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## "God was the first anaesthetist": obstetrics and pain in Lisbon at the turn of the 20<sup>th</sup>

century

*"Deus foi o primeiro anestesista": a obstetrícia e a dor em Lisboa, na viragem do século XX*

**Francesca De Luca**

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# “God was the first anaesthetist”: obstetrics and pain in Lisbon at the turn of the 20<sup>th</sup> century

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*Francesca De Luca*

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In this article, I analyse the historical emergence of pain management in obstetric literature and practice and how it affected the constitution of a new epistemology of obstetrics in Portugal. The text draws largely on archival research on biomedical articles and theses from mid-19<sup>th</sup> up to early-20<sup>th</sup>-century Lisbon, revealing an emerging and shifting biomedical understanding of pain and the labouring body, the agency of the obstetrician, and the political role of obstetrics. The research is part of a longitudinal anthropological study of childbirth pain approached as a locus where affectivities, shifting ontologies and biopolitics merge. Rather than considering childbirth pain as a taken-for-granted physical phenomenon, its materialization within the specific biomedical and historical context of Portugal at the turn of the 20<sup>th</sup> century is analysed.

**KEYWORDS:** pain, childbirth labour, Portuguese obstetrics, anaesthesia, chloroform.

“Deus foi o primeiro anestesista”: a obstetrícia e a dor em Lisboa, na viragem do século XX ♦ Analisa-se, neste artigo, a forma como a gestão da dor no parto surgiu na prática e na literatura obstétrica e como afetou a constituição de uma nova epistemologia. A partir de uma pesquisa de arquivo de artigos biomédicos e teses, produzidas em Lisboa, entre a segunda metade do século XIX e as primeiras décadas do século XX, pretende-se focar o conhecimento biomédico, emergente e incerto, sobre a dor e o corpo em trabalho de parto, a agência do obstetra e o papel político da obstetrícia. A pesquisa faz parte de um estudo antropológico longitudinal, com uma abordagem da dor como *locus* onde se fundam afetividades, ontologias em mudança e biopolíticas. Em vez de considerar a dor como um fenómeno físico tido como certo, pretende-se traçar a sua materialização no contexto biomédico e histórico português específico, na viragem do século XX.

**PALAVRAS-CHAVE:** dor, parto, obstetrícia portuguesa, anestesia, clorofórmio.

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*UMA HORA PEQUENINA!*, LITERALLY MEANING “A LITTLE HOUR”<sup>1</sup> IS AN expression with which pregnant women are occasionally greeted in Portugal, especially when they are nearing childbirth. It is an omen for a quick delivery, a wish for labour to be short, hinting at its pain without actually mentioning it. At antenatal classes and in pregnancy booklets distributed in health centres, pain is invariably evoked by describing the onset of labour in terms of discomfort; uterine contractions are depicted as similar to menstrual cramps, but stronger in intensity. In the clinical context, pain is considered a troublesome side-effect of the physiology of labour, and addressed exclusively in terms of the techniques available to relieve it.

Such negative connotation of pain is not, however, universal, nor is it homogeneous within biomedical settings. The pain associated with labour is subject to different apprehensions, depending on how childbirth is understood and managed. Where supporters of “natural” childbirth (re-)claim women’s innate capacity to endure and be empowered by birthing, portraying pain as necessary and transformative, contrastingly, defenders of obstetric interventionism underline the futility of physical suffering, and the benefits of a painless delivery (Davis-Floyd 2001; Vuille 1998). For Arcidiacono (1985) both configurations tend towards a denial of the hardship of labour, of that strenuous work of parturition to which the etymology of the word labour refers: the *travail* (in Portuguese *trabalho de parto*).<sup>2</sup> Indeed, whether conceiving pain as “pointless, scandalous or healthy,” different models of childbirth converge in what Vuille defines as “a new norm in matter of parturition that – endorsing an ideological discourse – can be called the ideal childbirth” (1998: 14-15).

Parturition as *good experience*, as the quest for a smooth entry into motherhood, became the motto of a consumerist turn in reproductive health that took place across Europe and the United States during the 20<sup>th</sup> century (Lusztig 2013; Michaels 2014; Stokes 2003; Wolf 2009). The “ideal parturient” which emerged during this period (beginning in Portugal in the 1950s) rejoiced in the experience of childbirth and felt no pain, either thanks to new anaesthetic technologies, or because pain in itself was a conditioned reflex that she had been physically and psychologically re-educated to dispel (cfr. psychoprophylaxis in Bermudes 1955; Monjardino and Dinis 1955). These seemingly polar approaches to pain at some point intersected, hence recourse to pharmacological relief is included today within technologies of the pregnant self that also incorporate meticulous attendance to the body and the relishing of the birthing experience (Foucault 1988; Lupton 1999).<sup>3</sup>

1 Unless otherwise indicated, translations from Portuguese and Italian are mine.

2 Literally “the work of birth.”

3 Beside the clinical prenatal courses that became popular following the rise of psychoprophylaxis – that taught mainly breathing and relaxation techniques –, contemporary examples of this [continues]

This article is concerned with the constitution of childbirth pain in biomedical settings in Portugal, and draws on both primary research in the obstetric ward of Hospital de Santa Maria, in Lisbon, and the study of archives and places in the city that bear the memory of Portuguese obstetric history from the second half of the 19<sup>th</sup> century onwards.<sup>4</sup>

Recent decades in particular have seen pain management become a determinant factor in pregnant women’s choice of birth setting in Portugal. Until the beginning of the 2000s, the uncertainty of the availability of an anaesthesiologist during labour in Lisbon’s public hospitals led many pregnant women that could afford it to give birth in private clinics, where pharmacological management of pain was assured. Today, Portuguese anaesthesiologists and obstetricians who endorse the pharmacological management of labour advocate widespread coverage of analgesia supply in public hospitals (in Hospital de Santa Maria virtually 99% of childbirths involve the use of analgesia),<sup>5</sup> and analgesic or anaesthetic substances represent the only means of labour pain management in most Lisbon’s hospitals. Professor of obstetrics Luís Mendes da Graça, former director of the Maternity Department in Hospital de Santa Maria, defends analgesia as the only valuable tool for pain management in labour, criticizing the “romantic idea” that a woman should endure the pain of childbirth, and considering the absence of pharmacological intervention in labour as something that “belongs to the past.”<sup>6</sup>

In this article, I depart from contemporary discourses and pharmacological practices surrounding labour to explore, through a genealogy of childbirth pain (Foucault 1980), the historical events that paved the way to the

attention to the pregnant body are the flourishing of specific courses in fitness centres and the specialized cosmetic market for pregnant women.

4 This study was funded by doctoral grant SFRH/BD/93020/2013 provided by the Portuguese Foundation for Science and Technology (FCT). To search for obstetric archives in Lisbon, I carried out multi-sited fieldwork across the city that incorporated libraries or museums where medical theses are stored, and old hospital wards where obstetricians operated. The latter include the fifth floor of Hospital de São José where was once situated the Infirmary Santa Bárbara; the Hospital de São Lázaro, today closed to the public and in a state of abandonment, that hosted the first public maternal hospital in Portugal, Maternidade Magalhães Coutinho; the Maternidade Alfredo da Costa; the Hospital Egas Moniz (once Hospital do Ultramar), which in the 1950s became a site for the implementation of psychoprofilaxis.

5 This unofficial estimation comes from my fieldwork observations in the delivery ward (*bloco de parto*) of the Hospital de Santa Maria (from January 2016 to March 2017), confirmed through interviews with the nurses and anaesthesiologists of the obstetric department. Official statistics for the years 2011-2012 reported that obstetrical analgesia administration reached up to 90% in vaginal births (see < <https://web.archive.org/web/20161021020518/http://www.anestesiologia-chln.pt/index.php/servico-de-anestesiologia/atividades/110-analgesia-do-trabalho-de-parto> > (retrieved from the expired website < [www.anestesiologia-chln.pt](http://www.anestesiologia-chln.pt) >, last consulted on September 17th, 2017).

6 This opinion, stated during a personal interview with the author in January 2017, has also been published online in an article which promulgates the benefits of the epidural (see < <https://www.medicosdeportugal.pt/info/utentes/gravidez/epidural-dar-a-luz-sem-sofrimento/> > (last access in October 2018).

present situation in Portugal. Genealogy, describes Foucault, is situated within the articulation of the body and history. “Its task is to expose a body totally imprinted by history and the process of history’s destruction of the body” (Foucault 1980: 148). To allow the labouring body to emerge from this process of history’s “destruction,” I investigate encounters between the obstetrics profession and emergent anaesthetic technologies in Lisbon from the second half of the 19<sup>th</sup> century to the first decades of the 20<sup>th</sup> century. I suggest that the discovery of the potential use of anaesthesia in childbirth and its consequent application not only broadened and reinforced obstetricians’ domination of parturition but also led to a new conceptualization of labour pain as an ontological phenomenon, localized in the organs but separable from the act of giving birth (Carneiro 2005; Jesse 1933; Simões 1943).

Drawing from Sara Ahmed (2004), by deconstructing what pain is I provide a contextual analysis of what pain does, meaning what practices and policies were mobilized around the polysemic concept of pain. This conceptualisation can be distinguished from Scarry’s (1985) evaluation of pain as an inner experience that disrupts language, and focuses instead on pain as a contextual and relational phenomenon grounded in meaning. Specifically, I analyse the constitution of childbirth pain that emerged from the clinical encounter following the discovery of anaesthesia. “Meaning is immediate in pain,” Pollock observes, “although pain is always already mediated by what it has meant, by its past in language, stories, histories, discourse. What pain is and what it means conjoin [...] in the palpable forms of its embodied practice” (Pollock 1999: 119). In my analysis, I purposely adopt a semantics encompassing the affectivity of pain in obstetrics, to delineate how the newfound possibility to act on pain, bound within a discourse of obstetricians’ duty to relieve women’s suffering, simultaneously bolstered Portuguese obstetricians’ political commitment to modernization.

Firstly, I draw briefly on a bibliography of oral accounts of and popular narratives pertaining to homebirth and the condition of women in Portugal, to compare how, traditionally, pain was at once constituted as somatization and semantization (Le Breton 1999). Subsequently, I trace the introduction of obstetrical anaesthesia in Portugal, including the emblematic death in childbirth of Queen Dona Maria II. Contextualizing physicians’ practice within the decrepit Santa Bárbara Infirmary in Hospital de São José, I will analyse the emergence and articulation of an ontological pain as a precursor to a renewed epistemology of obstetrics.

The archival research which forms the basis of this article – scientific journals, political and historical booklets and theses to obtain a surgeon-obstetrician degree – were all produced by obstetricians or students from the Santa Bárbara Infirmary during the second half of the 19<sup>th</sup> to the first decades of the 20<sup>th</sup> century. Most of the medical theses and articles analysed were based

on the trials carried out in the infirmary related to the application of anaesthesia during childbirth. Today these documents are scattered across various locations in the city of Lisbon.<sup>7</sup> Largely unexplored, they shed unique light on the historical roots of the contemporary biomedical constitution of childbirth in Portugal.

#### LOCATING THE BIRTH SCENE:

#### THE SLOW ERADICATION OF HOME BIRTH IN PORTUGAL

This article focuses on the emergence of an understanding of pain in childbirth that was triggered by the first implementation of anaesthesia in a clinical setting in 1848. Until the first decades of the 20<sup>th</sup> century, obstetrics was not an institutional specialization of the Portuguese medical-surgical schools but one of the numerous disciplines in which medical students were required to train.<sup>8</sup> According to Carneiro (2008), the development that obstetrics underwent during the second half of the 19<sup>th</sup> century was fostered by a growing market demand for medical assistance in childbirth. Given this demand, during the late 19<sup>th</sup> and early 20<sup>th</sup> century physicians worked hard to distinguish obstetrics from the home delivery assistance provided by general practitioners (Caton 1999: 86). Obstetricians thus increasingly worked beyond the walls of the hospital through *clínica civil*,<sup>9</sup> attending in particular the complicated deliveries of the upper classes (Salgado 1880). Through the manufacture of special portable devices such as anaesthetic masks and dropper bottles, ether and chloroform were at the disposal of the obstetrician both in the hospital ward as well as at the home-based childbirths s/he attended.<sup>10</sup>

Indeed, hospital births were scarce in Portugal in the decades under analysis (1850s-1920s), and would remain so at least up until the 1960s in Lisbon

7 The articles and booklets referred to were largely consulted in the National Library of Portugal, while obstetrical theses and hospital reports were accessed in the Library of Hospital de São José, in the Museum of Dermatology of the Hospital dos Capuchos and in the Library of the Portuguese National Institute of Legal Medicine (INML) and the library of Hospital Egas Moniz. I am indebted to Dr. Manuela Marques of the INML for her patience and invaluable assistance in uncovering these precious materials in the institute archive. I am also grateful to Dr. Célia Pilão of the Lisbon Central Hospitals for encouraging my curiosity and allowing me to explore the forgotten places where the history of Lisbon obstetrics unfolded.

8 Many renowned Portuguese obstetricians, such as Magalhães Coutinho and later Alfredo da Costa and Augusto Monjardino became popular among their peers for having pioneered surgical techniques in other medical fields before dedicating their professional lives to obstetrics and gynaecology.

9 *Clínica civil* (civil clinic) was the term used by physicians to distinguish their private practice from hospital work.

10 Women started graduating in medicine in Lisbon by the end of the 19<sup>th</sup> century, one of the first obstetricians being Adelaide Cabete, who graduated in 1900.

and throughout the 1970s in rural Portugal (Mendez 1956; Freire 2010).<sup>11</sup> In 1956 obstetrician M.L. Mendez published a contentious article denouncing the fact that 80% of childbirths in Portugal still took place at home, of which 56% he categorized as “unassisted” (Mendez 1956). This definition was situated within an agenda that sought to promote the use of hospitals nationwide as part of the modernization project and deliberately disregarded the universe of informal assistance in childbirth provided by *parteiras*, *comadres* and *curiosas*,<sup>12</sup> that reproduced an empirical and oral tradition relatively disentangled from the medical domain.

Throughout the 20<sup>th</sup> century the domestic environment became more permeable to obstetric intervention. While midwife (*parteira*)-led home births and biomedical obstetrics had coexisted for centuries (Carneiro 2008), this period saw an eradication of the historical association between childbirth and home, backed by social and political change (Baptista 2016; Freire 2010; Wolf 2009; Pizzini *et al.* 1981). The transformation of the birthing scene – and the associated roles of those who attended it – depleted the social and symbolic meanings that had been reproduced through traditional midwifery practices around labour. In the next section, through an analysis of oral histories and ethnographies of fertility rituals and childbirth in Portugal, I attempt to articulate the holistic understanding of pain that homebirths had sustained.<sup>13</sup> The meanings associated with pain can be seen to have been embedded within the specific context in which childbirth occurred.

#### “PAIN TEACHES TO GIVE BIRTH”: EXPLORING A HOLISTIC SENSE OF PAIN

The imminence of labour in the majority of home birthing scenes called for the presence of women, be these family members, neighbours more or less expert in birthing (*comadres* and *curiosas*), and designated midwives (*parteiras*)

11 According to the clinical records of the obstetric ward of Hospital de São José, admissions in the ward did not follow a progressive increase in the time-frame taken into consideration, varying from 307 new admissions in 1848-49 to 803 in 1868-69, having a pick with 1100 admission in 1902-1903 and dropping to 565 in 1918-19 (cfr. Sacadura 1939a). Presumably, what fostered the recourse to hospital assistance and progressive increase in hospital births in the 20<sup>th</sup> century was the creation of Maternal Hospitals starting from the 1930s.

12 The Portuguese term *parteira* corresponds to the English *midwife*, applicable both to licensed and unlicensed (traditional) practitioners. The *parteira* was conventionally regarded as more knowledgeable than the *comadres* and *curiosas*, the latter designations referring to experienced women, family members and neighbours who normally attended childbirth (Carneiro 2008).

13 To compare the development of a new, obstetrical constitution of pain in the 19<sup>th</sup> century to a “traditional,” holistic one, I draw from available ethnographies and oral histories referring to homebirths mainly from the mid 20<sup>th</sup> century, assuming that the practices and knowledge reproduced in the domestic environment remained more or less unchanged from the previous century.

whose status was often not formalised (Carneiro 2008; Pizzini *et al.* 1981). In remote, sparsely populated mountain regions it was sometimes necessary for the husband to attend childbirth, acting as the physical support that the parturient would grasp in her effort to bear down (Crimi Stigliolo 2005; Gionelli 2005; Piteira 2012; Ribeiro 1990). Assistance in labour mainly depended on the proximity – social, affective, physical, residential – of the attendants; care of the birthing woman would be limited to the delivery and immediate post-partum periods or could extend to overall support to her household (Silva 1995; Gionelli 2005).

The empirical knowledge of the informal *parteiras* – unrecognized by the biomedical system and by the state – was inscribed, above all, in their own embodied experience; to be socially acknowledged as a capable attendant, a woman had to have been “marked by the event of childbirth” (Joaquim 1983: 83). Furthermore, the reproductive energies of an older woman, possibly already a grandmother, were regarded as having “cooled down,” which added value to her assistance. In this context of homebirth unsanctioned by the medical profession, childbirth unfolded through a series of corporeal and symbolic practices that, rather than focusing on relieving pain, were aimed at hastening labour. While the concoctions, amulets and ointments – the material culture of non-biomedical attendance in labour – were easily discredited by obstetricians for their lack of scientific evidence (Sacadura 1947a; Simões 1943), the *parteiras* had an “individual and social function” within the birthing chamber that clinicians could not grasp: “they surrounded, permitted the cries of the woman as a way for her to ‘ride’ this imaginary, this corporal clutch, this moment of rebirth that is, for the woman, the act of giving birth” (Joaquim 1983: 84). In this intimate setting, labour unloosed “those feminine anguish, desires, obsessions and ravings that the midwives patiently knew how to redirect” (Joaquim 1983: 84).

Within the enclosed and often exclusively feminine context of home birth, the pain of labour did not emerge as an isolated or material (i.e., physiological) aspect of childbirth, but was an element of a broader social canvas that saw suffering as inherently constitutive of a woman’s life. In Teresa Joaquim’s monograph (1983) on traditional fertility practices and childbirth narratives in Portugal, pain surfaces in popular proverbs as an inevitable mark of women’s passage to adulthood, echoing the harshness of life (“Mother, what is marriage? Daughter, it is sewing, birthing, crying”).<sup>14</sup> Pain in childbirth is expressed variously as a disenchantment with romantic sexuality (“For a pleasure, a thousand pains”),<sup>15</sup> the pangs of labour acting as a corporeal guide in

14 “Mãe, que é casar? Filha, é fiar, parir, chorar” (in Joaquim 1983: 25).

15 “Por um prazer, mil dores” (in Joaquim 1983: 30).



the transformative process of parturition (“Pain teaches to give birth”),<sup>16</sup> and embodying the successful social transformation from woman/wife to mother (“Giving birth without pain, rearing without love”).<sup>17</sup> Consequently, the experience of labour as work (*trabalho*), as hardship, and the recognition of the pain endured by women during childbirth was reflected in the social status acquired through motherhood.

According to Giacomini (1985), the dynamics of childbirth within the enclosed space of a feminine universe, when labour was accompanied by the laments, chants and birth recollections of the surrounding women, produced a “pain-based, excitatory model of birth where the expression of pain, encouraged by the other women, was at once a liberation from anguish and an assertion of the reality of childbirth” (1985: 49). In contrast with this gendered and engendering understanding of pain as a landscape within which home birth practices were performed and transmitted, the obstetrical practice of administering ether or chloroform in labour – both in the home and in the hospital setting – would generate a collapse not only of the values traditionally ascribed to pain, but also of the relationships of proximity established through childbirth attendance. The introduction of anaesthesia to the birthing scene would catalyse the expansion of a male-dominated obstetrics enterprise which divested pain of its traditional meaning, created a new emphasis on the need to intervene in women’s suffering, and overturned the role of the midwife by prohibiting the administration of drugs by non-medical assistants.

In the following sections, after describing the arrival of obstetrical anaesthesia in Portugal, I will present two historical events that are emblematic of the political mobilization of the concept of pain in modern obstetrics which began towards the second half of the 19<sup>th</sup> century: the death in childbirth of Queen Dona Maria II, and the speech made by obstetrician Alfredo da Costa to the Council of the Medical-Surgical School of Lisbon in 1906.

#### THE ADVENT OF ANAESTHESIA IN PORTUGUESE OBSTETRICS

The introduction of anaesthesia into obstetrical practice in 1847 triggered a process that irrevocably transformed both biomedical understanding of pain and childbirth, and the lexicon surrounding them. In October 1846 dentist William T.G. Morton demonstrated, before an astonished audience, the anaesthetic properties induced by the inhalation of ether – a chemical agent – in surgery, in the operating theatre of Massachusetts General Hospital in Boston, later baptized the “Ether Dome.” In January of the following year,

16 “A dor ensina a parir” (in Joaquim 1983: 68).

17 “Parir sem dor, criar sem amor” (in Joaquim 1983: 68).

in Edinburgh, T.J. Simpson administered ether on a parturient with a pelvic deformity, and later discovered and experimented with chloroform in a normal (as in non-instrumental) delivery, anaesthetizing more than 1500 women in the following three years and publishing numerous articles that conferred on him international fame (Caton 1999; Wolf 2009). While the administration of anaesthesia, especially in childbirth, generated animated debates within the medical milieu, it also gave rise to international disputes over who had implemented it first; medical professionals were immediately aware that they were faced with a revolutionary discovery (Carneiro 2008; Caton 1999; Sacadura 1947a; Wolf 2009).

Portuguese obstetricians were not far behind in experimenting with the “sweet sleep” (Coutinho 1857); indeed, *accoucheurs* from both sides of the Atlantic were soon similarly engaged (Santos 1871; Sacadura 1947a, 1947b).<sup>18</sup> In 1848 Câmara Synval, in Porto, was the first to experiment with anaesthesia on a parturient with labour dystocia, publishing later that same year “Application of chloroform in an instrumental delivery: first case in Portugal” (Synval 1848) which (controversially) claimed primacy over chloroform that was being tested during this period in Lisbon by José Magalhães Coutinho (Carneiro 2008; Sacadura 1947a). Such competitive efforts to associate themselves with the pioneering use of anaesthetics reveal how, in the international debate between critics and supporters of anaesthesia in childbirth (Caton 1999), the Portuguese obstetrical community leant towards the latter camp. An anonymous article from 1848 entitled “Chloroform in childbirth and theology,” for example, defended Simpson’s use of chloroform in childbirth, criticizing those physicians that, “envious of his discovery,” had “arisen the clergy against him” by appealing to the punishment stated in the Old Testament: “In pain you shall bring forth child” (Anonymous 1848). The article praised Simpson’s counterargument, made on the same Calvinist theological grounds of his detractors, which claimed that when God extracted Adam’s rib to create Eve – considered the primordial surgical operation – he had previously induced him to a deep sleep. Similarly, it was argued, the obstetrician and the surgeon were now capable of sparing humanity from pain.

Though Portuguese obstetricians officially endorsed anaesthesia in childbirth, they did not systematically adopt it, unlike, for example, several British and North American Hospitals (Wolf 2009; Caton 1999; Michaels 2014). Anaesthesia was administered in Santa Bárbara ward mainly in the form of trials, but news of its amazing effects and its associated prestige swiftly allured the social elite: chloroform also entered Portugal through a royal route.

18 The French term *accoucheur* was used in the medical articles and theses alternatively with the Portuguese term *parteiro*, to designate obstetricians (also referred to as *obstetra*). See also footnote 24.

## PORTUGUESE CHLOROFORM À LA REINE

In April 1853 Queen Victoria of England gave birth to her eighth child, after demanding to be anaesthetized during the second phase of labour (expulsion). Countering criticism by doctors and newspapers, her praise of the new painless experience represented a major boost for Simpson's discovery, and consecrated, at least symbolically, the use of chloroform in childbirth, which in obstetric treatises earned the name of "chloroform *à la reine*" (Villar 1892; Caton 1999). In November of that same year chloroform travelled from the Royal Court in England to the Court of Portugal, sent by Queen Victoria herself to King Ferdinand, on the occasion of the eleventh "lying in" of his wife, 34-year-old Queen Dona Maria II (Bonifácio 2005). After a night of unproductive labour, the Portuguese Queen died, allegedly of exhaustion. The shock of her death was followed by the popular celebration of her character as a *boa mãe* (good mother); an example of maternal rectitude (Sacadura 1940; Bonifácio 2005).

While many critics – mainly the most renowned obstetricians of the time – accused the Court physicians of incompetency, and even murder, the use of chloroform during the birth was not acknowledged by the physicians' accusers, a detail apparently considered unimportant. This silence, at a time when critics of obstetric anaesthesia in Europe and further afield earnestly proclaimed the dangers and potential lethality of chloroform, speaks volumes concerning the professional stance of Portuguese obstetricians regarding its administration. "Notwithstanding some protesters who were frightened for one or another fatal case, the idea of anaesthetic has still gained ground" – praised Magalhães Coutinho eleven years after the discovery of ether (Coutinho 1857).

The letter of the Duchess of Ficalho to her brother the Count of Lavradio, and the correspondence between the Empress of Brazil Dona Maria Amélia and Queen Victoria following D. Maria II's death, provide an alternative glimpse as to what unfolded in the mortal birthing scene (Andrada 1937; Leitão 1958; Bonifácio 2005).<sup>19</sup> As was customary, the Duchess, together with other representatives of the aristocracy, had been called to attend to the Queen's childbirth, informed by the physicians that labour was proceeding slowly but smoothly. Entering the chamber, however, she thought the Queen appeared "troubled, and even a little out of her habit" (Andrada 1937: 329). Like the Duchess, the Empress also considered it unusual and eventually deemed it fatal that the Queen, rather than expressing the normal discomfort of labour, manifested a "lethargic exhaustion" (Leitão 1958: 316), that over time turned

19 The correspondence between the Empress D. Maria Amélia and Queen Victoria refers to the letters dated November 27<sup>th</sup>, December 10<sup>th</sup> and December 17<sup>th</sup>, 1853 (in Leitão 1958); the letter of the Duchess of Ficalho is contained in Count of Lavradio's memoir dated November 28<sup>th</sup> 1853 (in Andrada 1937).

into “the greater prostration, her strength finished, nature was inert” (Leitão 1958: 318). Labour stalled until the morning, when the physicians performed a “horrible surgery” (Andrada 1937: 329), albeit “even before the child was extracted, the doctors considered her lost” (Leitão 1958: 316). Addressing Queen Victoria’s questioning as to whether the chloroform that she had sent to King Ferdinand had been used or not, the Empress responded, “I did not know that you had sent chloroform to Ferdinand and I am not sure whether, in the circumstances of our poor Maria’s delivery, with that lack of pain, that lethargic exhaustion, it would have been agreeable to employ it.” But reflecting on D. Maria II unusual behaviour, D. Maria Amélia added if “they even knew how to apply it safely, since we do not have large experience with its use here” (in Leitão 1958: 316; Bonifácio 2005: 249-250).

Nearly a century later, the obstetrician Costa Sacadura reconstructed the Queen’s fatal childbirth based on extensive historical sources and medical bulletins (Sacadura 1940). Dona Maria II’s health condition had deteriorated over the years, her last labours had been prolonged and complicated, ending in stillbirths, and the physicians at Court had warned her of the perils of yet another pregnancy. Costa Sacadura’s anamnesis did not endorse the regal physicians’ account of the Queen dying of fatigue and weakness, neither did he address D. Maria Amélia’s doubts regarding the use of chloroform. Instead he diagnosed a worn out uterus, obesity and probable heart dysfunction as decisive factors in the Queen’s death. Although he initially claimed to be shedding light on the tragic event through the accomplishment of modern obstetrics, his text soon turned into a moral manifesto, whereby the Queen’s sacrifice became a symbol of motherly rectitude in opposition to the perils of 20<sup>th</sup>-century “triumphant immoralities” – namely the diffusion (in some European countries) of birth control programmes and Neo-Malthusianism. Praising how, when warned by her doctors against risking another pregnancy, the Queen allegedly answered, “if I die, I die in my role” (Sacadura 1940: 15-16), he presented a positive vision of the suffering of motherhood against which “the pain of infertility exceeded any human pain, even that, irreparable, of death” (1940: 7).

Costa Sacadura obfuscated the presence of chloroform and the lack of physiological pain in his account of Dona Maria II’s labour, while at the same time describing her childbirth in terms of maternal sacrifice and suffering, adopting what I term a political affectivity that morally spurred the obstetrics community to action. Obstetric intervention in the pain of labour was, in fact, advocated to appease women’s fear of childbirth and boost national birth rates. Yet, as I will demonstrate in the next section, it was at the turn of the 19<sup>th</sup> century that physicians’ lobbying for the modernization of Portuguese obstetrics (through the creation of dedicated maternal hospitals and the recognition of obstetrics as a medical specialization) began to employ a lexicon that built on a political use of pain – in its broader sense of suffering – as the

motivating factor (Ahmed 2004; Sacadura 1919, 1929, 1939b; Stokes 2003; Wailoo 2014).

“THE ANTECHAMBER OF A FEMALE HELL”:  
CONTEXTUALIZING PAIN IN LISBON

Lisbon’s sole maternal ward, up until 1931, was the Infirmary Santa Bárbara, located in a loft on the fifth floor of Hospital de São José. This is where the first doses of ether and chloroform in childbirth were administered, from 1848 onwards (Coutinho 1857; Sacadura 1947a, 1947b). The theses and articles reporting these experiments rarely describe the premises where they took place, and the ward disappears behind a medical gaze (Foucault 1998 [1963]) that focuses on the dosage of the composites, the appliances, the corn-shaped handkerchief, and the bodies and reactions of the labouring women observed. Towards the end of the 19<sup>th</sup> century, after having visited some of the main maternal hospitals in Europe, the director of Santa Bárbara ward and Professor of Obstetrics Alfredo da Costa held a series of seminars, resulting in a famous speech proffered before the Council of the Medical-Surgical School of Lisbon (1906) where he denounced the miserable conditions in which pregnant women were received in Hospital de São José, and the degraded state in which obstetric knowledge was pursued in Lisbon.<sup>20</sup> These concerns formed part of a new campaign for the creation of dedicated institutions for maternal health, such as those in major European cities, which were setting the pace of modernization.<sup>21</sup>

“Maternity or antechamber of a female hell?” Costa titled his presentation, describing the “unclassifiable inhumanity” experienced by pregnant women in Lisbon’s only maternal clinic (published in Sacadura 1939a). The description of the maternity infrastructure evokes desolation: the ward was hosted in the cramped space of an old fifth-floor attic, only accessible through a narrow and high wooden staircase that had witnessed many fatal deliveries of women in labour who had not reached the ward in time. The ward lacked proper appliances, and parturients lay on filthy mattresses or cots arranged on the floor when service capacity was reached. From this miserable backdrop described by Alfredo da Costa certain characters emerged, women, children and visitors, providing a glimpse of a public otherwise lost to history. In the “nefarious proximity” of the ward, he described, stood together the “tubercular, syphilitic, erysipelas, ulcerous, eclamptic and maniac,” with no space for the pregnant who sought anonymity, and no rest for those recovering from surgery

20 Alfredo da Costa was Professor of obstetrics in the adjacent Medical-Surgical School of Lisbon.

21 The speech was later published by Costa Sacadura, and endorsed with other colleagues, after the death of Alfredo da Costa (in 1910), to lobby for the creation of the maternal hospital that will eventually open, named after him, in 1932.

(Sacadura 1939a: 17). This panoply of women mingled, in Costa’s text, with the broken-down spaces of the maternity ward, where “everything is mixed, confounded, levelled before the moral and sociology, hygiene, pathology and obstetrics!” (1939a: 18). Patients’ rest was disturbed by the distressing physical proximity whereby “beside the honest wife that receives news from her husband [...] gesticulates the harlot near her lover, who brings greetings from her girlfriends from Mouraria!” (1939a: 18).<sup>22</sup> The anguish was exacerbated by the sounds, “the hoarse voice of the syphilitic whore” (1939a: 18), the continuous transit of personnel, the smells “not at all subtle” that crowded the infirmary day and night, intensified “if by chance in the ward are also taking residence half a dozen negroes [*pretas*], as it is happening now” (1939a: 20).

Alfredo da Costa’s vivid descriptions, laced with classist and racist commentary, mobilized an idea of childbirth pain as contributing to the decay of the ward – “echo cries and laments of those who enter the apex of expulsive pains.” In his speech, in fact, the inaptitude of the ward and the poor condition in which Portuguese women gave birth mingled with the physical and social degeneration of the Portuguese race (cfr. Cabete 1900). As Sarah Ahmed observes, “pain can shape worlds as bodies, through the ways in which stories of pain circulate in the public domain” (Ahmed 2004: 15). Costa’s discourse before the Council of the Medical School not only exposed the inadequacy of Lisbon’s institutional maternal care but elaborated, effectively, a politics of pain (cfr. Wailoo 2014) which would be the flag unfurled by his successors following his death to advocate for reform in the field of obstetrics, and would mark the future direction of the profession.<sup>23</sup>

#### ANAESTHESIA, THE LABOURING BODY AND THE ONTOLOGICAL PAIN OF CHILDBIRTH

As already described, Santa Bárbara ward hosted the first attempts to test parturition under “the suspension of the phenomena of sensitivity” (Coutinho 1857: 329). Even though anaesthesia administration never became standardised, experiments with new substances established the rhythm of clinical practice within the delivery room (Simões 1943). By 1880, in addition to

22 At the time of Alfredo da Costa’s speech, the popular neighbourhood (*bairro*) of Mouraria bordered the slopes of the hill on which Hospital of São José is located. Mouraria, with its low rank prostitution, was often represented as a *bairro* of decadence and degeneration (cfr. Bastos and Carvalho 2011).

23 More than 20 years after Alfredo da Costa’s premature death (in 1910), the biggest public maternal hospital in Portugal was officially inaugurated and named after him. The Maternidade Alfredo da Costa opened to the public in December 1932, though it had been preceded by the opening of another smaller maternal hospital, the Maternidade Magalhães Coutinho (January 1931), in the historical premises of the old Hospital of São Lázaro, beside Hospital of São José.

ether and the favoured chloroform, amylene, nitric ether, aldehyde, Dutch liqueur, benzene, carbon disulphide, laudanum, morphine and chloral had also appeared (Salgado 1880; Paiva 1916; Jesse 1933). This experimentation, rather than seeking to provide patients with new recourse from pain, appeared to be motivated by the obstetricians' desire to acquaint themselves with international techniques. In the words of Magalhães Coutinho, "it was not with the aim to generalize these applications, that we started the trials in the clinic. We simply wanted to judge, through our own experience, the reasons that had been raised *not to multiply these attempts*" (Coutinho 1857: 329, italics added).

As in the case of surgeons, anaesthesia had simplified obstetricians' performance of what had previously been challenging interventions, such as invasive foetus extraction. With the application of ether and chloroform in normal childbirth to relieve women from labour pain, anaesthesia expanded obstetricians' realm from that of pathological delivery to all childbirth. As already noted, registered midwives in hospital wards were prohibited from administering anaesthesia, so their traditional task of assisting the parturient during labour was eclipsed by the function of the obstetrician overseeing the use of anaesthetic and monitoring its effects. This focus on pain enlarged the responsibilities of the *parteiro* (obstetrician) in the birthing scene, accelerating, in turn, the process of subordination of the *parteira* (midwife).<sup>24</sup> The hospital setting, which increasingly accommodated childbirth, would "crystallize a division of labour following a gendered matrix" where the obstetrician treated – while the licensed nurse-midwife took care of – the parturient (Carneiro 2005: 78).<sup>25</sup> Even if in Portugal, as already observed, the hospitalization process was slow and non-linear, the second half of the 19<sup>th</sup> century marked, nonetheless, the emergence of interventionism pertaining to labour, which began with the management of pain, resulting in a new epistemology that transformed obstetrics from the "art" to the "science" of parturition (Barreto 2007).

In the following section, through an analysis of the theses and articles produced in Santa Bárbara ward as a result of experimentation with anaesthesia, I will attempt to delineate the empirical conditions that permitted the emergence of a specific obstetric understanding of pain in childbirth. The possibility of controlling the labouring body in the delivery room obliged obstetricians to address certain issues. Firstly, as already alluded to, obstetricians were confronted with the need to justify the suppression of pain in normal deliveries<sup>26</sup>

24 Male obstetricians referred to themselves mainly as *parteiros* or *obstetra*. This second denomination would apply later also to women obstetricians, while the term *parteira* always referred to the assistant midwife, which in the following decades became a nurse with specialization in midwifery.

25 As Carneiro observes (2005, 2008), women started to enrol in Lisbon's Royal School of Medical and Surgical Sciences only towards the end of the 19<sup>th</sup> century.

26 The use of the forceps and the intra-uterine manual inversion in case of dystocia were considered instrumental deliveries that justified the use of anaesthesia, as for surgical operations.

on a religious and ethical basis, explicating their intervention in relation to a punishment that was understood to have been decreed by God himself in the Old Testament.<sup>27</sup> Another problematic aspect was the encounter with a new corporeality – the unconscious woman – that challenged previous frameworks for the interpretation of pain. Finally, the use of anaesthetics compelled obstetricians to define what pain was, and to develop a biomedical lexicon around it.

Clergy censure of the alleviation of pain in childbirth was a topic that engaged all obstetricians in Portugal who dealt with anaesthesia. The narrative on which every obstetric thesis relied, following Simpson’s original defence (cited earlier), compared the compassionate agency of the physician with the will of the Creator – “God was the first anaesthetist” – and referred to the parturient’s free choice about being anaesthetized (Sacadura 1947a). At the same time, arguments in favour of anaesthetization were propounded largely on secular grounds: the elimination of pain was, it was argued, a moral and ethical duty, which interested the obstetrician as much as the surgeon since Hippocrates’ dictum *divinum est opus sedare dolorem* (alleviating pain is a divine work): “every time a doctor can suppress pain, he realizes one of his most useful missions, and childbirth pain, though physiological, is still pain, that he should endeavour to eliminate” (Simões 1943: 53).

While the history of childbirth anaesthetics reveals that, from its very beginning, women also sought painless childbirth, it has also stressed how class disparity shaped not only women’s power of negotiation, but even the outcomes of this process (Wolf 2009; Stokes 2003; Michaels 2014). In more than one instance the parturients of Santa Bárbara were reported as actively seeking “that whiff,”<sup>28</sup> whose wonders circulated in the ward thanks to “the propaganda made by those who had first had the occasion to try out its beneficial effects” (Villar 1892: 24). On the other hand, anaesthesia appealed to obstetricians in terms of its ability to discipline bodies and became an explicit element of their agenda, whereby “putting an end to the disordered movements of the suffering woman, and relaxing the abdominal muscles, constitute one of the best adjuvant of the surgeon” (Sarmiento 1898). Ahmed has observed that “the charitable discourses of compassion more broadly show us that stories of pain involve complex relations of power” (Ahmed 2004: 22). The compassionate quest to nullify pain cannot be separated from parallel efforts to control and contain the emotional parturient, frequently depicted as anxious, delirious, hysterical; the liminal expression of feminine corporeality (Joaquim 1997). The archive is replete with descriptions which overlap the

27 Nearly every thesis analysed refers to the Genesis 3:16: “I will greatly multiply your pain and your conception. In pain you shall bring forth children.”

28 “Aquelle cheiro” (Coutinho 1857: 331).



moral duty of the obstetrician to deliver women from pain with an impulse to gain control of their labouring bodies.

As Javier Moscoso has pointed out,

“The arrival of anaesthesia in the operating theatre brought about unhurried dialogues and controlled gestures. Although the appearance of narcotic gases did not in itself change the scenery of experience, it did allow the protagonists to interpret a different comedy. The surgeon no longer behaved like executioner, but like a gentleman. The patient, on the other hand, no longer endured the operation like a martyr, but like a corpse” (2012: 116-117).

Portuguese obstetricians usually administered anaesthesia tentatively, starting with low doses that were later adjusted, depending on the effects obtained. While some parturients reacted immediately, losing consciousness, others alternated between excitement and stupor; the majority presented a state of drowsiness occasionally interrupted by apparent expressions of alertness, coinciding with uterine contractions. After the effects of anaesthesia faded, many women did not remember having given birth, even if they had cried or moved during the final phases of childbirth, which left obstetricians in “philosophical doubt” (Synval 1848: 83) as to whether the unconscious state induced by anaesthesia involved insensitivity or simply amnesia. What was the parturient really feeling during that “deep sleep”?

French physiologist François Magendie had strongly criticized the use of anaesthesia in childbirth, claiming that it not only “stole” the patient’s conscience but also provoked erotic dreams in women (Coutinho 1857: 329). Though he firmly dismissed these assertions, Magalhães Coutinho noted in one of his early cases, “when the woman woke up [...] she said that not only she hadn’t felt any pain, but also that the remedy we gave her had produced a very enjoyable sleep. Could this be a case of what Magendie complained about?” (1857: 332). Faced with immobility, occasional groans and amnesia upon waking, obstetric inquiry into what really happened in that “senseless abandon” (1857: 329) was replete with uncertainties and innuendos. Coutinho, however, ruled out any possible association between childbirth (whether painful or not) and sexual pleasure: “Some obstetricians argue that it is not chloroform but childbirth itself that can give pleasant sensations to the parturient... Apart from the pleasure of maternity, we don’t acknowledge any other” (1857: 332).

Effectively, the new corporeality of the anaesthetized parturient had robbed the obstetricians of the key signs upon which they had historically constructed a reliable interpretative framework. Before anaesthesia, the progress of labour had been interpreted through a hermeneutics of the various groans and cries of parturients; obstetricians understood the physiology of labour through changes in the quality and intensity of women’s laments. The following passage

elucidates the importance of the parturient’s cries in rendering the progress of labour intelligible to obstetricians:

“During the period of dilatation [...] contractions have a certain regularity [...] women are agitated, cry out involuntarily, but not as in the following period when [...] they close the glottis during the effort. [...] The pains become now stronger than ever, it seems like all the vulvar region is torn, the screams are more violent than before” (Branco 1899: 40).

The discomfort felt by obstetricians on hearing the crescendo of women’s cries during labour played an important role in the decision regarding when they would administer anaesthesia. Analysing the effects that the cries of labouring women have on hospital attendants, historian Jaqueline Wolf describes how, in several interviews she conducted, women who experienced birth without medication reported that the transition period<sup>29</sup> is the most painful part to sustain, whereas the second stage of labour – birthing – was mostly described in terms of effort, of hard work, even joyful, and it was often sustained by cries. She deduces that “the unsettling sights and sounds of second stage labour are probably why doctors, beginning with the introduction of anaesthesia in the mid-nineteenth century and continuing well into the 1960s, customarily administered general or regional anaesthesia only at the end of the second stage labour, as the baby’s head crowned” (Wolf 2009: 5).

While, according to the obstetricians’ interpretation, pain was evident in women’s cries and agitation, it was also understood to be dependent on their subjective capacity to endure. This was predicted through the parturient type, a variable that was articulated (at least up to the first decade of the 20<sup>th</sup> century) through the humoral theory, where a “sanguine temperament” corresponded to a robust physique and would bear pain better than a “lymphatic type,” generally considered to be of weak constitution (Coutinho 1857; Santos 1871; Salgado 1880; Villar 1892; Paiva 1916). Moreover, echoing an idea popularised by the success of obstetrician George Engelmann’s publication “Labour among primitive peoples” (1883 [1882]), the experience of childbirth pain was understood to be influenced by the “level of civilization” of a people, and, within the same race, by social class. Ranking bottom in sensitivity were the “savage” women, who allegedly delivered babies feeling no pain, while in civilized societies it was working women, especially farmers, who were considered less prone to suffering during childbirth (Villar 1892; Paiva 1916).

In any case, before the uncontrolled spasms of the expulsion phase, all women were deemed at risk of being left traumatized or in shock by the pain

29 The phase of labour when the cervix finishes dilating, preceding the expulsion phase.

of delivery. While obstetricians did not falter in their conviction that they were working for the suppression of this potential trauma, they also questioned the necessity of pain and the ambiguity of childbirth being the only painful physiological act.<sup>30</sup> “What are the reasons,” questioned Villar, “to call physiological an element, whose absence does not produce any effect against labour, and whose presence can often cause irremediable disasters?” (1892: 14). The imposition of anaesthesia upon childbirth pain thereby signalled the power of obstetrics over nature, based on an ethics of compassion.

More than any other phenomenon in the history of western philosophy, childbirth had resulted in the characterization of women as liminal creatures, constantly at the threshold of sociality. The uterus – which Plato had compared to an animal – being a pivotal symbol of their ungovernable corporeality, determined women’s behaviour, subjecting them to their instincts (Laqueur 1990; Joaquim 1997; Pizzini *et al.* 1981). Now obstetricians could govern the uterus by controlling the pain expressed through it.

Emancipated from the old idea that “uterine contractions have the name of pains [*dores*] as there is virtually no contraction in labour that is not painful” (Branco 1899: 38), the new epistemology of childbirth instigated a conceptual separation of pain and contractions in labour. “Pain was for a long time considered an inseparable companion of childbirth labour; this idea rooted so deeply in the spirit, that today pains are still synonymous of uterine contractions” (Villar 1892: 11). While the formulation of this separation was unambiguous, obstetricians in Portugal struggled to adapt to the new lexicon, often still describing contractions as “pains.”

Taking pain out of parturition equated to separating the parturient’s conscious self – suffering, anguished, uncontrolled – from an organ. In the process of the development of a modern, technical lexicon around birth, pain gained the ontological status of a disembodied phenomenon which, causing trauma, needed to be acted upon. “Nothing proves that childbirth pain is a useful or indispensable physiological phenomenon,” claimed Villar, “on the contrary, its suppression, or at least its reduction, is the biggest advantage” (1892: 69).

While engaged in an epistemological effort to ground pain and contractions within an organicist vocabulary, obstetricians nonetheless continuously drew from an emotional idiom for support. “Painless childbirth,” as argued in Soares’ thesis, “has always interested the obstetrician and deserves to be dealt with in cold blood [*sangue frio*] and without passion” (Soares 1925: 1); listing what he considered harmful methods of administering barbiturates in

30 The dilemma of childbirth being the only painful physiological function (compared to breathing, blood circulation or digesting, for example) characterizes many obstetric texts over the decades, and became a central question – though with different answers – both for the apologists of anaesthesia and, later, for the supporters of psychoprofilaxis.

childbirth, the obstetrician later observed that “intravenous administration gives results of impressive brutality” (1925: 47). Here pain seems to fall under that “set of problems of social relationship or existential meaning” – as argued by Lutz and White (1986: 427) – “that cultural systems often appear to present in emotional terms [...]. While the force that moves people to deal with these problems may be conceptualized as purely somatic [...] the emotion idiom is often the central one.”

Childbirth anaesthesia triggered a technology of pain articulated through the control of the labouring body (Foucault 1988). As a consequence, the physiological pain that emerged from the early trials as a material, manageable phenomenon, became distinguished conceptually from emotions, with the severity of the first depending, in part, on the woman’s temperament and capacity to control the second. At the same time, while obstetricians in the Infirmary Santa Bárbara were working on the constitution of an ontological labour pain, disembodied and disentangled from women’s (and obstetricians’) emotional dimensions, it can be seen that their agency also resonated through a broader obstetric politics entrenched in affective discourse, which moved beyond the microcosm of the ward, entering the wider populace.

## CONCLUSIONS

“Pain, which almost always lacks justification, does have a history” writes Spanish historian Javier Moscoso (2012). With an eye on the contemporary biomedical understanding of childbirth pain in Portugal that advocates for broader national coverage of pharmacological practices in labour management, I have delved into the history of obstetrics in Lisbon to uncover how childbirth pain came to be constituted as a subject of clinical and political interest. My general aim was to discover what ideas of pain were produced and circulated at that specific socio-historical juncture, and how they mobilized obstetric agency.

This analysis is distinguishable from Elaine Scarry’s “ontological fallacy” (Bourke 2014: 17), which led her to approach “physical pain” (rather than a person in pain) as an entity with agency, an idea crystallized in her most quoted reference that “physical pain does not simply resist language but actively destroys it” (Scarry 1985: 4). I, instead, focused on the languages and politics that were actively generated around the pain of childbirth in a historical phase when the borders between physical pain and moral suffering blurred continuously in biomedical accounts, concurring with Ahmed that “the affectivity of pain is crucial to the forming of the body as both a material and lived entity” (2004: 24). As Geoffrey Galt Harpham observed, Scarry has treated pain “as an immediate and monochrome physical experience, a baseline of reality,” rather than recognizing its complex and multifaceted quality (Harpham 2001: 208). The archival research described has allowed me to

unfold the local, historical process in which a new biomedical understanding of childbirth pain as a physical phenomenon was produced, in the mist of an international biomedical debate on childbirth that encompassed moral dilemmas, heuristic doubts and national professional interests.

This genealogy of labour pain begins with the discovery of anaesthesia, which corresponded to the emergence of pain as a specific object of obstetric knowledge (Foucault 1980) and to the arrival of the new medical technique in Lisbon. To create a comparative analysis, in the first section I analysed the understanding of childbirth pain traditionally reproduced within traditional midwifery-led homebirths and conveyed through popular proverbs. Within this context, the hardship of childbirth was mingled with the anguish of women's existential condition, reflecting a life marked by hard work, and committed to sacrifice. Pain was managed through practices that, while focused on hastening labour (moving, squatting, massaging, chanting), also had a cathartic or liberating function aimed at pain endurance. In comparison, the emergence of anaesthesia and its incorporation within obstetrical practice was founded on the control and management of the disordered labouring body.

As the analysis of the theses reveals, grounding their knowledge on the (elusive) absence of those signs – the facial expressions, cries and spasms – that reputedly conveyed the presence of pain to the clinician, obstetricians came to conceptualize pain as a disembodied, ontological phenomenon, distinct from uterine contractions, that could be separated from the physical act of parturition, while still being physiological in nature. The new epistemology of obstetrics which ensued reveals complex relations of power: the will/duty to deliver women from pain overlapped with the need to experiment with the new substances available in order to keep up with international obstetric practice. As obstetricians reassessed their competences in the delivery room, they expanded their domain into non-pathological parturition. In the same time-frame in which anaesthesia was being tested in Santa Bárbara ward, a specific obstetrical lexicon around pain was being created, a language that alternated between techno-scientific assertiveness and affective engagement.

Two historical events that resonated within Portuguese obstetrics – Queen D. Maria II's mortal childbirth and Alfredo da Costa's speech on the condition of Santa Bárbara Infirmary – are particularly emblematic in this regard. Both events were coeval with particular phases of experimentation in obstetric anaesthesia, and the physical aspect of pain was eclipsed in the retrospective use that obstetricians made of anaesthesia in the first decades of the 20<sup>th</sup> century.<sup>31</sup> Both occurrences in fact served as symbols of Portuguese obstetrics'

31 D. Maria II's death was presumably marked by the use of chloroform in her last childbirth, while da Costa's speech was accompanied by sketches of an ideal maternal infirmary that included a specific area for instrumental labour and anaesthetics.

commitment to birthing mothers – be it due to the threat of Neo-Malthusianism or to the lack of proper infrastructural conditions. The analysis of these two events aids understanding of how labour, childbirth and, indeed, motherhood were inscribed within a broader rhetoric that mobilized the role of obstetricians in alleviating women’s suffering and pain through anaesthesia, becoming the foundation for modern obstetrics in Portugal.

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