



# **Making a man, a great man: Ephraim McDowell, ovariectomy and history**

Jean Bowra  
PhD Candidate  
Centre for Social Change Research  
Queensland University of Technology

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**Paper presented to the Social Change in the  
21<sup>st</sup> Century Conference**

**Centre for Social Change Research  
Queensland University of Technology**

**28 October 2005**

# **Making a man, a great man: Ephraim McDowell, ovariectomy and history**

*Jean Bowra*

*Centre for Social Change Research, QUT*

## **Introduction**

Doctor Ephraim McDowell is described in literature as ‘The Father of Ovariectomy’ and even, on occasion, as ‘The Father of Abdominal Surgery’ (see Ridenbaugh, 1890; Schachner, 1921). Such titles indicate that McDowell could be considered as a ‘great man’, a surgeon whose unique contribution to medicine can be described as a definitive moment in the history of surgery. Without any intention of denying that McDowell was, indeed, a brilliantly innovative surgeon, this paper will explore some of the conditions of possibility that allowed one surgeon to emerge as a leader in his field. McDowell was not the first to enter the abdomen of a patient, nor even the first to have that patient survive. Yet his operation is recorded almost as the moment when modern abdominal surgery began.

Using the archaeological approach of Foucault, it can be shown that certain conditions of possibility allowed McDowell to assume his titles (Foucault, 1972). One cannot present definitive answers to such riddles, but this paper will raise questions for consideration. Questions that may cause us to reflect on the presentation of history and to investigate in more detail how certain achievements are recorded. This work will question whether Ephraim McDowell was born to be a ‘great man’ or was he instead fortunate in the way history has described him.

Two operations will be illustrated here, that of Doctor Ephraim McDowell, carried out in 1809 and that of Doctor Robert Houstoun performed in 1701. After describing the operations, details of the debate surrounding both procedures will be recounted. This will be followed by a presentation of some of the conditions of possibility that may have allowed McDowell to become so renowned. No definitive answers will be given here. Rather, this work will encourage us to reflect on how some individuals attain historical importance while others virtually disappear from our memory.

## **Doctor Robert Houstoun**

The first procedure to be discussed is that conducted by Doctor Robert Houstoun in 1701, an operation that has been reported as the earliest ovariectomy, although this is widely debated within medical circles (see for instance Lizars, 1824; Shaw, 1728; Shepherd, 1965). However, whether or not this was an ovariectomy, it was an operation that opened the abdomen, penetrated the peritoneal wall and exposed the intestines to the outside eye. Therefore one could say that if not the instigator of ovariectomy, Houstoun could be regarded as the father of abdominal surgery. That this has not occurred will be further explored later in this essay.

In his operative report, documented in the *Philosophical Transactions of the Royal Society*, 1724, Houstoun revealed his reasons for attempting the procedure at all, a very dangerous pursuit in the early Eighteenth Century (Houstoun, 1724). A pain in her left side had troubled his patient since a difficult birth thirteen years previous to her consultation with Houstoun. During the preceding two years the pain had worsened and her ‘belly’ had grown so much in size that the woman was experiencing difficulty in breathing. Her problems had increased to such an extent that she was bedridden and scarcely “eating as much as would nourish a sucking child” (Houstoun, 1724, p.3). Because her tumour had become so enlarged, the woman was forced to lie on her back and, according to Houstoun, this had caused the skin on the abdomen to abrade severely. Such excoriation, when coupled with lack of comfortable rest and depleted

appetite, had produced severe emaciation in the patient. Therefore one can understand that Houstoun would be seeking any means of alleviating this woman's condition.

However, these indications of suffering may not in themselves have led to an operative procedure because cases of dropsy of the ovary were most often, in this period, treated by 'tapping' or draining the fluid from the affected area (Astruc, 1985; Shaw, 1728; Wiseman, 1993). However, Houstoun makes one very significant observation. When describing the huge mass of the tumour and its position in the abdomen, he stated that "it drew towards a point" (Houstoun, 1724, p.3). And a pointed tumour was believed to be one that would putrefy most quickly (Lowe, 1987). From this observation, the operation Houstoun proposed was more a puncturing of the abdomen, rather than the removal of a diseased ovary. And it was an operation to which his patient agreed.

Thus Houstoun's reasoning can be clearly seen as an attempt to puncture the abdomen in the hope that the fluid contained within would escape, much as one would lance a boil or an abscess. This supposition is supported by the doctor himself when he stated that after incising a one inch opening using an abscess lancet and finding no issue of fluid, he enlarged the wound to two inches "and even then nothing came forth but a little thin yellowish serum" (Houstoun, 1724, p.3). He continued his incision a further two inches and discovered that the orifice contained only a 'glutinous' substance. It is apparent from these observations that his intention had been to relieve the patient by lancing a mass that drew to such an obvious point and that the supposed removal of her ovary was an unintentional result of this operative procedure.

When faced with an abdominal cavity filled with a slippery substance, Houstoun was forced to resort to a most unusual medical instrument to remove it all. He used a fir-splinter, "such as the poor in that country use to burn instead of candles", wrapped with lint for thrusting into the wound (Houstoun, 1724, p.3). He proceeded to remove the substance using a motion similar to that of whirling fairy floss, turning and winding, eventually withdrawing more than two yards of the material. Since the mass was described as about ten inches wide and was followed by a further nine quarts of similar material containing pieces of membrane which he thought were parts of an ovary, this could be considered as invasive abdominal surgery.

It is clear from Houstoun's description that he believed that he had removed at least part of the patient's ovary and that he had definitely opened the abdomen and exposed its contents to the outside air. And opening the abdomen was not considered feasible even in the advance European medical centres (Cartwright, 1967; Dally, 1991; Mort, 1987). Surgical knowledge that could be tested was still scanty and surgery was largely confined to the outside of the body. Without anaesthesia patients were exposed to agony and the risk of shock from internal operations deterred surgeons from intervening except in dire emergencies. Therefore the danger in opening any of the body's major cavities – the abdomen, chest or cranium – meant that a catastrophe in one of them led almost exclusively to death. These sentiments were certainly also true for the period in which McDowell operated, so Houstoun's operation has to be considered as innovative for the early Eighteenth Century.

## **Doctor Ephraim McDowell**

Moving forward to a little over a century later, we will now explore our second procedure, that conducted by Doctor Ephraim McDowell. McDowell actually performed three ovariectomies before documenting his procedure in *The Eclectic Repertory and Analytical Review* in 1817. However, for the purpose of this paper, we will look at his first and most famous operation, that conducted on Mrs Jane Crawford in 1809.

When McDowell was consulted in this case, he thought he would be assisting with the delivery of twins. However, after a vaginal examination that showed the uterus to be empty, he concluded that the problem was an enlarged ovary (McDowell, 1817). Therefore, right from the beginning of the operation, and unlike Houstoun, it is clear that McDowell was prepared to remove a tumour. McDowell gave Mrs Crawford information about the dangerous nature of her condition and at no time did he mention he considered 'tapping' the offending tumour. He also openly admitted that he had never seen such a large tumour extracted, "nor heard of an attempt or success attending any operation, such as that required: (McDowell, 1817, p.242).

It was clearly indicated by McDowell's first incision, which was nine inches in length, unlike Houstoun's one inch cut, that McDowell was preparing to remove an ovarian tumour. Given the length of the incision one can see that his intention was to gain access to the abdominal cavity and thus the tumour he believed it contained. When faced with such a large tumour, it was apparent to McDowell that it would be difficult to remove it completely. Therefore, after tying a ligature around the fallopian tube, quite near the uterus, he cut open the tumour. He describes the tumour as "the ovary and fimbriated part of the fallopian tube very much enlarged" (McDowell, 1817, p.243).

This, then, was how the world's most famous ovariectomy was performed. It is widely documented and has earned its perpetrator the title of "Father of Ovariectomy" and the fore runner for abdominal surgery. But we can challenge this title, or, at the very least, consider if there were some conditions of possibility that allowed McDowell to be christened thus, rather than acknowledging that Robert Houstoun should hold the position.

### **Debate surrounding these procedures**

The question of who was the world's first ovariectomist and where the procedure began has become what one could describe as an "often childish controversy" (Shepherd, 1965, p.37). Doctors of the Nineteenth Century and later were divided in their beliefs about who was the first to find success with this procedure and McDowell's claim was clearly not supported by all concerned. There are claims that doubt about McDowell began to surface within his own lifetime and that the argument continued on both sides of the Atlantic (Schachner, 1921). This debate had several components.

First, there was much hair splitting over the actual term 'ovariectomy' and this was used to either defend McDowell or promote Houstoun as the first to perform this procedure. Schachner claimed that the use of the word ovariectomy was at the centre of the whole controversy (1921, p.146). This is because, literally, the word means 'cutting into' but not removing an ovarian tumour, and there is little doubt that Houstoun did cut into a tumour a century earlier than McDowell (p. 146). Schachner defines the argument over the operation further when he explains that Houstoun's operation should correctly have been called an ovariotomy (incision for drainage) and McDowell's operation an ovariectomy (removal of tumour) (p.146). So it is evident that some of the debate surrounding these procedures certainly centres on the misuse of medical terminology.

Second, those that hasten to discredit McDowell are also quick to expose many supposed instances of earlier ovariectomies. These are instances other than the procedure performed by Robert Houstoun and naturally these proposals are roundly critiqued by supporters of McDowell such as Schachner (1921) and Ridenbaugh (1890). For instance, there is a claim that the ancient Kings of Lydia removed the ovaries of women who they wished to use 'in service' rather than utilising eunuchs. Schachner, however, cites Doctor Peaslee's research that showed that this procedure was more likely to have been either the removal of the uterus or clitoridectomy (Peaslee cited in Schachner, 1921). And such is the case with other examples.

Commenting on Atlee's *Table of all known operations of Ovariectomy from 1701-1751*, Schachner notes that Atlee mentioned four procedures that preceded McDowell's operation. These were operations performed by Robert Houston, L'Aumonier, Dzondi and Galenzowski (Schachner, 1921). Both Schachner and Ridenbaugh (1890), being supporters of McDowell, refute these claims. For instance, they note that Dzondi actually operated on a young male and Galenzowski performed an incision and drainage similar to Houston (Schachner, 1921). Schachner calls these claims of earlier operations "concrete illustrations of the confusion, errors, and contradictions that are interwoven with the life and the work of McDowell" (p.156). Perhaps these cases were not 'perfect' ovariectomies, however they did enter the abdomen and therefore proved the viability of such surgery. However, overall, they appear to have been relegated to pawns in this medical debate rather than being remembered for their own unique contribution to medical knowledge.

Although Robert Houston did not describe cutting and tying the pedicle to remove the tumour when he reported the description of his operation, Lawson Tait, a renowned late Nineteenth Century surgeon, claimed there was little doubt that he did indeed perform this procedure (Schachner, 1921). However, Ridenbaugh claimed this was merely Britain's attempt to "procure for Great Britain precedence in the performance of this operation" (1890, p.92). She added that if Houston had cut the pedicle, then he would have mentioned it in his paper. Shepherd (1965) sums up this argument when he says that the real nature of Houston's operation will forever be in doubt despite Tait's claims. This reveals that perhaps there was some animosity between Great Britain and the United States over claiming the world's first ovariectomy.

This debate has also included claims that Ephraim McDowell did not actually perform the operation on Mrs Jane Crawford, instead the procedure was conducted by his nephew, Doctor James McDowell (Schachner, 1921). Although Schachner is unsure where such claims originated, he believed they were merely another attempt to discredit Ephraim McDowell. However, he does cite a letter from Mrs Crawford in which she says that she thought that James McDowell did the cutting and dressing and that Ephraim McDowell merely assisted. Since James died before Ephraim published his account he can hardly add to this debate. However, Schachner believed Mrs Crawford was confused due to the huge strain of the ordeal (p.136). For Schachner, the whole purpose of this debate is clear. He stated that it "only raged because McDowell was a backwoodsman without a diploma to practice" (p.xvi).

It is evident from this information that there is little doubt Robert Houston's operation was radical abdominal surgery for its time. However, his achievement has been subsumed in the shadow of Ephraim McDowell's fame. We may assume that both sides in this debate have some basis for their claims, but history has widely reported that Ephraim McDowell is the 'Father of Ovariectomy'. Therefore, to understand why this happened, it is helpful to examine some conditions of possibility that allowed this belief to become so commonplace.

### **Conditions of possibility**

As stated earlier in this essay, it is not the intention of this work to detract from Doctor McDowell's achievement. What is proposed here is an alternative way of viewing his position in history. Rather than assume that this backwoodsman, practising as a doctor without formal qualifications, was indeed a brilliant innovator, we can consider some conditions that were present, conditions that may have contributed to his place in the history of medicine.

### ***Frontier Location***

One theme that emerges from the literature is that which emphasises McDowell's frontier location. Ridenbaugh (1890) claimed that "perhaps it was the pioneer spirit which gave him the courage to make the experiment" (p.4). Schachner (1921) noted that such a location meant a doctor needed to be self-reliant and prepared to utilise his 'mother wit'. He added that a frontier location also meant McDowell needed to rely on common sense and courage to a very high degree. Therefore, when faced with a life-threatening tumour, he was able to make the decision to operate without "dodging the issue" or discussing his plan with other medical practitioners (pp.144-45). Schachner indicates that such was not the case in British metropolitan centres and notes that the operation would never have been attempted if McDowell was practising medicine in Edinburgh (p.144). This was due to the centralisation of power and control in these centres, a move that was leading to the increasing regulation of medical practice. Therefore there is an argument that because McDowell was on the fringes of civilisation, he was more free to experiment. Houstoun did not share this freedom.

So, our first condition of possibility suggested in literature that documents McDowell's success, is that of location, frontier location. Being free from the restraints of politically governed metropolitan medicine, McDowell was able to experiment. But one should also note the auxiliary traits that are assigned to McDowell because of this frontier location. As a backwoodsman he is assumed to have had a high degree of courage, common sense, freedom, self-reliance – all enabling him to confront a life-threatening condition and successfully overcome the challenge. It is clear that assigning such traits to *all* backwoodsmen can be construed as blatant stereotyping and assuming McDowell possessed these traits simply because of his location certainly appears as unfounded.

It is also interesting to note that between 1821 and 1840 McDowell's procedure was followed by no less than eight American surgeons attempting ovariectomy, some with and some without success (Schachner, 1921, pp.158-60). In Britain, however, there were only four who attempted the operation in this period. Lizars in Scotland, Granville who was unsuccessful, and Jeaffreson and King, provincial surgeons who operated together and who Schachner claims were the first successful English ovariectomists (pp.194-5). Schachner indicates that these were provincial surgeons and that the English provincials were progressive, a clear comparison to McDowell and his frontier spirit. However Schachner believed that those surgeons in metropolitan areas were plagued with "discouraging conservatism" (p.196).

### **Communication**

Some historians have identified a condition of possibility that not only allowed McDowell to perform his operation, but added to the wide readership of his results after he published his account. This was his access to his Scottish teachers, especially Doctor John Bell. The colonial period of American surgery relied on graduates of either Scottish or London medical schools (Leonardo, 1943). Ovariectomy, or the possibility of conducting such a procedure was certainly suggested as possible by both John Hunter and John Bell (Cartwright, 1967). Cartwright is in little doubt that John Bell, as a teacher, would have directly influenced McDowell. Bell was believed to have lectured on ovarian disease and openly discussed how to operate for the removal of cysts (Shepherd, 1965).

According to Ephraim McDowell's nephew, James McDowell, Ephraim published a report on his ovariectomies mainly to please John Bell because Bell was the major contributor to his confidence in performing the procedure (Ridenbaugh, 1890). Doctor Jackson, an American surgeon, supports the claim made by James McDowell, believing that it was John Bell's teaching that led to Ephraim McDowell attempting ovariectomy (Ridenbaugh, 1890). Although Ridenbaugh refutes this, saying "the idea of ovariectomy originated in the fertile brain of Dr. McDowell", it would be difficult to

assume that Bell's teaching was of no importance (pp.11-12). But it is more than the teaching of Bell that can be construed as a condition of possibility that contributed to McDowell's place in medical history.

McDowell is known to have sent a copy of the report on his operations to John Bell (see Ridenbaugh, 1890; Schachner, 1921; Shepherd, 1965). However, Bell was in Rome where he died shortly after and the article fell into the hands of Doctor John Lizars who was stimulated enough by the paper to attempt the operation himself (Shepherd, 1965). When Lizars published his own results in Britain, he included Ephraim McDowell's account as an appendix to his work. This publication is another important condition of possibility that allowed McDowell's work to be widely published in both his native United States and also in Great Britain. The fact that Lizars published the paper of McDowell with his own brought the work to the notice of surgeons in Great Britain and opened the procedure to wider debate. Robert Houston, on the other hand, published in a journal with a much narrower audience and it was not until his work was examined in later years by the likes of Lawson Tait and Spencer Wells that any real attention was given to Houston's contribution to medicine.

Lizars has been recognised as the 'practical originator' of ovariectomy for Great Britain (Fergusson cited in Shepherd, 1965). In fact, Leonardo goes as far as to suggest that Lizars' publication allowed the "practical possibility of the operation to become generally known" (1943, p.301). Therefore McDowell was fortunate to have his name linked with a man who contributed to the development of this procedure on the other side of the Atlantic. This was a condition of possibility that was not shared by Houston.

Although Houston is denied the possibility of being the instigator of abdominal surgery by Schachner (1921), the author does admit that Houston's operation led to an alternative to tapping ovarian tumours (p.156). This innovation was the incision and drainage of ovarian cysts. However, it was not widely adopted in Britain at the time, instead becoming a procedure more favoured in France. McDowell, on the other hand, saw his procedure attempted and debated in both the United States and Great Britain and this could have occurred because of the wider readership of his account in these countries. Ridenbaugh (1890) notes that during the time of McDowell, medical journals were almost unheard of and the medical profession was not as well organised as in her day, therefore this would have been even more applicable at the time Houston operated (p.79).

## **Conclusion**

From the evidence presented it is apparent that Doctor Houston performed what can only be described as daring and innovative surgery for such an early period in our medical history. Yet his contribution is certainly not acclaimed with the same fervour shown for the operation performed by Ephraim McDowell a century later. McDowell is frequently described as a great man, a brilliant surgeon. What this essay has done is indicate just a few of the conditions of possibility that may have contributed to McDowell's reputation.

Rather than simply accept that McDowell's ovariectomy was an isolated example of one individual's excellence in surgery, this work prompts us to consider other factors that led to McDowell being so widely remembered and celebrated. Robert Houston did not have his work widely published, nor did he have it adopted by a respected university surgeon such as Lizars. His small innovation in draining cysts was more widely adopted in France than in his native England. He lacked the elusive 'frontier spirit' that is supposedly one of the precipitating factors which allowed McDowell the freedom to repeat his operation. Therefore McDowell had more than one case study to

present to the medical world. Houstoun, being constrained by his metropolitan location and the politics that governed behaviour there, could not freely 'experiment' as McDowell had done.

When one considers the debate that surrounded both Houstoun and McDowell with regard to who was indeed the world's first ovariologist, it is all too easy to accept the commonly held belief that the 'great man' prevailed. That Ephraim McDowell, single handed, armed with frontier spirit and surgical brilliance, opened the abdomen for further experimentation. This is recorded as a single definitive moment in surgical history. What this paper has endeavoured to illustrate is that certain conditions of possibility were operating that assisted McDowell's claim. And these conditions were not available for Doctor Robert Houstoun. Although this paper has discussed only a few of those conditions, it is hoped that this will be enough to stir us into further consideration of how history records a 'great man'.

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