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MATERIAL WITNESSES: DECONSTRUCTING NETWORKS OF CREDIBILITY AND
OBJECTIVITY IN MEDICAL NARRATIVES FROM MARY TOFT TO THE
CONTRACEPTIVE PILL

KRISTA ELIZABETH ROBERTS

161 Pages

In this dissertation, I argue that to better understand the tangled, embedded human and nonhuman subjects and how their testimonies function in western medical history, we need to first understand their erasure. By using *relationality* as a reading method, I break apart *who* and *with whom* individuals make medical decisions by considering what constitutes evidence. In the Mary Toft case, *expert witnessing* informs the ways in which a reader trusts what the narrator claims. The medicolegal conventions of courtroom testimony shape the ways in which medical men wrote their pamphlets. These men shore up their credibility through descriptions of nonhuman animals and of material actants. I found these descriptions to hold either equal or greater credibility than Toft herself, even though Toft herself lied and these descriptions are flawed. Thus, it is through narrative devices that the medical authors of these pamphlets redeem themselves.

I also critically engaged *objectivity* throughout this project. The emphasis on maintaining *objectivity* and thus explanatory power seeps into the intimate spaces of medicine at home and of foodstuff in the nineteenth century, particularly milk. This seepage into the domestic space may appear to be an affront to Victorian values, since the home was the bastion of the family and privacy; however, increased regulation of foodstuff and of public hygiene by the late nineteenth

century, coupled with medical science's authority over what it means to be *clean*, meant that the middle classes soon undertook to clean their personal spaces—inside and outside the body.

I continue to critically engage *objectivity* in the fourth chapter. My reading of twentieth century examples of patient package inserts that accompanied early forms of contraceptive pills questions a patient's use of these texts. I find that these informational sheets can contribute to withholding, skewing, or misleading descriptions of the risk(s) of these medications. This medical information clog is thusly used as proof that medical experts are essential to interpreting medical knowledge for patients rather than as proof of needed clarity in the text. Additionally, I find that potential resolutions to the issue of obstructing knowledge flow have failed. Later editions of *Our Bodies, Ourselves* take on the narrative strategies that position the reader as helpless, the text as facilitative, and western medicine as the most authoritative, meaning the battle to unseat medical patriarchy's hold over our bodies has been lost.

In the fifth chapter of this dissertation, I redesign English 160: Introduction to Studies in Women's Writing as "Women Medical Writers/Writing Women's Medicine." I develop a posthuman feminist pedagogy by building upon Karin Murriss's *posthuman child* to reimagine what characterizes an active student. This reimagining allows me to develop a course that introduces students both to the troubles and contradictions within our very own western medical culture and to the scholarly practice of critical intersectionality as a research strategy. The design of this course especially affects life writing pedagogies and the design of life writing courses as I use archival materials in the classroom. Teaching these skillsets to undergraduates differs from other solutions medical narrative scholars have suggested. By including nonliterary genres, like the ones I studied in this dissertation, in undergraduate literary study because this is where the interpretation of patient/illness happens. Author/practitioners interpret, assume, and preconceive

descriptions based on these nonliterary genres, so it makes sense to study those very texts. Thus, if we are to truly think critically about moral issues in western medicine, then we must include the sites at which these moral issues are brought to fruition.

KEYWORDS: Feminism, History of Medicine, Literature (Medical), Narrative Medicine, Posthumanism, Women's Literature

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A Dissertation Submitted in Partial
Fulfillment of the Requirements
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DOCTOR OF PHILOSOPHY

Department of English

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Dedicated to my Nana, my mother, and myself.

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K.E.R

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CHAPTER ONE: INTRODUCTION

Living Writing through Life Writing: Deconstructing Networks of Credibility and Objectivity in Medical Narratives from Mary Toft to the Contraceptive Pill

Statement of Problem

In the National Academy of Medicine's special publication, "Caring for the Individual Patient: Understanding Heterogenous Treatment Effects," the authors write that, despite their fields' acceptance of evidence-based medicine, there remains a "fundamental incongruity": "Evidence is derived from groups of people, yet medical decisions are made by and for individuals" (ix). It appears comforting, then, to Science and Technology Studies (STS) scholars and activists, that this field has begun to interrogate its oppressive practices by questioning how it identifies subjects. Indeed, a quick revision to relieve the passive-voice constructions in the quote could appear as follows: *groups of people provide medical evidence, yet individuals make medical decisions*. However, I note that a key generalization remains, and it reveals a much deeper problem with medical representation: groups of people. While it is no doubt useful for these authors to categorize quickly the masses of human animals, nonhuman animals, material actants, bacteria, viruses, and so on, that all comprise the myriad of research subjects for centuries, such a generalization contributes to the very problem these author seek to identify. In other words, using *groups of people* to signify all research subjects erases each research subject's important contributions to the pool of evidence. Another problem remaining is the *individual* who makes medical decisions. Is this meant to be the practitioner or the patient? It is unclear from the wording, explicitly anyway, but clever readers will note the intended audience of the special publication. *Individual* likely signifies the clinician, or the collaboration between patient and

clinician. Thus, the fundamental incongruity this special publication seeks to resolve remains flawed because the authors have wrongly identified the source of the problem.

This project intervenes in the fields of life writing studies, posthuman feminism, and medical narrative to develop a means of archival recovery, through reading strategies, in order to resolve the problem of a monolithic research subject. By identifying medical genres as life writing, I contribute to each aforementioned field in many ways. One, I have organized this dissertation historically, moving from the eighteenth century to the twenty-first century; yet, each chapter contains its own case study. Organizing the dissertation in this way permits greater focus on key theoretical concepts, rather than on the historical narrative I spin, and on questioning the all-knowing medical practitioner who interprets data—the *individual who makes medical decisions*—at key points in western medical history.

I also use this dissertation to pose new reading strategies for these medical life writing genres. In the early chapters, where my focus is on archival recovery of human and nonhuman narrative contributors that were not given credit for their influence, I adapt Sidonie Smith and Julia Watson’s theorization of *relationality* as they define it in their first edition of *Reading Autobiography: A Guide for Interpreting Life Narratives* (2001). They write, “[t]he self-inquiry and self-knowing of many autobiographical acts is relational.... [O]ne’s story is bound up with that of another, suggest[ing] that the boundaries of an ‘I’ are often shifting and flexible” (64). While the genres I use in these early chapters—pamphlets, letters, domestic home manuals, satire—are not all autobiography as we might expect, they are each *autobiographical*¹. Indeed,

¹ I mean *autobiography* as a self-referential narrative spanning a subject’s life (or, as close to birth and as close to death/current as possible). Thus, I mean *autobiographical* as individual, subject-authored works that do not meet the generic expectations of *memoir* but are still rhetorical, relational moves to self-narrate.

using Smith and Watson's earlier formation of *relationality* reveals the autobiographical nature of these genres, which ties back both to my motive of posing new reading strategies and to problematizing the monolithic research subject. Part of the work involved in breaking apart *who* and *with whom* individuals make medical decisions rests with one's ability parse for who does the evidencing. Because my answer is human women and nonhuman animals are the un(der)acknowledged testifiers, I need relationality since it helps me relocate what knowledges they contributed. And, furthermore, declaring these genres life narrative, and challenging the authors' self-constructions of credibility, I am continuing to question what types of narratives should be considered life writing/life narrative, and how key life narrative concepts formulated without these forms might need revision.

In the later chapters, I critically engage with *objectivity* through my focus on those cases highlighting women's health and nonhuman animal contributions. I examine how authors of domestic health manuals and of patient package inserts legitimize their professional knowledge over that of a patient/research subject by controlling the means to access to that knowledge. I find, in both these cases, that nonhuman animals—cows—are favored over human women, and that synthetic material actants—contraceptive pills—are favored over the hormones a human woman produces herself, which I discuss later in this introduction. Bound together by medical science's obsession with performing objectivity, the intimate relationship between human women and livestock changes. In the third chapter, cows become the ideal producers of milk because they produce without human interference, allegedly. This animal-based ideal changes. In the fourth chapter, I explore in the how both human women and livestock are unideal and require medical interference by means of the same hormone by the mid- to late-twentieth century. In these case studies of synthetic estrogens and progesterones, I examine the contradictions and

their implications on the health of human women and livestock health, on women's health activism, and on testimonial legitimacy in western medicine.

Nonhuman animal and material actants affect the treatment decisions clinicians make or recommend to human women (and to livestock) since nonhuman animals and material actants comprise many of the research subjects grouped together. I'm thinking here of the many human medical research participants and of the animal medical research participants used in the development of medical therapies, tests, cosmetics, and so on. Developing the reading strategies I ask for in this project would better appreciate the important role these forgotten lives have had on health and wellness. Thus, if work to resolve the "fundamental incongruity" identified by the National Academy of Medicine is to take place, that evidence is derived from these groups of lives but individuals make medical decisions, it ought to start with what we understand the problem to be: the "groups" providing evidence are treated as monolithic rather than polythetic both between and across species. My project is to interrogate whose stories comprise medical evidence, how medical practitioners construct life narratives with that evidence, and how we can better illustrate the roles humans and nonhumans play in acts of well-being.

Autobiography and Medical Genres

Smith and Watson acknowledge that "autobiographical narrative and history writing might seem synonymous...however, life narrative cannot be reduced to or understood only as historical record. While autobiographical narratives may contain information regarded as 'facts,' they are not factual history about a particular time, person, or event. Rather, they incorporate usable facts into subjective 'truth'" (*Reading Autobiography* 2nd ed, 13). By declaring medical genres life writing/life narrative, and claiming that these genres are autobiographical, I am continuing the work of challenging the distinction Smith and Watson have laid out. Indeed, in this project, I am

working from the premise that objectivity, valued by some historians, scientists, and medical practitioners alike, is itself a narrative construct. Shelia Fitzpatrick emphasizes that historians “do not have an explicit [Autobiographical Pact], and the theoretical assault of the past 20-30 years on objectivity as a historian’s goal, as well as the rise of oral history and memory studies, have muddied the waters,” making it harder and harder to distinguish between writing history and writing about yourself (17). I add to this that other professional realms, like science and medicine, also do not have an explicit pact, yet they, too, engage in narrative acts that do not clearly distinguish between writing about oneself and writing medicine. Therefore, what I hope to accomplish with this project is a renewed interest in analyzing forgotten lives in a medical context. In simpler terms, I hope to reconsider medical writing as a form of historical writing, and in doing so, I seek to bring the recent *assault on objectivity* (to use Fitzpatrick’s phrase) to scientific writing.

I am also working from the premise that, as a narrative construct, objectivity characterizes the author as much as it characterizes the data. While I use case studies to frame each chapter of this project, common across these cases is the re-centering work I do. Smith and Watson, and also Jeremy Popkin, theorize that historians “preserve the professional norm of objectivity and truthfulness [writing history] pledges by establishing distance from their material and typically removing or qualifying any reference to themselves.... Autobiographical narrators, in contrast, place themselves at the center” (Smith and Watson, *Reading Autobiography* 2nd ed 14). Again, my case studies challenge this rhetorical move. By selecting which data, indeed, which research subjects (human women, nonhuman animals, material actants), to include in medical testimonies, practitioners engage in a very specific narrative-based rhetorical move. Because practitioners must construct themselves as authoritative, objective, and thus credible,

and accomplish this rhetorical move by controlling descriptions of others. This act places practitioners into the center of these genres, although that is not to say they are the only occupants. As Jemma Deer puts it, “All letters are traces, but not all traces are (human) letters” (178).

Some of those genres, which contribute to the earliest attempts to describe, and thus to narrate, the processes of living bodies, are nonverbal. Before medical imaging could peer inside a closed body, medical students and practitioners used and produced fugitive sheets. Fugitive sheets, sometimes referred to as medical flapbooks, represented human bodies for centuries before technological picturing did. Pantin Carticle writes that these visuals served as “a surrogate for the eye-witness experience” (10). Meaning, in times when vivisection was impossible and autopsy contentious (and at times illegal), these fugitive sheets pictured the inside of bodies. Fugitive sheets “possessed an absolute and singular feature: its central topic was the human body. This fact had a great impact on its meaning, its relationship to artistic representation, its sources of inspiration and its reception” (Carticle 11). Thus, their essential role as research subject proxies makes fugitive sheets the textual link between medical object and medical subject. Knowing this history, we can understand that both fugitive sheets and contemporary picturing serve as interfaces for interpreting bodies. As interfaces, these texts should face scrutiny as translators; however, they do not. Instead, practitioners regard such interfaces, which are narrative devices, as more trustworthy than the words of the human the images represent. Considering fugitive sheets lets us know that biopower extends further back into history than the twentieth century. Therefore, to build a richer picture of the human body as something greater than a textual object, I use this dissertation to return to and parse the medical cases and their texts published between the proliferation of imaging technologies in the twentieth century and the

widespread use of fugitive sheets in the eighteenth century. While not always dependent upon pictures, such eighteenth and nineteenth century medical texts hold the key to understanding how medical objectification became embedded into western medical practice.

Narrative fuels medical theories and processes (medical imagination) as the device with which patients, doctors, and researchers communicate about bodies. With the advent of internal imaging technologies, though, there are now more than just a medical practitioner's descriptive observations. A medical practitioner may *check* or *verify* what a patient describes through the use of internal imaging, thus supplementing human testimony with additional texts. Catherine Waldby, in *The Visible Human Project* (2000), reads twentieth and twenty-first century medical imaging technologies, particularly 3D modeling, as raising an important biopolitical question of medical objectification. On the one hand, Waldby claims, biomedicine as a practice protects lives, particularly human lives. On the other hand, biomedicine engages in these protective actions by generating knowledge and treating the human body as an experimental object and/or passive biomass (7). This biomedical objectification is not new or exclusive to visual genres, which is why I attend to verbal genres in this project. The complexities of constructing disease and individual roles are what I seek to study.

In *The Birth of the Clinic* (1973), Michel Foucault reasons through the relationship between practitioner, patient, and disease, explaining four principles of “configuration(s) of disease”: One, eighteenth-century medical practitioners identify disease as “historical” rather than “philosophical”; Two, disease is where analogies define essences; Three, similarities between diseases reveal the rationalized order of disease; and Four, “we are dealing with species that are both natural and ideal. Natural, because it is in them that diseases state their essential truths; ideal insofar as they are never experienced unchanged and undisturbed” (5-7). Foucault,

then, articulates a western medical process through which practitioners interpret knowledge of disease, via their own observations and descriptions, use this knowledge to define the discrete boundaries between other ailments, categorize these ailments and diseases from those discrete boundaries, and apply these categories of disease to other living beings. Through such configurations of disease, western medicine establishes and maintains its explanatory power because, in order for this process to continue, a practitioner must play a part. This process is best described as a form of collaborative life writing. What the concepts of collaborative writing, biopolitics, and biopower offer this project are a means to understand the effects of longstanding control over medical decisions. Because medical decisions are made by credible, objective practitioners, and credibility and objectivity are narratively constructed, these powers of influence affect the way we live and the ways those around us live. This is living writing through life writing.

The practitioner works as a coaxer, the patient as the coaxed, and the disease as the text². Narrative, particularly life narrative, is a foundational process and tool of western medicine because, without narrative, there would be no configurations of disease, meaning there would be no means by which to distinguish myself *well* and myself *unwell*. Indeed, the historical process of writing a letter to one's doctor reveals a much deeper context of collaboration in describing illness. Wayne Wild, in *Medicine-by-Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (2006), indicates that, in eighteenth-century consultation letters, patients had much more diagnostic control because the conversation took

² Smith and Watson use the terms *coaxer* and *coaxed* in their explanation of autobiographical acts (see *Reading Autobiography*, 2nd ed, 64-69). They describe many people, institutions, cultural imperatives that all solicit autobiographical acts (65). In a sense, I am adding *medical research and health testimony* to their list of everyday, solicited autobiographical acts.

place through letters: “[S]tudy of rhetoric in doctor-patient letters must be sensitive to the tension and the vying for authority that describe this complex relationship” (9). Thus, in illness letters, an eighteenth-century patient conveyed trustworthiness and authenticity, and the doctor responding did the same in kind. Robert Weston acknowledges that, as domestic caretakers, women often wrote on the behalf of patients too ill to write themselves (73). These contextualized, layered negotiations between writer/patient, patient/practitioner, and writer/practitioner complicate reading either text as grappling for a patient’s right to construct themselves. Narrating illness was a collaborative act, and that narrating illness was, and still is, collaborative has been sublimated in more modern times. Such sublimation devalues what anyone other than a practitioner, specifically women, knew and experienced. Thus, by studying the gradual erasure of everything affecting medical narrative *other than* the practitioner, I use this dissertation to recover women’s illness writing, but also the nonhuman animals and material actants involved in narrating illness. Because western medicine works from the premise that a medical object cannot know its own condition (this information must be gathered, then interpreted by a medical knower, and then explained back to the patient), I intervene by considering texts that challenge this premise. The uneven distribution of power in medical knowledge is precisely where this dissertation project starts. In order to understand how nonhuman testimony gained greater credibility than human patients, I study forms of nonhuman testimonies from several centuries, allowing me to explore how the discrediting patients evolved (or hasn’t evolved).

Lorraine Code writes that “[o]bjectivity, quite precisely construed, is commonly regarded as a defining feature of knowledge per se. So if women’s knowledge is declared to be *naturally* subjective, then a clear answer to [what can she know] emerges. . . . The answer is that [her sex] disqualifies her as a knower in the fullest sense of that term” (10). Women, then, cannot offer

objective testimony. In a medical context, this means that women cannot offer accurate depictions of their illness experience(s). Women, particularly those in a patient/object role, cannot offer objective testimony, and this old problem is very much one I seek to revisit in this dissertation. Scientific knowledge is subjective and objective (Code 27) in so far as the masculine circumstances of the knower are of primary value. Knowledge, in feminine circumstances, needs additional support, because it is subjective. This support, I argue, takes the form of nonhuman animals and material actants due to the additional criteria concerning “evidence, justification, and warrantability...questions about their character; their material, historical, cultural circumstances; their interests in the inquiry at issue” (Code 7). Thus, if I am to use this dissertation to revisit the discrediting of patients, then this same project must also revisit the roles of nonhuman animal and material actants because these supplementary data were called upon to (re)assert women’s testimony.

If this project is to attempt such recovery, I must continuously identify the limits of evidence and of reconstructions. Life writing scholar Leigh Gilmore offers a launch point into this labor, theorizing sites of autobiographical trouble, or “limits.” What she calls limits isn’t an indication of an endpoint, cliff, or a wall at which we meet nonnarrative, but rather, the building anxiety a reader faces as recognizable elements of narration muddle, clamor, or depart altogether. I understand this phenomenon as particularly salient to my study. The desire to identify clearly what stories our fragments of the past hold has led to forcing genres on them, when sometimes all we have are pieces that we might never wholly understand. What I mean here by “understand” is to have a picture of the evidence that provides some closure, catharsis, or other affective potential. I mean that, sometimes, narratives culled from historical evidence serve only

to comfort those of us in the future by (mis)representing the past; these times are objectifying for the subjects who can no longer speak.

Western medical narratives are perhaps the most salient example of the limits of genre and narration. Part of this trouble arises from the human practice of attribution and ownership. Gilmore rightly points out that “Trauma is never exclusively personal; it always exists within complicated histories that combine harm and pleasure, along with less inflected dimensions of everyday life” (*Limits* 31). Thus, trauma narratives, of which illness narratives/western medical narratives are a subset, cannot be attributed to any one factor or any one owner. While Gilmore considers the macro-possibilities of life writing’s limits, the placing of a personal history of trauma within a collective, this project considers the micro-possibilities, or that the personal history of trauma is itself a collective of material and nonhuman agents. The collective nature of trauma narratives offers a glimpse into the paradox surrounding collaboration and patient testimonies. To return and answer my earlier question: can medicine do valuable work without devaluing the subjects involved? It depends. In order to maintain its own authority, western medicine must keep its role as the interpreter of knowledge. Code describes this as a knowledge transaction. The western thinker, in this context the medical authority, receives information from the object of study, in this context the research subject or patient. The western thinker/medical authority then interprets these data for laypersons, which are either a broader public, fellow medical authorities, or the research subjects and patients themselves. If such an interpretative role is of greater value than either the object rendered or the subject described to, then western medicine cannot do its valuable work without devaluing its subjects.

Rita Charon, in *Narrative Medicine* (2006), illustrates that western medicine, while it has grown in its ability to respond to biological threats to life/living organisms, cannot “help a

patient grapple with the loss of health and find meaning in illness and dying” (3). Charon supports this assertion by identifying the history of literature-and-medicine, which was an interdisciplinary academic turn in the 1980s. Charon recalls a patient of her own who “taught [her] about the power of the clinical imagination,” which is a practitioner’s ability to formulate a patient narrative out of guesswork. This guesswork is itself a component of narrative medicine and is one with deep implications for patient treatment—social treatment and medical treatment. Charon asserts that clinical imagination divides doctors from their patients, themselves, their students, one another, and society in “impractical” ways (7). Charon’s purpose is to illuminate the need for narrative knowledge in western medicine so that doctors can better help patients emotionally heal by enabling better responses to emotional needs. What is missing from Charon’s exigency, though, is a thorough narrative knowledge. Narrative knowledge should include the ways in which constructions of self and other are collaborative in nature. Narrative knowledge in this context should, too, address the ways in which technologies and nonhuman subjects participate and collaborate in these constructions because technologies and nonhuman subjects act as co-testifiers to patient narratives. Without better understanding the influence credibility and objectivity have had on western medical narrative, we cannot fully appreciate the implications of practitioners presuming to formulate patient narratives³, and, thus, presuming medicine can best help anyone grapple with illness and dying.

By approaching medical narrative through specific life writing case studies, I establish a different perspective with which to study patient narratives. Indeed, rather than starting from a foundational disciplinary question, *how can narrative study contribute to western medicine*, which is the seat of Charon’s scholarship, I invert the question: *how can western medicine*

³ Unless, of course, the practitioner is in the patient role themselves. Practitioners, too, fall ill.

contribute to narrative study. This inversion is significant because I am not setting out to perpetuate new categories of disease/being, which is a solution to Charon's perceived problem of a practitioner's inability to help a patient grapple with loss of health and well-being, as I've identified above. For a practitioner to "help" a patient grapple with loss, the practitioner would need still more explanatory power over the condition of living. That is the very outcome I seek to avoid in this project. Instead, I use this dissertation to problematize the foundation of western medicine's explanatory power and to explore posthuman feminist pedagogy as a means of resolving submission to this power structure. The answer, then, to *how can western medicine contribute to narrative study*, is that, through an exploration of life writing genres, western medicine can offer insight into how biographical fragments turn into narratives because this tool is how western medicine controls knowledge.

Illness Narratives as Historical Forms

The analysis I make in each chapter depends upon modifications made to two life writing concepts: relationality and the autobiographical pact. Smith and Watson write in their first edition of *Reading Autobiography* that relationality, as a narrative concept, suggests that the self-narrator's story "is bound up with that of another" and invites us to "think about the different kinds of textual others through which an 'I' narrates the formation or modification of self-consciousness" (*Reading* 1st ed, 65). Two components of relationality that they notably drop from their second edition of the same text are the contingent others and the significant others. Contingent others are, according to Smith and Watson, those who "populate the text as actors in the narrator's script of meaning but are not deeply reflected upon," and significant others are those "whose stories are deeply implicated in the narrator's" and through whom the narrator understands her or his own self-formation (*Reading* 1st ed, 65). Work in postcolonial theory, life

writing studies, and other cultural studies fields likely informed the revisions to the second edition—those being the absence of these contingent/ significant categories from their discussion of relationality; however, I would like to return to these categories in this projects while also working with newer diagrams of relationality as a concept. I return to contingent/ significant others not to belabor the problem of perspective when determining a category, but quite the contrary. I use contingent others because of our lack of perspective for several others in historical documents. I cannot retrieve enough of Mary Toft’s life, ever, to render her a significant other, let alone a subject in her own words. And I certainly cannot understand rabbits, let alone rabbits that have been dead for hundreds of years. Instead, I illustrate the purported subject’s absence from the documents used as evidence. That is, I read for the partial descriptions of these others that exist as evidence of the subject (or, more accurately, as the author understands the subject). I modify the concept of relationality to do this reading, though, to make mention of nonhuman subjects is a new approach to this analysis. In doing so, I use this project to further trouble the *groups* that provide medical evidence, as these groups ought not be presumes solely human.

Since so many life narratives are spoken for at one textual site, who, then, is the subject of a life narrative? And why should this work of destabilizing occur within the context of western medicine? In medical narrative studies, queries into the ethics of engaging with ill humans stem from the history of western medicine, and necessarily the history of science. Rita Charon and Martha Montello write that human responses to illness are “neither biological nor material phenomenon,” and that attempts to respond to ill humans reflects what meaning(s) might be derived from their descriptions (*Stories Matter* ix). Charon and Montello later state that a “narrative approach to bioethics focuses on the patients themselves: these are the moral agents who enact choices. Theirs are lives ruptured by the [transformative event].” They also argue that

these stories do, or should, form the “canon” of medical practitioners (*Stories Matter* xi). I take issue with these sentiments for two reasons: one, there are material responses to illness. My body responds to an infection in ways that my mind cannot. Two, the focus on patients is false. Indeed, the intended purpose of the kind of narrative medicine proposed in *Stories Matter* is for practitioners to better treat ill humans. Even though ill humans can benefit from having practitioners who are better listeners, we mustn’t forget that these practitioners have at stake their own personal interests that can supersede benefit to the patient. Narrative study into illness, then, must work to accommodate the multiple interests at stake in a specific case. Doing so underscores the collaborations necessary to make medical narrative, collaborations that are erased through the act of constructing objectivity and credibility.

Ann Jurecic, in *Illness as Narrative* (2012), shifts perspective from Charon’s, turning from points of view as constructing forces to how cultures and subcultures act as constructing forces. While Charon focuses on narrative acts between human individuals, Jurecic expands to consider the narrative possibilities of illness as narrative subject itself. Jurecic, like Waldby, Lisa Carwright, and other medical feminist scholars, relies upon twentieth-century examples to construct her argument. Jurecic’s goal is to respond to what she identifies as the recent development of the illness memoir—in how to read them, to theorize them, and how to use these to make new medical knowledges. But Jurecic’s work is limited to the twentieth century, and, through this historical limit, the challenges made do not seep far enough into the imposing institution of western medicine.

While it is true that patient-authored illness memoirs have recently proliferated, it is a mistake to limit this genre to the twentieth century. Doing so neglects the illness narrated in texts such as *A Journal of the Plague Year*, *A Memorial of the Last Days on Earth of Emily Gosse*,

among others, as well as illness as metaphor and punishment in hundreds of literary works. The existence of these older forms of illness memoir, illness narrative, and life writing featuring illness suggests that the human impulse to narrate one's illness is, in fact, more than a response to changes in "culture, medicine, media, literacy.... Medical professionalization; the rise of modern health care; the emergence of the women's movement and the gay rights movement; the etiology of the AIDS virus; the inability of master narratives to give meaning to suffering in the modern era; and technological advances" in both medicine and publication (Jurecic 10). Rather, what these older works demonstrate is the constant, old struggle against medical objectification. This struggle is more specific than sociocultural influences and not sparked by social progress and/or social change. Medical imagination exercises hegemony over patient experience. The tool with which it accomplishes this dominance is narrative.

Furthermore, this focus on the twentieth century and forward for medical examples fails to contextualize the coaxing narrative process in medicine. Medical narrative is always a coaxing process: doctors request specific information from their patients. This relational co-authorship is well-documented and has already been historicized. Wild uses the private-practice letters of James Jurin, William Cullen, George Cheyne and others to chronicle the influence letter writing had on etiquette and ethics in medical diagnosis. Robert Weston, in *Medical Consulting by Letter in France, 1665-1789* (2013), observes a similar generic influence with a much larger sample of medical correspondence letters in France. Weston observes that

[t]he practice of medicine is tripartite...[it] also involves the illness, whether real or imaginary...The purpose of the healer was however more complex [than that of the patient]. Not only did he or she seek to cure whatever ailed the sick, but in addition it was an enterprise undertaken for reward, be that monetary, prestige, or some other form of

self-gratification. An illness may have been perceived differently by the patient and the healthier. The patient primarily viewed the illness as a symptom, or more likely, a series of symptoms. The physician or surgeon saw it rather in terms of a disorder which once identified could be named and addressed. (4)

What Weston describes here is not only a challenge to medical objectivity as an ideal perspective but is also a posthuman relational collaboration. The actants in this scenario are human and nonhuman: patient, doctor, illness. Additionally, the letters with which patient and doctor factor into the shaping forces of what ultimately becomes the illness narrative. These consultation letters provide evidence of a much longer history of medical imagination and medical objectification than currently acknowledged, but such letters are not the only historical examples of medical imagination and objectification. In each case study, I explore further genres that evidence the shaping forces of western medical practitioner's authority over describing health as an ideal. Such descriptions importantly become the oppressive measuring stick by which patients and research subjects must conform.

The control over narrative identity in these conditions relates to science's obsession with objectivity. Jurecic notes that "[i]f illness is beyond expression in language, translation of the experience into words misrepresents, even contaminates the real event" (10). Here, Jurecic considers the relationship between illness and trauma as asymptotic in nature: we only every approach traumatic re-presentation but never fully represent it. To add to Jurecic's observations, illness narrated in other contexts, namely clinical or legal contexts, also can only approximate experience. This paradox informs approaches to patient testimonies because of the aforementioned limits. Supplementing patient testimonies with tests and examinations, while

sometimes offering a fuller picture of the ailment, often works to discredit what people say about their own bodies, particularly when those people are women.

Historicization of this discrediting is important. For example, Karen Harvey, in her essay, “What Mary Toft Felt: Women’s Voices, Pain, Power and the Body,” claims to reconstruct Mary Toft’s feelings through her multiple confessions (35). While Harvey likely can catch a fragment of Toft’s experience, she fails to attend to the distance between herself and Toft, who pretended to birth rabbits, and the influence of the objects producing that distance. Toft was illiterate, so her three confessions were taken by James Douglas, a doctor in the case who had at stake his own professional reputation. These factors influenced the confessions Douglas took. We can say, then, that there were obstacles limiting the empathetic negotiation between Douglas and Toft. So, too, are there obstacles limiting the empathetic negotiation between contemporary scholars and archival texts. While scholars might be able to catch a glimpse of the fragments of Toft’s experience, it would be unethical to state that we can know what she felt, and it would be just as inappropriate to claim that if we were to have Toft’s own words in front of us. Historicizing this case would attend to our developed expectations of testimony, but, more importantly, historicization of Toft’s case prevents us from retroactively diagnosing her. Without Toft’s input, diagnosing would be an act of medical authority. It would be making medical decisions for her without her.

In the same vein, it is inappropriate to group this troubled reconstruction into the broader category of women’s voices as Harvey does. The trouble here is the fabrication of singularity, which neglects this case’s complexity. Even if we were there, observing events as they happened, we would still be witnessing the events unfold through a different perspective, what Kwame Anthony Appiah likens to a mirror. Appiah writes of the fallacy in thinking one’s little

shard of the mirror can reflect the whole (8). The evidentiary pieces we have of a case like Toft's are fragments of such a mirror. We look at them to think we can identify this piece's relationship to the whole, to ourselves, and to the past; however, the shard can never actually replicate what it once was. Instead of attempting to describe what we think is the reflection, such as reconstructing Toft's experience through the words of upper-class professional men from nearly three hundred years ago, I work to locate a number of authors/collaborative actants in each case presented within each chapter. Doing so renders the distance between these actants and a reader/listener visible while problematizing the single perspective suggested by dominant western medical narratives. Again, it is the singular perspective making medical decisions without the patient/research subject that I seek to investigate. Thus, this project exposes the limits of singularity by locating collaborative actants in the case studies of each chapter.

Posthuman Feminism and Trauma

Donna Haraway has offered an answer for how to re-imagine a scholarly context, not just for humanities and social science scholars but also for medical and hard science scholars that enable us to work for something other than progress:

Some scientists I know express this kind of bitter cynicism [that the world is over and it is too late to save], even as they actually work very hard to make a positive difference for both people and other critters. Some people who describe themselves as critical cultural theorists or political progressives express these ideas too. I think the odd coupling for actually working and playing for multispecies flourishing with tenacious energy and skill, while expressing an explicit 'game over' attitude that can and does discourage others, including students, is facilitated by various kinds of futurisms. One kind seems to

imagine that only if things work do they matter—or worse, only if what I and my fellow experts do works to fix things does anything matter. (3-4)

We do not need to hail medical practitioners as ultimate decision makers or patients as having unassailable ethics. What we do need is to better understand the effects human animal decisions have upon those around us; working towards this understanding means studying the ways in which medicine tells its stories. Thus, Haraway's critique of expert work informs this project. By asking what groups of actants comprise the medical evidence use to make medical decisions, I am offering a deconstruction that perhaps troubles more than it "fixes"; however, this critical work still matters. It matters because representation—of self and of others—matters.

Reading the material actants in medical narratives starts the practice of acknowledging that what humans use to make meaning and to construct our lives matters, and it matters deeply at the limits of language and genre. While this practice is relevant in many contexts, I focus this project on medical narrative in part because of the role materials play in health. Medicines are material actants that interact with bodies to transform them; this is a material performance of medical narrative. With medicine's crucial role in the narrative, it makes sense that this dissertation's work with nonhuman animals and actants within the field of medicine because of the multiplicities of others and of selves at work, particularly if we are to keep with the trouble, or if we are to begin to understand how human interests have inflicted terror upon nonhuman and human subjects alike.

Considering the possibility of humans inflicting terror, harm, and/or unspeakable horror onto other humans and nonhumans builds upon the nonhuman ethics dimension of Haraway's scholarship. She writes that

It matters with which ways of living and dying we cast our lot rather than others. It matters not just to human beings, but also to those many critters across taxa which and whom we have subjected to exterminations, extinctions, genocides, and prospects of futurelessness. Like it or not, we are in the string figure game of caring for and with precarious worldings made terribly more precarious [by human decisions]. (55)

It matters which collaborative constructions we make in our medical narratives. That is, the meaning making exchanges here are, at least, twofold: the multiple subjects of medical life narratives become-with, and the conjunctive human-centric narratives become-with one another. There is cycling and replacement between subjects and between narrative formulae. In other words, the subject is in constant motion, and thus the narrative is in constant motion. For example, in the third chapter, I analyze Victorian-era food adulteration laws alongside several versions of domestic home manuals. What I find is that the desire to perform objectivity runs parallel between ideal Victorian readers and ideal Victorian food makers. To keep the text *clean*, one had to engage in self-erasure, materially and textually, in the case of milks. These fluid subjects and fluid narratives comprise medical evidence because milk has long been understood as a healthy foodstuff; controlling the female bodies making milk, bovine or human, interestingly compares to controlling the female reader. Acknowledging such fluidities of ideal beings contributes to academic and practical understanding of facts and of information since we can better understand the groups making medical evidence, again, both textually and materially. These medical evidence-makers are, in a way, producing testimony.

Scholarship on testimony currently, and logically, has been firmly seated in trauma studies. For example, Jeffery Alexander posits collective narration as an exercise of social hierarchy, expressing that whichever/whomever “wins” the battle to claim hurt or social injury

“is a matter of performative power” (2); yet, how can the nonhuman *win*, or be heard? The human-centric nature of scholarship on trauma studies has neglected to attend to the traumas of nonhuman animals, opting instead to focus on human-to-human interactions and performing claims over nature (and thus nonhuman animals). By acknowledging that nonhuman medical testimony exists as material evidence, I use this dissertation to bring nonhuman animals and material actants into considerations of trauma and testimony. Each chapter in this dissertation, with the exception of the pedagogy chapter, pays attention to three medicalized cases. The western medical perspective, which has been the dominant narrative in considerations of credible evidence, positions each case as a battle of humans vs. nature. Using Smith and Watson’s concept of relationality, I critique how humans actually use illness narratives as a means of fighting with one another, rather than with nature. Humans intentionally attend to or neglect aspects of nonhuman and material identity to construct a “winning” narrative. This means they fail to respect the nonhumans, materials, and other humans (mis)constructed in their stories. It is important what and whom we use to think for/with, to tell stories to/for/with, to relate to/for/with, to describe for/with, and to link to/for/with; it matters “what stories make worlds, what worlds make stories” (Haraway, *Staying with the Trouble* 12). Re-covering just a few of the other life narratives stemming from the same circumstances as the dominant medical narratives begins to speak with the matter humans use to treat other human and nonhuman animals. These mis/constructions have effects, and cycle through cultural treatment practices. These are the groups of people *and* nonhumans providing medical evidence. It is important to acknowledge how their forced collaboration affects medical knowledge because that medical knowledge is how we make decisions about our lives.

However, *our* lives means more than just one individual's decision since decisions are not made in perfect laboratory conditions. What I mean here is that medical decisions made on behalf of human health affect more species than humans; to return to the case study presented in the third chapter, cows have very much had their lives affected by medical evidence and human medical decisions. While nonhuman animals do not share all our experiences, they do share in the experience of medical objectification. Working to recompile the data/medical evidence into forgotten subjects is, then, a retrieval of lifeless, objective data. Rendering a subject as a list of data is objectifying, despite the purpose or intent of that rendering. This applies to nonhuman animals, too. Thus, this dissertation recompiles the data of forgotten contributors to medical knowledge in order to pose new strategies for reading medical life writing genres. By focusing on archival recovery of important yet disassembled contributors to medical knowledge, this dissertation contributes both to medical narrative studies and to life writing studies.

Brian Richardson writes that “we need to go far beyond the notion of a humanlike narrator (and, correspondingly, humanlike characters) to identify this most unnatural narrative situation and develop new categories like the fraudulent, permeable, and the disframed narrator” (xviii). Richardson understands the paradox of fiction/ nonfiction as a question of the limits of fictionality, ultimately coining the concept, “unnatural narrative,” to describe narration defying human capacity (i.e., animal narrators in works of fiction). There is something to be said for identifying the speaking for others that seems to be part-and-parcel for fiction and which is presented to us examples of humans narrating *for* animals rather than *as*; however, I recognize the need for a starting place, and the starting place I take is acknowledging the existence of these nonhuman life writing acts. Thus, relationality offers a better means of understanding narration comprised of human and nonhuman contributors because it insists upon the multiplicity of

narration, and thus, the multiplicity of subjects and others. Intended or not, *unnatural narration* suggests in its conceptual coupling that human and nonhumans do not typically compose together, which, of course, is one of the presumptions I seek to undermine with this dissertation.

Cynthia Huff proposes that life writing scholars use Haraway's work to "stay with the trouble" of life narrative and its study, and that we do so by "giving the animal and the machine as much primacy as the human in the stories of lives mutually lived" (3). Thus, Huff suggests a major revision to one of the foundational theories of life writing studies, the autobiographical pact, which explains the interaction of reader and author through the interface of the text and subsequent social contracts of truth and identity mutually negotiated (4). To begin to address the layers of (re)conceptualizing, Huff asks us to realize the fluidity of "text" first and the historical context of recovering lives that makes her work possible. As distant as the 1980s and as close as the present, literary studies, including the study of autobiography, concerned itself primarily with the work of "great" men; shifts in the university, such as the advent of women's and gender studies programs, antiracist activism, and postcolonial study all contributed to challenging the formerly-dominant syllabus. This wave of inclusion, though, faced an historical problem: since the lives of the privileged were most likely to be archived, how do we recover other voices? To (re)construct the lives and literatures of others, scholars turned to previously-disrespected forms of writing, like diaries, letters, logbooks, marginalia and more, which are the only fragments of lives lived by a great number of people. Now that fragments of lives are appreciated as key evidence of lives, it makes sense that, given the nonhuman turn, scholars begin to recover key evidence of nonhuman lives.

I use non-literary forms of life writing in the following chapters of this dissertation, which is certainly not a novel vehicle for research; however, I use genres that few would think to

categorize as *life writing*, let alone as wholly significant to approaching inquiries into credibility and authority. Marlene Kadar, in “Whose Life is it Anyway? Out of the Bathtub and into the Narrative,” identifies how such pamphlets, domestic health manuals, patient package inserts, and other genres are indeed life writing: “life writing is the broad term used by Evelyn Hinz and Donald Winslow to refer to a genre of documents or fragments of documents written out of a life, or unabashedly out of a personal experience of the writer” (89). Medical genres, formal or informal, are life writing because they are documents written out of a life. Thus, by using this dissertation to query how authority and credibility factor into the discrediting of others to the credit of the author, it logically follows that I should use genres of documents and fragments of documents uncommonly identified as literature (and rarely, if ever, as literary). The texts I use, pamphlets, letters, home reference manuals, and patient package inserts, are each written out of a life and for life—in that they are for the maintenance of the reader’s material wellness. It is because “life writing includes more than just stories” (Kadar 89) that I must use such texts. By using these genres, I am contributing to life writing scholarship by acknowledging life writing, particularly these forms, as key sites of the other, specifically the nonhuman other.

Foundational Life Writing Concepts

To conceptualize his foundational concept, *the autobiographical pact*, Philippe Lejeune did not only use autobiography or biography or literary forms of life writing. Indeed, Lejeune uses closely related genres as not-autobiography as a key part of his own definition of what *is* autobiography. Lejeune writes: “Any work that fulfills all the conditions indicated in each of the categories [form of language, subject treated, situation of the author, position of the narrator] is an autobiography. Genres closely related to autobiography do not meet all these requirements [memoirs, biography, personal novel, autobiographical poem, journal/diary, self-portrait or

essay]” (4). Importantly, the literary form of *autobiography*, then, is not the category with which to understand the texts used in this dissertation. That said, the pamphlets from the Mary Toft case do present prose narratives in which the narrator and the author are one in the same and convey a retrospective point of view, as are Thomas Hames Pearmain and Cresacre George Moor’s *Aids to the Analysis of Food and Drugs* (1895; 1899) and *The Analysis of Food and Drugs* (1897), as is *Our Bodies, Ourselves*, and as are patient package inserts. The primary aim of these texts may not be to convey the author/narrator’s own life; indeed, the primary aim, I argue, is to enforce the author/narrator’s view of ideal objectivity and ideal health onto the reader/subject. But this does not make these texts non-autobiography. Instead, they are *autobiographical* because of the self-narration necessary to establish the author/narrator as authoritative. These genres re-present fragments of authors and of subjects, medical fodder and reader, that make them key to understanding characterization in medicalized contexts.

However, the autobiographical pact limits the acts we can conceptualize as life writing to human acts alone. Lejeune, while he does trouble his own definition of *autobiography*, does not allow for the flurry of authors often necessary to construct credibility. As a means of opening up the field of life writing studies to nonhuman acts of life writing for study, Huff proposes the “zoetropic pack” as a means of making kin with the crowd of authors, readers, and materials whose lives are part of a text, albeit not all of those involved are making use of human language to do their work. Scraps of lives, like medicines, descriptions, legal documents, etc., themselves convey life narratives and contribute to life narratives. These texts have their own human makers who are also archived into such materials; the letters written about Mary Toft, for example, are at once fragments of her life, the author’s life, and the life of the intended recipient. They are also composed of the material that bears traces of the lives of those who made that material. Thus, the

autobiographical pact is insufficient for such representations of humans let alone the nonhuman subjects involved because it cannot accommodate the fragments of human or nonhuman lives present in a text. For instance, paper is a material life narrative of a tree because paper is made of tree pulp. Thus, if a scholar wanted information about trees from a moment in history, she might locate paper documents and observe specific qualities in the paper or forensically test them for information about those trees. A life narrative about that tree is then (re)told. By diffracting material meanings, I intend to look at the many lives used to construct a single life.

Informing the way in which I approach the material and the nonhuman is Arthur Frank's work in *The Wounded Storyteller* (1995). Frank writes that "the body is not mute, but it is inarticulate" (27). What Frank describes here is that bodies, through what we understand as symptoms, address ourselves and medical practitioners. This relates to nonhuman animal subjects and dead subjects in life narrative because theorizing how nonhuman animals, dead subjects, and/or bodies contribute to life narrative, we must attend to what we mean by address. That is, a key aspect of being a life narrator is "address[ing] readers whom they want to persuade of their version of experience" (Smith and Watson 7). Because medical evidence is made to convince, it follows that address informs ethical concerns in this project. By reading medical evidence as provided by groups of nonhumans and humans, this dissertation promotes further study into the implications such multiplicities have upon medical decisions and upon public perceptions of medicine.

Jane Bennett points to food as an obvious example of nonverbal collaborative life writing between human and nonhuman actants: "That food can make people larger is a fact so ordinary and obvious that it is difficult to perceive it as an example of a nonhuman agency at work. The case becomes a bit stronger, perhaps, when we learn of hitherto unrecognized powers of dietary

fats, in particular their ability to make a qualitative as well as quantitative difference” (41). Materials ingested, like foods and medicines, engage in “different” acts in “different bodies, and with different intensities even within the same body at different times,” sometimes even producing “different patterns of effects, though not in ways that are fully predictable” (Bennett 41). These materials pass on and on between human and nonhuman animals and into the earth until they are ubiquitous in some trace amount, thereby resulting in (theoretical) posthumous harm. However, to attempt to wrestle back narrative control is an exercise of human primacy. To return to the National Academy of Medicine’s realized problem, this is why current reading practices wrongly presume *medical evidence* to be singular, but it is also how medical practitioners are taught to presume *groups of people* are the singular species providing medical evidence. Instead, the site of a medical narrative, then, holds many collaborations across the character roles (patient, practitioner, illness, etc) as collaborative networks. Also, at the same site, the process of narrating is collaborative, too; the characters all work together to compose. Thus, in using a posthuman relationality in this dissertation, I attend to the meaning making at these two levels: bodies narrated and bodies narrating.

Material Actants and their Contexts

Vibrant matter, Bennett’s best-known term, has the capacity to “resist or to obstruct human projects but it also includes the more active power to affect and create effects” (Bennett 48). In illness narratives, for example, drug effects are only “side effects” when they are not intended. Indeed, the whole medical rhetoric of “side effects” speaks to Haraway’s call for acknowledging the impacts of human decision-making. In other words, narrative medicine needs to better accommodate the material subject, and humans need to stop pretending that we can control bodies with materials, nonhuman animals, and/or technologies. Our decision(s) makes meaning

with our bodies and with the worlds around us. Attending only to what humans intended to happen neglects our most intimate neighbors: nonhuman actants as medicines and medical knowledge-makers. Medicalized nonhuman actants are “the most personal of material objects, swallowed, inserted into bodies, rubbed on by anxious mothers, used to express care and intimately empower the uncertain individual” (Whyte, Reynolds, van der Geest, and Hardon 3). Thus, my proposal in this dissertation to engage in reading practices that acknowledge these intimate actants in medical narratives works to respect these intimacies.

Considering the intimate relationship between material actants, humans, and nonhuman animals (veterinary sciences is implicated here, too), Chris Caple’s *Objects: Reluctant Witnesses to the Past* offers a perspective on the relationship between objects themselves and their context as human artifacts:

Objects act as symbols encapsulating the beliefs of a given culture at a particular moment in time through their physical form and decoration. This is often preserved through the object’s continued survival and is referenced by future generations. Thus objects should also be seen as palimpsests, having an evolving series of meanings over time.... [O]bjects can be seen as possessing three forms of identity:

In use, functioning and having an effect on the world.

The symbolic meaning of the object, its role in the cultural code; as such, every object echoes and reinforces the meanings of the codes of the culture.

Embodying and signifying past experience: through its appearance it carries ideas and information about the past into the present. (7)

Blending together Caple’s understanding of how objects/artifacts offer evidence of the past and Bennett’s understanding of how objects offer their own cultures outside of human culture, I work

from the premise that material actants each have their own narrative, but that narrative is very much predicated on the role a material actant plays in human culture. In other words, Caple's and Bennett's work together allow me to question the parroting humans engage in when speaking as a material actant. Caple also states that "[t]he context in which an object appears invariably helps define its meaning. Since most symbols signify to members of the same culture and since the members of a culture will share many experiences and ideas in common, members of that society can normally 'read' the symbol, within its context, correctly" (Caple 9). Meaning, I will need to discuss both descriptions authored by those involved in each chapter's case and how I encounter this information concurrently. Indeed, I address the need to recover lives and to identify the limits of reconstruction possible in each chapter.

My approach to collaboration in illness narratives can be traced to Kristeva's concept of the abject, the idea that material and metaphorical constructs can negotiate, disrupt, or invent identity (4). Kristeva writes that:

[Abjection] does not respect borders, positions, rules. The in-between, the ambiguous, the composite. The traitor, the liar, the criminal with a good conscience, the shameless rapist.... Abjection, on the other hand, is immoral, sinister, scheming, and shady: a terror that dissembles, a hatred that smiles, a passion that uses the body for barter instead of inflaming it, a debtor who sells you up, a friend who stabs you... (4)

Kristeva's theory of abjection enables me to examine the materials, nonhumans, and humans that together make meaning in illness narratives with an eye to motive; material actants and nonhuman animals are spoken for because these subjects must be kept discrete and controlled. To return to my earlier mention of Code's theory of knowledge transaction, wherein the western thinker/medical authority receives and interprets information from the object of study for

laypersons, the need for material actant and nonhuman animal narrative to be controlled is easily understood. Through the addition of a sanctioned human interpreter, the object of study, be it a human or nonhuman research subject or patient, is seen to be kept apart from the layperson. But the real boundaries between patient, practitioner, and research subject are fluid; it is possible to be each, either, any, or all, at once. Therefore, abjection informs the rationale for perceiving medical knowledge/testimony inaccessible. Without an interpreter, there would be a vague risk of illness, disease, or death through contact with medical material evidence. A posthuman, medical life writing reading, then, does away with this vague sense of risk and gets into the dirt and death.

Chapter Outline

In Chapter Two, I accentuate the limits of Philippe Lejeune's autobiographical pact using Smith and Watson's original (first edition) conceptualization of relationality. That is, relationality as a concept describes the functional bond between contingent others and significant others in life narrative. The case study I use to challenge the autobiographical pact is of Mary Toft, who, being a poor, illiterate woman from the eighteenth century, could not herself pen an account of her rabbit birth hoax. As such, I analyze surviving accounts, which are dictated confessions, doctor's pamphlets, and popular satirical autobiographical-*ish* narratives as a means of accounting for the life writing occurring before Lejeune declares his pact begins (1770). This transforms our idea of life writing/narrative by rethinking the autobiographical pact as a gradual, learned approach to reading, and it troubles the singularity of authority in medical narrative. What I find is that, in this medicolegal context, *expert witnessing* informs the ways in which a reader trusts what the narrator of a life writing text claims. I further challenge scholarly study by considering the relationship Toft maintains, or doesn't, to this popular narrative about her life. What I find is that

material actants and nonhuman animals hold either equal or greater credibility positions in these confessions and pamphlets despite Toft being very much the center of the events. These findings challenge configurations of medical narrative by redressing the spectacular characterizations expert witnesses turned her into.

The case study at the center of my third chapter follows my use of contingent others and significant others through to the nineteenth century and domestic home manuals. Extending from the problematic professionalization of medical witnesses and testimony in the eighteenth century, I use this chapter to ask where women could be narrative contributors in a medical context. Because of the continued professionalization of western medicine, the emphasis on maintaining objectivity in medical contexts proves exclusionary to women even when the women are readers practicing medicine at home—an intimate space. The intimacies between human and cow, especially regarding human health, depend upon our common text of *milk*. When milk is depersonalized through objectivity, both as a narrative strategy and as an idealized material condition, this intimacy is erased. I contextualize these important exclusionary strategies within the Victorian life narrative frame of self-help. The application of self-help values, coupled with medicoscientific ideals of objectivity, further erase the role women play in the history of western medicine and, disconcertingly, erases the woman from her own narrative. This chapter's revealing of women's narrative erasure challenges our reading of medical history as male-dominated, and also, human-dominated.

Continuing these case studies of discredited women's medical testimonies, I account for far more recent texts, patient package inserts developed for contraceptive pills, in the fourth chapter. From what I have shown in the chapters preceding this one, women are contingent to their own medical life writing and women, through ideals of objectivity, are erased from life

writing of which they ought to be the focus. I find that, despite the rationalization for objectivity by medical authorities as bringing medical witnessing closer to truth, early examples of patient package inserts work to blame the user/patient for negative drug effects, even in instances where the carcinogenic, carcinotropic, and cardiovascular disturbances are well known to the medical community. Furthermore, the twentieth century brought the promise of addressing women's discrediting by means of the popularization of women's health activism and second-wave feminist politics; however, as I show through a close reading of several editions of *Our Bodies, Ourselves*, this promise is never realized. Indeed, I discover the most recent edition of what was the most popular and trusted feminist health reference has begun to engage in the very exclusionary narrative strategies it set out to oppose.

In the fifth chapter, I discuss my design of a section of English 160: Introduction to Studies in Women's Writing as "Women Medical Writers/Writing Women's Medicine." In designing this course, I develop a posthuman feminist pedagogy by building upon Karin Murriss's *posthuman child* in order to reimagine what characterizes an active student. This reimagining allows me to develop a course that introduces students both to the troubles and contradictions within our very own western medical culture and to the scholarly practice of critical intersectionality as a research strategy. My design brings students to bear the *bad news* of western medicine's oppressive histories, which our own oppressive histories, while asking students to locate themselves within this context, particularly by challenging what it means to be an individual.

The final chapter concludes the project by circling back to the issues at the heart of this introduction: archival recovery, posthuman reading strategies, and medical life writing genres. I further develop, in this conclusion to the project, the link between life and death by considering

the implications my suggested reading practices have. In other words, by asking to acknowledge nonhumans and material actants in medical life writing, I am very much asking to acknowledge the role dead and death play in constructing life. Pew Research Center polls of the U.S. public suggest most have overall positive views of medical research scientists and medical practitioners; however, the same polls suggest the U.S. public are “more mixed” when it comes to “trust them to do a good job, show concern for the public’s interest, and provide fair and accurate information” (Medical research scientists, Pew, online). Furthermore, Pew finds that there is “widespread skepticism among the public when it comes to issues of scientific integrity” (med. research scientists, Pew, online). A central concern of this chapter, then, is how the posthuman reading strategies keep-with the trouble by highlighting the paradox of trusting medical authorities with skepticism. These concerns close the project, but offer no closure, to the concern of the National Academy of Medicine’s *fundamental incongruity*: evidence is derived from groups of people, yet medical decisions are made by and for individuals.

CHAPTER TWO: LEGAL MEDICAL WITNESSES IN EIGHTEENTH-CENTURY ENGLAND AND THE PROBLEM OF CERTAINTY: THE MARY TOFT CASE

Introduction

The medical imaginary, prior to imaging technologies that could peer inside a body without surgery, depended upon descriptions. To author a case narrative, in the eighteenth century, practitioners compiled many texts—visually or verbally descriptive—to reconstruct a timeline, the body, the symptoms, and the procedures in place of a working, visible body. Descriptions of the human body and its “normal” working conditions functioned in a number of contexts, most notably, legal and public contexts. Although it was then impossible to watch—to witness—the events and the workings of the human body, medical practitioners still described bodily functions, and some did so in the court of law. Scholars studying the history of anatomical diagram and description, like John Bender, argue that diagrams (and subsequent verbal description) held “explanatory power” over the objects rendered (Bender 14). This chapter pursues a different, albeit related, route. I understand this explanatory power, particularly in cases where alternative points of view do not remain, to be an oppressive force. Bender writes that the reader/observer’s “activation of diagrammatic correlation coexists with analogous cultural forms that play to the viewer’s secret emotions” (55). What Bender does not study is what happens to object(s) rendered for the vicarious pleasure of these authors/illustrators and readers/observers. I seek to detail the oppression of human women, nonhuman animals, and material actants via these explanations. The explanations, or testimonies, may never be recovered, but they may be supplemented.

In 1726, Mary Toft, a poor, illiterate woman who had a miscarriage (of at least one human baby) a few months prior to the events, began to produce body parts of rabbits from her

vagina. The “miraculous births” occurred from October through the end of November of that year, with Toft’s legal confessions dictated the first week of December. She was originally medically tended to by John Howard, a male midwife or surgeon⁴ before being tended to by a flurry of other medical practitioners, including: Nathaniel St. Andre, Samuel Molyneux (secretary to the Prince of Wales), Cyriacus Ahlers, Richard Manningham, and James Douglas. No doctor publicly declared her a fraud until after her December confession(s).

Sir Richard Manningham, Cyriacus Ahlers, and other medical professionals were not only involved in the case but published pamphlets of their own. Douglas took at least three dictated confessions from Mary Toft, and the depositions of Edward Costen, Richard Stedman, John Sweetapple, Mary Peytoe, Elizabeth Mason, and Mary Costen were published together in 1727. In addition, a “Lemuel Gulliver” published his account—actually a satire written by Johnathan Swift—and William Hogarth provided a satirical illustration as did a number of other satirical artists of the time. Due to the mass of publicity surrounding the case and considerable media published on its occasion, we must read the narrative dependency between Howard and St. Andre in the former’s pamphlet as a response to the criticism both faced.⁵ Their narrative characters and thus public figures depend upon their having been duped, not by each other, but by Toft. Thus, when feminist historians discuss their subjectivity, we must consider the role this pamphlet plays in the illustration of these characters for the larger, dominant narrative. For ages, the dominant narrative of the Toft case was that medical men triumphed over the fraudster from the very beginning, never believing her but struggling to get her to admit her fraudulence.

⁴ He is in some texts referred to as a male midwife and in others, a surgeon.

⁵ The University of Glasgow Library, the institution which holds the originals of Toft’s dictated confessions, writes that Howard “had to answer to charges of being concerned in the ‘Cheat and Conspiracy of Mary Toft’ but the case against him was dropped and he remained a respected figure in Guildford” (<http://special.lib.gla.ac.uk/exhibns/month/aug2009.html>)

Historians, like Dennis Todd, have since provided evidence to the contrary. Most of the practitioners, St. Andre in particular, believed that Toft was producing rabbits and possibly parts of other animals.

There is a subsequent version of St. Andre's pamphlet published in 1774. Some of the introductory content in the 1774 edition is framed as a preface written by a male midwife (not Howard but an Andre Ceitor) who declares Howard a "toad fancier." The postscript following this preface describes a "very extraordinary Account of a Woman being delivered of four Toads, within this last Year, has appeared in the *Journal Encyclopedique*, published Monthly at Paris by Bouilon" (viii). Cody identifies the woman as Catherine Berna, but Berna's hoax was immediately identified by male medical practitioners; in Berna's case, the "magistrates and doctors uniformly [are historically reported to be] doubt[ful of] Berna's claims," and the female midwives similarly credulous (138). This switch a mere generation later underscores the importance of the Toft case when studying medical authority and credibility.

Witnessing, Legal and Medical

Before I discuss my analysis, I should define how I use *witness* in this chapter, as it is distinct from *eye witness*. It is informed by legal context, particularly public medical inquests. In cases of abnormal deaths, English courts would convene a medical inquest in which the body would be physically present; these inquests occurred as early as the seventeenth century and through the late Victorian era (Burney 35). At such a medical inquest, a practitioner in the field would use the victim's dead body to convince lay jurors and judges of a cause of death: "The jury is to be sworn and charged to inquire upon the view of the body how the party came by his death, whether by murder by any person, or by misfortune, or as *felo de se*" ("Historia

Placitorum Coronae” 60). The jury witnesses the medicalized description of the body’s state; the evidence is the narrative constructed by the medical experts.

These experts describe what the wounds *tell them*, as if it were a secret code, because these experts are the only ones capable of engaging in modest witnessing. As the “discourse of objectivity began to take shape to provide a buffer of authority for experimentalists” (Chico 17), scientists and medical practitioners seeking to be understood as scientific, rational men, would mimic the perceived un-*self*-interest of material actants in their descriptions and testimonies—this is the modest witness⁶. Legal medical witnesses notably were some of the last modest witnesses to be publicly accepted as more valid than their lay witness or immodest witness counterparts.

I couple this legal-medical context of witnessing to Steven Shapin and Simon Schaffer’s concept of *virtual witnessing*. Virtual witnessing is a technology that “involves the production in a *reader’s* mind of such an image of an experimental scene as obviates the necessity for either direct witness or replication. . . . It was therefore the most powerful technology for constituting matters of fact” (60). What the medical practitioner’s pamphlets do, then, is function as this type of technology. The facts of the Toft case established via medicalized descriptions of the rabbit (and other animal) parts troubled the reader/public because the same descriptions were given by practitioners believing Toft and those disbelieving her.

Sidonie Smith and Julia Watson’s concept of relationality provides me with a close-reading method to examine how characterizations of each participant depend upon the characterizations of another. Many subjects have disappeared or been relegated narratively to an

⁶ “The modest witness is the individual who is objective by virtue of erasing himself through his privilege” (Chico 21).

other position, including the named participant in this chapter, Mary Toft. Despite being the name through which the case is remembered, Toft herself exists only as a relational other in all of the surviving literature. In spite of her position as narrative other, the Toft case, as it is remembered, names her above others, indicating Toft as the medical and legal subject. Toft's reconstructed perspective, however, is not merely a matter of immodest witnessing. Tita Chico writes that the immodest witness "bear[s] out the logic of self-interest undergirding claims to objectivity, revealing [objectivity's] limitations and contradictions, as well as the literariness of their characterizations that in some instances promise superior insight" (46). Toft cannot be an immodest witness because she is not a witness; Toft, in the medical descriptions/testimonies, exists only as a pregnant body-object having no real investment in the outcome.

Legal and medical constructs of trustworthiness, credibility, and certainty in the Toft case depended upon the very participants they cast as untrustworthy, incredible, and uncertain. In the following, I use the Wellcome Library's digitized pamphlets from practitioners involved in the Toft case and publicly published satires to illustrate how the Toft case was constructed and tried through public literature. I read the flurry of satires, in particular an anonymously published pamphlet claiming to be in Toft's own hand as replacements for what had been legal practice: from the seventeenth century through the eighteenth century, "experts performed not as adjudicators or trusted private advisors to judges but as *viva voce* witnesses whose presentations were to be evaluated, like those of other witnesses, by a lay jury" (Landsman 446-47). Stephan Landsman notes that the prosecution was far more likely to call upon an expert medical witness than the defense by a ratio of three to one (452), and that throughout the eighteenth century, England departed from permitting lay witnesses to testify on medical matters (such as cause of death) (454). The Toft case occurs inside of the shift Landsman's study observes. This shift, I

argue, should inform scholarly approaches to satire in the Toft case. These satirical responses served as a reaction to the exclusion of lay witnesses in medical matters and as a backlash to the growing legal authority of medical experts and their affiliation with the monarch. The satires turn Toft into an immodest witness character.

My reading of the Toft case in this chapter is an extension of Lisa Forman Cody's in *Birthing the Nation*: "[D]octors, political economists, scientists, and others scrutinized the bodily and the strange for important professional and epistemological reasons that had deep ramifications in the conception of emergent identities" (7-8); my chapter identifies the Toft case, in particular the struggle between doctors, lay persons, and the law, as an instance having deep ramifications on emergent identities. The Toft case provided an instance where medical practitioners had to configure a means of being wrong while maintaining their authority over matters of the body. The Toft case demonstrates the troubled history of this objective medical witnessing and the material evidence used to (co)construct it. Material actants—rabbit bodies and dung pellets—are produced to fortify a medical witness's testimony, they are co-opted into human life narratives. Lucinda Cole analogizes this process as a "composite of characteristics packaged for human consumption" (4). Toft, too, is relegated to a package of characteristics like the rabbits. While the divide between human animals and nonhuman animals ought to be, and has been, troubled by posthuman feminists and animal studies scholars, it is curious to note that the descriptions of the material actants and nonhuman animals are given greater credence than both the descriptions of and the testimony of a human woman.

Many of the present-day protocols Leigh Gilmore identifies as oppressive constraints contemporarily to women's testimony actually developed in the eighteenth century. Testimony, as a genre, refers to "bearing witness [and] to the protocols in which it must be offered;

[testimony] evokes legal testimony and its juridical framing as a ready context for any testimonial speech” (Gilmore, *Limits* 5). Furthermore, testimony represents more than the “truth,” if it represents truth at all. Testimony, particularly in eighteenth-century legal and medical cases, functions to represent authority, thereby establishing a set of rules by which legal and/or medical witnessing must occur. It is better to think of *credibility*, rather than *truth*. In my theorization, I prefer to distinguish between the two; this study of the Toft case problematizes practitioner credibility rather than embodied truth. A credible witness and/or testimony establishes a trust bond between author and reader. It is from this trust bond that action is taken. In medical contexts, the author might be the patient seeking to convince a medical practitioner of their symptoms. In a legal context, the author might be the medical practitioner interpreting material actants as evidence of cause-of-death. Either way, there exists unspoken rules about establishing one’s credibility. Of course, Toft did not actually give birth to rabbits, and I do not mean to suggest she did. What I seek to do is to study the construction of medical authority using a case in which that medical authority was wrong. The Toft case and the satirical treatment of it provides an instance before the hierarchy of witnessing between author/reader existed, uprooting this prominent assumption in the field of life writing studies.

Legal history scholars note a shift in the role of a medical witness in eighteenth-century legal cases, and I focus on three key aspects of this shift: the function of hearsay evidence, development of the *expert witness*, and the function of certainty. Each of these aspects shaped witnessing in eighteenth-century cases, particularly those at the intersection of law and medicine. The Toft case is special in that it provides an additional layer of complexity. Toft is a fraud, and the public tried the experts through a series of satires, pamphlets, and tracts published on the occasion. This case has had implications for medical knowledge for centuries to follow, though,

necessarily, I limit the scope of this chapter to texts published within a few years of the events. Using a medical hoax rather than a wrongly accused person or some other case allows me to sidestep discussions of truth in favor of studying the development of credibility. Indeed, Toft lied. The means by which witnesses constructed their credibility are clearer in the Toft case than they would be with another example. The fact that a witness can be credible and yet so very wrong, as many are in the Toft case, adds complexity to current discussions of women's testimony and witnessing in general.

Legal framing of testimony, particularly medical witnesses, develops out of a need to aid in ascertaining truth. James Oldham notes two devices, which we will see in the primary texts from the Toft case, that functioned to "aid" such truth-seeking: the oath and the party-witness rule. The party-witness rule meant that parties involved in the litigation (either as defendant or plaintiff) could not testify (Oldham 104). Indeed, the "most blatant and commonplace type of testimony," legally permissible hearsay, "was caused by the party-witness rule" (Oldham 104). Somehow, Oldham writes, the "facts" had to be on-record and established; since parties themselves could not testify, lay persons and experts were called upon to describe what they witnessed in connection to the dispute (104).

Medical witnesses in the long eighteenth century saw a shift in their authority as the weight of expert testimony in English courts grew (Landsman 454). Whereas before, nonpractitioners and practitioner's assistants could be called upon to verify what the practitioner claimed, this shift meant a departure from such practice. Concurrent with the exclusion of lay persons and amateur professional verification of medical witnesses, eighteenth-century courts began to "demand a higher degree of certainty" from medical witnesses (Landsman 456). Proof *beyond a reasonable doubt* became a stronger factor in medical testimony. As such, direct

testimony, such as eye witnesses, declined in value to English courts, while circumstantial evidence, such as expert witnesses, was given greater credence (Landsman 459). In the Toft case in particular, we can see such replacement of the lay witness. To life writing, and to medical narrative, this devaluing of lay-witness testimony in favor of expert reconstructions presents an issue for medical cases that one does not need a medical degree to understand. While they may have diminished value and participation in court, the public perception, a trial in and of itself, saw lay-witness participation as satire. I discuss satire at the end of this chapter.

On its title page, St. Andre's 1727 pamphlet provides evidence of multiple subjects. On this page, readers find the title: "A Short Narrative of an Extraordinary Delivery of Rabbets, Perform'd by Mr. John Howard Surgeon at Guilford," and further, "Published by Mr. St. Andre Surgeon and Anatomist to his Majesty," as well as "Printed for John Clarke, at the Bible under the Royal-Exchange" (1). The autobiographical pact as it is written would have the reader search for the author's name and to it readers would, entering a social contract, attribute the "I" narration. In other words, the author's name on the title page is the same as the "I" narrator. It is apt in a written testimony, like that presented by this pamphlet, to apply the pact. As a means of building trust with the narrator, a reader would want to determine if the author is in fact the narrator.

Applicability of the Autobiographical Pact to St. Andre

Philippe Lejeune, a foundational scholar in the field of life writing studies, theorizes that "[i]n order for there to be autobiography (and personal literature in general), the *author*, the *narrator*, and the *protagonist* must be identical" (Lejeune 5). In some configurations, this pamphlet does this matching. Yet St. Andre's pamphlet poses some challenges, and these challenges result from his inclusion of other perspectives written in "I" narration. Before I begin

to address these other perspectives, however, I acknowledge the limits Lejeune himself places on his ubiquitous concept. Lejeune writes that the autobiographical pact, a foundational close-reading method in life writing theory, is not designed to accommodate life writing this old:

[H]istorically, [the autobiographical pact] does not claim to cover more than a period of two centuries (since 1770) and deals only with European literature; this does not mean that the existence of a personal literature before 1770 or outside Europe must be denied, but simply that our way of thinking about biography today becomes anachronistic or not very pertinent outside of this area. (4)

What Lejeune states here could exclude St. Andre's pamphlets, even the 1774 edition since there certainly was not a sudden change in self-narration in England in 1770. While on the one hand, life writing texts like St. Andre's pamphlet support Lejeune's acknowledged limit here, they do, too, evidence further limits of the concept outside of the simple historicization of genres and modes of self-narration. Because St. Andre's self-narration in this pamphlet engages in early stages of legal- and medical-authority constructions, one would expect there to be some proto-autobiographical pact in effect. That is, there must be some kind of signal between reader and author, or else we would not know *who* addresses us in such instances of self-narration. If these testimonial pamphlets are public, verbal versions of the expert court witness, then the author must be signaling somehow their authority to the reader. If not via the autobiographical pact, then such signaling must occur through some other means.

These means, then, should be in the arrangement of the narrative itself. Readers understand when viewing the title page that, inside the events of the pamphlet, St. Andre will likely be observing John Howard deliver rabbits. According to Lejeune, this qualifies the pamphlet as a witness narrative/homodiegetic, wherein the narrator and the principal character

are not identical (7). The individual investment of named participants, however distant from the events of the narrative, shapes the “I” narration in the pamphlet. The largest name on this title page is actually John Howard; the reader encounters evidence that the “I” is not Howard on the fourth page:

The first Intelligence I received of this Matter, was on the 5th Instant, when I saw a very particular* Account of a woman living at *Godliman* lately delivered of five Rabbets by Mr. *John Howard*, Surgeon at *Guildford* in *Surrey*, a Man of known Probity, Character, and Capacity in his Profession, who has practis’d Midwifery for above these thirty Years.

*This Account was taken the 4th Instant at *Guildford* by Mr. *Davenant*. (4-5)

In this sentence, the reader first encounters a distinction between “St. Andre” and “Howard”; yet it is still clear that Howard is essential to St. Andre’s narrative. Howard, a fellow medical practitioner, is then a significant other to St. Andre’s narrative via Howard’s own words as they are represented to us in St. Andre’s text. The significant other is a component of relationality as theorized by Smith and Watson in the first edition of *Reading Autobiography*.⁷ Significant others are those an author reflects deeply upon to aid in their characterizations of self and others; contingent other and historical other are two additional components of relationality. Contingent others are not deeply reflected upon but are mentioned in the narrative, whereas historical others function as an ideal or a model through which an author communicates itself. St. Andre, to build credibility, must relate to a historical other or closely identify himself with authoritative significant others. Howard is such a significant other. The representation of Howard in St. Andre’s pamphlet leads to a false positive of sorts, wherein the “I” in this instance may or may

⁷ The second edition of *Reading Autobiography* relies more on Butlerian concepts of performativity. I discuss my decision to rely upon the first edition’s conversation in the introduction to this dissertation.

not be St Andre or Howard, as people do lie or mislead. Rather than an either/or, which the autobiographical pact would have us determine (one person signified), he is more than a significant other, as he is called upon to verify St. Andre's testimony, and his "I" collapses into St. Andre's.

To further illustrate the problem the auto/biographical "I" presents in "A Short Narrative . . .," narrative theorists might consider this pamphlet as having dimension rather than being linear. From one direction, readers could attribute St. Andre's narrative and the perspective represented only to St. Andre; from another direction, readers might interpret Howard's narrative, albeit a smaller shape in this landscape than St. Andre's. St. Andre takes care to illustrate that there is another *other* present: Mr. Davenant, by footnoting it in the above quoted section. The letter from Howard and, too, Davenant, co-construct St. Andre's "I" for the reader. They all depend upon one another to situate themselves in the narrative.

Relationally, narrative theorists could identify at least Howard as a "significant other" of St. Andre's life writing text—Howard is indeed deeply reflected upon; however, I suggest that Howard is more than deeply reflected upon, he is *depended* upon. St. Andre finds it necessary to transcribe "verbatim" the second account he received from Howard, going so far as to reproduce the signature as well. In this transcribed letter, the "I" subject shifts to Howard: "Since *I* wrote to you, *I* have taken. . . . *I* do not know how many Rabbets may be behind: *I* have brought the Woman to Guilford for better Convenience. . . . *I* am, Sir, Your humble Servant, John Howard. . . . If you send a Person, let him bring a letter from you" (St. Andre, 2-3; emphasis added). This shift in "I" referent and subsequent shift in "you" referent illustrates the constructive dependency of these two subjects.

Such positioning between these two characters mimics the swearing of an oath and the party-witness rule. Oaths are actually reproduced in the pamphlet for the public audience, serving to situate these texts as sworn testimonies. The question remaining, then, is how St. Andre resists being characterized as party to Toft, the defendant, and he does so by aligning himself with Howard and maintaining distance from Toft. By not reproducing Toft's words, St. Andre does not shape his testimony as the hearsay permitted in court ("I heard the defendant claim . . ."). This distance also lends to his resistance in regard to certainty, or at least avoids implicating himself as a contributor to the hoax. It is, too, reflective of the greater demand for certainty seen by eighteenth-century English courtrooms. This is where the modest witness and virtual witnessing come into play. The authors of Toft pamphlets present their case, using the same descriptions of Toft, the events, and the rabbits, via objective *modest witness* role so that they may be understood as rational, scientific men (as opposed to men floundering in the mystery of a woman's body). The reader, encountering the descriptions, is provided an opportunity to "rationally" evaluate the circumstances and evidence, which is virtual witnessing.

St. Andre constructs himself as an expert, modest witness by using the same maneuvers he would use were he speaking in an eighteenth-century courtroom, albeit a less certain witness than what contemporary readers have come to expect. Certainty in medical testimony became less a matter of judgment and more a demonstration (Landsman 457). That is, the better a witness could demonstrate that they were certain, by swearing an oath or by repeating testimony from other experts, the more reliable and trustworthy they were. St. Andre, in this pamphlet published after Toft's confession(s), demonstrates his conclusions by using scientific language to describe these material actants, although this language and what would be relevant was still developing into an eventual *standard* throughout the eighteenth century. This does not mean that

observations about a patient's body were not conveyed (absent of input by the person these observations represent). These data are characterizations of material actants and nonhuman others (the rabbit bodies and the dung pellets). By presenting these data rather than Toft's own testimony, St. Andre backtracks from any misguided certainty afforded by believing deceptive humans, essentially claiming *here are the events, you judge them*. St. Andre uses the medical imaginary on the rabbit bodies to explain how he thought they originated from Toft. By piecing together the proto-biometric data into an expert witness testimony/medical narrative, St. Andre does not claim that the rabbit births originated inside Toft.

Even with the sub-terminology of relationality that involves the significant other and contingent other, the narrative relationship between Howard and St. Andre still presents a quandary. St. Andre does not “deeply reflect” (Smith and Watson 65) upon his relationship with Howard, and yet, he still relies upon Howard to situate his own role in the Toft case. He goes as far as including Howard in his own words—which is not a right afforded to Mary Toft, the medical subject. Constructing Toft as a list of symptoms, descriptions, and disease narrative⁸ suggests objectivity. The human component is removed. Organs and other nonhuman evidence cannot lie because they are not human; however, this should not mean that expert witnesses cannot misread such nonhuman evidence. Oftentimes, though, as is clear by the Toft case, expert witnesses and their credible testimonies do misread these evidentiary materials. What was happening, though, was a standardization of performing credibility, importantly informed by legal contexts. Like scientific diagrams, which Bender identifies as “embrac[ing] both scientific and aesthetic orientations” and “recasting innate and idealized knowledge in terms of the materiality and limits of human perception” (81), the frames for expert testimony, too, were

⁸ By “disease narrative,” I mean a narrative limited by the initiation/conclusion of an ailment.

embracing scientific orientations and recasting innate and idealized knowledge. The Toft case, an instance where innate knowledge and the limits of human perception meet, provided a test for these new expert testimony frames. As many of the medical practitioners involved did not suffer loss of reputation, with the exception of St. Andre and a few others, these frames passed.

One person about whom there should be no doubt as to her significant relationship to the narrative presented both publicly across various media interpretations, as well as individually in St. Andre's autobiographical pamphlet, is Mary Toft. And yet, St. Andre never refers to her by name, opting instead to describe the case as "an Extraordinary Delivery of Rabbets" in his title and "[a/the] Woman" in his prose. Roughly halfway through the text, St. Andre almost addresses the exclusion:

I shall give no other Account of the Woman, than what I think pertinent to this Subject: By the Several Questions which I put to her, I was informed, that she was born and bred at *Godlyman*; She seem'd to be of a healthy strong Constitution, of a small size, and fair Complexion; of a very stupid and sullen Temper: She can neither write nor read: She has been married about six Years to one *Joshua Toft*, Junior, a poor Journey man Clothier at *Godlyman*, by whom she has had three Children. The account she further gave of herself, was, that on the 23rd of April last, as she was weeding in a Field, she saw a Rabbet spring up near her, after which she ran . . . this set her a longing for Rabbets, being then, as she thought, five Weeks gone with Child. . . . The same Night she dreamt that she was in a Field with those two Rabbets in her Lap, and awaked with a sick Fit, which lasted till Morning; from that time, for above three Months, she had a constant and strong desire to eat Rabbets. (22-24)

Just as in the confessions taken by Douglas, we have Toft's words conveyed to us. This blurb of classical biography, one in which the narrator has researched the subject, does not suggest that Toft is significant to the case and thereby to St. Andre's self-construction. She is not deeply reflected upon, in spite of this pamphlet being a resource to the larger, dominant medical narrative of Toft's trickery. The blurb begins with some minor proto-biometric data before transitioning quickly to Toft's descriptions of her relationship to rabbits: "the Orifice of the *Uterus* so far closed, as not to admit of the little Finger"; "After three or four very strong Pains, that lasted several Minutes, I delivered her of the Skin of the above-said Rabbet" (12). In these quotes, we see proto-biometric data that indicates size, shape, duration, and other measurements (though these were as yet to be standardized). These are descriptions of Toft's body and bodily functioning, rendering her a medical object. Furthermore, these descriptions begin and end with her relationship to the rabbit births.

St. Andre, thus, constructs himself as a *rational* man of medicine by co-opting Howard into his autobiographical "I," a move the autobiographical pact has not been designed to accommodate. Furthermore, as a piece of evidence supporting the larger, dominant narrative of the Toft case, Toft herself is notably absent in voice and present only through contingent other constructions; descriptions of Toft exist only in relation to the rabbits, which suggests their nonhuman animal lives are of greater evidence to the motives and goals of the authors of the evidence. Cody theorizes that Toft's contemporaries thought Toft "perpetrated a monstrous scandal through her female cunning, and this dovetailed with contemporary beliefs about the wily dangers of pregnant women's minds" (130). If Cody is correct in her claims of Toft's contemporaries, then it makes sense that the rabbit evidence would be given credence over a

human woman. Rabbits could be tamed and domesticated; science and medicine struggled to do the same with human women bodies.

The formal and final evidence that the rabbits birthed by Toft were not gestated inside of her were the dung pellets: “In the *Rectum* of this Animal [rabbit], which remain’d affixed to the Body, we found five or six Pellets, much of the same Colour and Consistence as the common Dung of a Rabbet, little Bodies, like dried Fragments, being matted together with a mucous Matter . . .” (St. Andre 11-12). St. Andre describes these dung pellets using the same narrative prerogative as he did when describing Toft and the rabbits. This suggests that these material actants function in this pamphlet at least as contingent others. While not a form of address—we cannot gather an intentionality of the rabbits for us to notice the dung—these material actants, that is, the dung pellets, offer testimony. This nonhuman testimony occurs within the frame of human culture and motive. St. Andre interprets the dung pellets as evidence the rabbits grew inside Toft, while other practitioners (Douglas and Molyneux, for example), use this same material actant as evidence the rabbits were born outside Toft. Medically and legally, the more credible witness would be held as the more truthful witness. St. Andre’s description functions, too, as an act of virtual witnessing. Here, the text “points to sensory experiences that lie behind the text” and it “constitutes a visual source” itself (Shapin and Shaffer 61). As a technology, the facts of the case are only established—are dependent upon—the expert medical witness’s interpretation of them.

Further complicating the autobiographical pact of “an Extraordinary Delivery” is that the “I” switches on the thirty-second page from referring to St. Andre to referencing Molyneux, another man involved in the scandal; Molyneux wrote and dated a sworn statement, indicating that “I Have carefully read the above Narrative,” yet avoids swearing to the accuracy of the

births (32). Molyneux is not mentioned on the title page, and yet, his sworn statement here, testifying that the “Gentlemen who are sufficient Judges will determine that Matter [the accuracy of the Births] upon proper Evidence; I can only certify, That I did draw up a Relation as is above-mentioned . . . and I can further affirm, that I did not perceive the least Circumstance of Fraud in the Conduct of this Affair while I was in Guilford” (32). Molyneux’s sworn autobiographical statement here adds to the truth value of St. Andre’s perspective while distinctly avoiding making a claim about the case itself. Readers do not have much data about Molyneux provided in the pamphlet. This would suggest interpreting him as a contingent other, but I suggest that we read him as a significant other. Indeed, without this sworn testimony, St. Andre’s autobiographical “I” would be an altogether different subject. St. Andre invites readers to cast judgements by including Molyneux’s testimony about St. Andre’s willingness to go along with a hoax; he must be in earnest pursuit of the truth of the matter since he has gone through the effort of including this testimony.

The autobiographical pact as it is written cannot accommodate the constructive dependency between these two subjects and the reader’s credibility process. Without Howard, St. Andre bears the full weight of medical knowledge in this case; indeed, it is because Howard contacts St. Andre that the latter gets involved in the first place. Without St. Andre, Howard would have no other professional witness to the Toft case. It is Howard and St. Andre together, along with other, less identifiable professional subjects (like the footnoted “Mr. Davenant”) who attest to the premise of the hoax. The “I” narrator of “A Short Delivery . . . ,” then, is at least bifurcated, albeit unevenly. In other words, the “I” narrator ought to be considered split into representing more than two subjects; however, the largest piece of this split would represent St. Andre. The essentiality of these subjects to the “I” constructed is thus undermined by suggesting

one could locate a single author. Thus, St. Andre's pamphlet illustrates two limits of the autobiographical pact: its inability to cope with older forms of life writing in which the author is not plainly stated, and its inability to cope with a collective "I."

While Molyneux's sworn statement appears in "I" narration, the sworn statements of John Howard, Mary Toft and Mary Costen (the mark of each is provided at the end of the same), and Elizabeth Helmes occur in the third person, evidently dictated and recorded by James Clifton and the mayor at the time. Again, these sworn statements add to the truth value of St. Andre's narrative, though Toft's will come out soon as a lie. This form of collaboration fortifies the "I" narration throughout St. Andre's narrative and the pamphlet at-large; the attributed voices add to the truth value of St. Andre's perspective. A well-trained western reader, both in the eighteenth century and now, can clearly see who is where and who helped take dictation. The pamphlet, particularly in the section of the testimonies of these others, presents the kind of human narrative collaboration we have been trained to read. Instead, the pamphlet frames these human collaborators as they might appear in a court of law at the time of the incident.

Manningham, Satire, and Mimicry

Sir Richard Manningham published his "An Exact Diary Of what was observ'd during a Close Attendance Upon Mary Toft, The pretended Rabbet-Breeder of *Godalming in Surrey*, From Monday Nov. 28, to Wednesday Dec. 7 following Together with An Account of her Confession of the Fraud" in 1726.⁹ The text is not formatted as what readers might expect a diary to be: there are no discreet entries as the entire tract is in one narrative. Unlike St. Andre, Manningham's diary does not couple with the letters of others; Manningham's text presents no overlap in "I" narration, no shifts between author/subject, like those I have discussed in St.

⁹ The Wellcome copy I use has, handwritten, "Published 12 Dec. 1726."

Andre's; however, Manningham does include a letter he writes to the "Honorable Mr. Molyneux," in which he writes of a "Discovery of a Fraud in the Affair in the Country," writing further that he believes that "our Endeavours fully to detect the Cheat may prove most effectual, and the unnatural Imposture may most clearly appear to the Publick," before concluding that limiting access to her would be useful and not achieved well in prison (28-30). Manningham, though detailing the invasive, physical observations he undertook as a medical practitioner, aligns himself more clearly with the law here. Manningham self-narrates as having known the entire time that Toft was a fraud.

Manningham, unlike St. Andre, was present for Toft's confessions and relates the process at the end of his diary:

On *Tuesday* the 6th, Sir *Thomas* threaten'd her severely, and began to appear the post properest Physician in her Case. . . . I urged her very much to confess the Truth; and told her, I believ'd her to be an Impostor. . . . I resolved to try a very painful Experiment upon her, and was accordingly prepared for that Purpose; whereas if she would ingeniously confess the whole Truth, I would speak to several of the Nobility in her Behalf. . . . I assured her also there was no Time for Delay; and if she would not confess, I should immediately proceed to the Operation. These Threats made great Impressions upon her. . . . *Mary Toft* owned that there was nothing in her Passage, when I examined her, only that time when I took the Piece of Bladder from her, which she had put into her Body, a little before I came to her, on *Monday* the 28th of *November*, 1726. . . . I had often told her, if I found twenty Rabbits at times in her Body, it would go for nothing with me; for I should never be convinced. . . . Dr. *Douglass* [sic] who was so kind as to write down her

Confession from her own Mouth, will I hope shortly oblige the World with it at large,
when she has discover'd the whole. (31-37)

This section of the diary is the closest representation of an actual dialogue engaged in with Toft, rather than with her vagina and its contents. Notably, the testimony occurs primarily in the first person, indicating Manningham's thoughts on the case rather than Toft's confession and positioning Manningham not as a legal medical witness but as one exempt under the party-witness rule. Manningham's testimony to what Toft said renders Manningham as a witness for the prosecution, rather than a legal medical witness or a defendant/plaintiff in his own right.

James Oldham writes that, despite the party-witness rule, "[e]yewitnesses to alleged crimes could testify. . . . So also could witnesses who overheard comments by the parties, or who observed their behavior. . . . The interested witness prohibition, however, precluded testimony from anyone with a pecuniary interest in the outcome of the litigation" (108). Thus, Manningham functions as both a legal medical witness, as he was, after all, a renowned surgeon, and he functions, too, as a lay witness to Toft's confession. St. Andre had to establish the value of his testimony by self-association with other medical practitioners; Manningham does so too but these associations are further spread out. Manningham associates himself with the valued lay witness and with other legal medical witnesses.

Manningham ends with what could be read as a legal oath: "Thus have I given a full and faithful Account of every material thing which occurred to me during my constant Attendance upon *Mary Toft* from *Monday*, the 28th of November, 1726, to December the 7th following, which I thought my self obliged to communicate to the World, as well for their Satisfaction, as the Justification of my own Conduct" (37-38). Both legal medical witnesses and lay witnesses providing exempt hearsay evidence would have sworn oaths. "Oath-taking establishes a

conventional truce in which further investigation is henceforward proscribed” (Herzfeld 318). Manningham’s oath, then, insists that his testimony is complete and no further investigation should be completed. James Douglas, who took Toft’s confessions, published his own account in which he challenged Manningham’s claims that he never believed Toft (Seligman 357). While picking apart the wealth of texts published regarding this matter in search for a *truth* would be futile, what we can know is that these authors establish the credibility of their testimonies by associating with other people and framing their testimonies as they would occur in court. These medical witnesses, then, borrow authority from the legal system in a case that made the medical profession “appear so ridiculous in the eyes of the general public” (Seligman 349).

One such manner of ridicule is through the publication of “Much ado about Nothing: or, the Rabbit-Woman’s Confession” (1727). This satire claims to publish Toft’s confession “in *puris naturalibus*, (i.e.) in her own Stile and Spelling” (9). Toft, who was illiterate, did not actually write this down just as she did not write out the confession(s) made to Douglas. The extremity of the spelling errors makes clear that this is the case. The postscript offers what could be compared to an aside to the reader:

Thof I be ripurzentid as an ignirunt littirat Wuman, as can nethur rite nor rede, yet I thank God I can do both; and thof mahaps I cant spel as well as som peple as set up for authurs, yet I can rite trooth, and plane *Inglish*, wich is mor nor ani of um all has dun. As for settin my Mark to a papur, it wos wen I wont well, and wos for goin the shortist wa to work: if tha had axt me to rite my name, I wood hav dun it; but tha onli bid me set my mark, as kunclooding I cood not rite my nam, but tha was mistakn. (Tuft 22-23)¹⁰

¹⁰ *Though I be represented as an ignorant illiterate Woman, as can neither write nor read, yet I thank God I can do both; and though mayhaps I can’t spell as well as some people as set up for authors, yet I can write truth, and plain English, which is more than any of them all has done. As*

What this section of satire demonstrates, and what occurs in a number of other satires, is that the maneuvers with which the medical practitioners constructed themselves as credible were interpreted differently by the public. Claiming to have written the tale in “plane *English*” points to the material descriptions and the verbose medical terminologies used to recount evidence. Interestingly, this satire condemns both those who believed Toft and those who did not, as it claims to convey more “truth” than “ani of um all has dun.” The popularity of this satire, other satires (including a print by William Hogarth and a prose work by Jonathan Swift), and of the medical tracts suggests a limit to expert credibility in the eighteenth century. Furthermore, “*Much Ado*” demonstrates a virtual (lay) witness. The virtual witness, in scientific matters, “[Deployed] the same linguistic resources [as actual experiment replication] in order to encourage the physical replication of experiments or to trigger in the reader’s mind a naturalistic image of the experimental scene” (Shapin and Schaffer 60). The satires replicated the authority experiment of the Toft case wherein nonexperts re-created the events of the experiment/case for the reader. They also allowed for lay witness participation that more closely matched with early eighteenth century courtroom dynamics—that is, before the role of expert medical witness was credible in its own right.

Satires poking fun at the credible yet wrong testimony of medical practitioners show readers, too, that the legal and medical contexts of expert testimony, specifically via the constraints these contexts demand, once limited the credibility of witnesses. Cody writes that “satirists asked, first, whether observers [of the hoax] could trust what they witnessed to begin with, and, second, whether *males* could be objectively observant, but personally disengaged,

for setting my Mark to a paper, it was when I wasn't well, and was forgoing the shortest way to work: if they had asked me to write my name, I would have done it; but they only bid me set my mark, as concluding I could not write my name, but they were mistaken.

when it came to the female reproductive body” (132-33). “Much Ado” clearly sides to the negative—that observers could *not* trust what they had seen, and that the practitioners (and their many opinions) could not be objectively observant or personally disengaged. This influences the autobiographical pact and troubles its application to future cases, even those after 1770. If the witness, the “I” narrator in the instances of these medical pamphlets, cannot be trusted to recount what they had seen, then it follows that eighteenth-century readers would be skeptical of whom they should attribute the tale to in the first place. Whom the *reader* observed to be the author/narrator/protagonist could be in doubt. Contemporary issues of “fact checking” and “alternative facts” support the exigency of this study and the re-placement of this reader skepticism when encountering narrative.

I close this chapter acknowledging that authority functioned much more on the consent of the public than it does now. In other words, the Toft case demonstrates how the lay witness was valued as much as the expert witness in the eighteenth century. Unfortunately, the historical record of the Toft case has been altered: “Within a generation . . . doctors and other commentators largely rewrote the history of the case, claiming that scientific, medical men had not been duped, but had instead triumphed over women’s deceptions and the gullibility of the common people” (Cody 121). What coupling the medical pamphlets and satires such as “Much Ado” does is work to replace the forever absent perspective of Toft herself. The satires provide an important counter to the historical record of the Toft case, wherein the doctors triumph, with one where science and medicine are much less certain.

CHAPTER THREE: HELP YOURSELF: COWS, WOMEN, AND REPRESENTING VICTORIAN MEDICAL SUBJECTS

Introduction

In the introduction to this dissertation, I state that the advent of women's and gender studies programs in the university contributed to a new wave of inclusion through posing challenges to the syllabus of "great" white men and encouraging attempts to recover and to (re)construct the lives and literatures of those erased. A crucial methodology as this work continues involves a skillset somewhat resembling forensics. Now that scholars appreciate fragments of lives as evidence, and, indeed, even as testimony, to lives erased, it makes sense that posthuman feminism and life writing studies meet at this juncture. Posthuman feminism can learn from life writing studies methodology of close reading that highlights the dependencies and the collaborations erased. Life writing studies can learn from posthuman feminism how to begin the labor of acknowledging the evidence and testimonies of nonhuman lives collected alongside the fragments of erased humans.

In the previous chapter, I focus primarily upon contingent others and significant others and their role in establishing a witness's credibility to acknowledge those erased via relationality in the narrative. This chapter invokes a third category Sidonie Smith and Julia Watson identify as key to relationality—the historical other. Smith and Watson write that historical others become "identifiable figures of a collective past. . . . In some autobiographies a narrator reads his or her 'I' as having engaged such figures as models or ideals" (*Reading Autobiography* 1st ed, 64). They theorize the historical other as one who develops into a "generic model of identity" through which a narrator constructs herself (64); the historical other is a common text between reader and author and establishes sameness and articulates difference. I engage the historical other as a

means of locating the *ideal* constructed by Victorian medical objectivity. My goal is to examine the formation of scientific ideals, and the pattern I identify is in part co-constructive. Unlike the Toft case, wherein the reader evaluated the text/author's credibility, late Victorian era medical literatures are tools for the reader's self-evaluation. It is the reader in this case who must perform credibility; however, the reader first needs help by way of tools to complete this performance. Such tools come from the credible, medicoscientific authority (i.e. the *objective* narrator) when considering at-home health and well-being. Victorian medical literatures are such tools for public citizens to establish themselves as a piece of the medicalized ideal, as I explain in this chapter.

Important to the study of western medicine, which I have and continue to understand as a subset of western science, is the near invisibility of women. Naomi Oreskes problematizes what she understands as a focus on the "ideal of objectivity," noting that "focusing on objectivity, feminists are in concert with commentators past and present, of both pro- and antiscience persuasions, who have characterized objectivity as the central ideal of the sciences" (89). Oreskes goes on to ask if objectivity is *the* central value of western science, answering that modeling oneself a *hero* is as much a value to western science as the performance of objectivity (89-90). Oreskes successfully troubles the focus on objectivity as a singular ideal. I add two further complexities: one, that nonhuman animals and material actants can and do function as heroes of western science, and two, that there is often substantial overlap between the ideal of objectivity and heroicism in western science and medicine. Take, for example, penicillin in the polio narrative (or syphilis narrative), tamoxifen in the breast cancer narrative, vaccines in the advancement of medicine narrative, and so on. These material actants are hailed as heroes, yet,

the others participating are erased. Moldy Mary¹¹ contributed to penicillin, tamoxifen was supposed to be a birth control pill, and vaccine development relied upon cows. Not only are these nonhuman animals and material actants examples of heroes, but they are examples of ideal objectivity. Furthermore, they are, too, potential retrieval sites for the erased others because these medical hero narratives represent collectives not individuals.

In this chapter, I follow the professionalizing of medical testimony into the nineteenth century and the parameters in which it was offered (i.e. the historical other as objective/ideal) because medicalized representations of milks in medicalized texts affect and reflect the lives of human women while limiting their capacity for response. While the human woman readers are collaborators, their lives are still erased in favor of scientific men constructing objectivity. By performing objectivity, and/or hailing one as a medicoscientific *hero*, practitioners and their readership ignored the many collaborators who made their *discovery* possible. Oreskes identifies the issue of women's scientific and medical invisibility as stemming from arguments that women "tend to do science in a less objective, i.e. less detached or more contextualized, manner," or that there is a "female style of doing science" (88-89). Oreskes focuses, of course, on the women exceptions—that is, the few women who were in public spaces doing science. However, in Victorian Britain, some privileged women had access to science and medicine at home via medical literatures. Such texts allowed invisible human *male* interference in centuries-old women's work and violated the boundary between public and private spaces.

¹¹Mary Hunt, aka "Moldy Mary," was the laboratory assistant in 1941 Peoria, IL who found the rotten melon that produced a strain of mold prolific enough to mass-produce penicillin.

Methodology

Victorian medical literatures brought scientific/medical authority into the private sphere. More explicitly than in the Toft case, Victorian science and medicine attempted to “push aside the church and religion as authority in knowledge” (Levine 4). Instead of appealing to a preexisting authority, as I illustrate medical professionals appealing and aligning with legal authorities in the Toft case, Victorian scientists and medical professionals maintained that they were authorities in their own right. They sought to split from the authorities upon which medicine had previously relied. I highlight this departure in this chapter because credibility, in the case of medical texts, relies upon the performance of objectivity by reader *and* author.

There are many connotations and sentiments signified by the word *objective*, particularly in the history of science and medicine. Objective can mean a goal, an unemotional opinion, reliability, procedure, just, and more (Daston and Galison 82). My use of the word signifies this collage of meanings, but most notably, the practice of self-erasure. Victorian scientists, like their long eighteenth-century counterparts, continued to purport that their narrative practices allowed materials studied to speak for themselves: “‘Let nature speak for itself’ became the watchword of a new brand of scientific objectivity that emerged in the latter half of the nineteenth century” (Daston and Galison 81). Thus, nineteenth century medical practitioners and scientists were self-interested in negating and erasing signs of human influence on their objects of study. To do so was heroic.

These allegedly *blank* results became idealistic insofar as they were reproducible no matter who did the experiment. My study in this chapter is less about arguing that objectivity is impossible, flawed, or a device of the patriarchy; rather, it is about recognizing the webs of nonhuman and human animals erased by such practices. Indeed, this is the time period of Francis

Galton's Anthropometric Laboratory. In 1884, at the International Health Exhibition in London, visitors could have their "physical and mental characteristics" measured in seventeen different ways, with copies sent home with the participant/specimen and copies kept by the organizers (Lundgren 453; Galton 205). Data generated by this exhibit would be comparable to the livestock and breeding shows instigated by the Crystal Palace Exhibition in 1851. Furthermore, such biometric data would serve as testimonies in ways somewhat comparable to the rabbit and human data gathered in the Toft case. The descriptions serve as allegedly blank—objective, that is—biographies in what is an imposed singular perspective. The participants, after all, cannot be tied back to the biometric data kept. That "blank" perspective was, and still is, very much white middle-class western male, yet this perspective is held to be the ideal perspective to convey objective, scientific, medical data. Objectivity, thus, is seen to transcend the complications of human sociocultural, economic, and gendered factors when it does not.

Objectivity is the pretense that an author can erase the imaginary boundary between the practitioner and his object of study. George Levine, in *Dying to Know: Scientific Epistemology and Narrative in Victorian England* (2002), writes that Victorian scientists grappled with self-erasure to establish objectivity (3). That is, these scientists knew that they were speaking for their objects of study yet did so anyway. Victorian scientists inherit this value from the long eighteenth century, as I discuss in the previous chapter. Concerned with their own personal investments, St. Andre and his cohort narrate Toft's body as a series of anatomical and character descriptions in order to mimic legal, credible testimony. In this chapter, I discuss how medical ideals of cleanliness and ideal substances are used as character evidence for/against human women. These ideals, when coupled with the Victorian self-help movement, hold material actants as ideal, and therefore objective, witnesses after whom human women ought to model

themselves. I find that, in the knowledge-making collaborations from which important medical contributions were made, the roles of women and cows are either minimized or demonized as a part of constructing this ideal witness. While objectivity erases both practitioner and object of study (human women, for example), the practitioner gleans professional benefits from the procedure whereas the object of study faces medicalized oppression. Practitioners become heroes. Participants become invisible.

Many studies of Victorian women as medical subjects speak to the development of human psychology as a field of study (see Kahane; Arieno; and Siegel). This focus on psychology has neglected the other sciences and medical fields developed in the Victorian era, and thus, has neglected the numerous forms of oppressing women and female bodies in the nineteenth century. While the relationship between hysteria, gender, and treatment is important, it is just as important to study the other effects of patriarchal medicine in the Victorian era. Important as it might be, the study of psychology does not contribute to my focus in this chapter.

Studying the historical other, or ideal, in the Victorian era provides cultural context to narrating credible testimony and how science and medicine further exercised self-referential constraints from the eighteenth century. The Victorian British value of self-help acts as an ideal form of personhood, and one through which everyone could improve their own, specifically material, condition (Altick 257). Application of this cultural value did not stop at the limits of encouraging the lower classes to seek self-reliance; S. S. Schweber, by noting how tightly coupled the scientific community was to other intellectual communities, identifies how self-help informed the pursuit of self-regulating machines (14). Self-help also informed the pursuit of medical advancements by providing people with access to scientific discoveries with which they could help themselves live in an ideal condition of human health; however, living this idealized

life meant self-erasure. The ideal Victorian is synonymous to the self-regulating machine in two ways: one, that the subject is falsely understood as objective/absent, and two, that humans participating in self-regulation could become close to this condition. To be an objective machine is to be a scientific hero.

I use milks as the specific example in this chapter because both human women and nonhuman animals, specifically cows, produce milk to feed people. Furthermore, food adulteration legislation in the Victorian era predicated the need for at-home scientific food evaluation. By food adulteration, I refer to human animals rendering edible material unclean via intentional additives. This correlates with the narration of an objective self in that to get either an ideal food or an ideal self, one must erase traces of humanity. Devoid of scientific motive, milk and the nonobjective are neither noxious nor innocuous. It is humans who read these meanings into these nonhuman subjects and categorize them as either good/bad, science/pseudoscience. Lise Wilkinson notes that human ideas about “putrefaction” were “ever perceived as detrimental to health,” and that, in addition to such notions, humans developed a “causal relationship of putrefaction to disease” in animals, nonhuman and human alike (131). Wilkinson states that human attempts to identify a particular “putrefying agent” via rational, scientific process began in 1808¹² (131). Alternately, Keir Waddington says that the “idea that unwholesome meat should be a public health concern emerged in Britain in the 1850s, when attention shifted from the question of ‘pure’ food free from adulteration to the problem of ‘clean’ food” (636). This shift in public concern parallels a shift in medicine: concerns turned from keeping the body “pure” from disease to keeping the body “clean.” Adulterants are, subsequently, evidence of human

¹² Of note is that, also in 1808, the U.S. ceased importation of new slaves and had to rely upon existing populations to supply new laborers.

interference that must be erased. Thus, public health interest offers the motive needed to transgress the sanctity of the public/private spheres.

Historical Context

I see this shift in ideals from keeping the human body “pure” from disease to “clean” as a gesture towards individualism informed by the budding monism philosophy. To keep pure is to inhibit any further interaction, whereas to keep clean is to remove interactants. Sublimation of the Christian religion exists, materially, here. A brief section of the *British Medical Journal*’s 1892 volume describes the low death rate in London as being due to “adopting ordinary sanitary precautions,” “vigorously enforcing the provisions of the Public Health Acts,” and “the fear of the Lord” (651). Even in this authoritative medical journal, authors make rhetorical moves to align themselves with religious authorities: this section also cites the Victorian mantra, “cleanliness is next to Godliness.” A powerful motivator to improve sanitary conditions across the country, this mantra also evidences the relationship between religion and science despite attempts to value science’s institutional authority apart from religion. For example, an 1894 article, “The Unity of Thought and Thing,” published in *The Monist*, declares that religion has “run its baneful course and [should be] superseded by reason” (208). The many scientific and philosophical challenges to Christianity are important because the *reason* behind one’s hygienic behavior shifts. While religious reason emphasizes cleanliness of behavior and thus of body, the newer ideological approaches emphasize hygiene (cleanliness of material). If, then, there is no separation of mind and body (Monism), spirit and flesh, then we find new implications for the old impulse to purify. Thus, the state of public health legislation and scientific/religious authority in the 1890s makes this timeframe of interest to my study of credibility, witnessing, and objectivity.

Coupled with this impulse to clean ingested materials is the expansion of reading material and literacy in the Victorian era. Jennifer Phegley maintains that the expansion of reading materials, some directed specifically to women readers, “empowered women to make their own decisions about what and how to read” (Phegley 2). As “protectors of morality,” middle-class women were also “protecting middle-class values and preserving the cultural health of the nation” (Phegley 5-7). The interaction between women readers and medical reference guides was mutually beneficial; medical reference guides became a means of protecting morality, the health of the nation, and the health of the household. Victorian print culture, specifically the proliferation of public health texts, sought to provide enough scientific information for people to rely on self-evaluation of foodstuffs rather than on government agencies to enforce marketplace compliance. Thus, scientific objectivity became an essential component of the self-help ideal, and consequently, an ideal mode of self-narration. Levine observes this phenomenon across novels and autobiographies of “great men” from the Victorian era; this chapter considers the lesser-studied texts of nonfiction pamphlets and medicalized genres as key to regulating Victorians in nonprofessional contexts.

An example of adhering to middle-class values resulting in protection of the nation would be Samuel Smiles’s *Self-Help* (1859). Smiles describes many “great” persons, mostly men, and how these individuals helped themselves, the nation, and humanity:

‘Heaven helps those who help themselves’ is a well-tried maxim, embodying in a small compass the results of vast human experience. The spirit of self-help is the root of all genuine growth in the individual; and, exhibited in the lives of many, it constitutes the true source of national vigour and strength. Help from without is often enfeebling in its effects, but help from within invariably invigorates . . .(1)

According to Smiles, the way in which the metaphorical health of the empire and the overall well-being of the empire can improve is for individuals of all classes to help themselves; rather than waiting for an act of government or a leader to come along and help members of the lower class (or, sometimes, middle class), all people can improve themselves (Smiles 4).

One such way for Victorian humans to improve themselves is to read, preferably nonfiction. Reading meant encountering the objective author¹³, which would provide an example of how to alter oneself to become objective. Smiles, both in his introduction and later by biographical vignette, provides appropriate reading material:

Biographies of great, but especially of good men, are nevertheless most instructive and useful, as helps, guides, and incentives to others. Some of the best are almost equivalent to gospels—teaching high living, high thinking, and energetic action for their own and the world’s good. The valuable examples which they furnish of the power of self-help, of patient purpose, resolute working, and steadfast integrity, issuing in the formation of truly noble and manly character, exhibit in language not to be misunderstood, what it is in the power of each to accomplish for himself. . .(7)

Notably, Smiles advocates that people model themselves after great men, which gestures to the same rational, scientific mores the medical men modeled themselves after in the Toft case. Doing so makes Smiles himself a model, an historical other, while also replicating hundreds of other historical others, all derivatives of the same objective, *cultureless* ideal.

Victorian readers would have understood Smiles’s human representation, strangely, as objective, whereas twenty-first century readers might be less inclined to do so. That said, when

¹³ While there are narrative theorists, including myself, who would argue that an author can never be objective, I mean here to indicate the intersection of this scientific ideal of objectivity and the direction of the lesson, which is author-to-reader in this instance.

Smiles defines how *he* intends the reader to make use of the text and of the concept of *self-help*, he directly interferes with the (pseudo)scientific descriptions of ideal Victorians, therefore contradicting reading his text as objective. This nuanced instance of human interference is not recognized as a negation of objectivity because of the nature of the text. The biographical vignettes provided function as snapshots or images. Daston and Galison indicate that images were examples of “machines taking over [representation]” in this time period (81). Thus, Victorian readers understood the text to take over the representation of these great men, rather than Smiles representing these men in the manner he wished them to be. It is the self-regulating, *objective* author that Victorians understood as representing these men. This paradox guides how I understand the oppression and erasure of nonhuman and human animals through scientific milk standardization—ideal milk at once represented this objectivity and represented a heroic subject. Clean milk could save the less fortunate, meaning human animals had evolved themselves via scientific means, and it is the objective, machine-like author who can get us there.

From the mindset that there is much to learn about improving oneself from reading about great men, these lessons transfer from public social behavior to private socialized behavior. The middle classes soon undertook to clean their own bodies, both externally and internally. A crucial tool for self-help in personal health was the proliferation of available medical literatures. Such texts enabled people to maintain their own wellness by receiving instruction from authorities/ great men. These texts also *accidentally* allowed women to participate in scientific experimentation and to witness the miracle of science, albeit in private. Importantly, women could not interact with formalized scientific knowledge-making¹⁴. Women’s at-home

¹⁴ While there are some exceptions to this rule, such as Elizabeth Blackwell, Florence Nightingale, and Marie Curie, these are not the obliterated participants I discuss here. These women had class advantages, among others, contributing to their exceptionalism.

experiments, tests, and procedures provided limited involvement in private medical knowledge-making as these took place in a domestic, private space rather than a public—albeit limited-access—forum. Indeed, science was often invoked as another form of reasoning, in addition to religious reasoning, for keeping women separate; however, Levine identifies an important qualifier to this overlap: “[I]f science can be invoked to keep women in their place, the silencing of preconceived notions remains a condition of adequate knowledge—and for finding a way for women to get out of that place” (Levine 7). Levine suggests that scientific objectivity provided an opportunity for women, when writing science, to escape their constraints. While Levine is correct here, the social standing and power a woman needed to do this should not be lost on us, nor should it be lost that freedom only came from using the languages of their oppressors. It means requiring the performance of a masculine ideal, which is in this case self-help. Marked as “at-home” scientists or “lady” scientists, these categories are at once more distinct yet further from the ideal. Marked language, after all, renders these human categories far more visible in a context that devalues human visibility. In other words, a *marker* of privilege is its invisibility, particularly through identity terms, which presumes the unmarked/unremarkable to be normal/standard (see Launius and Hassel). Marking scientists as “at-home” or “lady” transforms them into *abnormal* and *visible*, both of which are enemies of an objective stance.

To understand the effects of public medical texts published at the end of the nineteenth century, we must first consider food adulteration legislation since these laws offer context for such texts. This legislation informs the perceived need of the Victorians for personal texts that describe a scientific process whereby individuals can evaluate their foodstuffs at home. P.J. Atkins identifies the duration of England’s food control history (or at least attempts at control), which spans over 800 years, noting the economic benefits food adulteration provided

government and tradesmen (“Sophistication Detected” 319).¹⁵ The Adulteration of Food and Drink Act of 1860 made it a legal offense to “knowingly” sell foods that had been watered down or otherwise adulterated (Fallows 31). Ultimately rendered toothless by uncertainties surrounding who was responsible for enforcement, this 1860 Act was one of the first attempts at consumer protection (Fallows 31). Updated in 1872, the Act required counties and boroughs to appoint analysts despite continued disputes over what constituted an adulterant and what constituted an acceptable ingredient (Fallows 31). Finally, in 1875, “adulteration” was dropped from the title of the legislation, which changed the Act to the Sale of Food and Drugs Act of 1875 (Fallows 32).

This 1875 version of the law defined “food” as “every article used for food, drink, by man other than drugs or water” and introduced the provision, “No person shall sell to the prejudice of the purchaser anything which is not of the nature, substance or quality demanded by such purchaser” (Fallows 32). Subsequently, there was a new demand for definitions of “quality” foods and for these definitions to become widespread and their methods of evaluation standardized/made objective.

Victorian Medical Literatures

Read as a response to such legislation, then, authors of Victorian medical literatures did not shy away from including dozens of scientific standards, procedures, and definitions of foods and

¹⁵ Such benefits include:

1. Foodstuffs in short supply could be profitably ‘stretched.’ Where the food system was inefficiently organized or quite simply unable to keep up with demand, retail prices were often high per unit of sale and the rewards of adulteration therefore substantial.
2. Foodstuffs where demand could be encouraged: many foods were coloured or otherwise modified to make them look, smell or taste more attractive.
3. Perishable foods were treated in order to prolong their shelf life and deteriorated items were ‘recovered’.” (Atkins, “Sophistication Detected” 318)

drugs, in particular milks. Charles Morton Aikman's publication, "Milk: its nature and composition" (1899) starts by acknowledging the links between the popular foodstuffs, milk, and pandemics:

Increasing attention has been given, during the last few years, to the highly important question of milk as a source of tuberculosis. It would seem as if public attention were at last aroused to the grave dangers attending its use in the raw state. According to the findings of recent Royal Commissions on the subject of tuberculosis, there can be no doubt that the consumption [as in tuberculosis] is largely contracted through partaking of tuberculous milk. It is consequently to be hoped that the day is not far distant when only sterilised or pasteurised milk will be used—especially in the feeding of children. . . (vii).

Such rationales link legal, governing authority to medical authority. This rationale also emphasizes the responsibility of the consumer in keeping the country clean of tuberculosis; in other words, the individual reader is responsible for keeping the nation-body clean. Here, the reader participated in self-help—protect yourself from tuberculosis—and in national defense—protect the greater good.

Additionally, encountering texts like these meant the reader encountered nonhuman biographical vignettes, manufactured by objective authors, from which readers could learn objective science. F. W. Pavy covers Joule¹⁶, Mayer,¹⁷ Helmholtz (sic)¹⁸, and, indirectly, Fahrenheit in the introduction to his "A treatise on food and dietetics" (1874). Recounting the labor of these white, western men works in the beginning of his piece, Pavy draws upon the

¹⁶ A *Joule* is now a measurement of energy named after James Prescott Joule.

¹⁷ Julius von Mayer was a German physicist and physician held to be one of the founders of thermodynamics.

¹⁸ Hermann von Helmholtz is also a renowned physicist.

credibility of these men while also instantiating to the reader the sense of self-improvement via reading this text. Reading these biographical vignettes of great scientific men alongside their namesake contributions would mean a reader encounters knowledge via life writings. These are people to model our lives after, and there is the bonus of a medicoscientific lesson, too.

To return to milk, particularly that from cows, this substance very much needed regulation via a scientific process, which we know from the many laws passed legislating milk purity and from the realization that milk could transfer diseases. For example, the author of “Hygiene: a manual of personal and public health” writes that “[i]nasmuch as milk supplies all the food necessary for health and growth during the first year of life, we may expect it will afford us some guidance as to the necessary constituents of a diet for the adult, although, the conditions of life being altered in the latter, we can hardly expect the same proportions of the different materials to hold good” (Newsholme 12). Milk, then, is a model text for humans just as are the biographical vignettes in *Self-help* and in Pavy’s long, referential introduction to great men. While some adaptation may be necessary, the text/substance remains the best model. Milk’s position as an ideal holds water in the contexts of Christianity and of science: milk is part of the ideal land—*the land of milk and honey*. As scientific approaches emphasize that there is no separation of mind and body (Monism), spirit and flesh, then the use of a nonhuman as a model for human ideal would not seem as peculiar. We are what we eat. *Mens sana in corpore sano*.

The parallels between idealizing human men and nonhumans do not exist only in verbal prose—they do as well in numerical biometric data. Recall Galton’s Anthropometric Laboratory at the International Health Exhibition, wherein the goal was to “show the public the simplicity of the instruments and methods by which the chief physical characteristics of man may be measured and recorded” (Galton 205). While such firm biometric data was novel to the nineteenth century,

it was not the first era in which scientific men measured and characterized milk, other nonhuman actants, or nonhuman animals. Atkins acknowledges that English scientists conducted laboratory tests on fluids, specifically milk, throughout the eighteenth century and developed exacting devices for specific measurements: “By 1800 there were lactometers for milk, saccharometers for sugar in the brewing process, acidimeters for laboratory reagents, salinometers for measuring salt in solution, and so on” (*Liquid Materialities* 1491). The devices of these early experiments became essential weapons with which the Victorians fought attempts to adulterate food supplies. Scientific validity of these devices and methods depended upon an author’s ability to align himself with other scientific and legislative authorities. These “temporary alliances” (*Liquid Materialities* 1496) between human and material were contingent throughout the nineteenth century. That is, because this science was new, and milk varies across species and varies in material composition, scientists faced difficulty in narrowing down what constituted an ideal composition. The changes in legislative acts reflect this difficulty, but more importantly, what would emerge as an ideal composition depended upon an author’s self-construction as scientific hero. Thus, narrative is as much an ideal scientific tool as a lactometer. Ideal characteristics could be evaluated using biographical vignettes *and* biometric data.

The male scientists authoring the ideal human were not totally oblivious and likely viewed objectivity more as a mode one adapted for scientific writing rather than a pure and incorruptible perspective. Atkins rightly asserts that Victorian scientists did not deny the “objective reality” of material actants and understood issues of personification and social influences when describing these materials. These Victorian scientists understood that they were characterizing certain materials as good and others as bad based on their new science; however, as Atkins acknowledges, Victorian scientists did not view this issue as interfering with their

“right” to examine and to study these materials (*Liquid Materialities* 1513). Nor, I add, did these Victorian scientists view publishing their work publicly as an attempt to control the substance in question. What Victorian medical literatures demonstrate is the attempt to standardize human behavior, particularly human women and cows, via the medicoscientific literatures I have referenced in this chapter. The heroic narratives inside these texts imply that a reader could, if properly motivated, improve one’s own nutrition via scientific examination of their foods. If that food is human breast milk, the implications of these attempts to control human behavior entangle nonhuman animals and material actants in constructions of heroes.

Part of the rationale for this nuanced erasure is that milk had to travel a great distance between cow and human consumer, providing a challenge for the nineteenth century market. Indeed, to guarantee the purity of one’s milk, consumers preferred to have the cow brought to the doorstep, to buy from suburban cowkeepers, or to hire their own milkmaids (Atkins, “Sophistication Detected” 320). Still, milk retailers were known to add water to their product and to hide the “thin or bluish” appearance of altered products; these retailers would then add flours, starches, boiled carrot juice, vegetable dyes, chalk, or even brains in an attempt to bring the adulterated milk back to the same or similar consistency, smell, texture, and taste as its unadulterated version (Atkins, “Sophistication Detected” 321). Thus, Victorian medical literature provides a tool with which people could maintain their own, and therefore the nation’s, wellness. Healthy people meant a healthy nation. More so, these texts also developed a nonhuman historical other/ideal. By listing what milk *should* contain, these scientific tables mimic the biographical vignettes in *Self-Help*; a reader can make quick reference to how milk ought to be in the same manner that Smiles’s text permitted the quick reference to how they ought to be. In

other words, Victorian medical literature and Smiles's allowed a reader quick reference to an ideal: Smiles to a human (man), Pearmain and Moor to substances/material actants.

The texts I have referenced in this chapter, including *Aids* (1895; 1899) and *Analysis* (1897), are responses to the content of food adulteration Acts, to the method of these Acts, and the actions of milk retailers: that it is human action that causes outbreaks of deadly disease. Human actants (mis)place substances into milks for nefarious, capitalistic purposes. Milk retailers were known to add materials to their milk products, not to attempt preservation but to attempt to stretch the product cheaply. Soured milks could be made to appear fresh and short supplies could be volumized at low cost. Traces of human interference like the presence of adulterants in the food supply then came to signify the same unideal as nonscientific readers—incredible. Foods altered outside the cloak of objectivity meant that human interference could be seen, and thus these foods could not be trusted. These nonhuman substances could not be trusted to nurture. Altering foods in the name of medicine and science meant that the human aspect disappeared (allegedly). As much as *Aids* and *Analysis* are responses to this new legislative agenda, then, these texts are responses to the intensified moralization of objectivity throughout the Victorian era because they violate the boundary between public and private spaces.

It no longer was enough to be seen to be moral, objective, and ideal in public. There is now a script by which one must be moral, objective, and ideal in private. If there is no separation between mind and brain, spirit and body, then the pretense to keep the public and the private discrete collapses. Although Victorian scientists and medical practitioners knew that they were imposing human culture onto nonhuman materials and animals, they did so anyway because of what they determined to benefit the greater good. J. Alfred Wanklyn, for example, defends his

motives for publication, and, indeed, his credibility, by recounting his history of working on various government bodies:

During the year 1871 I devoted much attention to the subject of milk-analysis, and besides making many hundreds of analyses of milk purchased in different parts of London for the *Milk Journal*, was employed by Government in an investigation into the milk supplied to the Metropolitan Workhouses. I have likewise examined the milk supplied to the Hospitals in London.

This author's credibility cannot, thus, be untied from his work ensuring pure milk to the most unclean of the population. He is, in Victorian standards and measurements, an ideal man, because he uses his life to cleanse the lives of others. He cleans those in hospitals, workhouses, and prisons by ensuring they ingest clean milk, and he cleans his readership by offering an exemplary autobiographical vignette with which the reader may self-measure. The greater good, of course, would have connotated exclusively human animals, and predominately white upper-middle class men.

Interestingly, human women are not the ideal foodstuff producers. The authors of *Aids* and *Analysis*, and of *Milk-Analysis* offer tables delineating the scientific standards which specify what their reader might consider an ideal food provided by a seller. This table thus troubles reading human women as a different category than cows; both are milk-producing subjects catalogued in the table. Pearmain and Moor explain, using cow's milk as a standard/ideal, which animal milks are comparable to human milk and, when consumers desire to increase intake of certain milk features, i.e. specific gravity, which might be effective substitutes to replenish specific nutrients (24). In their explorations of animal milks, Pearmain and Moor clearly sought to locate a superior replacement for human milk, writing after a conversation between

themselves about milk dilution and condensed milks: “This led us to wonder whether it was possible to prepare a condensed milk, at a price not exceeding that of the best brands of condensed milk, which should, on dilution, yield a liquid closely approximating to the composition of human milk. An account of this preparation will be found at p. 83” (*Analysis* 1897, 74). Notably, formula had already been introduced in 1867. That introduction of formula, though, suggests the transfer of ideal nurturer from human to nonhuman and foreshadows the onset of vitamin science in the early 20th century.

At the end of the nineteenth century, Victorian manufacturers bypass human milk in favor of a more controlled substance and a more controllable subject—first as cow’s milk, because of the religious belief that humans are superior to animals, and then as tinned/ canned milk, because the material content of milk, a vital life source, can be controlled down to the smallest material in the canning and manufacturing process. Ironically, vitamin science in the early to mid-twentieth century would reveal that such industrialized food eliminates key components of human nutrition; consequently, newly-professionalized nutritionists and physicians proposed that western populations were “starved for vitamins,” in part due to the modern processing of the most widely-available foods (Apple 6).

Importantly, the human is not the standard across the discussion of milks in the Victorian medical literatures I have cited throughout this chapter, yet it would be a mistake to consider milk a nonideal food at this moment in the Victorian era. Pearmain and Moor write that milk is “the only article occurring in Nature which combines in the right proportions all the necessary elements requisite to secure the proper nutrition. For children it is rightly considered the ideal food; but it is too voluminous to serve for the sole diet of adults” (*Analysis* 1st ed. 1-2). Thus, concurrent with the scientific data Pearmain and Moor provide on what unadulterated milk

should be, *Analysis* and *Aids* effectually set measurements for this milk composition and for the ideal diet. Wanklyn, too, offers a table with numerical data used to characterize the ideal milk composition (1). Because of the advice given in works such as these, human mothers come to be thought of as unable to provide necessary nutrition for children. Instead of ensuring the health of human women, thereby taking care of mother and child, these authors suggest the way around the issue is to supplement with another animal's milk. Ignored are the intersecting issues of nutrient-deficient industrialized foods and feeding poor people. Also ignored are the nonhuman animals making this kind of ideal human nutrition possible.

Both women and cows are scientifically subjugated, or, in other words, women and cows are objects erased. Indeed, just as many doctors and scholars involved in the Toft case (and those studying it since) have attributed the *cause* of Toft's monstrous births to maternal impression¹⁹, the same ideas appear in how medicoscientific practitioners understood and explained milk adulteration. Wanklyn writes that "[i]t is known that violent mental emotion exercises an unfavorable influence on the secretion of the mammary gland; and a fit of anger has rendered the milk of the human mother poisonous to the child. No doubt the milk of the cow is more or less liable to similar influences; and cows which are giving milk should not be driven or harassed in any way" (65). Wanklyn's application of maternal impression here to nonhuman animals (cows) and material actants (milks) further solidifies the relationship between these not-human men. The erasure of women and cows, and the justification of their scientific subjugation, is justified because these animals cannot control their emotions properly. It is up to rational, scientific men to help them, and thus, to help humankind, by developing a process to protect milk. Such

¹⁹ *Maternal Impression* is the notion that birth defects and abnormalities stem from emotional distresses caused to a pregnant woman.

external intervention thus protects the food supply by subverting dependencies upon the female gender, no matter the species.

Furthermore, the implications this science had for Victorian mothers echoes what Margaret Homans identifies as a key aspect of ideal Victorian womanhood. Homans writes that “Victorian women knew simultaneously that, like Mary’s motherhood [mother of Jesus], their own was exalted as a vocation for women and denigrated relative to men’s activities” (157). The replacement of the mother’s material contact with her child by means of either formula or allegedly-superior cow’s milk is, in a way, men’s activities replacing a women’s vocation because men were involved in the science and industry that produced these alternatives. Using science to demote (human) mother’s milk is a two-folded oppressive action. First, human women are replaced by human men as suppliers of milk; and second, human women are replaced as knowledge-holders of childrearing. This context faults conclusions of Victorian motherhood as a denigrated vocation; if this vocation is so unimportant, why trouble ourselves to replace these women with professionalized men? Instead, the Victorian era saw the male colonization of motherhood using science and medicine. Medical and scientific authorities, usually men, became more credible experts on motherhood and childrearing than women.

Women, Medical Professionals, and the Ideal Reader

Claire Furlong indicates that Victorian magazines, by providing a public venue in which readers could be advised whether to make their own decisions about their health or to rely on medical professionals, politically maneuvered and commented on the “value” of the newly available and newly widespread medical information (Furlong 33). That is, by encouraging readers to pursue their own research and/or trust their intuition, as opposed to seeking advice from someone formally-trained (or considering which medical matters were severe enough to

necessitate seeking out costly specialist advice), these publications offered an opinion on the value of formalized medicine in the Victorian era. Medical literatures from this time period accomplish nearly the same thing. By providing methods by which readers can evaluate foods, as well as “updated” standards, the authors were encouraging their readers to pursue their own scientific analysis of foods and drugs; however, these readers could not be women. While women were not explicitly excluded from Victorian self-help ideals, their responsibility was to “bear or literalize” the words of men, making women always represented but never representing (Homans 161). There is also the issue of some texts being addressed specifically to students, and women were unlikely to be medical students at this point in western history.

While there are a number of women writers and women scientists in the Victorian era, such as George Eliot, Ada Lovelace, Elizabeth Garrett Anderson, and others, they are the exception, not the rule. Oftentimes their representations of women still reflect science’s androcentrism or these women remained outside scientific and medical communities altogether. The difference here is not that these women participated in objective science/medicine whereas others did not (Oreskes 90). Rather, medical narrative practices erase the group effort, the collaborative work, that goes behind even the most entangled scientific ideals. It is in these groups that we find delicate webs of human/nonhuman collaboration. Scientific heroism erased women and nonhuman efforts by obscuring these collaborations *and* by constraining the category of *work*. What *work* meant and means still to science erases and devalues important contributions made by women and nonhuman animals.

The 1858 Medical Act would eventually seek to restrict and to regulate who counts as a medical professional, which runs counterintuitive to self-help ideals (Furlong 34). But what Furlong identifies as an “interactive” opportunity between the reader and the magazine editors

shifts towards the end of the nineteenth century. Firstly, the act of seeking out medical advice and knowledge from a practitioner becomes an act of self-help, and secondly, the need for a magazine to behave as a proxy or a motivator for this action would collapse—though, admittedly, it does not disappear. It was, as Hughes and Lund write, “the perseverance and delay of gratification necessary for middle-class economic success” that echoed in serialization (4). This kind of delay, idealized in the histories of the great scientists referenced and of those characterized in *Self-help*, reflects authorial control. The authors force their reader(s) to practice self-control, training them how to use the text while reinforcing the expert’s purview by recommending and controlling the reader’s behavior. Just as Smiles’s exemplary humans indicate to readers how they ought to use the biographical vignettes to self-measure, the characterizations of humans and material actants throughout various Victorian medical literatures indicate how readers ought to use food and science to improve themselves further. Such impositions are not understood as a violation of objectivity because it appears to address how the reader might self-regulate. Again, rather than characterizing the reader’s self-construction as an aspect of the private space, and therefore the reader’s intimate knowledge, these medicalized texts illustrate a turn away from the firm private/public Victorian spheres.

The publisher of Pearmain and Moor’s texts, Baillière, Tindall and Cox, suggests that the works at-hand, while likely written for early students of medicine, were also intended for “advanced” middle-class Victorians who read medical texts at their leisure. These readers could be women. Sarah Bull, in her article “Managing the ‘Obscene M.D.’,” examines the relationship between the censorship of “obscene” medical texts, ideal male readership, and the formation of a medical authority. She writes that censorship laws in the mid-Victorian era “hinged on the notion that male professionals were a special class of reader,” and that “‘regular’ medical authors

corrupted vulnerable readers,” particularly in cases where the content referred to sexual health, women’s health, or drugs for sexual ailments (725). Texts like those I read in this chapter could be dangerous, if read recreationally, in presenting sexual innuendo to the vulnerable at-home women scientists. Food substances, like milk, characterized in public medical texts might appear to a contemporary audience to be wholesome, but consider where we find milk and the types of milk from various animals specified in these texts. Ideal milk has come to mean either cow milk or human breast milk. Women readers, thus, had to perform another layer of masculinized detachment, despite their own bodies being part of the content because of the risk of emotional outbursts affecting milk production inside or outside the body.

Ideal human nutrition requires nonhuman animal input; however, it is the material actant which is given primacy over the living entity in this case. These material actants represent ideal objectivity as they have come to represent complete absence of human/animal interference. Tendencies to elevate material actants in this manner are not only inaccurate but reflect the practice of erasing the infinite numbers of others whose lives contribute to this collaborative life narrative—men included. Such erasure limits a reader’s ability to conceptualize a (human) self beyond human interest since readers are not in the practice of establishing the in/visible, or un/marked, entities collaborating in narrative characterizations.

Revising this oppressive practice begins with recognizing how the ideal of objectivity and medical heroism exclude others and with acknowledging that medicine needs both nonhuman and human animals. A contemporary example is the struggle for authority in patient/practitioner interactions. Who better understands what sickness is? As the academic field of narrative medicine continues to question how practitioners might better understand patients (Charon 7), it

is imperative to highlight discussions of how the ideal of objectivity and medical heroism interfere with patient/practitioner communication.

CHAPTER FOUR: THE WOMEN'S HEALTH MOVEMENT, CONTRACEPTIVE PILLS,
AND KNOWLEDGE: TESTIMONIAL AGENCY IN LATE TWENTIETH-CENTURY
WESTERN MEDICINE

Representation of the world, like the world itself, is the work of men; they describe it from their own point of view, which they confuse with absolute truth.

Simone de Beauvoir, *The Second Sex*

Introduction

A practitioner wielding health knowledge over a patient presents an inescapable power dynamic. For example, a human woman experiencing what she identifies as side effects of a medication can be overruled by a practitioner; such instances occur regularly and are well-documented²⁰. Sincere attempts to respect patient wishes regarding a right to know/not to know in the context of biometric data are quite clear in the case of genomic sequencing. Indeed, western medical practitioners have identified a patient-driven negotiation of presenting genetic disease risk and test results, presenting at least one context in which “physician as gatekeeper” is replaced with “patient as gatekeeper”: “[Physician as gatekeeper models] are inconsistent with the European Convention on Human Rights and Biomedicine which states, ‘Everyone is entitled to know any information collected about his or her health. However, the wishes of individuals

²⁰ See: Abbasi, Jennifer. “Can Acupuncture Keep Women on Their Breast Cancer Drugs?” *JAMA* vol. 320, no. 8, pp. 744-46. doi:10.1001/jama.2018.11068; Ortiz Healy, Vikki. “We Want to Make Our Voices Heard: Women Battle FDA over Contraceptive Device, Saying It Causes Painful Side Effects.” *Chicago Tribune*. 8 May 2018, <https://www.chicagotribune.com/lifestyles/health/ct-life-essure-problems-20180503-story.html>; Charlotte Wessel Skovlun, Lina Steinrun Mørch, Lars Vedel Kessing, et al. “Association of Hormonal Contraception with Depression,” *JAMA Psychiatry*, vol. 73, no. 11, November 2016, pp. 1154-62. doi:10.1001/jamapsychiatry.2016.2387

not to be so informed shall be observed.’ Honoring a patient’s choice ‘not to know’ respects an individual’s autonomy” (Townsend et al 6).

What I discuss in this chapter predates this sentiment and presents an additional context: the contraceptive pill. For reasons owing to narrative credibility and legal accountability, as I will show, medical practitioners misuse the right not to know. Patient package inserts, which could have been a key piece of communication between patient and practitioner, best clarify how practitioners and pharmaceutical companies continue to control medical knowledge. One such example comes from the American Medical Association, which, in a collective letter to the Federal Drug Administration in March 1975, argued against patient package inserts because “[t]he physician is the one who is able to ascertain the patient’s physical and emotional characteristics and whether a particular patient has need of such information” (qtd. Watkins, “Deciphering the Prescription,” 97). The rationale for paternalistic control over medical information, which importantly includes plainly-stated medication dangers, is that were patients to be told they would have a particular side effect, they would experience that side effect. Here I am speaking of confirmation bias and of the placebo effect, and how many western medical practitioners believe that simply mentioning a side effect or a disease will cause a patient to think wrongly that they have such a side effect or a disease. Regardless, physicians and drug manufacturers have and continue to exercise the position that a practitioner must control the medical knowledge provided to a patient. Often, medical knowledge that makes it to a patient includes mild risks (i.e. headaches and blurred vision) alongside morbid risks (i.e. cancer and blood clots/stroke/heart attack), but practitioners offer little to no explanatory precedent or public education connecting these risks to a patient’s own circumstances. Withholding such knowledge,

and decontextualizing such knowledge when offered, keeps the decision with the practitioner, not the patient, and presents a misapplication of a patient's right not to know.

To illustrate the co-constructive categories of those who know and those who do not know, I use Lorraine Code's *What Can She Know? Feminist Theory and the Construction of Knowledge* (1991). Code's description of a Knowledge Transaction and this transaction's relationship to gender allow me to engage in a rich conversation about where human woman and nonhuman animals participate in western medicine. Regarding patient package inserts, this is exceptionally important. While not the first medication requiring a specific, patient-directed insert, oral contraceptives have been the most widely debated and discussed medication necessitating such literature. Women would be the primary readership of this literature. Thus, using Code's work affords me the opportunity to question how patient package inserts are, or are not, a response to a patient's right to know a medication's side effects.

In earlier chapters of this project, I analyze descriptions of nonhuman animals and material actants used as credible models of the human body, particularly the human woman body, in order to decenter human knowledge in a western medical context; in proving how medical knowledge derives from nonhuman animals, material actants, and incredible human animals, I seek to challenge human primacy. Proxy testimonies, which are the *data* gathered from the incredible participants I just listed that are then spoken for by western medical practitioners, continue to work as scientific models throughout the twentieth and into the twenty-first century. Like these proxy testimonies, medicalized data regarding risk has, once federally mandated to be published, been obfuscated through the use of technical jargon and material actant data; the relationships between a patient and her risk, once broken into chemical reactions, work to maintain knowledge control and to depersonalize medication risk. Analyzing both

patient package inserts and the collectively authored feminist *Our Bodies, Ourselves*, I find that information on contraceptive pill risk continues to be depersonalized.

That said, whereas Victorian-era practitioners and their readership performed objectivity credibility by self-erasure, twentieth-century activist witnessing sought to redress these modes; however, I argue that such attempts have failed. Just as in the Mary Toft case and in nineteenth-century medical literatures, wherein the author's credibility depends upon a reader's acceptance and a complimentary performance, patient-directed literature in the late twentieth century values nonhuman actants as more credible witnesses to human woman health than the human herself. As I will show, examining patient package inserts (PPIs) and the 1973, 1984, and 2011 editions of *Our Bodies, Ourselves* illuminates how the (re)entrance of western women's testimony into western medicine throughout the twentieth century does very little to restore patient agency.

Knowledge Transactions and Gender

Code writes “an imagery of knowledge acquired for purposes of manipulating, predicting and controlling nature and human nature, animated by representations of knowledge as a prized commodity which is capable of legitimating its possessors' authoritative occupancy (and sometimes abuse) of positions of power, as they recast the natural world as a resource for human gratification” is central to post-industrial era rhetoric (Code 150). To restate, Code claims here that western thought indoctrinators understand knowledge as acquirable and manipulatable; once acquired and manipulated, western thinkers understand knowledge as a capacity tool with which to predict and to control natures human and nonhuman. Knowledge in this sense is of value to western thinkers because it reinforces their position as superior and knowing, which, through circular reasoning, also enhances the credibility of the person(s) wielding it.

When this kind of *knowledge* is derived from nonhumans, it is the task of human medical practitioners to translate nonhuman knowledge for the good of *mankind*. There are at least three categories in these knowledge transactions: western thinker (medical practitioner and/or researcher), lay person (patient), and object of study (nonhuman animals, patients, and/or research subjects). In Code's model of western patriarchal hegemony, western thinkers receive knowledge from the object of study and interpret this knowledge for the lay person or other western thinkers. As this model applies specifically to western women, the many nonhuman research subjects, livestock fed diethylstilbestrol (DES), and nonhuman animal research subjects, then, it is the medical practitioner who receives knowledge from the object of study. The medical practitioner then reinterprets what material actants "know" of animal bodies. Incomplete in this cycle is the linkage between woman and her hormones; indeed, for western thought to maintain control over nonhuman actants and women, the relationship between nonhuman actant and woman must be denied. In other words, by unrecognized the knowledge transaction between nonhuman actant (hormone) and woman, medical practitioners oppress people by denying testimonial agency and experiential-based epistemologies. Women don't know, and can't know, how hormones affect their bodies.

Such transactions are gendered, and it is the same transaction Code identifies between western medicine and those categorized as *woman*. The oppressive structure transcends the bodies themselves and localizes its oppressions upon one's role in the system. From the first efforts in Early Modern Europe to exclude women from healing professions, men became, through extensive legislative efforts and required institutional certifications, the only credible medical authorities (see Leigh Whaley's *Women and the Practice of Medical Care in Early Modern Europe, 1400-1800* [2011]). This is not to say that women did not practice medicine,

professionally or domestically. It does mean that the “male” gender was, through intentionally exclusive measures, the only credible medical authority. The “female” gender participated largely as patient, though sometimes she could be a philanthropic nurse or benevolent wife, if her class standing permitted. Thus, it was only male practitioners who encountered credible knowledge, and these male practitioners interpreted the knowledge for the patient. While women make up about a third of full-time physicians and surgeons in the U.S. (Cheeseman Day and Christnacht), the role of western medical practitioner is itself gendered male because of the profession’s sociocultural norms. Of those norms, I focus specifically upon objectivity, which, as I describe in the third chapter, has become a way in which any gender may perform masculine credibility.

History is fraught with examples of deviations and challenges to women’s relative exclusion/inclusion to western science and medicine, one of which I take up in the second chapter by focusing on the Mary Toft case; however, by and large, male practitioners were the norm in Europe and in North America. As I quoted previously, western thinkers have “found women inferior in countless ways,” resolving to interpret and to explain women’s experiences back to women and to a broader public (Code, *What Can She Know?* x). That is, women, who were the medical professionals before such exclusionary laws existed, and who were and still are the research subjects and patients, held dual roles in a western knowledge transaction. She is the body of knowledge and the patient, but the western thinker/male practitioner is needed to lift the data from her body and then again to interpret that data for her. This is knowledge theft because the explanations are wrongly attributed to the practitioner rather than the body of knowledge/researched subject. At the endpoint of these acts of knowledge theft, western male

thinkers can use their freshly occupied authority to restate the fruits of their labor to women but not to nonhuman actants.

Such knowledge transactions complicate feminist medical ethics further, as this framework routinely provides fresh means of discrediting what women, trans* and cis*, have to say about their bodies. Divorcing women from their bodies pretends that a greater knowledge gap between lay person and object of study occurs than what may actually exist. Without the pretense that we need a doctor to tell us what is wrong, western medical practitioners' dominance over knowledge, and their position as more credible than the object of study/patient, would collapse. Such collapse is my goal. Stephen Abblitt describes the human subject as "lack[ing] the solid, hard-drawn psychic and corporeal boundaries we imagine separate us from nonhuman species, nonanimal living matter, and our external environment—as compostists, we are porous, permeable, leaky and leaking" (510). In keeping with the trouble occasioned by posthuman feminist life writing, my goal in this chapter is to compost²¹ the categories of Code's knowledge transaction as they relate to oral contraception. Reading the boundaries between medical authority, object of study, patient, feminist health activist, and others all as leaky and leaking redistributes western medicine's explanatory power because *anything* across any category may testify to health and wellbeing.

I use this chapter to analyze available literature, most patient-directed, from the mid- to late-twentieth century for how nonhuman actants became more knowledgeable about the human woman body than the human woman herself. The exclusion of trans* women in these contexts, or more accurately their erasure, disallows serious conversations on the personal safety of all

²¹ As I define in the Introduction to this dissertation, *compost* is a term Donna Haraway uses to describe collaborations between nonhuman and human subjects, alive and dead subjects.

women and the deadly nature of medicine’s hormonal experimentation. While I do not distinguish between trans* and cis* women in this chapter, I do note trans* women’s ethynyl estridol usage as a transition aid. Hormone Replacement Therapy (HRT) uses the same synthetic estrogens common in contraceptive pills and devices²². This synthetic estrogen is the same nonhuman actant I discuss throughout this chapter; my focus on twentieth-century Patient Package Inserts (PPIs) and other manufacturer literature limits my discussion as these literatures make no mention of this usage. Also, because my focus in this chapter is on the contraceptive pill and livestock, thus reproduction, I mostly refer to cisgendered women. There is still much to discuss regarding HRT and transgender women, not in the least how western medicine has offered an already disadvantaged population the choice between medical risk and gender risk—transitioning via a known poison should not be the singular, potentially harmful, choice it currently is.

This false decision is, thus, emblematic of the very configurations posthuman feminism seeks to trouble. Human animals and nonhuman animals taking/fed synthetic hormones are a posthuman assemblage, albeit one in which the decision rests not with the entity consuming the synthetic hormone but with the medical authority. Tully Barnett writes that “[I]f narratives about disease both complicate understandings of a ‘whole’ and ‘healthy’ human organism and threaten to reinforce it as the norm” (45). Thus, human animals and nonhuman animals *on* synthetic hormones become the *norm* as these forced assemblages become examples of whole and healthy beings. The disease in this instance is unregulated female bodies. The troubles I present to such assemblages are, as I’ve stated previously, issues of consent. Nonhuman animals

²² Angeliq, Climara Pro, Combipatch, Femhrt, Estraderm, and many other FDA-approved HRT medications contain estradiol. See FDA, “Menopause: Medicines to Help You,” <https://www.fda.gov/consumers/free-publications-women/menopause-medicines-help-you>

have no say in what constitutes their own health conditions. Human animals, the women on synthetic hormones particularly, are engaged in a false sort of informed consent. The patient package inserts I study, which should be directed towards a patient and should help them to decide to take the drug, work instead to remove a manufacturer's legal liability.

Margaret Sanger and The Let-Down

Before I return to my focus upon objectivity and credibility in PPIs and *Our Bodies, Ourselves*, I am first going to discuss Margaret Sanger. Anyone even the slightest bit informed about the history of contraception in the U.S. is at least passingly familiar with the name Margaret Sanger. There is much existing scholarship existing singing her praises and her work done to ensure contraceptives (medicines and devices) could reach the public. Sanger faced the U.S. Court of Appeals for the Second Circuit in New York City, New York, after she was caught importing a package of contraceptives from Japan through Hannah Stone (Katzive 127). The outcome of this case, and other legal battles, were fought by Sanger and her allies; without these legal battles, the restrictions upon "obscene material" via the Comstock Act of 1938 would not have been revoked, and contraceptives as we know them now in 2021 would not be accessible. Ester Katz declares that Sanger "not only led the American movement [for birth control] but also sought to globalize birth control by organizing international conferences and cultivating contacts among scientists, economists, social reformers, and population control leaders around the world" (xxv).

Many of the pleas found in Sanger's letters and pamphlets emphasize the plight of the working woman:

It is the big battalions of unwanted babies that make life so hard for the working woman and keep her in poverty and stress from generation to generation. Every mother feels the wrong that the State imposes upon her when it deprives her of information to prevent the

bringing into the world of children she cannot feed or clothe or care for. She resents this with all the bitterness of her strength and will rejoice to find some information contained herein, to help the mothers free themselves from the burden of too frequent pregnancies.

(Family Limitation 3)

An intersectional analysis of Sanger's reasons here makes clear that working class women need to be saved from their own fecundity, and this saving ought to come from the middle and upper classes; Sanger is not discussing the burden unwanted pregnancies have upon all women, she focuses specifically upon the burden additional poor people make for poor people. Rather than addressing the systems of socioeconomic privilege that make it impossible to raise many children or addressing the patriarchal norms of a man's conjugal "rights" to a woman's body, Sanger elects instead to place the labor of population control upon the working class. If Sanger had her way, *I would not be here*. My maternal grandmother is the eldest of many; she dropped out of school at the age of twelve to help take care of the house and children. If my great-grandfather received a living wage, would he have pressured my great-grandmother to keep having children and thus stay on government support? And, if my great-grandmother had access to contraceptives, how would that have paid the working class what they're worth?

Contraceptive access is too often held as the cure-all to class oppression when it is simply yet another means by which people seek to control women's bodies.

Sanger's notions of enabling others to help themselves is not a fresh sentiment nor is it exclusive. In the previous chapter, I discuss Samuel Smiles's *Self-help* and the proliferation of Victorian medical literatures written for those at home to take their own steps to protect the greater good. Indeed, there are still more parallels considering Sanger's emphasis on personal cleanliness and hygiene: "If a woman is too indolent to wash and cleanse herself, and the man

too selfish to consider the consequences of the act, then it will be difficult to find a preventative to keep the woman from becoming pregnant” (*Family Limitation 3*). Despite being many years apart, despite being across the ocean, despite this being a woman nurse, this sentiment still holds. Sanger’s reputation comes from her *empowering* others to help themselves, yet she is still the translator of medical knowledge in this transaction. The western medical ideal of clean, controlled bodies is thus imposed upon the spoken-for working class. Furthermore, Sanger is not addressing all women, who all face oppression on the basis of sex. Rather, Sanger lets down the feminists seeking a hero(ine) by adopting the same ideological stance as the western patriarchy we seek to tear down. This let-down is not exclusive to Sanger, however, nor has it stopped. I will return to this later in this chapter as I discuss the evolution of the feminist title, *Our Bodies, Ourselves*.

Nonhuman Animals and Hormones

Early twentieth-century copies of the *Physician’s Desk Reference*²³ and Eli Lilly’s edited *De Re Medica*, released before 1960, name various estrogens as pharmaceutical products: estriol²⁴, estrone, ethinyl estradiol, diethylstilbrestol²⁵, dienestrol, hexestrol, and stilbestrol to name some of the most prevalent. The *Merck Veterinary Manual*, a similar publication geared

²³ The *Physician’s Desk Reference* eventually collated patient information sheets into a reference manual. Patients suing manufacturers for the damages DES has caused often use the PDR in evidence. In 2020, the publication is now all but exclusively online.

²⁴ Estriol is no longer FDA-approved for human consumption but may still be used to treat urinary incontinence in spayed female dogs (Incurin).

²⁵ The Delaney Clause, which prohibited adding carcinogenic additives to food, was modified in 1962 to address DES. These modifications meant that the synthetic hormone known to cause miscarriages, birth defects, and cancers in humans and in nonhumans could be used in cattle “as long as residues of the product did not remain in edible tissues.” (FDA “Regulating Cosmetics, Devices, and Veterinary Medicine After 1938). The implications being that the use of cancer-causing medicines is acceptable in nonhuman animals and that there exists a standard for what constitutes “residue.”

towards the care and treatment of nonhuman animals, describes the use of estrogens for “fattening animals” and estrus for “hormone control” and “receptivity in the female cat” (*Merck* 1360). There is further evidence that pregnant mare urine has been used as a hormone replacement therapy at least in the nineteenth century.

What the mid- and late-twentieth century illustrates is not the initiation of medicalized hormone usage but the further standardization, or medical normalization, of human women and nonhuman female bodies. The medications named in both the *Physician's Desk Reference* and the *Merck Veterinary Manual* show this. The change from unregulated, nonscientific medical-ish substance to manmade synthetic hormones represents further erasure of human women in order to achieve an objective ideal. Indeed, what we see at this point in time is the augmentation of this mindset to include nonhuman female counterparts: naturally-derived hormones, like those found in urine from pregnant mares, are replaced for their more objective counterparts, synthetic hormones. Medical men thus extend their explanatory purview from describing naturally-occurring phenomena to replicating such phenomena via scientific devices and substances. What this history has to do with contraceptive pills is this: western medicine, a masculine field, takes over hormone production for human women and nonhuman female animals. The dynamic has shifted from a nonhuman animal ideal to a material actant ideal; the material actant is manmade, but is not human or animal, making it more objective.

The denial of, or to put it less sinisterly, the exclusion of nonhuman animal research establishing increased cancer risk due to contraceptive pills speaks to the climate of denial patterned in other subjects, such as climate change and secondhand smoke, which occurred in this same mid-twentieth century context. Naomi Oreskes and Eric M. Conway identify the precedent of “fighting science with science” in the tobacco industry, which speaks to the tobacco

industry's funding "distracting research" that exploited the medical uncertainties surrounding the causes of cancers and cardiovascular disease to produce credible testifiers for the industry's case (13). The same occurs with synthetic hormones in the U.S. in this same era. In the contraceptive case, medical researchers' descriptions of nonhuman animal research subjects and the effects of synthetic estrogens on those bodies is not credible enough to stop the drug's usage, thus enacting testimonial suppression. This case provides a clear example of how the twentieth-century feminist health movement failed to establish testimonial agency because medical authorities undermined women's testimonies and medical data in favor of upholding the *empowering miracle* of oral contraceptives. Perhaps even more disconcerting, by the early twenty-first century, *Our Bodies, Ourselves*, which exists in response to health-based testimonial suppression, begins to do the same.

Enovid: The First



Fig. 1. Enovid, 5mg pamphlet distributed with doctor’s samples and/or with a bottle of tablets. Shown with sample. Image courtesy of the Science Museum Group Collection, © The Board of Trustees of the Science Museum.

Enovid was the first synthetic estrogen to be marketed as an oral contraceptive. Though, when the drug first came to the U.S. market in 1957, it was approved to treat *disturbances of menstruation*. In 1960, the FDA approved Enovid’s use as a contraceptive. The packaging above shows what will become contested language. Until this point, manufacturers, as dictated in the 1938 Federal Food, Drug, and Cosmetic Act, had to provide prescribing information on the labels of their drugs, which meant that a practitioner’s ultimate authority over knowledge began to leak because practitioners now had to make sure a patient better understood what the drug did; however, this mandate could be easily subverted by the simple phrase “literature would be sent

upon request” (Siegel Watkins, “Deciphering” 95). Even in the 1960s, pharmacists, doctors, and manufacturers did not have to provide patients with all information they had available to a patient, but might, depending upon the drug, have to include specifications regarding use limitations or negative side effects. Observing FDA requirements, G. D. Searle & Co, the manufacturer of Enovid (now Pfizer) specified that the drug prevented ovulation. The notion that patients would be provided pamphlets with their prescriptions is, in the 1950s and 1960s, a novel one; since the Durham-Humphrey Amendment of 1951, which clarified which drugs required a physician’s prescription and established two classes of drugs: prescription and over-the-counter, mostly habit-forming drugs such as narcotics and cocaine required a prescription. That there is any up-front text, let alone a full page’s worth of prescribing information, is rare for drugs in this time period, but the practitioner and drug manufacturer engage in specific moves to assert their authority and to suppress knowledge.

In the photographed text, which accompanied a Physician’s Enovid sample in 1962²⁶, descriptions on use are covered using an epistolary style: the text begins “To the patient:” and contains a blank line at the end for the doctor’s signature. Throughout this text, the author narratively conflates the manufacturer and the doctor by the use of phrases such as: “If you have any other questions concerning the pills, I will advise you” and “If [spotting] should happen to you, I will tell you how to correct it.” There is a blank line, too, for the doctor’s signature on this form letter. Such moves fit Code’s knowledge transaction rather neatly. The western thinker, in this case, is the “I,” who interprets the knowledge for the lay person, the woman prescribed

²⁶ August 20, 1962 is the date printed on the literature and is therefore the best estimate of a date. Notably, even after requiring serious revisions, PPIs and other accompanying literature may have been out-of-date as, at the time, drug manufacturers could “use up existing supplies of labels before printing news ones,” which could result in an information lag of several years. (See Kushner)

Enovid. More accurately, the pamphlet serves as a mimed oath to provide such an explanation should the woman inquire. Where the western thinkers, either manufacturer or doctor, received this knowledge is not clear from this pamphlet; the *where* is privileged knowledge, too, and is also exclusive to the “I.”

Compared to St. Andre’s “an Extraordinary Delivery,” which is a much earlier example I explore in the second chapter and also makes use of signed letter forms to bolster the author’s credibility, this mass-produced letter does very much the same. In the earlier chapter on the Mary Toft case, I discuss Molyneux’s signed and dated statement within St. Andre’s narrative. The shifting referential “I” in “an Extraordinary Delivery” suggests that readers interpret Molyneux as a contingent other to St. Andre’s; yet, as I argue in that chapter, Molyneux must be read as a significant other since, without his sworn and printed statement, St. Andre’s narrative and thus his autobiographical “I” would be substantially less credible. Despite approximately two hundred years’ difference, this Enovid pamphlet engages in the same narrative device: collective authorship co-constructing credibility. The pre-written letter, albeit using the doctor’s “I,” bolsters the credibility of both the manufacturer and the doctor. Any judgments against the authors, manufacturer or doctor, would call into question a large section of western medical authority because the patient then demands testimony from the authority. That is, if a patient were to ask further questions, the pamphlet indicates “I will advise you”: is this “I” the doctor or the manufacturer? The manufacturer wrote the letter, and the doctor signed it. It is unrealistic to believe that a doctor would refer a patient to the manufacturer regarding further questions, thus, the doctor would be left to answer any and all questions²⁷. The “I” refers to the manufacturer and

²⁷ While Enovid was the first western medicine approved for use as a contraceptive, both synthetic and naturally-derived estrogens and progesterones were widely available since the nineteenth century. For example, pregnant mares often contributed urine to early human

the practitioner who both hold the privileged answer to where knowledge of Enovid's safety and reliability comes from.

Perhaps most disturbing is the claim that taking Enovid while pregnant is not only safe but beneficial: “[A] woman may wonder if the pills will be harmful to her or to her baby if she should be pregnant when she starts taking them. The pills are actually used to help women continue a pregnancy when they have had miscarriages in the past. Thus, they have a beneficial effect if a woman is pregnant.” I say *disturbing* because, as soon as 1938, the FDA, medical researchers, practitioners, and manufacturers were well acquainted with the carcinogenic and carcinotropic characteristics of another synthetic hormone, diethylstilbestrol (DES), and federal mandates were ongoing in an attempt to remove DES from poultry and cattle feed, as well as to limit its use in human animals. In the U.S. Congressional Hearings on the Present Status of Competition in the Pharmaceutical Industry held before the Subcommittee on Monopoly of the Select Committee on Small Business, in 1970, many male practitioners came forward to testify to the deleterious and well-established carcinogenic effects of synthetic estrogens in oral contraceptives²⁸. The credibility of Enovid's doctor-manufacturer letter, then, conscripts the practitioner into liability. It is the doctor who is held accountable for unwanted outcomes, though it is the manufacturer who conducts and holds the researched outcomes. It is disturbing that western medicine either did not conceive of potential risk to patients via other synthetic hormones, or that manufacturers and doctors responded by protecting their legal liability over the health of people.

hormone replacement therapies. Evidence of label-specific estrogens pre-dating Enovid are found in trade literatures and in the Physician's Desk Reference.

²⁸ Dr. Hugh J. Davis's statement clarifies the firm research-supported concerns regarding synthetic hormones (i.e. DES, mestrol, ethynl estridol, among others).

The FDA Mandate: 1970s Changes

In response to political pressure and new research, the FDA made PPIs, which are the fine-print sheets found with prescription drugs, obligatory for all oral contraceptives in 1970. The specific language resulted from lengthy debate between congressional representatives, FDA officials, pharmaceutical industry representatives, doctors, women's activists, and pharmacists. Elizabeth Siegel Watkins has extensively researched the subject; and her research into the individual letters the FDA received in 1970 regarding the PPI issue indicates that, broadly, individual doctors and the American Medical Association opposed the PPI: "The physician is the one who is able to ascertain the patients physical and emotional characteristics and whether a particular patient has need of such information," thus maintaining the stance that PPIs indicate government interference between patients and doctors (Siegel Watkins, "Deciphering" 96-97). The PPI mandate, thus, could be cast as doctors losing this argument; however, I argue this is not the case. The language used in PPIs to obfuscate the conditions of the human body and the drug's effects indicate that, while the PPIs do exist, the doctors managed to maintain authority and control over a patient's knowledge of her own body because, due to the purposefully muddled relationship between the drug and the risks, it would be difficult for a patient to connect any negative effects to the drug. Trusting a doctor to provide *clear* information is a trust misplaced.

Copies of the actual printed PPIs from various manufacturers, brands, and years, when reviewed, as well as the modest instructions included on packaging, confirm the small changes in language, and thus in accountability, since the first inserts were included. For example, packaging from Ortho-Novum SQ, made around 1970, states the following:

The oral contraceptives are powerful and effective drugs which can cause side effects in some users and should not be used at all by some women. The most serious known side effect is abnormal blood clotting which can be fatal.

Safe use of this drug requires a careful discussion with your doctor. To assist him in providing you with the necessary information, a booklet has been prepared that is written in a style understandable to you as the drug user. This provides information on the effectiveness and known hazards of the drug including warnings, side effects and who should not use it. Your doctor will give you this booklet if you ask for it and he can answer any questions you may have about the use of this drug.

Notify your doctor if you notice any unusual physical disturbance or discomfort.

This small, short text certainly exceeds the legal warnings for oral contraceptives in the early 1970s. After all, it mentions outright that abnormal blood clotting is a possibility and is a quite concerning side effect. At the same time, studied and known side effects remain unmentioned, deferring instead to the judgment of the physician; I note, too, that the doctor in this 1970 text is referred to using masculine pronouns (he/him). Furthermore, the phrase “Your doctor will give you this booklet if you ask for it” is yet another instance of medical practitioners withholding knowledge and thus protecting their own authority.

Unlike the Enovid literature, the above-cited Ortho-Novum SQ ~1970 literature does not subsume the practitioner’s “I” into the manufacturer’s “I”. Instead, it is clearer, though the use of second-person pronouns, that the short text is the manufacturer speaking. In terms of informative practices, this move is an improvement of sorts. A reader-patient understands that more information exists, and she must consult that information to make the best decision about her body. The doctor’s role in providing this information is, though, a potential pitfall. Doctors may

run out of copies of the longer informative pamphlets or may be sinister enough to withhold the pamphlets entirely.

I have been able to locate two versions of a booklet that a patient may have encountered prior to and right at the mandate of these inserts. One is a ten-page text from 1974, titled “After your doctor prescribes Ortho-Novum tablets...” and contains the statement “the inclusion of the following information regarding oral contraceptives is required by the U.S. Food and Drug Administration.” The second, from 1967, is eighty-five pages long, and the booklet covers subjects such as “Understanding the Reproductive System,” “Understanding the Menstrual Cycle,” “Understanding Conception and Pregnancy,” “Understanding the Control of Conception,” “Understanding the Wide Choice of Methods for Conception Control,” and “Medical Procedures—physician’s instructions.”

In comparing these two supplementary texts, the most obvious question is *why would the later text be less thorough than the earlier?* Considering that doctors and manufacturers resisted the FDA’s involvement in dictating that patients *should* be told of side effects, and that these patients *should* have access to medical information about these drugs and the theories affecting their prescription, my conclusion is that, by legislating what goes into the PPIs, the FDA also legislated what remains *out* of the PPIs. The FDA therein equivocated a practitioner’s responsibility to discuss such information with a woman with a practitioner’s responsibility to answer a patient responsibly. For example, V. Herbert explains that, regarding the oral contraceptive, it is the practitioner’s responsibility to ask himself “if the potential detrimental side effects of this contraceptive are greater or less than allowing a pregnancy to occur” (555). Herbert names six steps a practitioner ought to take when prescribing a potentially hazardous drug: 1. Informed consent of the patient or authorized representative, 2. Physician is convinced

of his diagnosis, 3. Existing methods would be unsatisfactory, 4. Contraindications, 5. Possible side effects, and 6. The safety and usefulness of the drug; and Herbert describes, too, reputable sources for a physician: 1) animal experimentation; 2) previous clinical investigations; 3) dosage recommendations; 4) contraindications; 5) possible side effects; and 6) the safety and usefulness of the drug (555). Informed consent is the only step across considerations, like those Herbert lists, where a patient may voice any concerns, and still, the decision-making process rests with a physician interpreting and concluding on a patient's behalf. Such a process is not a collaboration between the physician and patient, and the process does not permit patient drug testimonials (either informal or formal). While Herbert's 1975 article is my example here, it is not a unique position. What remains left out of the FDA-mandated PPIs and out of Herbert's proposed assessment is patient access to the medical knowledge and to a permanent reference. Thus, descriptions of risk work to establish causal doubt, and PPIs failed to redress the power dynamic of medical knowledge. Therefore, the answer to why patient-directed literature grew less educational is because of the industry's attempts to confuse links between oral contraceptives and cancer. This also meant the object of study was less clear to the western thinker/physician, making it less likely they could accurately confer such information anyway. Indeed, rather than clarifying that the health benefits of oral contraceptives might be different than previously thought, the response was to state unclearly that risks may occur and that a physician should determine the best course of action. Thus, in order to maintain control, the FDA and physician response was to limit patient access to the theories and the research informing prescription recommendation through having to request further information from a party very much invested in withholding that information. The eagerness of the U.S. public for woman-controlled pregnancy prevention did little to encourage the reinstatement of thorough educational literature.

The 1980s: Adjusting for Updates

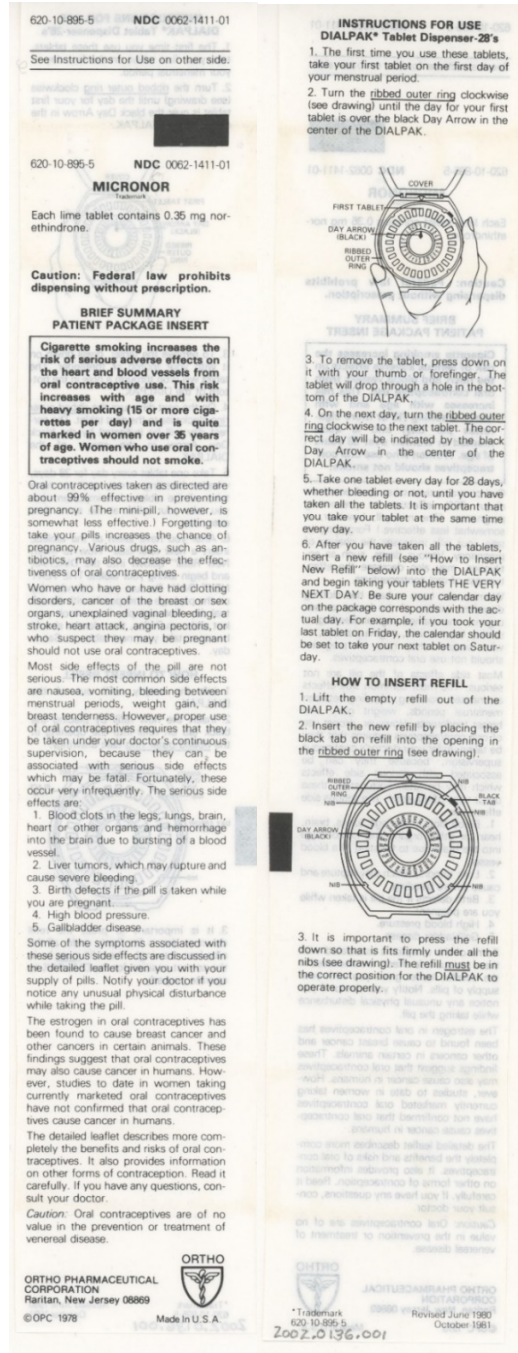


Fig. 2 An early 1980s copy of a Patient Package Insert distributed with Micronor. Image courtesy of the National Museum of American History (catalog no. 2002.0136.001).

A copy of Ortho Pharmaceutical Corporation's Micronor Brief Summary Patient Package Insert is a long, thin, double-sided sheet in small print. Unlike the pamphlets and booklets from

this same company in the 1960s and 1970s, this sheet does not inform the reader about the function of the hormones, both those her body produces and those in the contraceptive pill, in the ovarian and uterine cycles. It is possible that the referred-to “detailed leaflet” covers such information; however, my archival searches have been unable to locate a copy of such a leaflet from this era.

The sheet starts with information on the dose, 0.35mg of hormones, and a bolded and framed statement on the increased risk of blood clots due to cigarette smoking. The language in this sheet does not clarify, however, that this medication increases a patient’s risk of clotting disorders, which is why cigarette smoking is strongly discouraged while taking this medication. Instead, this warning works to blame cigarette smoking for such risks, thereby shifting focus from the pill’s deleterious effects on the body to how a patient ought to behave while on this medication. To clarify, I am not saying that cigarette smoking is healthy or that patients ought not be advised against it. On the contrary, what I am saying is that the phrasing here blames smoking for the “serious adverse effects on the heart and blood vessels,” which neglects the increased risk non-smokers taking this medication face, too.

Later, in non-bolded print, the insert states: “Women who have or have had clotting disorders, cancer of the breast or sex organs, unexplained vaginal bleeding, a stroke, heart attack, angina pectoris, or who suspect they may be pregnant should not use oral contraceptives.” Again, this section does little to specify why women with this medical history ought to use other forms of contraception. It isn’t until later that this medication’s side effects are laid out plainly, in a numbered list. Thus, if a reader makes it this far in this sheet, she has been primed to suspect other lifestyle and behavioral factors as the root cause of such serious side effects.

This version of the patient package insert further glosses over breast cancer risk:

The estrogen in oral contraceptives has been found to cause breast cancer and other cancers in certain animals. These findings suggest that oral contraceptives may also cause cancer in humans. However, studies to date in women taking currently marketed oral contraceptives have not confirmed that oral contraceptives cause cancer in humans.

This statement, particularly in its timing, the 1980s, ignores the wealth of published medical research in the U.K. and the U.S. identifying the hormones in various oral contraceptives as carcinogenic and/or carcinotropic. While pre-dating medical consensus on the matter, many of the practitioners called to testify before the 1970 Nelson Hearings cited medical studies as showing the same synthetic hormones produce breast cancers in many species of nonhuman animals²⁹.

²⁹ An excerpt from Dr. Hugh J. Davis's testimony before the Subcommittee on Monopoly of the Select Committee on Small Business, United States Senate, Second Session on Present Status of Competition in the Pharmaceutical Industry:

“The fundamental problem with the oral contraceptives can be readily understood by anyone: It is medically unsound to administer such powerful synthetic hormones in order to achieve birth control objectives which can be reached by simple means of greater safety. This view was expressed by prominent gynecologic endocrinologists prior to the approval of the pill for contraception 10 years ago, and subsequent history has shown that it is even more true today.

Meanwhile, 9 million women are consuming these compounds almost automatically and without much information about the hazards. The impression has been given the public that the oral contraceptives are nothing more than innocent natural female hormones. Yet milligram for milligram the synthetic chemicals used in these pills are 20 to 40 times as potent as the natural estrogenic substances. To think of them as natural is comforting but quite false. . . .

Cancers do not develop overnight. The lag period from the induction, the alteration of the first few cells, to the appearance of some fully developed and clinically recognizable cancers can take as much as 20 years. There is no reason to believe that the situation with respect to hormonally sensitive target organs such as the breast among women taking oral contraceptives is any different.

Shall we have millions of women on the pill for 20 years and then discover it was all a great mistake? Breast cancers have been induced in at least five different species of animals by treatment with the same synthetic hormones being marketed in the oral contraceptives. Every important agent which has been shown to exert a site-specific carcinogenic effect in humans has been shown to cause cancer in animals. There is no reason to presume that the single exception to the interspecific transferability of such experiments will turn out to be the oral contraceptives, however much we may wish it. . .”

Regarding medical credibility, then, there is a noted shift from what I identified in earlier chapters of this dissertation. The evidence disproving Mary Toft's claims hailed from nonhuman animals, albeit their fecal matter. In the third chapter of this dissertation, I reviewed food adulteration laws in the 1800s, particularly as they relate to milk. These laws, coupled with scientific medical literatures, implied human behavior was the primary culprit for the impurities in human milk and in cow milk. To be an adequate, well-informed citizen, humans had to erase all trace of their behavior from food production, something quite magical regarding milk production by humans. In this much later context, though, not even nonhuman animals (as research subjects) represent an ideal patient. All animals, human and nonhuman, had to be controlled scientifically, which meant controlling biology all the way down to the smallest material actants. An animal on synthetic hormones *is* an ideal patient because it is scientifically understood and controlled. Importantly, western medical science, through controlling the substance that makes animal bodies *female*, thus controls who and what can *know*.

What occurs in the twentieth century, then, is a further shift from women having credibility. Formerly, western scientists received knowledge from nonhuman animal studies and interpreted (testified) for the lay person. In the case of the contraceptive pill, the western scientist used objects of study to confirm what he already knew: that, in order to be fully understood, female animals had to be controlled medically. Code discusses this different (yet the same) transaction via stereotypes and experience. According to medicocultural stereotypes, a woman has access only to her experience, which is less credible than knowledge (Code 223). People, either lay persons informed by the authority or the western practitioner himself, apply these stereotypes as proof that they *know* what women are like and what they can(not) do (Code 223). In turn, this circular logic proves that telling a woman she might experience side effects means

she will believe she experiences those side effects, which (mis)shapes harm claims as the result of a malleable, flippant woman's mind at work.

The uncertainty established by such medical research functions within Code's knowledge transaction as the data/knowledge western thinkers receive from the object of study. In the case of medical research, these data are often nonhuman animals or longitudinal studies following pill consumers. By not acknowledging the interpretive, descriptive powers exerted, western science reinforces its own systematic sexism and human exceptionalism using the material actants hailed as essential to the U.S. second-wave feminist movement. To adapt Audre Lorde's often-cited assertion, the master's tools are used to reinforce the master's house.

The Women's Health Movement: A Short Ownership of Knowledge

The growing strength of women's health activism sought to bring back women's voices into the space of *authoritative* medical discourse. While women were midwives and nurses, as well as responsible for domestic first aid, few women have been in authoritative positions within western medicine. Midwives, for example, still defaulted to a doctor in difficult cases, and nurses still had to follow what their male doctors instructed. Challenges to male-dominated authority were made not only to heroes but to medical knowledge, too. The Boston Women's Health Collective's *Our Bodies, Ourselves* is an oft-cited example of women reclaiming authority over their own bodies. These women authors, and the efforts of many others, resituated women from receivers of male medical knowledge to producers of medical knowledge. Doing so meant people could practice medicine with or without a male practitioner as it had been done prior to the formalization of medicine in the nineteenth century.

However, there have been substantial changes made to *Our Bodies, Ourselves*, which has been republished many times since its first edition in the early 1970s. The edition published in

1973 includes its birth control pill information in the chapter titled “Birth Control.” Also in this chapter are discussion of “factors affecting our decision about birth control and our ability to choose,” information on available Intrauterine Devices (IUDs), diaphragms, cervical caps, condoms, foam-aerosol spermicides, jellies and creams, withdrawal, the Rhythm Method, tubal ligation, and more; briefly covered are, too, discussions of male contraceptive research, female contraceptive research, helpful organizations, and future readings. Each of these subjects is covered between pages 106 and 137, though much of the content reappears or references information elsewhere in the text (viii, *Our Bodies, Ourselves* 1973).

While longer, the 1984 edition reorganizes its discussions to place its conversation on Birth Control into a larger chapter on “Controlling our Fertility.” Covered in the chapter are anatomy and physiology, sexually transmitted diseases, advice on what to do/how to find out if one’s pregnant, abortion, and (then) new reproductive technologies (ix-x, *The New Our Bodies, Ourselves* 1984). The section on Birth Control in this edition spans pages 220 to 262, making it eleven pages longer than the 1973 edition.

The 1984 edition addresses the role of the FDA concerning patient trust of medication in response to the congressional hearings and legislative action regarding the safety and the morality of contraceptive pills:

The Food and Drug Administration (FDA) regulates the methods of contraception, deciding which ones are still experimental and which are legal to prescribe and sell, so we assume that they have been carefully tested before we use them. *All* birth control methods must be tested first on animals and then on women before the FDA approves them for marketing. Often, drug companies test new methods on women in Third World countries or poor women and women of color in this country. (See section on Depo-

Provera, p. 247). . . . FDA requirements take up to ten years of work before a drug is marketed, but it takes twenty years or more for some complications to become apparent. As a result, all women using the Pill or the IUD, for instance, become subjects in prolonged experiments (221, *The New Our Bodies, Ourselves* 1984)

In its ninth edition, *Our Bodies, Ourselves* (2011) maintains a chapter titled “Birth Control” under Part 3: Sexual Health and Reproductive Choices. Notably, the language changes from the firm stance on women’s participation as passive research subjects:

The Food and Drug Administration (FDA) approves all methods of birth control, and products that receive FDA approval have undergone up to ten years of rigorous research. However, it can take twenty years or more for some complications to become apparent, especially those that are rare but more serious. Drug manufacturers spend a lot of money promoting and marketing new methods, trying to convince you that they are the best. But new, heavily marketed brands are not necessarily any better than older methods, and they may pose risks that are not yet known. One of the greatest obstacles to women’s use of contraception is the fear of possible negative health effects from the use of hormonal methods or the IUD³⁰. Some women hear alarming stories that may be based on half-truths, bias, isolated cases, or old information, so it is important to seek out accurate and balanced information before making a birth control decision. It’s also important to consider the health risks of being pregnant, which are higher than those of using any form of birth control. (loc. 5004-14, *Our Bodies, Ourselves* 2011)

³⁰ Many IUDs contain synthetic hormones, but the newest version of *Our Bodies, Ourselves* (2011) does not mention that relevant information here.

Unlike earlier editions, the 2011 edition—now an ebook—does not contain the strong language regarding women’s misled participations in prolonged experiments with no certain results. Indeed, this edition takes a step back from the assertiveness in the 1984 edition and even the 1973 edition; in 1973, the collective authors write that those with “any disease or condition associated with poor blood circulation” should *not* take the Pill, particularly those “over thirty-five years of age” (115, *Our Bodies, Ourselves* 1973). The 2011 edition attributes this increased risk, even on the significantly smaller dose pills, primarily to smoking:

[Since the 1960s and 1970s] new formulations with low-dose hormones have been introduced, and today’s pills contain about one-eighth to one-tenth of the estrogen in early pills. Research has concluded that today’s birth control pills are safe for most women, and that healthy, nonsmoking women have little if any greater risk of heart attack or stroke than women who do not use the Pill. Any woman of any age has a tripling of her risk of blood clots while on the Pill, although this risk is still quite small overall. To put the risk in perspective, the risk of a blood clot during pregnancy is double the risk of getting a blood clot while on the Pill. Women with some cardiovascular conditions or some chronic illnesses and women over age thirty-five who smoke should not take the Pill. In rare cases, women who use birth control pills may develop liver tumors. Some evidence suggests that oral contraceptive use slightly increases the risk of getting cervical cancer or breast cancer among women under thirty-five, but these associations are controversial and have not been fully established. (loc. 5419)

The above excerpt illustrates just how much the authors of *Our Bodies, Ourselves* have transitioned their narrative strategies. Earlier editions provide citations, scholarly and scientific, coupled with women’s experiences. Doing so contributed to the text’s reputation as “America’s

Bestselling Book on Women's Health," and *Our Bodies, Ourselves* has sold millions of copies in thirty-three languages. The 2011 edition departs from the citation and testimony moves, instead favoring narrative strategies akin to the medicoscientific knowledge transaction evidenced in the patient package inserts. Doing so reestablishes the patriarchal knowledge transaction the founders of the Boston Women's Health Book Collective fought against. The 2011 edition's authorship translates knowledge to its readership and keeps the object of study/source of knowledge under-referenced, which establishes the authorship as a western thinker/medical authority. Indeed, moves such as "Research has concluded that today's birth control pills are safe for most women" and "Some evidence suggests that oral contraceptive use slightly increases the risk of getting cervical cancer or breast cancer..." do little to convey actionable knowledge to the reader. Instead, we must *trust* the authors to interpret the research for us, and in turn, they parrot the findings back in an obfuscated way. The 1973 and 1984 editions, by incorporating women's testimonies and citing medical research findings *together*, instead functions as an object of study itself. The reader, for a brief window in the twentieth century, could study the text to interpret the knowledge herself.

While the content of the 2011 edition is not wholly inaccurate as thousands more studies and outcomes have contributed to medical understandings of synthetic hormone's effects, one may wonder why would such a staunchly pro-women's medical knowledge text would back away from its insistence that women *with any* circulatory troubles should *not* take *any* pill? *Our Bodies, Ourselves* has been transformed from a radical move to acknowledge a woman's right to describe her own body for herself. The 2011 edition, and the current website, have used the narrative devices of western medicine, specifically those that remove accountability from the drug industry and from prescribers: collective authorship co-constructing credibility. Rather than

encourage the leaking between the often simultaneously-held categories of patient and object of study, *Our Bodies, Ourselves* encourages the leaking between medical authority and its own authorship by gatekeeping medical knowledge.

CHAPTER FIVE: POSTHUMAN FEMINIST PEDAGOGY IN AN INTRODUCTORY WOMEN'S WRITING COURSE: REDESIGNING, RECOVERING, AND REWRITING

Course Description

Throughout this dissertation, I have argued for implementing new reading strategies that can critically engage *objectivity* while revealing the networks of women, nonhuman animals, and material actants that contribute to our health practices. I have studied *how* knowledges of women's bodies has become western medicine's proprietary information "verified" by nonhuman animal and material actant testimonies. Advocating for such strategies is moot if there is not a means by which to practice these kinds of reading. I have, thus, redesigned an undergraduate course using posthuman feminist pedagogy in order to train nonmedical students to investigate critically the troubles and contradictions within our very own western medical culture. In this chapter, I consider how to engage in troubling knowledge production not just of women's writing and not just of western medical history, but of my and the students' reproductions of that knowledge as well. The course design includes recovery of nonhuman animals and material actants in the work of questioning who/what should feature in the history of western medicine.

English 160: Introduction to Studies in Women's Writing is a course students may elect for their General Education requirement at Illinois State University, which is a large university set in a rural midwestern location, and, according to their website, 1 in 4 students is from an "underrepresented background" ("About Us"); those completing a Women's and Gender Studies certificate choose between English 160 or History of Literature by Women (English 260), Women's Literature in a Global Context (English 261), or Studies in Women and Literature (English 360). Thus, while English 160 is a 100-level course, the students enrolled comprise a

wide set of majors and have vastly different backgrounds and prior coursework because they are not currently required to take English 160 before any other women and literature course.

The use of “writing,” rather than “literature,” in the course title reflects the English Studies model at Illinois State University. Students study the texts produced but also should engage in the sociocultural and historical circumstances around the writing of those texts. Thus, the title offers an opportunity to explore a myriad of approaches to women’s writing—not just novels by major authors, but a diversity of the genres: letters, recipe books, diaries, oral histories, patient descriptions, and more. Including informal literature in this course highlights how the diversity of genre mirrors diversity of authorship, and to study such genres in an introductory contexts opens the course to recovery efforts. In other words, students in this course get a taste for the research skills needed to reconstruct the lives of minorities. To appreciate genre diversity is to appreciate embodied diversity.

Pedagogical Approach

In their Introduction to the Modern Language Association’s *Teaching Literature and Medicine*, Anne Hunsaker Hawkins and Marilyn Chandler McEntyre argue for the value of literature and medicine courses not only for pre-med students but also for general education undergraduates: “literature and medicine may provide a model for interdisciplinary study and initiate interdisciplinary dialogue on campus. . . . Students from both the sciences and the humanities learn something about their own styles of thinking that deepens self-respect, curiosity, and confidence in bridging disciplinary differences” (12-13). While this is certainly true, my literature and medicine approach to English 160 critiques the disciplines of medicine and of history, separately and together, in order to encourage students to take up the activist work of recovering erased histories.

Snaza and Weaver write that posthuman philosophy has the potential to reconfigure education. The whole thing: not just pedagogy, not just curricular design, not just educational research, and not just disciplines or even institutions. . . . And this is because it has been assumed that education is only for and about humans – Man as the measure of all things, and ‘whether [research is] quantitative or qualitative’ – all presume a knowing ‘human’ researcher capable of objectively knowing the students, teachers, schools, and curricula s/he observes, measures, and seeks to understand. (qtd. Murriss, “Propositions for Posthuman Teaching” 105)

The prerogative of applying posthuman philosophy to education, and specifically to a women’s writing and medicine course, rests with the students’ and teacher’s entanglements with the ongoing knowledge production and knowledge subversion in western medicine. In other words, we are ourselves entangled in western medicine. A posthuman feminist pedagogy asks teacher and student to work together to tease out these troubles

Karin Murriss describes a posthuman pedagogical approach as a “navigational tool” that “offers a different *relational ontology*” in order to “reconfigure subjectivity” by means of establishing a “posthuman child” and a “sympoietic *diffractive teacher* (human or nonhuman)” (“Posthuman Child and the Diffractive Teacher” 2). Thus, a teacher’s role regards schooling as knowledge production, students as knowledge producers, and collaborations as existing between and across species. While students enrolled in English 160 are not children, they have been trained to engage in learning as passive agents. Johnmarshall Reeve identifies that, while students are “sometimes proactive and engaged in classroom learning,” they can still be reactive and passive (225). This contradiction suggests many misalignments in the ongoing conversation, one of which is the definition of *active student*. When I imagine an *active student*, I imagine

someone who seeks knowledge on their own, inside and/or outside the classroom. It is thus possible for a student to be reactive and passive inside the classroom yet still be an active learner. Posthuman pedagogical approaches like what Murriss describes offer an opportunity for the educator to (re)embrace such miscategorized students because knowledge production activities and assignments must happen inside and outside a classroom. In a posthuman pedagogical model, students must go, research, and report back, and this dimension provides depth to the category of active student.

The women's writing course I have designed focuses on western medicine, which offers many opportunities to explore entanglements since students must reference their own experiences and must make use of research strategies in order to identify erasures. At the same time, students see the western medical institution itself as an authority over the knowledge of women's bodies, and indeed, their own, across all genders as western medical patriarchy functions systemically *and* locally. Thus, a standard attempt to instruct students that we should challenge western medicine is insufficient, not in the least because doctors or other practitioners of western medicine often hold counterclaims to patient experiences, and we cannot finish undermining this explanatory power in the span of one course. Students should drive the process of casting doubt onto the practices and inclinations of medicine if it is to be a long-lasting lesson students integrate into their private lives. Therefore, what may appear to be a simple pedagogical task of scaffolding antecedent knowledge into course-specific scenarios is an epistemological challenge to students. Where I start the epistemological questioning is by challenging hero narratives.

As I covered in Chapter 3, the scientific and medical contributions of women and minorities have been erased or appropriated because these populations are stereotyped as

“tend[ing] to do science in a less objective, i.e. less detached or more contextualized manner” than their white male counterparts (Oreskes 88). Thus, in order to be recognized as a contributor to western medical science—to be hailed a “hero”—women and minorities must engage in the same *objective* performances. Medical authorities use material actants as “objective” evidence, which I have challenged in other chapters of this dissertation. These medical authorities also use these objective perspectives to fashion themselves into scientific heroes who accomplish great medicoscientific progress individually, despite being part of a team supported by numerous others, human and nonhuman. Having students define the structure of a hero narrative, identify historical examples of hero narratives, and then work to recover the contingent others surrounding the hero narrative’s subject are all posthuman feminist pedagogical strategies because students learn to re-value diversity and inclusion in medicine. It also means that students are active posthuman children because they must identify who/what is involved in their own ongoing narrative.

Undermining or questioning to take down the tool of oppression, the hero narrative, is not enough. Students, really anyone doing critical work, want some direction as to where to go from here. If there are no heroes, then what is there? Instead, we work to develop diffractive self-narratives. Alyssa D. Niccolini, Shiva Zarabadi, and Jessica Ringrose describe this work as “kinshipping.” Kinshipping, they describe, is

[A]n apt moniker for how intersectionality might merge with posthumanist thinking. A ship temporarily contains while hailing futurity through what it moves and passes on. Shipping signals traffic, transfer, conveyance, movement. Shipping additionally carries histories of how capital and profit and particular materialities from particular localities

are carried in at times exploitative ways. Indeed, we can map the traffic of the colonial world through its shipping routes. (331)

They blend this understanding of *shipping*, then, with Donna Haraway's *kinning*: "Who and whatever we are with, we need to make-with—become-with, compose-with" (qtd. Niccolini, Zarabadi, and Ringrose 331). Kinshipping is exactly the way forward from the criticism of hero narratives undertaken in English 160. Rather than hailing a white, western male as the great giver of life, the writing assignments in this course have students practice the skills of writing themselves as becoming-with, composing-with the humans and nonhumans in their daily lives, particularly in a medical context.

Theoretical Rationale

I settled upon medicine as a theme in response to a commonplace students repeat to me all too often: "Women didn't write anything until the 20th century." This commonplace compliments another, "women were not active in western medicine until they were admitted to medical schools." This course, "Women Medical Writers/Writing Women's Medicine" responds to these assumptions by addressing issues of erasure and of exclusion. I ask students on the first day: Who do you call when you get sick? With a handful of exceptions, they respond: my mother. Western women are at-home caretakers, career nurses, medical practitioners, midwives—Why doesn't your mother count? Why is your father feminized by caretaking labor? How could it be that we know what has and has not worked in midwifery if women weren't involved in medicine until now? What's the difference between *miscarriage* and *abortion*? Each of these questions works to invite students to use the course to examine their lived realities.

To tackle these commonplace assumptions, I design an historically broad reading list, which begins the explanatory work of how women were active in western medicine and why

their work is unattributed. I include texts that inform medical practice at our midwestern, central Illinois location as a relevant hook for students. At the same time, focusing on geographical location provides students a timeline: these are the histories of us, this is where we are now, this is what we still do. Thus, ISU's student population can see where and how what we discuss affects them. This geographical focus highlights for students enslaved women's histories, indigenous traditions, criminal witchcraft, and forced migration of foreign-trained medical practitioners. This course clarifies that these histories exist now.

Casting these everyday scenarios as an issue of agency and objectification allows me as an instructor to build upon the simple survey of feminist work with which the bulk of my students are at least passingly familiar. Indeed, it is rather difficult to locate a student, who chooses to enroll in English 160: Introduction to Studies in Women's Writing and has not at least eavesdropped on a discussion of the objectification of persons. The issue I focus this chapter upon, then, is how to connect what students think they know about the ways in which western medical patriarchy objectifies persons to how these oppressions actually occur.

Leah Misemer's "English 177: Literature and Popular Culture, the Graphic Novel" contributes to the way in which I have conceptualized many of the assignments for this course. Much like Misemer's course, Eng 160 was comprised of students "aiming to satisfy" the Humanities credits of their degree or of the WGS undergraduate certificate. Misemer, in describing the documentary projects her students completed about the members of the comics community in Madison, Wisconsin speaks to my course in a few different ways. One, the outcome she describes (the community was accepting and excited to participate with these students) is something that I would have liked to occur in my courses.

Two, Misemer notes that “people who love comics are used to proselytizing. . . . The desire to discuss comics makes those involved in the comics community eager to speak with students investigating the medium for a class” (132). The rhetorical situation she frames, that the students are not bothering these community members, is an important one. Inexperienced student activists are quite concerned with getting their alternate/unique perspectives into public discourse without considering the ethics of doing so; student projects seeking to amplify those efforts either stopped at the classroom door or fell into the pitfalls of speaking for others. Thus, a women and medicine approach to English 160 needs students to examine western medicine’s speaking for others. While many of the readings I teach in English 160 address this trap, Catherine Ceniza Choy’s *Empire of Care: Nursing and Migration of Filipino American History* (2003) is the assigned book I discuss at length here.

Choy carefully maps the contours of Filipino American forced migration using the nursing profession as her primary example. The very notion that western medicine could be used as a mobile colonizing tool troubles the medicalized proselytizing and global caretaker rhetoric pervasive in many underthought activist efforts. In other words, thinking about how U.S. ideas of health and wellbeing work to characterize this country as knowledgeable and healthy while other countries (like the Philippines) are characterized as ignorant and deadly does important self-reflective work. Acknowledging that there are many health cultures globally and domestically starts the work of reconsidering proselytizing impulses, which is a transnational feminist criticism of our current context.

Katie Hogan’s “Come Closer to Feminism: Gratitude as Activist Encounter in Women’s and Gender Studies 101” addresses the “bad news”/negativity with which many WGS introductory courses engage. My course design does engage this message; it is *bad news* that the

systems we trust to keep us healthy perpetuate oppression, historically and contemporarily. And many students find it *bad news* that the church mission trips to foreign countries might have done more neocolonial work than charitable work. Hogan, to redress feminist critique's bad news, extends her practice by acknowledging the sentiments in tandem with bad news; of course, people resist a movement that constantly engages in these negative tones. Her solution to this issue is to approach these courses with a "carefully constructed [syllabus] designed to encourage cognitive/intellectual awareness of the astonishing achievements of WGST" (Hogan 231). She notes that her students write "Letters of Gratitude" to women these students have identified as having a significant impact on their lived realities; however, my research in Eng 160 suggests limits to the contexts in which students will express gratitude. While the students wrote an Acknowledgements section in their final projects, these letters often reflected superficial considerations of their sitpoints³¹ in systemic medicalized oppression; however, these Acknowledgements sections were opportunities some students took to practice *kinshipping*, a term I have described earlier in this chapter. These students were able to realize their actions as shaping and shaped by people, animals, and materials in their day-to-day lives. Thus, these students were able to apply the criticism of the hero narrative and individualism to themselves.

Reading List

We start the semester with Monica Green's edited translation of *The Trotula*. It is widely held to be the first medical textbook despite being woman-authored (or, perhaps, collectively woman-authored). The first medical school students *studied a woman-authored text*, which emphasizes, again, the wrongness of women being inactive in western medicine until now. What *The Trotula*

³¹ "Sitpoint" is the feminist disability studies replacement term for "standpoint" to include wheelchair users.

Question introduces to students is a cause and effect example of *erasure*. Because *The Trotula* is left out of history and medical education, therefore twentieth and twenty-first century women participating in medicine demonstrate progress. Indeed, nursing and biology majors confess to never having known about *The Trotula* and wonder why this text would not be taught. Indeed, *The Trotula*'s exclusion has troubled some students so much that they have written to me after the course has ended, asking further questions about the troubled authorship, editing, and translation history of the text, and comparing *The Trotula*'s popularity and use to the Bible; *isn't this really just the science/medicine version of the Bible? Why are science and religion looked at in different ways?* In other words, students recognize the significance of a medieval woman-authored text, foundational to western medicine, and relate this case to commonplace assumptions about women's role in western medicine.

Students in English 160 read health and medical cookbook manuscripts, which were written and maintained by women, alongside historical information about western medical licensure and criminal witchery in Early Modern Europe. These genres provide examples of how women, despite being formally excluded via licensure and degrees, still contributed to medical knowledge and still practiced medicine. Historical information presented via diverse genres illustrates the work of recovering women's lives and (re)attributing women's knowledge, thereby demonstrating to students how archival literary studies remains a crucial subject and skillset for what they recognize is needed work in diversity and equity. We need to turn to a breadth of genres to piece together women's lives and roles, and to a breadth of geographic locations to contextualize our current historical moment.

After studying Early Modern Europe, we turn the decolonial eye onto ourselves. To accomplish this critical self-analysis, we use Patrisia Gonzales's book, *Red Medicine*:

Traditional Indigenous Rites of Birthing and Healing. This text introduces colonialism and imperialism as critical concepts and as methods contributing to false uniformity; indigenous health traditions continue today, and students relate their family traditions to the need to hide nonwestern practices. For example, while reading *Red Medicine*, students with Central American and South American ancestry contribute to class conversation, usually describing home remedies that function as ties to family heritage in spite of decades in a new country. One such tradition, which was new to me, is the use of chicken eggs to cleanse one's aura, spirit, or bad energy. Related to the cultural concept from *Red Medicine*, *la limpia*, one may use this egg, make the sign of the cross and recite some prayers, and then crack the egg to "read" it. As it turns out, many students had not only heard of this, but began to share openly how their grandmothers swear by this ritual. This deep connection, precipitated by a posthuman collaboration, chicken-human, frames the content and the course objectives as personally relatable and reiterates the applicability of archival literary studies. In other words, teaching a book on indigenous medicine helps students understand who else is erased and excluded from western medical history. We use ourselves as our examples.

Understanding intersectionality as a tool rather than a catchy phrase leads us to the how of the matter. In group discussion we cover how shocked, disgusted, horrified, and embarrassed we are by these histories, and in group discussion we practice transforming these reactions into responses. Issues of diversity, equity, and inclusion hurt. It hurts to learn that our medicalized distinction between *miscarriage* and *abortion* stems from the U.S.'s slave history, but that does not mean it should not be taught. It means providing students an opportunity to transform this hurt into action. By learning these stories, students have specific examples with which to interpret and to understand the ways in which this country interacts with its citizens and with

other countries. Thus, when protests break out over sociocultural and racial health disparities, students from this course will understand why. Teaching basic research methodology to a 100-level course gives students the means to do deeply personal critical research.

The course follows a Unit-to-Subunit structure, which I've outlined below with specific readings included:

Early Western Medicine

Excluding Women

Warner, "The Pitfalls of 'Objectivity'"

Oreskes, "Objectivity or Heroism? On the Invisibility of Women in Science"

Green, *Making Women's Medicine Masculine*

Whaley, *Women and the Practice of Medical Care in Early Modern Europe*,

1400-1800

Stealing Knowledge and Erasing Authors

Green, ed. *The Trotula: An English Translation of the Medieval Compendium of*

Women's Medicine

Ehrenreich and English, *Witches, Midwives, and Nurses: A History of Women*

Healers

"Health and Medicine in Cookbooks"

Mary Toft's Three Confessions

Frances Burney's Mastectomy Letter

Western Medicine as Colonizing Force

Before the U.S.

Gonzales, *Red Medicine: Traditional Indigenous Rites of Birth and Healing*

Forming the U.S.

Schwartz, *Birthing a Slave*

Imposing the U.S.

Choy, *Empire of Care: Nursing and Migration of Filipino American History*

I selected the primary source readings—personal memoirs, letters, and essays—organizing them chronologically and gesturing towards missing perspectives (poor, non-white, non-U.S., male, trans*, and more). I also included 18th century materials to challenge the misconceptions that cancers are a contemporary issue and that activism began in the 1980s. Students possessing a point of contention stemming from deep knowledge is a way in which I am intentionally encouraging them to participate and thus to challenge what they read/ watch. The course

structure contributes to the development of individual context—exploring historical context relates to recognizing what makes our entanglements possible because it offers some explanation of *why* and *how* we reached where we are now.

These readings help students reach the following goals and objectives:

- ❖ Challenge basic assumptions of the history of medicine, particularly regarding the participation of women & minorities
- ❖ View contemporary problems with an historical perspective
- ❖ Demonstrate skill in oral discussion, critical reading, primary research, and written argumentation
- ❖ Describe the role(s) of women in medical institutions and recognize the impact of meaningful and inadvertent exclusion
- ❖ Recognize the historical and cultural connections between medical practices and medical texts
- ❖ Problematize notions of “individualism”

In order to assess students’ achievement of these objectives, I have course activities and assignments that has them apply the knowledge gained from the readings in the two major papers for the course. Students thoroughly research a woman or a medicinal substance discussed in the course to argue for its significance to the history of medicine. Students have written on subjects

such as James Barry³², Henrietta Lacks,³³ Florence Nightingale,³⁴ Rosalind Franklin,³⁵ Lavender, Honey, Cinnamon,³⁶ and more. These papers require implementing the skills and analysis practiced in the classroom. Producing research-based arguments illustrating their subject's importance means students contribute to a culture of diversity and equity, moving them past realizing an action ought to be made and into making the action themselves. For example, one English 160 student sought to produce an informational pamphlet. Their pamphlet would provide better access to nonwestern pre-, peri-, and post-natal services in the Bloomington-Normal area. While they ultimately realized there were not enough nonwestern resources or nonwestern practitioners in the area willing to publicize themselves, this student learned an important lesson about the continued effects of cultural oppression. Thus, the pedagogy instantiated in this course serves as a model for reimagining General Education courses as the space for student action because students have many lines with which to entangle themselves. These entanglements are key to integrating kinshipping into one's pedagogy and one's presence in the university. Students diffract their own self-narratives, yes; however, they also diffract their position inside the institutions of western medicine and higher education. Because we question who and what makes our engagements and our performances in the course possible, both in

³² James Barry was a practicing physician who was discovered "to be female" upon their death. Students writing on Barry are encouraged to explain which pronouns they use and why, as well as explain their opinion on the outing of individuals from the archive.

³³ Henrietta Lacks's cervical cells were the first used as a standardized human cell line in medical research. Her cells were not taken with her consent, and Lacks's family never received compensation.

³⁴ Florence Nightingale is hailed as the "mother of modern nursing," yet her rationale for many sanitary reforms are racist in nature.

³⁵ Rosalind Franklin took the first x-ray crystallographic image of DNA, but, not realizing she had, placed the image in her desk drawer. Jim Watson and Francis Crick later took this image and used it to publish the results in *Nature*, which led to their receiving a Nobel Prize.

³⁶ Lavender, honey, and cinnamon all feature heavily in early modern medical receipt books. Honey in particular has been re-established as potentially antimicrobial.

discussion and in a section of their final, students and teacher explore together the sacrifices of others needed to engage in the critical work we do. In other words, we ask who has historically been in this classroom, who is in it now, and who is still outside the room.

Furthermore, requiring students to use their academic skillsets, i.e. research and argument, to practice some critical social justice work connects the content and such skills to the ongoing sociocultural climate. While I did teach this course prior to 2020, wherein U.S. civil rights and public health reach(ed) a breaking point through the Covid-19 outbreak and public calls to defund the police, the inclusive reading list and intersectional approaches used would not change. Indeed, to participate, either as public leaders or citizens collaborating with public activists, students need practice seeking out erased stories and arguing for those to be reintegrated into public consciousness. I used the following prompt for both papers:

Papers

I require both papers to follow 8th Edition MLA formatting. Our Milner Library has many copies of this updated format and style guide, as well as online resources to ensure your ability to access the information. Unless it is a complexity not clearly addressed in these resources, please do not ask me to “check your formatting.”

***Wikipedia* is not sophisticated enough of a source for college-level research and should not be a pillar of your research.**

The due dates for these papers are listed in the Schedule section of the Syllabus yet might be updated in subsequent revisions. Note that I will never move the due date forward but could move it back.

In 3-4 pages, you’ll complete biographical research on a woman OR a medicinal substance we’ve encountered in our materials. You’ll address her/its contributions to the field of medicine, any texts she/it produced, and the impact her/its contributions have made on our present. **I’m looking for you to explain how your sources prove her/its significance to the history of medicine.**

We’ll briefly visit some examples of whom I consider acceptable subjects in class, but your job is to locate relevant individuals, to demonstrate primary research skills, and to craft an argument as to this individual’s importance to the history of medicine and health. Thus, focus on producing a **convincing paper as to why this individual should be recognized for their importance**, rather than writing a report that reiterates basic biographical data.

Example Theses

Good: Moldy Mary’s contribution to western medicine should be recognized because without her work, we would not have a mass-producible strain of penicillin.

Not-so-good: Moldy Mary found the melon that we got penicillin from and that’s important. *[Needs why answers: why is the melon important? Why is penicillin important? Why is Mary’s finding the melon important? Etc.; nothing convincing provided]*

Even Better: The devaluing of Moldy Mary's work in the history of western medicine provides an example of how scientific heroism excludes women. [*Sets up an elaborate, staged analysis of Mary's life/ work in which you also demonstrate your critical thinking in relation to scientific heroism.*]

Nonhuman example: The devaluing of the melon in Moldy Mary's story illustrates how nonhuman subjects are not recognized as major contributors to human health and wellness.

Even Better nonhuman example: The melon in Moldy Mary's story is as important a scientific hero as Alexander Fleming or Mary Hunt; however, the human-centric nature of scientific hero narratives renders this fruit's contribution largely forgotten. [*Sets up a unique "why should we not forget nonhuman participants" argument*]

Research for this assignment might start with one of the texts in our course, but it should not end there. I expect you to consult academic sources, such as any published scholarly biographies on your subject, *Biography and Genealogy Master Index*, *Who's Who*, *Women Writers Online*, *Women and Social Movements in the United States, 1600-2000*, and various national biography dictionaries. Useful books include *Women Healers* by Brooke and *Women and the Practice of Medical Care in Early Modern Europe, 1400-1800* by Whaley.

Of course, you're invited to make use of the primary sources the Milner Library has (they have quite a number!). If enough students are interested in pursuing this route, we can arrange for a group visit/ workshop. You're also welcome to consider nonhuman subjects as potential topics (i.e. aloe juice, balms for breast cancer, corsets).

All sources should be listed on a Works Cited page, which does not count towards the required page length for this assignment.

Your first and second papers should be different subjects but will be the same thesis—why is your subject significant to the history of medicine? Why should we remember her/it?

OMG Where do I start???; or, This paper makes me want to puke!!

If you are panicking after reading this assignment sheet rather than thinking about potential subjects, *come to my office hours*. Let me help you—it's my job!

Importantly for the students, I provide example theses and explained that I am not looking for a report but an argument, which I also reviewed in class. We reviewed the troubleshooting component of the assignment sheet and practiced drafting theses together. Doing so helped students understand that their choice of subject is key to writing a strong paper as believing in their subject's importance and value would inherently strengthen their argument; reviewing argumentation and thesis drafting in this way proved far more useful to students than badgering them with the question, "So What?," which is how I had been taught as an undergraduate student! Importantly for my goals as a feminist teacher, selecting their own paper subject meant students exercised agency in this course, albeit agency limited by the nature of assessment and grading. Nonetheless, self-selecting paper subjects meant students practiced the academic activist

work of inclusive history practices and that students had to be active knowledge producers either inside or outside the classroom. Having to decide themselves who/what is included or excluded meant students *felt* that decision and its implications. This experience prepares and braces students for the activist work they may take on, or for the decisions they may make as employers and managers, or for the petitions they may make for integrative and inclusive practices.

I required students to produce a scrapbook as their final exam. It consisted of four parts: Acknowledgements, Review, New Materials, and Explanation. The Acknowledgements section sought to engage students in problematizing notions of their own individualism by mapping out clearly who/what sustained them, supported them, and/or contributed to their performance in the course. I hoped this would be an opportunity for students to engage in self-life writing as a critical act of producing knowledge; the remaining parts of the scrapbook build upon this sentiment as students re-view what they self-identify as important in the Review section, supplement these subjects with academic research articles in the New Materials section, and describe how their puzzle fits together in the Explanation section. Because the students interweave their own lives with those they interact with daily and with the course's subjects, my teaching exercises a posthuman feminist pedagogy.

Conclusion

The resistance to feminism, in part from the aforementioned negativity, and the resistance to critique of a system established to sustain lives, stems from identical cultural issues; the seemingly contradictory sentiments actually beg further inquiry into public pedagogy because of the ways in which people are taught to feel about a particular issue. For example, during the 2020 COVID-19 pandemic, which is when I am writing this chapter, there is an ongoing public debate about wearing personal masks in public. One position is that not wearing a mask is a

personal choice, and its rebuttal is that, because wearing a mask protects others rather than oneself, it should not be a personal choice to wear a personal mask in public. This course did not foreshadow a pandemic by any means; however, by asking students to problematize notions of individualism and to view contemporary problems with an historical perspective, students in this course learn to apply its lessons to this public health issue, as well as others, and think critically about such an oversimplified public debate. While epidemics, pandemics, and other infectious disasters are not the central thread of this course material, the approaches and skills taught in this course could be applied easily to the COVID-19 pandemic, as well as other futures and histories alike.

A course asking students to appreciate the diversity and complexity of western medicine, erasure of women and minorities from medical history, and how to redress erasure should also ask students to recognize the work done by activists in the past (and the work being done now), to appreciate it while noting that work's limits and flaws, and, consequently, to initiate improvement of this work. Because feminist health activism seeks to resolve issues in medical practices, the two practices are forever entangled. A posthuman feminist pedagogical approach begins the work of purposefully untangling and re-tangling histories.

English 160
Introduction to Studies in Women's Writing
"Women Medical Writers/ Writing Women's Medicine"

Instructor: Krista E. Roberts

Office: 201F Stevenson Hall

Office Hours: Tuesdays and Thursdays 11am-12pm (but always by appointment)

Email:

[@kristaeroberts](mailto:kristaeroberts)

Overview

In this course, I ask you to rethink what gets to count as "literature" and "writing" with the goal of meeting women on their own terms, at the site of their own, often unrecognized, participation in literature, writing, and knowledge formation. That means that we will be reading non-traditional texts, such as receipt books, letters, diaries, and portraits so as to learn the names of some women who contributed to medicine and what they contributed. We will address women in medicine from two perspectives: (1) How women contributed to healing practices, how they were denied participation, and how these roles reflect historicocultural concerns; (2) How ideas about individualism negate, erase, or deny these contributions and histories.

To do this, we'll consider the formation of the western medical field via the first universities in the Early Modern Era and how women's participation was forced out of this space, then we'll travel to North America and read about Indigenous medicine to consider how women were/are seen as forces of healing. We'll read about how slave women we forced to participate in medical "developments" in the Antebellum South (U.S), and we'll read about Filipino nurses being forced to travel to the U.S. There is much more out there regarding medicine and women's writing, and I hope that you feel encouraged to pursue it should you care to do so.

This course is interdisciplinary. I see it as part Medical History, part Literature & Cultural Studies, part Gender Studies. You likely will notice different disciplinary intersections, and I encourage you to share such relevant observations. This enriches the experience of this course for all of us!

By the end of this course, students will be able to:

- ❖ Challenge basic assumptions of the history of medicine, particularly regarding women & minority participation
- ❖ View contemporary problems with an historical perspective
- ❖ Demonstrate skill in oral discussion, critical reading, primary research, and written argumentation
- ❖ Describe the role(s) of women in medical institutions and recognize the impact of meaningful and inadvertent exclusion
- ❖ Recognize the historical and cultural connections between medical practices and medical texts
- ❖ Problematize notions of "individualism"

There is much to cover, and we won't be able to cover it all unless you participate in our course discussions. And, to participate actively in our course discussions, you need to keep up with the readings.

This course is designed like a survey in two ways: we cover a number of historical time periods in one semester, and we cover a number of cultural contexts in one semester (though all of these contexts are anchored to our position in the United States). At times, this course might feel like a road trip; we'll drive by a number of cities and know where they are, but we'll only stop briefly at a number of them. It is my hope that you take up exploring the "cities"/contexts that we drive by further on your own and use this as fodder for class discussion.

How is this a "Women's Writing" course?

Higher education is changing. Literary Studies is changing, too. Previously, one could expect to only take courses on "great" authors or literary movements. The trouble with using this layout in a Women's Writing course is that it can mislead students into some of the following assumptions: some authors are held as unique contributors to literature (and we must read and appreciate their texts in spite of whatever nasty behavior the author engaged in), an author's embodiment is falsely held as a predictor of the text they will write (i.e., "women write about x, y, and z in a, b, or c fashion), everyone other than a white western straight man did not participate in knowledge making until Feminism, and so on.

As a response, this course provides a specific context in which we can explore the skills of retrieving "lost" people. Instead of only reading novels by someone like Virginia Woolf or Margaret Cavendish, we read what women were *writing* while everyone else was published. This works to build your skill in critical thinking by asking where we can find evidence of influence. In doing so, I do not mean to suggest that "big name" authors are unimportant, but rather, I find that in order to adequately prepare undergraduate students for future endeavors, we must involve critical reading, critical writing, and critical researching narrowed by a specific context.

I have designed the course with its required enrollment in mind in that, whether you're interested in the subject matter or not, you can still learn from this course. Likewise, if you're at a research and learning skill past the 100 level, the subject matter is likely to engage you at some point.

I'm not a doctor/ nurse/ medical practitioner! How will I pass this course?

You do not need to have extensive medical knowledge to pass this course—we focus on finding participants rather than applied medicine. That said, if you find yourself returning to a particular medical subject, then I encourage you to investigate on your own!

I do not encourage you to practice on yourself or someone else any of the medical procedures or to consume any of the medicinal substances we read about in archival materials without first consulting your doctor.

What “Safe Space” means in this course

We are all *trying*—sometimes we misstep, misspeak, disagree, succeed—and you should contribute to ensuring a “safe space” for everyone. This means treating each other with respect, tolerance, and consideration. If you disagree with an idea someone presents, state your objections to that idea civilly and avoid attacking the person presenting it. This also means *listening* when a peer attempts to explain how you inadvertently offended them, should that be the case. Just because you are uncomfortable does not mean that you are unsafe.

This course is not an attempt to change anybody. Instead, I expect you to be capable of academic regard and civility for the perspectives presented in this course. What you do outside of this course is your business.

All opinions *are not equally valid*, but all should be treated seriously. Opinions need to be measured or evaluated against available information, data, authoritative comments, expert experience, etc. Academic civility includes not disrupting class discussion or presentations by leaving early or coming in late, talking out of turn or to your neighbor, and not making “fun” of unfamiliar material or perspectives.

“Safe space” does not mean that you are not accountable for your actions/ words/ opinions, or that you have to always agree with the instructor. Your presence in this course means that you agree 1. To recognize what your *emotional* reactions are/might be, and 2. To ensure that your reactions do no harm to your peers, to yourself, and to me.

“Passive aggressive” and/or attempts to undermine another’s position will not be tolerated and may result in failure of the course. As the Instructor, I reserve the right to shut down any conversation taking place in the classroom; refusal to abandon conversation deemed inappropriate may result in your dismissal from the classroom and, indeed, from the course.

A Feminist Guide to Undergraduate Studies

Adapted for the undergraduate classroom from Sarah Wasserman’s “A Feminist Guide to Graduate Studies (and Beyond).”

The term ‘feminist’ here does not depend on your definition of gender: whether you think gender is fixed or fluid, biological or socially constructed. Practicing a feminist mode of intellectual engagement in the undergraduate classroom means creating a respectful environment in which collaborative work and equitable exchange lead to shared learning. You are responsible for your behavior.

Self-reflection is key. Pause to ask yourself questions about your expectations and behavior:

-Do I allow space for others to contribute? Do I recognize that others might require more time to enter a conversation than I do? Do I push myself to contribute to discussions even when I’d rather remain quiet?

-Are my tone and body language conducive to respectful and productive exchanges? Do I tend to assert myself more forcefully around specific people? Do I apologize or self-efface unnecessarily? When I speak, do I seek to overshadow or to get revenge on someone else?

-Do I approach texts and discussions with an open mind—not to demonstrate my knowledge or intelligence but to learn from the text and the conversation?

-Do I accord the same amount of authority and respect to female faculty as to male faculty? To female writers? To female classmates? (same for openly LGBTQ+, people of color, and nonnative speakers)

-Of whom do I ask affective labor?* When I want to share personal concerns or need emotional guidance and reassurance regarding professional issues, am I thoughtful about who I approach, when I do so, and how I ask for such help? Am I mindful that affective labor is labor?

-Do I accept that I will make mistakes? Do I accept that others will make mistakes? For learning to happen, we must accept and forgive mistakes. Despite our best intentions, we sometimes misspeak, misjudge, and offend. We should not allow a fear of such actions to paralyze us. Think of mistakes as learning opportunities and respond to others' errors as you would like them to respond to yours.

Remember that in this community, we are partaking in a shared and collaborative effort: we're in this together!

*affective labor is like emotional labor, which we'll discuss some in this course. Think of those in your life who listen when you need to vent, whom you expect to be a good listener, and how you respond when someone fails to provide affective labor.

Other

Please don't take to using emails to me in lieu of asking questions in class. I usually spend a few minutes addressing any upcoming "big" assignments, and any questions you have should be asked then. Any questions of intellectual substance should certainly take place in class, since that's the reason we're all here and not at home, warm and with our pets. And, of course, please do not email me with a question that is clearly addressed in this syllabus/ in an assignment sheet. By not filling my inbox with excessive emails, you help me answer urgent or personal matters in a timely manner.

I don't much care what you call me ("Krista," "Ms. Roberts," "K-Robs," etc), just as long as you name me something—please don't refer to me as "hey."

Women's and Gender Studies (WGS) Minor

This course counts for the WGS Minor. The WGS notes the value of this minor as being:

"The minor in Women's and Gender Studies (WGS) enhances any undergraduate major by integrating a working knowledge of gender issues with the student's field(s) of study. WGS employs gender as an analytical category, along with race, class, ethnicity, ability, age, nationality, and transnationality to focus on women's contributions to society and the gender implications of cultural, political, and economic processes.

We are engaged in innovative collaborative scholarship, teaching, and service that promotes new knowledge and socially responsible activism. By broadening a student's knowledge base, this interdisciplinary minor has theoretical and practical applications in scholarship, the workplace, and personal growth and relationships as students become global citizens who value lifelong learning and social justice."

To apply please visit: <http://wgs.illinoisstate.edu/academics/undergrad/>

Participation

I expect you to be actively engaging with your peers and with me through verbal participation and that this participation will be relevant to the course. Answer the questions of your peers, share concerns, comment on items of interest, etc. Please do not rely solely upon me to drive the conversation as doing so limits what you get out of this course. If you have a paralyzing fear of speaking in public, come and see me immediately so that we can come up with a plan of action.

In order to run discussion as seamlessly as possible, do make sure you get my attention before you speak. Please do so via the traditional raising of your hand or wiggling your fingers at me. I need you to wait until the person to whom you're responding has finished before you start responding. Thank you in advance for understanding.

As the cost of university study increases, more and more students find themselves with back-to-back courses before heading to work, leaving inadequate or even no time to feed themselves. I do not mind if you need to eat a snack in class to sustain yourself. We're people first.

Assignments

Shorties (7-9) = 40%

Paper 1 = 20%

Paper 2 = 20%

Final/ Scrapbook = 20%

Because this is an English course, I expect all materials to be cited and formatted according to the 8th Edition MLA handbook. Our very own Milner Library holds several copies and has a webpage with examples of commonly-cited sources. If you choose not to use the Milner's resources, **refer *only* to <https://style.mla.org/> for further information. I am particular about this, so please make sure you follow the directions the MLA have laid out.**

Shorties: These are brief assignments graded on a credit/ no credit basis. There will be between seven to nine "shorties" throughout the course: they may be take-home, pop quizzes, 1-page papers, summaries of the reading, term definitions, oral or written, group or individual. The imperative of these assignments is not punitive, but rather, serves to supplement and/or to prepare you for discussion.

Papers: In 3-4 pages, you'll complete biographical research on a woman OR a medicinal substance we've encountered in our materials. You'll address her/its contributions to the field of medicine, any texts influenced, and the impact her/its contributions have made on our present. I'm looking for you to explain how your sources prove her/its *significance* to the medicine.

Final/ Scrapbook: Due when the university schedules our "final exam," you will turn in a "scrapbook" project containing some materials gathered from throughout the semester, new writings/analysis, an "acknowledgements" section, and some visuals. Use as much glitter as you'd like.

Grading & Late Work

We cannot discuss your grade on an assignment until 24 hours after you received it. Remember that you earn your grade by performance, not negotiation. Unless I have made an error in computation, please do not ask me to raise your grade.

Teaching is only one component of my employment at ISU; I also engage in research/publishing, other teaching, service work, and a private life. The due dates have been carefully selected not to interfere with these other components, and I've done the best I can to take into consideration the potential course load you may have in addition to this one.

Thus, I do not accept late work under any circumstances. I *might* provide an extension of a deadline as long as you can argue to me your ability to do the work better with an extension. Extensions ought to be sought well in advance of the deadline, ideally more than 24hrs in advance. This is non-negotiable.

ISU does not allow for the reporting of – or + (A- or C+, for example).

On graded items which are not on a pass/ fail basis (Shorties), I use the following grading schema:

To earn a C, a student must:

- Respond to the constraints of the assignment
- Focus on the topic
- Order parts logically
- Develop parts with sufficient detail
- Develop assertions
- Have a beginning, middle, and end.
- Provide enough elaboration, appropriate examples, and analysis to make the intent understandable
- Have sufficient control of standard written English that errors, including grammar, punctuation, and spelling, if present, do not cause serious confusion

To earn a B, a student must meet the requirements of a C and:

- Provide strong opening and closing paragraphs with clear purpose and sophisticated thesis

Recognize complexities and show evidence of serious consideration of the topic
Support most points with appropriate, well-analyzed examples and intelligent arguments
Show clear logical development and organization throughout
Have few errors. If present, they must not interfere with communication

To earn an A, a student must meet the requirements of a B and:

Support all points with appropriate, fully-analyzed examples and compelling, insightful arguments

Maintain a distinctive voice and consistent viewpoint
Show persuasive logical development and organization throughout
Have interesting, varied, logical sentences
Have nearly error-free writing

A grade of D results from:

Failing to respond clearly to the assignment
Lacking in the qualities listed above
Errors which cause substantial confusion or incoherence

A grade of F results from:

Plagiarism
Significantly failing to meet the constraints of the assignment
Not completing the assignment
Not turning the assignment in on time in its specified format (i.e. emailing a copy, late, rather than printing it and turning it in on the due date)
Two or more faults listed in D above

Attendance

I expect you to be present—physically and mentally. You may miss two classes without it affecting your grade (which is a week of class).

Upon the third missed class, your grade will be lowered by a third (i.e. B to B-). Should you continue to miss class, your grade will continue to decline and your participation grade will obviously be affected, too.

If you fall asleep in class or put your head down, you will be required to leave and will be marked absent. Even if you talk in your sleep, you cannot fully participate if you're not awake. Do not argue with me about this as you'll only steal class time away from those awake and engaged.

Academic Honesty

Don't plagiarize.
Don't pay other people to do your work.
Don't cheat.

If I discover plagiarism or any flavor of academic dishonesty in any of your work for this course, *you will fail the course immediately and I will report the incident to the Dean of Students for university action.*

Required Reading

[*Women and the Practice of Medical Care in Early Modern Europe, 1400-1800*](#)

[*Birthing a Slave: Motherhood and Medicine in the Antebellum South*](#)

[*Red Medicine: Traditional Indigenous Rites of Birth and Healing*](#)

[*Witches, Midwives, and Nurses: A History of Women Healers*](#)

[*Empire of Care: Nursing and Migration in Filipino American History*](#)

[**The Trotula: An English Translation of the Medieval Compendium of Women's Medicine**](#)

You aren't required to purchase all of these, but you do need to read them. If people want to try to share the library copies, that's fine, but please don't offer excuses that you couldn't find the book or that you don't have the book (and thus can't participate)! Remember, too, that used copies are often available through internet outlets.

E-books are available for all assigned texts. If you opt for an e-book version,

1. Make careful note of where key discussion points are (so we can find them together in class)
2. Experiment with the "read-to-me" feature. Listening/noting works better for some
3. Do not be tempted by social media sites or messaging apps on your computer. I expect those seated near you to "snitch" if you succumb to the temptation excessively

If you do not have the assigned reading on the day we discuss it in class, we all expect you to still have extensive notes. Do not rely solely upon the kindness of others for textual references, and we all need you to point us to a specific page/location in order to best understand you.

Useful Resources

Finding Primary Sources

https://nyam.org/library/collections-and-resources/recommended-resources/?utm_content=buffer91f33&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

Understanding Pharmagraphics

https://wellcomecollection.org/articles/WaAiJycAAF2MuN0M?_ga=2.155605555.90522598.1514846474-228591336.1514574725

Further Reading

<https://recipes.hypotheses.org/about>

<http://capone.mtsu.edu/kmiddlelet/history/women/wh-bio.html>

<https://jcswhms.harvard.edu/history>

<https://collections.nlm.nih.gov/?f%5Bdrep2.subjectAggregate%5D%5B%5D=Physicians>

CHAPTER SIX: CONCLUSION

In this dissertation, I have argued that to better understand the tangled, embedded human and nonhuman subjects and how their testimonies function in western medical history, we need to first understand their erasure. By using *relationality* as a reading method, I break apart *who* and *with whom* individuals make medical decisions by considering what constitutes evidence. The Mary Toft case starts my analysis. In the Mary Toft case, *expert witnessing* informs the ways in which a reader trusts what the narrator claims. In other words, the medicolegal conventions of courtroom testimony shape the ways in which medical men wrote their pamphlets. These men shore up their credibility through descriptions of nonhuman animals and of material actants. I found these descriptions to hold either equal or greater credibility than Toft herself, even though Toft herself lied and these descriptions are flawed. Thus, it is through narrative devices that the medical authors of these pamphlets redeem themselves.

I also critically engaged *objectivity* throughout this project. I examine how authors of nineteenth-century medical literatures legitimize their knowledge over human women by controlling access to that knowledge. I also track this phenomenon through to the twentieth century, using a newer genre, patient package inserts, as well as copies of *Our Bodies, Ourselves* to rethink how these texts function as life writing and, therefore, open the medical profession's narrative strategies for revision. Additionally, I found that the medical issues I discuss reach as far back, if not further, into the eighteenth century, particularly regarding the professionalization of medical witnessing and testimony. The emphasis on maintaining *objectivity* and thus explanatory power has, I find, seeped into the intimate spaces of medicine at home and of foodstuff in the nineteenth century. Milk is exemplary since it is commonly acknowledged as a vital source of human health and since it is sourced from nonhuman animals and women alike.

This seepage into the domestic space may appear to be an affront to Victorian values, since the home was the bastion of the family and privacy; however, increased regulation of foodstuff and of public hygiene by the late nineteenth century, coupled with medical science's authority over what it means to be *clean*, meant that the middle classes soon undertook to clean their personal spaces—inside and outside the body. In short, this permeation was not seen so much as an offense to the sanctity of the private, domestic space as it was considered a righteous protection of public health. One kept oneself clean, inside and out, for the sake of the greater good. These observations about sociocultural anxieties are important to medical narrative study and to nineteenth-century studies because Victorian medical literatures were written with the distinct purpose of aiding nonprofessionals with medical decisions. Including these genres, and the other pamphlets, inserts, and later manuals, as critical life writing samples in this study brings a fresh perspective to the study of medical testimony that illuminates many scholarly fields, such as life narrative and medical humanities. We must include these materials in scholarly study if we are to better understand how and why human and nonhuman subjects, and their testimonies, grow into the very evidence used to control the lives of both.

I continue to critically engage *objectivity* in the fourth chapter. After successfully erasing the intimacies between women and health, women and nonhuman animal, and women and knowledge, what is left is whose fault disease is. Is it the fault of the practitioner? Or is it the fault of the patient for behaving in an unideal manner? I find it is implicitly the latter. As I apply relationality and critically engage objectivity, I find that in the twentieth century examples of patient package inserts that accompanied early forms of contraceptive pills worked to blame the user/patient for negative drug effects, even in instances where the carcinotropic, carcinogenic, and cardiovascular disturbances were well published within the medical community. This means

that influential medicalized texts western women use to make medical decisions about their bodies can withhold, skew, or mislead through descriptions of the risk(s) of these medications. This clog in the uptake of medical information is thusly used as proof that medical experts are essential to interpreting medical knowledge for patients rather than as proof of needed clarity in the text. The reader, in this project primarily women, always had to or has to rely upon a medical practitioner for textual comprehension.

Such case studies also reveal that the erasure of nonhuman subjects and women from western medical history connects to the practice of narrating credibility. In order to construct himself as credible, the male practitioner intentionally aligns or misaligns himself with contingent and significant others, just as St. Andre did in his pamphlet on the Toft case, and just as the manufacturers of Enovid did in the very first contraceptive pill packaging. These works are not acknowledgements of whom and of what makes our knowledge; rather, they are instead short biographies on the greatness of man, or of a man. Such built-up reputations are then used as the rationale for making medical decisions on behalf of others and for legal protections.

I have also argued that this patient-practitioner dynamic has been reified in western knowledge production. Indeed, I find that potential resolutions to the issue of obstructing knowledge flow have failed. For example, as I discuss in chapter four, the foundational second wave feminist title, *Our Bodies, Ourselves*³⁷, now mimics the very same narrative strategies it once rebelled against. This mimicry highlights an important misalignment within American

³⁷ In the 1970s, the Boston Women's Health Book Collective wrote and distributed *Our Bodies, Ourselves* in response to patriarchal control over medical knowledge of women's bodies. As I explain in chapter four of this dissertation, this title saw many editions and now exists online as a website. Sometime after the 1984 edition, the title begins to back away from its message of patient independence and to move towards the problematic patriarchal, doctor-knows-best rhetoric that brought this title into fruition.

feminism's long-term goals and its strategies to achieve those goals. In other words, American feminist health activism, in using these same narrative strategies to construct its own credibility, either mistakenly or purposefully erases women and nonhumans involved in knowledge making. This mimicry, though, appears to validate this second wave feminist title and its authors in the eyes of western medicine. That said, I understand this validation as a step backwards. Because *Our Bodies, Ourselves* takes on the narrative strategies in later editions that position the reader as helpless, the text as facilitative, and western medicine as the most authoritative, the battle to unseat medical patriarchy's hold over our bodies has been lost.

In the fifth chapter of this dissertation, I propose that a step to redress the oppressive practices discussed in this dissertation is to teach students how to read against exclusions. Thus, I redesigned English 160: Introduction to Studies in Women's Writing as "Women Medical Writers/Writing Women's Medicine." In designing this course, I develop a posthuman feminist pedagogy by building upon Karin Murrin's *posthuman child* to reimagine what characterizes an active student. This reimagining allows me to develop a course that introduces students both to the troubles and contradictions within our very own western medical culture and to the scholarly practice of critical intersectionality as a research strategy. My course design brings students to bear the *bad news* of western medicine's oppressive histories, which are our own oppressive histories. Bearing this bad news means asking students to locate themselves within a western medical context, particularly by challenging what it means to be an individual. The design of this course especially affects life writing pedagogies and the design of life writing courses as I use archival materials in the classroom. Furthermore, the assignments students complete require them to pursue archival research on their own to argue for/against a particular subject's

significance to the history of medicine. By practicing such research and argumentation, students may convert the academic skill of argumentation into the social justice skill of advocacy.

Teaching these skillsets to undergraduates differs from other solutions medical narrative scholars have suggested. In *Teaching Literature and Medicine*, which is part of the Modern Language Association's Options for Teaching series, Anne Hunsaker Hawkins and Marilyn Chandler McEntyre list three reasons for including courses in literature and writing in medical school curricula: one, such courses "teach physicians how to listen more discerningly to their patients' stories," two, literary study may help confront a physician's "assumptions, biases, and preconceptions" all of which affect how a text/patient's story is interpreted, and three, "literary skills enable physicians to think both critically and empathetically about moral issues in medicine" (5). Hunsaker Hawkins and McEntyre do not include nonliterary genres, like the ones I studied in this dissertation, in their reasoning for including literary study in western medical curricula. It is important to include nonliterary medical genres in medical narrative courses because such texts are, as I've shown, where the interpretation of patient/illness happens. Author/practitioners interpret, assume, and preconceive descriptions based on these nonliterary genres, so it makes sense to study those very texts. Thus, if we are to truly think critically about moral issues in western medicine, as Hunsaker Hawkins and McEntyre suggest, then we must include the sites at which these moral issues are brought to fruition. Excluding such nonliterary medical genres means medical practitioners are not engaging fully with the benefits of literary study since they would not be considering how credibility and objectivity affect the interpretation of medical knowledge.

That said, I further disagree with Hunsaker Hawkins's and McEntyre's reasons. I do not think that medical narrative should be exclusive to medical school alone³⁸. For example, the most prominent program in narrative medicine, Columbia University's Master of Science in Narrative Medicine, targets medical practitioners. Each of the brief descriptions of Core Courses in this program either mention clinical applicability or, more specifically, using narrative medicine as a means to better question patients (*Narrative Medicine*, "Curriculum and Courses"). While informing medical practitioners of the implications of their narrative use is essential, this is by no means an integration into medical school curricula, nor does it involve the historical burden, nor does it involve how to do integrative work. Thus, interventions must begin at an earlier stage, which I suggest is at the general education undergraduate level. There are also ethical questions about developing a program with the explicit intention of manipulating an intersectional tool to serve one's professional career, but such questions are for future study.

Because it is not the sole responsibility of medical practitioners alone to fix issues of disclosure, erasure, and oppression, it is important for us, as patients and medical subjects, to understand when these forces are at work in our own interactions. Self-advocacy is crucial, too. Medical practitioners are not capable of fixing this issue alone since they have a reliance, indeed an *over* reliance, upon the concept of objectivity. Recognizing our own import and relevance empowers us. While Hunsaker Hawkins and McEntyre cover the benefits of literature and medicine courses in the undergraduate setting, their considerations reflect the need to involve how constructions of self and of other affect medical knowledge.

³⁸ While Hunsaker Hawkins and McEntyre do not outwardly state that medical narrative should be exclusive to medical school, the primary focus of their introduction and their selected inclusions in *Teaching Literature and Medicine*, which is published by the Modern Language Association, involve integrating formal literature into pre-med and medical curricula.

As I state in the introduction, without better understanding the influence that credibility and objectivity have had on western medical narrative, we cannot fully appreciate the implications of practitioners presuming to formulate patient narratives, and, thus, presuming that medicine as a profession can best help anyone grapple with illness and dying. Therefore, my problem with the Modern Language Association's *Teaching Literature and Medicine* collection is precisely where the fifth chapter, and the entire dissertation, intervene. I have not set out to perpetuate new categories of disease/being, but, rather, I have set out to challenge the explanatory power western medicine presumes it holds over the ways in which we tell lives, and we treat lives—human and nonhuman. We must be sure to acknowledge the nonhumans involved, too, if we are to better appreciate the effects of medical decisions, because these lives affect how we understand medical heroism, objectivity, and medical evidence.

The U.S. public is already skeptical of our current approaches to medical decision making. A 2019 Pew Research Center report finds that across the U.S. “there is widespread skepticism among the public when it comes to issues of scientific integrity” (“Trust and Mistrust” 14). These questions involve how much medical research scientists “care about the best interests of the public,” “provide fair and accurate information,” and “admit mistakes and take responsibility” (“Trust and Mistrust” 15; 7). Indeed, this report finds that 38% of adults believe medical research scientists admit mistakes and take responsibility only a little/none of the time, 48% believe medical research scientists admit mistakes and take responsibility some of the time, and 13% believe medical research scientists admit mistakes and take responsibility all or most of the time (Pew, “Trust and Mistrust” 33). These data complement another finding in an earlier report: “a majority of Americans say that when they make decisions about treatment for a serious health problem, they do their own research in addition to seeking advice from a doctor or

other health care provider” (Pew, “Vast Majority” 26). This report strongly suggests that the U.S. public understands the value of medicine as a practice, yet sometimes seeks ways to learn medical knowledge themselves. This dissertation offers a modest explanation for the attempts to step around the practitioner’s role in the knowledge transaction. *Our Bodies, Ourselves*, which was once a feminist tool with which the public could learn reliable medical knowledge for themselves, has, as I show in the fourth chapter, taken steps back toward practitioner-controlled information in later editions. These findings are of particular importance to our twenty-first century context; with so much *unreliable* medical(ish) information available online, why would the publishing collective of *Our Bodies, Ourselves* let their foundational title take such a backwards step? Further research is needed, as full access to the Boston Women’s Health Book Collective archives at Harvard University’s Schlesinger Library would be required; however, based upon the findings of this dissertation, I speculate that the “backwards step” is at least somewhat informed by medical malpractice legislation.

Keeping-with the trouble, to use Donna Haraway’s term, means harmful misconceptions cannot gain traction, and it means anxieties and concerns of all gain respect. A larger, future study to extend the work initiated by this dissertation would add breadth to our knowledge of the ways in which nonhuman life writing exists, where it exists and where it does not, and more. This dissertation contributes to that kind of foregrounding scholarship and begins the labor of unpacking nonhuman life writing acts which run concurrent to human attempts to narrate the unnarratable (trauma). This dissertation, for me, has been a long and deeply personal process. To return to and to revise the National Academy of Medicine’s fundamental incongruity with which I started this dissertation: *many* medical subjects make evidence, yet medical decisions are made by *individuals* for *many*. Part of this revision means recognizing the roles subjects, others,

materials, practitioners, and patients all play simultaneously in the testimonies we use to make our decisions.

During the time I have worked on this dissertation, I have seen the citizens of this country reveal their divisions across many public issues, and, particular to this dissertation, the role experts, expert knowledge/testimony, and public health play in that division. I say this because, as I close this project, I feel I need a way to acknowledge that I am writing amid global pandemics of COVID-19 and of misinformation. I originally sought out to question how medicolegal evidence shapes how we think about women's bodies and what women say about their bodies. This project has taken natural turns toward the implications of medical objectivity as I've worked on it, and it is bitterly timely. If the U.S. is going to begin to heal the divisions of "how they view the value and objectivity of scientists and their ability to act in the public interest" (Pew, "Trust and Mistrust" 14), we need to start by acknowledging the many involved in medical decision making and to start taking responsibility for medicine's mistakes.

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