

If a medical school student or resident looked up “miscarriage” in the index of *Blueprints Obstetrics & Gynecology* (2013), they would be directed to “spontaneous abortion.” Denoting a pregnancy that ends before 20 weeks, spontaneous abortion occurs in 15% to 25% of all pregnancies, and this “number may be even higher because losses that occur at 4 to 6 weeks’ gestational age are often confused with late menses” (15). Of all first-trimester spontaneous abortions, the guide notes that up to 80% are associated with abnormal chromosomes. The remaining percentage are caused by “other factors,” “environmental exposures” listed well after infections, maternal anatomic defects, and immunologic factors. In sum, the guide concludes, a “large number of first-trimester abortions have no obvious cause” (15)—in other words, most spontaneous abortions do not occur because of something within the pregnant person’s control.

What is the history, then, of the term “miscarriage,” a word that blatantly suggests otherwise? As the *Oxford English Dictionary* tells us, when “mis-” is prefixed to verbs, it is with “the sense ‘badly,’ ‘wrongly,’ ‘perversely,’ ‘mistakenly,’ ‘amiss’” (“mis-, prefix1.” *OED Online*). The noun, “miscarriage,” denotes instances of misconduct or misbehavior; failures, blunders, and mistakes; mismanagement and maladministration (“miscarriage, n.” *OED Online*). In its etymology alone, “miscarriage” suggests, at best, that the person carrying the child has failed to manage the “other factors” that cause less than 20% of spontaneous abortions. At worst, the pregnant person has deliberately caused harm to an unborn child.

In early modern gynecological manuals, the terms abortion and miscarriage are used interchangeably, with little distinction between the two. This is, perhaps, because male physicians had little to no way of knowing if an “untimely birth” was purposeful or not. The Caroline law passed in 1624 shows the anxiety surrounding the inability to police and know reproductive bodies. The law placed the burden of proof on women when a pregnancy did not end in the birth of a healthy child (Riddle 135). *The Birth of Mankind* (1560), one of the best-selling gynecological manuals of the early modern period, describes various causes of women delivering “before the fruit be ripe” in the chapter “Of Aborsements, or Untimely Births.” These causes include, but are not limited to, “overmuch stirring of the body”; “sudden anger, fear, dread, sorrow, or some sudden and unlooked for joy”; and a “diseased and grieved” womb (138). Women are advised to avoid intemperate weather conditions; bathing-houses with hot baths and vapor baths; “overmuch drunkenness and excess feeding,” and more (137). The lists go on and on.

The chapters on spontaneous abortion in *Blueprints* and *The Birth of Mankind* could not be more different—on the surface, it seems that enlightenment thinking has benefitted pregnant women

and their care, that physicians-to-be are now given the facts, re-directed should they look up “miscarriage.” But as any person who has been pregnant will tell you, how pregnancy loss is imagined and understood has *not* shifted—there is a reason *miscarriage* is still indexed in post-Enlightenment physician manuals, however much a misnomer. Male physicians’ anxiety over not being able to control reproductive bodies has a legacy pregnant people still grapple with today; the beliefs behind the word *miscarriage* are still present in our cultural imagination—that women, in particular, are untrustworthy, that female desire must be policed, regulated, and ordered.

In the recent collection, *Communicating Pregnancy Loss: Narratives as a Method for Change* (2014), Patricia Geist-Martin writes of her miscarriage experience as one of powerlessness: “Nature stepped in”; “nature spoke,” (ix). Nicholas Culpeper, an early modern physician, in *A Directory for Midwives* (1684) similarly describes miscarriage as “Nature rejecting” a body “as not being fit for the nourishment of the Child” (112). Geist-Martin’s anthropomorphizing of nature, however, is distinct from Culpeper’s, less harsh. As the editors of the collection write, pregnancy loss “is a disorder. That is, for couples and individuals who had hoped for a child, pregnancy loss is a ‘disordering’ of the story they had intended to tell, a disruption in an imagined life story” (Silverman and Baglia 8). As Geist-Martin evokes, along with other essays in this collection, pregnant people often struggle to understand this disorder as natural and common—however devastating. The very language available to Geist-Martin and the other narrators in this collection is intimately tied to that of early modern physicians—and physicians today—who advise and treat their patients out of the belief that the pregnant body must be ordered, managed, and controlled to avoid miscarriage.

As someone who was pregnant recently, I recognized the overbearing and often contradictory advice in *The Birth of Mankind*, on “How a Woman With Child Shall Use Herself,” more than I did the facts presented in *Blueprints* (103). I got pregnant right away, and all of the sudden it seemed that everything that made up my environment, from what I ate and drank—coffee and alcohol, in particular—to the medications I took for depression and anxiety, to the hot yoga I did daily, were missteps that put my unborn child at risk. It became clear that my desires and needs *could* be controlled and effaced but sometimes at the expense of my own health and sanity—that, ironically, the anger, fear, dread, and sorrow I felt discovering rule after rule mattered less than the fact that taking NyQuil for a bad cold, for example, was now a misuse of my pregnant body.

I’m not alone. In *Expecting Better: Why the Conventional Pregnancy Wisdom Is Wrong—and What You Really Need to Know*, Emily Oster devotes a chapter to “Miscarriage Fears,” opening up the chapter with “In trying to learn the truth about alcohol, and, in particular, caffeine, it was hard to avoid discussion of miscarriage” (69). While researching this book over the course of her own pregnancy, Oster notes that miscarriage was “something I thought about—worried about—a lot” (69). Getting to the root of these fears—who plant them, how they are cultivated and grown—is crucial to rethinking what might be done to offer pregnant people more ease in how they carry their pregnant bodies, and less shame after the devastating experience of a spontaneous abortion.

Of note are some of the responses to Oster’s book (one that my own OB-GYN had in his office as a reference text) such as her presentation of the facts on environmental factors like caffeine and

alcohol, what *good* studies demonstrate (that, in moderation, neither caffeine nor light drinking has been proven to cause miscarriage or harm to an unborn child). The President of ACOG (the American College of Obstetricians and Gynecologists) has publically discredited Oster and her research, saying in an NPR interview that alcohol intake during pregnancy is more dangerous than heroin or cocaine. The affective experience of pregnancy, and of spontaneous abortion, is characterized by this continued fear-mongering, by baseless claims such as these from physicians in positions of power (for a report on physicians' mixed opinions on alcohol intake during pregnancy, see here). As Oster notes in her book, there are of course activities to avoid while pregnant if possible—smoking, binge drinking, etc. Most pregnant people I know do their very best to ensure the safety of their unborn child. But taking pregnant people's fear, anxiety, and shame seriously—as opposed to hypothetical risk—reveals that we have never been modern when it comes to the “ordering” of desiring female bodies, of how we treat women with needs.

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