

Spring 2019

The History of Gynecology Through an Intersectional Lens

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Recommended Citation

Williams, Madeleine, "The History of Gynecology Through an Intersectional Lens" (2019). *Writing Excellence Award Winners*. 81.

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GQS 494

The History of Gynecology Through an Intersectional Lens

In 1845, three slave women named Anarcha, Lucy, and Betsey were brought to the home of Dr. James Marion Sims. Anarcha, Lucy, and Betsey were given to Sims by their enslavers with instructions to treat them for vesico-vaginal fistula, a condition typically caused by traumatic or prolonged birth. At the time, no cure existed for the condition. Sims proceeded to perform experimental surgeries on the women for four years, all without anesthesia. Anarcha endured thirty operations alone before Sims declared that she had been cured.

Sims subscribed to beliefs that were commonly held by physicians and laypersons about biological differences between black and white bodies. Sims believed that black women had a lower sensitivity to pain, and this, to him, justified his experiments. Sims has historically been portrayed as the “father of gynecology,” and there have been statues of him in multiple places around the country.

My thesis investigates Sims’ practices and beliefs using works from a number of authors, including C. Riley Snorton, Diedre Cooper Owens, Harriet Washington, and Hortense Spillers. Spillers wrote of a concept called *pornotroping*, in which captive bodies are stripped of their identities, cultures, and humanity and are reduced to their physical anatomy, what Spillers calls *flesh*. In my thesis I also examine how these topics connect with current medical practices. While most of us can agree that this story is horrific, Sims’ practices live on in medicine today.

I discuss numerous studies that have shown that black women are at risk for a number of obstetric and gynecological conditions, are less likely to receive appropriate treatment, and are more likely to have complications and die. While there are many social and cultural factors that may contribute to these disparities, such as access to care and chronic discrimination-related stress, evidence suggests that implicit biases of physicians may also come into play. Studies have shown that white doctors typically favor white patients and believe black patients to be in less pain than they really are. Treatment decisions are then made based on these biases, resulting in unequal and inadequate care for black patients. Studies have also shown that, like Sims, doctors and researchers today still believe that there are innate differences between black and white bodies. This is a modern example of Spillers' idea of pornotrope, in which black patients are reduced to their physical, biological attributes and are seen as something other than a living, breathing, feeling human.

Pornotrope

In her essay *Mama's Baby, Papa's Maybe: An American Grammar Book*, Hortense Spillers discusses the idea of "pornotrope," or stripping a person of their humanity and reducing them down to *flesh*.¹ During slavery, Africans and African Americans were pornotrope, as they became more like cattle than real humans—only valued in their physical utility. Spillers argues that modern discourse continues to pornotrope those who endured slavery, as Americans typically focus on the physical brutality of slavery and not the systemic disruption of multiple African communities and cultures and subsequent detachment of Africans and African Americans from those communities and cultures. In only discussing slavery in terms of

¹ Hortense J. Spillers, "Mama's Baby, Papa's Maybe: An American Grammar Book," in *Diacritics*, Vol 17 (Baltimore: The Johns Hopkins University Press, 1987), 67

the physical horrors Africans and African Americans endured, we continue to pornotrope them and strip them of their humanity.

Spillers also touches on medical experimentation on slaves. She argues that during medical experimentation, slaves are subject to “atomizing,” in which they are divided and categorized in terms of their physical ailments. When the body is reduced to flesh for the purposes of medical experimentation, “the entire captive community becomes a living laboratory.”²

Anarcha, Lucy, and Betsey

One of the most infamous stories of medical experimentation on slaves is that of Dr. James Marion Sims. Sims was a prolific surgeon and is often regarded as the “father of modern gynecology.” His creations, including the Sims sigmoid catheter, the Sims vaginal speculum, and the Sims position for vaginal and rectal exams, were revolutionary at their time, and are still taught in gynecology today. Perhaps Dr. Sims’ most notable contribution was a cure for the conditions vesicovaginal fistula and rectovaginal fistula, or VVF and RVF. These conditions are caused by traumatic and/or prolonged birth in which damage forms between the vaginal tract and the bladder, or the vaginal tract and the bowels. VVF and RVF typically cause consistent leakage of urine or feces from the vagina.³

Sims’ treatment of women with VVF and RVF began in 1845 in Montgomery, Alabama when three young black slave women was brought to him by their owners. Their names were Anarcha, Lucy, and Betsey. In Sims’ writings, he often uses their names interchangeably. Sims agreed to attempt to treat them and began experimenting on them with different types of sutures

² Spillers, “Mama’s Baby, Papa’s Maybe: An American Grammar Book,” 68.

³ Michael Stamatakos, Constantina Sargedi, Theodora Stasinou, & Konstantinos Kontzoglou, *Vesicovaginal Fistula: Diagnosis and Management*, 131-132

and catheters. Sims treated his slaves as simply bodies to be experimented on, ignoring their cries of pain and operating on the women dozens of times without anesthesia. They were pornotroped--reduced to the utility that their organs could provide for medical advancement. Author Diedre Cooper Owens says in her book *Medical Bondage: Race, Gender, and the Origins of American Gynecology* that “for pioneering gynecological surgeons, black women remained flesh-and-blood contradictions, vital to their research yet dispensable once their bodies and labor were no longer required.”⁴ Anarcha was operated on 30 times alone before Sims declared that she was cured. Many of the operations were performed in front of numerous other doctors and patients, often with the experimentee completely nude. One of the women, named as Lucy by Sims, experienced tachycardia, fever, and blood poisoning after her first procedure and nearly died.

In these four years, these women were stripped of their humanity and treated as if they felt no pain. At the time, slavery was often justified through such false beliefs about the bodies of black people. In 1856, an essay by A. P. Merrill was published in the *Southern Medical and Surgical Journal* called *An Essay on some of the Distinctive Peculiarities of the Negro Race*. Merrill wrote extensively on what he believed were biological, anatomical differences between black and white bodies including thicker skin, different skull shapes, and lesser lung capacity. Merrill argued that “[the black man] requires less sleep than the white man; has greater insensibility...they submit to and bear the infliction of the rod with a surprising degree of resignation, and even cheerfulness.”⁵ Other authors of the time wrote about the benefits of using African-Americans for surgical experimentation. According to historian Harriet Washington in

⁴ Diedre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology*, (Athens: University of Georgia Press, 2018), 3

⁵ Merrill, Ayres Phillips. “An Essay on some of the Distinctive Peculiarities of the Negro Race.” *Southern Medical and Surgical Journal*, 12 1 (1856): 34-35.

Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present, “One of the most tenacious [racist] beliefs was that blacks did not feel pain or anxiety, which excused painful surgical explorations without anesthesia on blacks.”⁶ These racist medical writings were extremely influential in that they “offered laypersons and professionals alike foundational texts that modeled how to treat and think about black and white women and their perceived differences based on biology and race.”⁷

Sims subscribed to these beliefs and believed that African American women could endure more pain than white women. In the case of Lucy, an enslaved experimentee, Sims operated on her for hours, using only opium to treat the pain. Sims’ biographer, Seale Harris, wrote that “through all the attendant pain and hemorrhage Lucy bore up admirably, flinching only slightly; for this was, she knew, part of the price she had to pay for being made again a normal woman.”⁸ Harris goes on to say, “Sims’s (sic) experiments brought them physical pain, it is true, but they bore it with amazing patience and fortitude – a grim stoicism which may have been part of their racial endowment.”

J. Marion Sims gave few personal details about the women in his writings. He rarely mentioned their status as slaves other than in his autobiography, despite this status being relevant to each case. Not only were the women given to Sims by slaveowners, but VVF and RVF were significantly more common in slave women due to several factors. According to C. Riley Snorton, enslaved women were at higher risk of VVF due to little or no access to prenatal care, poor nutrition, and giving birth at a younger age. Enslaved women were also forced to perform field work throughout their pregnancies, further contributing to serious prenatal, perinatal and

⁶ Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*, (New York: Doubleday, 2007), 58

⁷ Cooper Owens, *Medical Bondage*, 18-19

⁸ Seale Harris, *Woman’s Surgeon: The Life Story of J. Marion Sims*, (New York: Macmillan, 1950), 88

postnatal conditions.⁹ Snorton, in his book *Black on Both Sides: A Racial History of Trans Identity*, argues that the prevalence of VVF among African American women was used as “evidence of their racial inferiority,” and that “the pelvis was also a critical site for producing racial hierarchies among nineteenth-century anatomists and sexologists intent on finding bodily ‘proof’ of black inferiority.”¹⁰ This aspect of the epidemiology of VVF and RVF was neglected in Sims’ writings. In his 1852 article “On the Treatment of Vesico-Vaginal Fistula,” Sims notes that VVF “occurs primarily in first labours where the pelvis is small...but I have seen it in those advanced in life, who had given birth previously to many children,”¹¹ acknowledging that the condition was prevalent in young mothers, but choosing to describe them in terms of pelvis size instead of age and their conditions as slaves.

Dr. Sims often said in his literature that Anarcha, Lucy, Betsey, and the other experimentees consented to the experiments. In “Two Cases of Vesico-Vaginal Fistula, Cured,” published in 1854, Sims says that the three named women consented to nearly forty surgeries in four years, “not only cheerfully but with thanks.”¹² One can imagine that a woman in pain from such a condition, especially after enduring potentially dozens of previous operations, would be desperate for some sort of relief or treatment. It is also hard to imagine one would consent to thirty operations without anesthesia, however. Harriet Washington argues the opposite of Sims’ claims in her book *Medical Apartheid*:

Each surgical scene was a violent struggle between the slaves and physicians and each woman’s body was a bloodied battleground. Each naked, unanesthetized slave woman had to be forcibly restrained by the

⁹ Cooper Owens, *Medical Bondage*, 45

¹⁰ Snorton, *Black on Both Sides*, 19

¹¹ Sims, James Marion. “On the Treatment of Vesico-Vaginal Fistula.” *The American Journal of the Medical Sciences*, 45 (1852): 59-82.

¹² Sims, James Marion. “Two Cases of Vesico-Vaginal Fistula, Cured.” *New York Medical Gazette and Journal of Health*, 5 1 (1854): 1-7.

*other physicians through her shrieks of agony as Sims determinedly sliced, then sutured her genitalia.*¹³

In truth, the reality of the experimentees' wishes and needs are unknown. No writings or journals by the women are currently known. In an NPR interview with Vanessa Northington Gamble, host Shankar Vedantam asked if there is any way to know whether the experimentees really wanted what was happening to them. Gamble, a historian and physician, responded:

*We do not know that. The only thing we know is that Sims said that these women - one of the women - clamorously wanted to have the surgery. They wanted to be cured. One of the things in this story that's missing are the words and voices of the women themselves not being translated by Sims.*¹⁴

In this way, even centuries after Sims' experiments ended, Anarcha, Lucy, Betsey, and the others continue to be pornotroped. Their voices are erased, and their entire lives are reduced to those four years of pain. While we will likely never know whether these women wanted the surgeries, we do know that as slaves, they could not consent.

J. Marion Sims in Literature

Literature regarding J Marion Sims is varied in its acceptance of his practices. Some scholars argue that Sims acted within the ethical standards of his time. Authors such as gynecologist L. Lewis Wall say that because slavery was legal at the time, and anesthesia was only still being developed, that Sims' actions are defensible.¹⁵ Wall argues that since Sims' writings indicate that the women agreed to the surgeries, that this must be taken as true. Because of Sims' dozens of failures in treating VVF and RVF, many of his nurses and doctors abandoned

¹³ Washington, *Medical Apartheid*, 2

¹⁴ Vedantam, Shankar. "Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology". *Hidden Brain: A Conversation About Life's Hidden Patterns*. February 16, 2016. <https://www.npr.org/transcripts/466942135>

¹⁵ L. Lewis Wall, *J. Marion Sims and the Vesicovaginal Fistula: Historical Understanding, Medical Ethics, and Modern Political Sensibilities*, 66

his research during the four years of his experiments. Thus, he instructed his experimentees to assist with operations and other aspects of each other's care. Bizarrely, Wall argues that because his experimentees helped Sims operate on each other, this indicates that they consented to the procedures. Wall's writings on Sims completely disregard the concept of consent as it pertains to enslaved women. In his autobiography, *The Story of my Life*, J. Marion Sims describes his negotiation with the slave owners:

*If you will give me Anarcha and Betsey for experiment, I agree to perform no experiment or operation on either of them to endanger their lives, and will not charge a cent for keeping them, but you must pay their taxes and clothe them. I will keep them at my own expense.*¹⁶

Sims clearly thought of this as a business transaction, and by his own writings, never gave the women any opportunity to refuse the procedures. According to Harriet Washington in *Medical Apartheid*, the relationship between slaves and physicians was really “a slaveholder-physician dyad, with the slave left outside, unconsulted, uninformed, and with no recourse if she or he was unsatisfied, injured, or killed—a medical nonentity.”¹⁷ Wall's assertion that any of these women willingly consented to, in some cases, dozens of operations, is completely absurd. Wall argues that authors who engage in modern discussions of Sims are often guilty of “presentism,” or framing the past within the context of the present. He argues that “Sims could not have known what ethical standards would be observed in 2017.”¹⁸ While there is validity in the argument that current ethical standards had not yet been adopted, that does not mean that his actions were morally right. Slavery was undeniably unethical, as is operating on someone without their consent, regardless of the “ethical standards” of that time. Of course these standards had not yet

¹⁶ J. Marion Sims, *The Story of My Life*, (New York: D. Appleton & co., 1884), 236

¹⁷ Washington, *Medical Apartheid*, 46

¹⁸ Lewis Wall, *J. Marion Sims*, 67

been developed--ethical standards in medicine were developed *because* of things like Sims' experiments.

Wall discusses the difficulty of Sims' procedures in a very bizarre way. He states:

*Sims achieved this success by operating on a number of enslaved African American women with fistulas between 1846 and 1849. Doing this took incredible perseverance on his part, and substantial endurance on the part of his patients. In one case, it took him 30 attempts before he was finally successful.*¹⁹

Wall's use of the word "incredible" to describe Sims' hardships, and "substantial" to describe the hardships of his experimentees, is representative of his overall disregard for the negative impact of Sims' experiments. Wall's description of the women's "endurance" feels like an after-thought, and his framing of the 30 procedures performed on Anarcha as difficult for Sims (without regard for the tremendous trauma of being operated on 30 times) is appalling. Wall goes into great detail about the physical trauma of VVF, which is important, but hardly mentions the impact of forced operations without anesthesia and being forced to assist with operations on other enslaved women as well. Furthermore, according to historian Martin Pernick in his book *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America*, after anesthesia was discovered in Massachusetts in 1846, "use of the new discovery spread with unprecedented speed."²⁰ Pernick argues that within months, anesthesia was being used in hospitals worldwide. It is hard to imagine that throughout the three years that Sims experimented after anesthesia was invented, doctors in Paris and London were able to access anesthesia, yet Sims, in Alabama, was not.

¹⁹ Lewis Wall, *J. Marion Sims*, 67

²⁰ Martin S. Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America*, (New York: Columbia University Press, 1985), 3

Other authors who have written about Sims have focused their attention on the women and their experiences with a critical lens on Sims' practices. For example, Diedre Cooper Owens' book *Medical Bondage* discusses the importance of centering the lives and experiences of slaves in our modern discussions of slavery and medicine. Cooper Owens argues that more attention should be made to the contributions that Anarcha, Betsey, Lucy and the others made as nurses in Sims' experiments. She says that "the occupational status of his enslaved patients as nurses has been consistently overshadowed by discussion of their illnesses"²¹ and that their roles as nurses, as mothers, as slaves, and as women should be looked at as much as, if not more than, their roles as patients or experimentees. According to Cooper Owens, "these enslaved women knew more about the repair of obstetrical fistulae than most American doctors during the mid- to late 1840s,"²² and the contributions they made to the field of gynecology are much heavier than historians have given them credit for.

C. Riley Snorton, in his book *Black on Both Sides: a Racial History of Trans Oppression*, writes about a similar idea, also expanding on ideas about pornotroping and "flesh" from Hortense Spillers' essay and applying them to Sims' experimentation. Snorton brings up the fact that Anarcha, Lucy, Betsey, and the others continued to perform slave duties around Sims' property between operations, and were instructed to assist with operations on the other women. The psychological impact of being operated on and simultaneously forced to operate on other enslaved women can only be imagined. Snorton questions why literature on Sims' experiments often neglects to discuss the relations between the women, as well as the other slaves who were kept on his property. According to Snorton:

If initially one pictures Sims' "hospital" as a site of racial containment and suffering, being both the domicile of those whom Sims personally

²¹ Cooper Owens, *Medical Bondage*, 2

²² *Ibid.*, 2

enslaved and the structure that housed his “patients,” it is also necessary to think about what other modes of relation occurred there without being overseen. What other modes of nourishment and care did they provide for one another? How did those whom Sims personally enslaved look after one another? How did those whom Sims personally enslaved look after Sims’ experimentees? And although their role as attendants was described as being totally under Sims’ direction, what adjustments did Lucy, Betsey, Anarcha, and the unnamed others make when holding the instruments—perhaps an imperceptible twist of the wrist or an ever so slight change in pressure administered in response to each other’s pain?²³

The physical trauma of what Sims’ experimentees endured is incomprehensible; however, literature that centers their physical trauma and dismisses the social, cultural, and psychological impacts as well as the social, cultural and psychological lives of the women, is guilty of modern pornotroping, in which the experimentees are reduced to their physical wounds and stripped of their experiences as human beings.

Vanessa Northington Gamble offered a similar point during her interview with NPR. When asked by Vedantam what Anarcha, Betsey, and Lucy would say to her if they were here today, Gamble says:

I think the story they would tell me would not start with Sims. I think the story they would tell me would be about their lives as enslaved women. It would begin there. It would begin how there were times where if that baby had survived, that the baby would have been taken away from them. They would talk to me about how, as being black women, their bodies were used sexually, that they did not have consent and that what happened to them with Sims was part and parcel of what their lives were at that particular time. But I think the other thing they would want us to know is that they were human beings and that they also deserve their story to be memorialized, that we have statues of Sims in Columbia, S.C., in New York City. There are portraits in medical schools of Sims. Where is their story?²⁴

²³ Snorton, *Black on Both Sides*, 29

²⁴ Vedantam, *Remembering Anarcha, Lucy, and Betsey*

In the same interview, Gamble references a 2011 study conducted by a team of urologists to learn about how Sims' work is portrayed in medical textbooks. Sara Spettel and Mark Donald White examined current and prior editions of two textbooks: one written for urology students, and one written for those studying gynecology. They found that while several of the books referenced Sims and his contributions to the field, it wasn't until a 2008 edition of the gynecology textbook *Te Linde's Operative Gynecology* that a paragraph was added that discusses the ethics of his practice. According to Spettel and Donald, the paragraph concludes, "it is generally believed that Sims was trying to enhance the lives of these women and was in concert with accepted mores."²⁵

This lack of discussion in medical textbooks about Sims' experiments begs the question: what else is missing? What do these textbooks say about other acts of racial and gendered violence in medicine? What are medical students learning in general about the intersections of race, gender, and medicine? How do the lessons medical students learn impact their future interactions with black patients?

Implicit Biases of Physicians

There is growing evidence to support the existence of implicit and explicit racial bias in medical professionals and its impact on black patients. A study conducted by Alexander Green et al. looked at implicit biases of internal medicine and emergency medicine residents. Implicit Association Tests, such as a speed matching test between black/white faces and "good/bad" concepts, showed implicit preference for white Americans and beliefs that black Americans were less cooperative with medical procedures.²⁶ In a similar study conducted by Adil Haider et al.,

²⁵ Spettel, Sara and Donald White, Mark. "The Portrayal of J. Marion Sims' Controversial Surgical Legacy." *The Journal of Urology*, 185 (2011): 2424-27.

²⁶ Green, Alexander et al. "Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients." *Journal of General Internal Medicine*, 22 9 (2007): 1231-38.

registered nurses were assessed for implicit racial and class biases. Results showed that 85.3% of RNs held implicit racial biases.²⁷

One of the most disturbing findings came from a study conducted in 2016 by Kelly Hoffman et al. Researchers examined common racist beliefs about medical differences between black and white people, such as “black people’s skin is thicker than white people’s skin.”²⁸ Results showed that half of their sample of white medical students and residents held these beliefs. These beliefs mimic those held in the 19th century by doctors such as J. Marion Sims and A. P. Merrill. The belief that black people’s skin is thicker than white people’s skin was written about extensively by Merrill.

Not only are they alarming to discover, but these biases can have severe consequences for patients. In Green et al.’s study, as implicit bias of physicians increased, so did their likelihood of treating white patients with coronary symptoms with thrombolytic therapy, and not giving black patients the same treatment.²⁹ While coronary symptoms do not always indicate a need for thrombolysis, the results show that there are racial disparities in treatment for coronary symptoms that are influenced by physician implicit biases. But implicit biases can have a more obviously dangerous effect on treatment outcomes for black patients. In a study conducted by Louis Penner et al., results showed that oncologists who had higher implicit bias scores had shorter interactions with black patients, and patients felt that these oncologists’ care was less patient-centered and less supportive.³⁰ In the study conducted by Hoffman et al., participants

²⁷ Haider, Adil et al. “Unconscious Race and Class Biases among Registered Nurses: Vignette-Based Study Using Implicit Association Testing.” *Journal of the American College of Surgeons*, 220 6 (2015): 1077-86.

²⁸ Hoffman, Kelly et al. “Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites.” *Proceedings of the National Academy of Sciences of the United States of America*, 113 6 (2016):4296-301

²⁹ Green, Alexander et al., “Implicit Bias among Physicians”

³⁰ Penner, Louis et al. “The Effects of Oncologist Implicit Racial Bias in Racially Discordant Oncology Interactions.” *Journal of Clinical Oncology*, 34 24 (2016): 2874-80

who endorsed racist tropes about black people were more likely to rate black people as being in less pain than white people, and give less accurate treatment recommendations for pain.³¹ This is direct evidence that not only are African-Americans still being reduced to flesh, seen as in less pain than they actually are because of old racist beliefs, but these racist beliefs are contributing to a major lack of adequate care for black patients.

Racial Disparities in Obstetrics and Gynecology

Major racial disparities exist today in a number of obstetric and gynecological conditions as well. One of these conditions is preeclampsia, also known as toxemia, or dangerously high blood pressure before, during, or after birth. Preeclampsia can lead to eclampsia, or seizures caused by high blood pressure. Both conditions can be fatal.³² According to a 2017 report by the Healthcare Cost and Utilization Program, black mothers are 60% more likely to develop preeclampsia, are more likely to have a severe diagnosis and develop eclampsia, and are more likely to die as a result.³³ A study conducted by Cynthia Gyamfi-Bannerman et al. looked at racial disparities in preeclampsia outcomes during delivery. What they found was striking—non-Hispanic black women with preeclampsia are more likely than non-Hispanic white women with the condition to experience eclampsia, stroke, renal failure, and acute heart failure or pulmonary edema.³⁴ Some sociologists suggest that chronic stress and discrimination explain these disparities. While these may certainly contribute, given the research on implicit biases of physicians, one can't help but consider how the way black women are perceived by medical

³¹ Hoffman, Kelly et al., "Racial bias in pain assessment and treatment recommendations"

³² Eunice Kennedy Shriver National Institute of Child Health and Human Development (2018). "About Preeclampsia and Eclampsia." <https://www.nichd.nih.gov/health/topics/preeclampsia/conditioninfo>

³³ Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality. (2017). "Delivery Hospitalizations Involving Preeclampsia and Eclampsia, 2005-2014." (HCUP Statistical Brief #222). <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb222-Preeclampsia-Eclampsia-Delivery-Trends.pdf>

³⁴ Gyamfi-Bannerman, Cynthia et al. "Racial disparities in preeclampsia outcomes at delivery." *American Journal of Obstetrics and Gynecology*, 220 1 (2019): 294.

professionals may influence health outcomes. An article written for the New York Times by Linda Villarosa shares the pregnancy and birth experience of a woman named Simone Landrum. In “Why America’s Black Mothers and Babies are in a Life-or-Death Crisis,” Landrum describes her symptoms being brushed off multiple times by her doctors, who simply prescribed Tylenol for her pain and told her to “calm down.”³⁵ Her blood pressure at the time was recorded by medical staff as 143/86—a reading that, combined with her symptoms, typically points to preeclampsia. It wasn’t until Landrum was being rushed to the hospital with severe bleeding that she was taken seriously. Her placenta had separated from her uterine wall, causing her to nearly bleed to death. Her baby, who she named Harmony, didn’t survive. This repeated dismissal of Landrum’s pain follows the pattern we’ve seen this far. Physicians ignore the repeated concerns of black patients, resulting in tragic consequences, including death.

Preeclampsia and eclampsia are not the only conditions disproportionately affecting black women. Racial disparities exist in other obstetric and gynecological conditions as well. A study conducted by Emily DeFranco, Eric Hall, and Louis Muglia found that black mothers had a higher rate and relative risk of birth before fetal viability.³⁶ A study conducted by Nevert Badreldin, William Grobman and Lynn Yee found that black and Hispanic mothers experience higher levels of postpartum pain, and are less likely to receive opioids while inpatient and during discharge.³⁷ While, like with preeclampsia and eclampsia, chronic stress and discrimination may play a role in these health outcomes,³⁸ we’ve seen the ways in which physician biases can impact

³⁵ Villarosa, Linda. “Why America’s Black Mothers and Babies are in a Life-or-Death Crisis.” *New York Times*, April 11, 2018. <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html>

³⁶ DeFranco, Emily, Hall, Eric, & Muglia, Louis. “Racial disparity in previable birth.” *American Journal of Obstetrics and Gynecology*, 214 3 (2016): 394.e1-7

³⁷ Badreldin, Nevert, William Grobman, & Lynn Yee. “Racial disparities in postpartum pain management.” *American Journal of Obstetrics and Gynecology*, 220 1 (2019): 206

³⁸ Williams, David et al. “Racial Differences in Physical and Mental Health: Socio-economic Status, Stress and Discrimination.” *Journal of Health Psychology*, 2 3 (1997): 335-351

clinical interactions and decisions. It is only logical to consider the contribution that physician-patient relationships may make to these disparities.

Kemi Doll et al. created a model that addresses racial disparities research specifically as it pertains to endometrial cancer. Black women are less likely to be diagnosed early with the disease, and are more likely to die from it than white women.³⁹ Researchers in this study looked at 48 studies on racial disparities in endometrial cancer incidence, diagnosis, treatment and mortality and examined how the researchers in each study defined race as a construct. What they found is that overall, researchers studying racial disparities typically look at biological and genetic factors that allegedly differentiate black women from white women, instead of considering social, cultural, or psychological factors that may contribute to these disparities.⁴⁰ Research on racial disparities in this disease typically construct race as biological, not social, and more often than not, don't find anything useful. Constructing race as biological and examining innate genetic differences between white and black women feels eerily similar to the writings and practices of nineteenth-century medicine. Furthermore, if black women experience poorer outcomes than white women with endometrial cancer, and the cause is genetic, this would imply that not only are black and white bodies innately different, but that black women are genetically inferior to white women. This is the same attitude that was held by physicians and laypersons alike during the nineteenth century and resulted in horrific abuses of black people by medical professionals. It appears, from the immense body of research on current inadequate treatment of black people by medical professionals, that history continues to repeat itself and black patients continue to be pornotroped.

³⁹ Kemi Doll et al. "Role of bleeding recognition and evaluation in Black-White disparities in endometrial cancer." *American Journal of Obstetrics and Gynecology*, 219 6 (2018): 593.e1-14

⁴⁰ Doll, Kemi, Cyndy Snyder, & Chandra Ford. "Endometrial cancer disparities: a race-conscious critique of the literature." *Journal of Obstetrics and Gynecology*, 218 5 (2018): 474-82

Kemi Doll et al. propose a model that implements Public Health Critical Race Praxis (PHCRP) into endometrial cancer disparities research. PHCRP is a methodology that applies Critical Race Theory to public health, often focusing on recognizing and eliminating racial disparities in medical conditions and treatment.⁴¹ Critical Race Theory, according to Chandra Ford and Collins Airhihenbuwa, “encourages the development of solutions that bridge gaps in health, housing, employment, and other factors that condition living.” Applying Critical Race Theory to public health “can provide powerful new tools for targeting racial and ethnic health inequities.”⁴² The model proposed by Kemi Doll et al. of incorporating PHCRP into endometrial cancer disparities research was adapted from Ford and Airhihenbuwa and consists of four phases. Phase one involves finding patterns in endometrial cancer disparities and placing them in context of current racial relations in the U.S. Phase two consists of critically examining the current body of research on endometrial cancer disparities and how researchers typically construct race. How is race operationalized? Do these definitions serve black women, or hurt them? Phase three involves forming new research questions that take into account the historic intersections between race, gender, and medicine and designing new studies that examine these intersections. Finally, phase four involves acting to eliminate these disparities by engaging healthcare providers and communities of black women.⁴³

While all of these phases are important in both discovering and eliminating racial disparities in reproductive healthcare, the role of the physician seems to be neglected by this model. Health care providers are part of phase four, however their role, beyond “engagement”

⁴¹ Doll, Kemi, Cyndy Snyder, & Chandra Ford. “Endometrial cancer disparities: a race-conscious critique of the literature,” 474-82.

⁴² Chandra Ford & Collins Airhihenbuwa. “Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis.” *American Journal of Public Health*, 100 (2010): 30-35

⁴³ Doll, Kemi, “Endometrial cancer disparities.”

with black communities, isn't clear. PHCRP emphasizes the need to center black patients in these discussions, which of course is important. After all, the erasure of black voices in medicine has been demonstrated for centuries. The responsibility to receive adequate, unbiased care should not fall on the backs of black patients, however. Most white patients, when seeking healthcare, typically do not need to be concerned with being perceived in a certain way and not receiving appropriate care. As we've seen with the above studies, more often than not, physicians favor white patients in their treatment. Black patients do not have this privilege. The responsibility for black patients to receive adequate care should fall to the physician treating the patient, not the patient herself.

Combating Bias in the Medical School Curriculum

Eliminating physician implicit bias must begin early on. This brings us to a question I posed earlier: What are medical students learning about the intersections of race, gender, and medicine? If we could target implicit bias early on, such as during medical school, physician-patient interactions may improve, and black patients may begin receiving better treatment. There is some research to suggest that medical textbooks help to solidify implicit biases in medical students. As discussed earlier, J. Marion Sims, at least as recently as 2011, is still portrayed by some urology and gynecology textbooks as a pioneer of medical advancement, while dismissing or downright ignoring the circumstances of his discoveries. Other portrayals and discussions of race and gender also exist in medical textbooks that may contribute to implicit biases of physicians. A study conducted by Lincoln Sheets et al. found that in a single edition of *Pathologic Basis of Disease, Professional Edition* by Robbins and Cotran, there were 31 statements naming race as a biological risk factor for certain diseases. Approximately two-thirds

of the assertions could not be supported by the literature in any way.⁴⁴ A student reading these 31 claims may very well come to the conclusion that black and white bodies are innately different and require different methods of care. Other studies have examined gender and racial representations in medical textbook imagery. Patricia Louie and Rima Wilkes examined four commonly-used medical textbooks and analyzed their racial and skin tone representations as they compare to nationwide proportions. They found that while the textbooks they examined had a racial distribution proportionate to the United States, they also overrepresent lighter skin tone as it compares to U.S. demographics.⁴⁵ Black cancer patients were also visually non-existent in these textbooks. Matthew Curry found similar results looking at nine health assessment textbooks for racial and gender representations. He found that women and ethnic minorities are underrepresented in photos of both nurses and patients.⁴⁶ If the majority of anatomical and other images medical students see are of white male patients, they may begin to form implicit biases and believe that non-white and/or female patients have different bodies and require different care for the same conditions as white and/or male patients. These early implementations of bias in medical school may contribute to how physicians interact with and treat women and black patients in the future.

Conclusion

The practices of James Marion Sims are undeniably horrific. The abuse that Anarcha, Lucy, Betsey, and the others endured cannot be imagined; however, their mistreatment went beyond a physical impact. These women, and many others, experienced social, cultural, and

⁴⁴ Sheets, Lincoln et al. "Unsupported labeling of race as a risk factor for certain diseases in a widely used medical textbook." *Journal of the Association of American Medical Colleges*, 86 10 (2011): 1300-3

⁴⁵ Patricia Louie and Rima Wilkes, "Representations of race and skin tone in medical textbook imagery." *Social Science & Medicine*, 202 (2018): 38-42

⁴⁶ Matthew Curry, "Patterns of race and gender representation in health assessment textbooks." *Journal of the National Black Nurses Association*, 12 2 (2001): 30-5

psychological impacts of captivity that should not be forgotten. They were repeatedly and constantly pornotrope, even after the experiments ended and their entire lives are now reduced to those four years of horror. Sims' legacy lives on in the medical community as a whole, as the health of black patients is routinely dismissed and mishandled, and they are treated as something "other." White physicians must have their implicit biases addressed and corrected, and medical students should learn early on about the history of race and medicine, myths about differences between black and white bodies, and how to interact with black patients and ensure that they are receiving acceptable and appropriate care.

In 2018, a statue depicting Dr. J. Marion Sims was removed from its standing in Central Park, New York City. The monument was installed in the park in 1934, just over 50 years after Dr. Sims' death.⁴⁷ Its removal came after years of protests against its memorialization. Initially, when I read this news, I remember celebrating. My view changed, however, after reading Vanessa Northington Gamble's interview with NPR. Gamble said that she felt conflicted about its removal because she is concerned that people will forget what happened to these women. She suggested replacing the monument with a memorial for Anarcha, Lucy, and Betsey. When asked what the statue would depict, Gamble said,

The statute would not be of the experiments because I think that it's important not just to think of them as victims of these experiments. It might be with the three of them together. Or it might be with their holding children, that they were mothers, that they were women. So that would be part of it. So it would not be their prostrate on the altar of science. I think what the inscription would say is Betsey, Anarcha and Lucy, **the mothers of modern gynecology**.⁴⁸

⁴⁷ New York City Department of Parks and Recreation, *Dr. James Marion Sims Sculpture*, 2018

⁴⁸ Vedantam, "Remembering Anarcha, Lucy, and Betsey"

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