“At midnight I was awakened by a very sharp pain,” wrote Mrs. Cecil Stewart, describing the birth of her child in 1914. “The head nurse . . . gave me an injection of scopolamin-morphin. . . . I woke up the next morning about half-past seven . . . the door opened, and the head nurse brought in my baby. . . . I was so happy.”1 Mrs. Stewart had delivered her baby under the influence of scopolamine, a narcotic and amnesiac that, together with morphine, produced a state popularly known as “twilight sleep.” She did not remember anything of the experience when she woke up after giving birth. This 1914 ideal contrasts with today’s feminist stress on being awake, aware, and in control during the birthing experience. In 1914 and 1915, thousands of American women testified to the marvels of having babies without the trauma of childbirth. As one of them gratefully put it, “The night of my confinement will always be a night dropped out of my life.”2

I am grateful to William J. Orr, Jr., and Susan Duke for their assistance in the preparation of this study. I would also like to thank Mari Jo Buhle, Norman Fost, Susan Friedman, Lewis Leavitt, Elaine Marks, Regina Morantz, and Ronald Numbers for their comments on earlier drafts of this paper.


2. Tracy and Boyd, p. 198.

[Signs: Journal of Women in Culture and Society 1980, vol. 6, no. 1] © 1980 by The University of Chicago. 0097-9740/81/0601-0012$01.00

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From the perspective of today's ideology of woman-controlled births, it may appear that women who want anesthesia sought to cede control of their births to their doctors. I will argue however, that the twilight sleep movement led by women in 1914 and 1915 was not a relinquishing of control. Rather, it was an attempt to gain control over the birthing process. Feminist women wanted the parturient, not the doctor or attendant, to choose the kind of delivery she would have. This essay examines the apparent contradiction in the women's demand to control their births by going to sleep.

The Process

The attendants, location, and drugs or instruments used in American women's birthing experiences varied in the early decades of the twentieth century. America's poorer and immigrant women delivered their babies predominantly at home, attended by midwives who seldom administered drugs and who called physicians only in difficult cases. A small number of poor women gave birth in charity or public hospitals where physicians attended them. Most upper- and middle-class women, who had more choice, elected to be attended by a physician, usually a general practitioner but increasingly a specially trained obstetrician, rather than a midwife. At the turn of the twentieth century, these births, too, typically took place in the woman's home; however, by the second decade of the century, specialists, aided partly by the twilight sleep movement, were moving childbirth from the home to the hospital.3

Physicians used drugs and techniques of physical intervention in many cases, although the extent cannot be quantified accurately. In addition to forceps, physicians relied on opium, chloroform, chloral, cocaine, quinine, nitrous oxide, ergot, and ether to relieve pain, expedite labor, prevent injury in precipitous labors, control hemorrhage, and prevent sepsis.4 In one study of 972 consecutive births in Wisconsin, physicians used chloroform during the second stage of labor in half of their cases and forceps in 12 percent.5 The reports indicate that drugs and instruments may have made labors shorter but not necessarily more enjoyable. Because most drugs could not be used safely throughout the labor and delivery, either because they affected muscle function or because they were dangerous for the baby, women still experienced pain. The use of forceps frequently added to discomfort and caused perineal tears, complicating postdelivery recovery. Maternal mortality remained

3. For more information on childbirth practices in this period, see Judy Barrett Litoff, American Midwives: 1860 to the Present (Westport, Conn.: Greenwood Press, 1978).
5. Ibid.
high in the early decades of the twentieth century, and childbirth, whether attended by physicians or midwives, continued to be risky.\(^6\)

Most women described their physician-attended childbirths as unpleasant at best. Observers of the declining birthrates among America’s “better” classes worried that the “fear of childbirth has poisoned the happiness of many women”\(^7\) and caused them to want fewer children. One woman told her doctor that her childbirth had been “hell. . . . It bursts your brain, and tears out your heart, and crashes your nerves to bits. It’s just like hell, and I won’t stand it again. Never.”\(^8\) In scopolamine deliveries, the women went to sleep, delivered their babies, and woke up feeling vigorous. The drug altered their consciousness so that they did not remember painful labors, and their bodies did not feel exhausted by their efforts.\(^9\) Both the women who demanded scopolamine and the doctors who agreed to use it perceived it as far superior to other anesthesia because it did not inhibit muscle function and could be administered throughout the birthing process. It was the newest and finest technique available—“the greatest boon the Twentieth Century could give to women,” in the words of Dr. Bertha Van Hoosen, one of its foremost medical advocates.\(^10\)

However, women’s bodies experienced their labors, even if their minds did not remember them. Thus observers witnessed women screaming in pain during contractions, thrashing about, and giving all the outward signs of “acute suffering.” Residents of Riverside Drive in New York City testified that women in Dr. William H. W. Knipe’s twilight sleep hospital sent forth “objectionable” noises in the middle of the night.\(^11\)

A successful twilight sleep delivery, as practiced by Dr. Van Hoosen at the Mary Thompson Hospital in Chicago, required elaborate facilities and careful supervision. Attending physicians and nurses gave the first

6. See, e.g., Dorothy Reed Mendenhall ("Prenatal and Natal Conditions in Wisconsin," *Wisconsin Medical Journal* 15 [1917]: 353–69), who reported, “The death rate from maternity is gradually increasing in Wisconsin, as it is throughout the United States” (p. 364). Dr. Mendenhall also noted that death rates for physician-attended births were higher than for midwife-attended births in Wisconsin (p. 353). I would like to thank Dale Treleven for calling this article to my attention.


9. Scopolamine is an alkaloid found in the leaves and seeds of solanaceous plants. It is a sedative and a mild analgesic as well as an amnesic, causing forgetfulness of pain rather than blocking the pain sensation. For obstetrical twilight sleep, scopolamine was administered with morphine—the most active alkaloid of opium—in the first dose and alone for subsequent doses.


injection of scopolamine as soon as a woman appeared to be in active labor and continued the injections at carefully determined intervals throughout her labor and delivery. They periodically administered two tests to determine the effectiveness of the anesthesia: the “calling test,” which the parturient passed if the doctor could not arouse her even by addressing her in a loud voice, and the “incoordination test,” which she passed if her movements were uncoordinated. Once the laboring woman was under the effects of scopolamine, the doctors put her into a specially designed crib-bed to contain her sometimes violent movements (see fig. 1). Van Hoosen described the need for the bed screens: “As the pains increase in frequency and strength, the patient tosses or throws herself about, but without injury to herself, and may be left without fear that she will roll onto the floor or be found wandering aimlessly in the corridors. In rare cases, where the patient is very excitable and insists on getting out of bed. . . . I prefer to fasten a canvas cover over the tops of the screens, thereby shutting out light, noise and possibility of leaving the bed.” When delivery began, attendants took down the canvas crib and positioned the patient in stirrups, familiar in modern obstetrical services. Van Hoosen advised the use of a continuous sleeve to ensure that patients did not interfere with the sterile field (see fig. 2). The canvas crib and the continuous sleeve were Van Hoosen’s response to a common need in twilight sleep deliveries: a secure, darkened, quiet, contained environment.

The Events

Twilight sleep became a controversial issue in American obstetrics in June 1914, when McClure’s Magazine published an article by two laywomen describing this newly popular German method of painless childbirth. In the article, Marguerite Tracy and Constance Leupp, both visitors at the Freiburg women’s clinic, criticized high-forceps deliveries (which they called the common American technique) as dangerous and conducive to infection. They contrasted these imperfect births to the safety and comfort of twilight sleep. The new method was so wonderful that women, having once experienced it, would “walk all the way [to Germany] from California” to have their subsequent births under twilight sleep. The physicians at the Freiburg clinic thought the method was best suited for the upper-class “modern woman . . . [who] responds to the stimulus of severe pain . . . with nervous exhaustion and paralysis of the will to carry labor to conclusion.” They were less certain

Fig. 1.—Patient in crib-bed waiting for examination. (Source: Bertha Van Hoosen. Scopolamine-Morphine Anaesthesia [Chicago: House of Manz, 1915], p. 48.)
Fig. 2.—Gown with continuous sleeve. (Source: Bertha Van Hoosen, *Scopolamine-Morphine Anaesthesia* [Chicago: House of Manz, 1915], p. 88.)
about its usefulness for women who “earn their living by manual labor” and could tolerate more pain.14

The women who took up the cause of twilight sleep concluded that it was not in general use in this country because doctors were consciously withholding this panacea. Physicians have “held back” on developing painless childbirth, accused Mary Boyd and Marguerite Tracy, two of the most active proponents, because it “takes too much time.” “Women alone,” they asserted, “can bring Freiburg methods into American obstetrical practice.”15 Others echoed the call to arms: journalist Hanna Rion urged her readers to “take up the battle for painless childbirth . . . Fight not only for yourselves, but fight for your . . . sex.”16 Newspapers and popular magazines joined the chorus, advocating a widespread use of scopolamine in childbirth.17

The lay public’s anger at the medical profession’s apparent refusal to adopt a technique beneficial to women erupted into a national movement. The National Twilight Sleep Association, formed by upper-middle-class clubwomen,18 was best epitomized by its leaders. They included women such as Mrs. Jesse F. Attwater, editor of *Femina* in Boston; Dr. Eliza Taylor Ransom, active women’s rights advocate and physician in Boston; Mrs. Julian Heath of the National Housewife’s League; author Rheta Childe Dorr of the Committee on the Industrial Conditions of Women and Children; Mary Ware Dennett of the National Suffrage Association (and later the National Birth Control League); and Dr. Bertha Van Hoosen, outspoken women’s leader in medical circles in Chicago.19 Many of these leaders saw the horrors of childbirth as an


experience that united all women: "Childbirth has for every woman through all time been potentially great emergency." Dr. Ransom thought that the use of twilight sleep would "create a more perfect motherhood" and urged others to work "for the betterment of womankind." Because they saw it as an issue for their sex, not just their class, and because many of the twilight sleep leaders were active feminists, they spoke in the idiom of the woman movement.

The association sponsored rallies in major cities to acquaint women with the issue of painless childbirth and to pressure the medical profession into adopting the new method. In order to broaden their appeal, the association staged meetings "between the marked-down suits and the table linen" of department stores where "the ordinary woman" as well as the activist clubwoman could be found. At these rallies, women who had traveled to Freiburg testified to the wonders of twilight sleep (see fig. 3). "I experienced absolutely no pain," claimed Mrs. Francis X. Carmody of Brooklyn, displaying her healthy baby at Gimbels. "An hour after my child was born I ate a hearty breakfast. . . . The third day I went for an automobile ride. . . . The Twilight Sleep is wonderful." Mrs. Carmody ended with the familiar rallying cry: "If you women want it you will have to fight for it, for the mass of doctors are opposed to it."24

Department-store rallies and extensive press coverage brought the movement to the attention of a broad segment of American women. Movement leaders rejoiced over episodes such as the one in which a "tenement house mother . . . collected a crowd" on a street corner where she joyfully told of her twilight sleep experience. Many working-class women were attracted to twilight sleep not only because it made childbirth "pleasanter" but because they saw its use as "an important cause of decreased mortality and increased health and vitality among the mothers of children." Some feared, however, that twilight sleep would remain a "superadded luxury of the wealthy mother" because it involved so much physician time and hospital expense. Although different motivations propelled the physician-advocates who believed twilight sleep was safe, middle- and upper-class women who wanted the newest

20. Tracy and Boyd, p. 145.
22. The connections between clubwomen and suffrage or other women's issues are explored in Altbach, pp. 114–15; O'Neill, pp. 49–76, 146–68; Ryan, pp. 230–31; and Eleanor Flexner, Century of Struggle: The Woman's Rights Movement in the United States (New York: Atheneum Publishers, 1970), pp. 172–92. The term "woman movement," in the nineteenth and early twentieth centuries, described the movement to better women's condition, including, but not limited to, the drive for suffrage.
23. Tracy and Boyd, p. 145.
25. Tracy and Boyd, p. 145.
thing medicine had to offer, and working-class women who wanted simple relief from childbed suffering, they were all united by their common desire to make childbirth safer and easier for women.

Van Hoosen emerged as the most avid advocate of twilight sleep in the Midwest. She received her M.D. from the University of Michigan
Medical School and worked at the New England Hospital for Women and Children in Boston before setting up practice in Chicago in 1892. Her enthusiasm for the method came from two sources: her strong commitment to the best in obstetrical care and her equally strong commitment to women's rights. Through her use of scopolamine in surgery and obstetrics, she became convinced that twilight sleep offered women a "return of more physiological births" at the same time that it increased the efficiency of physicians, giving them "complete control of everything." She guided many other physicians to the twilight sleep method. In terms of safety and comfort, she could not imagine a better method of birthing.

Increasingly, doctors began to deliver twilight sleep babies. Some traveled to Germany to learn the Freiburg technique and subsequently offered it to both private and charity patients. A few physicians even became enthusiastic about the possibilities of twilight sleep. "If the male had to endure this suffering," said Dr. James Harrar of New York, "I think he would resort very precipitously to something that might relieve the . . . pain." Dr. W. Francis B. Wakefield of California went even further, declaring "I would just as soon consider performing a surgical operation without an anesthetic as conducting a labor without scopolamine amnesia. Skillfully administered the best interest of both the mother and the child are advanced by its use." Another physician listed its advantages: painless labor, reduction of subsequent "nerve exhaustion that comes after a prolonged hard labor," better milk secretion, fewer cervical and perineal lacerations, fewer forcep deliveries, less strain on the heart, and a "better race for future generations" since upper-class women would be more likely to have babies if they could have them painlessly. There was also, it was claimed, an "advantage to

the child: To give it a better chance for life at the time of delivery; a better chance to have breast-feeding; a better chance to have a strong, normal mother.”

Despite the energy and enthusiasm of the twilight sleep advocates, many American doctors resisted the technique. They lashed out against the “pseudo-scientific rubbish” and the “quackish hocus-pocus” published in McClure’s and simply refused to be “stampeded by these misguided ladies.” These physicians did not believe that nonmedical people should determine therapeutic methods; it was a “question of medical ethics.” Other physicians refused to use scopolamine because they feared its dangers either to the mother or the child. The Journal of the American Medical Association concluded that “this method has been thoroughly investigated, tried, and found wanting, because of the danger connected with it.”

Because the evidence about safety was mixed, many doctors were frustrated in their attempts to find out whether scopolamine was harmful or safe for use in obstetrics. Earlier experience with the unstable form of the drug led some to refuse to try scopolamine again, although at least one pharmaceutical company had solved the problem of drug stability by 1914. “The bad and indifferent results which were at first obtained by the use of these drugs we now know to have been due entirely to overdosage and the use of impure and unstable preparations,” concluded one physician in a report on his successful results with 1,000 twilight sleep mothers in 1915. Dr. Van Hoosen had successfully performed surgery on 2,000 patients with the help of scopolamine by 1908 and began using the drug routinely in deliveries in 1914. She concluded after 100 consecutive cases that scopolamine, properly administered, “solves the problems of child-bearing” and is safe for mother and child. But the medical literature continued to express concern

34. Bertha Van Hoosen, Scopolamine-Morphine Anaesthesia, p. 101. Some physicians reported success using twilight sleep at home, but most thought the method best suited to hospital deliveries.


about the possible ill effects of a breathing irregularity in babies whose mothers had been given scopolamine and morphine late in labor.\textsuperscript{42} Doctors trying to understand the evaluation of twilight sleep must have been confused. In one journal, they read that the procedure was “too dangerous to be pursued,” while another journal assured them that scopolamine, when properly used during labor, “has no danger for either mother or child.”\textsuperscript{43} Increasingly, by 1915, medical journals published studies that at least cautiously favored twilight sleep (the January 1915 issue of \textit{American Medicine} published nine such articles),\textsuperscript{44} although they frequently ran editorials warning of the drug’s potential dangers and stressing the need for caution. Practicing physicians faced a dilemma when pregnant women demanded painless childbirth with scopolamine.\textsuperscript{45}

While physicians debated the desirability of using scopolamine in 1914 and 1915, the public, surer of its position, demanded that twilight sleep be routinely available to women who wanted it. Hospitals in the major cities responded to these demands and to physicians’ growing interest in the method by allowing deliveries of babies the Freiburg way.\textsuperscript{46} In order to gain additional clinical experience, and possibly in response to some women’s requests, some doctors used twilight sleep in hospital charity wards. But the technique was most successful in the specialty wards there upper- and middle-class patients increasingly gave birth and hospital attendants and facilities were available. By May 1915, \textit{McClure’s Magazine}’s national survey reported that the use of twilight

\textsuperscript{42} This condition, called “oligopnea,” usually resolved after a few hours, but it was frightening to observe, especially for attendants who had no experience with it (Gauss, “Further Experiments in Dammerschlaf,” p. 302).

\textsuperscript{43} See discussion of the Polak paper (n. 14 above) in \textit{American Journal of Obstetrics} 7 (1915): 798; and Hilkowich, p. 793.

\textsuperscript{44} \textit{American Medicine} 21 (1915): 24–70.


\textsuperscript{46} E.g., see \textit{New York Times} (August 22, 1914), p. 9; and (September 10, 1914); and the American hospitals mentioned in Tracy and Boyd.
sleep, although still battling for acceptance, “gains steadily” around the country.47

Because of the need for expertise and extra care in administration of scopolamine, the twilight sleep movement easily fed into widespread efforts in the second decade of the twentieth century to upgrade obstetrical practice and eliminate midwives.48 Both the women who demanded the technique and the doctors who adopted it applauded the new specialty of obstetrics. Mary Boyd desired to put an end to home deliveries when she advocated twilight sleep for charity patients: “Just as the village barber no longer performs operations, the untrained midwife of the neighborhood will pass out of existence under the effective competition of free painless wards.”49 Not only did scopolamine advocates try to displace midwives, but they also regarded general practitioners as unqualified to deliver twilight sleep babies. “The twentieth century woman will no more think of having an ordinary practitioner attend her in childbirth at her own home,” said two supporters, “she will go to a [twilight sleep] hospital as a matter of course.”50 Specialists agreed that “the method is not adapted for the general practitioner, but should be practiced only by those who devote themselves to obstetrics.”51 Eliza Taylor Ransom went so far as to recommend the passage of a federal law forbidding “anyone administering scopolamine without a course of instruction and a special license.”52

Some obstetricians used this issue to discredit their general practitioner colleagues and the midwives who still delivered large numbers of America’s babies. Another factor that might have pushed obstetricians to support twilight sleep was that births under scopolamine could be managed more completely by the physician. As one succinctly put it, anesthesia gave “absolute control over your patient at all stages of the game. . . . You are ‘boss.’ ”53 Physicians’ time at the bedside could even be used for other pursuits. “I catch up on my reading and writing,” testified one practitioner, “I am never harassed by relatives who want me to tell them things.”54

47. Anna Steele Richardson’s survey was reported in the New York Times (May 10, 1915), p. 24.
48. Litoff (n. 3 above), pp. 69–70.
50. Constance Leupp and Burton J. Hendrick, “Twilight Sleep in America,” McClure’s Magazine 44 (1915): 172–73. The argument about expertise appeared repeatedly (see, e.g., William H. W. Knipe, “The Truth about Twilight Sleep,” Delineator 85 [1914]: 4). Twilight sleep women were aware that theirs was an expensive demand. They expected the cost of physician-attended childbirth to jump from twenty-five to eighty-five dollars (Tracy and Boyd, p. 180).
53. Quoted from the New Orleans Medical and Surgical Journal in Miller (n. 1 above), p. 24.
How do we explain the seeming contradictions in this episode in medical history? Why did women demand to undergo a process which many physicians deemed risky and in which parturients lost self-control? Why did some physicians resist a process that would have given women an easier birthing experience and would have reinforced physicians’ control over childbirth in a hospital environment? Several factors contributed to the open tensions about the use of twilight sleep. One was safety. Many physicians rejected scopolamine because they did not have access to facilities like those at the Mary Thompson Hospital or because they believed the drug too risky under any circumstances. Because of the variability among physicians’ use of scopolamine and the contradictory evidence in the professional journals, we know that safety was a guiding motivation of many physicians. However, this is not enough to explain physician reluctance since so many doctors administered other drugs during labor despite questionable safety reports. Differing perceptions about pain during childbirth also contributed to the intensity of feeling about twilight sleep in 1914 and 1915. Although many physicians believed that women’s “extremely delicate nervous sensibilities” needed relief, others were reluctant to interfere with the natural process of childbirth. One anti-twilight sleep physician argued, “when we reflect that we are dealing with a perfectly healthy individual, and an organ engaged in a purely physiological function . . . I fail to see the necessity of instituting such a measure in a normal labor and attempt[ing] to bridge the parturient woman over this physiological process in a semi-conscious condition.” Women perceived, too, that some physicians used anesthesia only for “suffering when it becomes a serious impediment to the birth process.” However, women who had suffered greatly, or whose friends had suffered greatly, actively sought relief from their “physiological” births: They thought pain in itself a hindrance to a successful childbirth experience and “demanded” that their physicians provide them with more positive, less painful, experiences in the future.

Both sides in the twilight sleep debate grappled with a third important question: whether the women or the attendants should determine

55. Fifty percent of 100 general practitioners surveyed in rural districts and small towns in Wisconsin indicated that they used ergot during labor, although its use was blamed for “a very large per cent of necessary operations for repair of injuries to the floor and pelvic organs of the female patient” (Ford [n. 4 above], p. 257).


57. Tracy and Boyd, p. 149.

58. For physicians’ perceptions of “demanding” women, see, e.g., the discussion following the Rongy and Harrar papers, Transactions of the American Association of Obstetricians and Gynecologists 27 (1914): 382–83.
and control the birthing process.\textsuperscript{59} The women who demanded that doctors put them to sleep were partially blind to the safety issue because the issue of control (over pain, bodily function, decision making) was so important to them. Control became important when doctors refused to allow women "to receive the same benefits from this great discovery that their sisters abroad are getting."\textsuperscript{60} Twilight sleep advocates demanded their right to decide how they would have their children. Tracy and Boyd articulated this issue: "Women took their doctor's word before. They are now beginning to believe ... that the use of painlessness should be at their discretion."\textsuperscript{61} Although women were out of control during twilight sleep births—unconscious and needing crib-beds or constant attention to restrain their wild movements—this loss of control was less important to them than their determination to control the decision about what kind of labor and delivery they would have. Hanna Rion, whose influential book and articles had garnered support for the method, wrote:

In the old-fashioned days when women were merely the blindfolded guardians of the power of child-bearing, they had no choice but to trust themselves without question in the hands of the all-wise physician, but that day is past and will return no more. Women have torn away the bandages of false modesty; they are no longer ashamed of their bodies; they want to know all the wondrous workings of nature, and they demand that they be taught how best to safeguard themselves as wives and mothers. When it comes to the supreme function of childbearing every woman should certainly have the choice of saying how she will have her child.\textsuperscript{62}

Twilight sleep women wanted to control their own births by choosing to go to sleep. They were not succumbing to physicians or technology but were, they thought, demanding the right to control their own birthing experiences.

This feminist emphasis on control over decision making appears in the writings and lectures of the twilight sleep movement; its followers sought simple relief from pain.\textsuperscript{63} Many leaders were active suffragists

\textsuperscript{59} Other contributing factors cannot be developed here. Growing professionalization and specialization with medicine produced tensions among groups of doctors that surfaced during this debate. The method's German "origins" invalidated it with many Americans during the war years. My emphasis here on the issue of control is not meant to minimize these and other factors. However, because others, especially Lawrence Miller (n. 1 above) have explored the general outlines, I have focused on the previously unanalyzed question of decision-making power. Its importance, I think, is indicated by the intensity in the women's arguments on this issue.


\textsuperscript{61} Tracy and Boyd, p. 147 (emphasis in original).

\textsuperscript{62} Rion (n. 16 above), p. 47.

\textsuperscript{63} Tracy and Boyd claimed "four to five million" twilight sleep followers, obviously an exaggeration (p. 144).
whose commitment to twilight sleep was rooted in their belief in women’s rights.64 Although these activists agreed with most physicians that birth should increasingly be the domain of the obstetricians and that women should not suffer unnecessarily, they disagreed vehemently about who should decide what the birthing woman’s experience would be. They clearly and adamantly wanted women to have the right to decide their own method of birthing.65

In the face of advancing obstetrical technology, many physicians wanted to retain their traditional professional right and duty to decide therapy on the basis of their judgment about the medical indications. They refused to be “dragooned” into “indiscriminate adoption” of a procedure that they themselves did not choose.66 Even the doctors who supported twilight sleep believed that in the final analysis, the method of childbirth was “a question for the attending man and not the patient to decide.”67 It was principally this question of power over decision making that separated the movement’s proponents from its opponents.

The Decline

In the very successes of the twilight sleep movement lay the seeds for its demise. Pressured by the clubwomen’s associations and their own pregnant patients, doctors who had not been trained in the Freiburg method delivered babies with scopolamine. There was an enormous variation in the use of the drug, its timing through labor, the conditions in which the woman labored, and the watchfulness of attendants. As its advocates had feared, problems emerged when scopolamine was not properly monitored in a hospital setting. Following reports of adverse effects on the newborn, the drug fell into ill repute, and some hospitals that had been among the first to use it stopped administering it routinely.68

Those physicians who continued to advocate twilight sleep believed that accidents were due to misuse of the Freiburg method and not to the drug itself. Commenting on its discontinuation at Michael Reese Hospital in Chicago, Dr. Bertha Van Hoosen noted that “it is . . . probable that this adverse report demonstrates nothing more than the inexperience of the people using this anesthetic.”69 Dr. Ralph Beach agreed that “there is no doubt that all of the bad results which have been reported due to this

65. See esp. Tracy and Boyd, Rion, Ransom (n. 21 above), and Van Hoosen (n. 10 above).
method, are due to an improper technic, or the administration of unsta-
ble preparations.” Simultaneously, in 1915, some hospitals expanded
their obstetric services to offer twilight sleep, and others began cutting
back its use. Either because they judged the drug dangerous or because
they did not use it correctly, some hospitals found the method too
troublesome to administer on a routine basis to all patients. Most
reached a compromise and continued to use scopolamine during labor’s
first stage (when it was deemed safe), thus preempting their patients’
protests without compromising their medical beliefs. A second inhibitory
factor appeared in August 1915 when Mrs. Francis X. Carmody, one of
the country’s leading exponents of twilight sleep, died during childbirth
at Long Island College Hospital in New York. Although doctors and her
husband insisted that her death was unrelated to scopolamine, it
nonetheless harmed the movement. Mrs. Carmody’s neighbor started
a new movement to oppose twilight sleep, and women became more alert
to the question of safety than they had been. Doctors and some former
twilight sleep advocates, emphasizing the issues of safety and difficulty
of administration, began exploring other methods of achieving painless
childbirth.

The obstetric literature after 1915 indicates that twilight sleep did
not die in that year. The women’s movement may have failed to make
scopolamine routinely available to all laboring women, but it succeeded
in making the concept of painless childbirth more acceptable and in
adding scopolamine to the obstetric pharmacopoeia. In fact, obstetri-
cians continued to use scopolamine into the 1960s during the first stage
of hospital births. The use of anesthesia (including scopolamine) in
childbirth grew in the years after 1915, since women, aware of the possi-
bility of painlessness, continued to want “shorter and less painful par-
turition” and since physicians felt they could disregard these desires
“only at great risk to [their] own practice.”

The attempt by a group of women, including some feminists, to
control their birthing experiences backfired. The medical profession
retained the choice of birth procedures and perhaps gained additional

70. Beach (n. 33 above), p. 43.
73. See, e.g., Frank W. Lynch, “Nitrous Oxide Gas Analgesia in Obstetrics,” Journal of
the American Medical Association 64 (1915): 813.
74. See, e.g., Henry Schwarz, “Painless Childbirth and the Safe Conduct of Labor,”
American Journal of Obstetrics and Diseases of Women and Children 79 (1919): 46–63; an
Medical Association 81 (1923): 1090–96.
75. See the assessment of anesthesia used in childbirth in New York Academy of
Medicine Committee on Public Health Relations, Maternal Mortality in New York City: A
Study of all Puerperal Deaths 1930–1932 (New York: Commonwealth Fund, 1933), p. 113;
see also Joyce Antler and Daniel M. Fox, “Movement toward a Safe Maternity: Physician
569–95.
control as a result of this episode. Partial acceptance by the profession quieted the lay revolt, and women lost the power they had sought. Ironically, by encouraging women to go to sleep during their deliveries, the twilight sleep movement helped to distance women from their bodies. Put to sleep with a variety of drugs, most parturient women from the 1920s to the 1960s did not experience one of their bodies’ most powerful actions and thus lost touch with their own physical potential. The twilight sleep movement helped change the definition of birthing from a natural home event, as it was in the nineteenth century, to an illness requiring hospitalization and physician attendance. Parturient feminists today, seeking fully to experience childbirth, paradoxically must fight a tradition of drugged, hospital-controlled births, itself the partial result of a struggle to increase women’s control over their bodies.

History of Medicine Department and Women’s Studies Program
University of Wisconsin—Madison