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Mastering the Female Pelvis

Race and the Tools of Reproduction

And if in these days a moment can be spared for sentimental reverie, look again, I beg, at the curious speculum, and gazing through the confused reflections from its bright curves, catch a fleeting glimpse of an old hut in Alabama and seven negro women who suffered, and endured, and had rich reward.

—J. Chassar Moir, M.D., *The Vesico-Vaginal Fistula*

During the four years between 1845 and 1849, J. Marion Sims, M.D., conducted surgical experiments on slave women in his backyard hospital in Montgomery, Alabama. These women all had vesico-vaginal fistulas, small tears that form between the vagina and urinary tract or bladder that cause urine to leak uncontrollably. Through repeated surgeries, Sims attempted to repair the fistulas. He is now remembered as the Father of American Gynecology, Father of Modern Gynecology, and Architect of the Vagina. Following the eventual success of the surgical reparation, Sims won illustrious titles, awards, and fame worldwide and praising words in most contemporary gynecology and medical history texts.¹ By his own estimation he became “the second wealthiest of all American physicians.”² As we shall see, Sims’s fame and wealth are as indebted to slavery and racism as they are to innovation, insight, and persistence, and he has left behind a frightening legacy of medical attitudes toward and treatments of women, particularly women of color. These four years of surgical experimentation on slave women represent the foundation of gynecology as a distinct specialty.

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Through an investigation of Sims's practices, a number of important distinctions regarding the foundation of gynecology become clear. First, the institution of slavery served medicine in providing subjects for experimentation. The gynecological patients' position as slaves defined their status as medical subjects, situating them as institutionally powerless and therefore as fitting props for the experimenting white physician-turned-master-showman, who revealed, probed, and operated on their vaginas. Slavery enabled the foundation of gynecology and in the process helped define the proper objective of medical experimentation.

Second, the use of the speculum in North America was founded on slave women's bodies. This medical precedent prompts questions that will be asked throughout this chapter: What kind of woman is considered to be most appropriate for speculum examination? How does gynecological display structure physician-patient power differentials? The position of Sims's patients as slaves made them more fitting objects for speculum penetration and the physician's gaze while, at the same time, their status as slaves was reiterated by the physician's probing gaze and penetrating speculum as tools of medical discipline. An investigation of this historic medical innovation provides insight into the way gynecology continues to situate patients.

Third, Sims's surgical experimentation set a precedent for the medical institution's involvement in racist, eugenicist practices concerned with the reproductive capacities of poor women of color. His surgical reparation can be viewed as an early reproductive technology aimed at helping to optimize the reproductive capacity of slave capital. In a welfare-state economy, reproductive technologies to foster pregnancy are often marketed at wealthy, predominantly white women, whereas new technologies aimed at limiting reproduction are most often used experimentally on poor women of color and subsequently aimed at them through accessibility and legislated incentives. Norplant, a surgically implanted contraceptive, will be investigated as a technological offspring of Sims's surgical reparation of vesico-vaginal fistulas. This association does not assume or assert that either technology is inherently "bad" but rather points to the ways in which technological innovation and use are generated by and help reinforce ideological structures, including institutionalized racism. Thus an investigation of Sims's practices provides a look at foundational moments in gynecology. Racism, slavery, and the thrill of medical innovation were all joined in the early days of the discipline. Their reverberations are still felt today.

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Master Showman

As a historical player, Sims is key to a consideration of the relationship between performance and gynecology. In fact, performance is often enlisted as an explanatory model for Sims's behavior. In his autobiography, eulogies following his death, and a biography published in 1950, Sims is rhetorically positioned as a sensational surgical performer. His patients, however, are situated as passive, proplike objects rather than co-performers. By simply orchestrating the unveiling of the previously mysterious internal landscape of the live female pelvis, Sims gained vast fame and devoted followers, and his dramatic surgeries cemented his reputation as a master showman. Early in his career, he performed to a small audience of eager physicians in his makeshift backyard hospital, but later he played to larger and larger crowds at the Woman's Hospital in New York, as well as in famous operating theaters abroad.

Seale Harris, M.D., Sims's biographer and the son of one of his disciples, notes, "Sims had a great love for the theater and everything dramatic, and he was fascinated by P. T. Barnum's combination of master showmanship (for which he himself had a not inconsiderable gift)." In his autobiography, Sims mentions "spending time with my good friend Mr. P. T. Barnum" in the summer of 1849 in New Orleans.³ What might link a surgeon-slave master to a showman-ringmaster? Both exercise mastery over bodies, particularly grotesque bodies (in the sense of either open, oozing bodies or freaks). The high drama of surgery, like the daring circus feat, demands courage in order to perform that which seems impossible. And both the ringmaster and the surgeon-slave master perform to large audiences, commanding center stage.⁴

Barnum's shows and exhibits were simultaneously science, art, education, and entertainment. Oftentimes, ambiguities in race and even species served as the titillating freakishness for his exhibits. For instance, the Leopard Child, a young boy with vitiligo, a condition that causes abnormal pigmentation, was a "favorite with spectators at the American Museum."⁵ William Henry Johnson, an African American known as "Zip," was exhibited in Barnum's Gallery of Wonders as a missing link, which could be a "lower order of man" or a "higher order of monkey."⁶

Of special interest is Joice Heth, "a blind, decrepit, hymn-singing" slave woman for whom Barnum purchased "the right to exhibit." He claimed Heth was 161 years old and had been nurse to George Washington.⁷ Before her death, Barnum promised Dr. David L. Rogers, "an

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eminent New York surgeon who had examined Joice upon her first arrival in the metropolis, that he would have the opportunity to dissect her should she die while under Barnum's management."⁸ When the time came, there gathered "a large crowd of physicians, medical students, clergymen, and (naturally) editors, each of whom was assessed fifty cents for this extraordinary privilege." In the end, the surgeon found that Heth was not even eighty.

What is freakish is not the boy with vitiligo or the slave women with vesico-vaginal fistulas. Rather, the true atrocities are the methods enlisted to display the "freaks" and the atrocious types of intervention used. Both Sims's and Barnum's spectacles were consistently fashioned as simultaneously passive, proplike freaks and uncontrolled bodies in need of taming. Though one commanded center stage in a hospital and the other in a circus, what links Sims and Barnum is a fascination with difference, ambiguity, and pathology, a fascination that is premised on race, power, exhibition, and visibility.

The Fistula

Sims did not plan to found his career on "disorders peculiar to women." In his autobiography, *The Story of My Life*, he admits, "If there was anything I hated, it was investigating the organs of the female pelvis."⁹ Yet "women's problems" seemed to court him in his small general practice. He was repeatedly confronted with one particular condition: the vesico-vaginal fistula. Often a result of hard and extended childbirth, fistulas are what Sims referred to as "the sloughing of the soft parts."

Although white women also developed fistulas, when slaves developed them they were often blamed for not having called on white male physicians during difficult labor: "the [slave] women preferred to suffer in seclusion than to call for help at such time."¹⁰ As Elizabeth Fox-Genovese notes in *Within the Plantation Household*, slaves largely distrusted white doctors, preferring Black "root doctors" and herbal remedies, reflecting "African as well as local folk beliefs."¹¹ Elaborate systems of care were in place in many slave communities, providing slaves with treatments preferable to what they must have viewed as the dangerous practices upheld by the growing white male medical establishment at that time. But lay practitioners, particularly Black ones, were systematically denounced by physicians who relegated them to the realm of malpractice. In a eulogy for Sims, one physician recounted that Sims "was not slow in finding cases of this disgusting disease, particularly among

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the slave population, whose management in accouchement was generally confined to the ignorant midwives of their own colour.”¹² A favorite target of white male physicians, Black midwives were held responsible for the slaves’ vesico-vaginal fistulas.

Almost two-thirds of Montgomery’s population at that time was slaves. Sims’s participation in the institution of slavery is explained in his biography: “The Simses themselves owned a number of Negroes. . . . It was the only way that they knew, and to them it seemed a good one.”¹³ Sims even purchased a slave expressly for the purpose of experimentation when her master resisted Sims’s solicitations. Certainly the prevailing institution of slavery afforded Sims an opportune scenario in which to operate. Sims was then construed as their savior, an “evangelist of healing to women,” who could no longer turn his back on these helpless sufferers.¹⁴ Part of this messianic role included rescuing them from the “mis-management” of their own midwives.

Sims did not initially accept the challenge of the fistula. A slave master contacted him to check on a slave named Anarcha who had been in labor for three days. Sims proceeded to remove the baby with a forceps. All seemed to be fine with the woman, but five days later Sims found an extensive fistula that caused her to leak both urine and bowel. He had never before seen this condition and initially considered it a “surgical curiosity.” Later, after reexamining the literature and finding that the condition had been noted but no physician had ever successfully repaired it, he explained to the woman’s master that there was no hope of mending the fistula. In his autobiography, Sims re-creates his words to the master: “Anarcha has an affliction that unfits her for the duties required of a servant. She will not die, but she will never get well, and all you have to do is to take good care of her so long as she lives.”¹⁵

Here, Sims’s first concern is Anarcha’s ability to work. How would the fistula have made the slave unfit for her duties? While the fistula made this woman smell of bowel and urine, it would not have diminished her strength or ability to work. Sims’s comment could be a reference to the fact that slave women were viewed as the “breeding” property of their masters. The slave’s “duties” may refer not only to her labor as a slave in terms of work in the fields or house but also to her sexual and reproductive duties: “Owners had a financial interest in slaves producing children and openly encouraged ‘breeding.’ Women known as breeders brought higher prices on the slave market and might enjoy special privileges, such as a job in the master’s house rather than in the fields.”¹⁶ With this “disgusting disease” the slave would no longer be attractive or fit, thereby affecting her reproductive labor as a woman who

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would bear future slave labor. As Deborah Gray White asserts, "The perpetuation of the institution of slavery, as nineteenth century Southerners knew it, rested on the slave woman's reproductive capacity."¹⁷ Viewing Black female bodies as capital, slave owners found this bothersome condition troubling indeed. In addition, slave women were frequently approached as receptacles of white male sexual power: white men "expected to exercise sexual freedom with women slaves. Especially within the planter class, relations with black women provided white men with both a sexual outlet and a means of maintaining racial dominance."¹⁸ The smell of urine and bowel would undoubtedly undermine this particular means of maintaining power over slave women.¹⁹

Masters were not unfamiliar with slave women being unfit for their duties because of their reproductive organs. Slave women sometimes used the knowledge that masters were particularly invested in their reproductive abilities to their advantage. A number of historians of slavery have noted evidence that some slave women feigned illness related to their reproductive organs, "playing the lady," as it was called, in order to temporarily diminish or eliminate their workload.²⁰ By "playing the lady," slave women were performing white womanhood, enlisting illness as a mode of resistance in order to manipulate their white masters' historically situated fears regarding the delicate and unpredictable female reproductive organs so vital to the masters' profits. In the case of "playing the lady," we find that femininity, performativity, pathology, and the reproductive organs are frequently thought to be interdependent.

Some masters were unsympathetic to slave women's illnesses, feigned or otherwise, and created various performances of their own that discouraged such resistance. As White notes, "Some masters insisted on giving the 'patient' a thorough examination before excusing her from work."²¹ A slave who was "playing the lady" could potentially be faced with a master "playing doctor," a power-laden sexual and fact-finding threat. However, illness affecting slave women's reproductive labor was not taken lightly because it seriously threatened a master's earnings. Physicians such as Sims were called on to help when it was found that indeed the slave woman was not simply "playing."

About a month after Anarcha's examination, another slave woman, Betsey, was sent to Sims for inspection because she could not hold urine. She too had a fistula, and Sims sent her back to her master, explaining that he could do nothing. One month following Betsey's visit, Sims was contacted by a master whose slave Lucy had the same symptoms as Betsey. Despite Sims's protest that the master need not bother sending the woman, Lucy was sent and indeed, upon examination, was found to

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have a fistula. Sims gave her a bed in his homemade backyard hospital for “Negroes,” but he informed her she had to leave the following afternoon. In his autobiography he wrote: “She was very much disappointed, for her condition was loathsome, and she was in hope that she could be cured.”²² Thus, in the autobiography, the stage is rhetorically set for the entrance of willing experimentees.

The next morning Sims attended a white woman who had been thrown from a horse and had landed on her pelvis. Remembering an early lesson from a teacher in medical school, Sims believed that he needed to “relocate” the uterus, an idea consistent with nineteenth-century medical beliefs that the uterus could easily dislodge from its proper place, causing untold emotional and physical problems. In order to “relocate” the uterus, he had the woman assume a position on her knees and elbows, covered her with a large sheet, inserted two fingers into her vagina, and found, just as his teacher had promised, that a suction was created that extended the vagina to full capacity.²³ This event caused Sims to reconsider his ability to repair fistulas. If the vagina would “puff up” in this position, then why couldn’t he introduce an instrument that would enable him to visualize the fistula and thus repair it?

Conveniently enough, Lucy was still in Sims’s backyard hospital. He bought a pewter spoon on his way home. Upon arrival, he hurriedly assembled his two medical-student apprentices and placed Lucy in the knee-chest position for examination: “Introducing the bent handle of the spoon I saw everything, as no man had ever seen before. The fistula was as plain as the nose on a man’s face.”²⁴ This historic moment has since achieved mythological status as the first use of a vaginal speculum, commonly known as Sims’s speculum, in North America (see fig. 40).

“As plain as the nose on a man’s face” is a strange expression to use in conjunction with the initial “discovery” of vaginal visibility. It is as though Sims saw his own image, a self-portrait, reflected back at him in the pewter spoon. I will consider the implications of the speculum as a place for self-reflection later in this chapter. What is significant is the fact that the speculum was “discovered” in a slave woman’s body. Visibility, ownership, labor, capital, medical discovery, and slavery all met at the site of the first speculum exam.

The Speculum

Although vaginal speculums in various forms had been noted as early as A.D. 97, they had not found their way into modern American medical

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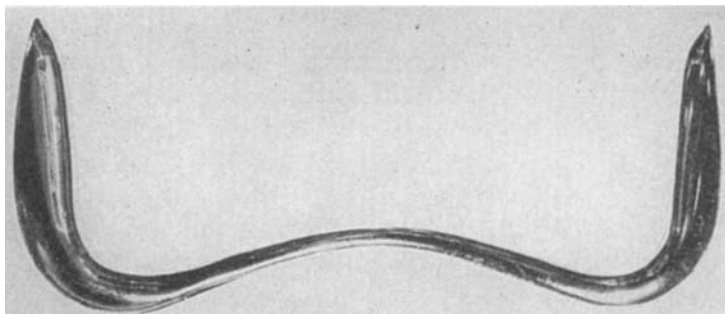


Fig. 40. Sims's speculum. In Emil Novak, M.D., and Edmund R. Novak, M.D., eds., *Textbook of Gynecology*. Baltimore: Williams and Wilkins, 1956.

practice until Sims examined Lucy.²⁵ There is no question that the speculum is a highly significant technology, and its discovery in part accounts for Sims's title, as the Father of Modern Gynecology. In eulogizing Sims, W. O. Baldwin, M.D., emphasized the instrument's importance:

The day which made him great was the day the idea of his speculum first dawned upon him—that day when he first conceived the thought of throwing an abundance of light into the vagina and around the womb, and at the same time obtaining ample space to work and ply his instruments. . . . The instrument caused his name to flash over the medical world like a meteor in the night. Gynaecology to-day would not deserve the name of a separate and cultivated science, but for the light which Sims's speculum and the principles involved in it have thrown upon it.²⁶

Images of light and enlightenment abound in Baldwin's text. By "throwing an abundance of light" into the dark cavity, Sims made the invisible visible. One cannot help but recall here Freud's notion of woman as "the dark continent" and its "link to the nineteenth-century colonialist imagination."²⁷ If woman is dark, in this case doubly "dark" due to her mysterious anatomy and African origins, Sims is the source of enlightenment, constructing knowledge about her internal depths. In her discussion of medical stories in women's films of the 1940s, Mary Ann Doane has analyzed the continual narrative return to images of light. She notes: "Light also enables the look, the male gaze—it makes the

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woman specularizable. The doctor's light legitimates scopophilia."²⁸ The light introduced by Sims's speculum allowed for an entirely new medical specialty premised on the vaginal spectacle. Sims drew the labial curtains, propped open the vaginal walls, and revealed an entirely new vision; this accounts for his epithet Architect of the Vagina. Making the internal structures of the live woman visible with the speculum allowed the enlightened knowledge of medical science to enter; physicians could now see and, therefore, manipulate this previously invisible zone. In this respect, the creation of the speculum participated in a Western medical tradition that was founded on visibility.²⁹ As in Luce Irigaray's notion of the speculum, the light thrown into the dark space is then reflected back onto the prestigious image of Sims himself, whose name flashed "over the medical world like a meteor in the night." Illuminating the inside of the vagina lit up his own career in the process, making him a guiding light to those physicians who had previously labored in the dark.

Baldwin, Sims's eulogizer, proceeds to compare the speculum to other great inventions: "It has been to diseases of the womb what the printing press is to civilization, what the compass is to the mariner, what steam is to navigation, what the telescope is to astronomy, and grander than the telescope because it was the work of one man."³⁰ In Baldwin's account, Sims alone discovered the instrument that would help organize the uncharted female landscape. This man-made invention was construed as yet another example of science's triumph over nature. The speculum served as yet another instance of man's progress in that it made visible the inner recesses of the female body, just as the telescope enabled a view of the outer depths of space. The speculum was like a compass in that it helped guide the physician into this unknown terrain. In this rhetorical construction, the female body is metaphorically produced as raw natural territory awaiting discovery and cultivation by the hands of male medical culture. On first using the speculum and viewing the inside of the vagina, Sims himself wrote, "I felt like an explorer in medicine who first views a new and important territory."³¹ Without science the female body was unruly and nonsensical; the speculum helped organize and establish the female body, particularly the female reproductive organs, as a place suitable for, and open to, medical intervention.

The narrative formulas used to describe Sims's medical adventures present classic scenarios: a hero triumphantly overcoming trial and tribulation, fighting battles in order to conquer new lands, build new spaces, and create new orders.³² Under all of this lies the female body, serving at once as obstacle and as object in need of discovery, conquering, and restructuring. Thus in historic writings about Sims, the female

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body, particularly the Black female body, becomes what Teresa de Lauretis refers to as a “plot-space,” marking the landscape that Sims, the medical hero, traverses in order to find fame, knowledge, and wealth.³³

Bearing the Pain

After Sims's first use of the pewter spoon and his view of what “no man had ever seen before,” he asked Lucy to stay and requested that Anarcha and Betsey be sent back to him. Believing he was “on the eve of a great discovery,” he asked their masters for consent: “I agree to perform no experiment or operation . . . 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.”³⁴ Since Sims had already argued that these women could not properly perform their duties as servants due to their “disgusting condition,” his offer must have seemed a good deal to the owners. He would not deplete their slave capital but would sustain their lives himself and might even repair them and thus return them to their original value. The backyard hospital for slaves was enlarged, and Sims set about inventing instruments, setting the stage for a show that would be extended time and time again, finally closing after a four-year run.

Who were the slave women on whom Sims experimented? We know them from Sims's autobiography and subsequent biographical writings only by their first names. Did they have husbands, partners, children, and loved ones whom they were made to leave for four years while Sims worked on them? Did they agree to his experimentation? Were they given any choices? Under what terms? What were their feelings toward their condition? Did they ever leave Sims's backyard hospital over the course of their tenure there? It is impossible to know. They did not write their own histories. Thus the ways in which Sims's surgeries related to these women's lives are left unknown; the documentation of their performances is subject to surviving writings mainly unconcerned with such incidental facts.

Lucy was the first to undergo surgery to suture together the edges of the fistula. With a patronizing flourish, Sims remarked on her fortitude: “That was before the days of anesthetics, and the poor girl, on her knees, bore the operation with great heroism and bravery.”³⁵ The pain these women must have experienced during and following these operations is inconceivable. And as if the pain of unanesthetized vaginal surgery were not traumatic enough, after this first operation, Lucy

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nearly died from infection due to a sponge Sims had left in her urethra and bladder.

Sims and Harris depict the slave women as inherently more durable than white women. About one hundred years after the surgeries, Harris echoes Sims's racist patronizing: "Sims's 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 or which possibly had been bred into them through several generations of enforced submission."³⁶ Causing the slave women great pain did not deter Sims from proceeding with the operations. Not only were the painful punishments administered to slave women by masters and overseers seen as a kind of "preparation" for the rigors of unanesthetized surgery, but slaves were viewed as genetically more predisposed than whites to the kind of domestication that trained them to bear pain.³⁷

Pathologizing Difference

Other cultural and historical factors allowed Sims to believe that slave women were appropriate subjects for such painful experimentation. It was possible for Sims to operate repeatedly and unabashedly on slave-women subjects in part because these women were viewed as abundantly symptomatic and pathological. Given a cultural backdrop that pathologized race and Black female sexuality alike, slave women with vesico-vaginal fistulas were triply symptomatic. Their first pathological symptom was their primary racial characteristic: their skin color. In a medical world that categorized life as either normal or pathological, people of the African diaspora were continually condemned to the category of pathological, their "abnormal" skin color serving as a foil for "normal" white skin. Pathological causes for this condition were concocted in order to explain its prevalence. Sander Gilman explains: "Medical tradition has a long history of perceiving this skin color as the result of some pathology. The favorite theory, which reappears with some frequency in the early nineteenth century, is that skin color and attendant physiognomy of the black are the result of congenital leprosy."³⁸ Such medical arguments, in collusion with racist and stereotypic scientific and cultural explanations and excuses, provided the grounds for differential "treatment."

The slave woman's second symptom was her sex, taken in combination with her skin color. Black female sexuality and sex characteristics were the site of great attention by a nineteenth-century scientific

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community that systematically found them to be pathological.³⁹ Black female sexuality, constructed as heathen, lascivious, and excessive, was used by dominant nineteenth-century scientific culture to counter its constructions of fragile and frigid (and also pathological) white female sexuality.⁴⁰ These differing constructions of white and Black female sexualities may account for the fact that Mrs. Merrill, the white woman who had been thrown from a horse, was covered with a sheet during examination, whereas unanesthetized Lucy underwent Sims's first experimental surgery while "about a dozen" male spectators watched. The spectacle of Lucy's genital display did not require limiting the number of spectators or providing an obscuring sheet. In this way, slave women may have been seen as more appropriate objects of study, for the experimenting physician believed that he need not worry about protecting the slave's modesty.

In the early nineteenth century, white European researchers documented physical evidence to provide proof of pathology. Black female genitals and "steatopygia" (protruding buttocks) were singled out as telling sites of difference and pathology. In their trips to Africa, researchers commented on the "primitive" genitalia of African women, particularly Bushman and Hottentot. Named the "Hottentot Venus," Saartjie Baartman (also referred to as Sarah Bartmann) was exhibited in Europe for over five years. She was clothed during live exhibitions, so her buttocks were of greater interest than the hidden genitalia. But following her death in 1815 in Paris, her genitalia took the spotlight: "The audience that had paid to see Sarah Bartmann's buttocks and fantasized about her genitalia could, after her death and dissection, examine both."⁴¹ Following her death, Georges Cuvier, a pathologist, presented "the Academy the genital organs of this woman prepared in a way so as to allow one to see the nature of the labia."⁴² The postmortem museum display of the Hottentot Venus's genitalia is reminiscent of Barnum's orchestration of Joice Heth's theatricalized autopsy. The surgical theater and museum display, spaces often reserved for serious scientific investigation, become Barnum sideshows. In both cases, public display of what is normally private—the genitals or the inside of the body—was used as evidence of freakish abnormalities. The genitalia of the Hottentot woman became the marker of her inherent pathology, her sex parts serving as a metonym for her pathological sexuality and therefore as fitting representatives for inclusion in an anatomical museum.

Given this historical context of the continual pathologizing of Black women, the third pathological symptom and only legitimate abnormality, the vesico-vaginal fistula, made these slave women ideal sub-

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jects for study. The vesico-vaginal tears, located in the mysterious inner cavity, were only accessible by a physician's probing fingers and tools. There were persistent questions regarding the moral and ethical appropriateness of examining white women's genitals and reproductive organs; Western society questioned the suitability of a physician penetrating such a private place traditionally reserved for the patient's husband.⁴³ Yet with the slave, these questions were laid to rest. Not only was she white man's property, but because of her racially legitimized pathological "nature," she was considered promiscuous and sexually voracious. The need to manipulate the slave's genitals in search of the vesico-vaginal fistula made her an apt surgical recipient.

Utilizing Sameness

Difference was vital to Sims's experiments. The slave's triple pathology allowed him to perform multiple operations. Western medical and scientific men in the nineteenth century tried to prove Black female difference, as is evidenced in the actual display of Sarah Bartmann's external genitals. Yet Sims's experiments were also premised on an internal sameness, his invention of the speculum providing the tool that allowed such sameness to be examined. If he could successfully mend a slave woman's fistula, then it was assumed that he would be able to repair *any* woman's fistula. This simultaneous sameness and difference is what made the slave women such fitting "human guinea pigs."⁴⁴ Slavery provided the ideal conditions for Sims's surgical experimentation. As we have seen, convenient racial pathologies legitimated surgical manipulation and unabashed pelvic observation of the slave women, while their palpably (and now visibly) analogous insides made them suitable white female correlates.

In Baldwin's eulogizing of Sims, he proclaims, "The time was ripe when Sims patiently began to work out problems which were essential to operative gynaecology. Even slavery had its uses in the pursuit of his ends. Who can tell how many more years the progress of the art might have been delayed if the humble Negro servitors had not brought their willing sufferings and patient endurance to aid in the furthering of Sims's purpose."⁴⁵ "The time was ripe" indeed, but not necessarily for the reasons that Baldwin asserts. Who was actually offering the slaves' "willing sufferings . . . to aid in the furthering of Sims's purpose"? Of course, it was the slave owners rather than the slaves themselves who initiated contact with Sims and who had the final say as to whether their

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slaves could remain in Sims's care. "The time was ripe" because Sims, an already reputable body mechanic, offered these masters a promising proposition: he would repair their laborer, making her fit for her duties. In a slave economy, this surgery held particular value. Not only did it repair the slave capital so she could work, but by ridding her of the fistula's "loathsome" and "disgusting" attributes the surgery also affected her likelihood to reproduce, a vital aspect of her role as slave.

Harris suggests that there were even greater risks to having a fistula. He maintains that some slave women were led to suicide by their "loathsome" condition. Harris's statement suggests that Sims's experimentation was really for the slave women's benefit. However, we may further ask, as Diana Axelsen has in an essay on Sims, how severe a disorder a vesico-vaginal fistula truly is and whether it merited such extreme attention: "While certainly a source of chronic discomfort and possible secondary irritation, and while obviously embarrassing in many contexts, vesico-vaginal fistula is not a disorder involving chronic or severe pain . . . the discomfort of vesico-vaginal fistula, in comparison to the effects of excessive beatings, chronic malnutrition, and other forms of physical and psychological aggression, hardly constitutes a probable motive for suicide."⁴⁶ Not to mention the tremendous agony of unanesthetized vaginal surgery. The pain and suffering these women endured was hardly a break from hardship. While none of the women undergoing Sims's experimentation committed suicide, four years of unanesthetized surgery on one's vagina might have been a much more likely motive than the vesico-vaginal fistula itself.

Lucy did not die following Sims's first surgical attempt but survived the infection, healing in due course for her subsequent operations. More slaves came to live in Sims's backyard: "Besides these three cases, I got three or four more to experiment on, and there was never a time that I could not, at any day, have had a subject for operation."⁴⁷ Sims rotated operations on his slave patients but could not make the operation work. Each time he would make adjustments to the procedure, but there was always a small fistula remaining, and a small fistula had the same result as a large fistula: it leaked. As one patient was healing, he would operate on the next (who would have just finished healing from her last operation), incorporating his latest surgical innovation.

Those physicians and students who had initially attended the operations, eagerly awaiting Sims's great success, lost interest. Without assistants, he trained the slave women to assist in each other's operations.⁴⁸ Thus the slave's role shifted throughout the surgical process: slave as laboring assistant or stagehand, slave as repairable capital, and

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slave as medical guinea pig. Women, particularly women of color, have been cast most often in similar roles throughout Western medical history: as either nurse, technician, or nonphysician assistant; and as subject of experimentation and manipulation particularly with regard to reproductive organs.⁴⁹ Their power in the medical apparatus has reflected the roles they have been assigned. However, since the abolition of slavery, the nature of the experimentation and manipulation of African American women's reproductivity has shifted with the changing status of African American women as reproductive capital.

Three years after Sims's experiments began, his brother-in-law, Dr. Rush Jones, visited Sims and implored him to discontinue his work on the slaves. He told Sims that he was working too much, that the cost of supporting the slaves was high, and that he was being unfair to his family. According to Sims's and Harris's accounts, Jones did not raise concerns about the slaves' welfare. However, Harris does note that there was talk in the community: "And socially the whole business was becoming a marked liability, for all kinds of whispers were beginning to circulate around town—dark rumors that it was a terrible thing for Sims to be allowed to keep on using human beings as experimental animals for his unproven surgical theories."⁵⁰ Nowhere else in Sims's biography or autobiography is there mention of the possible ways in which his treatment of the slaves was unethical. Rather, it is continuously emphasized that the slaves were there out of desperation and in the hope that Sims might rid them of their condition. In response to the townspeople's uneasiness with Sims's practice, Harris emphasizes that "the human guinea pigs themselves, however, made no complaints on this score." He uses the term "human guinea pigs" ironically here to imply the slave women's willing acceptance of their role as experimental animal, even though "dark rumors" were being spread around town. However, in an article on Sims in the *Journal of Medical Ethics*, Durrenda Ojanuga asserts that the women "were in no way volunteers for Dr. Sims's research." In fact, "the evidence suggests that Sims's use of slave women as experimental subjects was by no means the order of the day!"⁵¹ Thus Sims's practices cannot be viewed as historically acceptable or commonplace. Yet it is important to remember that these practices, nonetheless, instituted the foundation of gynecology as a distinct specialty.

Sims's tenacity in battling the fistula despite criticism from his relatives, friends, and colleagues is highlighted by both Sims and his biographer. He is rhetorically placed on a research team with the slaves in a dedicated search for a cure for their ailments. In the writings, it is as though no power differential existed between Sims and his experimentees. But

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the slaves themselves would not become famous; it was Sims who would wear the honors. According to Harris, Sims was so driven that when Jones begged him to stop the experimentation, Sims was steadfast in his commitment. As Harris describes: "It was like advising a dog that he will be out of breath if he doesn't stop chasing a squirrel—like advising Columbus to turn back because the voyage is long and there is no land in sight. Sims, once aroused, was a zealot."⁵² Even eighty years later the characterization of the slave woman as "dark continent" had not died out. Metaphors similar to the ones used to remark on Sims's speculum in 1883 were used by Harris to remark on Sims's actions. Once again, the slave body is metaphorized as an unruly, uncharted, dark continent containing rich mysteries and spicy secrets. While the explorer utilizes the telescope or compass, the physician dealing in female disorders will make use of the speculum. Sims, like Columbus, was determined to conquer a naturalized resource (the Americas or the female body), civilizing the previously "uncivilized" territory. Fame was at stake for both, dependent on brutality, racist notions of entitlement, and the institution of slavery. However, less glamorous than the comparison to Columbus, Sims is also referred to as a dog chasing the wild squirrel of surgical success. With the Columbus and dog metaphors, ideas of driven and instinctual behavior, exploration, conquest, and domestication are joined as a means of legitimizing racial and sexual domination.

Throughout his experiments, Sims made adjustments in the hopes of successful surgery. Each time he was frustrated by the small fistula that remained. Deciding he needed a different type of suture, he traded in his silk thread for a silver-wire suture that he had had specially made, and the fistula was repaired. He considered his silver sutures to be "the greatest surgical achievement of the nineteenth century."⁵³ In the summer of 1849 he operated on Anarcha, the first fistula case he had ever seen, and the operation was a success. It was Anarcha's thirtieth operation.

Master Showman's Second Act

In 1855 Sims founded the Woman's Hospital in New York, a place where women could go despite their economic circumstances. The hospital was the first ever dedicated to female disorders, and its wards were largely filled with destitute Irish immigrant women.⁵⁴ It would appear that this was a charity hospital for the good of the poor. But as was the case with the slaves in Sims's backyard, patients at the Woman's Hospital were frequently kept there "indefinitely" and underwent multiple surgeries.

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From 1856 to 1859, an early indigent Irish visitor to the Woman's Hospital, Mary Smith, survived thirty operations, the same number Anarcha endured in Sims's backyard. It must not be forgotten that these women, unlike the slaves, had the benefits of anesthetics. Before Sims was aware of the existence of anesthetics he had attempted surgery on white women, "but they seemed unable to bear the operation's pain and discomfort with the stoicism shown by the Negroes."⁵⁵ The widespread use of anesthetics finally allowed Sims to bring his surgeries to white women and allowed for the establishment of places such as the Woman's Hospital. The Woman's Hospital continually provided Sims with bodies on which he could experiment with new surgeries and instruments. Discoveries he made at the hospital were then utilized in his private practice in exchange for high fees.⁵⁶

Sims moved to Europe during the Civil War, retaining his position as a "loyal southerner."⁵⁷ With the help of anesthetics, Sims operated on numerous wealthy European women, including a countess in France; he often had large audiences filling his operating theater to capacity. He stayed in Paris, where he was a "hit": "Here I performed in the amphitheatre, in which Joubard de Lamballe had performed all his operations."⁵⁸ Thus he clearly measured his success by the surgeon stars who had frequented the same stage.

When Sims returned to New York with his European fame and confidence, he took center stage, making the Woman's Hospital into his own private experimentation theater—scores of medical men came to observe Sims's performance of daring surgeries. Here he performed controversial surgeries as well, including Battey's operation, which Sims helped "make respectable." In the 1870s Battey's operation, or bilateral ovariectomy (removal of both ovaries), became a fashionable surgery to "treat" a variety of illnesses including insanity, epilepsy, and nervous disorders that were believed to originate in the female reproductive organs.⁵⁹ The operation had the additional effect of sterilization.

On his return from Europe with his new titles, Knight Commander of the Legion of Honor of France, Knight of the Order of Isabella the Catholic of Spain, and Knight of the Order of Leopold I of Belgium, there was new concern about Sims's practices. His biographer attributes this to his contemporaries' jealousy of and weariness over Sims's success: "He was too cocksure, they felt, too reckless, too much inclined to hold the spotlight in a one-man starring part." The Board of Lady Managers, a group of rich white women who oversaw the "moral and domestic management" of the Woman's Hospital and whose help Sims

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himself had solicited in order to afford his hospital legitimacy, recognized that Sims was experimenting on his patients and objected to the large audiences Sims allowed into his operating theater. A Lady Managers' memorandum asks, "Is the Woman's Hospital to be made a public school or is it to be a Private Hospital where our afflicted Sisters can come without fear?"⁶⁰ They limited to fifteen the number of spectators allowed during operations. Outraged, Sims resigned from the hospital in 1875 and a few months later was elected president of the AMA, his well-publicized resignation apparently rewarded by this esteemed organization. In his presidential address he attacked the AMA's code of ethics, which oversees and disciplines physicians' practices. Sims asked his colleagues, "Did it ever occur to you that [the AMA's code of ethics] is capable of being used as an engine of torture and oppression?" Sims felt that the code was too strict, as reflected by the medical establishment's unease with some of Sims's practices.⁶¹

Throughout the latter part of his career Sims invented new tools and techniques for "treating" women. Contemporaneous with sterilizing the mentally disordered, Sims was seeking out innovative solutions to correct private patients' infertility. For example, he invented and used an instrument for the amputation of the cervix that he called the "uterine guillotine." A pioneer in artificial insemination, Sims was also taken with the practice of "splitting the cervix," supposedly in order to ease the travel of semen and menses through the cervical canal. Many gynecologists considered the practice "butcherous."⁶² Coining the term *vaginismus* to refer to female "frigidity," a condition that disallows penetration by the penis into the vagina, Sims proceeded to invent a number of methods to remedy the situation, including hymenotomy, incising the vaginal orifice, and dilating the vagina with various-sized wedges. In "treating" vaginismus, Sims would sometimes simply anesthetize the woman so that her husband could have intercourse with her in order to impregnate her. This procedure asserted the compatibility of the passive, anesthetized female body with gynecological as well as sexual manipulation. This relationship was mirrored one hundred years later in the use of anesthetized women for teaching medical students how to perform pelvic exams. The passive, powerless female pelvis is thus situated as a model receptacle for medical intervention.

Sims continued to enlist such passive female bodies in order to prove his master showmanship. In 1879, four years prior to his death, Sims threw a gala event, something between a trade show and a circus. For four days, he performed a series of varied operations on different women, ending in a dinner at Sims's house for fifty or sixty physicians.⁶³

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As if in response to the Board of Lady Managers' reprimand of Sims for his large audiences at the Woman's Hospital, the gala event openly defied the Lady Managers' protocol for proper surgical performance.

Between Sims and the Board of Lady Managers, the staging of the operative performance had been called into question. The Lady Managers disputed Sims's previously unlimited power over the type of gaze and manipulation practiced on his patients' bodies. The gaze he wished to have control over, however, was not only his own but also that of his audience-followers. Throughout his medical career, Sims was always in the spotlight; after Sims enlisted anesthetics, his patients were even more proplike than before. The fact that the patients at the Woman's Hospital were white undoubtedly influenced the Lady Managers' idea of appropriate modesty. Because of their race and position within antebellum southern society, the slave women had been more appropriate objects for exhibition.

The appropriateness of the slave women for exhibition and unanesthetized experimentation served as a legitimation of the institution of slavery, as is evident in Sims's eluogist's statement that "the time was ripe" for Sims's experimentation. Implicit in this statement is the idea that the ends, gynecology and the furtherance of medicine, justified the means, slavery. The implication is that it is fortunate for humanity in general that slavery existed if only because it helped foster medical innovation. And as we can see from Sims's practices following slavery, his attitudes toward women, their bodies, and reproductivity were undoubtedly affected by his longtime experimentation on slave women. Gynecology in the United States evolved through the bodies of slave women. While slavery was eventually abolished, inequality and institutionalized racism flourish. Certain populations, particularly poor women of color, are still viewed as more fitting experimentees for, and more fitting recipients of, new technologies than other populations. Unfortunately, the time is still ripe, and medical innovation is still the excuse.

Sims continues to be praised in the introductions to gynecology texts and medical-history books without reference to his questionable practices. When his practices are questioned, as they were in a 1970s article that appeared in the *American Journal of Obstetrics and Gynecology* titled "Reappraisals of James Marion Sims," many physicians were outraged and defended Sims. The author, Irwin H. Kaiser, M.D., was not particularly critical of Sims and even responded to Barker-Benfield's chapter on Sims in *Horrors of the Half-Known Life* that although "Sims was insensitive to the status and needs of women," he was simply a "product of his era" and that one must "be skeptical of judging 1850 decisions by 1975 norms." Kaiser's colleagues, as evidenced by their

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discussion following his piece, were outraged by *any* questioning of Sims's practices. Dr. Denis Cavanagh responded, "Lest this distinguished Society degenerate into just another social club, we all have a responsibility to supply the program committee with good scientific papers. In my opinion this paper damns Sims with faint praise and is one of the least impressive papers that I have heard before this society." Dr. Lawrence L. Hester Jr. concurred: "I rise not to reappraise J. Marion Sims, but to praise him—to praise him as the father of gynecology and not to condemn him as an exploiter of women." These responses illustrate the vehemence with which Sims's work has been supported.⁶⁴

While such a staunch defense of Sims might not commonly be found in print today, it is significant that the evolution of the specialty of gynecology is not openly considered and questioned in medical texts and medical-history books. If gynecology is premised on such practices, might the entire specialty be reconsidered in this light? If it were, we would surely find that the racism and misogyny underlying Sims's practices still flourish in contemporary medicine and its applications, particularly with regard to women and their reproductive organs. The decisions made in the mid-nineteenth century continue to directly and indirectly influence the lives of women today. This does not mean that practitioners have studied Sims or are aware of his historic importance. Rather the medical apparatus continues to accommodate and even reward such racism and misogyny.

Sims's experiments on slave women, his practice of ovariectomy on the mentally disabled, and his pioneering work in artificial insemination and infertility helped institute the idea that it was appropriate for medical professionals to seek out new ways of both limiting and fostering female reproductivity. Forever in search of a new tool or surgical technique, Sims was one of the earliest physicians to link female reproductivity with a kind of technophilia, publishing extensively on each new innovation. Sims's work also linked experimentation on the female reproductive organs to race and power, since his earliest experiments were executed on female slaves.

In order to explore the legacy of Sims's work, I will consider the contraceptive technology Norplant. Experiments with Norplant were conducted almost exclusively on poor third world women, and since its FDA approval in 1990 it has been coercively and even legislatively aimed at poor women of color in the United States and abroad as a solution to the threat of their reproductivity. Whereas new technologies that limit reproductivity are often aimed at poor women of color, con-

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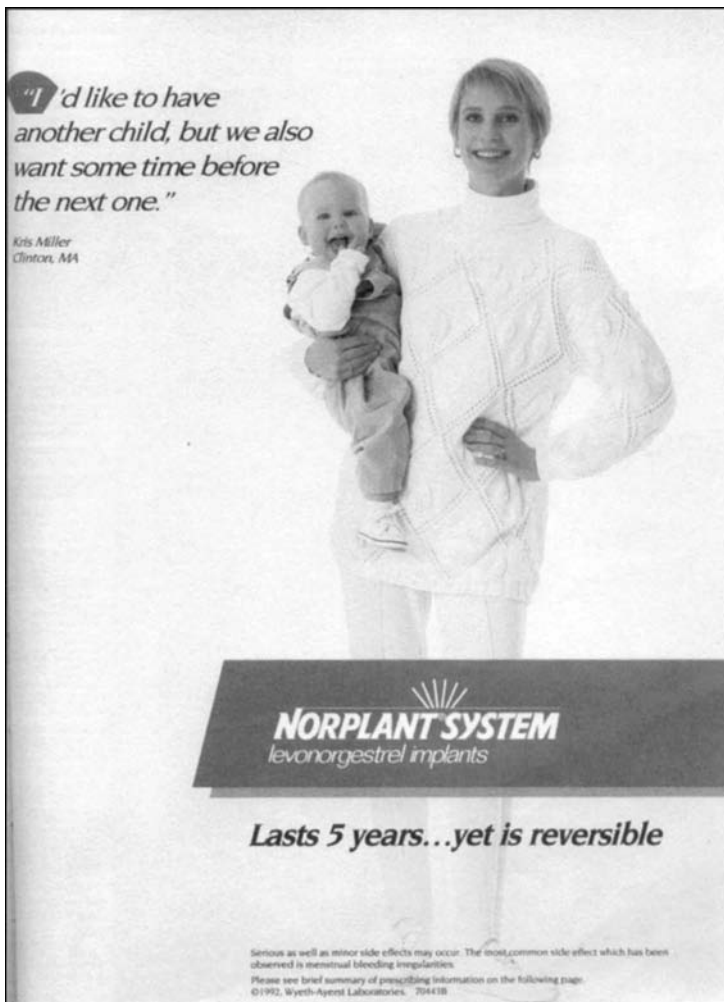


Fig. 41. Norplant advertisement. In the *Nurse Practitioner* (June 1992).

currently new reproductive technologies that extend or promote fertility (e.g., in vitro fertilization) are largely aimed at wealthy, white women. The impetus to enhance or contain reproductivity on the basis of race or social status can be traced to Sims's early practices.

Whereas Sims's vesico-vaginal fistula operations can be viewed as one of the earliest reproductive technologies, enhancing slaves' reproductive capacities and thus allowing them to continue their "duties" as

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"We're pretty certain that we don't want more children, but we wanted to leave the possibility open."

Kathy Hill
Jacksonville, FL

NORPLANT SYSTEM
levonorgestrel implants

Lasts 5 years...yet is reversible

Serious as well as minor side effects may occur. The most common side effect which has been observed is menstrual bleeding irregularities.
Please see brief summary of prescribing information on the following page.
©1992, Wyeth-Ayerst Laboratories, 70443A

Fig. 42. Norplant advertisement. In the *Nurse Practitioner* (July 1992).

“breeders,” Norplant is a form of temporary sterilization that prevents reproductivity. The historical conditions out of which each technology arose explain their opposite aims. Sims conducted his experiments at a time when the ruling southern whites could benefit from the reproductivity of slave women; Norplant has been developed as a response to the alleged need for new ways of controlling poor women’s reproductivity given the rhetorical backdrop of welfare crises and overpopulation.

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While arising out of very different historical conditions, Norplant and Sims's crude reproductive technologies are cousins. Both in Sims's time and today, certain women's reproductivity is valued over others', and new technologies are demanded in order to foster and prevent reproduction.

"Welcome to a New Era in Contraceptive Technology"

Approved by the FDA in 1990, Norplant is a subdermal contraceptive consisting of six small silicone-rubber capsules that are surgically implanted in a woman's arm.⁶⁵ The capsules diffuse a synthetic progesterone, levonorgestrel, that effectively inhibits ovulation and thickens cervical mucus, preventing pregnancy for up to five years. Because it is surgically implanted and removed, Norplant is physician controlled and "user soft." Theoretically, the user cannot designate when to start and stop Norplant; rather a health practitioner must insert and remove the capsules, making Norplant particularly prone to institutional abuse. Norplant has been especially attractive to the international population-control industry, for whom technologies that are effective, low maintenance, and provider dependent are valued. Norplant is mainly used in developing countries in Asia, Latin America, and Africa. The majority of Norplant's clinical or preintroduction studies were conducted in developing countries as well. Some fifty-five thousand women were included in these studies.⁶⁶

This seemingly science-fiction technology confirms the medical industry's presumption, asserted if not established by Sims, of the compatibility of the female body, particularly the female reproductive organs, with new technologies. Norplant, yet another case of science triumphing over nature, has been heralded throughout the world as a panacea technology. From Egypt, where the national press referred to Norplant as "the magic capsule," to the United States, where it has been heralded as "a birth control breakthrough," Norplant has received praise for its remarkable possibilities.

Its high-tech appeal was taken up by Norplant's advertising agents when they constructed a series of ads that pictured women meeting the viewer's gaze while responding to the question "Why do you choose Norplant?" White women and white families are dressed in white on a white background, constructing users as overwhelmingly modern, wealthy, and white (see figs. 41 and 42). Often, a contraceptive is at the center of the frame in pharmaceutical advertising (see fig. 44); that is, the product itself is pictured. However, because Norplant is placed

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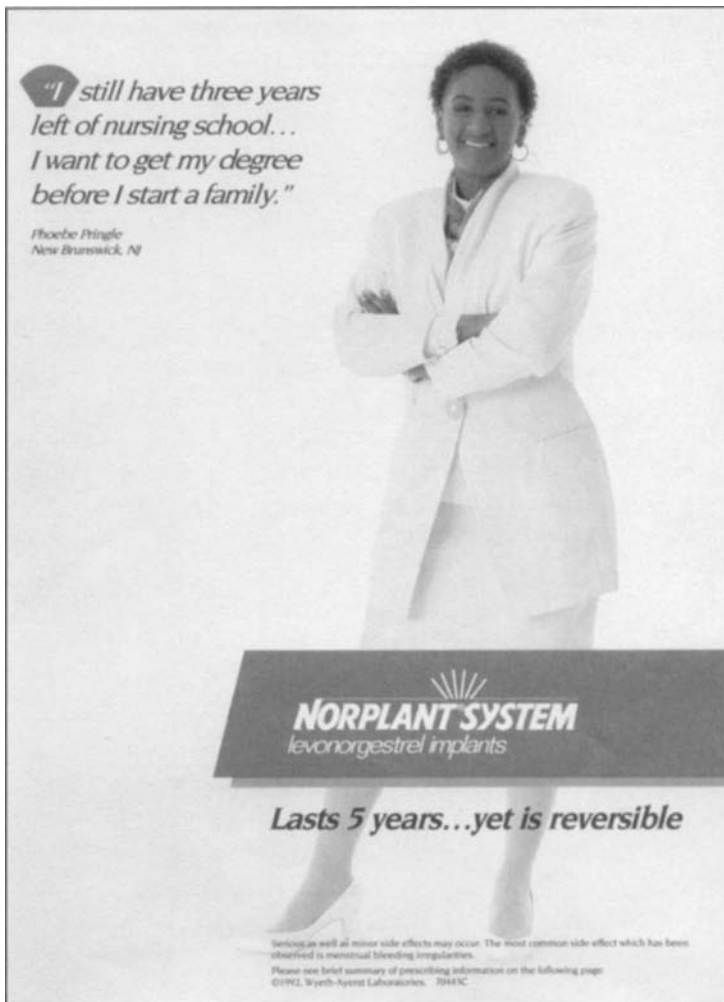


Fig. 43. Norplant advertisement. In the *Nurse Practitioner* (May 1992).

within the body, it is absent from the image, indicating that the woman shown has already securely incorporated Norplant into her modern body. One ad does picture an African American woman (see fig. 43). She too is dressed in the uniform white and set against a white background. Her reasons for choosing Norplant are not those of her white counterparts, who have either temporarily reached optimal family size or are taking a break between children. Rather, the woman represented wishes

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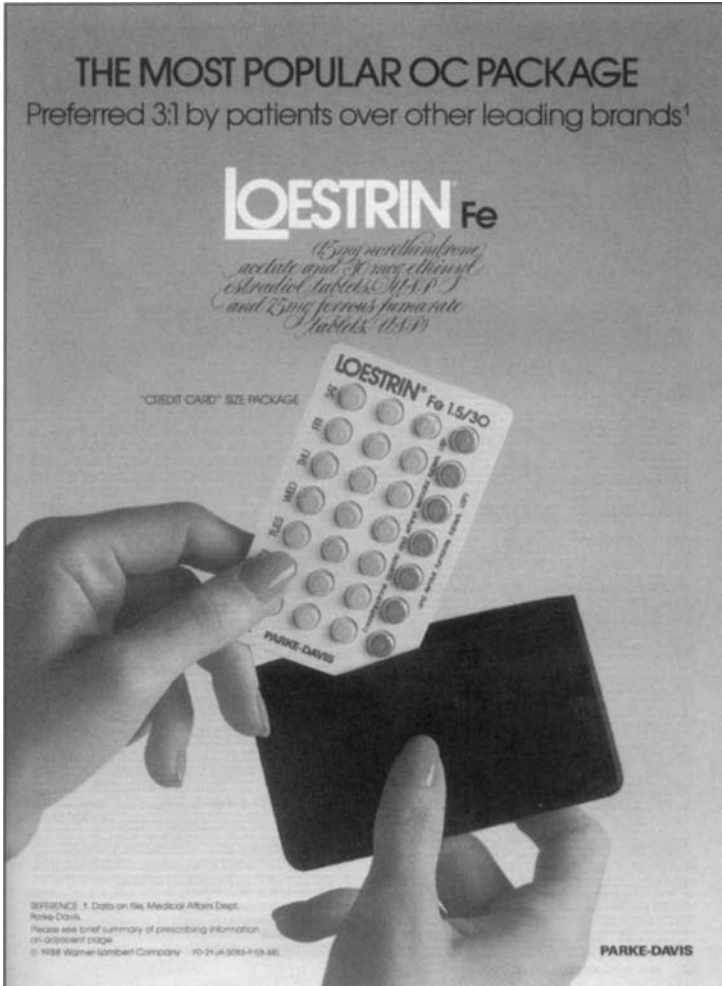


Fig. 44. LoEstrin advertisement. In the *Nurse Practitioner* (May 1989).

to finish school; she wishes to enter into a viable socioeconomic space that would allow her to support her future baby. Issues of supporting the young white children pictured in the ads previously shown are left un-addressed. It is assumed that personal, not economically motivated, choice is the reason a white woman or white family would decide to stop reproducing. The single African American woman, pictured child-less, is given an economic reason, and a societally acceptable one at that.

Both technological innovations, Norplant and Sims's vesico-vaginal

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surgeries, are proposed as ways of helping Black women be more “fit for their duties.” Sims’s vesico-vaginal fistula reparations would make the slave women more fit for their duties as breeders. In a slave economy, it is economically beneficial to those in power to repair slave capital so that she and her future progeny may provide labor. The slave woman’s reproductivity must be reclaimed *from* pathology. In a capitalist welfare economy, the reproductivity of the poor woman of color is her pathology. In the former case, reproductivity is economically beneficial to those with capital; in the latter reproductivity is believed to deplete economic resources. Whereas the slave women Sims experimented on were attributed a triple dose of pathology—race, sex, fistula—poor women of color today are still pathologized for the first two (race and sex), but reproductivity replaces the fistula as the third pathology.

Slave masters encouraged adolescent slave girls to have children; now “teenage pregnancy,” predominantly associated with poor women of color, is linked with gangs and drugs as an evil of modern society.⁶⁷ Norplant is seen as a new technology that can help put an end to teenage pregnancy and restore racial “balance” to the U.S. population. In December 1992, the front page of the *New York Times* told the story well. An article with the headline “Population Growth Outstrips Earlier U.S. Census Estimates” showed projections into the year 2050, where “white” population growth would remain steady while Black, Asian, and Hispanic populations would double at the very least.⁶⁸ Bedfellows with this front-page article was another piece titled “Baltimore School Clinics to Offer Birth Control by Surgical Implant.”⁶⁹ It is no surprise that the large majority of young women affected by this decision in the Baltimore area are poor African Americans. Norplant will not protect these teens from sexually transmitted diseases or educate them about their bodies and pregnancy, nor had any medical research addressed the health risks of Norplant in women under the age of twenty at the time such decisions were made. Norplant is used as a “quick fix” to the high teen birthrate in the Baltimore area and as a means of remedying uneven population growth.

Poor African American women who do have many children, women that ex-senator Russell B. Long referred to as “Black Brood Mares,” are often disdained for leeching tax dollars.⁷⁰ The duties of African American women today are viewed by the dominant culture as opposite to those of her slave ancestors. No longer is the African American woman in the Norplant ad expected to breed for her oppressors; now, new technologies such as Norplant aid her in becoming an educated, income-earning member of society *before* she has children. The narrative of these ads suggests that Norplant in fact serves a purpose similar to Sims’s

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reparative surgeries, playing into current dominant constructions of proper African American women's reproductive identity.

If poor women, particularly poor African American women, are not "fit for their duties," securing proper earning potential before they have children, Norplant has been seen as a technology that can remedy such misbehavior. The *Philadelphia Inquirer* published an editorial two days following FDA approval in December 1990, suggesting readers think about using Norplant as a "tool in the fight against African-American poverty."⁷¹ A few weeks later, California judge Howard Broadman ordered Darlene Johnson, a twenty-seven-year-old pregnant African American mother of four who had been convicted of child abuse, to have Norplant inserted or to serve a jail sentence.⁷² In 1993 Washington State, Arizona, Colorado, Ohio, Tennessee, North Carolina, South Carolina, and Florida all proposed incentive-based or mandate-based welfare reform linked to Norplant. For example, the proposal in Ohio would increase monthly Aid to Families with Dependent Children (AFDC) payments and offer a \$500 incentive for Norplant insertion or \$1,000 for sterilization. If a woman chose not to use Norplant and subsequently became pregnant, her benefits might be discontinued entirely or they might not be increased with the birth of the child. In Florida, the proposed reform set AFDC benefits at \$258 per month regardless of the number of children in the family, but a recipient with an effective implant would receive \$400 per month.⁷³ As the National Black Women's Health Project's newsletter asserts, "the line between incentive and coercion is fuzzy. The incentives are only being offered for one contraceptive—Norplant—to one class of women—poor, single, mothers on welfare—who are more likely women of color—what happened to choice?"⁷⁴

Women on welfare receive incentives for temporary or permanent sterilization; slave women received incentives such as better rations for prolific reproduction. It is unclear, however, what the slaves' "incentives" were for submitting to Sims's repeated surgeries. In their writings, Sims and Harris altogether disavow questions of the slaves' choice or consent by maintaining that the slave women were eager to be cured, willingly submitted to surgery, and even participated in the surgeries as Sims's assistants. Their positions as slaves authorized their "willingness" and consent, as they already had few legitimate choices regarding their bodies and everyday activities.⁷⁵ Similarly, we might consider how much "choice" a poor woman on welfare has when faced with such options regarding Norplant. And this "choice" is not as clear-cut as it may seem. Norplant does not serve as a simple on-and-off switch for fertility: there are a host of side effects that may accompany its use. The most common

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is a change in menstrual bleeding patterns. A significant number of women will bleed on and off throughout their cycle for the first year of use.⁷⁶ Other side effects include dizziness, headaches, nervousness, weight gain, weight loss, ovarian cysts, acne, infections at the implant site, nipple discharge, inflammation of the cervix, mood changes, depression, general malaise, itching, and hypertension.⁷⁷ The term *side effect* belittles the crushing impact any one of these symptoms may have on an individual's life.

Despite these foreboding possibilities, internal Population Council documents show that women in Indonesia, Bangladesh, and numerous other countries had difficulties getting Norplant removed due to resistant trial investigators whose scientific data "would be rendered incomplete."⁷⁸ Likewise, in early clinical trials done with Norplant, many cases of abuse regarding informed consent have been noted in numerous countries, including Indonesia, Brazil, Thailand, and Egypt. Medical innovation and experimentation are again used to legitimate oppression and control over the bodies of poor women of color. As in the case of Sims's experiments, it is "difference"—in this case, poor women of color's pathological race, sexuality, and reproductivity—that legitimates Norplant experiments and the product's continued use. And yet such studies are premised on a convenient user "sameness"—since Norplant will work identically on all female bodies, women of color will be adequate testing grounds for technologies to be potentially used on higher-valued white bodies in the future, if they so choose. Balanced between Western pharmaceutical companies, the medical establishment, and assorted governmental bodies, one finds a distinct colonialist attitude at work, not dissimilar to the rhetoric underlying writings about Sims. Dominant white forces go to faraway lands to identify their sameness with the exotic "other," while simultaneously establishing and maintaining the other's difference and reaping the benefits of the new land and culture.

In many states in the United States a woman on public aid who has received free Norplant is in a position similar to that of third world women facing resistant trial investigators: she can only have Norplant removed if a practitioner deems it medically necessary.⁷⁹ Changes in menstrual bleeding patterns, the most common Norplant side effect, are not considered by the medical establishment to be a reason to discontinue its use. And yet this single side effect may deeply affect the cultural performance of some women, particularly Native American and Muslim women. A report on Norplant issued by the Native American Women's Health Education Resource Center reads: "For Native Ameri-

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can women, the bleeding restricts their daily activity and prohibits them from participation in many traditional practices and religious ceremonies. . . . They do not attend sundances, sweats, or other spiritual ceremonies or go to any place where the pipe is used or to meetings of the Native American church. They also refrain from sexual activity. Ironically, the primary purpose of contraception—the ability to be sexually active without fear of pregnancy—then becomes a moot point.”⁸⁰ Norplant users are from a variety of ethnic backgrounds and engage in a variety of cultural practices that are not factored into the statistical and biological studies conducted by the pharmaceutical and medical institutions. Such “difference” is not considered significant alongside the benefits of Norplant as an effective, ethnicity-blind technology for “controlling” populations.

“It’s Your Choice”

Temporary sterilization in the form of hormonal contraceptives is a common visitor to foreign lands.⁸¹ Norplant is not the first contraceptive to be tried on women of color in its early stages of development. Poor women of color in developing countries are used consistently as experimental subjects in order to test new hormonal contraceptive technologies before they are used on North American women.⁸² The high-dose birth control pill and Depo-Provera, an injectable contraceptive, have each undergone these contraceptive trials, presenting women with a host of side effects and unknown long-lasting effects all under the auspices of population control.

Norplant, a form of temporary sterilization, is a participant in a form of eugenics deeply indebted to older, cruder technologies such as permanent sterilization. Norplant’s newness and technological sophistication help mask its appropriation for the same racist patterns of behavior that resulted in the systematic coercive and abusive sterilization of huge numbers of women of color in Puerto Rico, the continental United States, and abroad beginning in the 1940s. By 1968, one-third of the women of child-bearing age on the island of Puerto Rico had been sterilized. Most women sterilized had not been informed that the operation was, for all intents and purposes, irreversible.⁸³ Once again, one of the reasons these women were sterilized was so they could “fulfill their duties” as defined by U.S. manufacturing industries who needed cheap labor: “sterilization was perceived as a way to help ‘free’ them for employment, as opposed to, for example, providing good child-care facilities.”⁸⁴

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Funds from the United States were often involved in sterilization campaigns. For example, in the early 1980s the World Bank Project funded a program in Bangladesh that would give starving women relief wheat if they would be sterilized. Women also received monetary awards and a sari and sarong. In addition, physicians and staff received incentives for each woman who agreed to sterilization.⁸⁵ At that time, the director of obstetrics and gynecology at a New York municipal hospital explained, "In most major teaching hospitals in New York City, it is the unwritten policy to do elective hysterectomies on poor black and Puerto Rican women, with minimal indications, to train residents."⁸⁶ Sterilization abuse has been widespread and disastrous, affecting the lives of many women who have had to live with choiceless futures.

In the United States, the most flagrant abuses took place between 1970 and 1976.⁸⁷ Alabama, the home of Sims's backyard hospital, was also the state in which, more than a century later, two Black teenagers were sterilized without their consent or knowledge. This incident, known as the Relf case, was tried in the early 1970s; the court found "uncontroverted evidence in the record that minors and other incompetents have been sterilized with federal funds and that an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization."⁸⁸ The "incompetents" referred to here include mentally retarded and imprisoned women. These practices harken back to those of the Father of Modern Gynecology. As noted earlier, Sims himself practiced "female castration" on the "mentally disordered." Now such practices are taken up by Norplant. When introduced into Finland, its birthplace, Norplant was viewed as an inappropriate method for the majority of women but was targeted at very specific populations, one of them being "asocial women" (incarcerated, mentally ill, etc.). The category "asocial women" was "included in a commercial list of possible users given out by the manufacturer."⁸⁹ Though Norplant was viewed as an inappropriate method for most Finnish women, it was pushed as a first choice for many women of color. Certain women are deemed to be more fit users than others. As Purvis asks, "Are the women deemed 'unfit for motherhood' deemed fit for Norplant use?"⁹⁰ Whether subject to temporary or permanent sterilization or surgical reparation, the kinds of women targeted for medically sanctioned social control of their reproductivity—poor women, women of color, "asocial women"—are historically echoed.

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Hidden Visibility

In the rhetoric surrounding Sims's practices, the importance of making visible the inner recesses of the female body is clear. It was necessary for Sims to invent the speculum so that he could visualize the vagina in order to ply his instruments. The speculum made Sims famous, his future practices dependent on such visibility. As a technology, Norplant displaces the vagina or pelvis as the site of intervention. Norplant is not about spectacular visual display. Rather it is about spectacular miniature technology, a modern means of mastering the female pelvis. It is heralded because it is hidden. In addition, practitioners do not have to "get their hands dirty" by viewing or manipulating the reproductive organs themselves. Norplant enlists a different theater of operations. The inner arm becomes a control booth for the reproductive organs, from which the six silicone satellites release their hormones. Sims's daring and spectacular surgical feats are met today by technologies that regulate the female reproductive organs from afar.

Norplant's manufacturer's claims about its invisibility have come under fire. There is concern that Norplant, particularly in thin women, *does* mark the body. The capsules are indeed visible, serving as a sort of contraceptive tattoo or brand. The implications of these markings for population control are ominous.⁹¹ In addition, scarring, particularly among women prone to keloids (African, African American, Middle Eastern, Mediterranean, etc.), has been a problem for many women using Norplant and one of the factors that led to a class-action suit originating in Chicago on behalf of scarred users.⁹² The women involved in this suit stated that they were not properly informed before insertion. Although Norplant's distributors claim that it may be surgically removed in twenty minutes, some users have had a string of removal attempts, resulting in broken capsules (with large amounts of hormones flooding the body), excruciating pain, and significant scarring.

Besides the many cases of inadequate preinsertion counseling and informed consent, one of the worst problems associated with Norplant use abroad as well as in this country is the woman's difficulty having Norplant removed.⁹³ Many women, particularly poor women, have trouble finding practitioners who will agree to its removal: either practitioners are trained in insertion and not removal or they do not deem the woman's removal request medically necessary.⁹⁴ Having control over when and how one has surgery is largely a factor of a woman's social status, thus directly related to race, class, and economics. This

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was as true in Sims's time as it is today. After Sims had operated twice on a white woman, Miss C., for a harelip, he "was eager to perfect his handiwork with a third" operation.⁹⁵ However, Miss C. refused, satisfied after two operations. The slaves in Sims's backyard hospital and the indigent women at the Woman's Hospital in New York did not have such clear options.

Nor do poor women today. In my work at a women's health clinic, I have heard stories—horrifying but not unexpected stories—of women so pained by Norplant's effects on their bodies and frustrated by the unwillingness of medical practitioners that they attempted to remove the implanted capsules from their own arms. For them, freedom from Norplant was worth the pain of self-surgery without anesthetics.

There is no need for "sentimental reverie" over lost history in looking at the speculum, as J. Chassar Moir romantically suggests in the epigraph to this chapter. If we do gaze at the "curious speculum," we will catch much more than "a fleeting glimpse of an old hut in Alabama and seven Negro women who suffered, and endured, and had rich reward." Not only will we see that slavery served medicine, but we will also see that poor women, particularly poor women of color, continue to serve medicine. Meanwhile medical technologies serve those in power, be they slave owners or concerned taxpayers. By gazing into the "curious speculum," we might consider just how gynecology positions poor women of color and women in general and how it is decided just who is a fitting subject for medical experimentation and display. Gazing into the speculum reminds us to question the politics of visibility, of what is made visible—heroes and obstacles, ringmasters and silver sutures, cervixes and vaginas for surgical manipulation—and what is left invisible—pain and suffering, power differences, slave identities, questionable origins, semi-visible contraceptive technologies. By gazing into the speculum, we may consider how this tool may have solidified the medical institution's involvement in racist, eugenicist practices concerned with the reproductive capacities of poor women.

Gaze into the "curious" speculum. Look again and again and again and reflect on the formation of the medical specialty called gynecology.

NOTES

1. See Jessica Mitford, *The American Way of Birth* (New York: Dutton, 1992), 39. Mitford's discussion of Sims is largely based on G. J. Barker-Benfield, *The*

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Horrors of the Half-Known Life (New York: Harper and Row, 1976), chap. 10: "Architect of the Vagina."

2. Mitford, *American Way of Birth*, 39. Irwin H. Kaiser, M.D., states that "Sims and the other gynecological surgeons made their money by applying the hospital discoveries [made on slaves and poor white women] in private practice, where they charged stupendous fees." See his article, "Reappraisals of J. Marion Sims," *American Journal of Obstetrics and Gynecology* 132 (1978): 878.

3. Seale Harris, M.D., *Woman's Surgeon: The Life Story of J. Marion Sims* (New York: Macmillan, 1950), 107.

4. Historically, there has been a connection between circus freaks and medical institutions. In London, for example, physicians were sought after to bless new freak shows with reviews declaring the verity of their freakishness. Often medical men would denounce the show, but then later they would purchase the skeletons of dead freaks in order to display them at the medical school. See Richard Daniel Altick, *The Shows of London* (Cambridge: Harvard University Press, 1978), 260.

5. A. H. Saxon, *P. T. Barnum: The Legend and the Man* (New York: Columbia University Press, 1989), 79.

6. Saxon, *P. T. Barnum*, 76, 99.

7. Saxon, *P. T. Barnum*, 68.

8. Saxon, *P. T. Barnum*, 71.

9. J. Marion Sims, M.D., *The Story of My Life*, ed. H. Marion-Sims, M.D. (New York: D. Appleton and Company, 1886), 231.

10. J. Chassar Moir, *The Vesico-Vaginal Fistula*, 2d ed. (London: Bailliere Tindall and Cassell, 1967), 2.

11. Elizabeth Fox-Genovese, *Within the Plantation Household: Black and White Women of the South* (Chapel Hill: University of North Carolina Press, 1988), 171. Also see Deborah Gray White, *Ar'n't I a Woman?: Female Slaves in the Plantation South* (New York: W. W. Norton, 1985), 124–25.

12. W. O. Baldwin, "Tribute to the Late James Marion Sims, November, 1883," in *The Story of My Life*, by J. Marion Sims, M.D. (New York: D. Appleton and Company, 1886), 429.

13. Harris, *Woman's Surgeon*, 95.

14. Sims, *Story of My Life*, 23.

15. Sims, *Story of My Life*, 277.

16. John D'Emilio and Estelle B. Freedman, *Intimate Matters: A History of Sexuality in America* (New York: Harper and Row, 1988), 99–100. D'Emilio and Freedman cite Angela Davis's discussion of the value slave women placed on motherhood for their own reasons. See Angela Davis, "The Black Woman's Role in the Community of Slaves," *Black Scholar* 3 (Dec. 1971): 2.

17. White, *Ar'n't I a Woman?*, 79–80.

18. D'Emilio and Freedman, *Intimate Matters*, 94.

19. While an undeniably unpleasant condition for women to have, it is important to note that fistulas usually do not affect a woman's ability to conceive.

20. White, *Ar'n't I a Woman?*, 80. Todd L. Savitt, "Black Health on the Plantation: Masters, Slaves, and Physicians," in *Science and Medicine in the Old South*, ed. Ronald L. Numbers and Todd L. Savitt (Baton Rouge: Louisiana State University Press, 1989), 345.

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21. White, *Ar'n't I a Woman?*, 82.
22. Sims, *Story of My Life*, 230.
23. Many of the normal positions of the uterus were considered pathological in the early practice of gynecology; thus "replacing the uterus" was a common procedure. For example, in Henry T. Byford's *Manual of Gynecology* (Philadelphia: P. Blakiston, 1897), there is a description of the maneuver that Sims learned as a medical student: "The uterus may be replaced by putting the patient in the knee-chest position (Campbell), admitting air to the vagina, and pushing the fundus toward the promontory of the sacrum with a blunt instrument like a drumstick. . . . When the fundus is dislodged from the hollow of the sacrum, gravity completes the replacement. This is a good method for the replacement of the pregnant uterus" (246). A number of physical and mental disorders were linked to the uterus. "Local treatments" to the uterus consisting of manual relocation, leeches, and "injections" of various substances were common practice. See Ann Douglas Wood, "The Fashionable Diseases: Women's Complaints and Their Treatment in Nineteenth-Century America," in *Women and Health in America*, ed. Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1984), 222–38.
24. Sims, *Story of My Life*, 234–35.
25. See Harold Speert, M.D., *Obstetric and Gynecologic Milestones* (New York: Macmillan, 1958), 447–49.
26. Baldwin, "Tribute," 434.
27. See Mary Ann Doane, "Dark Continents: Epistemologies of Racial and Sexual Difference in Psychoanalysis and the Cinema," in *Femmes Fatales: Feminism, Film Theory, Psychoanalysis* (New York: Routledge, 1991), 209–48.
28. Mary Ann Doane, *The Desire to Desire* (Bloomington: Indiana University Press, 1987), 61.
29. See Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Random House, 1973).
30. Baldwin, "Tribute," 434.
31. Sims, *Story of My Life*, 235.
32. Donna Haraway locates this trope of the "hero-scientist" in an immunology textbook from 1987. She maintains that "science remains an important genre of Western exploration and travel literature." See Haraway, "The Biopolitics of Postmodern Bodies: Constitutions of Self in Immune System Discourse," in *Simians, Cyborgs, and Women: The Reinvention of Nature* (New York: Routledge, 1991), 205.
33. Teresa de Lauretis, *Alice Doesn't: Feminism, Semiotics, Cinema* (Bloomington: Indiana University Press, 1984), 127–28.
34. Sims, *Story of My Life*, 236.
35. Sims, *Story of My Life*, 237.
36. Haris, *Woman's Surgeon*, 99.
37. Diana E. Axelsen, "Women as Victims of Medical Experimentation: J. Marion Sims' Surgery on Slave Women, 1845–50," *Sage* 2, no. 2 (1985): n. Axelsen questions "Sims' continued failure to use ether or to seek out current research in the area of anesthesiology." She implies that no attempt was made on Sims's part to help alleviate the slave women's pain.
38. Sander L. Gilman, "Black Bodies, White Bodies: Toward an Iconography

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of Female Sexuality in Late Nineteenth-Century Art, Medicine, and Literature," *Critical Inquiry* 12 (autumn 1985): 231. Winthrop D. Jordan, *White over Black: American Attitudes toward the Negro, 1550–1812* (New York: W. W. Norton, 1968), 517–21.

39. Black male sexuality was undeniably constructed as pathological too. But the link between Black female sexuality and genitalia was repeatedly drawn, whereas Black male genitalia were left out of the discussion. When Gilman examines autopsy reports from the late nineteenth century, he finds that Black female genitalia are discussed but that there is no discussion of Black male genitalia whatsoever. See Gilman, "Black Bodies, White Bodies," 218.

40. For a discussion of this dichotomy, see Hazel Carby, "Slave and Mistress: Ideologies of Womanhood under Slavery," in *Reconstructing Womanhood: The Emergence of the Afro-American Woman Novelist* (New York: Oxford University Press, 1987), 20–39.

41. Sander L. Gilman, *Difference and Pathology: Stereotypes of Sex, Race, and Madness* (Ithaca: Cornell University Press, 1985), 88.

42. Gilman, *Difference and Pathology*, 88 n. 19. For a contemporary take on the Hottentot Venus, see Lisa Jones, "Venus Envy," in *Bulletproof Diva: Tales of Race, Sex, and Hair* (New York: Anchor Books, 1994), 73–77.

43. Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (Madison: University of Wisconsin Press, 1989), 138–39.

44. See Harris, *Woman's Surgeon*, 98. Historically, Africans and in turn African slaves were considered to be beasts, thus making them particularly fitting "guinea pigs." See Jordan, *White over Black*, 228–34. See also Todd L. Savitt, "The Use of Blacks for Medical Experimentation and Demonstration in the Old South," *Journal of Southern History* 48, no. 3 (1982): 332.

45. Sims, *Story of My Life*, 470.

46. Axelsen, "Women as Victims," 12.

47. Sims, *Story of My Life*, 241.

48. Sims, *Story of My Life*, 241.

49. This is not to belittle the great achievements of Black female health-care professionals regardless of their role, but rather to point to the fact that Black women have often been excluded from positions of power within the medical establishment. Black women have had to fight tremendously hard for inclusion even as assistants. See Darlene Clark Hine, "Mabel K. Staupers and the Integration of Black Nurses into the Armed Forces," in *Women and Health in America*, ed. Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1984), 497–506. For exceptions to the idea of limited roles for Black women in the health professions, see Sheila P. Davis and Cora A. Ingram, "Empowered Caretakers: A Historical Perspective on the Roles of Granny Midwives in Rural Alabama," in *Wings of Gauze: Women of Color and the Experience of Health and Illness*, ed. Barbara Bair and Susan E. Cayleff (Detroit: Wayne State University Press, 1993), 191–201; and Melissa Blount, "Surpassing Obstacles: Pioneering Black Women Physicians," in *The Black Women's Health Book: Speaking for Ourselves*, ed. Evelyn C. White (Seattle: Seal Press, 1990), 44–51.

50. Harris, *Woman's Surgeon*, 99.

51. Durrenda Ojanuga, "The Medical Ethics of the 'Father of Gynaecology,'

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- Dr. J. Marion Sims," *Journal of Medical Ethics* 19 (1993): 28–31. See also Todd L. Savitt, *Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia* (Urbana: University of Illinois Press, 1978), 293.
52. Harris, *Woman's Surgeon*, 92.
 53. Cited in Barker-Benfield, *Horrors of the Half-Known Life*, 96.
 54. Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (New York: Doubleday, 1978), 125.
 55. Harris, *Woman's Surgeon*, 109.
 56. Barker-Benfield, *Horrors of the Half-Known Life*, 102–3.
 57. Barker-Benfield, *Horrors of the Half-Known Life*, 98.
 58. Sims, *Story of My Life*, 295.
 59. See Lawrence D. Longo, "The Rise and Fall of Battey's Operation: A Fashion in Surgery," in *Women and Health in America*, ed. Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1984), 270.
 60. See Harris, *Woman's Surgeon*, 298.
 61. Harris, *Woman's Surgeon*, 129, 135, 288.
 62. See Barker-Benfield, *Horrors of the Half-Known Life*, 110.
 63. Barker-Benfield, *Horrors of the Half-Known Life*, 105.
 64. Kaiser, "Reappraisals of J. Marion Sims," 878. See also S. Buford Word, M.D., "The Father of Gynecology," *Alabama Journal of Medical Science* 9, no. 1 (1972): 33–39.
 65. The front cover of Wyeth-Ayerst Laboratories' Norplant information booklet for consumers reads: "Would you like up to 5 years of continuous birth control that is reversible? Welcome to a new era in contraceptive technology."
 66. I find one volume on Norplant particularly helpful. See Barbara Mintzes, Anita Hardon, and Jannemieke Hanhart, eds., *Norplant: Under Her Skin* (Amsterdam: Women's Health Action Foundation, 1993), 90.
 67. White, *Ar'n't I a Woman?*, 98.
 68. Robert Pear, "Population Growth Outstrips Earlier U.S. Census Estimates," *New York Times*, Dec. 4, 1992.
 69. Tamar Lewin, "Baltimore School Clinics to Offer Birth Control by Surgical Implant," *New York Times*, Dec. 4, 1992.
 70. Thomas M. Shapiro, *Population Control Politics: Women, Sterilization, and Reproductive Choice* (Philadelphia: Temple University Press, 1985), 118. This very term was used during slavery to refer to slave women who could reproduce efficiently. See White, *Ar'n't I a Woman?*, 105.
 71. See Faye Wattleton, "Using Birth Control as Coercion," *Los Angeles Times*, Jan. 13, 1991.
 72. See Stacey L. Arthur, "The Norplant Prescription: Birth Control, Woman Control, or Crime Control?" *UCLA Law Review* 40, no. 1 (1992): 1–101; and Gretchen Long, "Norplant: A Victory, Not a Panacea for Poverty," *National Lawyers Guild Practitioner* 50, no. 1 (1993): 11–13. The attempt to control African American reproduction by means of the judicial system has a long and sordid history. See Dorothy E. Roberts, "Crime, Race, and Reproduction," *Tulane Law Review* 67 (1993): 1945–77.
 73. Shana Morrow, "Welfare Reform and Reproductive Freedom," *Planned Parenthood, Chicago Area, "Political Affairs Perspective"* (fall 1993): 2–3, 7.

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74. National Black Women's Health Project, "Facts: Norplant" (newsletter) 1992.

75. Issues of "choice" and informed consent haunt another set of medical experiments that occurred about eighty years following Sims's experiments and less than forty miles from Montgomery. These experiments, which happened in and around Tuskegee County, were nontherapeutic, meaning no new technology (e.g., surgery or device) was being tried. This time poor, illiterate African American men were the subjects, not slave women. Men were chosen who had been infected with syphilis but who were never told that they had syphilis. Instead the white Public Health Service (PHS) practitioners told them they had "bad blood." In exchange for being part of the study, the men received free physical exams, lunch on the day of the exam, and burial insurance. No treatment was ever given; instead their slow physical and/or psychological deterioration was monitored over the course of forty years (1932-72). This study has been superbly documented by James H. Jones in his book *Bad Blood: The Tuskegee Syphilis Experiment*.

At first sight, it might seem as though Sims's work and the PHS study have little in common other than geographical proximity. Yet both projects are founded on similar attitudes regarding Black bodies, Black sexuality, and the relationship of these bodies and sexualities to pathology. Both syphilis and vesico-vaginal fistulas are conditions related to genitalia and therefore sexuality. Syphilis is a sexually transmitted disease that is often associated with sexual promiscuity. The contraction and transmission of the disease were therefore readily associated with African Americans. As Jones notes, "No disease seemed more suited to blacks than syphilis, for physicians were certain that exaggerated libido and sexual promiscuity had led to a high incidence of the disease among blacks." Both Sims's and the PHS's experiments are symptomatic of a pathological, white-dominated medical mindset that devalues Black bodies. Why not let these societally less powerful people experience prolonged suffering and pain? Suffering and pain might lead either to reparation or to death depending on the desires of those officiating the "treatments." The slave woman would be more helpfully repaired; the poor Black man after slavery would be more useful dead.

76. Robert A. Hatcher, M.D., M.P.H. et al., *Contraceptive Technology 1990-1992*, 15th rev. ed. (New York: Irvington, 1994), 307.

77. Mintzes, Hardon, and Hanhart, *Norplant*, 10.

78. The Population Council, "Norplant Worldwide" no. 16 (Nov. 1991): 2.

79. American Health Consultants, "Clinicians, Patients, Medicaid: Is Anyone to Blame for Norplant Removal Dilemma?" *Contraceptive Technology Update* 14, no. 10 (1993): 152.

80. Native American Women's Health Education Resource Center, *The Impact of Norplant in the Native American Community* (June 1992): 13.

81. The back cover of Wyeth-Ayerst Laboratories' Norplant information booklet for consumers reads: "Ask your doctor if the Norplant System is right for you. . . . It's your choice."

82. Mintzes, Hardon, and Hanhart, *Norplant*, 90.

83. Betsey Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice* (New York: Harper and Row, 1987), 232.

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84. Hartmann, *Reproductive Rights and Wrongs*, 232.
85. Hartmann, *Reproductive Rights and Wrongs*, 213.
86. Hartmann, *Reproductive Rights and Wrongs*, 241.
87. See Shapiro, *Population Control*, 107.
88. Cited in Hartmann, *Reproductive Rights and Wrongs*, 241.
89. Eeva Ollila, Kristiina Kajesalo, and Elina Hemminki, "Experience of Norplant by Finnish Family Planning Practitioners," in *Norplant: Under Her Skin*, ed. Barbara Mintzes, Anita Hardon, and Jannemieke Hanhart (Amsterdam: Women's Health Action Foundation, 1993), 61.
90. Ollila, Kajesalo, and Hemminki, "Experience of Norplant," 61. Here the authors cite A. Purvis, "A Pill That Gets under the Skin: Norplant Could Spur Birth Control—and Stir Controversy," *Time*, (Dec. 24, 1990), 45.
91. Hartmann, *Reproductive Rights*, 200.
92. *Jane Doe, Annrita Garcia, Mary Roe, and Leticia Walker v. Wyeth-Ayerst Laboratories*, 93 L 11096. See Heather M. Little, "No Panacea: Norplant Suit Charges Failure to Educate Patients," *Chicago Tribune*, Oct. 31, 1993.
93. Inadequate counseling and informed consent as well as the practice of inserting Norplant in women who are medically at risk have been well documented within the Native American community. See Native American Women's Health Education Resource Center, *Impact of Norplant*. An overview of this study was printed as "Native American Women Uncover Norplant Abuses," *Ms.*, Sept./Oct. 1993, 69.
94. See American Health Consultants, "Too Much or Too Little—Access to Norplant Implants Fuels Ethics Debate," *Contraceptive Technology Update* 14, no. 9 (1993); and "Clinicians, Patients, Medicaid: Is Anyone to Blame for Norplant Removal Dilemma?" *Contraceptive Technology Update* 14, no. 10 (1993).
95. Barker-Benfield, *Horrors of the Half-Known Life*, 95.