SUMMARY

This thesis investigates how gynaecology was established as a medical speciality in Sweden in the 1860s and onwards. Power, professionalisation and the production of scientific knowledge are central themes – especially in relation to gender. One central assumption in this study is that scientists actively construct the world rather than passively discovering it, and that science is constructed in a specific historical context. Knowledge and science is a way of ordering the world, and the ways in which this happens are related to the organisation of society. Furthermore, it is not anyone who is allowed to define what is scientific. The acquisition of the privilege to formulate scientific knowledge is one of the foundations of professionalism, a privilege intimately connected with the devaluation of knowledge of other groups. To own the privilege of defining science is to be powerful. Previous research has shown that gynaecology as a discipline depends upon notions of Woman as radically different from Man. Through an investigation of the creation of the new discipline and of early professionalisation processes I show *how* this has manifested itself within Swedish gynaecology. I investigate the importance of the fact that gynaecology developed in an (initially) all male environment; as well as whether, and if so how, gynaecology can be said to have reproduced and contributed to notions of sex-difference and a gender complementary way of thinking.

The empirical study is framed by an essay prologue and epilogue on women, power, medicine and actors in the history of art, highlighting the issues of women's bodies, sexuality and health.

The Science of Woman

The first part of the thesis – *The Science of Woman* – is the empirically most substantial one and consists of eight chapters. Here I outline how gynaecology was established and institutionalised in Sweden, early career-paths as well as the development of therapy methods and theory. The emphasis lies upon the period between the 1860s and 1900 (chapter 1 to 7), while the period 1900 to 1925 is discussed more briefly (chapter 8).

In chapter 1, "Looking into Woman", the instrument *speculum* is discussed, an instrument that was used to, literally-speaking, give insight into the womb. Through a brief elaboration on contemporary literature and early psychoanalysis a wider context of scientific ideals is outlined. The chapter also discusses the first cases of gynaecological surgery in Sweden, in addition being the first abdominal surgery, as well as the study journeys undertaken by Swedish physicians to meet international experts in the field. A central form of surgical intervention was *ovariotomy*, the removal of one or both of the patient's ovaries, used in cases of cysts or tumours in the ovaries. In chapter 2 the first professor, Anders Anderson, is presented. He was installed at Karolinska Institutet (KI), in 1864. The following chapters discuss his successor at KI (chapter 3) as well as the creation of a second chair

at Uppsala University and the first professor holding it, Otto Lindfors (chapter 4). Taking the careers of these three professors as the point of departure the development within antisepsis, succeeded by asepsis, as well as some important surgical interventions (e.g. caesarean sections) are discussed. In chapters 1 to 4 it is assumed that physicians constantly constitute themselves as *both* professionals *and* gender: as men or (a few decades later) as women – as "physicians" or "women physicians". This is done both in encounters with patients, with colleagues in formal and informal settings, on study journeys, when writing scientific articles, when applying for positions, when writing complaints about appointments, as well as in the private realm. Anderson and Lindfors were gynaecologists and poets – both activities seem to have been important to them. Furthermore, both they and Netzel, and the following professors in obstetrics and gynaecology, were married men and family fathers. It is argued that these connections are important. In the chapters I investigate and outline the gynaecologists' representations of the development of their field, the *narratives* about gynaecology that they create (and recreate). I perceive these as key components in ongoing meaning- and identity-constructing processes of professionalisation. What is placed centrally and what is hidden away in the narratives about gynaecology? How far in unison are these narratives? Are there any dissenting voices? If so, coming from where? And do they have an impact upon the main narrative?

Chapter 5, "Controversial operations", discusses some surgical interventions that gained attention internationally. These interventions were developed when ovariotomy already was established as a cornerstone of gynaecological surgery. Skilful ovariotomists were bestowed with honour and glory and in the 1870s and 80s bold surgeons tried to develop new kinds of surgical interventions. Several of these were never used widely in relatively conservative Scandinavia. This is especially true as regards the contested and later infamous so-called normal ovariotomy or "Battey's operation" which was the removal of healthy ovaries to cure e.g. nervous inflictions, back-pain or migraine.

A diagnosis that on the contrary gained wide and long-lasting influence was the so-called *deviation of the uterus*; especially it's position backwards (*retro-deviation*). The diagnosis was followed by a number of therapeutic methods. The majority of the physicians accepted this diagnosis and only a few (in Norway Berendt Vedeler and in Sweden Mauritz Salin and Carl David Josephson, inspired by Vedeler) seriously contested it. The alleged deviations were thought to cause similar symptoms as the ones mentioned above in relation to normal ovariotomies, i.e. everything from nervous inflictions to headache and coughing. The treatment was in most cases attempts to fixate the position of the uterus by attaching it to the wall of the abdominal cavity, e.g. with nails, stitches, or various forms of so-called pessaries. This was both painful and risky for the patients: many suffered from peritonitis and cases of death were not uncommon.

In the 1860s a layperson – i.e. not a physician – the lieutenant, and later major, Thure Brandt developed an alternative therapy that later was used in relation to the supposed changes to the position of the uterus. "The major's non-interventionist method", and the controversy surrounding it, is discussed in chapter 6. Brandt, who was trained at the Central Institute of Gymnastics, belonged to the same social class

as the physicians and he was very popular among women, not least among the wealthier ones. In the ongoing professionalisation processes the physicians were engaged in a boundary work excluding others. However, it was not easy for them to respond to Brandt and his method. Furthermore, it was not just patients that appreciated Brandt's uterus massage (also called genital gymnastics). Quite a few physicians showed an interest in a treatment that in comparison with surgery was substantially less interventionist. The chapter outlines the uterus massage popularity-curve within the Society of Physicians.

Chapter 7, "In the Shades", deals with ethical problems and that which tended to be hidden away by the narratives on gynaecology. These topics are introduced by an account of a scandal unfolding in 1875 and with far-reaching consequences for future gynaecological practice and for what could be called the "esprit de corps". The point of departure is a serious mis-diagnosis and -treatment that led to the very painful death of a pregnant woman. Furthermore, it was a midwife who reported the case to the superior physician. He, professor Fredrik August Cederschjöld, was outraged by the responsible physician's callousness and therefore reported the case to one of the sessions of the Swedish Society of Physicians. The representatives present were outraged too, not just by the mistreatment, but also by the fact that a *midwife* had the nerve to report a physician and that Cederschjöld argued for punishment. The chapter discusses another case that also concerns a phenomenon which (in my interpretation) the Society of Physicians wanted to distance itself from: an article with a unique design – it could work both as information and advertisement - by the prominent manufacturer of medical instruments Max Stille, who was also an honorary member of the Society.

In chapter 8, "Authority", I return to what, by contrast, stands out as the sunny side of gynaecology – or at least the side the gynaecologists themselves wanted to show publicly. Three characteristic features of institutionalisation are discussed (besides the creation of professorships): the creation of a society where members are elected in accordance with certain criteria; the foundation of a scientific journal; the publishing of a book for education in gynaecology. Between 1877 and 1893 a Nordic journal on the topic was published from Copenhagen (*Gynekologiske og obstretiske meddelelser*), but it would take until 1921 before *Acta gynecologica scandinavica* was founded, which was followed by *Acta obstetricia et gynecologica scandinavica* in 1925. Of the three features mentioned above, the first to happen in Sweden was the publishing of Carl David Josephson's two-volume *Textbook in Gynaecology* (*Lärobok i gynekologi*) 1901-02, followed by the formation of the Swedish Society of Physicians' subsection of gynaecology and obstetrics in 1904. Both of these events are discussed extensively.

The first empirical study shows that the gynaecologists were very successful in establishing scientific authority. Their way of building up the discipline was even a model within Swedish medical science. Shortly after their formation of the first subsection of the Swedish Society of Physicians, other disciplines would follow their example.

Women Physicians and Physicians for Women

The second part of the thesis – *Women Physicians and Physicians for Women* – investigates how the gynaecological construction of womanliness was related to women physicians and how women physicians themselves engaged with this notion. A central theme is the strategies used by women physicians to enter into a profession as manly as gynaecology had become. Furthermore, how women gynaecologists engaged with their men colleagues' therapeutic methods as well as their views on patients and women.

Chapter 9, "Womanly medicine – and women as colleagues in medicine?", concerns the discussions in the parliament, the Board of Health (Sundhetskollegium), and at the universities which led to certain university studies, including the one to become a physician, being opened up to women. After the opening in 1873, it took 15 years before Karolina Widerström as the first woman was examined as a physician. The predecessors of Widerström who did not finish their (Swedish) studies are also discussed. During these years the Swedish Society of Physicians, the women's movement as well as the *Journal for the home* (*Tidskrift för hemmet*, reconstituted as *Dagny* in 1886) followed news about women physicians from abroad with great interest.

In chapter 10, "Pioneers", three generations of the first women physicians' education, careers and lives are portrayed in a group-biography. The same could be said about the previous account of men professors in obstetrics and gynaecology. However, the selection-criteria are different: while the protagonists in part I are clearly defined through their formal positions as representatives for the discipline, the protagonists in part II are not as much a self-evident choice. They were chosen because, from the beginning in 1916, they constituted the *Women Physicians' Permanent Committee* (Kvinnliga Läkares Permanenta Kommitté, KLPK), an interest group promoting e.g. women's right to higher public positions. Widerström was a central force in close co-operation with other members: Ada Nilsson, Alma Sundquist, Lilly Paykull, Elin Odencrants, and Andrea Andreen. Later also Nanna Svartz was included. Widerström, Nilsson and Paykull mainly worked as women physicians, while Sundquist shared her time between gynaecology, venereology and public health. Both Andreen and Svartz were prominent within internal medicine: Svartz aquired the doctor's degree in 1927, Andreen in 1933. In 1937 Svartz became the first woman professor in Sweden with a public position.

The women physicians in focus are in other words no average physicians but rather – on a par with the men professors – a women elite. While most women physicians worked in private practices, the physicians in focus chose to work for the rights of both women physicians and other academics. Furthermore, they were dedicated to women's rights, improved health and living conditions in general. The choice to especially work with women patients can be seen as strategic, since certain parts of medicine were regarded as appropriate for women, e.g. by the Board of Health. However, it can also be regarded as an expression of a deeply-anchored interest in a politics for women.

Finally, in chapter 11, "Organising", the KLPK work for the professional rights of women physicians is investigated. I look at both the interaction with men allies and with opponents. The latter concern mainly the Board of Health (Medici-

nalstyrelsen) and the university faculties of medicine. In principle the thesis ends with the law of competence (*behörighetslagen*), giving women the right to employment in public institutions, such as hospitals and universities, coming into force on 1st July 1925 – even if I also, with help of some examples, point out the resistance that was lingering even after that.

Together, the two parts confirm that when gynaecology was created as a modern discipline within medicine, the notion of Woman being different from Man was taken as the point of departure. Both the Woman and the Man that the gynaecologists et al. took for granted – often named the Human Being – were anchored in a specific historical context. Within this context, Woman was constructed as deviant, and therefore a science of Woman could be presented as needed. (A comparable science of Man cannot be found at this point in time; the human beings that were discussed within contemporary anthropology were other Others).

The Gender of Gynaecology

In spite of gynaecology portraying itself – at least initially – as the Science of Woman, this discipline can hardly be characterised as "womanly". It was certainly important to postulate theories about Woman and to develop methods to investigate and treat women, but initially all practitioners of Swedish gynaecology were men. During the last decades of the 19th century the academic professionalisation of gynaecology was closely interlinked with the development of surgery of the abdominal cavity and, if anything, the gynaecological practice was strikingly "manly". Just as with most professional milieux at this point in time, men and homosociality shaped medicine, including gynaecology.

The period investigated can be said to be characterised by medicalisation and a belief in science. Whether marriage as an institution became more important for social control in general is not possible for me to say. However, I argue that marriages were important in the medical professionalisation of gynaecology – especially for men aspiring for professorships. Examples from biographies and encyclopaedias show that a majority of university professors and other prominent bourgeois men were married. However, the family-based networks supporting these men had an extra dimension in the case of gynaecologists. For them, it was of great importance for their credibility – morally *and* professionally - to be able to present the right kind of sexuality. Not just heterosexuality, but the right kind of domestic(ated) and procreative sexuality. While a certain amount of eccentricity seems to be acceptable as regards e.g. anatomists working with dead bodies, the demands on gynaecologists – working with the most intimate body parts of living women – seem to be different. If not necessarily consciously, Anders Anderson and Otto Lindfors can be said to having strengthened their positions through their gender-essentialist poetry. Apart from functioning as a creative outlet and as a sign of morality, their writing can also be seen as a kind of emotional and psychological relay between the bourgeois home and the bloody surgery table. It is worth noticing that as regards marriage, the opposite can be seen in the case of women academics, including physicians: for a long period only unmarried women could be appointed to higher

public positions. To be both married and professionals was *not* perceived as a guarantee for propriety in the case of women.

In the perspective of men gynaecologists, the women physicians' inroads into gynaecology seem to be problematic in multiple ways. The women questioned gender-essentialist notions through their sheer existence. During the discussions on an education reform in the 1860s and 70s, women physicians were portrayed as especially fit for gynaecology – and in the very same period this discipline was formed as a surgically interventionist speciality with strong manly connotations, attractive to army-physicians. Furthermore, the women physicians were recruited from the men physicians' own social class and were therefore potential wives/sisters/daughters. The women were also competing for the patients who seem to have welcomed the possibility to turn to a woman physician. For men gynaecologists, there were many strong reasons for guarding their homosocial discipline.

Within the framework of the professionalisation of gynaecology, attempts at gendered demarcation can be seen, used by men gynaecologists/physicians against women colleagues. These attempts were met by the women through inclusionary closure. Here it should be emphasised that the thesis concerns two gendered elite-groups among physicians: academic men career gynaecologists on the one hand and, on the other, feminist activist women physicians mainly in private practice.

Through different strategies, the women physicians managed to turn the arguments that their opponents used to their advantage in the struggle for full professional rights. Initially the women physicians used gender-essentialist notions and statements in parliament and from the College on Health on women's special qualifications as physicians for women and children. Later, they argued that competence should be assessed on the basis of qualifications – not male gender. These strategies turned out to be successful in the struggle for professional rights. For the former members of the Women Physicians' Permanent Committee it was a big event when Nanna Svartz became professor in medicine in 1937.

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However, in spite of the appointment of Svartz, it would take a long time before women physicians entered into the academic bastion in a more extensive way. Within obstetrics and gynaecology it would take exceptionally long: it was not until 1998 that Britt-Marie Landgren was installed as a professor at Karolinska Institutet. In spite of formal rights and full membership of the profession, it was for a long time difficult for women to establish themselves within academic gynaecology. Professionalisation processes are complex and gender continues to be important – both for men and women physicians.