from New York institutions offering medical services. He noted that as a matter of practice, many physicians treated venereal cases “under some other name” in their official reports.¹³ They renamed sexually transmitted diseases because several public dispensaries and hospitals had regulations forbidding the admission of venereal patients. Sanger noted that the trustees at a hospital in a New York sister city, “which receives a yearly grant from public funds, has in its printed rules and regulations: ‘No person having “Gonorrhea” or “Syphilis” shall be admitted as a charity patient.’”¹⁴ One can speculate that this hospital’s nonadmission policy on syphilitics and those with gonorrhea was predicated on moral beliefs about a person’s character based on the sexual nature of these infections. Other facilities such as prison hospitals could not institute discriminatory admittance policies. The census figures of those inmates who were recorded as having “venereal diseases” were far greater than those of most hospitals. As the resident physician at Blackwell’s Island, a correctional facility, Sanger found that incarcerated women had higher rates of sexually transmitted infections than those who were not imprisoned. These institutions tended to house a disproportionately large number of Irish immigrant women. In his study, Sanger compiled an index of most of the venereal patients treated in New York City—area hospitals and dispensaries in 1857. Table 4.1 lists the reported figures from hospitals for women patients.

TABLE 4.1 Number of Reproductive and Sexually Transmitted Illnesses in Greater New York City

<i>Institutions</i>	<i>Cases</i>
Penitentiary Hospital, Blackwell's Island	2,090
Almshouse, Blackwell's Island	52
Workhouse, Blackwell's Island	56
Penitentiary, Blackwell's Island	430
Bellevue Hospital, New York	768
Nursery Hospital, Randall's Island	734
New York State Emigrants' Hospital, Ward Island	559
New York Hospital, Broadway	405
New York Dispensary, Centre Street	1,580
Northern Dispensary, Waverly Place	327
Eastern Dispensary, Ludlow Street	630
Demilt Dispensary, Second Avenue	803
Northwestern Dispensary, Eighth Avenue	344
Medical Colleges	207
King's County Hospital, Flatbush, Long Island	311
Brooklyn City Hospital, Brooklyn, Long Island	186
Seaman's Retreat, Staten Island	365
TOTAL	9,847

Source: Sanger, *History of Prostitution*, 593.

Unfortunately, the statistical data on the medical lives of Irish-immigrant women is scant when compared to the data on enslaved women, and the reliability of these figures is problematic for many reasons. Despite the ambiguity of Sanger's figures on racial identity and disease, they still provide enough information for contextualization. Poor and immigrant communities were frequently overpoliced, and their members were incarcerated more often than the general population. The figures reported do not provide an exact calculation of how many of these patients were Irish born. However, with the disproportionate number of Irish women who were imprisoned because of prostitution, it is likely that a large percentage of these prisoners were of Irish descent. Further, these alarming statistics point to the roles and growing importance of medical professionals who treated women suffering from sexually contracted infections and reveal how poor white women's sexual labor was linked not only to vice but to disease.

Irish immigrants were familiar with dehumanizing descriptions of them that compared them to Africans and apes. In essence, they were used to anti-Irish Anglo racism, and connections were constantly made through public

discourse and in the writings generated in the medical and scientific worlds to illustrate the limitations of their whiteness and the relative close ties they had with blackness. As anti-Irish and antiblack racism gained a larger platform, obstetrics and gynecology became another area where white antebellum-era medical men could make claims about gender, difference, and race with scientific authority.

During this same era, the entrance of American gynecology as an emerging medical specialty dependent on women's sick bodies made Irish-born women an attractive patient population for northern-based doctors who had begun to work primarily on women. Some gynecologists like James Marion Sims, who had previously worked within slave communities, extended their surgical work to include Irish women in the charity wards of northern hospitals. For southern migrants like Sims, it was not much of a stretch to treat poor Irish women patients as he had enslaved women because much of the Anglo world's racial science, popular literature, and racially biased views of this group held that Irish women were able to withstand physical pain just as black women could.

The case of Mary Smith, Dr. Sims's first New York State Woman's Hospital patient, exemplifies how poor Irish women had to navigate a medical system in which doctors explained women's biological sicknesses in ways that also gave meaning to women's nature and the world men and women occupied. Medical historian Charles Rosenberg states, "Explaining sickness is too significant—socially and emotionally—for it to be a value free enterprise."¹⁵ Dr. Sims's Woman's Hospital could not be a neutral healing space, for it separated rich women from poor women and endowed only men with the liberty to become experts on women's diseases. When Sims asserted that the New York hospital would become "a place in which [he could] show the world what [he was] capable of doing," he was also claiming that his hospital would serve as a site for his personal and professional aggrandizement.¹⁶

Mary Smith was an Irish immigrant from western Ireland, the country's poorest region, and had arrived in New York as a single mother and a poor sick woman. She would come to represent thousands of poor Irish immigrant women who were connected to New York City's hospitals. Historian Bernadette McCauley states, "By midcentury, the patient population at city hospitals was overwhelmingly foreign-born. . . . By 1866, more than half the admissions had been born in Ireland."¹⁷ Hospital administrators, some of whom might have harbored nativist sentiments against foreign patients, sometimes created hostile environments for Irish immigrant patients like Mary Smith. One Massachusetts General Hospital trustee member claimed that the Irish, as a group, were ignorant and unappreciative medical patients.¹⁸ He stated, "They cannot appreciate & do not really want, some of those conveniences which would be

deemed essential by most of our native citizens.” He believed that sick Irish men and women would be more comfortable and appreciative if they were treated in a “cheap building” instead of more expensive and well-maintained hospitals.¹⁹ Living in 1850s New York City, Smith had to have been aware of anti-Irish sentiments held by New Yorkers, and perhaps because the Woman’s Hospital was new, she sought services from a hospital that did not have a history of anti-Irish nativism.

As a homeless and sick immigrant woman with severe gynecological ailments, Smith sought treatment in the charity ward of the newly opened Woman’s Hospital of the State of New York in 1855. Her name was the first one listed in the hospital’s admittance records.²⁰ Smith developed her reproductive and gynecological conditions in Ireland. She had first given birth at twenty-one years old, and she described both her labor and delivery as difficult. By the time she immigrated to Manhattan, complications from her earlier delivery had caused Smith to develop the worst case of obstetrical fistula that Dr. Sims had ever seen. While performing a pelvic examination on Smith, Sims and his protégé, Thomas Addis Emmet, noticed a strange mass in her upper vaginal area. The surgeons excised a fishing-net covered wooden ball, used as a pessary, from her scar tissue. The ball, which had been inserted while she lived in Ireland, was used to keep her fallen womb inside her body. Additionally, she had a herniated bladder that had also prolapsed. She had become incontinent, her vulva had been rubbed raw because of urine leakage, and her stench, caused by rectal and vaginal incontinence, made her a “most offensive and loathsome object,” according to Sims.²¹

As he had during the mid- to late 1840s with his enslaved experimental patients, Sims operated on Smith numerous times without anesthesia in front of many onlookers. In Smith’s case, Sims and Emmet performed thirty surgeries on her over a period of six years. Although Sims left the country in 1859 to perform gynecological surgeries such as clitoridectomies in Europe, his junior colleague, Thomas Emmet, continued to work on Smith until the early 1860s. Over this period of time, Sims operated on Mary Smith even more frequently than he had on his enslaved patients. Additionally, Smith was allowed to work in the hospital performing menial labor just as Sims’s enslaved patients worked under his watchful eye in the Alabama fistula-repair hospital he had had built for them.

As a southerner and former slave owner, James Marion Sims, along with his Virginia-born junior colleague, Thomas Emmet, was familiar with surveilling women’s bodies, especially those who fell outside the bounds of racial and class normativity.²² As in Alabama, Sims eventually lost the support of his community at the Woman’s Hospital, particularly fellow doctors and board members.

The Woman's Hospital's Board of Directors threatened to dismiss him because of the number of onlookers in the medical theater during operations.²³ It is unclear whether the board threatened Sims with dismissal out of respect for patients, or if it was a case of order for the hospital.

Although Sims was reliving some of the same infamy he had experienced as a doctor to slave women, he did diverge from his usual practices with regard to publications. He did not publish any articles about his surgical work on Mary Smith, even though his early surgical interventions with her were successful. For a doctor who was such a prolific medical writer, it is confounding that Sims did not seek publication on this set of fistula surgeries. Perhaps he remained silent about this case because he had botched his last surgery on Smith's vulva and vagina. Sims had removed bladder stones from her, and in his attempt to do so, he had irreversibly ruined the meticulous surgical work that Emmet had performed on Smith during Sims's residency in Europe. Sims's mistake created another fistula and damaged the tissue surrounding Smith's urethra. He abandoned his treatment of her and left her in almost the same physical shape in which he had initially found her over five years prior. Sadly, she died two years later, as a "common street beggar" not far from the Woman's Hospital.²⁴

The staggering numbers of poverty-stricken Irish immigrant women like Mary Smith, who suffered from various physical ailments, helped to create an urban nascent welfare system. One of the thrusts of this kind of northern reform was to provide medical care for the poor, and immigrants overwhelmingly constituted this lot. Historian Kevin Kenny notes that in New York, the majority of Irish-born people lived in the city's poorest wards, the "First, Fourth and Sixth," amid deplorable living conditions. Kenny also found that by the "1850s, as many as 30,000 Irish men, women and children, could be found living in cellars in New York City, without light or drainage." The Irish "accounted for an estimated 70 per cent of the recipients of charity and over 60 per cent of the population of almshouses."²⁵ As a result, nineteenth-century antebellum-era Irish immigration was markedly different from earlier cycles of European immigration. Irish immigrant women tended to be single and older than previous European women immigrants entering the United States. They were also poorer as a whole; by the 1850s, the Irish made up 51.2 percent of poorhouse populations in Buffalo, New York.²⁶ Popular newspaper editor Hezekiah Niles, a nativist, wrote a number of articles detailing his disdain for the Irish because they, in his estimation, overcrowded city almshouses and were an economic burden on communities collectively and specifically on native-born white Americans.²⁷

Already dealing with racist ideas about themselves as "lustful" and "hyper-sexed" creatures, poor Irish-born women also suffered from a prevailing

dogma that they were incapable of exercising self-control. The fact that a disproportionate number of poor Irish immigrant women worked in the sex trade placed many of them in the position of becoming single mothers. Unlike slave women, there was little “worth” attached to Irish women who birthed children as single women. A reporter with the *New York Independent* sarcastically wrote, “Did wealth consist in children, it is well known, that the Irish would be rich people.”²⁸ In an examination of sex and reproduction, Helen Lefkowitz Horowitz writes, “An important motive behind understanding the sexual body in the nineteenth century arose from the drive to control reproduction.”²⁹ Although white Americans were concerned with Irish women’s high birthrates, their concerns and consternation did not result in total control of Irish women’s reproduction as it did for enslaved women. In the American imagination, Irish women immigrants, like black women, embodied unbridled sexual immorality. Due to the disproportionately high rates of Irish immigrant women who were jailed because of prostitution and the high number of births outside marriage among them, this group of women seemed to perfectly fit the country’s idea of the sexually promiscuous and deviant woman.³⁰ So within this context it is understandable that Hezekiah Niles had such animosity toward the Irish.

Similarly to journalists, medical doctors were also publishing articles that extended the anti-Irish critique to describe the sexual lives and gynecological conditions of Irish women. In these journals, doctors used revealing language that was strikingly similar to speech they employed to detail enslaved black women’s bodies and sexual behaviors. In an 1838 article in the *American Journal of Medical Sciences*, Dr. J. B. S. Jackson related a conversation that his colleague, Dr. Ezra Palmer, had with an Irish patient at the House of Industry in South Boston, a poorhouse.³¹ The Irish woman was questioned after the death of her German roommate. The patient shared that the twenty-five-year-old German woman intimated to her that she “had a child in her own country.” Jackson did not believe the Irish woman’s account. He wrote, “As will appear by the dissection, this must have been impossible. . . . She was never married, and . . . she was the daughter of a respectable farmer; the story may have been fabricated by the person who told it, from the love for falsehood which many of the low Irish seem to have.”³² The autopsy later revealed that the German woman was hermaphroditic; she did not have a uterus. The doctor privileged his class biases over the possibility that the daughter of a “respectable farmer” might have lied about motherhood.

These kinds of medical experiences were happening throughout the North. In 1840 Pennsylvania, Dr. George T. Dexter was asked by a colleague to examine an eighteen-year-old Irish girl who suffered from persistent hiccups that caused her to convulse violently.³³ What transpired over the next few

months proved so unsettling for the patient that she ran away from her home, the site of her medical treatments. After several visits over a period of about two months, a nurse informed Dexter that the girl had wanted “to cut off a wart on her leg.”³⁴ He soon discovered from the patient that she had several warts, but they were “genital” warts. The teen told the doctor that when she “cut them off the hiccough subsided.” She then confided that she had been masturbating for two years to stop the hiccoughs. It was after her confession that Dr. Dexter determined he needed to “test” the veracity of her statements. His assessment included pressing “gently but firmly upon the clitoris outside her linen, with [his] my hand, and the convulsions gradually subsided, and she went to sleep.”³⁵ During the next day’s visit the girl informed Dexter that her hiccups were caused this time because she hit her back against her bedpost. Dexter decided that clitoral stimulation would stop her hiccups and spasms. His clitoral-based treatment went on for nearly four months. This was a strange curative practice for a doctor to choose, for he had derived, from his patient’s revelations, that masturbation caused her hiccups.

Dexter was allegedly disgusted by the details of the girl’s masturbation, although he continued questioning her about the practice. He stated, “She did not seem to have any hesitation in answering my questions.” He even added in his notes that the young woman revealed to him, “so great” was her “venereal passion, that she carried to bed with her, a constant companion, a large piece of *wood shaped like a penis*” (italics in the original).³⁶ As exceptional as this case is, it becomes even stranger. Not wanting to be “deceived,” Dexter brought in several of his “professional brethren” to examine and treat the teenager. They found that her hiccups and spasms were caused by spinal pressure, and the cure was genital stimulation. The doctor also believed she was unaware of her “depraved condition” because she was a member of a local religious society that he considered immoral. The course of treatment stopped, not because Dexter and his colleagues ended it but because the girl “left town.” He seemed surprised that “she did without informing” him “of her intention to do so.”³⁷

The fact that George T. Dexter could publish a “Singular Case of Hiccough Caused by Masturbation” in a leading medical journal exemplifies how Irish women’s sexual lives, like black women’s sexualities, could be discussed indiscriminately, bluntly, and easily. Dexter’s Irish immigrant patient experienced a twofold gaze: a metaphorical one from the medical journal’s readership and a literal one from the team of doctors assembled to “cure” her of her “venereal passions” and hiccups.³⁸

Like the pregnant enslaved woman mentioned in the first chapter whose genitalia were exposed publicly as she lay bleeding on the kitchen floor of her master’s house, the treatment of the young Irish woman demonstrates how

doctors treated and wrote about black and foreign-born women without thought to their sensibilities. In journal articles, black and Irish women served as flesh-and-blood symbols of biological abnormalities linked to race. This act of framing was a function of the social process of not only defining difference but also identifying how to respond to “otherness.” As a medical doctor, Dexter could link disease to socially unacceptable behavior such as masturbation, a “capricious” attitude, and even running away from home secretly. Although he and his peers relied on masturbation to cure this woman, in Dexter’s article, only the patient was deemed sexually deviant. However, the tenor of these men’s writings reflects their belief that racial difference existed between them and the patient. Also, at the heart of the doctor’s anger over his patient’s running away from home was his consternation that he could not continue treating her and could only guess the specific causes of her condition and not name it definitively. As medical historian Charles Rosenberg argues, “If it [illness] is not specific, it is not a disease, and a sufferer is not entitled to the sympathy . . . connection with an agreed-upon diagnosis.”³⁹

Medical journals and the rise of gynecology allowed a new group of professionally trained doctors legitimate spaces to introduce and strengthen their racialized attitudes concerning the medical lives of racially stigmatized people and their supposed pathologies. Specifically during the antebellum era, an emergent class of gynecologists and other doctors integrated science and biology as they framed and defined diseases, gynecological ones included. Through their medical practices and professional writings, they began to define medicine. Medical educator Alan Gregg describes these men’s work as “the study and application of biology in a matrix that is at once historical, social, political, economic, and cultural.”⁴⁰

As scientific racism became bio-racism, many early American gynecologists were participating in creating theories about race and gender, especially about black and white women although they knew that these women’s physical bodies were intrinsically the same. Bio-racism integrated both medical and scientific research to prove how biologically distinct black and white people were from each other. Antebellum-era white supremacy did not allow a space for one to address this kind of racialized cognitive dissonance. For example, Charles Meigs, a noted Philadelphia gynecologist, shared with his students the following assessment of women via his published lectures. He stated that a woman was “a moral, a sexual, a germiferous, gestative and parturient creature.”⁴¹ Although he did not describe women racially, the racial climate and etiquette of the day dictated that he was referring to the white woman as the universal representative model for all women. Yet it was the preserved womb of a black cancer victim that Meigs displayed in his Philadelphia museum as a

teaching tool for his colleagues to learn how cancer affected all women's uteri. The universal template for woman might have been white, but the fluidity of nineteenth-century racial categories could expand to include whoever fit a doctor's medical needs at any given time.

Pioneering gynecologists like Meigs knew the importance of medical writings within society. Their publications helped their peers understand the varied medical experiences of Irish women. Historian Alan Kraut has reported how doctors compared Irish immigrant women patients to other European immigrant women. One doctor wrote, "Germans were praised [because] . . . they seemed 'docile and affectionate' to the doctors . . . the reverse was said of the Irish." Another doctor described a mentally ill Irish patient as having "nymphomania," and he linked the disorder to her morality. He described her as "vulgar," just as Dr. Dexter characterized his Irish teenage patient as immoral.⁴² Clearly, the public nature of these women's sexual behaviors made them easy targets for doctors to moralize against them. Medical men also knew that these women were not "normal" by nineteenth-century definitions, and yet these women were further penalized for their Irishness.

These medical journal articles also inform scholars about how indigent Irish-born women made decisions about their bodies and responded to medical procedures they underwent as a result of lengthy hospital stays. In 1844, C.C., a nineteen-year-old pregnant woman, was admitted to the Philadelphia Almshouse and Hospital to deliver her child. Dr. George Burnwell, the physician who treated her, described C.C. using three adjectives, "short, stout Irish."⁴³ Arguably, Burnwell used a lexicon that linked race and class and inferred that despite the obstetrical problems that the pregnant teenager might have had, as an Irish woman, she was strong and healthy. C.C. represented a flesh-and-blood metonym for the urban white scourge: she was a poor, unmarried Irish woman who relied on charity during her pregnancy and childbirth.

Nineteen hours passed, and C.C. had still not given birth. Alarmed, doctors bled the young woman and administered ergot, a rye-based pharmaceutical that was used to induce uterine contractions during deliveries. After two days, Dr. Burnwell knew that C.C. would deliver a stillborn baby; he had to surgically remove her fetus. Immediately after he began the procedure, the young woman's "uterus fell away," and doctors administered stimulants to revive her.⁴⁴ She entered the hospital to give birth and left the building childless and sterile.

Like C.C., Irish immigrant women created and responded to the interventions made into their medical lives in various ways. Some obtained professional medical help, some entered the field of nursing, some relied on home-based traditional medicines, and some sought solace away from the formal medical gaze of white men. It is important to understand this group of women within the

context of a comparative medical model that highlights how modern American gynecology impacted their lives. Historians of the antebellum era have drawn comparisons between the oppression of enslaved people of African descent and that of poor Irish immigrants for several generations in their scholarship on whiteness, race, politics, and identity. This scholarship has centered on the development of black and Irish nationalism, the political economy of slavery, and the wage slavery that recently immigrated Irish laborers suffered under during the nineteenth century. Yet the medical lives and experiences of Irish immigrant women were not parsed for careful analytic review.

Labor relations were sometimes present in boss-doctor-patient exchanges. It was a common practice that employers intervened on behalf of their domestic servants if the women were exceedingly ill. During the mid-1860s, Mary McC.'s boss sent the twenty-one-year-old Irish cook to be examined by leading gynecologist Dr. T. Gaillard Thomas at either Bellevue or Charity Hospital in New York City.⁴⁵ How could Mary McC. decline the services of Dr. Thomas if she had no initial say in selecting him as her physician? Young Irish immigrants did not have a long American culture of traditional and naturalistic health care as did enslaved women. Clearly, when writing about the ethical policies that governed doctor-patient relationships, the AMA conveniently imagined patients as either white men or white women. The poor and immigrants who were relegated to tenement living seemed not to be considered by doctors; they lay outside the power structure where medical men could only negotiate and barter power with white men and perhaps elite white women.

The starkest difference that existed in the treatment of these enslaved black women and Irish immigrant women lay in what happened to them after their surgical encounters. As their sick bodies were healed, black women returned to slave communities to toil. Poor Irish women's improved health status allowed them to continue to work for wages as free women. Thus, the development of the domestic service industry in northeastern cities like New York and Boston has a direct link to the work of early gynecologists. These men were responsible for "fixing" Bridget's body ("Bridget" was a derisive name for Irish women).

Irish women who married and gave birth to children were afforded opportunities to improve their lots in life because they were not owned, no matter the dire circumstances they faced. They did so by vending, educating their children, and marrying native-born American white men. Many second-generation Irish women became nurses and teachers because of the efforts of their mothers. Further, the American-born daughters of Irish immigrant women did not face the risks of sexual abuse that occurred aboard ships sailing from Ireland to America. This situation also heightened the differences between the daughters of poor immigrants and enslaved women. Enslaved

girls would always be subject to the same abuse that their mothers had suffered and could not rely on education to better their situation. Although many Irish immigrant servants, like their enslaved sisters in the South, were at the mercy of sometimes-unscrupulous employers who took advantage of them sexually, the fact remained that Irish immigrant women could choose to leave their employers. Throughout northern cities, the number of Catholic-run charitable organizations located in Irish tenements directly dealt with issues of sexual abuse. Slave women did not have the same kind of formal mechanisms in place to deal with complex and damaging issues like rape and molestation by their owners.

Irish immigrant women also relied on the Catholic Church to be involved in their healing. The reality for this group of women was that, unlike enslaved women, they could integrate their religious beliefs into the formalized hospitals they used. Irish Catholic sisters and the subsequent charitable organizations that they ran created “cultural sites” for healing to occur. To combat nativists’ beliefs that the Irish would be “a permanent dependent class in America,” these Irish-Catholic spaces proved that Irish-born women could be enterprising, productive, and “clean” citizens.⁴⁶

Sick women who battled gynecological illnesses or who had complicated pregnancies were often at the receiving end of doctors’ maltreatment. Mary Donovan, a pregnant woman with a spinal deformity, was one of those whom Dr. George Elliot, a Bellevue Hospital physician, recognized as needing his medical assistance. Elliot treated her in March 1857 and published a medical article about her birthing process with language bloated with descriptors that demeaned her body, intellect, class, and ultimately her race. While the doctor might have simply written clinical notes in dry and apolitical technical language, Elliot’s records of Donovan’s case demonstrate just how pervasive nineteenth-century ideas about biological differences were in women’s medicine.

Elliot first wrote his patient’s name, Mary Donovan, and the second word he used to describe her was “Irish.” He observed that the thirty-year-old first-time mother “attracted [his] observation . . . by her deformity.” After querying Mary for a few minutes about her pregnancy and her spinal deformity, Eliot determined she was a woman who possessed a “very low order of intelligence” and was “apt to exaggerate.” Eliot wrote that most of the pregnant women in the charity lying-in ward, where Donovan was hospitalized, lied about the dates they had become pregnant so that they could keep receiving “charity.”⁴⁷

After Donovan was informed that she would probably endure a difficult delivery, she gave Elliot her consent to quicken her delivery by administering a warm-water douche to induce labor. The doctor initially wanted to administer carbolic acid gas but decided against it due to time constraints. (Doctors in the 1850s used carbolic acid gas for the “treatment of painful affections of the

uterus” and to “induce artificial *accouchement*” or labor.)⁴⁸ Once the treatment began, Donovan offered “insane struggles” to stop the douching. She fought so vigorously to release herself from the restraints of the medical staff that Elliot finally administered chloroform to calm her.⁴⁹ After two days of the douche treatment, Donovan delivered a son on March 23, 1857, but he died a few hours later.⁵⁰ During Donovan’s treatment, four other doctors observed her along with Elliot. Her case was later used as a pedagogical tool in the pages of *New York Medical Journal* so that other physicians could learn how to perfect his douching method on other pregnant women. Elliot described Donovan as a patient who was violent, dumb, and defective, but her body provided a pathway for doctors to learn more about all laboring bodies even though she lost her baby in the process of his treatment.

Some Irish immigrant women acted outside gendered ideals and possessed physical abnormalities that encouraged doctors like Elliot to use women such as Mary Donovan to establish a race-and-religion-specific matrix that exceptionalized poor Irish-born women. Descriptions of Irish immigrant women in the medical literature are remarkably similar to the way doctors wrote about enslaved women’s bodies; black women were either amazingly strong or weakened when “white” blood was apparent. The *Georgia Blister and Critic*, an antebellum-era medical journal, published an excerpt of *Types of Mankind*, a book about mulatto women authored by controversial physicians Josiah Nott and George Gliddon. The article illustrates how some physicians used their writings to promote scientific ideas about biological distinctiveness. Nott and Gliddon wrote “that the *mulatto women* are peculiarly delicate, and subject to a variety of chronic diseases. That they are bad breeders, bad nurses, liable to abortions, and that their children generally die young.”⁵¹ One Irish physician wrote about the so-called peculiarities of pregnant Irish women in the *Boston Medical and Surgical Journal*. He urged doctors to rely on the traditional practice of bloodletting on pregnant Irish women because of “the strong, almost insurmountable obstinacy of the Irish with us.”⁵²

Some Irish immigrant women were like Eliza B., a thirty-five-year-old Irish nanny who suffered from gynecological ailments but resisted the absolute authority of medical doctors.⁵³ Eliza, who was single, suffered from the pain of an enlarged ovarian cyst for eighteen months. Her attending physician, Dr. T. Gaillard Thomas, one of the country’s leading gynecologists, initially described her as possessing a “morbid disposition.” The first physicians she saw misdiagnosed her as being pregnant. Eliza B. lived with severe abdominal pain for two years. Perhaps her “morbid disposition” arose from the fact that doctors initially dismissed her pain. She finally checked into a hospital on November 1, 1862, and agreed to undergo an ovariectomy.⁵⁴

The medical case of Mrs. F., a thirty-five-year-old mother of three who lived in Philadelphia, demonstrates how Irish immigrant women relied on each other and asserted their autonomy in obstetrical and gynecological cases.⁵⁵ Apparently very busy, Mrs. F. experienced a violent fall as she held her “quite heavy” infant while she attempted to use her chamber pot.⁵⁶ Unfortunately, she was well into her fourth pregnancy. Dr. Gegan visited her on the morning of January 30, 1859, to examine her. She had lain on her right side for twelve hours because she was in such immense pain, was weak, and was vomiting. During his visit, he determined that she must have ruptured her uterus even though he “could not reach the os uteri [cervix opening].”⁵⁷

At one o’ clock the next afternoon, Gegan asked if Mrs. F. believed that her child was alive. She stated, “I feel it all the time.”⁵⁸ After the physician left, she called her circle of women friends to nurse her during his absence and also to provide community care during her medical crisis. Trusting her five friends to safely change her position in the bed, Mrs. F. asked her them to physically turn her body on her left side. Upon Dr. Gegan’s arrival that night, she hastily offered an excuse for why her friends were lifting her; she allegedly felt “much better” and no longer suffered from “soreness on the right side.”⁵⁹ A few hours before her death, Mrs. F told the doctor that “she could distinctly feel the child move.”⁶⁰ Shortly after 7:30 P.M. on January 31, 1859, Mrs. F. died.

Dr. Gegan noted that the late patient’s husband was quite moved by his wife’s statement. The doctor remarked that Mr. F. agreed, only after his wife’s death, “that I should attempt the removal of the child, by abdominal incision.”⁶¹ Dr. Gegan respected the husband’s wishes regarding the performance of an autopsy. The politics of nineteenth-century respectability were being performed fully. Women were almost always seen as meddling when involved in male affairs, yet the doctor allowed “four or five” of Mrs. F.’s women friends to comfort her even while he was present. The doctor treated his Irish patient as a white “lady” for reasons he did not disclose, but one can assume she was accorded respect because she was married and perhaps so desperately wanted her child to live.

In another obstetrical case involving an Irish immigrant obstetrical patient, surgeons at the Philadelphia Hospital aided “Alice Mailey during her delivery.” In 1859, Mailey was placed under the care of nurses and physicians at the Nurse’s Home.⁶² She was twenty-nine years old, unmarried, primiparous, and considered healthy. Like the pregnancies of many women of the time, however, Mailey’s became complicated. She was placed under the care of Dr. D. Hayes Agnew, one of the nation’s leading surgeons. In a medical journal article, Agnew described Mailey’s childbirth as “severe.”⁶³ During her protracted delivery, her uterus “ruptured,” and the fetus shifted “into the abdomen.”⁶⁴ The

baby was delivered stillborn, and the mother was left with a “rent in the uterine walls” that had “extended through the cervix, and involved the vesico-vaginal fistula septum, giving rise to a fistula [hole].”⁶⁵ Agnew operated on Mailey four times, first at the Nurse’s Home and later at Saint Joseph’s Hospital, for the repair of her vesico-vaginal fistula.⁶⁶ After Mailey’s recovery, Agnew reported that she not only “enjoyed comfortable health” but also was “able to support herself as a servant in a private family.”⁶⁷

These immigrant women’s medical experiences show the range of treatment that Irish women received from doctors, from sympathetic to bigoted, and highlight some of the differences between their situations and that of enslaved women. Whiteness was extended to Alice Mailey, Eliza B., and Mrs. F., an act that no enslaved woman was ever given in the antebellum era.

By the early 1860s, as political definitions of blackness and whiteness were becoming firmer, native-born white Americans began to slowly extend a few privileges of whiteness to Irish women. However, early gynecologists were still writing about their bodies as if they were more “colored” than white. As Americans continued to cultivate their brand of nationalism, medicine and medical writings served as sites where race was being reified. After the Civil War, legislators in the former Confederate states created Black Codes, laws that used language from scientific racism to distinguish black people, white people, and “mulattos” from each other. Gynecologists who wrote about biological differences helped to create the environment from which those racist laws sprang. In their writings, they proclaimed that elite, native-born white women were fragile, normal women. Irish and black women, in contrast, were described as physically stronger and more sexual, and they were believed to suffer reproductive ailments at different rates than white women did. It was a nearly universal belief that black women and Irish women were more fertile than their white counterparts. Early gynecologists continued to promote the idea that these women were apelike and “more suitable” for gynecological experiments than white women.⁶⁸ Historian Laura Briggs has noted the contradictions in early gynecologists’ writings about immigrant women and black women, who were supposed to have easier childbirths. Early gynecologists’ writings featured Irish women who had protracted labors that lasted for days and were so difficult that medical men were involved, an unusual practice during the nineteenth century.⁶⁹ Often Irish women were mentioned in articles about the effects of multiple births. Dr. William Potts Dewees, one of the country’s most prominent obstetricians, saw one married Irish woman, Mrs. Haley, in July 1830 and detailed her fecundity and gynecological conditions. Haley was sixty years old, the mother of sixteen children, and apparently was still suffering from her many pregnancies. Potts Dewees wrote that his patients had

“suffer[ed] 3 abortions, early labour . . . she ha[d] suffered with the present prolapsus the past 6 years.”⁷⁰ Regardless of the contradictions they contained, medical writings about immigrant and black women represented one of the most popular sites for ideologies about black and white biological distinctions to be introduced and discussed.

Medical doctors and scientists who researched biological differences among the “races” connected Irish women to black women for reasons ranging from their supposed superior physical strength to their fecundity. By the end of the nineteenth century, physicians like Lucien Warner were thoroughly convinced that black and Irish women shared the same reproductive capabilities and superior health. Warner posited, “The African negress, who toils beside her husband in the fields of the south, and Bridget who washes, and scrubs, and toils in our homes at the north, enjoy for the most part good health, with comparative immunity from uterine diseases.”⁷¹

Gynecologists’ construction of black and immigrant women’s reproductive bodies as “medical superbodies” was a means to make sense of these women medically and also a rationale for how they were to be treated outside medical spaces. As noted in an earlier chapter, James Marion Sims’s father expressed disappointment with his son’s decision to pursue medicine. He believed there was no science, respect, or honor in the field. So for men like Sims who were as committed to healing patients as they were to establishing respectable, honorable, and lucrative careers, more than medical knowledge was at stake. They were contributing to the greater good by using bodies that were “fit for labor” to heal all bodies. Black lives mattered medically because they made white lives healthier and better. It was important for journal readers to know how these women, the unrecognized and often unnamed “mothers of gynecology,” responded to examinations, surgeries, experimentations, and even recovery because this knowledge enabled white men to more easily grasp science-based theories that explained why blackness, and to a lesser degree, Irishness, was so strange and pathological. The addition of disenfranchised Irish immigrant women to biomedical explorations of racial otherness did not explode existing categories but rather continued discussions about these women as one-dimensional objects to be understood without nuance. The medical narratives that were created based on these women’s gynecological treatment helped to further perpetuate the uneven cultural productions on biologically based racial difference. Racial categories were still being processed in the antebellum era, but modern American gynecology’s growth worked to lay a foundation on which both blackness and whiteness would be defined as separate and unequal for generations. The black female body was central to these discussions and medical knowledge productions.