

# Mother and Child Were Saved: Justifying the Caesarean Section in Nineteenth-Century England

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## Abstract

The Caesarean section has one of the longest continual medical histories. It has been recorded in antique medical texts, practiced throughout the medieval era, and utilized as an operative tool in modern medicine. Historians frequently understate the omnipresence of Caesarean sections by omitting the nineteenth century, instead presenting a distinct gap between medieval techniques and the “modern” operation. This implies that during the nineteenth century, physicians avoided performing the operation. However, there is historical evidence that practitioners utilized Caesarean sections prior to the discovery of anaesthesia and asepsis, despite its low survival rate. This article seeks to explain how medical practitioners selected and justified these techniques through an intensive examination of nineteenth-century medical journal articles. It focuses on the way that communal decisions, elevation of patient consent, and acknowledgements of foetal life contributed to a narrative of operative permissibility. It demonstrates the importance of the nineteenth century in establishing a mentality that justified and normalized a dangerous operation and paved the way for twentieth-century revolutions in technique.

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In 1878, the physician Henry Morris presented a case of patient death to his peers. Morris published an article entitled "Clinical Remarks on a case of Caesarean Section" in the prominent British medical journal, *The Lancet*.<sup>1</sup> He described the procedure and risks of the operation positively and then nodded to the existence of his patient. Morris informed his peers: "I regret, gentlemen, I cannot bring the patient upon whom this operation was performed before you. As in too many cases, she does not live to justify by her presence the treatment adopted to save her. I have only

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<sup>1</sup> Primary documents from the period under study alternate between spellings of 'Caesarean'. Sometimes the latter is used, but 'Caesarian' is also used. In this paper, I will use the more modern spelling of the former, but retain the latter spelling in quotations as used in the original material.

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these inglorious witnesses of its performance [namely] the faulty pelvis and the foiled uterus."<sup>2</sup> Despite Morris's positive evaluation of the potential and necessity of the operation, he did not have a record of success to support his claims. Nor did he consider an explicit success rate necessary, claiming that, "though the Caesarean is the most dangerous of operations, though 85 percent of the mothers and 49 percent of the children die, we must not be deterred from undertaking it in appropriate cases."<sup>3</sup> This unusual technique of differentiating necessary intervention from measurable success characterized nineteenth-century Caesarean sections. Morris typifies the perspective of nineteenth-century obstetric operators in his description of the patient as a statement to his successful judgment in ordering an operation and diffusion of blame for her death.

Caesarean sections were performed prior to the dispersal of knowledge on asepsis and anaesthesia and despite a lack of physiological knowledge about the nature and function of the uterus during labour.<sup>4</sup> Historians who understand surgical advancements in terms of successful operations thus tend to ignore the significance of the mid-nineteenth century as a period of theoretical development. However, as the case of Henry Morris demonstrated, the low survival rate of the operation did not deter practitioners from considering it to be a "necessary" procedure. The contribution of the nineteenth century to the history of Caesarean section was in the construction of a dialogue of possibility in which the Caesarean should be necessary in certain cases, and could result in the survival of both mother and child. This dialogue contributed to and enveloped advancements in surgical practice and led to the twentieth-century pronouncements of "successful" Caesarean sections in which the operation consistently saved both mother and child.

Due to the long history and many interpretations of the Caesarean section, it is necessary for me to be explicit in the terms of my study. Henry Morris defined the operation as consisting of "laying open the abdomen of the mother for the purpose of removing from the cavity of her womb the child which, from one of many causes, cannot be expelled or withdrawn through the natural outlet."<sup>5</sup> To this definition I will add that, for the purposes of this paper, that the operation must penetrate both the abdominal and uterine wall, excluding ectopic pregnancies. I have also chosen to limit my research to "conservative" Caesarean sections, which aimed to preserve a functional uterus after the operation, thus dismissing the trend of "Porro" operations that involved the extraction of the child and then total hysterectomy.<sup>6</sup> During the nineteenth century, there was no universal method for performance of the Caesarean

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<sup>2</sup> Henry Morris, "Clinical Remarks on a case of Caesarean Section," *The Lancet* 111, no. 2850 (April 13, 1878): 527, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)43540-4](http://dx.doi.org/10.1016/S0140-6736(02)43540-4).

<sup>3</sup> *Ibid.*

<sup>4</sup> Dyre Trolle, *The History of Caesarean Section* (Copenhagen: C.A. Reitzel Booksellers, 1982), 42.

<sup>5</sup> Morris, "Clinical Remarks on a case of Caesarean Section," 126.

<sup>6</sup> J.H. Young, *The History of Caesarean Section* (London: H.K. Lewis & Co. Ltd., 1944), 43.

section. Instead, it was usually taken as an operation of last resort, particularly when the female genitals were malformed and thus natural labour was impossible. This technical uncertainty did inspire discussions of proper technique, most specifically the question of where to make incisions during the operation. My paper focuses on the decision to initiate surgery and post-surgical justifications, and I have chosen to omit further discussions of technique from this paper.

My thesis is in direct opposition to the treatment of the nineteenth century in popular historical surveys of the Caesarean section. In *Get Me Out*, Randi Hutter Epstein indicated that there were four precursors to successful modern surgery: the discovery of germs and response of asepsis, the introduction of anaesthetics, the rise of hospital births which produced higher doctor control over labour, and an increased need for intervention due to physiological factors like rickets.<sup>7</sup> These innovations and conditions developed over the nineteenth century, but did not gain prominence or consolidation until the twentieth century. In distinguishing eras of the operation most historians have created divisions in the style of J.H. Young, who divided its history into three stages: operations performed prior to 1500, those between 1500 and 1876, and those from 1876 onward.<sup>8</sup> He determined these periods as first, post-mortem attempts to save the child; second, early attempts on a live patient; and, finally, "the development of the modern technique."<sup>9</sup> Historians like Carter and Duriez perceive the nineteenth century as a period of developmental stagnation, with unchanged obstetric techniques until the 1870s.<sup>10</sup> Indeed, most historians have dismissed the relevance of the Caesarean section in the nineteenth century. In *With Child: Birth Through the Ages*, Jenny Carter and Therese Duriez indicate that "despite isolated successes, ... [the operation] only became viable at the end of the nineteenth century."<sup>11</sup> Irving Loudon presents a similar perspective, claiming that the "nineteenth century would turn out to be more a period of stagnation than progress in maternal care" and that "the practice of obstetrics... was virtually the same in 1870 as it had been in 1780."<sup>12</sup> Ann Dally went so far as to omit mention of nineteenth-century surgery, claiming that the "operation that has become increasingly popular during the twentieth century is Caesarean section."<sup>13</sup> My research indicates that despite these perspectives, nineteenth-century obstetricians did consider Caesarean section to be a permissible tool in their arsenal of delivery

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<sup>7</sup> Randi Hunter Epstein, "From Kitchen-Table to the Art of the C-Section" in *Get Me Out: A History of Childbirth from the Garden of Eden to the Sperm Bank* (New York: W.W. Norton & Company, 2010), 159.

<sup>8</sup> Young, *The History of Caesarean Section*, 22.

<sup>9</sup> *Ibid.*

<sup>10</sup> Jenny Carter and Therese Duriez, *With Child: Birth through the ages* (Edinburgh: Mainstream Publishing Co., 1986), 119.

<sup>11</sup> *Ibid.*, 38.

<sup>12</sup> Irvine Loudon, *Death in Childbirth: An international study of maternal care and maternal mortality 1800-1950* (Oxford: Clarendon Press, 1992), 172.

<sup>13</sup> Ann Dally, *Women Under the Knife: A History of Surgery* (London: Hutchinson Radius, 1991), 211.

techniques in complicated births. They published papers detailing their procedures despite the low statistical rate of success. My research question does not deal with the existence of the operation in the nineteenth century, but instead why it was selected and how physicians and surgeons justified their use of the operation.

O'Dowd and Phillip indicate that "the [Caesarean] operation was very slowly becoming slightly more popular, or perhaps slightly less unpopular" during the nineteenth century.<sup>14</sup> To understand this shifting popularity, I have examined the nineteenth century as a site of discussion and rationalization about situations and patients who required surgery. I focus on the nineteenth century because prior to this period there is little direct evidence indicating the regular performance of Caesarean sections by surgeons.<sup>15</sup> In doing so, I examine the nineteenth-century process of transition toward the modern operation. This paper can be loosely divided into five sections, each exploring a crucial feature of the developing narrative of justification for Caesarean sections. I begin with a brief history of the Caesarean section and the unique English history of obstetric intervention. This contextualizes debates over the necessity and validity of the operation. Next, I explore the way that physicians decided upon the performance of the Caesarean section, looking at the way that these men acted as a collective to impart authority and share responsibility, the way that the rise of physical examinations allowed them increased knowledge of the subject, and the terms in which the Caesarean was deemed an appropriate form of intervention. Third, I examine the role of the female patient and the issue of consent, particularly the way that women were described in articles as being active volunteers in the surgery. Fourth, I deal with the issue of the unique nature of the Caesarean as an operation capable of saving two lives and the significance of including the foetus as a patient. Finally, the issue of surgical outcomes, either in failing to save one or both lives, or the description of a successful operation, concludes my research. I discuss how surgeons defended themselves against cases of patient mortality and how they described patient survival. Collectively, these sections depict the nineteenth century as a period of discussion and rationalization of an extreme surgical technique.

My sources begin in 1827 and are drawn exclusively from the medical publications of *The Lancet* and the *British Medical Journal*. The starting date is indicative of the first publication of these journals. I have chosen these publications due to the nature of journal articles, which indicate contemporary medical interest but do not necessitate the extensive involvement indicated by the publication of a full book. Practitioners could perform and publish one case of Caesarean section in a

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<sup>14</sup> Michael O'Dowd and Elliot E. Phillip, "Caesarean Section" in *The History of Obstetrics and Gynaecology* (New York: Parthenon Publishing Group Ltd., 1994), 162.

<sup>15</sup> Renate Blumenfeld-Kosinski, *Not of Woman Born: Representations of Caesarean Birth in Medieval and Renaissance Culture* (Ithaca: Cornell University Press, 1990), 41.

journal. Using *the Lancet* and *the British Medical Journal* provides broader access to the way that the operation was perceived by unspecialized physicians. They were selected first by the doctors for submission, then again by the editors "as reports of cases they considered interesting in some way."<sup>16</sup> Published articles also offered surgeons the opportunity to defend themselves.<sup>17</sup> This rhetoric of diffusing blame is an aspect of the normalization of the Caesarean section. The nature of these sources means that my research focuses on the perspectives of the writers, rather than broader social contexts or patient accounts. This bias informs the way I approach the structure of my paper, as well as my choice to focus on medical perspectives rather than social or political. I accept the historical premise that no significant procedural changes occurred between 1827 and 1881, but I also consider it necessary to examine the reality that operations were still reported. The way that surgeons described their patients and justified their operation is interesting to understand in light of this "procedural stagnation." Through examining the relationships between obstetricians, their peers, mothers and children, I aim to construct how surgeons justified performing the operation. I then move to the conclusions and remarks of surgeons, which explain how surgeons defined success and understood patient death. I thus reconstructed the context in which Caesarean operation was made permissible under unfavourable statistical odds of survival.

The nineteenth-century Caesarean section must be understood as a discreet moment within the long continual history of the procedure. Records demonstrate that the operation was performed in both the classical and medieval periods, but only began to emerge in professional dialogues in the eighteenth century.<sup>18</sup> Despite criticism from prominent surgeons like Ambrose Pare, narratives of potential success also began to emerge.<sup>19</sup> In 1581, Francois Rousset advocated the practice of Caesarean and began assembling cases of successful performance. He forwarded the necessity of surgery as a radical and heroic procedure, indicating that amenable preconditions included large, malformed, or dead fetuses, twins, problematic presentations, or narrow female pelvises.<sup>20</sup> However, his case notes all contained hearsay successes; he left no record of successfully having personally performed the Caesarean section.<sup>21</sup> The product of late-medieval and early modern Caesarean section was not physical advancements in technique, but the production of an analogy of feasibility.<sup>22</sup> This

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<sup>16</sup> Sally Wilde, "Truth, Trust and Confidence in Surgery, 1890-1910: Patient Autonomy, Communication, and Consent," *Bulletin of the History of Medicine* 83 (2009): 311.

<sup>17</sup> *Ibid.*

<sup>18</sup> For further information on this subject, please see Katharine Park's, *Secrets of Women: Gender, Generation, and the Origins of Human Dissection* (New York: Zone Books, 2006) and Blumenfeld-Kosinski, *Not of Woman Born*.

<sup>19</sup> See Young, *The History of Caesarean Section*, 25, and Carter and Duriez, *With Child*, 106.

<sup>20</sup> Blumenfeld-Kosinski, *Not of Woman Born*, 40.

<sup>21</sup> *Ibid.*, 41.

<sup>22</sup> *Ibid.*, 46.

concept dismissed mathematical qualifications of success and instead indicated potentiality. Surgeons considered themselves armed with the knowledge and skills to attempt Caesareans without the guarantee of patient fatality.

Continental Europe embraced the procedure of the Caesarean section and integrated it into the canon of obstetric practices. In England, the concern for the safety of the mother was the primary factor in choosing an operation. This primacy was assisted by unique English obstetric developments, particularly the figure of the "man midwife," documented by Adrian Wilson in *the Making of Man-Midwifery*. Childbirth was traditionally considered to be the realm of women, typified by the figure of the midwife who had intimate knowledge of the birthing process and assisted mothers in labour. Men were called into the birthing room only in extreme situations, after extraction of the foetus by women had been attempted and failed. Wilson argues that these early surgical interventions were characterized by the task of saving only the mother, as the child had been dead and often labour had continued for days before the entrance of the male surgeon.<sup>23</sup> However, the introduction of the tool of the forceps shifted the relationship of male medical figures with child fatality. Forceps allowed practitioners to grasp the child's head, reduce its size to mimic the natural moulding process that occurred in childbirth, and exert traction for removal.<sup>24</sup> The assumption of this medical technique provided an alternative to embryotomy through craniotomy. Practitioners could assist the natural process of childbirth with higher access to and control over foetal position. Because of the tools of forceps and a concurrent increase in male education towards female genitals, the figure of the man-midwife could now save children in difficult labours. Wilson describes this as a "benign circle" in which a successful birth inspired women to call in the male figure earlier, creating greater ease in his delivery of the child and ensuring his place in the delivery room.<sup>25</sup> Now welcome and associated with saving both mothers and children in difficult labours, the man-midwife and his forceps displaced both the female midwife and the male surgeon. As a result, man midwives were now allowed earlier and increased access to the pregnant female body. This paved the way for normalizing surgical intervention in pregnancy.

Despite the popularity of forceps, embryotomy remained a consistent feature of emergency obstetric practices in England. Embryotomy was performed specifically through craniotomy by use of a crotchet, which pierced the child's head and drained fluid and brain, allowing for skull compression and producing traction to withdraw a dead foetus.<sup>26</sup> The necessity for preference over embryotomy remained

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<sup>23</sup> Adrian Wilson, *The Making of Man-Midwifery: Childbirth in England 1660-1770* (London: UCL Press, 1995), 50.

<sup>24</sup> *Ibid.*, 65.

<sup>25</sup> *Ibid.*, 97.

<sup>26</sup> *Ibid.*, 20.

prevalent in English medicine throughout the nineteenth century, typified by the perspective of G. B. Knowles that "[t]his, in short, is a general rule, which is invariably kept in view, and acted upon by every experienced and well-informed practitioner; inasmuch as the life of the mother must always be considered as more valuable than that of the child."<sup>27</sup> The mother's life was prioritized over that of the foetus, and intervention maintained her bodily integrity. This concern is pivotal in appreciating the English dialogue on Caesarean section. Any technical or surgical developments had to combat the long-established position that the primary concern of a practitioner assisting in labour was the mother's health. The male-midwife's popularity was an improvement on traditional intervention techniques, not a break of rhetoric. Their station preserved mother's life while also managing to save the child.

In this light, the Caesarean section was a particularly daunting surgical choice because it was a dangerous and frequently fatal operation for the mother, and thus compromised the primary patient of the medical interaction. To protect oneself from blame, the decision to initiate Caesarean section was never described as an individual choice enacted by a physician or surgeon. Instead, article authors made it clear that they functioned as a community of professional observers in promoting surgical intervention over embryotomy. When W.H. Thornton proposed the Caesarean section to his patient, it was after "[t]he case was now seen by three other practitioners [namely], Mr. Alfred Rhodes, Mr. G. S. Rhodes, and Mr. R. N. Halliwell; and as it was the unanimous opinion that craniotomy was impracticable."<sup>28</sup> G.E. Yarrow emphasized the authority and independence of these encounters:

Choice, therefore, had to be made between cephalotripsy and Caesarean section. Under these circumstances, I sought the counsel of Dr. Burchell, the surgeon-accoucheur to the hospital. Upon examining the patient he was of opinion that Caesarean section would give the best chance to mother and child, in which I fully concurred.<sup>29</sup>

Yarrow chose a peer in a position of power and authority and indicated that Dr. Burchell established his own examination before coming to the same decision of treatment. He again distributed the perception of necessity when he indicated that, "On consultation with my partner, Mr. Sidney Turner, it was decided to perform

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<sup>27</sup> G.B. Knowles, "Observation on the Caesarean Section," *The Lancet* 57, no. 1443 (April 26, 1851): 456, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)73990-1](http://dx.doi.org/10.1016/S0140-6736(02)73990-1).

<sup>28</sup> W.H. Thornton, "On a successful case of Caesarian Section," *The Lancet* 69, no. 1752 (March 28, 1857): 314, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)20821-1](http://dx.doi.org/10.1016/S0140-6736(02)20821-1).

<sup>29</sup> G.E. Yarrow, "Report of a Case of Caesarean Section," *The Lancet* 100, no. 2563 (October 12, 1872): 523, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)55545-8](http://dx.doi.org/10.1016/S0140-6736(02)55545-8).

Caesarean section, which was done at 11 A.M. with his assistance and that of Mr. Plimmer."<sup>30</sup> Not only did multiple professionals concur with his profession of necessity, but they also were also indicated as present during the operation and could attest to the described procedures. Peer discussion was an important method of diffusing responsibility. By acting as a collective, surgeons and obstetricians achieved dual aims. First, they protected themselves from litigation by amassing support for their decisions prior to the operation.<sup>31</sup> This protection was particularly necessary in the Caesarean section because the percentage of fatality was so high. Secondly, physicians and surgeons established themselves as an authoritative community who could and did speak to necessary treatments and acted as a coherent whole. To defend against claims of malpractice, surgeons functioned in a group to indicate that they had collectively established that the operation was the only viable choice.

J. M. Munro Kerr et al. reviewed the performance of Caesarean section in the first half of the nineteenth century in *Historical Review of British Obstetrics and Gynaecology 1800-1950*. They perceived that although "the mortality rate was very high [and] indeed, some obstetricians... condemned it out and out ... the majority, however, accepted responsibility for employing it when circumstances were desperate."<sup>32</sup> This sense of necessity rather than practice specialty is indicated in the broad range of practitioners who published their encounters with Caesarean section.<sup>33</sup> The majority of practitioners discussing Caesarean section in *The Lancet* made no claim to particular experience or proficiency. Instead, these operators understood the Caesarean as a final chance to save the mother and child, a situation without alternative. Practitioners like G.B. Knowles stated that in cases of contracted pelvises, "there could be no question as to the mode of practice to be adopted, and even Dr. Lee, I should think, must admit that in such a degree of deformity the Caesarean section was the only alternative."<sup>34</sup> James Hawkins stated that his peers "coincided in opinion with me that the Caesarean section was the most feasible- the only means whereby the life of the foetus could be preserved, and, under the circumstance, the most favourable to insure the life of the parent."<sup>35</sup> The nature of the Caesarean section as an emergency operation allowed surgeons to give a nod to the

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<sup>30</sup> John H. Galton, "Case of Caesarean Section," *The Lancet* 117, no. 3014 (June 4, 1881): 909, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)33467-6](http://dx.doi.org/10.1016/S0140-6736(02)33467-6).

<sup>31</sup> Wilde, "Truth, Trust and Confidence in Surgery," 322.

<sup>32</sup> J.M. Munro Kerr, R.W. Johnstone, and Miles H. Phillips, *Historical Review of British Obstetrics and Gynaecology 1800-1950* (Edinburgh: E & S. Livingstone Ltd., 1954), 31.

<sup>33</sup> In my research, I evaluated at least thirty different authors, including twelve anonymous contributions.

<sup>34</sup> Knowles, "Observation on the Caesarean Section," 456.

<sup>35</sup> James Hawkins, "Successful case of Caesarean operation: mother and child saved," *British Medical Journal* 72 (May 15, 1858): 386-7, accessed March 5, 2012, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2251201/>.

traditional prioritization of the woman's life while still indicating the necessity of the operation. Robert Greenhalgh indicated that,

While fully subscribing to that old established axiom of British midwifery, that under no circumstances should the life of the mother be jeopardised for that of the child, still I shall endeavour to show that there are cases in which the pelvis is so much distorted, and craniotomy and extraction attended with such difficulties and hazards to the mother, that one is certainly bound to consider the child, and give it a reasonable chance of life by performing the Caesarean operation.<sup>36</sup>

Thus, the life of the child became a factor particularly in cases where the mother's life was already endangered. In cases of emergency intervention, morality shifted to examine broader benefits of the operation. In this context, the life of the child could be acknowledged because this consideration did not further compromise the life of the mother. The foetus as a patient emerged as a factor of obstetric operations.

This physician confidence was supplemented by a transition in the way that surgical necessity was defined. In a heading within *With Child: Birth Through the Ages*, Carter and Duriez described the nineteenth century as "medicine becomes effective." They perceived a culmination of eighteenth-century probing of ideas and problems with nineteenth-century advancements and refinements of technique.<sup>37</sup> This contributed to a higher level of physician confidence in their ability to perform surgeries. This perspective was complimented by the ideal that good health could be a normal state of being, which it was no longer necessary to function under perpetual discomfort or pain.<sup>38</sup> The desire to avoid pain opened the door for more radical surgery with the intention to "fix" longer-term problems and terminate pain. Where previously low levels of pain were acceptable, now intervention became appealing. This perspective can be seen in literature on the necessity of the Caesarean section. Henry Morris indicated that, "we ought to operate, though we know the patient will probably die from exhaustion, haemorrhage, blood poisoning, or peritonitis. Death from either of these causes is far less terrible than death attended with the pains of labour going on unsatisfied till either the uterus ruptures or its power is exhausted."<sup>39</sup> The risk of fatality was seen as appropriate due to the potential abbreviation of the experience of suffering. In this situation, the terms of success were in flux. Physicians replaced the primacy of survival with the idea that mediating pain was the ultimate goal, regardless of later consequences. Painlessness was more important than

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<sup>36</sup> Robert Greenhalgh, "A Clinical Discussion on the Caesarean Section: and its claims as an operation of selection," *British Medical Journal* 2, no. 489 (November 30, 1867): 489, accessed March 5, 2012, <http://www.ncbi.nlm.nih.gov/pubmed/20744935/>

<sup>37</sup> Carter and Duriez, *With Child*, 110.

<sup>38</sup> Guy Williams, *The Age of Miracles: Medicine and Surgery in the Nineteenth Century* (London: Constable & Company, 1981), 1.

<sup>39</sup> Morris, "Clinical Remarks on a case of Caesarean Section," 528.

avoiding fatality. Potential patient survival and the rhetoric of necessity to eliminate suffering combined in nineteenth-century Caesarean sections to make the operation appear permissible in emergency cases.

Statements of the necessity of operations were established through physical examination. The inclusion of touch in medical interactions had gradually increased throughout the early modern period. In the nineteenth century physical examinations became an expected norm. As men, physicians and surgeons had traditionally been limited in their access to the pregnant female body. This relationship shifted in the nineteenth and twentieth centuries, as men gained increased access to the pregnant body. In "the Rise of Physical Examination," Roy Porter discusses the increasing frequency and importance of tactile examinations in medical procedure. He indicates that this tactile relationship was a "ritual enactment of the identities of being a doctor and being a patient."<sup>40</sup> Furthermore, he states that the role of a doctor conferred special privileges.<sup>41</sup> In the specific case of the surgeon-accoucher and labouring mother, these privileges included the right to investigate the female abdomen and genitals and make pronouncements about the viability of birth and procedures of assistance. In turn, this access and physicality conferred increased power to the physician. They could impose their knowledge through information gained independent from female bodily self-perception.

The significance of physical exploration indicating the necessity of operation was evident in all the sources. W.H. Thornton described how he had "made an examination per vaginam, and felt what I supposed to be the head presenting, covered by the uterus, and was unable to detect any dilatation, or satisfy myself as to the position, of the os uteri. I discovered that she was the subject of recto-vaginal fistula."<sup>42</sup> The action of touch was also necessary in Dr. Hare's diagnosis; he described,

I could find no entrance into the vagina, nor could I introduce my finger horizontally between the perinsum and uterus, which I had never failed to do in all other cases, however low the presenting body might be. I felt convinced, during the last examination, that the uterus adhered all round the pelvis, and that the vagina was totally obliterated.<sup>43</sup>

These pronouncements indicated that through touching, physicians could establish the untenability of natural birth. This constructed situations in which Caesarean

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<sup>40</sup> Roy Porter, "The rise of physical examination" in *Medicine and the five senses*, eds.. W.F. Bynum and Roy Porter (New York: Cambridge University Press, 1993), 179.

<sup>41</sup> *Ibid.*, 180.

<sup>42</sup> Thornton, "On a successful case of Caesarian Section," 313.

<sup>43</sup> Dr. Hare, "Singular Case in Midwifery," *The Lancet* 9, no. 232 (February 9, 1828): 696, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)92790-X](http://dx.doi.org/10.1016/S0140-6736(02)92790-X).

section was possible because the vaginal canal was either too small or closed. The extent of these investigations allowed for conscientious decision making in which the Caesarean became a surgical fix.

Physical examinations contributed to establishing the nature of the Caesarean operation as a last resort. This extremity was emphasized in published physician accounts. David Johnson described attempting the range of delivery techniques before "finding it, therefore impossible to accomplish the delivery, and feeling assured that it ought not to be delayed any longer," he proposed the Caesarean section.<sup>44</sup> Johnson had "grasped the feet, intending to bring them down and delivery by turning... but ultimately abandoned that idea," attempted craniotomy and found that "although the whole of the brain was evacuated, ...yet with all the exertions we dared use by the aid of the crochet and Dr. Davies's forcepes, [sic] the head still maintained its position."<sup>45</sup> He had thus exhausted the entire repertoire of delivery techniques before resolving to perform surgical intervention in a final attempt to save the mother's life. J.G. Swayne related a similar case in which "[t]urning was attempted, but without success. Craniotomy was then performed; but it was found impossible to extract the head. Finally, the Caesarean section was had recourse to."<sup>46</sup> This spectrum of technique emphasized the finality of the Caesarean section. By the time it was proposed, alternative means of delivery had been discounted. In these cases, the only chance to save the mother lay through the Caesarean section.

It was at the crux of surgical decision making that authors of *The Lancet* articles integrated the patient into the decision making process. Traditionally, the fear of surgical intervention characterized the relationship between female patients and physicians because the introduction of a surgical dialogue in obstetric proceedings indicated abnormality and danger in the birthing process. Women associated operation with bodily invasion, the death of their child, and the knowledge that their own demise was imminent.<sup>47</sup> Despite this tension, the female patient was a predominant and active figure in the reports of Caesarean section and references to patient consent occurred in all of the records of Caesarean operation. The significance of this exchange was emphasized by cases in which consent did not promptly occur, including that of David Johnson. Although he had decided that surgical intervention was necessary, he recalled being "disappointed for several hours, not being able to gain the consent of the patient, while her friends lived ten

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<sup>44</sup> David Johnson, "Brief notes on a case of preternatural and difficult labour, followed by the Caesarean section," *The Lancet* 80, no. 2044 (November 1, 1862): 475, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)30881-X](http://dx.doi.org/10.1016/S0140-6736(02)30881-X).

<sup>45</sup> *Ibid.*

<sup>46</sup> J.G. Swayne, "The Address in Midwifery," *British Medical Journal* 2, no. 178 (August 15, 1863): 180, accessed March 5, 2012, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2325794/>.

<sup>47</sup> Wilson, *The Making of Man Midwifery*, 50.

miles away."<sup>48</sup> Johnson eventually gained her consent and operated, but his options were limited by her approval and the provision of access to her body. Authors also assigned autonomy and significance to women through descriptions of mothers submitting to the operation bravely and calmly. Women, "courageously submitted to this operation," which in turn added to the perception of their inclusion in the medical dialogue.<sup>49</sup> Their courage was particularly noteworthy in the first half of the nineteenth century, in which surgical operations were performed without anaesthesia. As a result of the inclusion of the female patient perspective in publications, physicians who faced criticism could indicate that a body of willing patients existed. The brave mother transcended fear of surgical intervention in the hopes of saving herself and her child.

To emphasize the significance of patient consent, authors positively characterized the women that they interacted with. James Edmunds indicated that his patient "was a calm, intelligent woman," and in doing so he situated her as a figure of maternal authority in accepting the operation.<sup>50</sup> The use of the words "calm" and "intelligent" indicated that the woman had rationally evaluated his suggestions and participated in the decision of a treatment. Women were also perceived as being brave and capable during the operation. Thomas Radford was a proponent of Caesarean section without anaesthetic, and described his patient positively as accepting and thriving under operative conditions. He informed his peers that "[d]uring the whole time her mind was calm, she never even uttered a complaint. She remarked that her sufferings during the operation had been much less than what she had endured previous to it."<sup>51</sup> Radford returned to the motif of the calm and self-controlled women throughout his publications on the Caesarean section. He objected to anaesthetic on the grounds that "it was unnecessary, she possessed in such a high degree tranquility, calmness, and resignation of mind. Moral courage is superior to anaesthesia."<sup>52</sup> Creating the figure of the strong and willing female patient lessened the association of surgery with danger and blame for fatality. Self-controlled women appeared to be aligned with physicians. The role of patients as active parties in surgical decisions disassociated them with powerlessness. Therefore, the potential for narratives of blame and victimization were minimized by article authors.

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<sup>48</sup> Johnson, "Brief notes on a case of preternatural and difficult labour," 475.

<sup>49</sup> Anonymous, "Caesarean Operation successfully performed twice on the same person, by Dr. G. Shenk, of Siegen," *The Lancet* 9, no. 214 (October 6, 1827): 10, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)96960-6](http://dx.doi.org/10.1016/S0140-6736(02)96960-6).

<sup>50</sup> James Edmunds, "On a case of Caesarean Section. Hard cancer of os and cervix uteri; six days' labour; no dilation; abdominal hysterectomy' mother convalescent, and child living," *The Lancet* 77, no. 1949 (January 5, 1861): 4, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)41216-0](http://dx.doi.org/10.1016/S0140-6736(02)41216-0).

<sup>51</sup> Thomas Radford, "A Successful Case of Caesarean Section, with Remarks," *British Medical Journal* 1, no. 13 (August 1849): 457, accessed March 5, 2012, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2487966/>.

<sup>52</sup> *Ibid.*, 459.

In Sally Wilde's "Truth, Trust and Confidence in Surgery," she indicates that despite the habit of obtaining patient consent, the provision of information was relatively rare.<sup>53</sup> However, this does not seem to be true in the case of Caesarean section; submissions to *the Lancet* emphasize the degree of information provided to patients. James Edwards indicated the full scope of information he provided to his patient prior to the operation in 1849. He said,

I now explained the cause of her suffering and danger, gradually breaking to her the alternatives of her position ... I made her fully understand each procedure, with its risks and contingencies. I told her that the first would cut through a mass of diseased tissue, immensely supplied with blood vessels, whose mouths would be out of reach, and would bleed so largely that both herself and child would probably perish; that I thought the latter, by direct incision into the bowels, though so frightful to contemplate, was the less dangerous.<sup>54</sup>

J. C. Lory Marsh indicated that,

[e]very fact connected with this case was weighed over in consultation, and it was agreed to explain to the woman her dangerous condition, both from the progressive nature of the disease in the pelvis, and the impossibility of being delivered by the natural passages without the aid of instruments, certainly fatal to the child, and in all probability to herself also.<sup>55</sup>

This emphasis on the degree of information provided further implicated the woman's importance in the process of consent. However, this process also obscured the reality of the relationship between the patient and surgeon. Treatment technique was not chosen by the patient, but instead proposed by the surgeon. Patients were informed of dangers and then consented.<sup>56</sup> This balance of power can be seen at Guy's Hospital, where "Dr. Oldham... decided upon Caesarean Section, to which measure the patient at once assented."<sup>57</sup> In every case, discussion was made within a physician collective and then presented to the patient for approval. Thus, the extent to which the patient was involved was actually an indication of her willingness to approve the dangerous procedures selected by the professionals, emphasizing the

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<sup>53</sup> Wilde, "Truth, Trust, and Confidence in Surgery," 315.

<sup>54</sup> Edmunds, "On a case of Caesarean Section," 4.

<sup>55</sup> J.C. Lory Marsh, "On a Case of Acute Mollities Ossium Occurring in a woman during her third pregnancy, upon whom the caesarean operation was performed. Preservation of the child. Subsequent death of the mother," *The Lancet* 82, no. 2098 (November 14, 1863): 560, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)59497-6](http://dx.doi.org/10.1016/S0140-6736(02)59497-6).

<sup>56</sup> Wilde, "Truth, Trust and Confidence in Surgery," 315.

<sup>57</sup> Anonymous, "Guy's Hospital. Caesarean Section; Mother and Child Saved," *The Lancet* 58, no. 1462 (September 6, 1951): 227, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)78936-8](http://dx.doi.org/10.1016/S0140-6736(02)78936-8).

knowledge and authority of physicians through the extent of patient involvement and trust.

Approval of the patients as mothers was an important step in performance of the Caesarean section, because the operation was the "only operation in which two lives are concerned."<sup>58</sup> As Victorian women, the primacy of the role of motherhood indicated that women were more willing to sacrifice for their children.<sup>59</sup> Ludmilla Jordanova explains the increasing perception that women were defined physically, psychologically, and socially by their reproductive role.<sup>60</sup> The female reproductive and caring role was invested with political significance during a period of concerns about the wellbeing of the family unit.<sup>61</sup> Because reproduction and childcare were viewed as the defining features of women, room was opened for increased discussion of the responsibilities of pregnant patients to their children. Surgeons applied ideals of Victorian ideology in their expectations of the behaviour of female patients and patients accordingly submitted themselves to more invasive procedures for the health of their children. Traditionally, medieval Caesarean sections had considered the foetal life only when the mother's death was confirmed, but by nineteenth century, a shift in priority had occurred. Dr. John William Ballantyne perceived an "increase in the value set upon foetal life" in 1902 that can also be seen in surgical rhetoric on the necessity of nineteenth-century Caesarean section.<sup>62</sup> This narrative was first proposed in eighteenth-century dialogues like those of William Smellie, who indicated his "great uneasiness" at "loss of children" due to unsuccessful intervention in vaginal intervention.<sup>63</sup> Smellie emphasized that, "because the mother and child have no other chance to be saved...it is better to have recourse to an operation which hath sometimes succeeded than leave them both to inevitable death."<sup>64</sup> This developing unwillingness to compromise foetal life made the traditional English practice of craniotomy less viable, as the threat of destroying a still-living child for the sake of the mother was always present.

The balance of foetal life and death became the most important aspect of establishing procedure in cases of intervention. J.N.C. Cooke indicated that, "the Caesarean operation is now no longer necessary, except when the child is alive, in which case, like the other French accouchers, he would not sacrifice the child, but

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<sup>58</sup> Young, *The History of Caesarean Section*, 2.

<sup>59</sup> Jane Lewis, "'Motherhood Issues' in the late nineteenth and twentieth centuries," in *Delivery Motherhood: Maternal Ideologies and Practices in the Nineteenth and Twentieth Centuries*, eds., Katherine Arnap, Andree Levesque, and Ruth Roach Pierson (London: Routledge, 1990), 3.

<sup>60</sup> Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (Madison: University of Wisconsin Press, 1989), 29.

<sup>61</sup> *Ibid.*, 54.

<sup>62</sup> Sara Dubow, *Ourselves Unborn: A history of the fetus in modern America* (Oxford: Oxford University Press, 2011), 11.

<sup>63</sup> Wilson, *The Making of Man Midwifery*, 125.

<sup>64</sup> O'Dowd and Phillipp, "Caesarean Section," 160.

would operate for its extraction."<sup>65</sup> This awareness of the foetal role in childbirth is an early indicator of the rise of consciousness regarding foetal life. In the nineteenth and twentieth centuries, the same perspective would be demonstrated in the context of anti-abortion crusades. Increasing narratives about "foeticide" and "intrauterine murder" were indicative of the importance of the early formation of a parenting relationship with the unborn child.<sup>66</sup> This concern for foetal wellbeing complimented Victorian narratives about the role of the mother and instituted an earlier system of concern for the life of the child. Both mothers and physicians acknowledged that the health of the child, not just the mother, was at stake in any decision regarding pregnancy care and childbirth techniques. Acknowledgement of the foetus as a living object necessitated the transformation of the child into a patient necessary of consideration in obstetric practices.

This development was aided by one of the few "notable advances" perceived by Kerr et al. in their summary of obstetrics between 1800 and 1850, the "recognition of the foetal heart sounds."<sup>67</sup> This eliminated the uncertainty of establishing a time of foetal death to permit religiously sanctioned craniotomy.<sup>68</sup> Surgeons could identify the life of the child as independent from female perception and without observation of foetal movements that were obvious enough to be externally perceived. The moment in the examination, in which the foetal heartbeat was registered, was vividly recounted by surgeons. James Edmunds recounted that he "had heard the brisk tic-tac of the foetal heart in the left iliac fossa."<sup>69</sup> As a result, he indicated the necessity of performing Caesarean section because other alternatives would compromise the evident life of the foetus. Edmund's descriptive terms emphasized the viability of the foetal life. Similarly, Robert Greenhalgh tracked a connection between the sound of the heartbeat and the success of the operation. In his case notes, he explained that, "the foetal heart was distinctly heard...The child...was extracted alive and vigorous."<sup>70</sup> J.C. Lory Marsh also indicated the identification of the foetal heartbeat as the crux of the pre-surgical examination. He explained that he and his colleague "each listened attentively for the foetal heart, which was heard below the umbilicus towards the left side."<sup>71</sup> The foetal heartbeat informed both the necessity and location of the

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<sup>65</sup> J.N.C. Cooke, "Caesarean Section and Embryotomy. To the Editor of the Lancet," *The Lancet* 31, no. 787 (September 29, 1838): 67, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)82729-5](http://dx.doi.org/10.1016/S0140-6736(02)82729-5).

<sup>66</sup> Dubow, *Ourselves Unborn*, 18.

<sup>67</sup> Munro Kerr et al., *Historical Review of British Obstetrics and Gynaecology*, 37.

<sup>68</sup> Joseph G. Ryan, "The Chapel and the Operating Room: The Struggle of Roman Catholic Clergy, Physicians, and Believers with the Dilemmas of Obstetric Surgery, 1800-1900," *Bulletin of the History of Medicine* 76, no.3 (Fall, 2002): 464.

<sup>69</sup> Edmunds, "On a case of Caesarean Section," 4.

<sup>70</sup> Greenhalgh, "A Clinical Discussion on the Caesarean Section," 489.

<sup>71</sup> Marsh, "On a Case of Acute Mollities Ossium Occurring in a woman during her third pregnancy," 560.

operation, so the practical benefits of locating a heartbeat also increased the practitioner's perception of their abilities. Nineteenth-century developments enabled the creation of a patient who could be evaluated as separate from the body of the mother and thus deserved separate consideration for care and treatment.

The survival of the child was emphasized as the greatest advantage imparted by performance of the Caesarean. Nineteenth-century published case studies constructed an experience of surgical practice beyond the act of incision. Authors indicated the preconditions and history of the patient and tracked the recovery of the patient to the point of their return to active life or death. These broad surgical narratives included the survival and development of newborn children. Thomas Radford reflected that he "extracted [the child] *vigorously* alive"<sup>72</sup> Similar cases include that of M. Pacquinot, in which *The Lancet* correspondent indicated that "[a]s it was plain that the child was alive, cephalotriety was rejected, and the Caesarean section resolved upon...The child was alive, of the male sex, and is now thriving."<sup>73</sup> The child's survival was integral in the surgical narrative of James Hawkins, who indicated that the mother "and the baby, a fine little girl, have frequently been in my surgery, and are at present in perfect health."<sup>74</sup> Survival of the child was also seen as offsetting the loss of the mother's life. John Taylor continued his case notes past the death of his patient, indicating that, "the child progresses very favourably, is fed on milk and water, and appears none the worse for its unnatural mode of birth."<sup>75</sup> These survival cases were deemed successful and were also explicitly contrasted with the loss of life in the craniotomy. J.C. Lory Marsh observed that "[i]n deciding between the two operations, the Caesarean section and embryotomy, the fact of the foetus having reached the full period of life, and being alive at the time, demanded that its life should not be recklessly destroyed."<sup>76</sup> Within the spectrum of obstetric intervention, the Caesarean section was one of the few surgical procedures that did not guarantee foetal mutilation. The abdominal incision circumvented the navigation of contracted pelvises and allowed for the extraction of children who otherwise would be removed in pieces after craniotomy and dismemberment to fit the contours of the mother.

Surgeons supplemented the benefit of saving foetal lives by constructing a narrative that diffused blame for patient mortality. The most prominent theme was

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<sup>72</sup> Radford, "A Successful Case of Caesarean Section," 457. Emphasis added by the author.

<sup>73</sup> Anonymous, "Successful Caesarean Operation. Performed by M. Paucquinot, of Tulle, France," *The Lancet* 70, no. 1780 (October 10, 1857): 366, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)38539-8](http://dx.doi.org/10.1016/S0140-6736(02)38539-8).

<sup>74</sup> Hawkins, "Successful case of Caesarean operation," 387.

<sup>75</sup> John Taylor, "A case of Caesarian operation successful to both mother and child," *The Lancet* 91, no. 2316 (January 18, 1868): 86, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)61177-8](http://dx.doi.org/10.1016/S0140-6736(02)61177-8).

<sup>76</sup> Marsh, "On a Case of Acute Mollities Ossium Occurring in a woman during her third pregnancy," 561.

the issue of delays in operation. Surgeons like Thomas Radford indicated that, "of the three women who died, we are not warranted to conclude that their deaths were not attributable to the operation. We have in all of them indisputable evidence that the mischief was occasioned by protracting it..."<sup>77</sup> Dangers of protracted labour included being "extremely hazardous to the lives of infants, and especially so after the discharge of the liquor amnii."<sup>78</sup> Delays also compromised the ability of the mother to survive the operation and subsequent infections. J.C. Lory Marsh indicated that after a summary of Caesarean sections, it "will be seen that but few of its deaths are due to the operation itself. One section of the operations has been done upon patients already moribund from exhaustion, or from the occurrence of fatal injury. These deaths are to be set down to improper delay, or to misdirected interference."<sup>79</sup> W.H Thornton similarly indicated that, "[t]he success of the operation depended no doubt upon its having been undertaken before any symptoms of exhaustion appeared..."<sup>80</sup> Exhaustion compromised the patient and detracted from the ability of success. These surgeons thus identified the nature of the operation as a last resort as the very feature that contributed to its high level of fatality; earlier operations would guarantee more survivors. The implicit solution would be increased access to patients and higher degrees of intervention. Only through physician involvement in pregnancy, childbirth, and postnatal care could patient fatality be avoided.

To emphasize the goal of survival, successes were flaunted in publications by the reminder or presence of a successful patient. Responding to the criticism of his technique by another surgeon, G.B. Knowles declared that "Lee, and others who may feel interested in this matter, that my Caesarian patient, Sarah Bate, lived five years after the operation, when she died of pulmonary consumption; her husband having died about twelve months previously of the same disease."<sup>81</sup> This description functioned on several levels to indicate Knowles's lack of blame. Both Bate and her child survived the initial operation, and Bate lived for years after healing from the procedure. Further, Knowles observed that her death was not related tangentially to the damage to her genitals, but rather to a disease she contracted from her husband. The implication was that her surgical recovery was complete. Thomas Radford used similar rhetoric to dismiss failed cases. He claimed that "[n]otwithstanding all the preexisting dangers in Caesarean cases, several recoveries have taken place."<sup>82</sup> Sally

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<sup>77</sup> Radford, "A Successful Case of Caesarean Section, with Remarks," 457.

<sup>78</sup> Thomas Radford, "Further Observations on the Caesarean section." *British Medical Journal* 1, no. 321 (April 4, 1868): 321, accessed March 3, 2012, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2309907/>.

<sup>79</sup> James Edmunds, "Report on a second case of Caesarean section in which mother and child recovered," *The Lancet* 108, no. 2780 (December 9, 1876): 821, accessed February 26, 2012, [http://dx.doi.org/10.1016/S0140-6736\(02\)49562-1](http://dx.doi.org/10.1016/S0140-6736(02)49562-1).

<sup>80</sup> Thornton, "On a successful case of Caesarian Section," 315.

<sup>81</sup> Knowles, "Observation on the Caesarean Section," 457.

<sup>82</sup> Thomas Radford, "Observations on the Caesarean Section and on Other Obstetric Operations."

Wilde argued that the possibility of safe surgery was more significant than the presence of practical results in spurring an increased willingness to operate.<sup>83</sup> Through identifying successful cases with complete recovery, surgeons demonstrated to their peers that successful surgery was possible and strengthened the position of Caesarean section as a viable treatment. Cases of success combined with dismissal of failure to construct the idea that, in favourable circumstances, the operation was consistently successful. Surgeon confidence inspired them to aspire to these successes.

The most powerful rhetorical tool utilized by surgeons remained within the unique nature of the operation itself. Just as the operation endangered two lives, it also had the potential to save both mother and child. The phrase "mother and child were saved" recurs in medical literature.<sup>84</sup> Guy's Hospital emphasized that "[i]t is plain that such an operation offers a chance of success where both mother and child would certainly die."<sup>85</sup> John Taylor and his co-worker were "of opinion that nothing but the Caesarean operation could save either mother or child."<sup>86</sup> The potential to save two lives with one operation drastically impacted medical professionals. James Edmunds decreed that "[i]rrespective of the actually successful results, we believed that Caesarean section gave this mother a better chance than embryotomy. Therefore we incurred not the painful task of weighing the infant life against increase of maternal risk."<sup>87</sup> Edmund acknowledged the reality of limitations on success, but considered the necessity of practice superior to the alternative of inaction while one or both of his patients, mother and child, died. This desire to preserve the two patients aligned with the dismissal of unsuccessful cases as being due to delays in operation. Together, the two techniques indicated that if the methods of determining surgical necessity were refined, more successful cases could be presented. Surgeons invalidated the presence of statistics through their proposal that more operations were necessary.

The refinement of this narrative of reciprocal decision-making and potential success was the most significant advancement of the mid-nineteenth-century. Surgeons began to enumerate reasons for performance of the operation based on their physical investigations of the mother and acknowledgement of the foetal life. Henry Morris indicated that,

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*British Medical Journal* 1, no. 321 (April 29, 1865): 423, accessed March 3, 2012, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2325601/>.

<sup>83</sup> Wilde, "Truth, Trust, and Confidence in Surgery," 303.

<sup>84</sup> This theme was particularly prominent in titles of journal articles, including James Hawkins' "Successful case of Caesarian operation: mother and child saved."

<sup>85</sup> Anonymous, "Guy's Hospital," 227.

<sup>86</sup> Taylor, "A case of Caesarian operation successful to both mother and child," 85.

<sup>87</sup> Edmunds, "On a case of Caesarean Section. Hard cancer of os and cervix uteri," 5.

It would be out of place in a surgical lecture to enumerate the conditions in which it is appropriate- nay, necessary, but I would epitomize the reasons for the operation as follows: - (1) To save the life of a foetus beyond the seventh month, providing the mother has not been dead for more than from twenty to twenty-five minutes. (2) To save the life of the mother and her child, or the life of the mother if the foetus is known to be dead, when delivery cannot occur in the usual way ... (3) To release the mother from suffering, even when she has little or no chance of recovering, provided that delivery cannot be otherwise affected.<sup>88</sup>

Morris's structure indicated the importance of foetal life and the potential benefits to the mother. It outlined the operation in its traditional structure, as a final resort after either the mother or foetus was already confirmed dead. However, it also incorporated the option of voluntary surgery, with a living mother and child, framed as an operation of kindness to alleviate suffering. This rhetoric supported his position that "we must not be deterred from undertaking it in appropriate cases."<sup>89</sup>

Appropriate cases were established in concert with other physicians and in light of thorough physical examinations. Higher access to the body supplemented physician knowledge of the childbirth process, and complimented increasing male demonstrations of authority on the subject. This access and authority developed out of the uniquely English relationship between medical professionals and childbirth, allowing practitioners the confidence that they could and should involve themselves in difficult labours. Additionally, Caesarean sections took advantage of shifting criteria of operative necessity, as the idea that assuaging pain was equally as important as preserving life came into popularity. The Caesarean provided an intervention of last resort, when natural childbirth was impossible and patient facilities were failing. The importance of the mother as an ally to surgeons helped to deter concerns about her role as a victim. Patients were characterized as strong, informed, and willing, during a period where issues of consent were not a primary feature of the surgical interaction. The role of the patient was increasingly conflated with the role of the mother, aided by Victorian perceptions of the primacy of the reproductive role and responsibility of mothers to their children, born or unborn. Independently, foetuses were increasingly recognized as patients to be acknowledged due to the acknowledgement of foetal heart sounds and the survival of the child was seen as justifying the suffering of the mother. Taken in concert, these developments allowed physicians to verbalize their potential power to save two patients through a single surgical procedure. The existence of the child, willingness of the mother, and skill of the patient were all touted in reports of the Caesarean section. It was increasingly seen as a viable option in difficult childbirth cases.

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<sup>88</sup> Morris, "Clinical Remarks on a case of Caesarean Section," 527.

<sup>89</sup> Ibid.

The discoveries of F.A. Kehrer in 1881 and Max Sanger in 1882 introduced the practice of effective uterine sutures to the medical community and revolutionized the potential for success in Caesarean operations.<sup>90</sup> Suture practice joined the innovations of asepsis and anaesthesia. Patient fatality rates dropped from 65-75 percent in the early nineteenth century to 5-10 percent by the end of the century.<sup>91</sup> These technological advancements were the culmination of a century of dialogue about the viability of Caesarean operations and the situations that increased successful interventions. Obstetricians persisted in performing the operation and justifying their decisions, transferring the procedure from the medieval *sectio in mortua* to a modern obstetric intervention. To do this, they created a narrative that depicted a coherent group of professional practitioners allied with an intelligent and willing patient to save the new life of the foetus. This technique dispersed responsibility for the decision to operate and was supplemented by postoperative rhetoric indicating that death was caused by delays in operation, not the act of cutting itself. Rather than criticize unsuccessful operations, authors in *The Lancet* implied that the only way to lower maternal mortality was to continue and prioritize operation. Surgical improvements responded to this context of continual practice with more effective operative techniques. The nineteenth century taught practitioners that both mother and child could and should be saved. In the twentieth century, their goal was realized.

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<sup>90</sup> Trolle, *The History of Caesarean Section*, 53.

<sup>91</sup> Carter and Duriez, *With Child*, 120.