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## Perspectives

# A Perspective on James Marion Sims, MD, and Antiblack Racism in Obstetrics and Gynecology

After the public outcry in response to the murders of George Floyd, Ahmaud Arbery, and Breonna Taylor, more than 18 organizations signed a collective action statement against racism in the field of obstetrics and gynecology (OB/GYN). A portion of the statement acknowledged, “Many examples of foundational advances in the specialty of obstetrics and gynecology are rooted in racism and oppression. For example, the mid-1800s surgical experimentation of James Marion Sims leading to successful treatment of vesicovaginal fistula was performed on enslaved black women, including 3 women, Betsey, Lucy, and Anarcha, who underwent repetitive gynecologic procedures without consent.” [1] This statement also made a commitment to officially designate “February 28 and March 1, the dates that bridge Black History and Women’s History months, as days for formal acknowledgment of Betsey, Lucy, and Anarcha, the enslaved women operated on by Sims, and other enslaved Black women who were subjected to abuse in the name of advancing science.”

This statement is important because Sims’s legacy, as the father of gynecology, has caused harm by contributing to race-based medicine that extends far beyond the direct suffering experienced by the black women who were the subjects of his surgical experiments. Sims’s legacy endures in the racist attitudes and actions—racism, not race—that contribute to persistent disparities in health outcomes for black people. It also endures in the often-warranted deep mistrust of the medical establishment that many black people carry to this day. Finally, it endures in the intellectual argument that Sims’s actions should not be judged using a modern lens because he was a product of his time. In this perspective, 4 black OB/GYN physician leaders re-examine Sims’s career, and we use our own stories to illustrate the effects of his legacy on our lives.

## Re-Examining James Marion Sims

James Marion Sims, MD, was born in Lancaster, SC, in 1813. After completing medical school, he gained notoriety as a “plantation physician” for plantation owners in Alabama. From 1845 to 1849, Sims performed

experimental surgeries, without their consent and without the benefit of anesthesia, on at least 14 enslaved black women. After 29 unsuccessful surgeries on Anarcha Westcott, Sims reported his first successful vesicovaginal repair. Although experimentation on black people was common during the slavery era, there was some opposition, and numerous contemporaries questioned the ethics of Sims’s work. A sympathetic 1950 biography included “dark rumors that it was a terrible thing for Sims to be allowed to keep on using human beings as experimental animals for his unproven surgical theories.” [2] Although the use of ether as a general anesthetic was novel at the time of Sims’s surgical experimentation, it was publicly demonstrated in 1846 (3 years before his first successful repair), and Sims was aware of its use [3]. Eventually, Sims moved to New York City and then traveled throughout Europe, where he offered vesicovaginal repair under anesthesia to mostly wealthy white women. He ultimately gained his reputation as the father of modern gynecology and as 1 of the most decorated American surgeons. Although Sims’s life and career have been extensively documented, we do not know the true perspectives of Betsey, Lucy, and Anarcha, or any of the other enslaved black women who were subjected to Sims’s surgical procedures. Their stories must be included in Sims’s narrative. We can only imagine how much they suffered from vesicovaginal fistulas, from surgeries without anesthesia, and from the denial of consent and freedom as enslaved people, and we acknowledge that their stories could have been ours if we had been born in that era.

## Know Her Name

It was an uncomfortable but familiar feeling, a mix of deep, seething anger and confusion. I was a third-year gynecologic oncology fellow preparing to meet with the chair of the department, and I decided that this was the day I would confront him. As 1 of the few black chairs of an academic department of OB/GYN, Dr. John Boyce was a source of both inspiration and pride for me, not anger. The object of

my anger was the oil painting that hung so prominently on the wall behind his desk. The scene depicted a barefoot, young black woman in a blue dress, with a red cloth tied around her head, who was deferentially kneeling in front of 3 white men. The men were all dressed in 19th century garb, and their dominance over the woman was obvious. I had finally built up the courage to ask why Dr. Boyce had chosen this piece of art that triggered me in such a powerful way. Typical of his teaching style, my question was met with a question. "Are you familiar with J. Marion Sims and Anarcha Westcott?" he asked, pointing to the black woman in the painting. Clearly, he knew I was not. Soon after, I brought back my newfound knowledge about Sims's quest to perfect vesicovaginal fistula repair and the number of surgeries he performed on Anarcha without her consent and without anesthesia. Dr. Boyce explained that the painting in his office, ironically part of a series commemorating "Great Moments in Medicine," reminded him daily of the suffering and sacrifice Anarcha, and many other black women whose names will never be known, endured in the name of medical advancement. I will never forget this moment. Why isn't Anarcha Westcott's story more well-known? It is high time we "say her name" too. —**Kevin Holcomb, MD**

### **We Felt Her Fear, Shame, and Humiliation**

We were 3 inexperienced third-year medical students on our OB/GYN clerkship rotation summoned by our chief resident to examine a patient who had been raped. The chief resident jerked open the curtain and a young black woman, who looked as though she could have been my cousin, lay crying, curled in a fetal position on a gurney. The chief resident looked at her with the most impatient attitude and shouted at her to move to the bottom of the gurney. Swaddling herself even tighter, she froze in place. He pulled out the stirrups and forcefully pulled her to the bottom of the gurney. "Open your legs now," he yelled as he tried to pry open her legs. Tears rolled down her cheeks, and she tightened her legs even more. He repeated even louder: "You have had bigger things put up there than this speculum before that felt good." He hastily performed the rape evaluation in a perfunctory manner, combing through her pubic hair, scraping her nail beds, and taking cervical cultures, all without a word. Her tears meant nothing to him. He did not acknowledge her pain and fear. He did not say that he felt sorry for what had happened to her. We stumbled back to our call rooms. I was numb. Back then, I did not know the lexicon of "implicit bias and structural racism." As a black woman, I along with my fellow students, determined that we were bystanders to a sexual assault and racist attack. Each of us was afraid that we would be penalized, labeled as troublemakers, and even kicked out of medical school. Yet, together, we reported the chief resident to the clerkship director and the dean of students, and the chief resident was required to apologize to us. We do not know what happened

afterward. Did the patient report him? Did he apologize to the patient? Did he have a blemish on his record? Did he undergo professional intervention? Did he continue his behavior? We do not know. What we do know is that the 3 of us stood united. We said something.—**Linda D. Bradley, MD**

### **I Was the Attending Physician in Charge**

I was the attending physician on the maternal–fetal medicine (MFM) service when a patient presented at 34 weeks with ruptured membranes and laboring. She was rushed for an emergent cesarean delivery for prolonged fetal bradycardia. During delivery, we discovered that the patient had a coagulopathy, and she was treated aggressively. We diagnosed her with acute fatty liver and admitted her to the intensive care unit, where she spent many days. The patient eventually required dialysis and extensive bowel resection for bowel infarction from hypovolemia. The MFM team rounded on the patient daily in the intensive care unit and comanaged her care with intensivists and surgeons. On multiple occasions, other attending physicians discussed the patient with the MFM fellow, who is a tall white man and was automatically assumed to be the attending. They completely ignored me until I made it clear that I was actually the attending in charge. For black physicians, the burden of credibility is placed solely on us. We are burdened almost daily with having to justify our expertise as physicians to colleagues, to other healthcare providers, to patients, and to the public.—**Ngina K. Connors, MD, MBA**

### **All I Remember Is Wanting to Be Heard**

I arrived in early labor at 38 weeks. I just could not catch my breath between painful contractions. I was aware that black women and babies were at higher risk for complications during birth, and I was worried. My husband and I, a black couple with a Harlem address, were admitted to the hospital with indifference. Many of the staff, nurses, and resident physicians did not know that I was a physician, who had graduated from the same medical school and hospital where I was giving birth. I did not tell them, and it should not have mattered. I tried to ask for an epidural, but my labor pains were openly mocked. It is hard to describe how humiliating it is to be dismissed when vulnerable. My pain was compounded by anger and frustration that my concerns were being ignored. All I remember is wanting to be heard. My husband spent a huge amount of emotional energy calmly advocating on my behalf, taking care not to be seen as an angry black man who could be readily removed by security. He was met with condescension and skepticism that I was really married to him, the father of the baby, a dismissive term still used on many labor and delivery services. What ultimately made a difference in our birth

experience was that my on-call and primary OB/GYN attendings were both black women. My husband insisted that we let my primary OB/GYN know I was admitted, and she came in for the delivery. Once she entered the room, I felt immediate relief. We were heard. Our son was born without complications, and everything ended well. I am grateful. Yet, I will never forget how I felt.—**Dineo Khabele, MD**

## Conclusion

We are all products of our time. We cannot ignore that James Marion Sims, a white male physician, rose to prominence primarily because of his surgical experimentation on enslaved black women, without their consent and without anesthesia, during the slavery era in the antebellum South. We cannot ignore that we are 4 of approximately 4% of the black OB/GYN specialists and approximately 1% of the black physician leaders in medicine [4] during the modern era of the Black Lives Matter movement. A legacy from Sims's era is the erasure of black perspectives, including the physical and emotional pain that black people experienced as slaves. We share our stories to document a window into our personal and professional lives as black physicians and patients. We illustrate how our history, patients, credibility, and bodies are easily disrespected and dismissed. We acknowledge that these stories do not fully reflect the breadth of our experiences, including the fact that our leadership positions do not protect us. More importantly, our stories are not unique. Although we applaud recent statements against racism, we are cautious. Public support for black lives has waxed and waned throughout American history. At this critical time in history, we urge persistent action from colleagues in medicine and science to eradicate antiblack and other forms of racism, even when it is not popular—for ourselves, for the health of our field, for the patients we serve, and for our nation.

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