TPWKY - Special Episode Wendy Kline & Exposed

EW: [00:00:00] Hi, I am Erin Welsh and this is, this podcast Will Kill You. Welcome to the latest episode of the T-P-W-K-Y Book Club series where I interview authors of popular science and medicine books about their latest work. We've started out very strong this season and we've got such a great lineup for the rest of the year. These are honestly some of my favorite episodes to put together. If you'd like to get a sneak peek at the upcoming books that we'll be featuring on these book club episodes, head over to our website. This podcast will kill you.com, where you can find a link to our bookshop.org affiliate account under the extras tab. Once you're on our bookshop page, you can see various T-P-W-K-Y book lists, including one for this. Book club series. I'll be posting more books there throughout the season, so check in regularly to see which books will be featured in the upcoming weeks and months. As always, we love hearing from you all about these and our other episodes, and so if you have anything that you'd like to share, reach out through the contact us form on our website. Favorite book club episodes so far? A book you'd like to see featured suggestions. For other episode topics, send them our way. Two last things before moving on to the book of the week. The first is to please rate, review, and subscribe. It really does help us out. And the second is that you can now find full video versions of most of our newest episodes on YouTube. Make sure you're subscribed to Exactly Right Media's YouTube channel, so you never miss a new episode drop.

With that business out of the way. I am so excited to introduce this episode's author and book. This week I got to sit down with Dr. Wendy Kline, professor of history at Purdue University and author to discuss her book exposed the Hidden history of the Pelvic Exam. If you've ever had a pelvic exam, you know the drill. I. The discomfort, the vulnerability, the waiting for it to be over. There are myriad ways that people feel about these routine exams from neutral to dread, and yet we don't really talk that much about them. Maybe we put up with them or maybe we avoid them, but at least speaking for myself, we don't question their existence how they originated or ways they can improve. We just accept them as a fact of life. As Dr. Kline demonstrates in exposed routine, pelvic exams are a relatively recent addition to preventative care guidelines, guidelines which are currently being revisited. To understand the present day landscape of routine pelvic exams, we have to explore their past, a past fraught with abuse and concealment.

Dr. Kline takes readers through the murky history of pelvic exams, and in doing so, reveals how the field of gynecology has been shaped, both by those who use shame as a weapon, as well as those who seek to empower women through knowledge about their own bodies. Exposed is so much more than a history and current assessment of one of the most commonly performed medical procedures. It reveals how the paternalistic view that medicine has held for women harms rather than helps. And it also highlights some of the incredible advocacy groups working to ask the crucial question, how can we make things better? I had such a fantastic time chatting with Dr. Kline, and I am thrilled to be sharing this conversation with you all. I do wanna note before we get into things that this episode does feature discussions of abuse and medical trauma, so please keep that in mind. With that, let's take a break and then get started.

EW: [00:05:00] Dr. Kline, thank you so much for joining me today.

WK: It is my pleasure. I'm delighted to be here.

EW: In your book Exposed, you take readers through the history of one of the most commonly performed medical procedures, the pelvic exam. And before we get into the murky origins of this exam, I would love for you to set the stage just by taking us through how a pelvic exam is done today. Kind of just an overview step by step, and importantly why they're performed.

WK: So a pelvic exam consists of three parts. The first is the examination of external genitalia, and then second is the speculum exam, and that's typically accompanied by a PAP test for cervical cancer. And then the third. Part is a bimanual exam and that is when the healthcare provider inserts one to two fingers into the vagina while using the other hand to press on the abdomen with the other hand in order to evaluate the pelvic organs. Fairly standard procedure, it hasn't changed a whole lot over the last century or so, and the primary purpose is. There are other aspects as well, right? Just to look for any abnormalities, discomfort, and opportunity to, to talk with provider. If you have any questions, either you or, or anything else.

EW: It is really remarkable and maybe a bit alarming how little it seems to have changed since it was first introduced. And I would love for you to take me through the origins of how this exam came to be, especially the role that was played by the so-called father of gynecology, James Marion Sims.

WK: Right? Yeah. And of course I could talk all day about this, right? Oh yeah. Women's genitalia was, was hidden, right. Um, unlike male genitalia, which is quite obvious, it was very difficult for anybody to, to see or know what it, what

a woman's reproductive organs actually looked like. And that all changes in the 19th century. James Marion Sims was a doctor in, um, in Alabama and he. Claims he takes credit, right? For discovering, quote, classic discover speculum. In, in actuality, there were other types of speculums, um, in France in the 1830s, for example. But uh, Sims was a master showman and took all the credit for this. He gets the idea when he is looking, peering into a patient's vagina. She's fallen off a horse and she's in all kinds of discomfort and he gets the idea of using a spoon and, and bending it to, um, kind of reflect and inserting it into a vagina. And he says this, like, I find it. His memoir introducing the bent handle of the spoon. I saw everything as no man had ever seen before. Right. So he kind of lays his flag, um, this idea of this new territory that he had, he essentially claims. And so it was in fact a fairly revolutionary. Actually see what had been hidden for centuries and centuries. And you know, on the one hand it's saved probably millions of lives. Um, it's changed how we understand gynecology, but there are some repercussions.

And I will also say that it didn't go uncontested. I mean, even many physicians or budding gynecologists in the mid 19th century were really uncomfortable with the idea. What's happening in the 19th century when, when you think about upper middle class, white womanhood, Victorian morality, and this idea that it was appropriate to appear inside a woman's vagina was highly problematic. So there was actually debates among gynecologists about whether touch was more appropriate than the gaze, right? And that. These doctors like, should we, should we go ahead and welcome this new tool or should we disdain it? And I think that's a really fascinating conversation and debate. Yeah. Between these doctors. The other thing is some of them are concerned that it's gonna turn women into like sex maniacs. They're gonna start loving having this put inside their vagina and it. Uh, so anyway, it, it, it wasn't immediately accepted as the ideal tool, but it was gradually accepted and [00:10:00] promoted by.

EW: We've come a long way in, in some, in some ways, uh, and not so much in others. But, you know, when I was reading your book, I found myself thinking a lot of course about pelvic exams and how I relate to them and my experience with pelvic exams. And I was wondering, you know, what, what your experience was like with pelvic exams or is like, and whether that's changed as you have as you worked on this book.

WK: That's a great question, Erin, and, and I'm surprised, like nobody's ever asked me that before. Uh, again, a lot of talks and, and that is not a question I've actually, I've had, and so, you know, I, I feel lucky because I, I feel like I'm one of the, those people that doesn't particularly enjoy it, it's unpleasant, but it hasn't been traumatic for me. I'm fairly comfortable with my body. I tend to have good

relationships with the doctors that I visit, the OB GYNs. Um, I'll talk about what I'm researching as they're probing inside of me, you know? I love that. Yeah. Um, but so I, I wasn't drawn to the topic because of, of some horrible thing that happened to me, which is I know for, for some people it's raise their curiosity about it. For me, it was more. Why are we not talking about this procedure? Right? Yeah. So many people endure this on a regular basis, and so someone like me, it's unpleasant, but for some people it's hugely traumatic.

EW: Right.

WK: Painful, terrifying. And yet we're not really supposed to talk about it for many reasons. Mm-hmm. And so. That kind of raised the question why is it something that we just don't talk about it when it's something that we all experience?

EW: Yeah. Just the, the expectation of this is what you have to do and that's it, and Yeah. And you just endure it. Yeah. And you know, but going back to the history of the pelvic exam and how it initially, when it was introduced, it was not, like you said something that a lot of people were like, absolutely, let's do this. And so who were the people who were likely to receive a pelvic exam in these early decades and who was not likely to receive one?

WK: Yeah. Great question and really important to this story. The first patients were basically the first Guinea pigs. And you can probably guess they were not, they were not white middle class women, and. This is fairly well known in the historiography, but James Marion Zims did most of his procedure first un enslaved patients, and we know about three in particular, Lucy, Betsy, and Anica, who endured multiple procedures countless times over a period of nearly four years without anesthesia. In part I, I should adds. Not frequently used in the 1840s when he was doing this, but still, you know, extremely painful. These were enslaved women who had all, were all suffering from sico vaginal fistulas, basically, um, a tear, um, between the vagina and the bladder as a result of prolonged. Childbirth and possibly also the use of forceps. We don't know specifically in these instances, but, you know, talk about tools that can actually really damage. Yeah. Um, and so, uh, he claims that what they were suffering was worse than death. So it, it was in their interest. To kind of endure these procedures because he was, he believed to be helping them. Um, but he was equally, uh, made the point that he was restoring labor to these women's quote unquote owners, right?

EW: Uhhuh Uhhuh.

WK: Um, but regardless, and there's so much we don't know because of course those voices are silenced. Um, we only know through observer. What they experienced, and even if they were consenting, they can't consent by virtue of the fact that they had no power to do so. They were enslaved women. So what does it mean that a procedure that's considered immoral or unethical or just distasteful to do on a white middle class woman is done on these? Then it would be appropriate to use on these other bodies. And that's basically what happens. Enslaved women, um, sex workers, basically women who were disempowered and, and of course if you think about it, one of the reasons Sims is interested in taking these tools and then applying them to the white. Middle and upper classes is money, right? That's where he, he's gonna get his clientele. That's where the [00:15:00] concern about suffering and alleviating suffering is gonna be focused on, but he needs the tools first.

EW: Let's take a quick break, and when we get back, there's still so much to discuss.

EW: Welcome back everyone. I've been chatting with Dr. Wendy Kline about her book exposed the Hidden History of the Pelvic Exam. Let's get back into things. And then once he had those tools, you know, still though his, the pelvic exam, the speculum was not, as you said, widely adopted. Right. Immediately. Yeah. And so then what were some of the things that led to, its increase in popularity, I guess, or its acceptability?

WK: Yeah. I mean there's, so there's a basic shift that occurs over. Roughly like a 50 to 70 year period from the emergence of gynecology as a medical specialty, which I should add comes hand in hand with the development of the speculum, right? Mm. It was the tool that justified the need for a male medical model. To differentiate themselves from, say, female midwives, right? Mm-hmm. So most of their work was done either with obstetrics, with childbirth, or with, um, patients that are suffering not on healthy women. Gradually there's a shift from pathological or surgical gynecology to preventive gynecology, and there are a couple of reasons for that. Kind in terms of developing gynecology as a specialty is obvious. They wanna expand their patient base, right? Don't want it be up to the patient to determine when they think they need to see a doctor. By pushing for preventive medicine and in this case preventive gynecology. You are widening your patient base. You're encouraging, you know, every woman of reproductive age should see a doctor on a regular basis and boom, suddenly you've got a much wider patient population now. I mean, that's the cynical part, obviously, you know, they believe that they were helping and oftentimes they were. Mm-hmm.

EW: Mm-hmm.

WK: But it. I have an entire chapter about one doctor, Dr. Robert Dickinson, who is the president of the American Gynecological Society in 19, makes a big case, you knows. We need to define ourselves as something other than surgeons of the female reproductive tract or organs, and we should be talking about sex and birth control and all these topics that male doctors. Most of them were male, are kind of skirting around as kind of, again, inappropriate. We shouldn't be talking about these things. We wanna show that we are morally upright, upstanding citizens. Uh, we're not perverts and therefore we should avoid talking about these things. Dickinson's like, no, that's exactly what we should be doing. Right. We should step in. And, and he, he, he basically suggests that. Doctors, gynecologists should also be marriage counselors. They should be talking about sexual discomfort. They should be asking about birth control, et cetera, et cetera. And again, it's a way of widening their base of asserting their authority. It paves the way for this notion of prevent gynecology. Then on top of that, you have the development of the pap smear, right? Ah, yes. And so that's a little bit later. It becomes kind of standardized in the early 1940s. George Papanicalou, that's why we have the name. Figures out, right? He's not even looking for this, but when he's taking cervical smears, first out of Guinea, literal Guinea pigs. And then he uses his wife, um, who, who volunteers cervical smears daily. For decades. Yeah. Decades.

EW: I couldn't get over that. I was like, what?

WK: Literally Guinea pig in the name of science and realizes that. Smear. There are any signs of. Is established, then there's a very clear reason why Hep C, you know, preventive gynecology makes sense, right? This is a way of early detection, trying to see if there's any signs. So it's kind of a gradual process, but I'm really interested in those kind of, those years in the twenties, up to the forties where there is talking as much about sex as they about vaginal health. I would say. Offering among other things, premarital pelvic exams, like getting a, a woman ready for her wedding night to ensure that she will kind of be [00:20:00] comfortable with sex.

EW: That was a fascinating chapter about Dickinson and that quote that you include where he says There is never a precise way of separating the woman from the doctor's idea of her. Uh, it just has been rattling around in my head ever since reading that.

WK: Oh yeah, he kept me up. There were many nights that I did not sleep when I was doing research for that chapter, and it came gradually because he has

terrible handwriting and all of this was scratched, scribbled onto tiny little note cards that I found in the archive. Oh my. So it took a long time to piece together exactly what he was saying and how he was saying it. And so the horror was kind of gradually Yeah. You know, and I, until I was realizing that abusing. Some of his patients, right. And acknowledging it in his own handwriting. And he is also a great case for a historian because he took prolific notes of every, um, because he saw his patients as case studies, he was kind of interested in learning from them.

And so as soon as he would examine them, he would write down, describe what happened. He would even quote. The conversation he would quote supposedly verbatim what the patient had said to him. So even though we don't have a record of these individual women, most of the time we have his quoting, his, his memory of what took place. And he is very upfront about what he is doing. So yeah, that. Really, really disturbing in terms of that. I also just wanna add on top of it, because I think this is really interesting because my first book was history of the eugenics movement. Well, Dickinson was a genic and he. Embrace not only sterilizing certain women, but encouraging the right type of women to have more children. And that's why he was so interested in premarital pelvic exams and the idea that that he's a marriage counselor because he wants to ensure that these women stay in stable marriages. Why? So they have more children and it's right kind. Right. So that's partly why he's kind of. Putting his foot in the door, opening this like wider conversation about women's roles, believing that gynecologists should in fact be these moral arbiters that come in and, and help stabilize marriages by having these kind of hidden conversations to ensure that that women continue to have sex and reproduce.

EW: That lens I feel like is so important. You know, his work or ideas or notes or practice or, and abuse didn't happen in a vacuum. Like he was a product of that. How eugenics was, had a hand in every, everything I. He seems to approach his patients from this framework of, I am not going to believe what they say. Like I am already doubting what this person is going to say to me. And I feel like this is, again, part of this, this larger trend that was happening around this time with the speculum and then other instruments being utilized by physicians to. Learn about their patient's bodies without having to actually talk to or listen to or believe the patient themselves. And what do you feel like were the consequences of this shift where suddenly a woman becomes an unreliable narrator about her own body?

WK: I think it's a really important shift, which is again, one of the reasons why I wrote this book. I mean, if I just step back for a moment and we think about science and technology doesn't happen in a vacuum. It is all about context and

agendas and you know, professionalization and attitudes about women in a particular time and place. So if you take a particular tool or procedure and you track it over the time while the. Procedure may not change that much. I mean, that's one of the first things we said. The tool is pretty much the same. The examination is pretty much the same, and yet the meaning behind it changes radically depending on different contexts. So in a time period in which Eugenics was extremely popular, the tool and procedure are. Back to your question about moments in which tools kind of replace listening to the patient, in this case, the female patient. I think it's a reminder of the extent to which this was a paternalistic, fairly misogynistic culture in which women's voices were not. Taken seriously. And they weren't always believed. And so for Dickinson, it's like [00:25:00] your genitals can tell me the truth more than your, your voice or your experience. And that's a very disturbing, uh, message, right? And this is among educated middle class women even you. The way Robert Dickinson did. What was he saying about Lucy, Betsy and Anica? Right. And what were they thinking? I mean, this is historians greatest tool and biggest frustration is the clues and then the absence of clues. Mm-hmm. And what we wish we knew, and there's so much we don't know. Mm-hmm. But we, we can expect. The power differential wasn't just male female, it was white, black, slaveholder. Um, is so much linked to power.

EW: Yeah.

WK: And the more disempowered a person is, the less likely their voice is going to be taken seriously. So my point is that even among white middle class women, they were not necessarily listened to. The tools became kind of the translator almost, or the interpreter to kind of herself. And in turn, very gradually this disempowering makes women less confident that they have the right to say, or that they, that maybe they don't understand their bodies or what's going on. They need the doctor or the tool to kind of explain to themselves, I'm jumping ahead, but that's what eventually leads to. Hold on a minute. We do know what we're doing. These are our bodies. So we are the experts of our own bodies. We, because we embody them, we don't need your interpretation, which we believe to be misogynistic, inaccurate, et cetera, et cetera.

EW: Let's take a quick break here. We'll be back before you know it.

EW: Welcome back everyone. I'm here chatting with the wonderful Dr. Wendy Kline about her book Exposed. Let's get into some more questions. How did it go from like a, an informational perspective of you seek a gynecologist because you need it to then preventative care? How did women learn or like come across that that's what they should do?

WK: Oh, that's such a good question. You know, before obviously there was, cervical cancer existed before the pap smear, right? Duh. Right. To have a diagnostic screening procedure was. Exciting. Right. Genuinely exciting. It did save a ton of lives even before that diagnostic tool. There's a recognition that just being seen by a doctor and examined an internal examination, even without the smear test could. Save some lives. The problem, as you've said, is how do you spread the word? Mm-hmm. Okay. So like in the 1920s and 1930s, you have gynecologists trying to push for early prevention and preventative gynecology, but they're not allowed to talk about it. Right? So a doctor at Johns Hopkins is complaining because he wants to publish. Newspapers and told newspapers. Don't wanna. Cervix uterus, right? I mean, all of these words that have all the stigma attached to it. And he's like, well, how do I get the word out if I'm not even allowed to talk about it? So he hires an assistant, her name's Florence Becker, and basically says, you know, it's up to you. Go spread the word in women only circles. Like tell your friends, organize women's groups. Talk about it. People's backs because it's not seen as appropriate to talk about it. Do you see how we get to where we are today where we still can't talk about it? Right. Right. I mean, this is the problem. Yeah. People were told they can't talk about it, so it becomes this like women telling their, their friends, their sisters, you should really see a doctor. It saved my life and that. That's still kind of a message in cervical cancer advocacy today, and I'm not saying it's a bad message, but it was the only way to spread the word because these doctors, you know, couldn't talk about it. Once you have the pap smear, I think they have more evidence. Scientific evidence to kind of prove, and that they're able to be a little bit more open about it. But it was, it was essentially a word of mouth campaign for [00:30:00] decades.

EW: Of course, that word of mouth doesn't make it everywhere. And so you see these disparities Yep. Uh, both historically and today in who is getting access to pap smears. And there are there, I mean, there's a myriad of factors that. Determine whether or not someone can get a pap smear, has access to a pap smear, um, doesn't want to get a pap smear, but you know, what were some of these disparities that emerged with these early studies trying to examine who was getting routine pelvic exams and who wasn't?

WK: Huge, massive racial disparities. And I, I think there are a couple of reasons for that. Accessibility and racism. Mm-hmm. So, and they're obviously overlapping, but by racism I also mean, um, mistrust that even campaigns to kind of reach out to women of color were problematic because black women understood. How racism and mistrust all kind of problems. Of course there's gonna be a reluctance. What do you really want from me? And, and why? Right, right, right. I shouldn't trust you. Um, but, but primarily access, um, you know, health insurance, uh, availability, access to. Any kind of treatment. Right.

Treat, uh, particularly in, in regions in which a two-tiered healthcare system, which prevented these women from entering most hospitals. Mm-hmm. So, um, that combination meant that this was primarily reaching white women. Oh, I should add the third is who were the women primarily, with some exceptions, word. University women, I forget, is it the American Association of University Women? I think she talks to a primarily white, middle class educated group. Right? They're spreading the word amongst their friends, their sisters, their club groups,

EW: right?

WK: Um, but not among others. Again, there are some, some exceptions to that and some awareness, which is why you get some, some black women. Being tested and seeking treatment, but it's to a much smaller extent,

EW: all problems that still exist in some form or another today. Um, and I wanna talk about that in a bit, but I, I also wanna get back into this idea of how the feminist movement and women sort of reclaiming the knowledge that should have been theirs. All along. And so who were some of the pivotal players in this time? And I would love for you to tell me more about self-help clinics and how they came to be and how those also changed the patient doctor relationship.

WK: Yeah. Oh my gosh. Well, do you have like 17 hours? Because that's how long I can talk about it. I've written a lot about this. Um, I think it's important. Set the stage. To how we get to this moment. So I talked about Robert Dickinson in general, these gynecologists until 1970 are male, primarily white male. 93% of all gynecologists in 1970 were male, which is very different from today, right? Yeah. Where the majority are female.

EW: Mm-hmm.

WK: And so these are women that are going to see male doctors. 1960 of the introduction of the birth control pill. Mm-hmm. It's intended for married women only. So a lot of women are going to the gynecologist only to get access to the birth control pill, or that's a primary motivator. And initially the requirements of getting the pill included getting a pelvic exam. Mm-hmm. That has since been, um, uncoupled. Right. But that was the rule. And so you've got millions of women going on the birth control, which means there are also millions of appointments made, right, and millions of pap smears, pelvic exams, and many of these doctors have inherited this kind of marriage, marriage counselor role. So they think it is their right. Why this woman is seeking the birth control pill is

she married. Some women would actually wear fake rings and pretend they were married, but more generally, just being paternalistic, making all kinds of claims about a woman's sexual behavior because she's seeking birth control pill. So, you know, that's the beginning of the sixties. It's a. We all know it's a turbulent decade, and by the end of it, it becomes clear that sexual liberation isn't necessarily liberating for women, right? There's an expectation to be sexually available. It isn't always in their best interest. So out of that springs a lot of anger about what is happening in the gynecologist's office. [00:35:00] And there's a meeting at a workshop on women's liberation in 1969 in a college in Boston, Emmanuel College, and there's a two hour meeting, and the, the topic is women and their bodies, and it's 12 women, and they're just, all they wanna do is come up a list of reasonable ob GYNs in the Boston area. They realize they can't come up with a single name, uh, literally a single name.

WK: And then they decide to keep meeting. And eventually that group evolves into the Boston Women's Health Book Collective that writes our bodies ourselves. And it's really the first women's health manual written by women for women, not by medical professionals, accessible information about their own bodies that they research themselves. Part of this anger is, is fueled. I mean, they see the, the gynecologist as sort of emblematic of all the problems of misogyny in American society. There's a great quote in vaginal politics, and it opens with a description of her first visit to a gynecologist where she says, I was naked, he was clothed, I was lying down. He was standing up. I was silent. He was speaking. It just kind of captured in this tiny little narrative, everything that had was silencing women and basically robbing them of their identity. So you fast forward to two options. One, fight against medical school quotas that are keeping women out of medical school. Mm-hmm. But secondly, many people realize that wasn't gonna be good enough. Now you start having more women going to medical school. They're subjected to jokes, they're ridiculed. They've got their professors putting up Playboy cartoons, kind of mocking them, sexualizing. The procedure. Mm-hmm. Et cetera, et cetera. And so you have other women that are creating these kind of lay feminist women's health organizations, lay meaning they're not run by MDs. Right. Um, and that's where the birth of self-help. That was a long-winded way of me getting to self-help,

EW: though. I loved it. I loved it.

WK: So the idea is you are the expert of your own body. And you don't need someone, you know, um, an intermediary that a so-called expert to show you or tell you things. And the way you do it is by spreading your legs, getting a mirror and a flashlight and a plastic speculum, and suddenly voila, you see your own cervix, your own vagina, the walls of your vagina. And for many, this was

incredibly revolutionary because. I could suddenly that gaze, which had started with sims mm-hmm. Saying, introducing the backhand this soon, I saw things as no man ever seen before. Um, they turned that on its head and basically see the speculum as a form, potential form of women's liberation. There's a great cartoon I have in the book of Wonder Woman holding the speculum. I love. These men to tell us we can have access to that information ourselves. Now, some of these women didn't just look, they did things right, including perform abortions. They're, um, the collective in Chicago, Jane, um mm-hmm. Taught each other how to do abortion. So it was very politically motivated at times and very radical, um, and empowering as well.

EW: Thinking about that period made me sort of wonder what are the components of a good pelvic exam. Yeah. Yeah. Like what? What makes a good pelvic exam? I think it's easy to, to think of ways that a pelvic exam is bad, but what are the good components I.

WK: Yeah. And in fact a lot of what we experienced today are a result of the Women's Health Movement kind of putting their foot down and saying, here are some demands. So another group, the Women's Community Health Center, which was a feminist women's health collective in Boston, partnered remarkably with Harvard Medical School for this kind of experiment. It doesn't last long. This is in 1974. I. But basically some of female Harvard medical students go to the center and say, we're not comfortable with how we're learning how to do a pelvic exam. In general, medical students in, in this time period, like in the fifties and sixties, are either learning on simulated plastic pelvises or on anesthetized patients. Or on prostitutes who are being paid, um, to do the exam. And there's a, a lot of debate about, you know, is this appropriate? So suddenly you have the emergence of these women going to more women going to medical schools, as these quotas are eliminated and the women are not comfortable with how they're learning it. And they go to the community health center and say, could help here. Could you volunteer? [00:40:00] You teach it teach and we learn how to do a pelvic exam on you guys and you instruct us, then we can, um, have a better sense of what's appropriate. And among the things they do is they come up with a, um, a list of guidelines that they require everybody at Harvard to use. And it's things that now are so obvious, like, warm the speculum right before you insert it. Make eye contact with your patients.

EW: Oh my gosh. That that had to be written out. Yeah. In the instruction is, yeah. Yes.

WK: Introduce yourself, like just basic things to set the woman at ease so that it is slightly less traumatic. Those are the things that are now ideally

commonplace and it's a result of that. But if you think about it, and I tell my students this than ethical problems perspective, what's. An anesthetized unconscious patient or on a plastic pelvis, there's no feedback. Right, right. Yeah. But the message is it doesn't matter if it hurts. Right. That what matters is that you do the exam, you see what you need to see, right? Yes. Rather than it cares about the

EW: patient. It's the patient's body part that you're interested in. Yeah. Yeah,

WK: exactly. Yeah. And so that kind of. That required an active conscious body that could provide some feedback, help to kind of change some of those attitudes, that there are ways to do this that are less traumatic. Yeah, and we, we should be talking about that, not just getting an accurate pap smear, whatever else. Right.

EW: Actually incorporating the patient into the goals of a pelvic exam. Speaking of, of using anesthetize women to train for pelvic exams, where, where do we stand with that today? In the us

WK: the, the fortunate thing is we're talking about it and there's been legislation. Um, it, it changes regularly, but now, yeah, certain states have legislation on the books. The training of medical students on women without their consent or under anesthesia for a procedure in which it's unnecessary, but on top of it now that recently, um, health and Human Services have said that. Receive federal aid are required to get consent for these procedures. When that story came out, people were either totally got it and said, this is, how can this be? Like, I'm horrified, right? I didn't even know this was happening. And others were like, oh God, one more consent form. Can we do nothing? Can we accomplish nothing? And if you looked at the comments, there was pretty clearly a gender divide, right? Not entirely, but it just, it speaks to this idea and it comes out of the history of medicine and how we, how we train doctors that. Apprenticeship model or this idea, you have to, you have to learn. You have to practice. How are you gonna do it? Um, do you need permission every time you look inside of a mouth or an ear? But of course, the vagina is a very different type of orifice, right?

EW: Mm-hmm.

WK: The boundaries between what's sex and what's medicine become very easily blurred. When you're talking about penetrating a vagina, and we know that because of cases like Larry Nassar and others, I, I talk about them in the book as White Coat Predators. These are people that have basically learned to

take advantage of the system to violate women for their own sexual desire rather than in the interest of the patient. And the problem is, even though most gynecologists aren't doing this, but we've created an environment where it's the potential. Is there. It goes back to that silencing and this, the fact that we don't talk about what goes on in the exam or what should go on the exam or any of that because.

EW: Shame is such a huge part of the silencing because we're taught to feel ashamed about our bodies. We're taught that it's not polite to talk about, and I, I want to sort of ask about like how this shame then has played such a huge role in making it difficult to recognize when something is an abuse, when something is crossing a line.

WK: It's a huge problem. It's a huge problem and such a. I mean if we go all the way back to pre James Marion Sims of the fact that these women's body parts were secret 'cause they were hidden and medieval Christian laws prevented looking at talking about these things. So it's, I mean, it's got a very long history. But in contemporary society, it's, it's still the case. I mean, studies show, for example, there was a study done in 2014 in the UK [00:45:00] that showed that a majority of women in the UK between the ages of 16 and 25 have a problem with using the term vagina or vulva. They just, they don't wanna say it. Um, and this of course leads to a basic lack of anatomical knowledge, right? It's not only half. Between the ages 25 and 36, surveyed in the same study could accurately identify parts of the vagina on a simple diagram. And then nearly one third of younger women admitted they avoided going to the gynecologist altogether due to shame and embarrassment. So there's a direct link, this discomfort, because we're encouraged from basically the day we're born not to, not to talk about these body parts.

WK: To be ashamed of them and et cetera, et cetera. And sometimes for protective reasons, right? But it's still the same problem that we don't, we don't talk about it. And, and this literally costs women's lives when they don't see a gynecologist and they develop a cancer and that this preventable, but they're just so. So that shame is very much still with us and it's political as well. I write about how this 2012, uh, Michigan State representative was banned. This is Lisa Brown, banned from speaking in the house for using the term vagina in a debate over an anti-abortion bill because her Republican colleague found it offensive to use the term vagina. So what does she do? She and other fellow female, uh, wo. Speak outside the steps of the, on the steps of the state capitol. They read the vagina monologue, just a of like, what else do you want me to call it? Right. So it's become politicized and that adds to that kind of discomfort, which again

translates to a silencing around the procedure itself and how it's supposed to happen.

Who is supposed to be in the room? How are you supposed to be touched? The fact that gloves should be used, all of these things that when the abuse occurs, it's often with young women who have no idea. Because they haven't been told and they're, you know, it's through these duplicitous men that know how to get away with it, you know? Right. It doesn't help but another survey, 2017 study asking hundreds of women just after getting a pelvic exam, the question, do you know why this examination is performed? Half of them couldn't answer. There's a lot of confusion about what it is, why it's done. There's debates. The American College of Physicians in 2014 determined that it should, the procedures shouldn't even be done anymore under for healthy, asymptomatic, non-pregnant women. But the American College of Obstetricians and Gynecologists still promotes it. So there's, I think that confusion has filter down to. More, the more general population. You know, why do I need it? What should I do? How, what is it and why do I do it? And I don't understand my own body part. And, and one of the things I hope people get out of my book is how important it is to have those conversations. To talk about it. Yeah. And talk about it with your gynecologist when you go in, what your expectations are and if you're afraid and, and pain and all of these other things that were sort of discouraged for. Advocating for ourselves.

EW: Mm-hmm. And I feel like that's such a huge part of this is, is advocacy, word of mouth, raising awareness, just sort of making this knowledge and information accessible. And that's, you know, something that you, your book is doing and it's, it's also something that you highlight in your book, the work of some advocacy groups like Survivor that really have done so much to. Provide this information, this baseline in a way that's not so, you know, fraught with all of the problems of walking into an exam room for the very first time, not knowing what to expect. And so I'd love for you to just talk about some of these advocacy groups and the work that they're doing.

WK: Sure. Yeah. And actually I was just speaking at the Survivor's Annual Cervical Cancer Summit in Washington, DC about three weeks ago. Survivor, for those listening, it's spelled C-E-R-V-I-V-O-R. Right. So it's survivors of Cervical Cancer, an organization created by Tamika Felder, who is amazing, very powerful, brilliant woman. Um, and a survivor herself, of course. But at this summit, which is was sort of equally informational, but also about creating a sense of community, enabling survivors to come together and tell their stories, talk about spreading the word, but shame kept coming up over and over again. I was really struck by this. So many of the people that got up to speak said that

when they found out they were diagnosed with cervical cancer, first of all, many of them wouldn't use the. [00:50:00] It's a female reproductive part, uh, but second, because it's v it's caused a sexually transmitted disease. So there's shame around how, you know, how one gets the, the virus that can lead to cervical cancer. So that, that deep level of shame, even when it's about something that you're a victim of, right? You didn't cause it.

Anyone can get HPV, you know, all it takes is one sexual encounter, but that level of shame, you know? And so when I got up and do my, did my reading, I said, let's go, let's go back. Even. Further, you know, it's not just cervical cancer, but, but shame more general about reproductive parts that we need to be talking about and we need to be sharing stories. They're very much about sharing stories and I saw my role as the hi, the only historian in the room of saying the stories that matter are. Absolutely the people in the room, but also historically, how can we breathe life into, you know, generations of women who have encountered this. So they're doing amazing work and recognizing that we need funding, we need federal funding, and we need studies done. We need to continue these studies in this political climate, but we also need to allow people to feel entitled. Speak about it and share stories and not be dismissed more generally. Yeah.

EW: Yeah. And so we are entering in a very frightening period for women's reproductive rights here in the US and I would love to hear your perspective on what we can learn from the past to help us better navigate what might be a very dangerous present and future.

WK: Oh, boy. Wouldn't I like to know the secret to that? Um, well, here's, here's one way I, I like to think about it. There are people who we're not gonna change everyone's minds, certainly not on certain issues. This is a divided country. It's a divided world when it comes to things like pregnancy, fertility, infertility, abortion, et cetera. But everybody should agree that access to basic healthcare, women's healthcare, should be a fundamental right. right? Right?

EW: Yeah.

WK: Women need to have access to basic healthcare. And if you start dismissing funds, um, but also criminalizing to the extent that they are, it's detrimental to the field of gynecological care.

EW: Mm-hmm. Right.

WK: And you're gonna see not only maternity healthcare deserts where it's very difficult to find, you know, an OB GYN in certain areas, but. More generally women's healthcare deserts where it will be harder and harder for women in particular parts of the country to find, to literally just find anybody to get a pap smear. Right? Um, or, or basic healthcare. Right. And that is abominable. Yeah, that is abominable. We're talking half the population, you know, I. Define misogyny, then take away the ability for women to get.

EW: Could not have said it better. It's, uh, I think we can look at the past to, to think about what we might see if, if this is taken away, it could be a very scary time going forward. But, um, yeah, I loved your book and, uh, I think it's so important to provide this, this broader context of this thing that so many of us experience all like regularly and don't think more about it maybe, or we do think more about it, but we don't know about the larger history of it.

WK: Right. And we, we don't have the language or the opportunity to kind of talk about it or, or see it as that it's a valid topic of conversation. Yes. You know, because if it was about men's healthcare, it would be, I even had, I had an academic, male academic when he asked me the title of my book and I told him, and he said. Well, that's a pretty niche topic, isn't it? I'm like, oh, yeah. Spoken by someone who's never encountered this. Right? I mean, hello. Thank you. Sexism 101. Right? So it's, it's dismissed by people who can't identify with it. Yes. And they don't even recognize that, that that dismissal. A political act. Yeah. Right. And it's, it's a way of, again, silencing. Oh, right. Oh, I'm sorry. I guess I shouldn't be talking about this because you don't find it interesting. So, yeah. I mean, even just to, to be able to talk about it, you know, read the book, share it with a friend, have a conversation.

EW: Well, I, I really wanna thank you so much for taking the time to chat with me today. I really appreciate it.

WK: My pleasure. It was, I love talking about this stuff.[00:55:00]

EW: A big thank you again to Dr. Wendy Kline for taking the time to chat with me. This conversation felt so meaningful to me. And if you enjoyed today's episode and would like to learn more, check out our website. This podcast will kill you.com, where I'll post a link to where you can find exposed the hidden history of the pelvic exam, as well as the link to Dr. Kline's website where you can find her other incredible work. Don't forget, you can check out our website for all sorts of other cool things, including but not limited to transcripts, quarantine, and placebo. Rita recipes show notes and references for all of our episodes. Links to merch. Our bookshop.org affiliate account are good reads

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