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MEDICALIZING GENDER: HOW THE LEGAL AND MEDICAL PROFESSIONS SHAPED WOMEN'S EXPERIENCES AS LAWYERS

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Cover Page Footnote

Research Fellow, Michigan State University College of Law. J.D., Michigan State University College of Law, 2013. This paper would not have been possible without invaluable assistance and inspiration from Hannah Brenner and the generous support of Michigan State University College of Law.

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EXPERIENCES AS LAWYERS**

Kathleen Darcy*

ABSTRACT

Despite significant progress, women in the legal profession still have not advanced into positions of power at near the rate in which they saturate the legal market. Scholars agree that simply waiting for parity is not sufficient, and, thus, they have identified many of the barriers that contribute to women’s difficulties. To date, however, the role that scientific and medical understandings play on the evolution of law, and on women as lawyers, has not received examination until now. To this end, I posit that medicine played a significant role in shaping societal expectations and assumptions about gender, and was similarly influenced by already-existing societal assumptions about gender. This created a complex and substantial barrier that kept women from exploring options outside the “spheres” of society they traditionally occupied. This article explores how medically-supported gender theories, in practice, have actually operated to limit women’s professional progress, relegating them to traditional gender roles and halting their ascension in the ranks of the legal profession. I examine how this barrier operates in three ways: how early women lawyers adopted these medical theories into views about their own gender; how society and those around these early women lawyers adopted these views to shape expectations about women as lawyers; and how the court explicitly and implicitly relied on these assumptions about gender to keep women out of the legal profession. An examination of how these medical and scientific theories about gender have shaped the ways society views gender, and vice versa, can help illuminate the discussion on the barriers that impede modern women lawyers.

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I. INTRODUCTION

*A. The Historical, Scientific, and Medical Understanding of Gender:
How It Shaped the Legal System of the United States*

This paper was inspired by reading the experiences of an early female lawyer¹ in the United States who briefly mentioned limitations placed on her sex² by the medical community, attributing them as a barrier to her ability to practice law. While scholars have explored the multiple barriers that have held women back from progressing further in society, one aspect scholars have not fully considered is how the medical understanding of both biological sex and gender has impacted women's struggles. Modern scientific understanding does not seem to question women's capacity to reason and exert themselves mentally without sacrificing reproductive capability, but an early understanding of the female reproductive system cautioned against women taking part in academic or intellectual endeavors, arguing that such limitations were necessary for the good of society.³ Medical advances often ended up significantly harming women, to the point where natural aspects of their biological sex were themselves viewed as symptoms, and, thus, women as a gender were viewed as "diseased."⁴

In this paper, I explore how these medical understandings of gender, biological sex, and sexuality, stemming from the Victorian era and traced to modern times, have impacted women within the legal

¹ Virginia G. Drachman, *Letters from 1888, Letter from Ellen A. Martin*, in *WOMEN LAWYERS AND THE ORIGINS OF PROFESSIONAL IDENTITY IN AMERICA* 73, 114 (1993) ("In addition to the difficulty of acquiring an acquaintance among business people and a general knowledge of affairs, women have to contend, unless very robust and healthy, with a physical condition that is very trying. I refer to the close relation between the brain and the organs peculiar to women, and to the fact that any trouble with those organs (and a celebrated anatomist says they seem made to get out of order) seriously affects the brain and the nervous system.").

² For the purposes of this paper, when I refer to "sex," I mean biological sex. When I refer to "sexuality," I mean sexual acts. When I refer to "gender," I mean the societal interpretation of sex based on historical context. The medical research and much of society during the time period that I discuss blurred the lines between these terms, using them interchangeably. So, the scientific understanding of "biological sex" ultimately used a pseudo-scientific rationale to *define* gender in society and the courts.

³ For further discussion on the history and the multiple elements of societal acceptance of women as inferior (religion, science, history), and a thorough discussion on Victorian construction of womanhood, see CYNTHIA EAGLE RUSSET, *SEXUAL SCIENCE: THE VICTORIAN CONSTRUCTION OF WOMANHOOD* 205-06 (1989) (discussing how science was used to validate the natural inferiority of women).

⁴ See discussion *infra* note 10.

system. A full exploration into how the medical understanding of women's health has shaped laws and court interpretations is beyond the scope of this paper; here I focus specifically on women lawyers' experiences within the legal system.⁵ The language of early court cases addressing whether women could function as lawyers points to preconceptions based on medical understanding of natural ability, thus relegating women to these prescribed roles within society.⁶ Medical theories of gendered diseases found their way into both common law and statutory language.⁷ In reality, however, societal norms and expectations shaped (and still shape) medical theories significantly. Reflecting on the societal norms throughout history, law was not viewed as a realm in which women were "naturally" equipped to participate.⁸ This understanding of what women were capable of stemmed in large part from the medical community, which, I argue, was in turn influenced by societal expectations.

I posit that medical understandings of gender actually placed undue limitations on women in society, relegating them to their traditional gender roles and maintaining the societal status quo, despite evidence challenging these traditional notions. I support this theory by focusing on women's experiences within the legal system as lawyers. The rationale for a focus in this area is simple: this is the primary area where women would have been able to challenge traditional gender roles using the legal system, had they been allowed. The access of women to the courts from within them, as lawyers, would have arguably been the most effective way to effectuate change in the way

⁵ The primary focus of my paper will be on the impact that medicalizing gender had on early women lawyers and its impact on women lawyers today. However, another area where medicalizing gender has had a comparable impact is on women within the legal system as rape victims.

⁶ See *Bradwell v. Illinois*, 83 U.S. 130, 141 (1872) (denying a female lawyer a license to practice law based on the "wide difference in the respective spheres and destinies of man and woman").

⁷ See Vivian Berger, *Man's Trial, Woman's Tribulation: Rape Cases in the Courtroom*, 77 COLUM. L. REV. 1, 69 n.394 (1977) (citing *Michigan v. Bastian*, 47 N.W.2d 692, 695 (1951) (holding that an alleged rapist should be allowed to proffer evidence that his alleged victim was a "nymphomaniac" who brought the sexual encounter upon herself)).

⁸ See, e.g., EDWARD H. CLARKE, *SEX IN EDUCATION; OR, A FAIR CHANCE FOR THE GIRLS* (Charles E. Rosenberg ed., Arno Press 1972) (1873); see also M.D.T. DE BIENVILLE, *NYPHOMANIA, OR, A DISSERTATION CONCERNING THE FUROR UTERINUS* 29-30 (Edward Sloane Wilmot trans., London 1775) (listing descriptions of causes for nymphomania and methods for cure, describing those afflicted with the disease as "debauched" and "dangerous," and describing those most likely to experience it as "young widows, especially if death hath deprived them of a strong and vigorous man").

the legal system treated and understood women. Therefore, denying women access to the bar kept them relegated to their traditional roles and kept them subjugated by the system without any means to enact change.

First, in Part II, I discuss how society shapes the discourse on disease. I delve into how the medical profession was shaped by societal expectations and how the medical profession in turn shaped societal expectations based on gender. In Part III, I discuss the concept of medicalization and how it relates to the modern day struggles and barriers for women in the legal profession. I then examine how medicalizing gender, by imprinting societal expectations of women into their very biological makeup, played a role in shaping how women viewed themselves, how society viewed them, and how the law treated them. In Part IV, I trace the history of medical understandings about sex and gender and discuss how it shaped societal understandings and impacted women. I primarily focus on the biological and neurological medical theories about women during the time period when the first female lawyers were seeking acceptance into the legal system of the United States. Next, I turn to the symptoms and treatments of “female illnesses” and examine how they were shaped by societal norms. I then address how these medical theories made their way into the language of the courts and how they impacted the first female lawyers in the United States.

II. DISEASE AS A SOCIAL CONSTRUCT

A. *Historical Understanding of Women’s Health: How the Doctors Shaped the Discourse*

i. How Society Shapes Disease

The role that scientific and medical understandings play on the evolution of law has not received as much attention as other formative contributors, but it has been significant. In practice, science and medicine gave weight and authority to theories on proper gender roles, as prescribed by biology. However, gender roles that were already in place actually were shaping *science and medicine* at the same time. In reality, “[d]isease is a scientific representation of illness that involves both a sorting of symptoms into discrete entities and a theorizing about causation and cure. As such, disease is not discovered but created.”⁹

⁹ Nancy M. Theriot, *Women’s Voices in Nineteenth-Century Medical Discourse: A Step Toward Deconstructing Science*, 19 SIGNS 1, 3 (1993).

Therefore, disease is necessarily shaped to some extent by societal norms and expectations. This idea is supported, generally, by the theory of “medicalization,” a theory in the field of medical sociology that was introduced to the United States in the 1950s.¹⁰ This concept acknowledges the power of medicine to “define and regulate social action.”¹¹ Thus, this cyclical relationship between societal norms and scientific and medical evidence validated certain gender roles within society that often placed women below men in the societal structure.

On the one hand, notions of female inferiority—physical, mental, and moral—dating as they did from antiquity, could hardly be considered novel. On the other hand, by virtue of the specificity of detail and inclusiveness of theory at its command, science was able to provide a newly plausible account of this inferiority. Measuring limbs, pondering viscera, reckoning up skulls, the new mandarins of gender difference were able to spell out in chapter and verse the manifold distinctions of sex.¹²

With research into the interaction of science, medicine, society, and the law, it is clear that “[s]cientific ideas did more than reflect the status quo; they helped maintain it.”¹³ Examining the experiences of women in the law provides particularly telling examples of the role that medical (and thus, societal) understandings of sex and gender played, because it shows how these understandings were indoctrinated and subtly worked against women from inside the system. Noga Morag-Levine, Professor of Law at Michigan State University College of Law, notes that health justifications had been used for legislative measures impacting and limiting the rights of women beginning in early nineteenth-century Britain and progressed into the U.S. court system, exemplified during the *Lochner* era with the so-called

¹⁰ See generally TALCOTT PARSONS, *THE SOCIAL SYSTEM* 289 (Routledge 1991) (1951) (proposing that the “therapeutic process” through medicine acts as social control in eradicating deviance); *MEDICALIZED MASCULINITIES* 2-3 (Dana Rosenfeld & Christopher A. Faircloth eds., 2006) (explaining that Parsons’ theory of sick individuals as “deviant,” and medicine as controlling that deviance, led to the wider acceptance of medicalization as a theory in the 1970s); Elianne Riska, *Gendering the Medicalization Thesis*, 7 *ADVANCES IN GENDER RES.* 59 (2003) (discussing how the medicalization thesis impacted and regulated social behavior as a culture and as a profession).

¹¹ *MEDICALIZED MASCULINITIES*, *supra* note 10, at 2.

¹² RUSSET, *supra* note 3, at 205.

¹³ *Id.* at 206.

“Brandeis Brief.”¹⁴ In this paper, I explore how, throughout history, the understanding of female sex, gender, and sexuality by the medical community has greatly shaped and, in practice, stunted the societal understanding and acceptance of the role of women as lawyers in the United States.

ii. The Power of Medical Authority

My focus is on how the early medical understanding of gender was used in the legal system to subjugate women and relegate them to their traditional roles, but also recognizing that some scholars may see this view as being too simplistic.¹⁵ However, I do not argue that only *men* used the medical understanding of female health to subjugate women, but recognize the role that women often played as both patients and physicians in this discourse.¹⁶ Nor do I argue that utilizing medical understandings about gender was necessarily *consciously* used to maintain the status quo—the motivation was likely subconscious, reflecting a bias to preserve a societal structure that was familiar and “safe.” I seek to investigate the medical community’s understanding of female health in the context of how it interplayed with the societal and legal understanding of the capacities of women as a class of people.

¹⁴ See Noga Morag-Levine, *Facts, Formalism, and the Brandeis Brief: The Origins of a Myth*, U. ILL. L. REV. 59-60 (2013) (discussing medical studies and health rationales in the law in the context of labor laws). Morag-Levine also notes the importance of the *Lochner* court’s rejection of presumptive constitutionality and its resulting adoption of a “newfound necessity to substantiate the claim on the connection between limits on the workday and better health” with judicial scrutiny of the legislative facts. *Id.* at 63. This entire process was necessarily shaped by the scientific information and understanding made available by the Brandeis Brief to the legislators and courts at the time. *Id.* at 90-91. This duality and crossover opened the door, beginning in Britain from the early nineteenth-century, for the health and societal interaction, which shaped how medical understandings of gender would be used in the law to relegate women to their societally-accepted roles.

¹⁵ See, e.g., CAROL GILLIGAN, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN’S DEVELOPMENT* (1982). Gilligan explores the theory that there are innate differences in male and female morality and delves into different psychological theories, which I do not do in-depth here, but instead include under the impact of “medicine” in general.

¹⁶ See Theriot, *supra* note 9, at 2. Theriot takes an interdisciplinary view and argues that “there was lively debate among nineteenth-century physicians over both gender and science; that women physicians, for professional, gender-specific reasons, articulated a self-interested view of women’s insanity and nervousness; and that women patients were active participants in the process of medicalizing *woman*.” *Id.*

The danger in using “scientific” or “medical” rationales to justify perceptions and assumptions about the different sexes is that this language connotes neutrality because of the scientific community’s roots in neutral experimentation and raw data. However, in reality, as Professor Carol Gilligan notes, theories that were “formerly considered to be sexually neutral in their scientific objectivity are found instead to reflect a consistent observational and evaluative bias.”¹⁷ So, while there may have been women participants in medicalizing women, this discussion focuses on how the biases forming medical understanding—by whomever they were shaped—intersected with the *legal* subjugation of women.

The structure of the U.S. legal system is such that the court was the forum in which laws were interpreted. Necessarily, interpretation of law is based on historical and societal norms and acceptance.¹⁸ After all, those who interpreted the laws were members of society, held the same assumptions, and accepted prevailing theories as fact as reflecting the time period.¹⁹ Thus, the courts very well may have been effectuating deeply embedded societal stereotypes about women from inside the very system that protected and granted rights to citizens. A biased view of the sexes grounded in science was pervasive in every aspect of society, not just in medicine. Gilligan notes “how accustomed we have become to seeing life through men’s eyes,”²⁰ shaping not only the early medical field (dominated by men), but language (*The Elements of Style*²¹ used examples of English usage focusing on accomplishments of men), psychological theories (Freud and the Oedipus Complex, implicitly adopting male life as the norm),²² and, in the 1880s, even clothing (confining women to corsets and other confining apparel, “conducive, not to action, but to standing”²³).

¹⁷ GILLIGAN, *supra* note 15, at 6.

¹⁸ See, e.g., Thomas Earl Geu, *Policy and Science: A Review Essay of Wilson’s Consilience: The Unity of Knowledge*, 44 S.D. L. REV. 612, 653 (1998) (agreeing that law is a reflection of societal norms); Cecil VanDevender, *How Self-Restriction Laws Can Influence Societal Norms and Address Problems of Bounded Rationality*, 96 GEO. L.J. 1775, 1790 (2008) (recognizing that as much as legislatures reflect on society’s norms, governments also, in turn, affect those norms through laws).

¹⁹ See VanDevender, *supra* note 18, at 1790.

²⁰ GILLIGAN, *supra* note 15, at 6.

²¹ WILLIAM STRUNK, JR. & E.B. WHITE, *THE ELEMENTS OF STYLE* (1959).

²² GILLIGAN, *supra* note 15, at 6.

²³ SUSAN J. HUBERT, *QUESTIONS OF POWER: THE POLITICS OF WOMEN’S MADNESS NARRATIVES* 59 (2002) (citing ROSE NETZORG KERR, *ONE HUNDRED YEARS OF COSTUMES IN AMERICA* 23 (1951)). In the 1880s, “[t]he resignation of women to a role of dependency was signified by the wearing of a dress based upon a feature of dress design which made women practically helpless.” *Id.*

Similarly, the existing laws that subjugated women based on the medical understanding of their gender were far-reaching. They covered every aspect of life, from property rights²⁴ to professional rights,²⁵ to criminal rights.²⁶ There are, then, multiple areas of the law that demonstrate the detrimental impact that incorporating flawed medical understanding and diagnoses based on sex has on the rights of women. However, the experiences of the first female lawyers is a particularly compelling example, because it is one of the only areas where scientific theories about gender were *explicitly* used to shape the laws governing women.

²⁴ See, e.g., *In re Strittmater's Estate*, 53 A.2d 205 (N.J. 1947). There, the court found that decedent, a woman who had tried to leave her estate to the National Women's Party (of which she had been a member for eleven years), lacked testamentary capacity and found her will to be invalid. *Id.* at 205-06. The lower court cited "feminism to a neurotic extreme" as evidence of her lacking testamentary capacity. *Id.* at 205. The court found that "[s]he regarded men as a class with an insane hatred" and was diagnosed by a medical witness as suffering from "paranoia of the Bleuler type of split personality." *Id.*; see also JESSE DUKEMINIER, ROBERT H. SITKOFF & JAMES LINDGREN, *WILLS, TRUSTS, AND ESTATES* 169 n.2, 171 (8th ed. 2009) (discussing that the court references Swiss psychiatrist Eugen Bleuler (1857-1939) and noting the extent to which "notions of capacity and insane delusion [are] based on social constructions of what is 'normal'").

²⁵ Beyond the discussion of the first female lawyers, Morag-Levine mentions that even within the Brandeis Brief, health effects of women were exemplified in terms of appearance, a social construct. See Morag-Levine, *supra* note 14. "In the cotton mills at Fitchburg the women and children are pale, crooked, and sickly-looking. The women appear dispirited." *Id.* at 67 n.44 (citing Brief for Defendant in Error, *Muller v. Oregon*, 208 U.S. 412 (1908) (No. 107)).

²⁶ For example, rape laws reflected assumptions about the biologically mandated "nature" of men and women. It is telling that defenses to a rape claim brought by a woman often cited the medical diagnosis of "nymphomania." See CAROL GRONEMAN, *NYMPHOMANIA: A HISTORY* 100-01 (2001). However, what is interesting is that "the male equivalent of nymphomania, satyriasis, was diagnosed far less frequently and treated quite differently. Specifically, the symptoms of flirting, seductive glances, and other behavior sometimes labeled nymphomania in women did not constitute a disease in men." *Id.* at xx-xxi. Further, elements of a rape claim requiring force and non-consent, as defined by early rape statutes, reflected assumptions about a man's aggressive nature and a woman's nature to resist. *Id.* at 99 n.18. In fact, "a doctor wrote in 1913 that rape wasn't really easy, because 'the mere crossing of the knees absolutely prevents penetration . . . a man must struggle desperately to penetrate the vagina of a vigorous, virtue-protecting girl.'" Sarah Begley, "Redefining Rape": A Brief History of Rape in America, *THE DAILY BEAST* (Aug. 22, 2013, 4:45 AM), <http://www.thedailybeast.com/witw/articles/2013/08/22/redefining-rape-tackles-the-the-rape-of-citizenship.html>; see also Berger, *supra* note 7, at 2-3.

III. THE IMPACT OF MEDICAL UNDERSTANDING OF WOMEN'S HEALTH ON THE FIRST WOMEN LAWYERS

A. Experiences of Women Lawyers: Why Medicine and History Matter

This paper examines in detail an important aspect of how women have historically interacted with the legal system: experiences of early women lawyers. This is one of the limited areas where early women had any interaction with the legal system. However, a question arises: why examine the experiences of early women lawyers?

The ways in which the medical community understood gender impacted early women lawyers in three ways: first, it shaped how they viewed themselves and may have placed limitations on themselves; second, it shaped how society viewed them and placed societal limitations on them; and third, it shaped how the court viewed them and placed legal limitations on them.²⁷ This complex influence of medical understandings about gender, then, potentially placed a three-fold barrier to women's progress as lawyers. There are those that may argue that historical theories about gender based on medical understanding may be a moot point in terms of scholarship on women in the law due to the progress women (and the medical community) have made in modern society.²⁸ However, it is worth discussion and exploration. First, language mirroring and adopting medically-rooted biases about gender has been explicitly adopted into some of our early common law. Second, despite significant progress by women in the legal profession, women today still have not reached parity with men in the practice of law.

Women are not progressing in the ranks of the legal profession at near the rate at which they saturate the legal market.²⁹ The numbers

²⁷ See, e.g., *In re Strittmater's Estate*, 53 A.2d at 205-06 (finding a female decedent who tried to leave her estate to the National Women's Party to have suffered from paranoia and man-hating).

²⁸ See Riska, *supra* note 10, at 82 (explaining that in contemporary society, both men and women are targeted in the medicalization of gender and noting that some argue that the targeting is "symmetr[ical]").

²⁹ In 2011, women comprised 47.3% of those awarded with Juris Doctorates. A.B.A. COMM'N ON WOMEN IN THE PROFESSION, A CURRENT GLANCE AT WOMEN IN THE LAW 4 (2013), available at http://www.americanbar.org/content/dam/aba/marketing/women/current_glance_statistics_feb2013.authcheckdam.pdf [hereinafter A CURRENT GLANCE] (citing A.B.A. SEC. OF LEGAL EDUC. & ADMISSIONS TO THE BAR, J.D. AND LL.B. DEGREES AWARDED, available at

of women in leadership positions (or even in the pipeline to obtain leadership positions) within the legal profession are abysmal, and, even worse, are stagnant. As of 2012, 96% of managing partners in the nation's largest law firms were men.³⁰ Only 15% of equity partners and 26% of non-equity partners were women.³¹ Further, women constituted "only 20% of the members of a typical firm's highest governing committee."³² Even in law schools, only 20.6% of law school deans were women,³³ and women made up less than 30% of tenured law professors.³⁴ These numbers have not significantly progressed in the past ten years but, instead, have virtually reached a plateau.³⁵

Amongst scholars, it is agreed that simply waiting for gender balance to come into the law is not sufficient.³⁶ Therefore, much research has been done to delve into the potentially unseen forces holding women back from professional progress.³⁷ Researchers have

www.americanbar.org/content/dam/aba/administrative/legal_education_and_admissions_to_the_bar/statistics/jd_llb_degrees_awarded.pdf.

³⁰ BARBARA M. FLOMM, NAT'L ASS'N OF WOMEN LAWYERS, REPORT OF THE SEVENTH ANNUAL NAWL NATIONAL SURVEY ON RETENTION AND PROMOTION OF WOMEN IN LAW FIRMS 5 (2012), *available at* http://www.americanbar.org/content/dam/aba/administrative/women/nawl_2012_survey_report_final.authcheckdam.pdf.

³¹ *Id.* at 10-11.

³² *Id.* at 14.

³³ A CURRENT GLANCE, *supra* note 29, at 4.

³⁴ AM. BAR FOUND., AFTER TENURE: POST-TENURE LAW PROFESSORS IN THE UNITED STATES 14 (2011), *available at* http://www.americanbarfoundation.org/uploads/cms/documents/after_tenure_report-final_abf_4.1.pdf.

³⁵ See Hannah Brenner & Renee Newman Knake, *Rethinking Gender Equality in the Legal Profession's Pipeline to Power: A Study on Media Coverage of Supreme Court Nominees (Phase I, The Introduction Week)*, 84 TEMPLE L. REV. 325, 326-27, 335 (2012). Compare A.B.A. COMM'N ON WOMEN IN THE PROFESSION, A CURRENT GLANCE AT WOMEN IN THE LAW (2014), *available at* http://www.americanbar.org/content/dam/aba/marketing/women/current_glance_statistics_july2014.authcheckdam.pdf, with A.B.A. COMM'N ON WOMEN IN THE PROFESSION, A CURRENT GLANCE AT WOMEN IN THE LAW (2005), *available at* <http://www.americanbar.org/content/dam/aba/migrated/women/reports/ataglance.authcheckdam.pdf>.

³⁶ For instance, if the current trend continues, it will be 212 years before women achieve gender parity on British boards. Lynn Martin, *Gender Parity on Company Boards—A 212 Year Wait*, THE GUARDIAN UK (April 29, 2013, 2:30 AM), <http://www.theguardian.com/women-in-leadership/2013/apr/29/gender-parity-212-year-wait>.

³⁷ See KARIN KLENKE, WOMEN AND LEADERSHIP: A CONTEXTUAL PERSPECTIVE 162 (1996) (noting that "[w]omen construct their leadership style based on different personal, social, and organizational experiences, in part because they lack realistic

attempted to explain why women in leadership have reached such stagnant low numbers. The “unique pressures placed on female leaders derive in part from the relation between stereotypes about leaders and stereotypes about women and men.”³⁸ “[D]espite the clear evidence that male and female leaders are similar in many personality traits and job-related behaviors,” gender stereotypes continue to persist, and women do not hold significant leadership positions.³⁹ Some theories suggest that women encounter societal “double binds” that express themselves in the workplace and make it too difficult for women to attain and keep leadership positions.⁴⁰ Double-binds are often called “catch-22[s]”⁴¹ or “no-win situations,”⁴² and refer to situations where women face societal pressure and hardship for choosing either of the two paths before them.⁴³

role models”); DEBORAH L. RHODE & AMANDA K. PACKEL, *LEADERSHIP: LAW, POLICY, AND MANAGEMENT* (2011); THE WHITE HOUSE PROJECT REPORT: *BENCHMARKING WOMEN’S LEADERSHIP 3* (2009) (illustrating that “while women may be participating in the workforce in equal . . . numbers relative to their male peers, they rarely make it to the top”).

³⁸ Linda L. Carli & Alice H. Eagly, *Overcoming Resistance to Women Leaders: The Importance of Leadership Style*, in *WOMEN & LEADERSHIP: THE STATE OF PLAY AND STRATEGIES FOR CHANGE* 127, 127 (Barbara Kellerman & Deborah L. Rhode eds., 2007).

³⁹ KLENKE, *supra* note 37, at 162. One explanation for the discrepancy between research on gendered leadership traits and leadership in practice, when women get to leadership positions, may be that the research itself is flawed. Undergraduate students are often the choice “subjects to study gender differences in leadership [, which] may result in [an] inadvertent overrepresentation of the differences between men and women [Where] practicing leaders often indicate that there are no differences between male and female leadership styles, students hold the opposite to be true.” *Id.* at 150. Studies suggest that young adulthood appears to be the age when differences between the sexes are maximized. *Id.*

⁴⁰ KATHLEEN HALL JAMIESON, *BEYOND THE DOUBLE BIND: WOMEN AND LEADERSHIP* 120 (1995).

⁴¹ *Id.* at 122.

⁴² *Id.* at 17.

⁴³ There are specific constructs underlying the double-binds, including “[t]he no-choice-choice; the self-fulfilling prophecy; the no-win situation; the unrealizable expectation[;] and the double standard. Each circumscribes choice.” *Id.* at 17. A no-choice-choice “casts the world as either/or, with one option set as desirable, the other loathsome.” *Id.* A self-fulfilling prophecy is “a false definition of the situation evoking a new behavior which makes the originally false conception come true.” *Id.* (quoting Robert K. Merton, *The Self-Fulfilling Prophecy*, 8 *ANTIOCH REV.* 193, 195). A no-win situation is where “by winning, you lose”—for example, “women are judged against a masculine standard, and by that standard they lose, whether they claim difference or similarity.” *Id.* at 18. “Unrealizable expectations are a corollary of the no-win situation.” *Id.* Finally, the double standard is a standard in which women’s actions are treated differently and judged differently for a longer period of time. *Id.*

I posit that these stereotypes and double binds may have a root in the same medicalization of gender that early women lawyers identified as a barrier to their progress. While much research has been accomplished to identify the double binds that may influence women in the legal profession, not much is known about where and how these double binds originated. If, in fact, they are rooted in science and medicine, the double binds may be even harder to break down and overcome, as they may have the weight of science and data behind them. This may explain why double binds still persist in society today, and acknowledging or identifying a source of origin may help combat their impact.

Some double binds that have impacted women's attempts to practice law are the societal assumptions (often incorporated into women's thinking) that:

- Women can exercise their wombs or their brains, but not both.
- Women who speak out are immodest and will be shamed, while women who are silent will be ignored or dismissed.
- Women are subordinate whether they claim to be different from men or the same.
- Women who are considered feminine will be judged incompetent, and women who are competent, unfeminine.⁴⁴

One example that has been flagged by the American Bar Association's Commission on Women in the Profession is that "women walk a fine line between being regarded as too feminine (and thus not tough, lawyer-like, or smart) or too tough (and thus unfeminine or not the kind of women male colleagues feel comfortable relating to)."⁴⁵ Further, women who do reach higher leadership levels are "scrutinized under a different lens [than] that [which is] applied to successful men, and for longer periods of time."⁴⁶ For example, unlike male leaders, every decision a female leader makes is analyzed in the context of her gender, and her successes are often attributed to luck or written off as flukes.⁴⁷ These double binds, once examined, reflect some of the same

⁴⁴ *Id.* at 16.

⁴⁵ *Id.* at 121.

⁴⁶ *Id.* at 16.

⁴⁷ Rosalind Chait Barnett, *Women, Leadership, and the Natural Order*, in *WOMEN & LEADERSHIP: THE STATE OF PLAY AND STRATEGIES FOR CHANGE* 149, 156-58 (Barbara Kellerman & Deborah L. Rhode eds., 2007).

presumptions about gender that the medical community attempted to diagnose and treat.⁴⁸ For example, the double bind that women can exercise their wombs or their brains (but not both) seems to *directly* stem from Edward Clarke's antiquated and unfounded assumptions about gender in 1873.⁴⁹

Another theory argues that traditional leadership models in the professional world value historically "masculine" attributes over historically "feminine" attributes.⁵⁰ These traditional leadership models promote traditionally-identified masculine attributes, such as being aggressive, ambitious, and analytical or possessing traits like self-sufficiency and dominance, instead of feminine attributes, such as being affectionate, cheerful, and childlike or possessing traits like kindness, helpfulness, and gentleness.⁵¹ The danger with these stereotypes is that they are not only descriptive, but also proscriptive, meaning that people not only expect women to be kind and gentle, but also prefer women to behave in such ways.⁵² A further result is that "women themselves reported that they were less inclined to see themselves as leaders or seek leadership roles."⁵³

When women succeed, they are viewed as having some special stroke of good fortune—a wonderful mentor, a luck break, being at the right place at the right time. Their success is treated as happenstance, an outcome over which they had no particular control. Not surprisingly, research shows that when women succeed, they rarely get credit for their success.

Id. (citing Madeline E. Heilman & Michelle C. Haynes, *No Credit Where Credit Is Due: Attributional Rationalization of Women's Success in Male-Female Teams*, 90 J. APPLIED PSYCH. 905 (2005)).

⁴⁸ See *supra* Part II.

⁴⁹ See discussion *supra* note 8. In 1873, Clarke published *Sex in Education; or a Fair Chance for the Girls*, in which he argued that women should not be allowed to educate themselves for the good of society because to so tax the brain by learning would directly impact the reproductive organs negatively, thus endangering women's chances of successfully reproducing and expanding society. CLARKE, *supra* note 8, at 42.

⁵⁰ JAMIESON, *supra* note 40, at 124. The widely credited study recognizing these gendered characteristics and their contribution to leadership ideals appears to be written by Paul Rosenkrantz, Susan Vogel, and others. See Paul Rosenkrantz et al., *Sex-Role Stereotypes and Self-Concepts in College Students*, 32 J. CONSULTING & CLINICAL PSYCH. 287 (1968) (discussing the relationship of self-concept to differentially valued sex-role stereotypes). For a discussion on modern comparative associations between gender and leaders, see Sabine Sczesny et al., *Gender Stereotypes and the Attribution of Leadership Traits: A Cross-Cultural Comparison*, 51 SEX ROLES 631, 642-43 (2004) (discussing different leadership stereotypes).

⁵¹ Carli & Eagly, *supra* note 38, at 127; JAMIESON, *supra* note 40, at 124.

⁵² Carli & Eagly, *supra* note 38, at 128.

⁵³ KLENKE, *supra* note 37, at 166.

Studies have found that “dividing human characteristics along gender lines is also likely to increase the attention we pay to particular behaviors displayed by men and women, as well as the possibility of exaggerated selective judgments.”⁵⁴ So, even when an attribute was present in both men and women, if it was dichotomized along gender lines, observers were more likely to look for and note those behaviors in only one gender.⁵⁵ The dichotomization of leadership styles is similarly split by expected gender lines.⁵⁶ This is recognized as another double bind—women are not only expected to exhibit attributes that are social- and service-oriented (communal) to be a successful woman, but are also expected to exhibit the attributes that are achievement-oriented (agentic) to be a successful leader.⁵⁷ If women are not bringing in business or racking up billable hours in the legal profession, they are seen as lacking the skills required to be leaders. However, if women attempt to achieve these goals using the same methods as their male colleagues, they are similarly disdained and face professional disapproval.⁵⁸ Finally, situational factors, such

⁵⁴ *Id.* at 144.

⁵⁵ *Id.*

⁵⁶ Some studies have even defined leadership styles as “acting like a man versus acting like a woman.” *Id.* at 146.

⁵⁷ Madeline E. Heilman, *Description and Prescription: How Gender Stereotypes Prevent Women’s Ascent Up the Organizational Ladder*, 57 J. SOC. ISSUES 657, 658 (2001); Carli & Eagly, *supra* note 38, at 128 (citing Virginia E. Schein, *A Global Look at Psychological Barriers to Women’s Progress in Management*, 57 J. SOC. ISSUES 675-88 (2001)).

Looking at the international managerial stereotype items illustrates rather dramatically the unfavorable way in which women are viewed, especially among males. Male management students in five different countries and male corporate managers in the United States view women as much less likely to have leadership ability, be competitive, ambitious, or skilled in business matters, have analytical ability, or desire responsibility.

Schein, *supra* at 683.

⁵⁸ A Supreme Court case involving discrimination on this exact topic involved an accounting firm and Ann Hopkins, a female senior manager who was denied a partnership. See *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989). She had “played a key role” in negotiating a \$25 million contract and was praised for her work, which was recognized to be “virtually at a partner level.” *Id.* at 233-34. Yet she was denied partnership because the firm claimed that she had problems with “inter-personal skills,” was “macho,” and “overcompensated for being a woman.” *Id.* at 234-35. This case was remanded because the lower courts had used the incorrect evidentiary standard. *Id.* at 258. On remand, the district court found that the employer was liable and that the proper remedy was an order declaring that Hopkins be made a partner and paid over \$300,000 in backpay. *Hopkins v. Price Waterhouse*, 737 F. Supp. 1202, 1216-17 (D.D.C. 1990). The Court of Appeals affirmed the decision. *Hopkins v. Price Waterhouse*, 920 F.2d 967, 970 (D.C. Cir.

as expectations about gender roles regarding women and parenting,⁵⁹ career/family conflict,⁶⁰ and the types of law deemed “acceptable”

1990). *Price Waterhouse* is indicative of how the professional world reacts to women attempting to fit a male stereotype of leadership.

⁵⁹ Women are often perceived as lacking aspirations to reach leadership levels compared to men, and this is often cited as the reason women “opt-out” of promotions or leave work when they get pregnant. Barnett, *supra* note 47, at 155-57. In fact, data from representative samples show that women are not opting out based on a desire to be at home, but in fact “intend to work and have families,” and that “their career ambitions mirror those of their male counterparts.” *Id.* at 156. In reality, the reason that women left work upon becoming a mother is that they were being “pushed out” of work. *Id.* at 155.

⁶⁰ Along these same lines, even if a law firm does have a “family friendly” policy permitting part-time schedules, lawyers are reluctant to take advantage because of fear of professional repercussions. A.B.A. COMM’N ON WOMEN IN THE PROFESSION, CHARTING OUR PROGRESS: THE STATUS OF WOMEN IN THE PROFESSION TODAY 6 (2006), available at <http://www.americanbar.org/content/dam/aba/migrated/women/ChartingOurProgress.authcheckdam.pdf>. [hereinafter CHARTING OUR PROGRESS]. This problem is even worse for women of color. “An African-American lawyer noted that women of color who are the first women in their families to become college graduates or professionals often lack the social and professional contacts needed to develop a client base.” *Id.* at 6. These “[m]ultiple and often competing demands from major life roles almost invariably create conflict and stress,” and career-family conflict is a common occurrence for women. KLENKE, *supra* note 37, at 179. Compounding this fact is that, if a woman does decide to stay in the work force, she essentially has a second job at home. *Id.* The reality is that, despite evidence of men participating more in household tasks, “sex-role distinctions [still] persist when it comes to the division of labor at home, with women continuing to handle the lion’s share of domestic and childrearing obligations.” *Id.* Thus, if women decide to stay in the work force, they face conflict between their societal and career demands. In the workplace, women lawyers are judged as insufficiently aggressive, too emotional, and not as serious about their careers as men, and when they *do* choose (or are pushed) to “opt for family leave or report sexual harassment, these stereotypes are reinforced.” CHARTING OUR PROGRESS, *supra* at 5 (quoting A.B.A. COMM’N ON WOMEN IN THE PROFESSION, UNFINISHED BUSINESS: OVERCOMING THE SISYPHUS FACTOR 13 (1995), available at <http://www.americanbar.org/content/dam/aba/migrated/women/publications/unfinishedbusiness.authcheckdam.pdf>). On top of these pressures, of the women who do reach leadership positions, their successes are rarely given credit in the news while their failures are immediately credited to an inability to balance “work and family,” an allegation that is not similarly thrown at men for their similar failures. Barnett, *supra* note 47, at 156-57. “[W]hen Brenda Barnes resigned from a high-level position at PepsiCo, a media feeding frenzy ensued, full of stories saying that she, and by extension other women, couldn’t handle work and family.” *Id.* at 156. Sara Lee Corporation subsequently hired Barnes as president, and she now heads a corporation that has operations in fifty-eight countries and employees of 137,000 people worldwide, but the media did not report her work in this position. *Id.*

based on gender,⁶¹ all similarly impact women's successes in the legal profession, and all are similarly impacted by gendered assumptions stemming from the medical community. So it is not necessarily women's natural inclinations or a pull to the home that takes women out of the running for leadership, it is instead the stereotype of the "natural order" that pervades the occupation and dictates who leads and who follows.⁶² By citing the "natural order," these stereotypes seem to stem from medicine's understanding of biology and gender.

While much research has been put forth on the barriers to women's progress in the medical and legal fields, one area that has not been fully delved into in either arena is the interaction between science and medical understandings and their incorporation into the legal system. Further, the extent to which the medical view of gender may have shaped these double binds has not been examined. Only by exposing every barrier that early women lawyers encountered may scholars illuminate the discussion of the struggles modern women lawyers face today.

⁶¹ This has a component that is influenced by scientific and medical understandings about gender as well. Within the legal profession, certain types of law are seen as more acceptable based on gender. For example, women have historically been more societally accepted in family law, as it is seen as a natural extension of their societal role as a woman and mother. The history of women in law supports that women were pushed into family law.

As women began to practice law, many were steered into areas where the practice fit the image of a woman lawyer. One of the areas where women were seen as a good fit by the legal gatekeepers was family law, with almost half of all women lawyers practicing some family law in 1967. Male attorneys viewed family law as a less than ideal practice area because so much of the practice involves interpersonal issues rather than strictly legal issues. Family law is also considered a lesser field because it is associated with a smaller income.

Sheila Simon, *Jazz and Family Law: Structures, Freedoms, and Sound Changes*, 42 IND. L. REV. 567, 579 (2009) (footnotes omitted) (citing CYNTHIA FUCHS EPSTEIN, WOMEN-IN LAW 102-03, 111 (1983)). Unfortunately, the author notes that "[s]teering women into family law continues. In a 2004 American Bar Association publication on women in law, in a section on career choices, [it states:] '[F]ields involving representation of women and children, like family law, have been considered naturally suited to women lawyers.'" Simon, *supra* at 579.

⁶² Barnett argues that the underlying reason why leadership is so gendered is that there is "an unspoken but firmly held belief that there is natural order in which males are innately and uniquely endowed to take charge, whereas females are innately and unique endowed to take care." Barnett, *supra* note 47, at 151. In this scenario, men are naturally equipped to lead while women are naturally equipped to follow. She argues that the belief in the natural order "permeates our thinking, our expectations, our perceptions of the world, and our pedagogy." *Id.* at 151-53.

As discussed above, medical understandings carry with them the weight of expertise, experimentation, and raw data, which—in practice—afford them great weight.⁶³ Arguably, the weight they carry is doubled if they are adopted into common law parlance by the courts, because then they have the weight of the law as well as of science behind them. If subtle (or not so subtle) biases existed in medical diagnoses or assumptions about gender, they may have subconsciously shaped expectations about women in society and in the law. Pulling apart medical authority on gender shows that these understandings, under the weight of medical and scientific authority, did in fact hold women back, relegating them to their traditional gender roles and keeping them out of the legal profession.⁶⁴ I refer to this as “medicalizing gender,”⁶⁵ borrowing from the sociologists who coined the idea of “medicalization” in the 1950s.⁶⁶

[M]edicalization is primarily a matter of defining already-problematic behaviors in medical terms [and] consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it. Medicalization occurs when a medical frame or definition has been applied in an attempt to understand or manage a problem.⁶⁷

Each part of this definition has been applied to women based on their gender. Any behavior that would increase their position in society, such as seeking an education, pursuing a profession, or acting in a way that would eschew traditional sexual, gender, or family roles, was immediately branded as an illness and relegated to the medical community.⁶⁸ Thus, it was medicalized. The crux of the discussion, however, is examining how this medicalization actually functioned to

⁶³ See *supra* Part II.

⁶⁴ Riska, *supra* note 10, at 82.

⁶⁵ In my discussion, I refer to “medicalizing gender” as the attribution of biological inferiorities as intrinsic to the female gender by the medical community, and how it subjugated early women lawyers.

⁶⁶ The power of medicine to define and regulate social action was introduced by Talcott Parsons, who, in 1951, wrote about medicine’s role in controlling deviance and, in the process (in true functionalist fashion), reproducing and strengthening the social order by holding the sick accountable to dominant social norms of productivity—a function that was beneficial to all.

MEDICALIZED MASCULINITIES, *supra* note 10, at 2; see also PARSONS, *supra* note 10.

⁶⁷ MEDICALIZED MASCULINITIES, *supra* note 10, at 3.

⁶⁸ Riska, *supra* note 10, at 82.

hold back women as lawyers. I break the discussion down into three parts: how women implemented this medicalization of their gender by self-diagnosing and limiting their own progress as lawyers; how society implemented this medicalization and limited women lawyers through expectations of societal “spheres”; and, finally, how courts incorporated medicalization into laws and placed legal barriers on women’s progress as lawyers.

IV. THE IMPACT: INTERNALIZED VERSUS EXTERNALIZED ADOPTION OF MEDICAL THEORIES ABOUT GENDER

A. Symptoms, Diagnoses, and Treatments: Shaping the Discussion of How Women Viewed Themselves

In order to facilitate a discussion of how these medical theories shaped societal views on gender in the context of women entering the legal profession, it is necessary to split the discussion into three parts. First, I explore how early women lawyers in the United States interacted with these medical theories and studies. Only by examining to what extent early women lawyers were aware of and accepted these theories can we explore how they may have been held back by them. This includes a discussion on self-diagnosis based on medical theories. By understanding, at a threshold level, the limits that these early women lawyers placed *on themselves*, we can, in turn, understand barriers to their progress. Second, I explore how medical understanding progressed through the 1900s, including how pervasively medical theories invaded society as a whole. Here, a discussion of which medical specialties were considered experts in “female illnesses” illuminates how “female illnesses” were, in turn, viewed by members of society. This also requires a discussion of treatments. Treatments for these “female illnesses” strongly reflected a desire to return women to their “proper” roles in society to “cure” them.⁶⁹ Finally, I will explore as to how medical theories on gender were incorporated into the U.S. legal system in the context of the first women lawyers. Here, I examine the language used in court cases—and, thus, adopted as part of U.S. common law—and explore how much of that language is shaped by medical understanding.

⁶⁹ *Id.* (noting that “the medicalization thesis has served as a heuristic device ... to reinforce women’s traditional sex role”).

B. Symptoms: Self-Diagnosing

The issue of women's health and sexuality was one that, much like today, was at the forefront of the minds of early women lawyers.⁷⁰ “[The] debate about women's physiological ability to endure the strains of law practice occurred within the context of the larger social debate about the fragility of women's health.”⁷¹

A desire to maintain traditional gender roles within the family and, thus, societal stability, along with a desire to maintain the status quo, often worked in conjunction with medical understanding and medical theories to continue to influence how society viewed women. The types of symptoms that were characteristic of nineteenth-century women's nervous and mental illnesses reflect the desire to maintain the norm.⁷² As discussed previously, disease is a social construct, and defining symptoms is part of defining disease.⁷³ While the symptoms for “female illnesses” were numerous and varied, it is clear that “the common characteristic of the symptoms was the unfeminine nature of the behavior or feeling.”⁷⁴ “Insane and nervous women were described as antimaternal, selfish, willful, violent, erotic—all of these inappropriate in terms of nineteenth-century definitions of womanhood.”⁷⁵ Describing these symptoms in the same terms as the societal understanding of the proper role and “sphere” of women made it near impossible for any who opposed them to challenge them without threatening to strike at the foundations of society.

Clearly, the power of medicine was significant in defining and treating these illnesses. The medicalization thesis posits that the medical profession has great power “as a culture and as a profession—to define and regulate social behavior.”⁷⁶ Eventually, an important shift occurred in how society addressed women's behaviors that did not meet social norms (*i.e.*, “deviant” behavior).⁷⁷ The shift was one that took this deviant behavior out of the moral or religious realm for

⁷⁰ Drachman, *supra* note 1, at 31.

⁷¹ *Id.*

⁷² Riska, *supra* note 10, at 66-67 (stating that “gender-biased medical knowledge and diagnoses and treatments . . . resulted in . . . overuse of drugs” and surgeries, such as hysterectomies); *see also* Theriot, *supra* note 9, at 17 (stating that “symptoms of insanity vary depending on time and place and that attaching names to peculiar behavior can be seen as the medical community's medicalization and labeling of inappropriate behavior as disease”).

⁷³ *Id.* at 3.

⁷⁴ *Id.* at 17.

⁷⁵ *Id.*

⁷⁶ Riska, *supra* note 10, at 59.

⁷⁷ PARSONS, *supra* note 10, at 320-21.

“treatment” and into one that was medical and scientific.⁷⁸ “The agent of social control was the medical profession, an institutionalized structure in society that had been given the mandate to restore the health of the sick so that they could resume their expected role obligations.”⁷⁹

In her chronicle about the struggle of early female lawyers in the United States, Drachman writes:

Prevailing medical wisdom defined women as physiologically unsuited to undertake rigorous mental work after the onset of puberty. The physician most responsible for popularizing this view was Edward H. Clarke, a professor at Harvard Medical College. In 1873, he published *Sex in Education; or, a Fair Chance for the Girls*, which explained the supposed weakness of female physiology to the general reader. Wrapped in the banner of medical authority, *Sex in Education* was an assault on the new phenomenon of coeducation. Clarke warned that women’s reproductive physiology made it unsafe for them to undertake any intellectual activity with the same rigor as men. Excessive study, he explained, diverted energy from the female reproductive organs to the brain, causing a breakdown in women’s health and threatening the health of future generations.⁸⁰

This study was widely read (and widely criticized),⁸¹ including by the members of the Equity Club, an early organization that brought

⁷⁸ Viewed within this frame, diagnoses (and diagnostic categories) are not neutral ‘discoveries’ so much as highly subjective interpretations, and a number of studies published in the 1970s and 1980s . . . traced the shift in interpretation of deviant behavior from moral to medical deficit, or ‘badness to sickness’ (nested in the secularization and rationalization of Western society. . .).

MEDICALIZED MASCULINITIES, *supra* note 10, at 3.

⁷⁹ Riska, *supra* note 10, at 59.

⁸⁰ Drachman, *supra* note 1, at 31; *see also* CLARKE, *supra* note 8, at 12 (“The problem of woman’s sphere, to use the modern phrase, is not to be solved by applying it to abstract principles of right and wrong. Its solution must be obtained from physiology.”) “[I]t is not true that she can [go to school and pursue studies] and retain uninjured health and a future secure from neuralgia, uterine disease, hysteria, and other derangements of the nervous system, if she follows the same method that boys are trained in.” *Id.* at 17-18 (emphasis added).

⁸¹ “*Sex in Education* reached beyond the boundaries of the elite women’s colleges in the Northeast to large public universities such as the University of Michigan. The

together the first female lawyers across the globe through letter correspondence.⁸² Ellen Martin, one of the early members, wrote that she felt she was being held back by biological factors, which sparked a debate amongst the women on the issue of women's health.⁸³ However, "[f]rom their letters, it was clear that Martin's views were in a distinct minority."⁸⁴ In fact, "[t]he Equity Club members overwhelmingly agreed . . . that it was the material conditions of women's lives, rather than a weakness inherent to women's reproductive physiology, that was responsible for their physical problems."⁸⁵

However, knowledge of these symptoms and of Clarke's theories was so pervasive that these women would both self-diagnose and be diagnosed by those around them.⁸⁶ Women would often seek to have themselves committed when they recognized in themselves feelings like "lack of interest in husband or family, violent feelings toward their children, and continual sadness or suicidal urges in spite of being well taken care of by husband or family."⁸⁷ What served as evidence of mental illness were actually behavior problems that threatened the status quo's accepted definition of feminine propriety.⁸⁸ These "symptoms" were then medicalized into the discourse and definition of female illnesses by the medical community, as well as by women themselves.

This meant that, in terms of medical treatment, doctors:

treated nervous and insane women as if their female bodies were defective. The most dramatic examples of this treatment philosophy were "local" treatments and sexual surgery. If the symptoms of nervous and mental

local bookseller in Ann Arbor sold over 200 copies of the book in a single day." Drachman, *supra* note 1, at 32. "The president and the faculty read it, and shook their heads doubtfully about the 'experiment in coeducation.'" *Id.* (quoting OLIVE SAN LOUIE ANDERSON, *AN AMERICAN GIRL AND HER FOUR YEARS IN A BOYS' COLLEGE* 96 (1878)); see Drachman, *supra* note 1, at 31-32 n.62 (listing works challenging Clarke in the years immediately after he published his study).

⁸² The Equity Club allowed the first women lawyers both in the United States and even in Europe a discourse to discuss problems they encountered in attempting to practice law. Women's health was at the forefront of many of these letters. See Drachman, *supra* note 1.

⁸³ *Id.* at 33.

⁸⁴ *Id.* at 34.

⁸⁵ *Id.*

⁸⁶ Theriot, *supra* note 9, at 18.

⁸⁷ *Id.* at 17.

⁸⁸ *Id.* at 18.

illness were unwomanly behavior and feelings, and if the causes were rooted in the female body, then the cures must produce some change in the woman patient's reproductive organs to change the woman's behavior.⁸⁹

Women themselves often were the ones who asked for this type of surgery or went into it under the urging of family and friends.⁹⁰

The role of female patients in self-diagnosing, thus, was important in perpetuating the cycle of gendered diagnoses relegating women to their traditional roles.⁹¹ Even if not explicitly turning themselves over to doctors at the first signs of unwomanly behavior, women likely suppressed these "unfeminine" thoughts and urges due to the knowledge of what was expected of them and due to a fear of failing at their medically and socially-proscribed gender role.⁹² The danger of using medical evidence in the courts at this time was that "[t]he nervous symptoms and deviant behavior of the nineteenth-century women patients were shaped by the constraints of gender and then were medicalized and therefore legitimized by medical representation as disease."⁹³

Holding a different view or questioning the medical wisdom challenged an understanding about gender that was at the foundation of how society was structured. That understanding, in essence, ties into the theories of "natural law," the very foundation of our society.⁹⁴ Natural law, it seems, further reiterated the concept of "separate spheres" based on gender that the court would eventually cite to keep women from practicing law.⁹⁵

⁸⁹ *Id.* at 21.

⁹⁰ *Id.* at 20-21.

⁹¹ "A reproductive theory of women's insanity and nervous disease dominated the nineteenth century partially because women experienced their reproductive lives as troublesome." *Id.* at 24.

⁹² *Id.* at 17.

⁹³ *Id.*

⁹⁴ Natural law was cited by those who formed the very legal system after which the U.S. legal system was modeled. "Treating the law of nature as a source of English law was strictly conventional, and the discussion bespoke Blackstone's concern to furnish England's law with the appropriate philosophical apparatus, which in this setting demanded a discussion of 'what we call ethics or natural law.'" David Lieberman, *Blackstone's Science of Legislation*, 98/99 LAW & JUST. CHRISTIAN L. REV. 60, 65 (1988) (citing WILLIAM BLACKSTONE, 1 COMMENTARIES ON THE LAWS OF ENGLAND 41 (Joseph Chitty ed., 1826)).

⁹⁵ "The constitution of the family organization, which is founded in the divine ordinance, as well as in the nature of things, indicates the domestic sphere as that

An enduring reliance on the “natural” order of the sexes allows women to be located as “other” and makes the dominance of men over women “natural.” Men are historically associated with light, reason, logic, and urban centers—culture, or the public sphere—while women are associated with darkness, nature, mothering, feeling, and superstition—nature, or the private sphere.⁹⁶

Many of the first women lawyers broke into the profession because a family member or husband served as a sort of mentor to give them confidence as to their abilities, despite what society told them about their limitations.⁹⁷ So, even despite these prevalent assumptions about gender, and even though “*Sex in Education* carried the weight of medical theory, the opinions of the Equity Club members grew out of their personal experiences,” where they found themselves, in practice, able to withstand and perhaps even thrive on the mental rigor of the legal practice to the same extent as men.⁹⁸

Unfortunately, while most women already practicing law observed the flaws in these medical theories, elsewhere in society these medical theories were trusted in the debate on women’s health.⁹⁹ This meant that most women would see their gender as an innate barrier barring even an attempt to delve into societal “spheres” that they believed they were ill-equipped for. This, in turn, meant that less women were willing to enter the legal profession, seeing this medical authority as a significant deterrent and trusting the expertise of the respected medical profession.¹⁰⁰ Further, as discussed later, the court could (and would) use medical authority as a legal argument to keep

which properly belongs to the domain and functions of womanhood.” *Bradwell v. Illinois*, 83 U.S. 130, 141 (1872).

⁹⁶ Lisa McLaughlin, *Discourses of Prostitution/Discourses of Sexuality*, 8 CRITICAL STUD. IN MASS COMM. 249, 250 (1991).

⁹⁷ “Notably, many of the early women lawyers had incredibly supportive husbands [], some never married [], and some became lawyers because or in spite of abusive and or cheating husbands they divorced [].” JOANNE BELKNAP, *THE INVISIBLE WOMAN: GENDER, CRIME AND JUSTICE* 551 (2014). However, “it was particularly difficult for married women to become lawyers unless they were married to a lawyer who was willing to train them.” *Id.*

⁹⁸ Drachman, *supra* note 1, at 34-35.

⁹⁹ *Id.* at 31; Theriot, *supra* note 9, at 20.

¹⁰⁰ *Id.* at 5; *see also* Drachman, *supra* note 1, at 33 (recalling that it was once accepted that a female lawyer’s “proper place was in the office” rather than in the courtroom).

women out of the profession and firmly and safely keep them in their “spheres” using the weight of medical authority.¹⁰¹

C. How Society Viewed Women as a Gender: Volleying Female Illnesses from Alienist¹⁰² to Gynecologist

i. Female Illness and Behavior as Linked to Reproductive Organs

As discussed above, women both self-diagnosed and were diagnosed by those around them, including friends and family members. They were often diagnosed by “[h]usbands [who] brought in wives for a variety of unwomanly offenses,” including “[disagreeing] too vocally, [losing] interest in personal appearance, or [neglecting] their children.”¹⁰³ There was also a large number of mothers bringing in daughters who were “insubordinate, sexually promiscuous, or not interested enough in socializing.”¹⁰⁴ The well-defined expectation of a woman’s place in society was part of what allowed friends and family members to diagnose these women. Women were expected to be in charge of the home and the family. Therefore, by defining female illness as one that threatened a woman’s ability to fulfill her gender role,¹⁰⁵ the medical community made women’s health a societal issue, not a personal health issue.

In order to best understand how the lives of the first female lawyers were impacted by popular medical understandings about gender, it is necessary to parse out a brief history of medical authorities that dealt with “female illnesses,” thereby shaping societal understanding of gender. Within the medical community, Clarke was far from alone in his opinion on women’s health. In 1887, an article referenced the well-known edict that “nearly all of those ills to which feminine flesh is heir are due either to disorders of the female reproductive organs, or so influenced by these organs as to constitute a particular class of diseases.”¹⁰⁶ These “ills” stretched beyond actual pain or sickness in reproductive organs or the rest of the body to encompass any sort of behavior on the part of women that was seen as

¹⁰¹ See Theriot, *supra* note 9, at 5 (noting that early gynecologists found female reproductive organs to be responsible for mental illness in women).

¹⁰² “*Alienist* was an earlier name for *psychiatrist*.” *Id.* at 3.

¹⁰³ *Id.* at 18.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 17.

¹⁰⁶ *Id.* at 3 (quoting Alice May Farnham, *Uterine Diseases as a Factor in the Production of Insanity*, 8 ALIENIST & NEUROLOGIST 532 (1887)).

unfeminine or any mental disorder that plagued women in the 1800s.¹⁰⁷

The discourse of society, then, was shaped by medical discourse, which was in turn shaped by the time- and place-specific medical practices, societal norms, and expectations.¹⁰⁸ Further, the different branches of medicine to which “female diseases” were relegated defined the lens through which female illnesses were viewed.¹⁰⁹ Medical agents expanded the authority of the medical community “into areas of life previously outside its purview” by “redefining social problems as medical ones and claiming that their own expertise was the most appropriate one to cure them.”¹¹⁰ To reiterate, the very structure of how disease is “created” not only reflects societal assumptions about gender but can also help reinforce them. By viewing the societal construct of the female gender as something that could be “diseased,” it was thus medicalized and passed into the realms of science and medicine.

The type of doctor to which “female illnesses” were relegated strongly shaped the discourse on the illnesses. For example, “[g]ynecologists specialized in the diseases of women, alienists specialized in mental illness [], and neurologists specialized in diseases of the nervous system.”¹¹¹ Gynecologists would thus root “female illness” to the biological function of reproductive organs, while alienists and/or neurologists would root “female illness” to the functions of the female brain. By relegating “female illnesses” that exhibited mental symptoms primarily to doctors who would look to reproductive organs for a biological cause, it grounded these diseases

¹⁰⁷ See *id.* at 6 (“[M]en who were in the process of creating a scientific specialty devoted to unveiling women’s otherness would see all of [women’s] complaints as rooted in their ovaries and uterus.”); Riska, *supra* note 10, at 66-67 (stating that “gender-biased medical knowledge and diagnoses and treatments . . . resulted in . . . overuse of drugs” and surgeries, such as hysterectomies).

¹⁰⁸ Theriot, *supra* note 9, at 6.

¹⁰⁹ *Id.* at 4. However, Theriot discusses how Farnham went on to present case studies to illustrate her conclusion that “uterine disease alone is seldom or never the cause of mental alienation [insanity].” Farnham, *supra* note 106, at 546.

¹¹⁰ MEDICALIZED MASCULINITIES, *supra* note 10, at 2-3. One theory posited in the 1970s was that the “increasingly technical and bureaucratic nature of Western society” was the force behind allowing medicalization of society as a whole. *Id.* at 3. By referring to “medicalization of society,” he meant “the exponential labeling of aspects of everyday life as medical in nature by medical agents.” *Id.* This may have stemmed from the professional desire of the medical community to expand their influence, but was facilitated by “the larger social context’s desire for technical solutions to social troubles” that “accommodated medicine’s tactics and tendencies.” *Id.*

¹¹¹ Theriot, *supra* note 9, at 4.

in the very biological elements that defined womanhood. If reproductive systems were seen as the root of illness, and these symptoms similarly defined a person as a woman, reproductive systems made femalehood carry a stigma of being diseased. “According to Farnham, the result of this widespread belief was that ‘the alienist and neurologist beheld his hysterical, melancholic and maniacal patients torn from his grasp and, *by the wave of public opinion*, cast into the hands of his brother practitioner, the gynaecologist.’”¹¹²

In claiming women’s physical and mental illness as gynecological territory, gynecological medical science collapsed the distinction between gender and sex . . . [w]hen applied to women’s mental illness and nervous complaints, *gynecological medicine suggested that women were mentally ill or nervous simply because they were female* and that their symptoms could be handled with physiological cures that, to late twentieth-century readers, appear to range from mildly punitive to unmistakably sadistic.¹¹³

By conflating women’s physical and mental illnesses into having the same root cause—the reproductive organs—women were set apart from men, reiterating societal expectations about women’s limitations. It should be noted that “physicians were less likely to connect men’s ailments to their genitalia, while assuming that women’s reproductive organs caused both physical and mental disease.”¹¹⁴ These diagnoses, in turn, presented a biological barrier innate to a woman’s gender that would threaten the family and, ultimately, the societal structure as a whole if a woman were to tax her reproductive organs by seeking an education or, worse, by delving into the legal profession.

¹¹² *Id.* at 3 (emphasis added) (citing Farnham, *supra* note 106, at 532). For more discussion on insanity in females by the medical community and of theories analogizing gynecologists’ attempts to medicalize childbirth (to drive out competition from midwives) and to have a theory of women’s mental illness that held the gynecologist to be the specialist of choice (to drive out professional competition in this arena as well), see Theriot, *supra* note 9.

¹¹³ *Id.* at 6-7 (emphasis added).

¹¹⁴ GRONEMAN, *supra* note 26, at 4.

ii. Next Steps: The Speculum and Early 1900s to a Neurological View

The invention and use of one tool in particular, the speculum, greatly influenced gynecological perception of women's illnesses.¹¹⁵ "This new tool encouraged an anatomical representation of women's complaints partially because previously invisible problems, some serious and some benign, suddenly became viewable."¹¹⁶ It does make sense that gynecology, a specialty that centered around the "otherness" and "essential femaleness" of a woman, would see all women's complaints as rooted in their ovaries and uterus.¹¹⁷ The relevance of whether women's illnesses were relegated to the gynecological or neurological specialties is important because "[w]hile the gynecological view of women's problems was based on the reproductive organs—and therefore open to clinical refutation—the neurological/psychiatric view was based on the invisible femininity of the nervous system—and therefore closed to clinical refutation."¹¹⁸ The changes in what branch of the medical community qualified as "experts" in female illnesses show that a "cure" for women, who seemed to stray outside of their societal sphere, was at the forefront of concern for society in the late 1800s and early 1900s.¹¹⁹

Eventually, the understanding of the medical community slowly came back to focus on a neurological view, partly due to the role of females in the medical profession.¹²⁰ Women physicians accepted that the mind and organs interacted, but often made less far-sweeping conclusions about the link or were less likely to believe the theory of cause and effect than gynecologists, especially after conducting clinical trials and studying patients.¹²¹ However, these

¹¹⁵ Theriot, *supra* note 9, at 6.

¹¹⁶ *Id.* (citing Ornella Moscucci, *THE SCIENCE OF WOMAN: GYNAECOLOGY AND GENDER IN ENGLAND, 1800-1929* (1990)).

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 10 ("Illustrations of the nervous system in the nineteenth century were of female bodies, whereas illustrations of the muscular system were of male bodies. Nerves were inherently feminine, and women were inherently prone to nervousness and to manic, depressive, or hysterical responses to life's difficulties.")

¹¹⁹ *See generally id.* at 4-10 (discussing how different theories of female illnesses competed against each other).

¹²⁰ *Id.* at 10 (illustrating that "[t]he contribution of women physicians to the professional discourse on women's insanity and nervousness formed part of the neurological and psychiatric case against gynecological thinking, although most women physicians who participated in the discourse were technically gynecologists (i.e., most treated the diseases of women).")

¹²¹ *Id.* at 12. "Medical women consistently supported the neurological and psychiatric position against the gynecological essentialism that tied women's

views were not adopted by the majority of medical professionals or the courts, despite being supported by clinical trials and empirical evidence that conferred to the medical profession an air of authority.¹²²

Importantly, across medical specialties, the “nineteenth-century physicians, no matter what their specialty, assumed that women and men were more different than alike and that the physiological differences between the sexes translated ‘naturally’ to different social roles.”¹²³ This widespread understanding by the medical community as a whole was clearly one that, as discussed later, courts eventually drew on in denying women the right to practice law.

iii. Treatments that Solidified Gender Roles: From Staying in Your Sphere to Surgery

The treatments prescribed to women in the late 1800s further reflected the medical and societal bases underlying female diseases. These treatments influenced society to keep women out of the legal profession. In 1890, Charlotte Perkins Gilman turned to Dr. S. Weir Mitchell when she was treated for neurasthenia¹²⁴ after the birth of her daughter, and was prescribed his famous “rest cure.”¹²⁵ This prescription, after a month of bed-rest, required her to “[l]ive as domestic a life as possible. Have your child with you all the time Lie down an hour after each meal. Have but two hours’ intellectual life a day. And never touch a pen, brush, or pencil as long as you live.”¹²⁶ Nervous conditions were linked with women’s ambitions; it

nervous and mental illness to their reproductive organs.” *Id.* These medical women, as Theriot discusses, often treated women who would have been “doomed [] to the knife” if they had gone to male physicians, whom they viewed as “young and thoughtless operators, aided if not by greed of gold, with errors in diagnosis.” *Id.*

¹²² *Id.* at 13.

¹²³ *Id.* at 9.

¹²⁴ Neurasthenia denotes “a mental disorder marked by chronic weakness and easy fatigability.” *Neurasthenia Definition*, DORLAND’S MEDICAL DICTIONARY FOR HEALTH CONSUMERS, <http://medical-dictionary.thefreedictionary.com/neurasthenia> (last visited Apr. 18, 2015).

¹²⁵ HUBERT, *supra* note 23, at 63. The rest cure “was consistent with the prevailing opinion of the time, which conceptualized mental disease as an organic condition that could be exacerbated by environmental stress. [The doctor’s] treatment of Gilman also reflects sex role expectations and the belief that intellectual work was harmful to women.” *Id.*

¹²⁶ *Id.* In citing Gilman’s autobiography, Hubert notes that this rest cure “only made Gilman’s condition worse” and led Gilman closer to losing her mind. *Id.* (citing CHARLOTTE PERKINS GILMAN, *THE LIVING OF CHARLOTTE PERKINS GILMAN* 96, 121 (1935)). Gilman’s condition was alleviated by being away from home, so she

was believed that mental breakdown occurred when women “defied their ‘nature,’ attempted to compete with men instead of serving them, or sought alternatives or even additions to their maternal functions.”¹²⁷

“[M]ost alienists and neurologists agreed with their gynecologist colleagues that women's reproductive organs dictated that women should restrict their activities and aspirations.”¹²⁸ For women seeking to enter the legal profession, this posed an immense barrier. “Because their interests lay outside the recognized sphere of a woman’s world they received little support and often little sympathy from their physicians, their society, and sometimes even their own family. These women had to define themselves to themselves, often in defiance of all authority figures around them.”¹²⁹ Thus, the obstacles that existed for women looking to break from the medically-defined “spheres” existed in the diagnoses of symptoms as well as the treatments prescribed for them.

Another treatment option available for women beyond the rest cure was surgery. “Operations were performed on both sides of the Atlantic for nymphomania, hysteria, dysmenorrhea (painful menstruation), epilepsy, ovarian insanity, and all manner of ill-defined female diseases.”¹³⁰ Women physicians, besides questioning the assumed link between mind and reproductive systems, often opposed the extreme surgical measures that were taken to “cure” women of the diseases that were diagnosed as stemming from their reproductive systems.¹³¹ For example, one oft-used cure called for the “removal of the ovaries from the pelvis” under the assumption that doing so “removes them from the head.”¹³² Women physicians who found little correlation between mental disease and reproductive symptoms in their case studies saw that this surgery did not address the cause of female patients’ symptoms.¹³³

decided to seek a divorce and then her condition improved. She did note that the rest cure had lasting deleterious effects. *Id.*

¹²⁷ HUBERT, *supra* note 23, at 64 (quoting CHARLOTTE PERKINS GILMAN, *THE LIVING OF CHARLOTTE PERKINS GILMAN* 96 (1935)).

¹²⁸ Theriot, *supra* note 9, at 10.

¹²⁹ HUBERT, *supra* note 23, at 64 (quoting Suzanne Poirier, *The Weir Mitchell Rest Cure: Doctors and Patients*, 10 *WOMEN’S STUDIES* 15, 35 (1983)).

¹³⁰ GRONEMAN, *supra* note 26, at 21. One particularly gruesome type of surgery was clitoridectomies (removal of the clitoris), which was a response to the “symptom” of excessive sexual desire. *Id.*

¹³¹ Theriot, *supra* note 9, at 12.

¹³² *Id.* (emphasis omitted) (citing E. M. Roys Gavitt, *Extraction of the Ovaries for the Cure of Insanity*, 1 *WOMAN’S MED. J.* 123-24 (1893)).

¹³³ See *supra* note 65 and accompanying text.

Alternatively, as a third treatment, in many cases, once women fit the symptoms of these “female illnesses,” they were institutionalized without any say in the matter.¹³⁴ Again, this was an explicit way in which those who surrounded women produced barriers to female professional advancement. In one particularly shocking case, two sane women were discovered to have been confined in a mental hospital in Britain for “about 50 years each simply because they had borne illegitimate children” in defiance of societal norms that resulted in their committals as “mad” beings.¹³⁵ However, tied to the acceptance and self-diagnosis of the women themselves, these seemingly barbaric “cures” were often not questioned by women patients.¹³⁶ It has been argued that the societal structure that relegated women to a gender role of “learned helplessness” may be part of the reason why these barbaric “cures” went unquestioned.¹³⁷ Since dependency has been supported and reinforced for women, as patients, they may have been less likely to question these practices than men.

Further, historically, “women have not been permitted the direct expression of aggression or assertion that men have been allowed without feeling guilty or unfeminine.”¹³⁸ So, even up to the 1950s-1970s in the United States, case studies show that women who exhibited “opposite-sex traits such as anger, cursing, aggressiveness, sexual love of women, increased sexuality in general, and a refusal to

¹³⁴ See HUBERT, *supra* note 23, at 60.

Commitment practices in the nineteenth century placed additional limitations on the lives of women. After a woman was declared insane, she no longer had even the illusion of autonomy. Judges, lawyers, doctors, and hospital staff defined the experiences of women mental patients, and the women’s own explanations could be seen as symptoms of insanity.

Id.

¹³⁵ PHYLLIS CHESLER, *WOMEN AND MADNESS* 162, 164 (1972). “The women’s parents went to local government officials for help with their ‘wayward’ daughters,” and the officials thus committed them. *Id.* at 162.

¹³⁶ See Theriot, *supra* note 9, at 17 (noting that “[i]n many cases women came to physicians asking to be committed”).

¹³⁷ Little girls are also kept closer to their mothers than are little boys; they are encouraged to seek support and are permitted to express dependency needs. They have, in the past, grown up expecting that they will be cared for by men. . . . To function more autonomously [] can therefore threaten a woman’s sense of “femininity.”

Malkah Notman, *Feminine Development: Changes in Psychoanalytic Theory*, 2 *WOMAN PATIENT* 3, 21 n.58 (1982) (citing W. Grove, *Sex Differences in the Epidemiology of Mental Disorder: Evidence and Explanations*, in *GENDER & DISORDERED BEHAVIOR* 23 (E. S. Gomberg & V. Franks eds., 1979)).

¹³⁸ Notman, *supra* note 137, at 20 (citing J. Zilbach, M. Notman, C. Nadelson, J. Miller, Presentation at International Psychoanalytic Association: Reconsideration of Aggression and Self-Esteem in Women (Aug. 1, 1979)).

perform domestic and emotional-compassionate services” were institutionalized.¹³⁹

This sheds light on yet another factor influencing why women experienced such immense obstacles in practicing law, even up until the 1970s. This obstacle was grounded in biological understanding and was extremely subtle, which is perhaps why it was not overtly identified as a factor that impeded women’s progress in the law. However, whether done consciously or not, a woman who exhibited personality traits deemed “unnatural” to her gender was pronounced “ill,” and entering a profession like the legal profession—one that was grounded in reason and required independence, intelligence, and autonomy—certainly challenged societal expectations for women.

D. How the Court Viewed Women as a Gender

When Belva Lockwood applied for admission to a federal court in 1873, the court denied her claims and declared that “even legislatures might not have authority over women’s legal status because it was ‘by an unwritten law interwoven with the very fabric of society;’ certainly, the court had no jurisdiction to admit a woman to practise [sic] before it.”¹⁴⁰ Furthermore, in 1875, when denying Lavinia Goodell’s application to the bar in Wisconsin, the Supreme Court of Wisconsin drew language and reasoning from *Bradwell v. Illinois*,¹⁴¹ discussion of “separate spheres.”¹⁴² The Supreme Court of Wisconsin overtly stated:

There are many employments in life not unfit for female character. The profession of the law is surely not one of these. The peculiar qualities of womanhood, its gentle graces, its quick sensibility, its tender susceptibility, its purity, its delicacy, its emotional impulses, its subordination of hard reason to sympathetic feeling, are surely not qualifications for forensic strife. *Nature has tempered woman as little for the judicial conflicts of the court room, as for the*

¹³⁹ CHESLER, *supra* note 135, at 164.

¹⁴⁰ MARY JANE MOSSMAN, THE FIRST WOMEN LAWYERS: A COMPARATIVE STUDY OF GENDER, LAW AND THE LEGAL PROFESSIONS 49 (2006) (citing *In re Lockwood*, 9 Ct. Cl. 346, 355 (1873)).

¹⁴¹ 83 U.S. 130 (1872).

¹⁴² *In re Goodell*, 39 Wis. 232, 236-38 (Wis. 1875). “[T]he civil law, as well as nature herself, has always recognized a wide difference in the respective spheres and destinies of man and woman.” *Bradwell*, 83 U.S. at 141 (Bradley, J., concurring).

physical conflicts of the battle field. Womanhood is moulded for gentler and better things [By contrast, a court] has essentially and habitually to do with all that is selfish and malicious, knavish and criminal, coarse and brutal, repulsive and obscene, in human life. It would be revolting to all female sense of the innocence and sanctity of their sex, shocking to man's reverence for womanhood and faith in woman . . . that woman should be permitted to mix professionally in all the nastiness of the world which finds its way into courts of justice.¹⁴³

This pervasive understanding of womanhood as shaped by the medical community's diagnoses of "female illnesses" clearly shaped the legal discourse about women entering the legal profession. The very language that discussed the "peculiar qualities of womanhood" identified women as other than men.¹⁴⁴ The Supreme Court of Wisconsin rooted this female peculiarity in "nature" and the very fabric of society, thus grounding this understanding in science and medicine.¹⁴⁵ The *Bradwell* court echoed the same sentiments and argued that to go against the natural order of men and women would in fact affect the structure of the family and, thus, the structure of society.¹⁴⁶ "The harmony, not to say identity, of interest and views which belong, or should belong, to the family institution is repugnant to the idea of a woman adopting a distinct and independent career from that of her husband."¹⁴⁷

i. Expert Testimony: Women's Voices in the Medical Community—Challenges and Contributions to Medical/Societal Understanding

Women physicians in the early medical profession may have pushed back against some of the prevailing medical assumptions about gender (much like their female counterparts did in the legal profession) based on their personal experiences. Further, early women physicians challenged medical wisdom with clinical studies and empirical evidence, which led them to different conclusions than those of their male counterparts and the rest of society. However, the views of

¹⁴³ *In re Goodell*, 39 Wis. at 245-46 (emphasis added).

¹⁴⁴ *Id.* at 245.

¹⁴⁵ *Id.*

¹⁴⁶ 83 U.S. at 141 (Bradley, J., concurring).

¹⁴⁷ *Id.*

women physicians were not taken seriously enough to rebut the gender assumptions in court.

Some women physicians made observations that, had they been adopted by society, would have directly counteracted the assumptions that courts relied on in ruling against allowing women into the bar.¹⁴⁸ In fact, these physicians noted, contrary to the court's reasoning that law would be too taxing and too dangerous for women to practice, that "one cause of insanity was 'monotony of work and thought,' [including] 'the treadmill of ceaseless care and toil to which so many conscientious souls are self-condemned.'"¹⁴⁹ In their findings, these early women physicians primarily noted insanity in women who were mothers, including those who had filled their gender role in their "sphere" perfectly.¹⁵⁰ They even gave a case study of a woman who was deemed insane even while she "was a 'most domestic woman' much praised by her husband for her devotion to home and family."¹⁵¹

Interestingly, their findings meant that women experienced insanity, even within the separate sphere that the Court cited in *Bradwell*, as a reason to keep women out of the legal profession in order to protect women from the insanity that would stem from overexerting themselves.¹⁵² This directly contradicts the medical reasoning the court used to keep women out of the profession.

It is worth noting that it has been discussed that the disparities of medical discourse between these early male and female physician colleagues was not a war between "good science" and "bad science," but rather that "both women and men physicians formulated concepts of women's mental illness from their different positions in the medical and gender power structures, positions that limited their vision even as their vision helped define their positions."¹⁵³ Thus, while the views of women physicians helped women receive better medical care, the

¹⁴⁸ Theriot, *supra* note 9, at 12 (referring to two women physicians: Grace Peckham, a New York City physician, and Jennie McCowen, an assistant physician in Iowa); see, e.g., *Bradwell*, 83 U.S. 130; *In re Goodell*, 39 Wis. 232.

¹⁴⁹ Theriot, *supra* note 9 (emphasis added) (quoting Jennie McCowen, *The Prevention of Insanity*, 2 NW LANCET 14, 17 (1882-83)).

¹⁵⁰ *Id.* "[O]ther women physicians argued that more education and greater freedom of life choices would prevent most cases of female insanity and nervousness. Women physicians took issue with their male colleagues who blamed women's nervousness on education." *Id.* at 13.

¹⁵¹ *Id.* at 12 (quoting McCowen, *supra* note 149, at 17).

¹⁵² *Bradwell*, 83 U.S. at 141 (Bradley, J., concurring) ("The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life.").

¹⁵³ Theriot, *supra* note 9, at 15.

overall societal understanding of this medical science was slower to evolve.¹⁵⁴

ii. Further Subjugation Within the Courts: Sexuality and Nymphomania

This section exhibits how strongly societal norms and preferences about gender shaped medical understandings. The desire to promote the stable, societally-favored, nuclear family (and preserve the role of the woman in that structure) influenced a medical understanding that supported the nuclear family structure and eschewed a medical understanding that would undermine or harm this norm. A woman stepping outside her accepted societal sphere was addressed swiftly in the courts.¹⁵⁵ If a woman did not fulfill her role as a wife and mother, either by seeking to become a professional or because of her unsuitable sexual behavior, the courts further relied on medical diagnoses.¹⁵⁶ In this way, physicians “helped to legitimate a code of sexual behavior based on rigid distinctions between feminine and masculine activity.”¹⁵⁷

One of the most prevalent ways that gender was medicalized was through nymphomania. Nymphomania was one of the most common diagnoses of “female illnesses” and was an attempt to define

¹⁵⁴ Several states passed laws by the end of the century that required women physicians to be appointed at state asylums to care for women patients. *Id.* Importantly though, women physicians’ privileged class position played a role in diagnosing female illnesses based on difference in living situations (privileged women were too bored; less privileged women worked too hard). *Id.* at 15-16. While this turned the diagnosis away from being purely based on sex, it was still flawed by its reliance on class and its view that mental illnesses were indicative of a failure of will or energy. *Id.*

¹⁵⁵ See, e.g., *Bradwell v. Illinois*, 83 U.S. 130 (1872); *In re Goodell*, 39 Wis. 232 (1875).

¹⁵⁶ In a case for divorce because of the wife’s infidelity, the wife claimed insanity, citing medical diagnoses that were gender-specific, including nymphomania. *Wray v. Wray*, 19 Ala. 522, 524 (1851). “In her case there is evidence of insanity, as contradistinguished from puerperal insanity, hysteria, moral insanity and nymphomania, before and during the time which is material and afterwards. Several of the physicians call it a case of moral insanity.” *Id.*; see also *Laudo v. Laudo*, 188 A.D. 699, 701 (N.Y. App. Div. 1919) (“To say the least, adultery committed under the irresistible impulse of that morbid activity of the sexual propensity which is called *nymphomania*, or more recently *erotic mania*, would certainly be ground for divorce, though not of indictment.”).

¹⁵⁷ GRONEMAN, *supra* note 26, at xix. Groneman also offers a discussion on the history of nymphomania and how changing societal norms helped shape ideas of masculinity and femininity, with a list of related resources. *Id.* at n.2.

“excessive” female sexual desires as a disease.¹⁵⁸ The medical diagnosis of nymphomania had power, firstly, because it was societally widespread. “Physicians writing for a popular audience diagnosed nymphomania in those women who actively tried to attract men by wearing perfume, adorning themselves, or talking of marriage.”¹⁵⁹ Further, nymphomania made its way into the courts and into legislation as a disease in multiple contexts.¹⁶⁰ However, what is interesting is that “the male equivalent of nymphomania, satyriasis, was diagnosed far less frequently and treated quite differently. Specifically, the symptoms of flirting, seductive glances, and other behavior sometimes labeled nymphomania in women did not constitute a disease in men.”¹⁶¹ This widespread acceptance of nymphomania, and other gender-related illnesses, impacted early female lawyers because it meant that they had barriers, placed by courts, on their personal life choices, such as their sexuality, as well as on their professional progress.

Even women adopted and accepted these diagnoses based on their gender, and this acceptance was indoctrinated in the courtroom. Whether overt or subconscious, this acceptance is expressed even in the legal community’s discussion and understanding of sex and

¹⁵⁸ Carol Groneman, *Nymphomania: The Historical Construction of Female Sexuality*, 19 *SIGNS* 337, 337 (1994). While nymphomania was a specific organic disease with an assumed set of symptoms, causes, and treatments, defining “excessive” female sexual desire was a fairly ambiguous concept, meaning that the symptoms and treatments reached into many aspects of female behavior. *Id.*

¹⁵⁹ *Id.* at 341.

¹⁶⁰ The most common context was rape, where nymphomania acted as a defense for the accused rapist to weaken the rape claim. If a female was diagnosed with nymphomania, her claim of rape was likely unfounded because she was unnaturally sexually driven and, thus, could not have been raped or likely had given her consent. See GRONEMAN, *supra* note 26, at xx-xxi; see also Berger, *supra* note 7, at 15-20 (discussing how courts considered a rape victim’s character for chastity as a major factor in rape cases). Nymphomania also made its way into the courts as a defense for women in divorce cases based on adultery. See *Wray*, 19 Ala. at 524; *Laudo*, 188 A.D. at 701; *Chew v. State*, 804 S.W.2d 633, 634 (Tex. App. 1991). During the trial of *Chew v. State*, the appellant presented the testimony of Dr. Lawrence Taylor, a qualified psychiatrist with expertise in sexual disorders. 804 S.W.2d at 634. Dr. Taylor described the illness of “nymphomania” as a condition occasionally found in females, consisting of an unmanageable sexual desire that results in dramatic frequency of sexual contact with a partner as well as indiscriminate sexual contact with groups. *Id.* Dr. Taylor testified that it was not uncommon for females afflicted with this illness to attempt to hide their condition from the general public as well as from their own family, and further, that those afflicted very seldom seek medical attention on their own. *Id.* Further, the doctor stated that “a female so afflicted could possibly be raped but that it was not probable.” *Id.*

¹⁶¹ See GRONEMAN, *supra* note 26, at xx-xxi.

gender, but most explicitly in *Bradwell v. Illinois*. There the court explicitly stated:

[T]he civil law, as well as nature herself, has always recognized a wide difference in the respective spheres and destinies of man and woman. Man is, or should be, woman's protector and defender. The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life.¹⁶²

The stress on nature's recognition of the limitations placed on a woman was what tied this legal understanding into the medical one. The legal reasoning pulled from the scientific one, almost as if relying on expert testimony about the very genetic and biological makeup of women. When the medical community stressed that women "naturally" do not have the disposition to do, think, or express sexuality in the same way that men do, because of something innate in their biological makeup—their reproductive organs—the court inferred that it had justification to use women's biological makeup as a rationale to keep women out of the legal profession.¹⁶³ Because this faulty societal understanding of women stemmed from a profession as grounded in science and in facts as the medical profession, it was indoctrinated into common law to squelch women's attempts to step outside the gender norm.

V. CONCLUSION AND NEXT STEPS

Medicalization of gender, then, impacted women in three distinct ways: through self-diagnosis and the application of medicalization of their gender; through external, societal application of medicalization of their gender; and through legal application of medicalization of their gender. The threefold influence from the medical community was both subtle and pervasive. It made women patients and women doctors part of the very discourse about women's health that was used to subjugate women from within the legal system.

¹⁶² *Bradwell v. Illinois*, 83 US 130, 141 (1872).

¹⁶³ See *Bradwell*, 83 U.S. at 141 (Bradley, J., concurring) ("The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life."); *In re Goodell*, 39 Wis. 232, 245 (1875) ("The peculiar qualities of womanhood, its gentle graces, its quick sensibility, its tender susceptibility, its purity, its delicacy, its emotional impulses, its subordination of hard reason to sympathetic feeling, are surely not qualifications for forensic strife.").

Again, this paper does not posit that an all-male legal system was pitted against women to subjugate them and relegate them to societally-approved roles. Nor does this paper argue that the subjugation was purposeful or overt. The subjugation was likely fueled simply by a subconscious desire to maintain the *status quo* of societal structure, which the cyclical influence between the medical community and societal norms continued to impact. However, there is value in having a conversation about the possible barriers to women's advancement in the legal profession that may have perhaps not been discussed in this context before.

These observations expose that, at the very least, the first women lawyers who sought entrance into the legal system had two major barriers to overcome: the indoctrinated and medically-supported view that the rest of society understood that women did not have the capacity to succeed in law *as well as* their own understandings about their limited capacities based on gender.¹⁶⁴ This is exhibited especially clearly in the concerns voiced by early female lawyers about whether or not their health could withstand the practice.¹⁶⁵ This concern unfortunately echoed in some of the double binds that still hold women back today, such as the assumption that a woman can have a family or a career, but not both. This understanding arguably stems from the “natural” order of the sexes, as the understanding of gender gave women a positive side—“sentiment and morality”—as well as a negative side—“ignorance and lack of intellectual powers.”¹⁶⁶

These societal assumptions about women, based on a pseudo-scientific understanding about physical and mental capacities of the sexes, shaped not only societal roles, but also strongly biased opinions of whether women had the capacity to succeed in the law. The

¹⁶⁴ Similar, dually-imposed diagnosis obstacles are also exhibited in women rape victims' experiences in the courtroom. Women rape victims were not only diagnosed as deviant by physicians, but were also made to doubt their own testimonies and self-diagnose themselves as deviant. GRONEMAN, *supra* note 26, at 98-99 (citing JOHN HENRY WIGMORE, 3 EVIDENCE IN TRIALS AT COMMON LAW 736 (4th ed. 1970)). Wigmore referred to experts on the female psyche to support his theories that science held the answer to false claims of rape. *Id.* at 99; *see also* HUBERT, *supra* note 23, at 58 (“Psychiatrists exerted such influence that . . . women internalized societal and psychiatric oppression and testified against themselves in their [psychological] narratives.”).

¹⁶⁵ *See* Drachman, *supra* note 1 (discussing the professional and personal challenges nineteenth-century female lawyers faced).

¹⁶⁶ McLaughlin, *supra* note 96, at 250 (citing L.J. Jordanova, *Natural Facts: A Historical Perspective on Science and Sexuality*, in NATURE, CULTURE, AND GENDER 42, 50 (Carol P. MacCormack & Marilyn Strathern eds., 1980)).

assumptions about the very structure of the legal profession were (and are) that the legal profession was founded in objectivity, rationality, and with a “gentlemanly” disposition. This understanding of which traits were necessary to succeed in the law explains why a societal and medical understanding that women were emotional, irrational, and flighty set such a high barrier for women entering the profession.¹⁶⁷

Much of the value in researching the impact that medical understanding of gender has had on our legal system is to begin a discussion of it in relation to the modern-day struggles of women in the legal system. While science and medicine have greatly progressed as of 2015, many deep-rooted norms, such as medicating women more readily than men, still remain. Gender-biased diagnosing, “a tendency for physicians and other health care professionals to mislabel women’s somatic complaints as non-serious and/or psychosomatic . . . has received considerable attention.”¹⁶⁸ Studies have shown that the pervasiveness’ of this gender-bias even impacts women self-identifying symptoms as serious, for fear of being labeled a hypochondriac due to gender bias, ultimately seriously threatening their health.¹⁶⁹ While it may not be overt, this historical influence may still affect women lawyers today.¹⁷⁰ In order to understand and

¹⁶⁷ This medical understanding also impacted the treatment of women as victims of rape in the courts. An assumption that a woman was inherently emotional, irrational, and flighty meant that rape laws would evolve to mean that the woman’s word was not to be trusted within the courts, culminating in legislation implementing the corroboration requirement. See *supra* note 26 and accompanying text.

¹⁶⁸ Shari Munch, *Gender-Biased Diagnosing of Women’s Medical Complaints: Contributions of Feminist Thought, 1970-1995*, 40 *WOMEN & HEALTH* 101, 102 (2004).

¹⁶⁹ Amanda Marcotte, *Women May Not Seek Help for Heart Attacks Because They Fear Being Seen as Hypochondriacs*, SLATE.COM (Feb. 25, 2015, 1:56 PM), http://www.slate.com/blogs/xx_factor/2015/02/25/women_and_heart_attacks_study_suggests_they_don_t_seek_help_for_fear_of.html; see also Maanvi Singh, *Younger Women Hesitate to Say They’re Having a Heart Attack*, NPR.ORG (Feb. 24, 2015, 4:26 PM), <http://www.npr.org/blogs/health/2015/02/24/388787045/younger-women-hesitate-to-say-theyre-having-a-heart-attack> (citing Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 8 *CIRCULATION: CARDIOVASCULAR QUALITY AND OUTCOMES* 1 (2015)) (“It’s interesting because the whole idea of female hysteria dates back to ancient times,” Tremmel says. “This is an ongoing issue in the medical field, and we all have to empower women patients, so they know that they need to not be so worried about going to the hospital if they’re afraid there’s something wrong.”).

¹⁷⁰ “Today, [w]omen are 48% more likely than men to be prescribed a narcotic, antianxiety, or other potentially abusable drug.” KATIE DARCY, *GENDER, LEADERSHIP AND ADDICTION IN THE LEGAL PROFESSION* 15 (2013) (citing STEPHANIE S. COVINGTON, *WOMEN & ADDICTION: A GENDER-RESPONSIVE*

deconstruct the barriers that still influence women lawyers today, it is necessary to look at the barriers' origins. Clearly, the medical community has had perhaps more of an influence on societal structure than has been realized or studied in the context of the legal profession. The fact that language that subtly references "nature" and "science" found its way into the courtroom, and into common law as a basis to preclude women from entering the legal profession, indicates that medicalization was a significant barrier to early women lawyers. It may, to some extent, still be a barrier to women lawyers today and may help unpack why women still have not reached parity with men in the legal profession.

This is a conversation that should be ongoing. Identifying every possible factor that could hold women back from reaching parity with men in the same profession has value. However, many of these barriers are extremely subtle or have never been identified in the context of women in the law. Only by addressing every aspect of society that may have played a part in forming a barrier for early women lawyers will it be possible to address the barriers that exist today.