

**Introducing the Speculum:  
A Textual Exploration of the Representations of Dr. J Marion Sims,  
“Father of Modern Gynecology”, and His Slave Medical Experimentations**  
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**Introduction**

But race is the child of racism, not the father.

And the process of naming ‘the people’ has never been a matter of genealogy and physiognomy so much as one of hierarchy...

As for now, it must be said that the process of washing the disparate tribes white, the elevation of the belief in being white... meant, first and foremost, to deny you and me the right to secure and govern our own bodies.

**Ta-Nehisi Coates, *Between the World and Me***

In his seminal work *Between the World and Me*, author Ta-Nehisi Coates pens an impassioned open letter to his son in an attempt to frame and validate the collective fears, frustrations and pain of attempting to survive as Black Americans today. With the countless breaking news stories of young black bodies dying at the hands of a predominantly white police force, Coates’ confession pulled on the heartstrings of most Americans, especially Black Americans, on how to conceptualize and verbalize the intense need to protect black bodies from harm’s way within a complex and centuries-old system of racial injustice and oppression. Since its release last summer, I have wrestled with these concerns on a more personal level---that of the healthcare realm. As a fourth year medical student, graduating in less than a month and venturing off to train for another 3 years of residency, I struggle daily to care for others’ lives in a profession with a history firmly rooted in the exploitation of the black and brown bodies I identify with most.

The following is a preliminary analysis of the textual representations of one of modern medicine's most revered surgeons and often considered founding gynecologist, Dr. James Marion Sims. As such, future collaborations with outside scholars in building upon this project are sincerely welcomed and encouraged by this author. While the qualitative study of specific published articles is the cornerstone of this particular project, to fully understand it is essential to grasp the rich historical context of both slavery and the development of Western medicine in the United States. Therefore, in an effort to best comprehend the complex intersectionality of race, sex, science, and medicine that spans the scope of this endeavor, this story weaves across multiple timeframes, from the Antebellum South to present-day medical school classrooms.

My interest in the history of medical experimentation and research began 6 years ago as an undergraduate at Brown University. In completing my thesis on contextualizing medical distrust within the African American community, I found a small paragraph online describing Dr. J Marion Sims. Its description was surprisingly subjective, given his controversial legacy founded on surgical experimentations of black slave women. Born in 1813 in South Carolina, Sims was the eldest of 8 children in a mainly poor family. His father was a local sheriff, and his mother ran the local inn. Sims navigated his way through school and upon entering secondary learning, decided to pursue a career in medicine, much to his parents' disapproval (the only other options being law and theology, both of which Sims rejected strongly). In his autobiography *The Story of My Life*, Sims recalls his father's reflexive discontent for the decision:

Well, I suppose that I can not control you; but [medicine] is a profession for which I have the utmost contempt. There is no science in it. There is no honor to be achieved in it; no reputation to be made, and to think that my son should be going around from house to house through this country, with a box of pills in one hand and a squirt in the other, to ameliorate human suffering, is a thought I never supposed I should have to contemplate.<sup>1</sup>

While it may seem harsh, it is not unreasonable to appreciate his father's distaste of the medical profession, given the overall skepticism of the field in the early 1800's. Western medicine's reputation was in its infancy. At the time, most aspiring medical students who could afford to trained in Europe, where medical and surgical advances were more widely published internationally.

Those coming from humbler means were confined to training at local schools within the United States, which failed to offer substantial clinical experience due to a lack of willing patients as participants. It is at this time that many medical institutions capitalized on the use of bodies, likely involuntary, from almshouses and morgues; more often than not, those who identified as African American slaves and/or criminals. Limited training resources left many medical graduates for wanting of firsthand clinical and anatomical experience, abandoning a generation of budding physicians to their own means for procuring patients and simply learning successful techniques as they went. Moreover, an ideological schism divided America's practitioners. The "Germ Theory", a concept widely accepted today that recognizes bacteria and viruses as disease-causing pathogens, would not be evidentially-proven until the late 19<sup>th</sup>-Century by Drs. Louis Pasteur and Robert Koch.<sup>2</sup> Until then, medical education and licensing was notorious for being capricious at best, with multiple conflicting disease and treatment theories circulating throughout the country. Therefore, patients chose their method of care from an array of practices: Thomsonian medicine, which focused on botanical remedies; water cures, bloodletting, cupping, leeching, amputations, and a heavy dependence on agents such as high-dose mercury, calomel, opium, and quinine.<sup>3</sup>

It wasn't until the Flexner Report was published in 1910, an unprecedented study of the state of the nation's medical schools conducted by white educator Abraham Flexner, that the biomedical model became the gold standard for medical training in the United States and Canada.<sup>4</sup> In over a 300 page-document, Flexner outlines his personal recommendations to standardize the medical education

system on a national scale, including medical licensing criteria still honored today. Nevertheless, Flexner dedicated a mere 2 pages to the concerns of African American physicians in-training. In his scathing critique, which explains that “[t]he negro needs good schools rather than many schools, ---schools to which the more promising of the race can be sent to receive a substantial education in which hygiene rather than surgery... is strongly accentuated”, Flexner single-handedly contributed to the dismantling of all but two African American medical schools in the United States.<sup>5</sup> Both schools, Meharry and Howard University, still operate to this day. Contemporary African American studies scholars highlight this historical event as a key instigator for the relatively small representation of licensed physicians of color today.<sup>6</sup>

Nevertheless, in 1835 Sims graduated from Jefferson Medical College in Philadelphia, at the age of 22 years old. Despite numerous attempts to procure and maintain a sustainable family practice in the South, Sims struggled hopelessly to treat the needs of his patients (his first 2 cases were both infants that died within the year). Sims eventually settled in Montgomery, AL and for a time, maintained a gradual streak of successes treating minor surgical cases as a plantation physician. In 1845, Sims was called to assist in a delivery for a young Black slave, Anarcha, who was 18 years old and in prolonged labor for over 72 hours. With the use of forceps, Sims successfully delivered the newborn, however within days the patient was noted to have developed urinary and fecal incontinence. Like many enslaved African American women in the Antebellum South, Anarcha developed a complication from her prolonged labor known as vesico-vaginal fistula (VVF), a tear in the soft tissues between the vagina and the bladder wall as a result of continued pressure from the newborn’s lodged skull, cutting off circulation to the surrounding tissue. This necrotic process leads to a sloughing of the soft tissue between the vagina and the bladder, often resulting in the woman’s inability to control her urine and quite possibly her bowel movements if the rectum is involved as well.

Many researchers today hypothesize that the overwhelming prevalence of VVF resulted as a combination of enslaved mothers' young ages at delivery (most in their teens) and a development of Rickets disease from Vitamin-D deficiency, likely due to nutrient-poor diets. One of the cruder complications of Rickets in women is a contracted, or atypically flattened, pelvis with a narrowed birth canal that easily results in difficult, painful, prolonged labors, and consequently, VVF. To comprehend the intricately webbed causalities of VVF for these slave women, is to grasp a mere fraction of the systematic health disparities endured by African Americans in the Antebellum South.

As historian Todd Savitt outlines, black slaves, and particularly in the Deep South, during the 19<sup>th</sup> century and prior, were a unique demographic prone to a specific set of disease and maladies unique to their enslavement. Numerous delinquent living and working conditions plagued black health in this era: slave quarters lacking windows and subsequent poor ventilation with dampened floors created an ideal breeding ground for fungus and bacteria on the slaves' food, clothes, and utensils; bedbugs, body lice, ringworm, pinworms; contaminated water and poorly cooked food, along with worm larvae infested soil and close proximity to farm animals' pens all contributed to a higher incidence of disease morbidity. Diets mainly consisted pork and cornmeal, with only a fractional group of slaves being capable to grow fruits and vegetables in their own yards, and that produce was often sold to make a meager profit towards purchasing their freedom. Shoes, or the lack thereof, were a significant contributing factor to the susceptibility of scrapes, burns, frostbite, and penetration of foreign objects. Irrespective of physical abuse and beatings induced by slave masters, unpredictable work-related injuries also threatened black slaves' bodies, including overturned carts, falls, drownings, animal kicks and cuts from axes or blades.<sup>7</sup>

Nevertheless, the livelihood of black slaves depended heavily on the slave owners' discernment, which was deeply invested, if only for personal and economic gain. First and foremost, black slaves were considered a financial investment that

was expected to produce maximum production for their purchase. It would behoove a master to ensure that, even the bare minimum, healthcare was needed to guarantee a slave could work. Secondly, black slaves worked for, served, and lived within close proximity to white slave owners and their families; therefore, it was imperative to limit the spread and properly treat any sign of disease on the property. The triage of care on a plantation was three-fold: self-medicine, family physician, and “irregular” practitioners, ie, Thomsonians, homeopaths, and eclectics.<sup>8</sup> Within the circle of self-medicine included a group of African American slaves who trained each other via oral tradition and apprenticeship to become nurses and midwives for their peers in minor medical emergencies. If the concern became more chronic or required surgical intervention, a visiting physician could be called to intervene. Therefore, the risk for black slaves then became, if their illness was severe enough to reach the master’s attention, the master’s decision on how to treat their ailment automatically super-ceded the slave’s wishes. This is essential to appreciating the disregard for medical mores with respect for enslaved black bodies.

For Southern physicians, their positions of diagnostic power gained notoriety among their colleagues, politicians, and white citizens alike. Arguably one of the most prominent and persuasive physicians was Dr. Samuel Cartwright. A self-proclaimed expert on “Negro medicine”, Cartwright spearheaded the Medical Association of Louisiana’s investigative committee in 1851 on the “diseases and physical peculiarities of our negro population”. He argued that slavery was medically beneficial to slaves, and the physical labor white slaveholders imposed on blacks helped their lungs “vitalize” blood to their brain that “liberates their mind”. His ongoing studies on the differences in lung capacities of blacks and whites led to his construction of a spirometer and standardization of lower lung capacities exclusively for the black race---a technology still in practice today. Perhaps one of Cartwright’s most notorious contributions to racial medicine was assigning specific diseases solely to Negroes, coining terms such as *drapetomania* (Greek for “runaway slave” and “crazy”) and *dyasthesia aethiopsis* or “rascality that designated a lack of

respect for the master's property". The physician recommended that the best cure was continued physical labor and corporal punishment "until they fall in to that submissive state which it was intended for them to occupy."<sup>9</sup>

Many doctors followed Cartwright's lead and employed their own medical research observations to explain supposed anatomical and physiological differences between black and white patients. In turn, white physicians could justify their own politically charged agendas in legitimizing the Southern stance on slavery coded in biomedical rhetoric. Certain practices such as measuring cranium and brain sizes to rationalize the inferiority of blacks to whites, to investigating supposed differences in lung capacity amongst blacks and whites, to substantiating the prevalence of certain diseases like pneumonia and heat intolerance on the basis of racial differences, and pursuing unfounded "treatment" experiments on slaves, collectively enabled Southern physicians to author notions of "whites in a position of medical and physical superiority over blacks, perfect for Southern sectional polemics and useless to the practitioner".<sup>10</sup> Additionally, the shared consensus among many white Southerners, physicians and lay people alike, attributed a belief in blacks' collective ignorance, slovenliness, and irresponsibility to the slaves' inability to control their own illnesses. One Southern planter was quoted, "They will never do right, left to themselves".<sup>11</sup>

For enslaved black women in particular, the implicit financial power of slavery played an essential role in demanding black female reproductive bodies as the essential procreative vessels for mass-producing future chattel. Therefore the concerns of Black women's reproductive health metamorphosed into an "economic incentive to govern Black women's reproductive lives" for white slave owners.<sup>12</sup> Secondly, any medical advances discovered on the bodies of enslaved black women could be deemed profitable for the recovered health and well-being of similarly afflicted white patients, who frequently benefited once the technique or process had been mastered.<sup>13</sup>

Back to Sims' case, he recalls in his autobiography that after examining Anarcha's VVF condition, he surrendered that her case was hopeless. In fact, he expressed his own aversion towards women's health in general:

...I had nothing whatever to do with midwifery... I never pretended to treat any of the diseases of women, and if any woman came to consult be on account of any functional derangement of the uterine system, I immediately replied, 'This is out of my line; I do not know anything about it practically, and I advise you to go to Dr. Henry or Dr. McWhorter.'<sup>14</sup>

However, plantation owners from various outside counties continued to bring more cases of Black slave women to his office, including Betsey and Lucy. Sims built a makeshift 8-bed hospital in the back of his home for monitoring the slave patients. "If there is anything I hated, it was investigating the organs of the female pelvis" he writes in the earlier days. However, a chance occurrence with a white female patient changed his perception of female care. The young woman had fallen off her horse, and was taken to Sims for extreme abdominal pain. Placing the woman in a chest-knees position on the examination bed, Sims was able to clearly identify and realign her prolapsed uterus, causing instant relief to the patient. This discovery ignited Sims' interests in attempting to correct the slave women's conditions. With the bent handle of a pewter spoon, Sims created the earliest prototype of the modern-day speculum and examined Betsey in the similar knee-to-chest position in his hospital. He recalled,

Arriving there, I said, 'Betsey, I told you that I would send you home this afternoon, but before you go I want to make one more examination of your case.' She willingly consented. I got a table about three feet long, and put a coverlet upon it, and mounted her on the table, on her knees, with her head resting on the palms of her hands. I placed the two students on each side of the pelvis, and they laid hold of the nates, and pulled them open...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.'<sup>15</sup>



With this began Sims experimentation in curing and perfecting his techniques on repairing vesico-vaginal fistulae. It is noteworthy to highlight Sims' use of "[s]he willingly consented" in describing the onset of his experimental endeavors, particularly during the times of slavery, and more significantly, prior to the general consensus of medical ethics among practitioners and laypeople alike.

As he mentions earlier, at first Sims depended on the assistance of fellow medical colleagues. However, as the years continued and the failed attempts accumulated, Sims found himself training the female slaves to physically hold down one another during his surgeries. It is unclear whether this was a willful and autonomous decision on the part of the female slaves. His first surgical case was on Lucy, a young slave woman who was noted to have endured a great deal of pain and complications under Sims' care:

That was before the days of anesthetics, and the poor girl [Lucy], on her knees, bore the operation with great heroism and bravery. I had about a dozen doctors there to witness the series of experiments I expected to perform... At the end of five days [Lucy] was very ill. She had fever, frequent pulse, and real blood-poisoning, but we did not know what to call it at that day and time.<sup>16</sup>

Sims continues to explain that his experiment in leaving a sponge in Lucy's bladder as an attempt to block the urine from dripping became considerably infected and hardened like stone. He writes, "[the sponge] had to come away, and there was nothing to do but to pull it away by main force. Lucy's agony was extreme... I thought she was going to die".<sup>17</sup> According to Sims, fortunately Lucy survived the ordeal and recovered completely from the surgical complication. Nevertheless, contemporary scholars still probe more deeply as to the how, more so than why, Sims managed to maintain the patients' participation (voluntary or not) during this lengthy and dangerous experimental undertaking.

One theory is the fact that Sims himself documents administering high-doses of opium to the slave subjects postoperatively, in an attempt to maximize its constipation-inducing effects to still their bowels while the stitches healed. This relatively unprecedented practice at that time begets the concern today that many of these women were potentially subject to opiate addiction over 4 years of consistent high doses, experiencing additional effects of sedation and pain management.<sup>18</sup> It wasn't until 1850, roughly 4 years after beginning, that Sims finally achieved a successful closure technique on Anarcha---her thirtieth operation.

Over the next several years, Sims' career catapulted to unprecedented professional success in the medical realm. He relocated to New York City where he established the first Women's Hospital at 83 Madison Ave, where the renowned Waldorf-Astoria hotel presently resides. He traveled around the world showcasing his surgical techniques, lecturing at the most prestigious medical institutions in Europe, serving as personal physician to Empress Eugenia of France, and even served as medical advisor to President Garfield after his assassination attempt. In the academic world, Sims was elected President of the American Medical Association, author of the first textbook on gynecological surgery, and his revered as the inventor of the Sims position and speculum still used in clinical practice today. Dr. Sims passed in 1883 from atherosclerotic disease. He was immortalized as the "Father of Modern Gynecology" by his colleagues and contemporaries in the surgical world, and to this day there stand several statues in his honor across the country; including his home South Carolina, and even on the northeastern border of Central Park, across the street from the New York Academy of Medicine.

Flash-forward several decades and the year is 2008 in Women & Infants' Hospital in Providence, RI. I am a third-year medical student on my first day of my gynecology clerkship. As the tour guide led us through the winding hallways of the newly re-vamped hospital, she stopped to point out an art installation gifted by a former physician. Entitled "The Obstetrical Stork", the piece was an amalgamation of various silver gynecological tools in the shape of a bird, with the speculum serving

as its beak (see visual reference below). I looked around wide-eyed as my classmates joined the tour guide in laughter at the supposedly silly display in the physicians' lounge. However, I was uncomfortable, and deeply disturbed; especially as a self-identifying black woman. Did my peers even know the history behind this tool? If so, how could they even consider the piece humorous? Maybe the tour guide would explain the beginnings of gynecology later on in her presentation? I waited for six weeks, but she never did. No one did. I delivered babies, learned how to perform episiotomies, was tested on performing a "patient-sensitive" pelvic exam and graded on how well I announced and introduced the speculum with each female encountered, but I was never given an explanation for how or why these practices came to be. And what's more fascinating, is that like most medical teaching facilities in the US, my training site was located in an urban neighborhood where most of my patients were black and brown women; who were probably also unaware of the history of gynecology. My stomach was tied in knots by the end of the rotation, and I made a promise to educate myself on the untold history of my personal and professional ancestors.



I was hard-pressed to find even a hint of ethical suspicion of Sims' work in the scientific literature until nearly 70 years after his death, at the heels of the Civil Rights Movement. Scholars began applying bioethical lenses on the inception of Sims' legacy, back to that makeshift backyard hospital in Montgomery, AL---before the accolades, royal recognition, and national acclaim. Did these slave women have informed consent (likely, no)? Once Sims' colleagues abandoned his failed attempts, did the women willfully volunteer to assist him in a purely altruistic endeavor (again, likely no)? Did Sims administer opium post-operatively for pain management, or coercion (unclear)? Steadily, a literary debate mushroomed across the pages of surgical and literature papers alike. Scientists and historians attempt to

grossly categorize Dr. J Marion Sims as either champion of women's health or villain of black medical experimentation.

The following study is my attempt to take a deeper look into the representations of Dr. J Marion Sims in scientific text and lay literature. My objectives specifically are: 1) To identify if and what trend there are in the description of Sims and his early vesico-vaginal experiments in Montgomery, AL, and 2) Critically analyze (in a preliminary way) the roles in which the fields of science and history depict such a controversial figure; to more broadly ask: 1) How does racism shape science, medical practices, and technical innovations? And 2) How does science shape medical knowledge?

## **Methods**

### ***Search strategy and data extraction***

This research was initially designed as a systematic textual review. Extensive searches on the engines PubMed, WorldCat, and Interlibrary Loan through Brown University provided the primary materials for analysis. Sources published from 1950 through the present were only included for this study. Search input also included various forms of Sims' name, including "James Marion Sims", "J Marion Sims" and "J M Sims". Over 153 primary articles met the aforementioned inclusion criteria. Abstracts were read for relevancy specific to the representation and biographical content of Sims, excluding isolated eponymous references (i.e., a single sentence mentioning a single surgical technique or simply "Sims speculum" with no further context were excluded). Ultimately, 32 scientific journal papers, 10 historical journal articles, and 10 historical non-fiction texts were included for review.

## Results

The studied articles reflect a range of representations and overall impressions conveyed in their respective texts. Therefore, all articles were categorized into one of three codes based on each paper’s objective (if, given), descriptive adjectives used, and overall tone of the piece: “Negative” or critique Sims’ process of medical experimentation, “Positive” or attempt to defend Sims’ experimentations as acceptable within the historical context of slavery during his life, or “Neutral/Unqualified” (lacks biased opinion or viewpoint is unclear; objective/informative/strictly biographical). See Table 1 for coding scheme and sample quotations:

**Table 1: Sample representations by coding scheme**

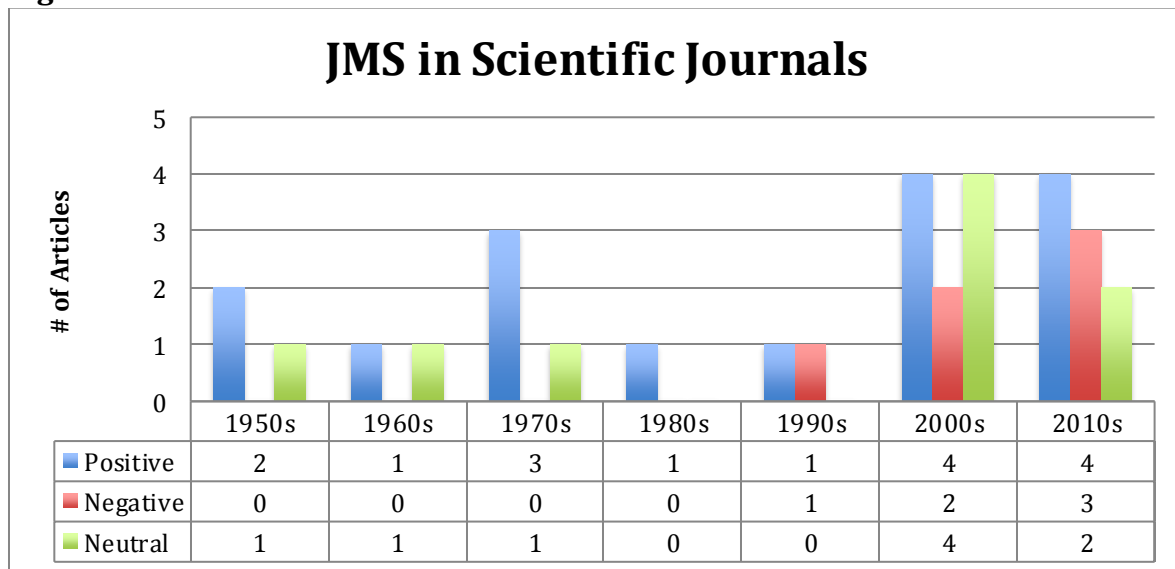
Code assigned and year of study	Journal	Quotation
<b>Negative</b>		
2004	<i>Southern Medical Journal</i>	“Messianic attitude”, “self-righteousness” (Sartin)
1997	<i>International Urogynecology Journal</i>	“Though admired for his persistence, dedication and tireless effort, he was criticized for his use of very vulnerable, desperate patients in an almost inhuman fashion.” (Elkins)
<b>Positive</b>		
1981	<i>Journal of South Carolina Medical Association</i>	“Transformed the management of [vesico-vaginal fistula], ...'almost with a magic wand” (No author given)
1950	<i>Cancer</i>	“His vision was prophetic and his courage leonine...many-sided genius” (Martin, et al)
<b>Neutral</b>		
2015	<i>International Urogynecology Journal</i>	“First described the routine closure of fistulas with initial success.” (Magudapathi, et al)
2012	<i>International Urogynecology Journal</i>	“Landmark work” (Stanford & Romanzi)

### *Chronological Trends*

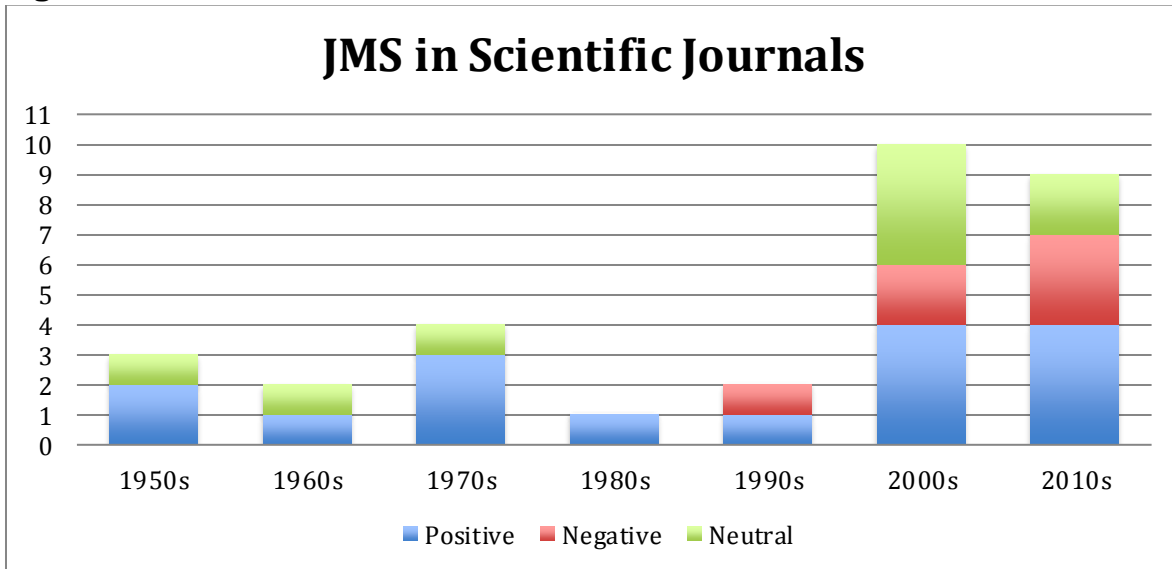
Thirty-one scientific articles were analyzed, published from 1950 to the present. Of those, several trends are evident across chronology (See Figures 1a and 1b). From

the 1950's through the 1980s, the general representation of Sims was either described as "positive" or "neutral". One excerpt from an article published in the American Journal of Obstetrics and Gynecology in 1978 comments, "'His original 3 subjects might never have tolerated the pain and misery of the repeated operations had they not been slaves. In the long run, they had reason to be grateful to Sims...'"<sup>19</sup> It is not until the 1990's that a "negative" representation is introduced into the published scientific literature, and its value triples by the 2000's. The overall trend in total papers published regarding Sims, regardless of representation, also increases dramatically by the 2000s. In total, there were 19 total articles published about Sims in the last 2 decades, compared to only 12 articles described in the previous 50 years. In the last 66 years, 52% of the scientific papers published represent Sims positively, 29% neutrally, and 19% negatively (See Figure 2).

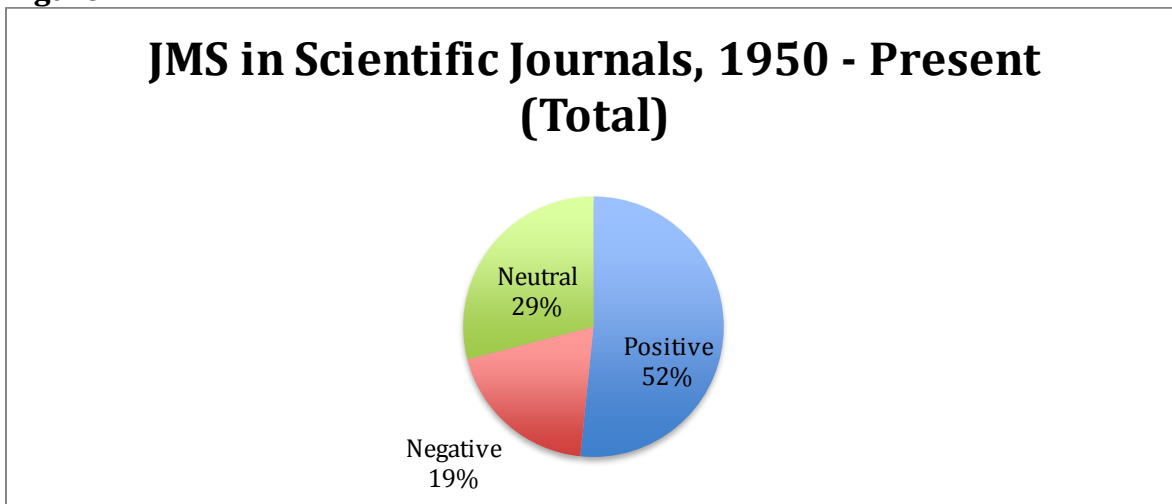
**Figure 1a**



**Figure 1b**



**Figure 2**

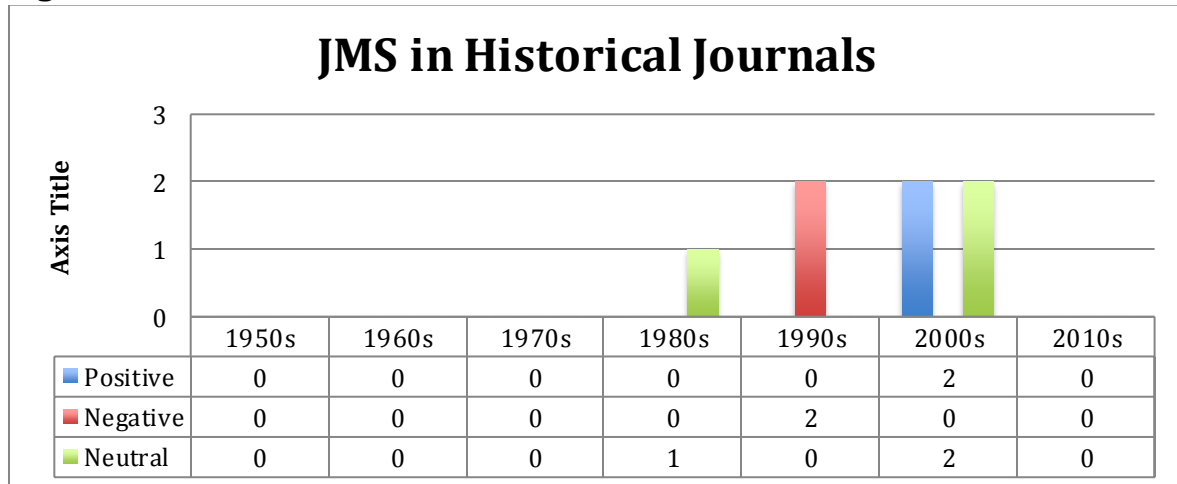


Comparatively, there was a relatively smaller sample size of historical articles, 10 in total (See Figure 3). Of the historical texts collected, representations of Sims first became apparent in the 1980s as neutral. The following decade, both articles published described a negative representation of Sims. In the early 2000s, 2 articles described a positive representation while 2 additional articles described a neutral stance; none were negative. In total, the representations are slightly more even than

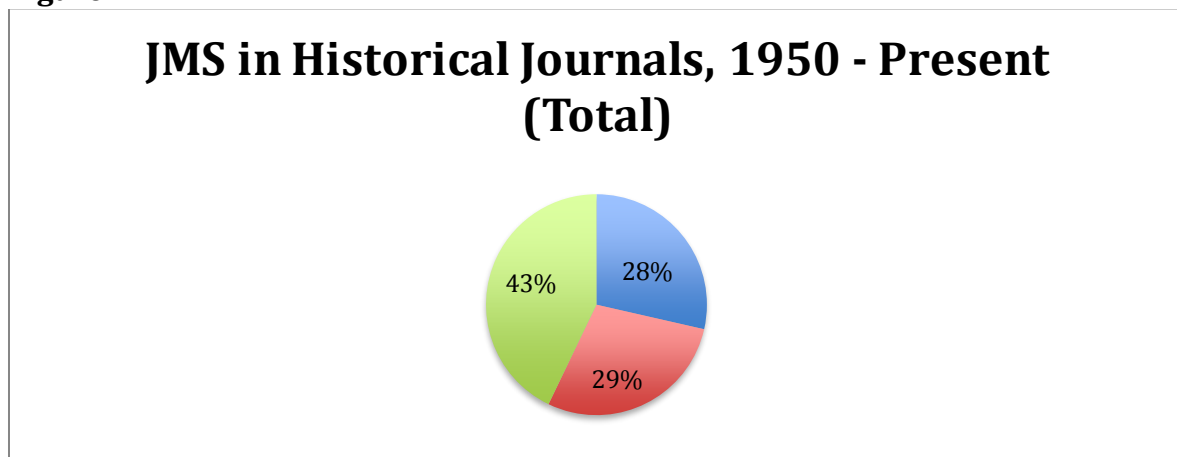


the scientific articles with a majority representing neutral: 43% neutral, 29% negative, and 28% positive (See Figure 4).

**Figure 3**



**Figure 4**

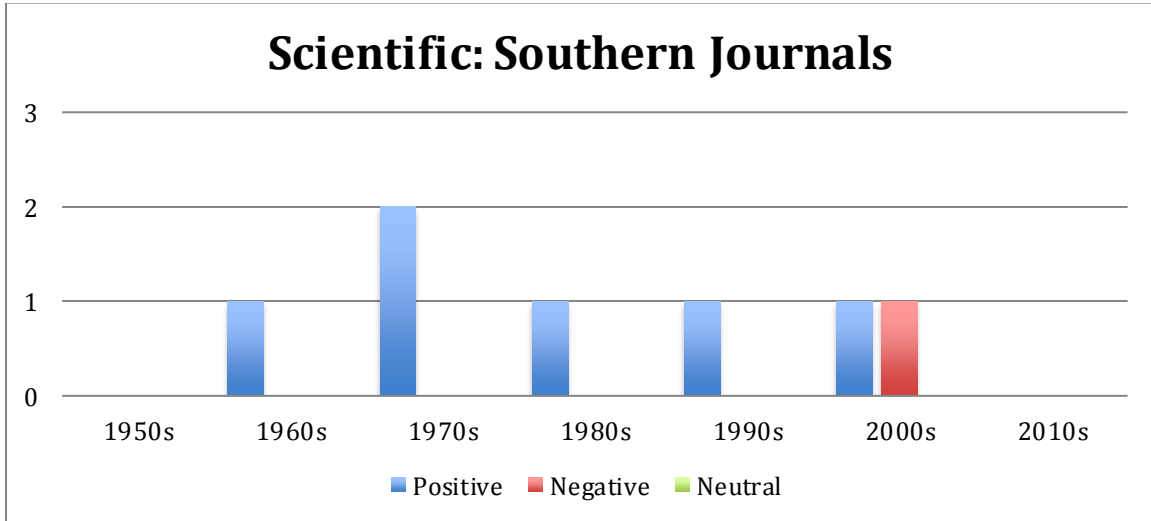


***Southern Scientific Journals***

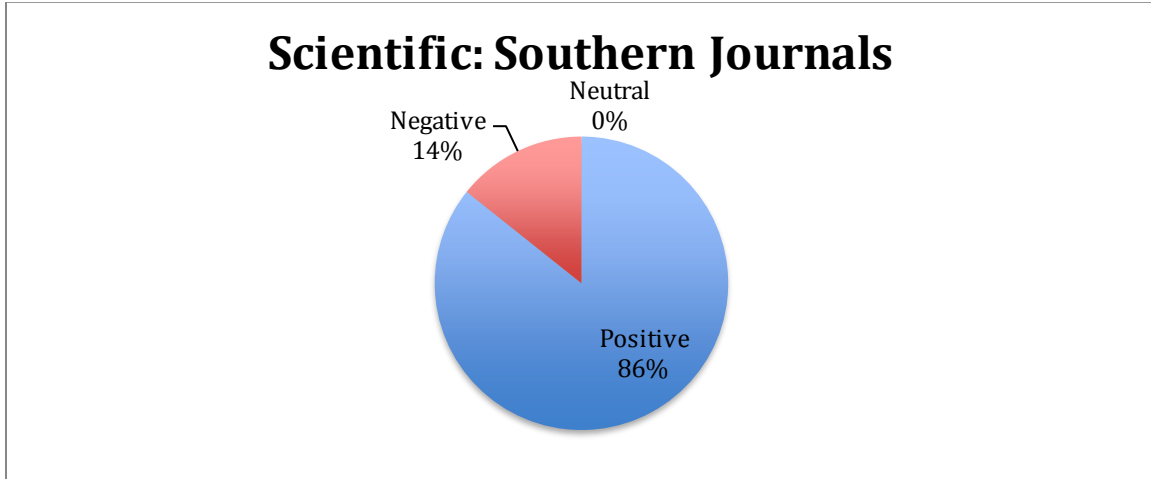
Within the scientific journals was a sub-group of journals published from the Southern region: Journal of Medical Association of the State of Alabama, The Journal of the South Carolina Medical Association, The Alabama Journal of Medical Sciences, and Southern Medical Journal. Collectively, these included 7 of the 31 scientific articles (22.5%) reviewed (See Figure 5). Of these, only positive representations were published out of the South until the 2000s, with just 1 article challenging another published paper also from the South. The overall representation of Sims

from the Southern journals highlights 86% positive, 14% negative, and none were neutral (See Figure 6).

**Figure 5**



**Figure 6**



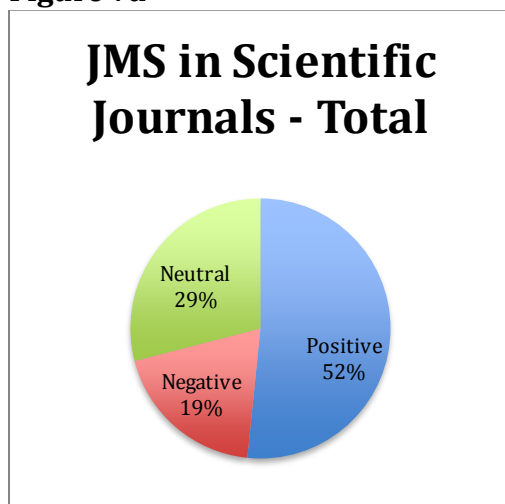
### ***Scientific vs. Historic Journals***

In comparing scientific and historic journals, the texts indicate that scientific articles overall represent Sims positively (52% majority), while historical articles represent Sims neutrally (43% majority), with a relatively even split between negative and positive (29% and 28%, respectively; See Figures 7a and 7b). One article published

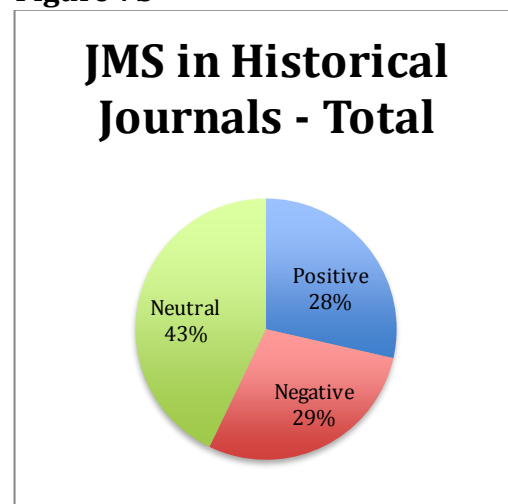
in the *Annals of Surgery* Journal in 2012 highlights a shared approach among many of the “positive” scientific papers that attempt to defend Sims’ experiments from bioethical concerns:

Some writers have criticized the ethicality and morality of his clinical practice because it involved the enslaved and indentured... The question of patient consent for surgery did not usually cause difficulties in the treatment of slaves, since relief of pain was the major concern for both master and bondsman. Ladies, both free and enslaved, who suffered from that calamity, desired the opportunity to be healed. Dr. Sims stated, 'My patients are all perfectly satisfied with what I am doing for them.' As other physicians abandoned him, because of his failures, his patients, striving for recovery, eventually served in that role.<sup>20</sup>

**Figure 7a**



**Figure 7b**

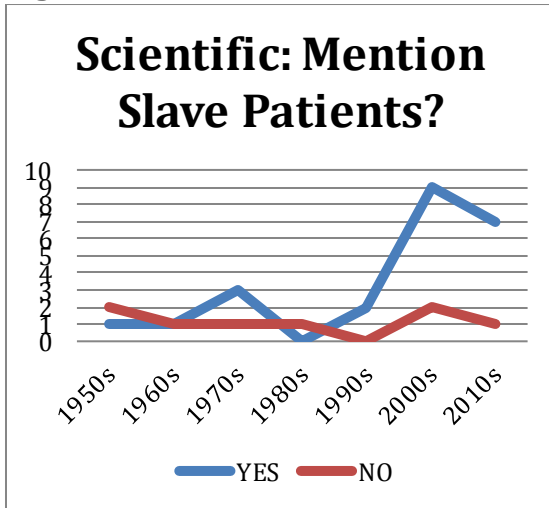


***Mentioning Slave Patients/Naming Anarcha, Betsey and Lucy***

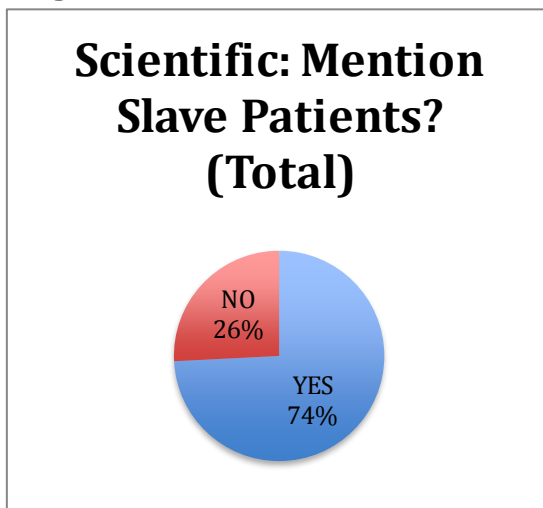
It is documented by several authors that towards the end of Sims’ career, he chose to remove the subjects’ race and enslaved status from any description of his earliest experiments, and instead illustrated reports of the procedure with images of bourgeois white women instead.<sup>21</sup> Therefore, all articles were reviewed for mention of the slave patients originally documented in Sims’ autobiography. He named at least three individuals: Anarcha, Betsey, and Lucy. Overall, within the scientific papers there is a gradual upward trend in discussing the slave patients’ involvement from the 1950s to the present (See Figure 8a). The exception is a complete lack of

their reference in the 1980s, however a 100% representation in the 1990's. Overall, 74% of the scientific papers mention the slave women, while 26% did not (See Figure 8b).

**Figure 8**

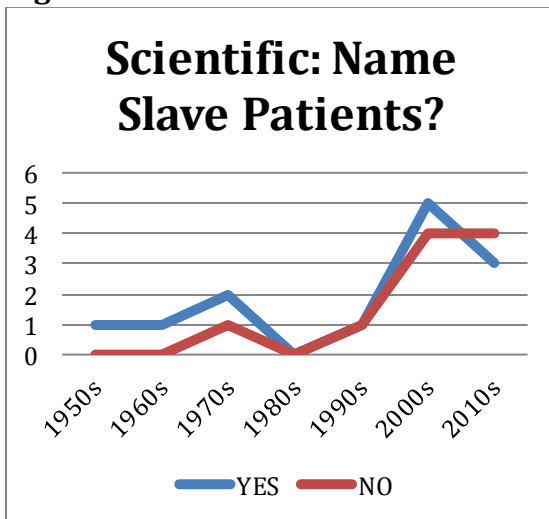


**Figure 8b**

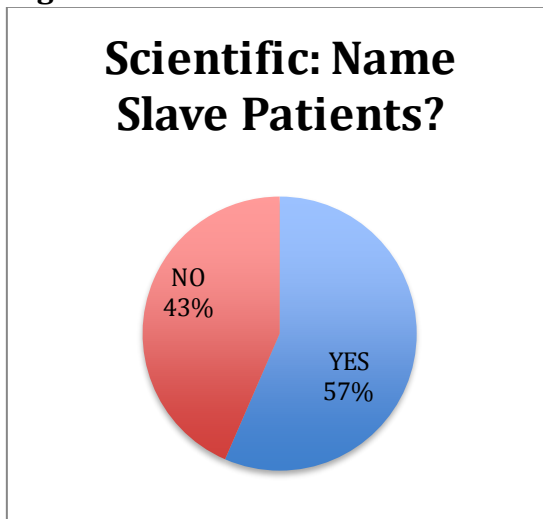


Of those articles that mentioned slaves ("Yes"), the scientific papers indicate an upward trend of either naming the patients or not (See Figure 9a). Overall, 57% of the scientific papers which mention the slave patients, also address them by name (See Figure 9b).

**Figure 9a**



**Figure 9b**

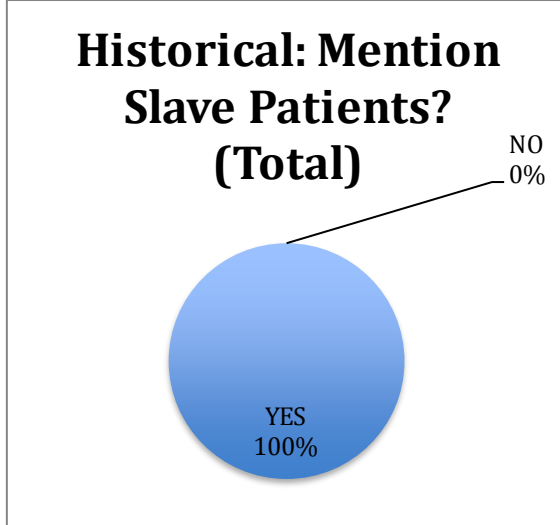


Comparatively, of the 10 historical articles reviewed, 100% of the papers mention Sims' slave patients, beginning in the 1980s through the 2000s (See Figures 10a and 10b).

**Figure 10a**

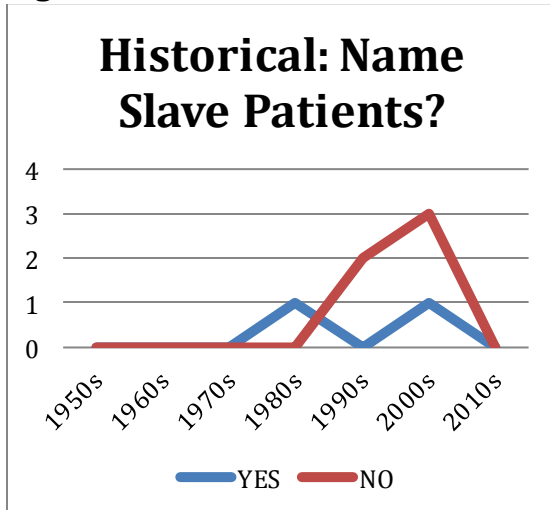


**Figure 10b**



In reviewing the historical papers that mention Sims' slave patients, the data indicates a greater tendency to not include the names of the slaves from the 1980's to the 2000's. Overall, 71% of the historical papers do not include the slaves' names, while 29% did (See Figures 11a and 11b).

**Figure 11a**



**Figure 11b**



## **Limitations**

Several limitations are applicable to this specific study, particularly the limited sample size of historical journal articles reviewed. It would be ideal to identify an equal number of articles of both scientific and historical journals within each distinct decade period. Furthermore, it is unclear how best to include the important and rich contributions of textbooks, scientific/medical and historical, to formulate a more complete scope of the available texts describing Sims and his earliest medical experiments. Lastly, the code "Neutral" could be sub-divided to differentiate between strictly informational text and those that include positive and negative representations simultaneously.

## **Discussion**

The aforementioned results underline at least 4 key tendencies of writers representations of Sims: 1) Though a greater diversity of opinions is becoming more apparent recently, scientific journals have maintained a pattern over the last 60 years of writing a positive representation of Dr. J Marion Sims in the published literature. 2) Southern-based journals have published the considerable majority of texts of Sims in a positive representation; coincidentally a native of the demographics they represent. 3) There is a relatively limited range of accessible historical journal articles on the representation of Dr. Sims; most information is derived from scientific interests. 4) While there is a steady trend to increase the mentioning of the slaves along with Sims in his experimentations, historical journals fail to directly name the women involved. A 4-year experiment becomes reduced to a paragraph. Thirty different surgical procedures on one individual become reduced to a sentence. And the individual experiences of Anarcha, Betsey, and Lucy become reduced to a simple mention as "slave women" in the literature permanently.

Today, the acknowledgment of Sims' and his medical experimentations is gaining more footing in both the scientific and historical spheres. However, it is evident from a preliminary reading that most authors fall victim to the ethical quagmire of how best to characterize Sims in history's dichotomous memory--- a

criminal, or a pioneer? In 2003, writer Barron H. Lerner published a piece for the New York Times regarding the modern-day debate between scholars over Sims' legacy. He summarizes if the surgeon should be considered today as, "[a] healer of women, or a doctor who used them as guinea pigs?"<sup>22</sup> Several historical nonfiction books paint an even sterner portrait with a more serious critique. As bioethicist and historian Harriet Washington graphically illustrates in her book, *Medical Apartheid*, "[e]ach naked, unanesthetized slave woman had to be forcibly restrained by the other physicians through her shrieks of agony as Sims determinedly sliced, then sutured her genitalia."<sup>23</sup> With such a controversial figure in history and textbooks alike, it begets the concern of what can or should be done to honor the young women who endured the most pain through these experiments.

In a recent episode of *NPR: Hidden Brain* entitled, "Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology" the question of how best to commemorate the three female patients is explored. Dr. Vanessa Gamble, physician and professor of medical humanities at George Washington University explains the injustice of the "words missing from the women themselves" in the published texts. Consequently, Gamble suggests erecting a statue representing the women as a direct response to the current statues of Sims' standing in Central Park, South Carolina and Alabama. She envisions the potential memorial to the three women as a depiction of them "holding children, with mothers... not recreating the... the altar of science".<sup>24</sup> Gamble is not alone in this vision, as scholars like Washington also urge for a statue erected in Anarcha, Betsey, and Lucy's names. When Melissa Mark-Viverito, an East Harlem councilwoman, petitioned for the removal of the Sims statue in Central Park on the grounds of racial and sexist insensitivity to the neighboring community, the city rejected the proposal on the grounds that it did "not remove art retroactively on the basis of content" but offered to include an informational sign near the statue for historical context. To this day, the language for the sign remains in deliberation.<sup>25</sup>

And yet, is the existence, or demolition, of a statue the true sign of ultimate justice being served in history and medicine? I would argue a strong “no”. As a medical student, with countless medical concepts, procedures, and protocols to memorize within a short 4 years, neither statue can realistically teach me the rich historical context and cultural competence effective to adequately manage a diverse patient load. It is simply unrealistic. The majority of learning in the medical school is completed through reading the latest published journals, textbooks, and listening to experienced physician professors in the lecture hall and on the wards.

## **Conclusion**

As health disparities continue to plague our people of color and other socially marginalized groups, it is imperative now more than ever to train upcoming physicians with a comprehensive course in medicine, well-being, and socially-conscious practices of care. It has been nearly 150 years since Sims’ first surgical experimentations and similar sentiments of biological differences in disease and pain tolerance are still rampant in our medical system.<sup>26</sup> As renowned anthropologist and scholar Anne Sterlo-Fausting outlines, physicians are often “taught---outright or through modeled behavior---to use racial generalizations and assumptions as shortcuts, resulting, at worst, in misdiagnoses and, at best, lost time reaching the right conclusion and treatment.”<sup>27</sup> Therefore, it is critical to provide a curriculum to medical students that paints the entire picture, with the entire cast present, in order to learn from, not repeat the lessons learned by our predecessors. Only through a medical pedagogy that focuses seriously on the fundamental scientific mechanisms of the body and question the antiquated ideologies of physiological differences, can we begin to collectively recognize and honor all cast members in the history of medical advancements. For the sake of our collective societal health, we must invite all persons, especially those abused by the medical system, to a seat at the table---not on top of it.

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- <sup>3</sup> McGregor, Deborah Kuhn. *From Midwives to Medicine: The Birth of American Gynecology*. Rutgers University Press: New Brunswick. 1998. Print. Pg. 18.
- <sup>4</sup> Duffy, Thomas P. *The Flexner Report --- 100 Years Later*. Historical Perspectives in Medical Education. Yale Journal of Biology and Medicine. 84, 2011. Pp. 269 – 276.
- <sup>5</sup> Flexner, Abraham. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*. Bulletin Number Four. The Carnegie Foundation: New York. 1910. Reproduced 1972. Print. P. 181.
- <sup>6</sup> Savitt, Todd. *Race and Medicine in Nineteenth- & Early Twentieth-Century America*. The Kent State University Press: Kent. 2007. Print. Pp 252 – 253.
- <sup>7</sup> Savitt, pp. 64.
- <sup>8</sup> Savitt, pp. 73.
- <sup>9</sup> Roberts, Dorothy. *Fatal Invention: How Science, Politics, and Big Business Re-Created Race in the Twenty-First Century*. The New Press: New York. 2011. Print. Pp. 89-90.
- <sup>10</sup> Savitt, pp. 62.
- <sup>11</sup> Savitt, p. 74.
- <sup>12</sup> Roberts, Dorothy. *Killing the Black Body; Race, Reproduction, and the Meaning of Liberty*. Vintage Books: New York. 1997. Print. P. 22.
- <sup>13</sup> Washington, Harriet A. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. Anchor Books: New York. 2006. Print. P.54.
- <sup>14</sup> Sims, P. 226.
- <sup>15</sup> Sims, P. 234.
- <sup>16</sup> Sims. P. 238.
- <sup>17</sup> Ibid.
- <sup>18</sup> Wall, LL. “Did J. Marion Sims Deliberately Addict His First Fistula Patients to Opium?” *Journal of the History of Medicine and Allied Sciences*. Vol 62, 3. 2006. P. 339.
- <sup>19</sup> Kaiser, IH. *Reappraisals of J Marion Sims*. American Journal of Obstetrics and Gynecology. 1978. Print.
- <sup>20</sup> Straughn, et al. *The Core Competencies of James Marion Sims*. Annual Surgery Journal. 2012. Print. P. 200.
- <sup>21</sup> Washington, p. 59.
- <sup>22</sup> Lerner, Barron H. “Scholars Argue Over Legacy of Surgeon Who Was Lionized, Then Vilified”. *The New York Times*. 28 Oct 2003. Print. P. F7.
- <sup>23</sup> Washington, P.2.
- <sup>24</sup> “Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology”. *NPR: Hidden Brain*. 17 Feb 2016. Web.
- <sup>25</sup> Gonzalez, David. “Sculpture of Paradox: Doctor as Hero and Villain”. *The New York Times*. 3 March 2014. Print. Side Street. P. 18.
- <sup>26</sup> Pediatrics, JAMA – abdominal pain, ER child abuse.
- <sup>27</sup> Sterlo-Fausting, Anne. “I Can’t Breathe”.