

THE PERSECUTION AND PROSECUTION OF GRANNY MIDWIVES

IN SOUTH CAROLINA, 1900-1940

By

Alicia D. Bonaparte

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Approved:

Professor Karen E. Campbell

Professor Jane Landers

Professor Gary F. Jensen

Professor Tony N. Brown

Professor Laura Carpenter

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DEDICATION

I dedicate this work to the granny midwives. I thank those granny women who inspired me to write this project and to continue learning about their art. May this piece of work and my continued research truly honor and respect this ancient and revered path of healing.

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CHAPTER I

INTRODUCTION AND BRIEF HISTORY OF GRANNY MIDWIFERY IN THE U. S.

In the early 20th century U.S., there were three predominant forms of midwifery: granny midwifery, lay midwifery, and nurse-midwifery. Granny midwifery is a derivation of lay midwifery which largely connoted home births attended by informally educated practitioners. However, there are some differences between granny midwifery and lay midwifery. The term granny midwife is a derivation of the term grandmother midwife; the term grandmother was used often because these midwives tended to be much older women. In order to become a granny midwife or lay midwife, a woman had to have a spiritual “calling” to the profession, have held an apprenticeship until the older midwife retired, or followed a family tradition of midwifery. As an apprentice, both lay and granny midwives needed to boast a combination of these prerequisites dependent upon the southern state and the former traditions of their supervising midwives who may have retired or died.

Granny midwives practicing in America in the early 1700s through the late 1800s tended to be African American, and not only functioned as birth attendants but also as their communities’ healers, had surpassed menopause or were currently menopausal, were based in rural communities, and also served in pivotal leadership positions (and for some religions) within their communities. Another distinction is that granny midwifery tended to primarily be an inter-generational occupation passed on in a matrilineal fashion.

White women have also been granny midwives; however, granny midwifery has been practiced predominantly by black women. White men have also been midwives and were known as man-midwives. Throughout the deep South during the colonial and antebellum periods, “countless generations of poor rural women, both white and black, were attended in childbirth by

granny midwives [which will hereafter be referred to as ‘grannies’], mostly black women whose skills were handed down from mother to daughter over the centuries” (Mitford, 1992: 173).

Oftentimes, lay midwives (including granny midwives) surfaced due to an increasing need within rural communities for healthcare providers and a distrust of doctors. The third form of midwifery, nurse-midwifery, emerged in the 1920s under the direction of Mary Breckenridge and involved formal training as a nurse and midwife (Lops, 1988: 405). Tutelage of a nurse-midwife included taking medical instruction from trained nurse-midwives, licensure examinations, and hands-on training under the supervision of a nurse-midwife. It is important to note that the arrival of nurse-midwifery came on the heels of social persecution of lay midwives.

They said the mother of their white Christ (blonde, blue-eyed, even in black-headed Spain) could never have been a black woman, because both the color black and the female sex were of the devil. We were evil witches to claim otherwise. We were witches; our word for healers. We brought their children into the world; we cured their sick; we washed and laid out the bodies of their dead. We were far from evil. We helped Life, and they did not like this at all. Whenever they saw our power it made them feel they had none (Walker, 1989: 196).

Alice Walker in *Temple of My Familiar* provides a profound insight as to why African American women and, more specifically healers such as granny midwives, were targeted and persecuted as participants in *birthing work* and later prosecuted within legislative statutes governing birthing work for noncompliance. Birthing work is a term I created that encapsulates the art of “catching” or delivering babies. Walker’s comments also help to elucidate why physicians made arguments for and lobbied for more restrictive legislative regulation of midwives due to a fear of these “witches” and their association to the devil because they were “the color black” and of “the female sex” (1989: 196). Moreover, Walker pinpoints how the respect given to healers made some whites question “power” relations in their communities.

After the antebellum period and into the late 19th century and 20th century--more specifically, between 1900 and 1940--health officials, more specifically medical doctors, came to

view granny midwifery and its proponents as perpetuating an unsafe or illegitimate form of medicine and subjected the practice of midwifery to various forms of criticism and prosecution. Physicians and other opponents of granny midwives' participation in birthing work used religious theology, patriarchal notions, racist or prejudicial notions, and inter-occupational conflict within birthing work as base for criticism of these healers and traditional birth attendants during the late 19th and early 20th centuries. Prior to this period, African and African American women for generations had been involved in various healing roles and positions within their respective communities, particularly as midwives.

This study asked the following questions: How did physicians use their professional writings to argue for the elimination of granny midwives from birthing work in the South Carolina from 1900 to 1940? More specifically and using the works of Starr (1982), Abbott (1988), hooks (1981) and Hill Collins (2000), did such physicians' writings include themes of racism, sexism, and/or inter-occupational conflict? And, did medical legislation regarding birthing work grow more exclusionary over time?

In particular, I focused on physicians' written advocacy for the elimination of the granny midwife in two medical journals, and particularly for the presence of themes. These *themes* are identified within explanations medical doctors and administrators stated that utilized racist and sexist biases, grannies' lack of formal education, and their alleged archaic or superstitious practices as evidence of medicinal ineptitude in an effort to ban granny midwives. I argue that their persecution-and prosecution-were due to the medicalization of birth by the formalized healthcare and legal systems; the professionalization of American medicine; and the restructuring of American healthcare which created surges of inter-occupational conflict within the field of birthing work between obstetricians, general physicians, and granny midwives. Medical journal articles oftentimes printed such persecutory comments or opinions, and prohibitive legal regulations may have made the prosecution of lay midwives possible. Consequently, women of

color suffered devaluation and stigmatization and were viewed as illegitimate medical practitioners.

As a means of illustrating how physician sentiments and medical lobbyists made arguments for eliminating granny midwifery, this research utilizes text from articles published from 1900 to 1940 in *The Journal of the American Medical Association (JAMA)* and *The Journal of the South Carolina Medical Association (JSCMA)* as well as South Carolina medical practice acts taken from the *American Medical Directory*. I also used the Sanitary Codes as published in the South Carolina State Board of Health Records because prior to 1930, midwifery regulations were encapsulated within the Sanitary Codes. Medical practice acts and the South Carolina Sanitary Codes are legislative statutes that detail what provisions those seeking to practice medicine in a particular state must adhere to. These data sources are more fully detailed in Chapters III and VI.

Arguments authored by physicians and medical lobbyists were based in racist, sexist, and inter-occupational conflict themes. Via exploratory qualitative analysis of these documents, I parcel out themes of persecution embedded in physician sentiments and methods of prosecution within medical practice acts. Generally speaking, medical journal articles, I argue, detail and/or illustrate the themes of racism, sexism, and inter-occupational conflict while medical practice acts helped to identify prosecution at the state level in the form of legislative acts which may have contributed to the decline of granny midwives in South Carolina.

This research illuminates how medical journals served as an appropriate and successful platform for arguments for midwifery abrogation. Within these journals, physicians as well as other medical professionals, lobbied strongly to their colleagues and state legislatures for the elimination of midwifery. I also argue that reports generated by advocates of the maternal healthcare movement condemning the effectiveness of midwifery bolstered physician censure of midwives. Consequently, midwifery was eliminated as a viable profession. Lastly, I argue that

this phenomenon exemplifies a historical trend in which affronted whites use racist and sexist commentary to hinder blacks from participating in various professions.

Research Intentions

Having focused on how grannies were relied upon, midwifery researchers overlooked both the state of South Carolina in their analysis of granny midwives. In addition, midwifery researchers have not examined how physicians viewed grannies in professional medical journals. This study fills this void by broadening the scope of research on granny midwifery and further establishing how their role within the history of healthcare was viewed and challenged by physicians and other health professionals in southern America. Also, this body of research has neglected to look at the intersections between race, occupational hierarchy, and gender in the field of birthing work as they relate to inter-occupational conflict. In essence, grannies were not targeted just for sexist or classist reasons as were their white female counterparts and midwives in general. Rather, race played a vital role in shaping public views of the capabilities of individuals as medical practitioners.¹ Specifically, my goal in conducting this study was to examine how physician commentary contributed to the demise of granny midwifery because most sociological and historical research has looked at how grannies were relied upon (see Robinson, 1984). Medical journals served as an appropriate and noteworthy forum for their ideas to be expressed and disseminated among other medical contemporaries and thus as an effective mechanism for midwifery abrogation.

Brief History of Granny Midwifery in the U.S.

During slavery and continuing into the first half of the twentieth century, African and African American women (and some men) served as healthcare providers, namely as grannies,

¹ Age is also another key element that few researchers discuss in regards to granny midwifery (Beardsley, 1987).

for their respective communities in the United States (Mitford, 1992; Lee, 1996; Dougherty, 1978; Beardsley, 1987; Susie in Lee, 1996; Davis and Ingram, 1993; Graves, 1960; Logan, 1989; Bogdan, 1990, Robinson, 1984; Savitt, 1978; Mathews, 1992; Webber, 1978; Jones, 1985; Gray White, 1999). American society valued these women due to the healing traditions and remedies they brought with them from the African continent; furthermore, their earliest role was to maintain a “healthy” labor force on southern plantations, particularly on rice plantations in South Carolina (see Savitt, 1978; Fraser, 1998; Schwalm, 1997; Hudson, 1994; Gray White, 1999; Jones, 1985, Sinkler, 2001).

Grannies were largely a social phenomenon of the southern states of the United States, particularly during slavery (Savitt, 1978; Rooks, 1997; Dougherty, 1978; Mitford, 1992; Lee, 1996) and research conducted on grannies focused on particular southern states such as Alabama, Virginia, Mississippi or North Carolina (Mathews, 1992; Savitt, 1978; Auerbach, 1968; Logan, 1989; see Borst, 1995 for studies regarding the experiences of northern lay midwives). And, in regards to examining where granny midwives fell in the healing hierarchy, Baer’s (1982) typology of black folk healers places granny midwives as a specialized group of black lay healers. During the late 19th century and into the 20th century, health professionals considered this southern healing tradition, along with lay midwifery overall, a subspecialty within the field of birthing work in comparison to formally trained men and women who attended medical and nursing schools based in the northern United States and earned degrees for their participation in birthing work (Rooks, 1997; Hoch-Smith and Spring, 1978; Lee, 1996; Davis and Ingram, 1993; Savitt, 1978; Sterk, et al., 2002; Donnegan, 1978).

Origins and Spiritual Beliefs of and Community Reliance on Granny Midwives on Plantations

The origin of granny midwives is central to understanding the significance of the granny midwives’ roles on plantations for both whites and blacks and how whites’ views of grannies

shifted over time. As stated earlier, the granny midwife presence in America is attributed to slave exportation from Central and West Africa. Central Africa served as a major exporter of South Carolina slave laborers; and, as a result, some of the healing traditions of slaves employed as medical workers were Central African in nature (Heywood, 2002; Hudson, 1994). Additionally, contact with other captured Africans via migration and changes in ownership among plantation masters allowed grannies and other slaves who occupied healing positions to draw upon West African herbal and plant knowledge.² For example, slave laborers, particularly healers/grannies, relied upon wild plants for medicinal purposes and to ensure healthy prosperity of blacks and whites in South Carolina and the Low Country of Georgia (Brown, 2002). Generally, at least one slave on any large plantation had learned and practiced midwifery. And, grannies, like most female slave laborers, had other roles which included leadership positions within slave communities, spiritualists due to their “calling” to heal, while others were caretakers for the young of other field and house slaves (Littlefield, 1981; Wood, 1974; Miller, 2002; MacGaffey, 1986; Heywood, 2002; Finkelman, 1989; Rawick, 1972).³

How did grannies occupy a more impressive status than other slaves? Nursing and granny midwifery were two roles, in particular, that granted slave women greater authority in comparison to those female slave laborers who worked solely in the field (Williams, 1972; Lee, 1996; Gray White, 1999; Schwalm, 1997; Rose, 1976). In addition, grannies garnered respect due to their age, life experiences, and an interdependent relationship between healer and community members that oftentimes lasted from birth into adulthood (Lee, 1996; Schwalm, 1997;

² Baer (1982) notes that despite such observations, “it is difficult to differentiate the concepts and practices in the ethnomedicine of blacks that are of African origin from those that are of European or even Indian American origin” (1982: 327). Moreover, “because of the secretiveness surrounding the activities of many black healers research on ethnomedicine thus far has proved in most cases to be uneven, impressionistic, and anecdotal” (1982: 327).

³ Grannies (as well as teenagers, pregnant or nursing mothers, and infirm slaves) belonged to a female group of slaves termed *partial hands* because they were unable to physically complete a full task such as cotton harvesting; yet, they also composed a large portion of a plantation’s labor force (Schwalm, 1997: 30; see also Hudson, 1994; Rose, 1976; Williams, 1972; Finkelman, 1989). Partial hands handled such tasks as babysitting young toddlers in the nursery, baking rations for field slaves, light harvesting in the field, as well as other menial tasks.

Finkelman, 1989; Hudson, 1994). Grannies also used food (e.g. teas for colicky children) as therapeutic agents for illness and maintained the passing of knowledge about the medicinal properties of particular foods and plants from mothers to young female children (Gray White, 1999; see also Beoku-Betts, 1994; see Figure 2 in Appendices for a listing of treatments employed by granny midwife Bidy Mason). This transmission of knowledge also fostered cultural reproduction and rebelling against dominant Western medical practices. The following discussion centers around the medical and communal authority afforded granny midwives and elucidates the level of reverence grannies held within their communities.

Spiritual Beliefs of Granny Midwives on Slave Plantations

Spirituality also played a vital role in the healing traditions of granny midwifery. Slave communities in South Carolina fostered the Angolan/Kongo belief that the spirit/soul and the body are joint entities; indeed, metaphysical understandings of the problem of ancestral spirits were the tenets of slave religion. Consequently, healing was the implementation of religious practice by *spiritual leaders or healers* within the community and slaves sought help from spiritual healers in the form of “charms [or medical treatments] to cure illness and to offset misfortune generally, but usually to find success in love or gardening” (Alho in Mullin, 1992: 185; Heywood, 2002; Lee, 1996; MacGaffey, 1986). Grannies’ importance also resulted from the fact that since whites viewed slaves as debased citizens, local white medics typically refused to treat blacks (Postell, 1951; Savitt, 1978; Mitford, 1992).

Not only were grannies vital healthcare providers, but some grannies were also freedwomen who worked for former plantation masters and who tended to the infirm with no extra cost to the plantation (Mullin, 1992; Gray White, 1999; Mitford, 1992; Jones, 1985). In fact, many masters employed grannies because it was more frugal than using local physicians who charged for their medical services. In fact, plantations called upon physicians only if there

were problems prior to or during childbirth. Some plantation owners even went so far as to hire out midwives to other local plantation owners as a means of acquiring more income. So, with this demand for midwives, the occupation flourished in rural areas prior to and continuing after slavery because grannies served black and white communities as freedwomen (see Lee, 1996; Logan, 1989).

Reliance and Ambivalence Towards Granny Midwives on Slave Plantations

Slave masters were, however, ambivalent about the medical efficacy of granny midwifery and of other traditional healing practices and practitioners and held contradictory views of grannies. On the one hand, plantation owners valued their services; yet, they also were apprehensive about relying completely upon traditional methods of healing for their slave laborers.⁴ “...[S]ome whites argued, slaves did not even care for their own personal health properly...masters and physicians confirmed [that blacks were incompetent doctors] but were powerless to combat [slave healing practices]” (Savitt, 1978: 171-2; see also Mullin, 1992). For example, white masters began to note that rebellious grannies prevaricated about new mothers’ work capabilities and acted as abortionists.

Consequently, southern whites assumed that blacks were completely negligent and/or incompetent of taking care of themselves or members of their respective communities. So, “the result was a dual system of healthcare, the two parts of which constantly conflicted with each other” (Savitt, 1978: 150). One result was a push towards using trusted **white male** physicians with formalized credentials, beginning in the late 1800s and continuing into the early 1900s.

⁴ Coincidentally, some slaves advised white *medical practitioners* on treatments of various ailments such as venereal diseases and poisonings (Moss, 1999). Of import is the resiliency of the retention of African approaches to healing, including granny midwifery, despite this onslaught of negative attention. In fact, their retention served as a form of resistance and a means of exerting control over themselves (Savitt, 1978: 173; see also Rawick, 1972; Gray White, 1999). For example, families retained their methods of healthcare in secret between slave quarters and within family generations (Savitt, 1978: 174-5).

Institutionalized, Sexist, and Racist Resistance to Granny Midwives

Institutionalized Resistance to Granny Midwives

For centuries, women generally occupied healing positions and were labeled as spiritual and community leaders (Hoch-Smith and Spring, 1978; Ehrenreich and English, 1973). Women serving as midwives in colonial America “were unregulated and allowed to practice without governmental intervention” (Weitz and Sullivan, 1992: 245). And, since healthy mothers and infants were blessings from God, those states which did regulate midwifery had moral licensure requirements focused solely on specific character traits and service obligations. “Licensing regulations typically specified that midwives attend all who needed their services, reveal the truth about illegitimacy and infanticide, and forswear abortions and magic. Civil and religious authorities rarely interfered in midwives’ practices unless witchcraft or other heresy was suspected” (Weitz and Sullivan, 1992: 246). In addition, midwives were oftentimes the only option for pregnant women in need of care and were preferable to barely trained medical men.

Reliance on midwifery care shifted in the post-colonial period due to institutional changes. According to Ehrenreich and English (1973), the professionalization of medicine by white male medical physicians relegated women to minor roles within the field of birthing work during the late 19th and early 20th centuries. Subsequently, a male takeover occurred within a previously female-led healthcare field through a process which dismissed/stigmatized women as incapable healthcare providers.

Medicine became professionalized in the United States during the late 1800s and the early 1900s (Rooks, 1997; Leavitt, 1987; Litoff, 1990; Reed and Roberts, 2000) meaning that medicine became recognized as “an esoteric body of knowledge, requiring extensive training, and being entitled to exclusive rights protected by law” (Numbers, 1988: 51). Therefore, in order to become a member of this occupational elite, one needed to have earned a medical degree or

served a protracted apprenticeship (Numbers, 1988: 51). In addition, women increasingly no longer viewed home birth as comforting or reassuring since hospitals were equipped with modern devices and anesthesia to assist in safe deliveries.

Dr. Joseph B. DeLee, an obstetrician, was one of the main proponents for hospital births. DeLee labeled birth as a pathological process and opined that only few women could escape damage during labor. He recommended using forceps, episiotomy, and ergot to induce uterine contractions to make birth more predictable (Leavitt, 1983: 298). His procedure became widely accepted and served as the impetus for putting pregnancy and childbirth “under the control of the specialist” which undercut the practices of traditional birth attendants to the point of a near monopoly over prenatal and postnatal diagnosis and treatment (Leavitt, 1983: 298). Medical and social acceptance of new birth technologies gave prestige to medical professionals.

Consequently, medical and nursing schools were seen as harbingers of improved American healthcare. As a result, the professionalization of medicine imposed minimum standards and strong limitations on ‘unqualified’ individuals (such as grannies) practicing healing (Reed and Roberts, 2000). These regulations, along with proponents of DeLee’s procedure, further reduced birthing work practiced by grannies.

Sexist Resistance to Granny Midwives

In addition to professional ostracization, grannies, as well as other lay midwives suffered from persecution and prosecution by the medical establishment due to sexist biases (devaluation of women in healing arts) and the belief that they were medically inept in comparison to new medically trained health practitioners (Ehrenreich and English, 1973; Schur, 1983; Lee, 1996). Moreover, physicians perceived grannies as medically inept because they believed that grannies utilized antiquated technologies in comparison to new medical birthing procedures like the use of forceps and episiotomies (Pringle, 1998; Radcliffe, 1989).

Not only was an age-old occupation targeted and maligned, but health professionals lambasted an entire sex as well. Obstetricians, gynecologists, and general physicians played pivotal roles in moving women out of birthing work by advocating for changes in medical legislative statutes and advocating that only men should assist in delivery since women were deemed incapable of performing such harsh work (Rooks, 1997; Mitford, 1992; Leavitt, 1986; Mathews, 1992; see Sullivan and Weitz, 1988 for contemporary changes in legislation). Control over the female form was usurped from pregnant women the moment they stepped into a hospital setting. Leavitt (1986) notes that oftentimes some women had no recollection of their birthing experience. New mothers simply awakened and were handed their new infants.

Circulars, also known as informative pamphlets, a media form used in campaigns by public health lobbyists and physicians against ethnic granny midwives (immigrant and black women) served as another measure of sexist persecution and defamation during the early 20th century. These circulars portrayed granny midwives as unkempt women undeserving of inclusion in the healing arts, much less in the general populace. Because their “likenesses [were] distorted and placed on circulars, . . . grannies had to fight their own bodily representations in a society where only females who were delicate enough to require hospitalization were constructed as women” (Susie in Lee, 1996: 39; see also Wertz and Wertz, 1977).

Racist Resistance to Granny Midwives

On top of institutional and sexist biases, racist beliefs about blacks and their capabilities added yet another level of persecution of granny midwives. Such persecution ranged from physicians’ derision of slave approaches to healing, and from other licensed medical practitioners, to the actual debasing of the entire continent of Africa as “the dark continent” (Gray White, 1999; Mathews, 1992; Rooks, 1997; Dougherty, 1978; Lee, 1996; Speert, 1980). Some physicians even labeled grannies as “a cross between a superstitious hag and a meddling old biddy,” an

evaluation which served as an attack against the very bodies and ages of black women who were well respected in their communities (Susie in Lee, 1996).

Yet, initially during the late 19th and early 20th centuries, “racism and lack of economic incentives were major factors in medical tolerance of southern black midwives” (Holmes, 1992: 258). Medical professionals’ tolerance included mandatory attendance at midwifery training seminars so that county health officials could be apprised of the number of practicing lay midwives, and midwives in attendance received lessons that espoused morals, Christian attitudes, and the importance of cleanliness (1992: 258). Moreover, supervisory structures implemented by county health departments encouraged dependency and shifted authority away from community-oriented midwives to local health departments. Consequently, “senior midwives were targeted for replacement by new recruits willing to accept the health departments’ dictated standards for midwifery practice” (Holmes, 1992: 258-9). Holmes (1992) does not specifically provide state by state statistics illustrating which southern states were more punitive or more tolerant of granny midwives. Looking at South Carolina in particular, the numbers of midwives decreased during the first two decades of the 20th century. In 1900, there were 197 midwives; in 1910, there were 119 midwives, and by 1920, there were 124 midwives (*U.S. Bureau of the Census, 1900; U.S. Bureau of the Census, 1910; U.S. Bureau of the Census, 1920*). And, despite the slight increase from 1910 to 1920, the number of midwives was significantly reduced from 197 in 1900 to 124 in 1920. Wertz and Wertz (1977) attributed the decreasing numbers of midwives to the proliferation of anti-midwifery legislation. As national agencies such as the Department of Maternal Health increasingly enforced these statutes, state regulations eventually reflected national trends of midwifery regulation. In essence, lay midwives suffered intolerance unless they either followed county health medical protocols or if area physicians opted to not venture into the rural populace to assist in birthing work. Many grannies who rejected “the white

folks way” and performed midwifery care the “the old time way” were forced out of birthing work (Holmes, 1992).

Even more important were the differences in how black midwives were treated compared to their white counterparts in the early 20th century. Within the south, the experiences of black midwives differed greatly from their white middle class colleagues’ (Holmes, 1992). More succinctly, black midwives received scorn while middle class white woman received respect, a reflection of institutionalized racism in American society. Institutional racism within society sets up a racial dynamic resulting in an unequal power structure between whites and blacks, particularly within socially sanctioned institutions like the medical profession. For example, Southern grannies received censure due to their supposed association with the supernatural and superstitious. “Even studies conducted by the United States Children’s Bureau, which was generally sympathetic to midwives, reported considerable superstition among ‘grannies’” (Litoff, 1996: 420). Consequently, blacks have historically been criticized for their participation in the medical profession, except for those who provided unregulated healthcare service for minority communities (Dula, 1994).

Pregnancy as Pathology and the Medicalization of Birth

During the early 1900s, physicians utilized fear to manipulate women, to legitimize their authority in birthing rooms, and to further thrust granny midwives out of birthing work. This manipulation was predicated on a paradigm shift regarding the mental, physical, and emotional stability of women known as the *cult of domesticity*. American women, typically women in the middle and upper classes, followed the tenets of the cult of domesticity and birthing rooms further embodied and carried out these beliefs. Briefly, the cult of domesticity charged that women were to embody the following traits: submissiveness, piety, domesticity, and purity (Giddings, 1994). Women socialized into these norms felt that pain was not to be borne by genteel women.

Furthermore, they believed that women should not seek to learn the skills or knowledge of a midwife.⁵ Such beliefs were widely espoused by middle and upper class white women.

In contrast, physicians believed that poorer and ethnic women were of “hardier stock” for childbirth and physicians accepted their utilization of midwives as birth attendants (Sterk et al., 2002). In particular, “some physicians...in the South argued that midwives should not be eliminated even if they provided only second-class care because too few doctors were willing to serve in rural communities, especially poor black ones” (Weitz and Sullivan, 1992: 246). This acceptance was, however, short-lived since poorer and ethnic minority women were increasingly coerced, under the auspices of the maternal healthcare movement during the second and third decade of the 20th century, to use licensed physicians for their prenatal and postnatal care. In addition, “physicians also hoped that eliminating midwives would force poor women to give birth in hospitals and thus provide medical students with necessary clinical experience” (Weitz and Sullivan, 1992: 246). So, eliminating midwives from birthing work served multiple purposes for both established physicians and budding physicians.

To further substantiate doctors preeminence as healthcare providers during the early 1900s, physicians and other licensed health professionals attached a “pathology” to pregnancy. For instance, physicians emphasized possible birth complications, such as death of mother and / or infant or risk of disease or puerperal fever associated with midwife-assisted births, to further advertise their expertise as proper birth attendants. Doctors felt that because of their educational accreditation and their knowledge of changes in birthing technology and preventative techniques that they could help save women from suffering induced by childbirth. This pathologizing of pregnancy spawned the medicalization of birth: a notion that birth was more than just a natural

⁵ Philip K. Wilson’s second edited volume—*Childbirth: Changing Perspectives in Britain and America 1600 to the Present*—provides readers with personal narratives written by women grateful for the anesthesia during labor in order for them to forget and in some instances forgo labor pains. In addition, physicians voiced their opinions regarding the physical and mental delicacies of women and how the birthing process could prove too laborious without drug interventions.

event and that it demanded the involvement of trained medical professionals to assist its occurrence (Rooks, 1997; Litoff, 1990; Leavitt, 1986; Lay 2000; Conrad, 2000).

Viewing pregnancy as a pathologic state was a historical viewpoint. In fact, prior to arguments made by male physicians, man-midwives attempted to emphasize “the complexity and potential dangers of pregnancy. They detailed accounts of women who had died in childbirth because the midwife had waited too long in summoning a doctor. Even man-midwifery critics conceded that physicians should be enlisted “during complicated and abnormal labors” (Litoff, 1990: 9). Tied into these arguments espoused by proponents of male-assisted births was the cult of domesticity’s tenets. Physicians frequently portrayed women “as frail and emotional beings who lacked the intellectual capacity to become competent birth attendants. [Doctors] argued that women were not capable of understanding the demanding regimen of a medical school education. Moreover, the nineteenth century was an era in which proper ‘ladies’ were expected to devote their entire lives to domesticity and motherhood” (Litoff, 1990: 9).

Also, medical doctors preyed upon the general public’s concern with the vitality of new mothers and their infants. Rooks (1997) argued that concerns with maternal and infant mortality rates were further impetus for physicians’ efforts to regulate and better maternal healthcare, which included limiting the work of granny midwives. For example, Mathews (1992) found that national concerns with infant and maternal mortality contributed to a sharp drop in the number of lay midwives in North Carolina beginning in the latter part of the nineteenth century (approximately 1890s) and continuing into the 1960s. Physicians in North Carolina sought to reduce the number of midwives by publishing health bulletins discrediting lay midwifery care. Health professionals used mortality rates as a platform to indicate “social welfare; comparisons between countries or ethnic groups provide an indication of the adequacy of a number of social services as well as the general health of the population” (Lantos, 1994: 68). Moreover, infant

mortality rates can be used to reflect the results of health interventions such as infant and maternal health care reform (1994: 68).

Legal Regulation of Midwifery

In essence, medical doctors reasoned that mortality among mothers and infants during the early 1900s were due to midwife-assisted deliveries. Subsequently, legislation specifically designed to either limit the practice of midwifery or eliminate it in its entirety birthed the prosecution of granny midwifery. Such prosecution consisted of physicians advocating for “restrictive medical licensing laws and more rigorous medical education” which negatively impacted lay midwives practicing their art (Weitz and Sullivan, 1992: 246). Consequently, midwives suffered social persecution and prosecution on local, state, and governmental levels (Rooks, 1997; Dougherty, 1978; Davis and Ingram, 1993; Mitford, 1992; Mathews, 1992).

Unfortunately, grannies had difficulty thwarting the efforts of their largely urban-dwelling persecutors because they lived and operated primarily in rural areas. Because rural living isolated these women, they could not form coalitions to fight for the continuation of their practice against well-coordinated physician criticism and maternal healthcare lobbyists during the late nineteenth century and early twentieth century. Midwives were also defenseless because this persecution and subsequent prosecution were multi-faceted. Some critics published damning remarks in medical journals and medical association papers, and advocated for the actual removal of granny midwives’ clientele to hospitals. More interestingly, some female physicians and black physicians also lobbied for an end to lay midwifery for fear of reprimands by the largely white male medical establishment (Rooks, 1997). Several researchers (e.g. Logan, 1989; Mitford, 1992; Dougherty, 1978; Mathews, 1992) debate precisely when midwives in the southeastern states were first subject to persecution and prosecution by health officials, but most place their advent sometime during the late nineteenth and or early twentieth century.

One primary reason the debate existed was because of differences among states' health concerns and reactions to midwives. As a result, midwifery laws varied widely. In 1900, twenty states had no midwifery regulations. In fact, until the 1920s, midwives in most states practiced without governmental control. Those states with midwifery regulation targeted midwives' alleged immoral conduct, such as participation in illegal abortions (Rooks, 1997). Litoff (1996) argued that despite unregulated midwifery prior to 1910, "the few regulations that were enacted were usually not enforced. Thus, little information with regard to the practices of midwives can be garnered from legal sources. In addition, much of the existing information about them was written by hostile observers" (1996: 429). Moreover, because few midwifery schools existed, "laws requiring education could not be enforced, and with few doctors positioned or willing to attend poor women, it was not practical to outlaw midwives. [In fact,] the only mention of midwives in some state laws was [their exemption] from the medical practice act" (Rooks, 1997: 21).

Once state legislation began requiring licensure for midwives, many formally trained midwives continued their practice undaunted (Rooks, 1997). Grannies, on the other hand, experienced persecution and prosecution because they opted to not seek licensure; and, because grannies tended to be elderly women, formal education, an essential prerequisite to licensure, was not an option for them (Mathews, 1992; Logan, 1989; Dougherty, 1978).

Several factors affected state treatments of and subsequent legislative statutes regarding midwives: physicians' opinions as to what roles lay midwives should hold in relation to physicians and hospitals, the race of lay midwives, and the degree or level of education obtained by lay midwives. By 1930, Massachusetts was the only state that officially abolished midwifery (Weitz and Sullivan, 1992: 246). In contrast, due to pressure from maternal healthcare advocates, many southern states such as Alabama, Florida, North Carolina, and Mississippi

regulated midwifery by requiring licensure and additional formal education within birthing work (Mathews, 1992; Logan, 1989; Auerbach, 1968; Rooks, 1997).

Although Beardsley (1990) argued that no state effectively regulated midwifery, Mathews (1992), in her examination of North Carolina Board of Health records published from 1900 to 1980, showed the impact that state officials had in eliminating this form of birthing work, beginning with the passage of law used to regulate midwives by licensure. Mathews's (1992) research revealed a marked decrease in the number of practicing lay and predominantly black midwives. Other southern states' licensure requirements shifted over time to become more controlling of lay midwifery care. For example, South Carolina's Sanitary Codes shifted from 1900 to 1937 to become more exclusive and regulatory of midwifery practice (see analysis of Sanitary Codes in Chapter VI).

In contrast, Barker (1993) argued that culture—rather than the actions of physicians and state lawmakers—was responsible for why women turned away from midwives to licensed medical personnel for their pregnancy and birth needs. Simply speaking, Barker (1993) asserted that because the terms *pregnancy* and *childbirth* were restructured and redefined by the medical establishment and greater society, an avenue arose for scientific medicine to control and safeguard pregnancy and birthing tasks.

Even at the federal level, there were some statutes, such as the 1921 Sheppard-Towner Act, that, in effect, addressed midwifery. This Act, lobbied for by female health advocates in New York and surrounding states, allocated funds to help each state create plans to ensure maternal and child health services. In an effort to address midwifery participation in the field of birthing work, some states used the monies to supervise and train midwives (Rooks, 1997; Weitz and Sullivan, 1992). Ironically, such efforts by state and local officials in southeastern states regulated or eliminated lay midwifery, particularly granny midwifery, since many grannies were unable to attend required courses or opted not to seek licensure (Rooks, 1997; Reed and Roberts,

2000; Fox and Worts, 1999). In addition, the Sheppard-Towner Act, despite being designed to provide states with money for improving maternal and child healthcare, was more concerned more with improving the healthcare of white middle class women in the United States. This class-based prejudice was evidenced by larger allocations of money to affluent urban areas while rural locales received considerably lower amounts. Also, urban areas tended to have organizations adept at assisting in the implementation of midwife training whereas rural areas lacked such organizations. As a result, the healthcare of rural poorer women (who were largely the client base of many granny midwives) was severely neglected such that there were few feasible choices in healthcare providers (Mathews, 1992; Rooks, 1997; Litoff, 1990)⁶.

Beardsley (1990) via a discussion of the intersection between racist and sexist oppression reviewed black women's healthcare problems in the early twentieth century. He concluded that "racial status was a far greater determinant" than gender or class of the healthcare condition of black women in America during the early 1900s. Succinctly, a woman's blackness was the primary identification which subjected her to white male supremacy. In particular, some educated Southerners felt that, because blacks were unfit for freedom, any expenditure of health and medical resources on them were wasteful (Beardsley, 1990: 122). In addition, white Americans lacked a desire to improve the lives of blacks. On one hand, the bulk of southern physicians and others opined that keeping blacks alive was not fruitful given their racial traits and low vitalities. On the other hand, most of the South's public physicians doubted this philosophy and argued that black mortality rates could be reduced. Turning his attention to black female healthcare, Beardsley (1990) described a relationship between racism and black female health that occurred in three eras. The first era (and most salient to this project) was the "era of denial" and this time period spanned 1900 to 1930. Beardsley (1990) contended that during these

⁶ *JSCMA* in its earliest publications printed accounts of Charlestonian society women that functioned as traveling nurses to assist with births. However, these nurses had a tendency to assist poorer white women rather than black women (see Smith, 1918).

decades, racism immensely affected the lives of black women by denying them healthcare while also placing many black women in “positions of permanent disadvantage” (1990: 123).

Being disadvantaged by the American healthcare system caused many black women in the North and South to suffer from pregnancy complications. Such complications occurred because black women hardly received care during pregnancy as a result of the physicians practicing mainly in cities and because many black doctors expected pay equal to white doctors. Sadly, many women and their infants perished (Beardsley, 1990: 124-5). Beardsley (1990) criticized the efforts of black midwives by stating that despite their good intentions, midwives lacked the competency to handle minor medical issues as well as sanitary procedures. He also found that “[n]o state effectively regulated its midwives until after World War II” (1990: 125).

Summary of the Literature

According to the literature, sexism, racism, and inter-occupational conflict served as bases for midwifery abrogation arguments. Criticisms of the mental and physical capacities of the poor, blacks, and women are just a few ways in which physicians worked to discredit granny midwifery as a practice. Prejudicial views supported by mainstream society worked to influence the arguments written by physicians and other health professionals. The professionalization of medicine, in addition, contributed to the onslaught of negative attention that granny midwives and midwives overall received for their participation in birthing work. White male physicians, like some of their slave-owning forebears, held ambivalent attitudes about granny midwives in birthing work. To a certain extent, southern physicians viewed midwives as a resource from which to learn obstetrical practices and to serve clients (namely the poor and blacks) that physicians held no desire to serve. On the other hand, physicians, citing the womb as a pathological entity, argued for their presence (and the forced absence of midwives) in birthing rooms and birthing work.

Midwifery legislation shifted due to the impact of the maternal healthcare movement and a pronounced concern for reducing infant and maternal mortality rates. The effect of this legislation varied in the South largely because states had different health concerns and their reactions to midwives differed. Some women relented to licensure requirements and continued midwifery practice, whereas granny midwives could not because of their age and limited access to education. Regulation by state public health departments assisted physicians and other health officials in reducing the number of granny midwives in southern states, such as North Carolina. And, maternal healthcare regulation severely restricted rural poorer women and blacks in choosing healthcare providers.

Limitations of Social Science Research on Midwifery and Granny Midwifery

Many social scientists and healthcare researchers have studied midwifery. Wertz and Wertz (1977) and Leavitt (1986) are heralded as two primary researchers of this medical occupation. The strength of their research and of others' (Speert, 1980; Rooks, 1997) is a thorough investigation of how midwifery was almost eliminated by the combined activities of the American Medical Association, white male and female physicians, medical schools, and some local, state, and national lobbyists for maternal healthcare (Rooks, 1997; Lee, 1996; Speert, 1980; Wertz and Wertz, 1977; Leavitt, 1986; Donnison, 1977). In addition, research on midwifery examines the impact that class ideology had on gender relations in the field of birthing work and the impact of modernity on maternal healthcare (Leavitt, 1986; Wertz and Wertz, 1977; Rooks, 1997).

However, granny midwifery was either altogether ignored or minimally discussed. Midwifery literature overall tends to focus on the plight of white female midwives (Wertz and Wertz, 1977; Leavitt, 1986; Lee, 1996; Mathews, 1992; Mitford, 1992; Beardsley, 1987). Also, such studies are centered on southeastern states such as North Carolina or Virginia (Savitt, 1978;

Mathews, 1992), and Lower South states such as Alabama, and Mississippi (Logan, 1989; Auerbach, 1968). Moreover, the minimal amount of literature that discusses granny midwifery is further limited by the fact that for some time granny midwifery was not considered a true occupation due to its lack of formal educational requirements or formal training (Robinson, 1984; Reid, 1989; Graves, 1960; Susie, 1996; Bogdan, 1990; Dougherty, 1978; Fraser, 1998; Auerbach, 1968; Hanlon, 1964; Beardsley, 1987; Smith and Holmes, 1996; Davis and Ingram, 1993; Lee, 1996). Rather, community members (both lay and professional) considered granny midwifery to be a “role” that some older black women played in their communities (see Robinson, 1984; Reid, 1989; Lee, 1996; Hoch-Smith and Spring, 1978; Beardsley, 1987; Fraser, 1998).

Researchers who argue that granny midwifery was not an occupation have ignored vital historical records such as slave narratives (Rawick, 1972) in building their claim that granny midwifery was not a healthcare occupation. The consequence of overlooking the vital history of black women, particularly as healers in America, is the lack of literature that discusses women of color who practiced this healing art and their contributions. More specifically, there is a lack of literature that carefully examines how granny midwifery was an occupation **in competition** with other birthing work occupations. Nor is there literature that examines how physicians effectively and profitably limited the practice of granny midwifery. Further, since grannies were concentrated in the southern states of the United States, research should attempt to detail each of the states in which grannies were active; making generalizations about the manner in which grannies were eradicated based on a few southern states is erroneous when a ‘fuller picture’ can be provided by studying each of these states individually.

Moreover, literature that discusses the 20th century healthcare of blacks in the South tends to focus on genetic predispositions to ill health, inequities of the American healthcare system as experienced by blacks, and the distrust blacks held (and continue to hold) towards the largely white medical establishment (Dula and Goering, 1994; Dula, 1994). As a result, the contributions

of black healers and their experiences within the field of medicine have been disregarded or minimally discussed. In addition, texts that discuss blacks and healthcare have a propensity to discuss blacks in urban settings rather than those in rural areas (Dula, 1994).

Barker (1993) argued that the demise of midwifery can be traced to American society's decision to redefine pregnancy which thereby permitted medical professionals to seize control of birthing work. In addition, Barker (1993) pinpointed how women (including female physicians) contributed to the medicalization of birth. However, she lacked a significant discussion regarding how this redefining and restructuring affected women in rural areas, particularly granny midwives who were heavily concentrated in these areas.

This work studies South Carolina, which has not received much attention from social researchers, and the story of its granny midwives. My project seeks to add to existing literature about blacks in healthcare, namely granny midwives. In particular, my goal is to add another component to research about midwifery abrogation in the South. Because granny midwives were based largely in rural settings, my research also places a lens on black healthcare providers in the rural South. I argue physician sentiments as expressed within journal articles supplemented and aided midwifery abrogation. In addition, examining how these arguments are couched in racism, sexism, and the threat of inter-occupational conflict assists midwifery researchers in understanding the social climate within birthing work and why granny midwives were seen as unwelcome healthcare practitioners. Also, examining articles authored mainly by white male physicians (particularly those in South Carolina) demonstrates how print media was effectively used as a platform for midwifery regulation and abrogation.

Granny midwives served an integral part in the healthcare of southern blacks and whites during the 1800s, and early 1900s. Literature that discusses granny midwives ranges from their origins to their experiences and to the reaction of the medical establishment to their presence. Within these bodies of literature, granny midwives take a backseat to the experiences of their

white counterparts. Literature primarily about granny midwives discusses how the presence of institutionalized racism and sexism laid the foundation for these women to experience both racist and sexist criticism as practitioners of birthing work by the largely white male medical establishment and healthcare lobbyists. Oftentimes, physicians' censure came on the backs of arguments for the medicalization of birth and the advent of the professionalization of medicine. Arguments couched within the ideology of the medicalization of birth labeled grannies as contributors to mortality rates among new mothers and their infants.

Examining midwifery literature to understand how physicians viewed granny midwives pejoratively only provides researchers with a moderate understanding of the abrogation of granny midwives. This inadequacy begs for an examination of relevant theory to understand the societal underpinnings of these physicians' behaviors and abrogation efforts. And, an analysis of arguments espoused by physicians within medical journals is prudent to see what physicians actually opined about midwives, their role in birthing work, and whether granny midwives were in inter-occupational conflict with medical doctors. Lastly, an investigation for shifts in midwifery regulation for the state of South Carolina demonstrates how racism, sexism, and the threat of inter-occupational conflict can shape the landscape of midwifery regulation.

In the next chapter, I discuss how theoretical explanations about the roles and social positions of blacks and women are beneficial for developing a greater understanding of the roots of physician opinions about granny midwives. In addition, theoretical explanations about the development of professions and how members within professions create hierarchies of power and influence also help to explain how physicians were able to advocate within medical journals for the removal of granny midwives from birthing work.

CHAPTER II

THEORETICAL CONSIDERATIONS

Women have been subjected for centuries to persecution simply due to their sex. Such persecution, based in various sexist and masculinist ideologies, has manifested itself through actions, behaviors, and societal constraints by which women are bound. Some of these constraints include occupational restrictions such as formalized roadblocks to medical practice, societal censure for women who opted not to participate in the cult of domesticity, and more specifically, marginalization of black women. I argue that the abrogation of granny midwives from birthing work was grounded in sexist, masculinist, and racist ideologies and demonstrated how black female healers suffered under societal strictures. In addition, physicians viewed granny midwives as competitors within birthing work. Consequently, doctors and other licensed health professionals worked to place midwives on the periphery of the medical profession.

A discussion concerning the manner in which physicians and other maternal healthcare lobbyists successfully abrogated granny midwives and their subsequent experiences during the early 1900s cannot focus on how racism affected these women without looking at how being female had an impact on their lives as well. The crusade against granny midwives was a devaluing and subordinating experience for black women in this occupation. Because the predominantly male medical community, with support from the American legal system, placed roadblocks to grannies practicing birthing work, granny midwives could no longer serve their clients and possessed *limited options* in regards to how and when they could practice midwifery. In other words, due to their sex and race, powerful and influential others restricted granny midwives from serving as primary practitioners within birthing work. This subordination provided the foundation for arguments couched in the medicalization of birth ideology. To

reiterate, the medicalization of birth touted that birth was a potentially risky process that required the attendance of a licensed birth attendant. The following paragraphs detail how the racist and sexist explanations aid in explaining why granny midwives suffered social persecution. In addition, examining explanations that detail how systems of authority were created in the medical profession aids in understanding how physicians were able to tout and strategically themselves as experts in birthing rooms while also placing granny midwives on the bottom rungs of the medical hierarchy.

Racist, Sexist, and Inter-occupational Conflict Explanations

Classifying Black Women as the “Other”

“The Black American Woman has had to admit that while nobody knew the troubles she saw, everybody, his brother and his dog, felt qualified to explain her, even to herself” (Harris as quoted in Hill Collins, 2000: 69). Some of these explanations, grounded in racial prejudices, worked in conjunction with sexist ideology and gender stigmatization to shape the treatment of black women, specifically grannies, in southeastern states during slavery and into the 20th century. As I stated earlier in Chapter I, whites held a considerable distrust of black healers and this distrust had historical roots. In order to put this distrust into a theoretical context, arguably, the original distrust of grannies stemmed from what feminist Barbara Christian depicts as “the enslaved African woman [becoming] the basis for the definition of our society’s *Other*” (Christian as quoted in Hill Collins, 2000: 70). This process of classification or categorization of a group or individual as an “other” is a significant act of marginalization. Marginalization encompasses placing individuals on the outskirts of society by using oppressive language and actions to perpetuate a system of exclusivity and domination. Black women experienced domination and as granny midwives they experienced oppressive language as published in

professional medical journals and were shunned from operating within the main sphere of birthing work.

Hill Collins (2000) states, “a generalized ideology of domination [produces] stereotypical images of Black womanhood which take on special meaning” (2000: 70). Hill Collins argues that those individuals responsible for creating these stereotypical images tend to occupy powerful and influential groups. As a result, such groups while being granted the authority to define societal values also “manipulate ideas about Black womanhood” which subjugates Black women and maintains a system of “intersecting oppressions” (2000: 70). Simply put, black women face not only racist oppression but sexist oppression as well. Moreover, such prejudicial notions enjoin the white male majority to create oppressive relationships and debasing designations. Social hierarchies based on race and sex rank white men first and black women last (hooks, 1981: 53). Inter-sectionality between sexual oppression and racial oppression is particularly relevant to this project because acknowledging this pervasive social phenomenon provides a clearer explication of how and why physicians advocated for the abrogation of granny midwifery.

Because “African American women’s status as outsiders (and women in general) becomes the point from which other groups define their normality” (Hill Collins, 2000: 5), this classification extended itself into other arenas that black women occupied including healthcare occupations. To reiterate, labeling groups as the *other* assists members of the dominant group to position themselves on a higher level within social hierarchies. In the case of healthcare occupations, this positioning foments inter-occupational conflict between the dominant group and the *other*. For the purpose of my thesis, white male physicians and other licensed health professionals represent the dominant group and granny midwives represent the other/subordinate group. To create this dynamic in birthing work, physicians maligned lay healers in order for physicians to be seen as medical experts. Physicians achieved this goal by labeling older forms of healing (granny midwives, botanists, homeopaths, and other traditional healers) as abnormal,

while labeling new and more technologically advanced medicine as normal. Grannies, due to their sex and race, represented the opposite of white males within society and white male physicians in the medical hierarchy. Not only did being black have an impact on how physicians viewed granny midwives (and blacks overall) but their sex and its social status affected the views physicians held towards grannies as well.

Subordination of Women as Reflected in the Treatment of Granny Midwives

One societal mechanism used to restrict women is stigmatization. Schur (1984) contended that the stigmatization and resulting devaluation of women is an antecedent of societal processes and labels. Stigmatization describes “social reactions [that] aim to isolate, treat, correct, or punish such individuals; and overall, in one way or another..., to contain them” (Schur, 1983: 38). In other words, individuals are given a particular stigma by xenophobic individuals as a means of punishing them. In the context of this thesis, white male physicians and other health professionals placed derogatory labels on the practice of granny midwifery; consequently, grannies were subjected to an apparent animus embedded in criticisms of their practice.

Although stigmatization implies “negative social and psychological consequences for the marked individual,” and because communities served by grannies accorded social honor and status to these midwives, psychological consequences may not necessarily have been their primary burden (Schur, 1983: 38). To be clear, I am solely concerned with the occupational ramifications of stigmatizing granny midwives within birthing work rather than with any psychological problems grannies suffered as a result of being removed from birthing work. Schur (1984) argues “the subordination of women is sustained through their being socialized for, and restricted to, limited aspirations, options, roles, and rewards” (1984: 11). This argument is important because it is also applicable when studying the experiences of people of color because both women and people of color suffered similar restrictive experiences in American society.

Moreover, examining the experience of black women involves not only looking at how sex affected their social location and experiences but also at how race affected their social location and experience as well according to Hill Collins (2000). Based upon the subordinate positions that blacks and women held in American society in the early 20th century, such categorization was typical within the medical profession.

For example, many medical schools during the early 1900s, denied entrance to both women and blacks, except to medical institutions built specifically for black students such as Meharry Medical College or female students such as the Philadelphia Medical College for Women. So, being black and female prevented many women from becoming physicians. I examine and describe how racism under girded efforts to eliminate granny midwives later in this chapter but I will continue to note the intersection of race and sex on the persecution and prosecution of granny midwifery while speaking primarily about how Schur's (1984) and others' theoretical conceptualizations contribute to understanding the power of sexism in physicians' arguments for limiting the practice of granny midwives.

Why were women restricted within or prohibited from medicine during this time period? As Schur (1984) argued, one of the primary reasons women suffer mistreatment by men, and more specifically within the medical field, is because gender stigmatization begins at birth and results from interactive processes of perception that create stigma-laden meanings for women (1984: 22). In a fashion similar to Hill Collins' (2000) arguments about how black women are perceived by society as the outsider/other, this stigmatization foments a classification of women as deviant beings and such designations become historical trends (Schur, 1983). In the context of this thesis, I argue that once men began to usurp the healing profession in America this deviant status became more pronounced for grannies not only because they were women and black but also due to their unwanted participation in birthing work.

During slavery and part of the post-bellum period, granny midwives experienced subjugation by whites because of their gender and race; yet, both whites and blacks were dependent upon grannies' participation in birthing work . However, as social conditions for white and black women and paradigms about male and female behavior shifted, principles steeped in white male hegemony worked to strategically place grannies on the periphery of birthing work. Thus, daily interactions between grannies and other members of society were overshadowed and significantly changed by stigmatizing arguments de-legitimizing granny midwifery as a healing art during the late 19th and early 20th centuries. Such interactions are significant because they demonstrate how predominant social agendas can engender an occupation's demise and even shape individuals' behaviors.

Returning to my earlier discussion of gender stigmatization, I stated that according to Schur (1984), social roles for and experiences of women are rooted in gender stigmatization which begins at birth. And, given these early social roles, interactions occurring between males and females include different social processes. Inferiorization, another social process important to my thesis, is the consequence of gender stigmatization and consists of three tenets. These tenets are: devaluation of women, an ascription of the deviant "other" status, and the acquisition of a role subordinate to dominant men. The cult of domesticity serves as an example of inferiorization. And, this ideology, in effect, provides evidence of the continued marginalization and subordination of American women, including granny midwives, beginning in the early 19th century and continuing into the 20th century. The cult of domesticity (also known as the cult of true womanhood) held the following cardinal tenets: "domesticity, submissiveness, piety, and purity in order to be good enough for society's inner circles" and only true women upheld these character traits (Giddings, 1994: 47). How did this ideology affect granny midwives? Changing middle class standards of behavior for women and men and the cult of domesticity contributed to white males and females both criticizing women for practicing or being interested in midwifery,

as well as in other occupations deemed inappropriate for women, such as factory jobs (Giddings, 1994: 47; Schur, 1983: 93). The cult argued that men occupied the public sphere and worked outside the home whereas women occupied the private sphere (which consisted of home and hearth) taking care of children and attending to household chores. Black women could not occupy these role designations, however.

In particular, Giddings (1994) contended that black women suffered a more difficult social persecution because although they were expected to follow the cardinal tenets of the cult of domesticity, their position in society prevented them from doing so. Consequently, black women were only allowed to occupy menial labor jobs. In addition, white mainstream society considered black women “unnatural, unfeminine, and thus a species of a different ...female order” (1994: 48). Again, the impact of the intersection between racism and sexism is evident in how black women were treated in American society. Given this understanding of black women’s roles in society at this time, how does such a discussion lend itself to the abrogation of granny midwives?

Gender relations between men and women are foreground for the creation and maintenance of unbalanced social and economic power structures. Categorical devaluation (or what Schur terms objectification) involves women being objectified and their personal qualities and actions are given secondary considerations. Moreover, he contends that women suffer from four forms of objectification: a) being responded to as a lesser sex which designates their personal worth in society-at-large; b) subordination; c) being ignored, dismissed, or trivialized (seen as non-persons); and d) having their social status attached to that of a man. Utilizing this typology to understand efforts and arguments posed by physicians to eliminate granny midwives, women (as the lesser sex) required the assistance of medical men to understand maternity and its biological processes; in some instances, legal postulates reflected such thoughts.

For example, the South Carolina Medical Association passed a resolution recommending that the duties of the County Health Director include disseminating “among the womanhood of

our land saner ideas of motherhood, inducing them to appreciate and obtain better obstetrics” (Barton, 1930: 268). Dr. Barton, while discussing medical legislation with fellow South Carolinian physicians, argued that it was the responsibility of the medical man to educate women about taking better care of themselves. Such arguments reflected the idea that women needed men to tell them about their bodies and motherhood while also discrediting illogical ideas women held theretofore about motherhood. Moreover, these arguments reflect Schur’s (1984) typology that the status of “healthy women” can occur by utilizing white male physicians (Barton, 1930: 268). Furthermore, women are “trivialized” as illogical individuals requiring professional male attention. Dr. Barton’s statements also questions women’s lack of appreciation for the field of obstetrics. Encouraging County Health Directors to distribute prenatal and postnatal information perpetuated the notion that licensed doctors were the only medical experts in birthing work. This encouragement further works to discredit female participation in birthing work.

As a result, physicians and other socially sanctioned healthcare practitioners placed midwives on the lower rungs of the medical hierarchy. Dr. Joseph DeLee, a nationally known obstetrician who advocated for the abolition of midwives, stated that women should demand better obstetrical services and stop using midwives. He believed that establishing maternity hospitals of “high class” where nurses and physicians could “be practically trained in obstetrics” would “naturally abolish the midwives” (“The Midwife Problem and Medical Education”, *JAMA*, 1911: 1786).

One of the main reasons that physicians and other health lobbyists attacked midwifery as a practice was because granny/lay midwifery and its practitioners were viewed as archaic in comparison to licensed Western medical practitioners. Dr. Josephine S. Baker, writing in *JAMA*, opined that “[t]he midwife is usually an ignorant, untrained woman” (“Has the Trained Midwife Made Good?”, 1911: 1787). And in *JSCMA*, South Carolina physician Dr. L. C. Shecut, in advancing progressive obstetrical education in South Carolina, stated, “[t]his course of teaching

will help them to learn the normal from the abnormal, and will be a great counteractor for the superstitions and false teachings of the old women and midwives” (1925: 116). And even those women who were permitted to practice midwifery still dealt with unequal power structures in accordance with Schur’s (1984) typology. For example, women who practiced midwifery in New York in 1907 were allowed to do so only under the supervision of a licensed physician, which consequently gave midwives legitimacy due to their attachments to a men (Rooks, 1997).

Advocacy for medical supervision of women and midwives was also present in South Carolina during the early 20th century. For example, addressing South Carolina physicians in *JSCMA*, Dr. Fry argued, “[a] great many women in city and country are delivered by midwives; much would be gained if the medical profession could educate the public so that these women would learn the necessity of placing themselves under medical supervision during pregnancy, even if they continue to be delivered by midwives” (Fry, 1911: 18). Such objectification in the guise of attachment to medical doctors continued after licensure requirements, which were couched in the rhetoric of the medicalization of birth (Wolfson, 1986; Wertz and Wertz, 1977). In summary, maternal healthcare advocates and physicians during the early 20th century responded to grannies due to their female nature; subordinated them by pushing for their elimination, while using pejorative commentary to trivialize granny midwife accomplishments. Although these four designations of objectification are important to understanding how grannies were treated, a firmer understanding is needed of the racist underpinnings within arguments made by many midwife abolitionists.

Racist Bias Towards Blacks and Black Women in American Society

Tatum (1997) provides denotations for racism and prejudice that are particularly relevant to this work. In fact, Tatum (1997) stated that prejudice is commonly defined as “a preconceived judgment or opinion usually based on limited information”, and racism as a “system of advantage

based on race” (1997: 5, 7). hooks (1981) contends that racist-sexist conditioning within America branded black women as creatures of little worth or value except as slave laborers **but not as persons**. Such viewpoints persisted beyond the days of enslavement and lingered among whites as natural beliefs to possess and proliferate (see Hill Collins, 2000 for a discussion of how racist and sexist ideology permeates society). Many whites used these assumed qualities of black women to justify oppression within the “seamless web of economy, polity, and ideology” that resulted in “a highly effective system of social control designed to keep African-American women in an assigned, subordinate place” (Hill Collins, 2000: 5). Moreover, this exclusion and oppression created pathways for the “elevation of elite White male ideas and interests” (Hill Collins, 2000: 5). This elevation of white male ideas and interests outlines how oppression was possible and persisted in birthing work.

Lorde (1984) further explains how oppression pervades society and thus how individuals, particularly women and blacks, occupy subordinate positions both in society and within occupations such as birthing work. Lorde (1984) contended that American society deemed profit potential, rather than human need, as a basis for goodness. Consequently, systematized oppression crafts a hierarchy which relegates blacks, the Third World, the elderly, members of the working class, and women as a surplus of dehumanized inferiors (1984: 114). In other words, such “binary thinking [superior versus dehumanized inferior]...categorizes people, things, and ideas in terms of their difference from one another” (Keller as quoted in Hill Collins, 2000: 70). So, oppositional constructs such as whites and blacks or males and females are stretched so that each is inherently opposed to its other and become fundamentally different yet related based upon their definitions (Hill Collins, 2000: 70). As I detail later, granny midwives received censure by white male physicians in birthing work based upon being different (female and black).

Ethnocentrism is another concept that assists in understanding how racial categorization contributes to the racist and sexist oppression that grannies endured during their eventual

abrogation in South Carolina. Levine and Campbell (1972) defined ethnocentrism as “when a person unreflectively takes his own culture’s values as objective reality and automatically uses them as the context within which he judges less familiar objects and events” (1972: 1). Simply put, “one’s own group is the center of everything, and all others are scaled and rated with reference to it” (1972: 8). Either description depicts a form of cultural arrogance that discredits or devalues individuals who are considered different or “others.” Sumner proposed that the in-group and out-groups are tandem concepts that underlie ethnocentrism. In-groups consist of group members who regulate peace, order, law, government, and industry. Out-groups are those groups exterior to but tied to the in-group and which are viewed as others-groups or interlopers. Each group fancies itself as superior to the other groups and looks with contempt on outsiders. As a result, each group considers its own folkways the only right ones, “and if it observes that other groups exercise other folkways, these excite scorn [and a perception of threat]. Opprobrious epithets are derived from these differences” (Levine and Campbell, 1972: 8). In examining how physicians’ professional writings supported efforts to eliminate the midwife and using Sumner’s constructs, granny midwives were the out-groups whereas physicians and other licensed health professionals were the in-group in birthing work.

Williams’s research offers an understanding of how ethnocentric attitudes particularly shape perceptions and the social experiences of the black woman in America with the comment that she “belongs to a race that is best designated by the term ‘problem’ and she lives beneath the shadow of that problem which envelops and obscures her” (Williams as quoted in Hill Collins, 2000: 3). People of African descent, since their arrival upon the shores of pre-colonial and colonial American shores, endured a constant barrage of negative consideration by European Americans. In addition, slavery as an institution productively fostered caste-like and racist

beliefs.⁷ For that reason, membership in the out-group of blackness contributes to black women's subjugation by whites or—for the purposes of this project—their removal from birthing work.

Ostracism is yet another social process that is key to understanding how and why physicians sought to eliminate granny midwives from birthing work. Masters (1986) defined ostracism as the “coerced or involuntary rupture of social bonds;” and within modern democratic systems, individuals are placed into the “unenviable positions of being trapped in silence with no legitimate right to exercise political voice, yet no possibility of escape” (1986: 231). Masters' (1986) contentions are grounded in biosocial explanations of human behavior; however, he puts forth an interesting thesis and relates it to how political institutions instigate or propagate ostracizing behavior. Members of society, when attempting to modify outcomes in decision-making processes (here, physician-assisted births or midwife-assisted births) and for personal benefit (solidification of physicians as medical authority and specialization of obstetrics and gynecology), will actively seek to force the *exit* of individuals who are in opposition or present obstacles to the accomplishment of sought after goals.

Gruter and Masters (1986) also stated that ostracism is deeply embedded within the legal tradition as a means of establishing formal and informal sanctions for the violation of social rules (e.g. licensing stipulations for medical practice). They also argued that “the usage of mass media and propaganda to magnify the effects of stereotypes and to provide powerful means for manipulating public opinion” threatens norms of equality, particularly within the legal system (Gruter and Masters, 1986: 3). Professional writings such as journal articles, circulars, and other defamatory media used by physicians and maternal healthcare lobbyists demonstrated the

⁷ Michael Mullin in *Africa in America: Slave Acculturation and Resistance in the American South and the British Caribbean 1736-1831*(1992) details how enslaved Africans were classified as good or bad workers based upon their ‘tribal’ origins (e.g. Coramantee were intellectual, stoic, and good workers whereas the Ibo were despondent and suicidal and considered problematic workers). These connotations also assisted many plantation owners in their perceptions that blacks required supervision to be effective workers. Mullin (1992) also details racist opinions of these ‘New Blacks’ as contained within plantation records and slave advertisements (1992: 28).

“otherness” of granny midwives, which served as a mechanism of differentiation used within the inter-occupational conflict (see Wertz and Wertz, 1977).

Moreover, Scott’s contentions (as quoted in Hill Collins, 2000) regarding how dominant and subordinate relationships are established and maintained are also relevant to this discussion of in-groups and out-groups. Scott contended that a suppression of knowledge fashioned by an oppressed group is the first step in *domination* and “makes it easier for dominant groups to rule because the seeming absence of dissent suggests that subordinate groups willingly collaborate in their own victimization” (Scott as quoted in Hill Collins, 2000: 3). Calls for and eventual advances in obstetrical and gynecological practices as well as critiques of midwifery care are two manners in which granny midwifery knowledge was suppressed. In a conference reported in *JAMA* examining the impact of midwives,

Dr. J. W. Schereschewsky of the U.S. Public Health and Marine -Hospital Service introduced a resolution, which was adopted by the section, to the effect that the teaching of obstetrics in the United States is at present inadequate and that no time should be lost in elevating obstetrics to the importance at least accorded to medicine and surgery; investigation of local midwife conditions was urged as a means of obtaining information; that the extension of outdoor obstetrical service be advocated as a method of preventing disease and a high mortality-rate (“Has the Trained, Supervised Midwife Made Good?”, 1911: 1787).

Dr. Schereschewsky demonstrated his primary interest in developing the field of obstetrics while also advocating that midwives should be investigated. In addition, Dr. Schereschewsky states that the field of obstetrics need to be elevated to the same importance “accorded to medicine and surgery” (1911: 1787).

While some doctors felt that the midwife problem could be solved by simply calling for their eradication, others felt that “[i]t is important to have something done for the benefit of the people who cannot have regular physicians but must have midwives. It is not alone a question of elevating the standard of obstetrical teaching” (“Has the Trained, Supervised Midwife Made Good? Shall Midwives be Licensed or Abolished”, 1911: 1787). Dr. Wilson, in *JSCMA*, advised

that obstetrical teams should be created as a means of dealing with rural midwives that deal with the poor and indigent. Wilson argued, “[these] teams should consist of a local physician and one or more colored trained nurses whose duty it would be to hold prenatal clinics and to care for cases during labor” (Wilson, 1928: 206). This “something done” equaled sending maternity care bulletins to women. These bulletins lauded that physicians provided the best care; however, women should possess certain information on pre- and post-natal care. See further discussion of this in Chapter V in regards to inter-occupational conflict. Physicians, writing in *JSCMA*, discredited granny midwifery by linking it to high rates of infant mortality and criticizing old healing practices thereby suppressing granny midwifery as an authoritative voice in birthing work.

The superstitious and time-honored midwife customs are responsible for the death of many babies that survive the hazards of birth, and the first days of life. It is the rule in the midwife class of deliveries that the baby is purged and ‘tea’d’ to the point of almost extinction. Upon this handicap is engrated vicious habits as to feeding hygiene and care. The ludicrous remedies for sore eyes, thrush, hives, etc., are familiar to us all (Simpson, 1928: 28).

As was earlier indicated, Savitt (1978) and others (Fraser, 1998; Lee, 1996) found that whites historically distrusted medicinal practices derived from the ‘dark continent’ of Africa and used by black women deemed ‘unclean women.’ This history of animus worked in conjunction with the racist and sexist practices under which black women suffered. The persecution and later prosecution of granny midwives exemplified how oppressive sexist, ethnocentric, and racist ideals of elite white males subordinated black female healers and led to their eventual abrogation from birthing work. In essence, because many white male physicians perceived that modern medicine predominantly practiced by whites held greater accord and utility, granny midwifery bore the brunt of medical condemnation. Some prejudicial actions against grannies (e.g. the printing of derogatory editorials about old Negro healers within medical journals) condemned

them as medical pariahs whereas prejudicial beliefs about Blacks added to the debasement of granny midwifery.

Misconceptions such as claims that grannies practiced witchcraft or were incapable of handling difficult birth presentations persevered because males were historically barred from birthing rooms (Rooks, 1997; Mathews, 1992; Lee, 1996; Lay, 2000; Schur, 1983). In addition, healing knowledge among grannies and other lay healers was private knowledge and not openly shared with other untrained individuals unless they were patients. Lastly, since traditional healing was *different* from the medicinal practices of newly licensed medical practitioners, an oppositional divide was advocated in order to oppress black women healers. The resulting system created an interlocking sexist and in some states, racist, domination of birthing work by white male physicians (Rooks, 1997; Mathews, 1992; Lee, 1996).

Drawing upon the conceptualization of ethnocentrism, Scott's assertions about how oppressors dominate oppressed groups, and Williams' description of how blacks were viewed in greater American society, I posit that white physicians, particularly male physicians, contended with success that they composed what Sumner terms the in-group. I believe that doctors, in part, achieved their goals by using their professional writings and their influence with legislative officials to develop legislation regulating midwifery. Consequently, they held the power to regulate the medical profession and those who desired entry. Therefore, white males were able to 'maintain' their dominant positions of power within the medical hierarchy and granny midwives continued to inhabit a subordinate status.

Theoretical Explanations for Inter-occupational Conflict Within Birthing Work

Changes within the field of medicine also influenced the treatment of granny midwives. The professionalization of medicine in the late 18th and early 19th century assisted in the stigmatization of granny midwifery and its adherents. Briefly, the professionalization of

medicine created an antagonistic and highly competitive environment in which grannies were subsequently targeted as the “other.” White male physicians fostered this environment by elevating their medical authoritative knowledge and simultaneously discrediting granny midwifery. Accordingly, former clients of grannies (white and black) began to use the services of licensed health professionals rather than the women who as lay practitioners had served them and their respective communities. In essence, grannies bore social (stigma) and economic (loss of clientele) consequences due to their particular medical practices and due to physicians’ desire to control that ‘terrain.’ In addition, the *medicalization of birth* promoted the idea that pregnancy and birth are problems or “troublesome ‘medical’ conditions or events which require at all times the intervention of physicians” (Schur, 1983: 93). As a result, the medical profession perpetuated this belief to “bolster its status and expand its jurisdiction” (Schur, 1983: 93). Yet, white male physicians were not solely responsible for the promotion of a negative occupational environment within birthing work. Societal processes, namely the socialization and designation of sex and gender roles, played a role as well. Herein lies another example of inter-sectionality; however, in this instance social constructions of sex and occupational choices are linked together and provide a fuller explanation as to the social processes used to remove grannies from birthing work.

The cult of domesticity advocated (among other stipulations) that women should be mindful of their delicate nature; this stipulation was extended to discouraging women from seeking medical knowledge that belonged exclusively to men. In addition, women were relegated to the following roles: “homemaker, mother, housewife, and family tutor of the social and moral graces” (Giddings, 1994: 47). And, as Giddings (1994) argues that during the late 19th and early 20th centuries that the “cult” provided an opportunity for white men to obtain jobs in the industrial sector that were previously occupied by women, the same opportunity could be argued for obstetricians fighting for “authority” within the field of medicine. Schur (1984) contends that

because women were ascribed a ‘deviant’ status and childbirth conceptualized as a medical problem, obstetricians and other health professionals created a campaign designed to bring into disrepute and eliminate the practice of lay midwifery. Literature from the sociology of occupations can also help to account for doctors’ efforts to eliminate granny midwives from birthing work.

Theoretical Underpinnings of the Professionalization of Medicine

Establishing a basic understanding of how professions are created, maintained, and legitimated in society assists the examination of how inter-occupational conflict between physicians and granny midwives developed. Abbott (1988) asserted “[p]rofessions [are] organized bodies of experts who [apply] esoteric knowledge to particular cases. They [have] elaborate systems of instruction and training, together with entry by examination and other formal prerequisites” (Abbott, 1988: 3). Prior to formalized medical education in obstetrics and gynecology, midwives were considered experts in birthing work and the healing arts were considered a female occupation or “woman’s work” (Hoch-Smith and Spring, 1978; Leavitt, 1983; Rooks, 1997; Donegan, 1978; Litoff, 1990). As a prerequisite, midwives served as apprentices underneath older midwives (who might be mothers or grandmothers) and during apprenticeship received various forms of training (such as herbal knowledge or procedures for dealing with birth complications) in caring for pregnant and new mothers and serving as traditional healers within their communities.

Such instruction, despite occurring beyond the hallowed halls of medical institutions and more formalized educational settings, does demonstrate that prospective midwives did undergo a supervised informal training and were not just providing healthcare carelessly or in ignorance. Yet, despite the fact that many grannies possessed these prerequisites, their form of birthing work

did not fall under what was understood as the medical profession. So, how and why were grannies excluded from the medical profession as participants in birthing work?

“...[P]rofessions...make up an interdependent system. In this system, each profession has its activities under various kinds of jurisdiction...” (Abbott, 1988: 2). Jurisdiction is defined as a claim to ownership or a set of practices. Once the field of medicine became professionalized and legitimized by the legal system in the early 1900s, physicians sought to dominate the field of birthing work as its primary practitioners. Their claim to jurisdiction came into direct conflict with lay midwives who had for centuries in the Americas served as the primary maternal and infant healthcare providers. This jurisdictional dispute within the field of birthing work between physicians and lay midwives (which includes granny midwives) created what Abbott (1988) terms “the determining history” of a profession. Abbott contends that jurisdictional battles birth organizational developments within a profession. In other words, ownership claims by both midwives and physicians of birthing work contributed to its development as a profession. For example, both licensure requirements and /or supervisory stipulations determined who could participate and remain within birthing work (Rooks, 1997; Wolfson, 1986). Consequently, white male physicians as members of State Boards of Health controlled who treated and aided women in childbirth. Those granny midwives who wished to practice feared certain consequences if they chose not to collaborate with these new participants in birthing work. So, many grannies acquiesced to the newly enforced medical standards of practice (Fraser, 1998; Lee, 1996; Mathews, 1992).

As a benefit from grannies’ acquiescence, medical students garnered further herbal and/or homeopathic knowledge of birthing work working alongside granny midwives during the early 1900s (Leavitt, 1986). Such knowledge was rarely taught in medical schools or in residency. Moreover, because physicians sought to increase their clientele, many advocated for legislative changes to accord them authoritative knowledge and exclusive control of birthing work.

Abbott (1988) posits that central elements such as jurisdiction (claim to ownership of a profession), public opinion, and cultural authority are key to understanding how and why particular groups of individuals can obtain “spaces” in occupational parking lots (e.g. positions within the field of birthing work). Moreover, once a profession asks society to acknowledge its exclusive rights to its skills and performances and obtains a legal jurisdictional claim, social structure and culture have an interdependent relationship within and affect the profession.¹

Lay Midwives Versus Physicians: Authoritative Knowledge of Birthing Work

In order for physicians to wrest control of birthing work from lay midwives during the late 19th and early 20th centuries, a shift in the ownership of birthing knowledge had to occur. Lay (2000) argues that the rhetoric of authoritative knowledge is determined internally within a community, or in this case, within the field of birthing work. Authoritative knowledge occurs through negotiation and is “sustained or modified when new experiences or theories are realized, and becomes authoritative when the community decides to recommend or establish a certain tool, procedure, or theory” (Lay, 2000: 21). Starr (1982) denotes authority as: “the possession of some status, quality, or claim that compels trust or obedience” (1982: 9). Consequently, one’s authority is demonstrated by voluntary compliance of others; yet, behind authority exists “reserve powers” that can be called upon to enforce authority. For example, one can be punished with dismissal for disobeying a managerial authority and this punitive action serves as a lesson to other subordinates that compliance is necessary to retaining their positions. An interdependent relationship develops which serves to sustain positions of authority and subordination. Granny midwives, in essence,

¹ Sociology of occupations literature would disagree that birthing work is a profession or is a set of professions. However, I would argue that the term ‘profession’ is applicable to the discussion of changes within birthing work. Simply put, the more powerful and influential individuals within a profession have the ability to create auspices of membership. Initially, women held sovereignty in birthing work. However, once the professionalization of medicine and the medicalization of birth opened the ranks of birthing work to men, new legislative rules were adopted in regards to who could and could not practice. Moreover, legal literature that I have found lays out birthing work as part of the medical profession which is particularly important because physicians were able to effectively use the American legal system as a means of further substantiating their authoritative knowledge. Wolfson (1986) argues that lay midwifery is a part of the medical profession and is governed by medical legislation.

became subordinates of physicians and other licensed medical professionals within birthing work because “authoritative knowledge about hinges on the expertise doctors achieved socially, economically, and politically” (Lay, 2000: 27). And, their livelihood as lay midwives was severely threatened and eventually eliminated as a result of them occupying the ‘dehumanized inferior’ or subordinate position.

“Authority, therefore, incorporates two sources of effective control: legitimacy and dependence. The former rests on the subordinates’ acceptance of the claim that they should obey; the latter [rests] on their estimate of the foul consequences that will befall them if they do not” (Starr, 1982: 9). Because socioeconomic status affords authority to in-groups, in-groups have some bearing on how occupations are legally regulated in addition to societal values, mores, and folkways. Hence, those in out-groups (or interlopers) are compliant with (or surrender to) these societal definitions and constructs as outlined in legal statutes which outline legitimate/legal and illegitimate/illegal practices. In the case of the elimination of granny midwifery, granny midwives as interlopers in birthing work had to be compliant with legislative statutes governing birthing work, which proved difficult given their age, access to resources, and educational limitations, and role models (Rooks, 1997: 24).

Starr (1982) continued by elucidating how those in authority are able to occupy authoritative positions. Professions and those who occupy positions of authority within professions replicate this system of interdependence between authoritative figures and their subordinates. Individuals considered in society to be professionals are ascribed a title of ‘superior competence;’ as a result, others, such as clients/patients and other practitioners within a profession, become dependent upon professionals’ expertise. Moreover, because professionals serve “as gatekeepers into and out of various institutions, [they] acquire means of ensuring compliance quite independent of any belief in the moral basis of their authority” (Starr, 1982: 11-12). In particular, Starr (1982) used the example of how physicians can be given further

authoritative voice simply due to a societal belief in their ‘therapeutic competence’ because doctors and other health professionals practice what is considered “a high and esoteric art” (1982: 12). As I discuss later in Chapter VI, this societal belief was in due in part to physicians operating as members of state boards of health who authored legislative statutes governing medical practice.

One manner in which physicians and other medical practitioners substantiated their authoritative stances was by disparaging grannies as medically inept since trained medical practitioners used newer medical birthing procedures and tools (Pringle, 1998; Radcliffe, 1989, Litoff, 1990). In addition, because pregnancy began to be viewed as a pathological condition beginning in the late 1800s and continuing on into the 1900s, physicians asserted that only legally trained individuals could “treat” this condition and keep new mothers and their newborns safe. Such assertions/claims served as manipulative tools that “pushed the scales” in favor of physician-assisted births versus granny midwife assisted births. Women began to trust the “expert” advice of physicians versus doing what seemed natural or right (Schur, 1983: 92). In addition, “the emphasis on health in [American] culture and the medical profession’s need to bolster its status and expand its *jurisdiction*’ encouraged an ever-widening conception of the conditions that require medical management and treatment [such as maternity and childbirth]” (Schur, 1983: 93). Beyond professionally managing childbirth to prevent complications, physicians and other healthcare professionals felt that hospitals were “the only site[s] in which such efforts can be carried out properly” (Schur, 1983: 94).

Starr (1982) also explained how far the medical profession’s authority can extend. “Its authority spills ...into arenas of moral and political action for which medical judgment is only partially relevant and often incompletely equipped. Moreover, the profession has been able to turn its authority into social privilege, economic power, and political influence” (1982: 5). During the late 19th and early 20th century, physicians worked collaboratively with state

governments to regulate medical practice. Initially, individuals labeled as *charlatans* and *quacks* were discredited as illegal practitioners. For example, *JSCMA* in the early 1900s published several articles lambasting individuals who used non-medical means of healing—or methods of healing not supported by evidential proof. “One of the misfortunes in matters medical in this country is, that with us the degree of M.D. and title of Doctor do not stand for anything distinct and definite...and I regret very much to say that most of the healers are frauds and are in the healing business just for the money there is in it” (Robinson, 1911: 135-6).

Such condescension and criticism of lay healers extended to midwives as well. For example, the advent of the federal Children’s Bureau of Health and the maternal healthcare movement in the early 1920s led to scrutiny of midwives as possible contributors to the alarming rates of infant and maternal mortality. Physicians, as well as other maternal healthcare advocates/proponents, felt that physician-assisted births would result in a significant decline in infant and mortality rates (Rooks, 1997; Mathews, 1992; Litoff, 1990). As a result, granny midwives and other lay midwives faced a dilemma about whether to continue as lay midwives; on the one hand, one group of physicians argued that women were incapable of healing unless under the supervision of male doctors. This group of doctors supported midwives continued practice. On the other hand, another group of physicians asserted that midwifery care was the root cause for high maternal and infant mortality rates in America; consequently, these doctors offered a threat to the continuation of midwifery practice. Litoff (1990) stated that physicians arguing for the abolition of granny midwives because of their supposed contributions to infant mortality did so as a means of cementing their authoritative position in birthing work and the medical profession overall.

Infant mortality rates, according to Lantos (1994), served as an indicator of health in American society. U.S. Department of Commerce, in reporting vital statistics rates for 1900 to 1940, states “infant mortality rate is of importance for several reasons. In the first place,

mortality is usually very high during the first year of life, and this in itself presents a challenging problem to the medical profession” (U.S. Department of Labor Force, 1943: 43). Given that doctors asserted that midwives contributed to rising rates of infant mortality, how credible were their arguments?

Census records for 1900 to 1940 indicate some trends that do not corroborate with physician arguments for the contributions of granny midwives to infant mortality rates, particularly in the case of South Carolina. Investigating the infant mortality statistics for South Carolina, I found, “South Carolina did not require birth certificates until 1 January 1915”. In addition, only three cities (Aiken, Charleston, and Spartanburg City) had state records of birth certificates and birth registration prior to 1915 (www.state.sc.us/scdah/vit.htm). Also of import is that the Book of Delayed Certificates for Birth prior to 1915 only three counties reported births: Barnwell, Greenville, and Horry (www.state.sc.us/scdah/vit.htm). Consequently, only infant mortality rates of reporting counties in South Carolina are available from 1900 to 1910. Looking at Table 1 and keeping in mind that Rooks (1997), Litoff (1996) and others found that doctors targeted midwives more specifically in the 1920s, U.S. and South Carolina infant mortality rates did drop between 1920 and 1930. However, looking at Table 2, the number of midwives decreased from 1900 to 1930 for South Carolina. This decline may be attributed to changes in midwifery legislation. As I discuss in Chapter VI, shifts in midwifery legislation contributed to midwives being forced to adhere to more restrictive standards in order to practice midwifery. And though infant mortality rates declined in South Carolina from 1920 to 1930, this decline may be due in part to the influence of the maternal healthcare movement rather than to a decline in the number of midwives. In addition, as I discuss later in Chapter IV, the public chastisement of South Carolina for having the highest infant and maternal mortality rates galvanized some physicians to educate women on prenatal and postnatal care.

Rooks (1997) found that declining infant and maternal mortality rates had little to do with the participation of midwives in birthing work. Rooks (1997) points out that maternal mortality rates peaked between 1900 and the mid-1930s (600 to 700 deaths per 100,000 births) and then declined because of the “availability of antibiotics, blood transfusions, and drugs to treat pregnancy-induced hypertension” (1997: 30-1). And, “high maternal risk could be associated with cheap untrained midwives or expensive over-zealous and unskilled doctors” (1997: 31). In fact, her review of a federal study completed by the 1925 White House Conference on Child Health and Protection “concluded that the association between midwife deliveries and infant mortality was due to high proportions of poor people in states with many midwives; they attributed the lack of a higher incidence of maternal deaths in those states to the care provided by the midwives” (1997: 29). Lastly, one of the main reasons that the U.S. suffered high infant mortality rates in the early 20th century was due to “poor social and economic conditions of both the urban and rural poor of that period” (1997: 31). As I discuss in my analyses chapters, from 1930 to 1940, physicians nationally and in South Carolina began to note other contributors to infant mortality besides midwives. And yet, despite such erroneous claims, physicians still achieved their interests within state and national legislatures and among the American populace.

In fact, legal and social credibility provided a suitable platform for medical authority. To this effort, laws required medical examinations and supervisory stipulations for lay practitioners; consequently, these statutes ensured credible dissemination of medical knowledge and healing. Lay (2000) argues that medical experts’ arguments regarding birth are based upon expertise that has social, economic, and political backing. Two particular ways that ensured credibility to medical professionals were: a) members of the medical profession pressuring legislators for the amendment of medical practice acts; and b) limiting entrance into medical institutions to secure their position as superiorly competent professionals. Consequently, a system was created in which an in-group’s terms are evidenced and favored over another’s; therefore, the dominant (in-

group) shapes public discourse such as influences upon law and social and professional practices (Lay, 2000: 31). As Schur (1984) contended, the relationships between women and men are based upon societal definitions of power. So, in the case of physicians versus midwives, the medical profession accredited men with far more medical authority than female lay midwives.

A community can either accept or reject as truth new competing knowledge. Within the field of birthing work, the medicalization of birth, the professionalization of medicine and medical technological advances shifted the authoritative knowledge of birthing work from lay midwifery to physicians and other licensed medical practitioners during the late 19th and early 20th century. Professional writings helped to further solidify doctors' foothold since physicians sought to demonstrate their medical proficiency and expertise. In the case of obstetrics, physicians lauded newer obstetrical procedures and instruments as improvements in maternal healthcare. Oftentimes, physicians compared newer treatments to the far less effective practices of lay midwives. Therefore, professional writings subjected members of the medical community to arguments that embraced a newer knowledge.

Legislative Support of Authoritative Knowledge in Birthing Work

Licensure requirements also assisted in shifting authoritative knowledge to doctors. Lay (2000) asserted that licensing rules and regulations “assume a particular knowledge system linked to formal education, abstract standards, and hierarchical relationships among practitioners” (2000: 32). How do licensing rules, regulations, and medical journals accomplish the creation of such a hierarchical system? Each of these entities either identified or opined who was permitted to practice, based upon having appropriate education and training; and according to physicians, rules and regulations protected the public from “unsafe” practitioners. In addition, legal definitions detailed the scope of practice as agreed upon by the state and the profession. Sometimes these definitions were the result of medical conventions about the medical profession as well as county

society meetings in which doctors expressed what resolutions were necessary for existing medical practice acts.

Weber emphasized that the impact law has on society, particularly within social institutions, speaks to how social, political, and economic changes occur. Law's presence is established when societal members are willing to use physical or psychological compulsion to guarantee order and conformity. These compulsions can come in the form of sanctions. "[Furthermore], the structure of every legal order directly influences the distribution of power, economic or otherwise, within its respective community... In general, we understand by power the chance of a man or a number of men to realize their will in a communal action even against resistance of others who are participating in the action" (Gerth and Mills, 1965: 180). In the profession of birthing work, white male physicians and other maternal healthcare advocates maintained their dominance in the field of birthing work by developing and instituting laws designed to abrogate lay midwifery.

Shyrock (1967) and Starr (1982) argued that medical doctors, in their history of attempting to formally organize, began in the late 19th century to seek licensure requirements again for medical practitioners. However, because many other professions sought licensure requirements, physicians were not yet considered "a powerful interest group" (1982: 102). "The occupations that pursued their interests through licensing were distinguished less by their political power than by their distinctive structural position within the economy" (1982: 103).

Weber found that individuals strive for power due to the resultant social honor. For white male physicians, their power and social honor were based upon their formalized medical training and overall societal acceptance as superior birth attendants beginning in the early 20th century. In addition, their social honor and status could be and was guaranteed by legal order via legislation. Yet, it is important to note that "legal order is rather an additional factor that enhances the chance to hold power or honor" (Gerth and Mills, 1965: 180). In other words, solely having the backing

of legal institutions may not guarantee an individual's or groups of individuals' powerful positions within society. Societal acceptance has a greater role in maintaining positions of power than a ruling legislative body. This societal acceptance came in the form of physicians' professional writings in *JAMA*, which was considered to be the premier medical journal and heavily relied upon for its content. This content included information about the role physicians play in society-at-large. And in the early 20th century, expression of tenets of the cult of domesticity (see later analyses of sexism in *JAMA* in Chapter IV). In addition, the American Medical Association was a nationally known group recognized as possessing medical knowledge. These sentiments molded the way in which American society viewed medical practitioners. In addition, some physicians advocated that medical doctors should use maternal and infant healthcare information taken from medical journals and distribute such information to pregnant women as directed by the Sheppard-Towner Act.

Prior to the 1920s, lay midwives were allowed to practice without regulation in several states. Yet, once national attention focused on reducing infant and maternal mortality rates, particularly in northeastern states such as New York and Pennsylvania, physicians, in order to avert blame, argued that granny midwives and other lay practitioners were primary violators of new medical regulations, thereby contributing to the unnecessary deaths of mothers and newborns (Rooks, 1997; Mathews, 1992).⁸ Additionally, prevalent racist notions about blacks as healers and sexist notions regarding 'the midwife problem' further rendered granny midwives' care incongruent with professional standards of medicine (Mathews, 1992; Lee, 1996). Lay (2000) posits that licensing rules are genres and that they assist in establishing "state-sanctioned authoritative knowledge" as well as in regulating professions because genres are rhetorical forms

⁸ Passage of the 1921 Sheppard-Towner Act was a pivotal event that applied pressure to physicians and other medical practitioners to do a better job of administering quality healthcare to pregnant mothers and their children. The Act's main purpose was to significantly reduce maternal and infant mortality rates on a national level (Rooks, 1997: 27). As a result, the Act further aided in the construction of hierarchical stratification within maternal healthcare because physicians in their efforts to administer adequate maternal healthcare defamed lay practices of medicine, particularly midwifery (Rooks, 1997; Litoff, 1990; Donnegan, 1978).

of communication “created in response to recurrent situations and ‘serve to stabilize experience and give it coherence and meaning’” (Lay, 2000: 33; Berkenkotter and Huckin as quoted in Lay, 2000: 32).

Coincidentally, genres limit the actions of community members, thereby creating an *other* because “genres affect power, status, and resources” (Lay, 2000: 33). To reiterate, Hill Collins (2000) argues that the creation of an *other* creates a dichotomous relationship—one versus the other. Hill Collins (2000) contended that this is how social realities are constructed and how people are categorized in the process. In relation to this project, the manner in which legislative bodies accorded licensed medical practitioners (namely physicians) power, status, and positive designations and lay practitioners (namely granny midwives) lesser power, status, and negative designations was an example of a dichotomous relationship. This dichotomy is a legislative extension of Schur’s (1984) and others’ (Hill Collins, 2000) contentions regarding women being categorized as the ‘other’ and occupying a deviant status in comparison to men; in this instance, midwives were deviant women because of their occupancy in birthing work. During this same time period, lay practitioners, namely grannies, suffered punitive actions for their healing practices, which resulted in a loss of power, respect, and agency in providing healthcare within rural communities. Moreover, grannies practiced at the risk of state prosecution. Here again, one notes how legal advocacy can impact society by allocating benefits to the privileged and such was the case for physicians.

Moreover, “when political institutions are formed, resources are usually available to provide ‘selective benefits’ for those in power (or [who] hold heavy political influence); in return, political authorities provide services that maintain ‘collective goods’ in the form of ...law and order” (Masters, 1987: 237). As a result, formalized rules of behavior in the form of law are created to protect the interests of those in power. Although grannies did not actively nor voluntarily remove themselves from birthing work, their exit was grounded in the demeaning

pressures of maternal healthcare lobbyists and physicians that were interested in the eradication of midwifery as a practice in America in early 1900s. In addition, physicians joining the American Medical Association (AMA) sought to delineate themselves as medical authorities and experts and to eliminate other occupations that made competing claims to expertise (Barker, 1993). Physicians using both the legislative system and their professional writings successfully placed themselves as medical authorities; as a result, views towards granny midwives and other lay healers held a pejorative slant. More specific examples of physicians' lobbying are discussed in detail in Chapter V.

Summary of Theoretical Considerations

In summary, grannies have been an integral part of American healthcare. They initially served southern plantation owners and their slave laborers as healthcare providers and birthing attendants. Because plantation owners held ambivalent attitudes regarding the credibility and validity of black healers, grannies experienced racist persecution due to a societal categorization as the "other". And, when grannies continued their practice during the post-bellum period and into the earlier half of the 20th century within rural communities in the South in direct opposition to the cult of domesticity's tenets and in competition with medical doctors, maternal healthcare advocates and male physicians subjected grannies (along with other midwives) to sexist and racist persecution through professional writings and legal restriction by way of licensure requirements or supervisory stipulations. Inter-occupational conflict between grannies and physicians further assisted the demise of granny midwifery as a medical occupation within the United States based upon the establishment of authoritative knowledge by physicians and the subsequent ostracism that grannies faced in birthing work.

In the following chapter, I detail the manner in which I investigated two medical journals, *the Journal of the South Carolina Medical Association* and *the Journal of the American Medical*

Association for evidence of racism, sexism, and the threat of inter-occupational conflict within physicians' professional writings. In addition, I discuss the methods used to analyze South Carolina's legislative statutes that governed medical practice and more specifically, birthing work.

CHAPTER III

METHODOLOGY

I proposed that laws, physician sentiments, and the professionalization of medicine contributed to the demise of granny midwifery in South Carolina between the years of 1900 and 1940. The year 1900 marks a time period during the professionalization of medicine in which medical schools served as a major impetus for pushing physician legitimacy (Rooks, 1997; De Vries, 1985; Donnison, 1977). This “push” for legitimacy aided in building a platform to delegitimize lay practitioners. De Vries (1985) contends that authority figures within occupations can effect change by legal intervention due to their connections to political actors. In this instance, physicians, interested in creating a medico-legal establishment, solicited lobbyists to stake their claims. These lobbyists, in turn, helped create and supported laws for physicians’ personal interests and gain (see earlier discussion of Lay, 2000 and Starr, 1982). As a result, formal medical training and the professionalization of medicine worked advantageously for licensed medical practitioners and deleteriously for lay medical practitioners. Moreover, newly licensed and educated doctors viewed lay healers as competition within birthing work. This competition was a consequence of new physicians experiencing difficulty in acquiring patients because grannies served as primary medical practitioners for many in both rural and urban populations (see Mathews, 1992; Rooks, 1997; Pringle, 1998; Fraser, 1998; Ehrenreich and English, 1973).

I chose 1940 as the end point of my examination because by 1930, lay midwifery was dwindling or states adopted lenient registration statutes. Moreover, lay midwives disappeared by the middle of the 20th century because midwifery training was not upgraded and their status and popularity declined (Weitz and Sullivan, 1992). In addition, society embraced hospital births

over home births beginning in the early 20th century. South Carolina required midwives to obtain midwifery certificates by the late 1920s and continuing on into the 1930s. Most of these newly licensed midwives were considerably younger than granny midwives and if granny midwives continued to practice, they did so surreptitiously.⁹

Medical journal articles served as data sources to illustrate what Rooks (1997) and others (Sullivan and Weitz, 1988; Mathews, 1992; Pringle, 1998) contended: midwives were labeled illegitimate practitioners, criticized for contributing to infant and maternal mortality rates, but later were acquitted of charges that midwives contributed to mortality rates. (See later discussion of how during the late 1930s physicians began looking at other causes for maternal and infant mortality rates in Chapter IV.)¹⁰ Medical journal articles and legislative statutes in the form of medical practice acts and Sanitary Codes are salient for this project within the time period of 1900 to 1940 because text within these sources reflect physician sentiments. In addition, Litoff (1990) argued that “[a]nti-midwife physicians published scores of articles on the American midwife problem during the early decades of the twentieth century. [More specifically,] between 1910 and 1930, the medical community and, to a lesser extent, the general public became embroiled in a vehement debate over the present and future role of the midwife in American society” (1990: 12).

Relevance of Medical Journal Articles

Opinions expressed within medical journal articles are an appropriate source of information regarding how physicians felt about midwives and of the types of arguments physicians made against midwives. In addition, my project adds to previous research on

⁹ Moreover, due to the volume of materials for this project, I opted to stop at 1940 to make the project more manageable and to demonstrate patterns of persecution and prosecution of granny midwives over four decades.

¹⁰ Some illustrative materials such as circulars authored by proponents of physician care and hospital births and slave narratives are also used as examples of language used to describe lay midwifery and/or granny midwifery (Rooks, 1997; Lee, 1996).

midwifery abrogation because few midwifery researchers have focused principally on opinions expressed by physicians within professional writings as a source of the social persecution that grannies endured. To review, physicians and other health personnel began arguing that there were increasing rates of infant and maternal mortality in the early 20th century and that midwives were the main cause of mother and infant deaths. Consequently, physicians and other health officials investigated midwifery practices and advocated that midwives improve the care they provided to expectant mothers and their newborns.

The obstetrician or midwife makes the initial call in practically all births, and in the absence of other agencies is in duty bound not only to attend to the birth and puerperium, but also to see that the child is properly started in life. Midwives with their practice limited by law to obstetrics are in need of enlightenment with regard to their duties to humanity. When this is properly addressed to them and it is shown of what great service judicious advice given by them to the mother will mean for the welfare of the child, they may be made influential agencies in the prevention of infant mortality (Koehler and St. Clair Drake, 1911: 26).

Here, Koehler and St. Clair Drake, writing in *JAMA*, proposed that midwives required further “enlightenment” about their roles as birth attendants in order to improve mortality rates. In addition, they viewed midwives as “influential agencies” in preserving infants’ lives, rather than as sole contributors to infant mortality rates. And yet, some physicians writing in *JAMA* also viewed midwives as a bane of public health.

The problem of infant mortality is to be solved through intelligent motherhood and the keynote of the work is to teach mothers how to care for themselves and their infants. Fifty per cent of births in this country are attended by midwives who are mostly untrained, ignorant women, and much unnecessary death, blindness and mental and physical degeneracy result (“ ‘Visiting Obstetric Nursing’ in American Association for the Study and Prevention of Infant Mortality”, 1911: 1785).

Rooks (1997) found that physicians employed journals as a means of expressing their animus toward midwives and doctors’ arguments for the elimination of midwives from birthing work. The aforementioned quotes provides an example of physicians’ arguments for abrogation

(see also Lay, 2000 in regards to how physicians advocated for positions of medical authority). In addition to research reports, such journals published letters advocating the interests of physicians and other medical practitioners, such as healthcare reform, higher pay for qualified medical doctors, and in relation to this project, the elimination of lay midwifery; these arguments appeared also in county society notes and letters to the editor. Thus, medical journals served as an optimal source for physicians' commentary on women and their wombs.

Specifically, I searched the *Journal of the American Medical Association (JAMA)* and *The Journal of the South Carolina Medical Association (JSCMA)*, and selected for analysis text (within articles) about midwives (including granny midwives), gynecological issues, women in medicine, and female patients.

I chose *JAMA* because it began on July 14, 1883 and reflected popular medical opinions and is the official journal of the American Medical Association. Furthermore, because *JAMA* is one of the oldest medical journals, its influence likely affected the beliefs and attitudes of physicians in different states. For example, *JSCMA* oftentimes quoted articles or opinions expressed in *JAMA* when referring to particular ailments or new medical techniques. I chose *JSCMA* because its first publication began in 1905 and is based out of the Medical University of South Carolina, which was one of the more prominent medical schools in South Carolina during the early time period of my study. In addition, *JSCMA* served, upon its inception, as the major source of medical information pertaining to and for medical societies in South Carolina.¹¹

Measurement and Operationalization of Text Within Medical Journal Articles

Journal articles from *JAMA* and *JSCMA* from 1900 to 1940 provided the textual data to be analyzed. *JAMA* publishes one issue for each week of the year, or 52 issues per year. Due to

¹¹ *JSCMA* is housed in the Waring Historical Library at the Medical University of South Carolina in Charleston, South Carolina.

the sheer volume of articles and time constraints, I opted to examine *JAMA* articles by looking at the first and last issue of each month of the following years: 1900, 1901, 1905, 1906, 1910, 1911, 1915, 1916, 1920, 1921, 1925, 1926, 1930, 1931, 1935, 1936, and 1940. I chose these time points after a full review of articles printed in the first and second decade of *JAMA* and in an effort to ascertain if physician sentiments shifted by the middle or end of a decade for the forty year time period of my study. My review entailed investigating whether physician sentiments were strongly represented within *JAMA*. I found that physicians did offer opinions about midwives but that they were interspersed through the decades rather than a concentrated incline from year to year. Therefore, I examined 408 issues within *JAMA*.

JSCMA publishes 12 issues per year; so, for the time period of 1900-1940, I examined all 492 issues. In addition, I examined all of these issues since my study's primary focus is on the state of South Carolina. Arguments or opinions expressed by physicians within *JAMA* or *JSCMA* served as my unit of analyses. For those instances in which an article produced contradictory opinions—which was oftentimes the case in articles that detailed conference discussions amongst physicians—I created separate units of text from each article.

Examining text for themes is the root of using grounded theory analysis. Grounded theory involves the repeated reading of texts to discover and label variables or categories and their interrelationships. In this case, my variables were indicators of my themes and investigating if these themes were interrelated demonstrates the presence of a relationship or relationships between these themes. Perceiving variables/themes in relationships is termed “theoretical sensitivity” and is largely affected by the methods a researcher employs and their reading of the literature (<http://www.analytictech.com/mb870/introtoGT.htm>). My project involves a variant of grounded theory in that I used theories related to my themes of persecution and prosecution to develop a preliminary list of themes to look for in order to explore how physicians used their professional writings to advocate for midwifery abrogation.

My investigation of this journals and my subsequent analyses of text were based on several different layers of criteria.

Preliminary Article Selection Criteria

In order to select particular text within the articles for analysis, I first developed a set of criteria for selecting articles. The list of criteria is as follows:

(a) I perused the table of contents for each issue of a volume. If I was unable to look at the table of contents for each issue, I utilized the subject indices located in the last section of the bound volumes.

(b) During my perusal of the table of contents, I looked for key terms that are related to obstetrical or gynecological issues and new or developing obstetrical practices or instruments. In addition, I looked for key terms associated with maternal healthcare practitioners (male and female) such as midwives, ob/gyns, midwifery, lay midwifery, grannies, birthing practices, “the midwife problem.” A variety of medical terminology describes obstetrical or gynecological procedures. When I initially started this research, some key terms I used to find articles relevant to my themes were: abortions, birth rates, birth canal, breech births, contractions, craniotomy (a birthing technique for infants with large heads), ectopic pregnancy, endometriosis, enteroptosis, episiotomy, fallopian tubes, fibroids, hysterectomy, infant mortality, labor, lay practitioners, maternal mortality, menstruation/period, ovarian cancer, ovarian tumors, ovary(ies), pelvic examination(s), pregnancy, puerperal sepsis, premature births, rural healthcare, toxemia, uterine cancer, uterus. These terms are not the sole basis for my choice to peruse an article though each of them proved helpful in finding relevant articles. As I searched journals, I added more terms such as home births and hospital births which alerted me to relevant articles.

(c) In addition to using such terms as guides, I also examined articles with subject titles focused on a relationship between mental illness and/or link to hysterectomy, physician arguments for medical licensure, criticisms of alternative medicine, articles that discussed or refuted the idea that women possesses feeble minds, articles that did or did not link women's delicate biological nature to why they are incapable of practicing medicine, articles about black health practitioners, and articles that did or did not criticize what were deemed "archaic"/outdated medicinal practices. These criteria proved useful when indices and tables of contents were unavailable or missing.

(d) Moreover, I looked for articles with arguments for or against lay practitioners and articles that discussed changes within medical practice acts in the U.S., articles that discussed physician advocacy for medical regulation, and for those that focused principally on South Carolina's medical practitioners. Again, I used these criteria when volumes did not include indices and/or table of contents.

After reviewing the articles within *JSCMA* and *JAMA* in the first decade (1900-1910), I realized that I would need to supplement my evidence of themes being present or absent as well as look for other key terms that would assist me in finding relevant text. For example, I realized that some articles that advocated hospital births over home births also contained evidence of racism, sexism, and/or inter-occupational conflict. Due to the volume of material, access restrictions within the Waring Library, and time constraints, I did not re-review previously searched journal volumes. However, and as a result of this new finding, I began looking for article titles that included terms such as hospital births or birth setting. In addition, I discovered that two prominent South Carolina physicians, Rosa L. Gantt and J. Marion Sims, voiced their opinions about 'the midwife problem' either in editorials or within county or state health reports. Consequently, I examined articles that were summaries of county and state health reports. In particular, I looked for sections within these reports which addressed maternal or child healthcare.

Other terms that assisted me in finding relevant articles for this project are child welfare and maternal welfare. These terms became more prominent within *JSCMA* during the early 1920s given that the child and maternal healthcare movement began to achieve greater public notice. Lastly, despite women not being fully represented within the medical hierarchy, some articles within *JSCMA* and *JAMA* began to discuss women operating as physicians, their experiences, and some of these articles contained commentary regarding whether women could provide adequate healthcare. I also examined article titles and articles that discussed women in the medical profession.

Once I identified each relevant article using the aforementioned criteria, I used another set of criteria in order to determine if each article should or should not be retained. Retention of an article entailed filing the article by year and by publication. The following criteria were my means of identifying relevant articles containing text for analysis as well as retaining the text for further data analysis.

Section I. Article Retention Criteria

In order to determine if an article should be kept for further analysis, I developed the following criteria:

- (a) Was there a mention of midwifery care? (If not, I omitted it from the analysis of text discussing midwifery; however, I reviewed the article to see if themes of racism, sexism, or inter-occupational conflict were present or absent within the text. These articles were kept to be used as illustrations of the tenuous climate in which grannies existed.)
- (b) If yes, were racist, sexist, or inter-occupational conflict themes present or absent?
- (c) If yes, which themes were present? In addition, I also looked for unexpected but relevant themes.

For those instances in which an article discussed midwifery care, I used the following criteria:

(a) Was there a mention of specific cases treated by physicians after a midwife's care or cases treated by a midwife?

If no, then I still reviewed the article to see if it contained remarks reflecting the presence or absence of racism, sexism, or inter-occupational conflict using the criteria for each respective theme detailed in Section II. If the article contained one or more of the themes, I reviewed the article using respective criteria as given in Section II.

(b) If yes, was there criticism of or praise for her care? If so, I kept the article for analysis of text which is coded re: midwifery care opinions among physicians and also to see if it contains remarks reflecting racism, sexism, or inter-occupational conflict using the criteria in Section II.

I also believed that, given my review of midwifery literature, physicians would seek to discredit midwives by criticizing their procedures or tools. Consequently, I used the following criteria to note if an article was acceptable for retention.

(a) If there was a mention of a new obstetrical procedure and/or tool, was there a criticism of methods used by lay midwives? If yes, I kept the article and identified and coded the relevant text as criticism of the inadequacy of midwifery care.

If no, I reviewed the article to see if it contained remarks reflecting racism, sexism, or inter-occupational conflict using the criteria for each respective theme detailed later in this chapter. Additionally, I kept such articles to illustrate how the medical establishment viewed and treated 'lay medical training' or to demonstrate shifts of authoritative knowledge.

Section II. Theme Criteria

A racist theme was indicated by:

- (a) articles in which physicians used exclusionary phrases such as “wouldn’t be allowed to practice” based upon one’s race (see *Vienna Correspondent*, 1910: 53 and *JSCMA*, 1908: 171-2);
- (b) articles in which physicians used racially derogatory terms such as “darkie” or “foolish negro woman” to discredit care given by black women;
- (c) articles in which physicians commented on the ignorance of blacks concerning general personal healthcare, in general, and particularly within the medical field (see *Jervey*, 1907: 371-2).

A sexist theme was indicated by:

- (a) articles in which derision of medical care administered by women of any race such as lack of competence among medical practitioners as expressed by physicians or other medical practitioners;
- (b) articles in which physicians discussed the “weaknesses of women” (e.g. cult of domesticity arguments; see *Jervey*, 1907: 334-336);
- (c) articles in which physicians linked mental illnesses suffered by women to their sex and/or the pathological nature of the womb.

The inter-occupational conflict theme’s presence was indicated by:

- (a) articles that detailed arguments for legislation outlawing midwifery/lay midwifery care;
- (b) articles that contained slurs towards midwives/lay midwives as professed by medical men or women;
- (c) articles that included a derision of midwifery care as expressed by medical men or women;
- (d) articles that contained comments made by physicians or other medical practitioners regarding how midwives were usurping their place in birthing work;
- (e) articles that mentioned physicians authoring of and advocating for the licensure of midwifery.

Each theme’s absence was indicated by:

- (a) articles that discussed medical care administered by women (including midwives) that did not criticize female medical practitioners;

- (b) articles that praised the medical competency of black women;
- (c) articles that depicted midwives as a valued and competent group within the medical hierarchy or that argued midwifery care was beneficial to women and/or the medical hierarchy;
- (d) articles in which lobbyists proposed legislation to permit unlicensed medical practitioners to continue practicing under the supervision of a physician;
- (e) articles that detailed or praised the medicinal knowledge of black healers or lay health practitioners in comparison to more formally and modern trained medical men and women.

I kept articles that included no racist, sexist, or inter-occupational theme to document the absence of patterns I expected during my period of examination. These articles demonstrate that physicians did not always use these themes of persecution and prosecution in their arguments for the elimination of the granny midwife.

Qualitative researchers employ different coding techniques for data analysis. In my case, I opted to code by hand my articles first and then later enter the text into the software package Atlas.ti. Coding assists researchers in categorizing qualitative data and describing the implications and details of these categories. It is advisable for researchers to begin with *open coding* which entails considering the data in minute detail while developing some initial categories. After completing this step, a researcher (or researchers) should move to more *selective coding* in which one systematically codes with respect to a core concept (www.socialresearchmethods.net/kb/qualapp.php). In order to codify the text in the medical journals, I used open coding. Open coding involves “identifying, naming, categorizing and describing phenomena found in the text” (<http://www.analytictech.com/mb870/introGT.htm>).

This study contains 373 units of text extracted from *JAMA* and *JSCMA*. These units of text range in length from a few sentences to full paragraphs and the authors could be physicians, medical correspondents, nurses, etc. I do not use full articles because oftentimes relevant text within articles did not occur until the middle or close to the end of a 2-3 page article. In addition,

some of these units of text consist of discussions between physicians within county or professional medical meetings. Within these texts are the presence and absence of themes of sexism, racism, and inter-occupational conflict; in addition, I found other predominant themes such as the medicalization of birth and the professionalization of medicine.

Within these publications, I searched for statements detailing physician attitudes. I expected that a preponderance of journal articles relevant to my project published leading up to and during the maternal healthcare movement in the late 1920s and early 1930s discussed the perceived threat of lay midwifery and espoused the safer, “medicalized” version of birth. In 1911 as printed in *JAMA*, during a medical convention addressing infant mortality, physicians discussed a need for a shift in how obstetrics and its practitioners are viewed by the general public. If midwives were better equipped or (preferably) abolished, then the field of obstetrics would not suffer insult and nurses and physicians would be the main practitioners of birthing work.

The public does not respect the obstetrician and will not pay him adequately. His standard is not so high as that of the surgeon. This lack of consideration for obstetrics extends through the hospitals and medical schools and the young men will not become either obstetricians or teachers but go into surgery or gynecology, which are better paid. The elevation of the standard of obstetrics in the opinion of the public first and in the schools afterward is the demand. When the women demand a better standard of service and cease employing midwives better service will be provided. This education of the women can be assisted materially in the women’s clubs throughout the country. Maternity hospitals of high class must be established more universally in which nurses and physicians can be practically trained in obstetrics. This will naturally abolish the midwives (“The Midwife Problem and Medical Education’ in American Association for the Study and Prevention of Infant Mortality”, 1911: 1786).

This section of text is the type of quote I expected to find which illustrates physicians’ sentiments towards midwives. This time period, arguments and events therein, I argue, helped further the elimination of South Carolina lay midwives and are consistent with midwifery

literature by Rooks (1997), Speert (1980), Donnison (1977) and others who discussed how newly licensed physicians and healthcare reform affected midwives. My project actually examines the arguments that physicians posed in their professional writings as well as within professional meetings about the presence of midwives in birthing work and the measures advocated for their eventual removal. For example, South Carolina physicians began to note in the early 20th century that medical education, particularly obstetrical training, was inadequate. In addition, general practitioners had not been introduced to newer gynecological and obstetrical techniques (Ross, 1933: 193-4). *JSCMA* and *JAMA* articles also featured discussions by doctors advocating hospital births as the safest place for deliveries. In addition, physicians in both journals criticized immigrant midwives and other lay practitioners for not being well-versed in newer obstetrical procedures (See Seibels, 1929: 295 in *JSCMA* and “ ‘The Midwife Problem and Medical Education’ in American Association for the Study and Prevention of Infant Mortality”, 1911: 1786 in *JAMA*).

Beyond simply commenting on the threat of lay midwifery, physicians also expressed racist and sexist sentiments within medical journal articles in the form of ethnocentric derision of granny midwifery care as well as in reported cases in which physicians placed blame upon the sex of midwives as the reason for their medical incompetence and contributions to increasing rates of infant and/or maternal deaths (see Wilson, 1906: 42). Medical journal articles also illustrated physician advocacy such as lobbying for required licensure for lay medical practitioners. Lastly, within medical journals, physicians also advocated for punitive action against midwives, quacks and charlatans.

Coding Text from Articles

Initially, after determining an article to be relevant and examining each article using the criteria described in Sections I and II, I photocopied each article. I attached a coding sheet which

had various codes linked to my three themes within the article. After I reviewed the article for relevant text, I placed a notation beside the appropriate code or codes (if the article's text illustrated more than one code) on the coding sheet. I then scanned or typed and saved each section of relevant text as separate plain text documents within Microsoft Word.¹² Upon a second review of each article, new codes revealed themselves. As these new codes appeared, I created an updated version of my coding sheet. Over time, these revisions entailed three different versions of the coding sheet. Consequently, I used the most updated version of the coding sheet for my last review of an article for relevant text.¹³

More specifically, relevant sections of text were indicated by key words I identified earlier as well as evidence of the presence or absence of racism, sexism, or inter-occupational conflict. In order to analyze data in Atlas.ti, text has to be named and saved as individual files. Given that both *JSCMA* and *JAMA* published conference notes, multiple sections of text were saved separately to differentiate between opinions expressed by physicians present at such meetings. Such text from both *JSCMA* and *JAMA* were opinions or arguments espoused by physicians or other health professionals and lobbyists. The length of my text varied based upon the overall *tone* of an article. For example, county and state health reports sometimes contained discussions among physicians on medical topic paper presentations. If physicians in discussion spoke at length on relevant topics, sections of relevant text were longer. So, as I stated earlier in this chapter, sections of text could range from one or two sentences to entire paragraphs. Oftentimes, the topics reflected pressing public health concerns, such as pellagra, tuberculosis, public milk supplies, and infant and maternal healthcare, and physicians gave their opinion of what they perceived to be contributors to health concerns and if allowed, possible solutions for

¹² This technique proved quite helpful when I inputted my text as primary documents within Atlas.ti as evidence of overlapping codes.

¹³ In order to make sure that my references were correct for the section or sections of relevant text, I noted citations on the back side of each article. After noting these citations, I created a file that listed all of my citations from *JSCMA* and created another file that listed all of my citations from *JAMA*.

these health concerns. In addition, in the case of medical society meetings, relevant text could consist of accounts of conversations between two or more physicians on one or more topics. Consequently, I examined these arguments using the aforementioned theme criteria to identify relevant text.

To address patterns such as a greater or lesser concern with midwifery as a problem or increased demand for medical licensure for midwives, I noted per decade how often relevant and irrelevant articles appeared in *JSCMA* and *JAMA* (see Table 3). Within this table, I noted such relevant articles such as those which discuss obstetrical or gynecological ailments because sometimes the health concerns shifted decade to decade between 1900 and 1940. *JSCMA*, in particular, was rife with irrelevant articles discussing the pellagra epidemic in South Carolina during the early 1900s. I also noted the number of relevant articles authored by physicians (see Table 4).

Description and Relevance of Legislative Statutes Text

Because law is typically governed by the ideals and beliefs of the ruling class, mainly mainstream white middle-class society, against those in lesser classes, it is my belief that regulations of granny midwifery in South Carolina assisted in the creation and reinforcement of the structure of the medical hierarchy. In an effort to demonstrate this, I examined legislative statutes in the form of medical practice acts. Legal documents are particularly important because they reflect changes regarding whether midwifery was a legitimate medical practice.¹³

Legal texts such as medical practice acts and licensure requirements reflect the self interests of physicians and health advocates of the time given the influence that doctors began to

¹³I had originally intended to find actual criminal cases brought against granny midwives but because their occupation is subsumed within lay midwifery my search has not uncovered any such cases. Also, descriptive information about cases may only mention a lay midwife rather than the title granny midwife and most of the cases I encountered in legislative documents occurred in later contemporary times such as the mid-1970s.

have within state legislatures. Since I am interested in how South Carolina physicians used their professional writings and legislative lobbying to eliminate grannies in birthing work, I examined South Carolina's medical practice acts from 1900 to 1940. I used the *American Medical Directory*—which published each state's medical practice acts—to study South Carolina. While looking at these statutes, I pinpointed changes in the legislation regarding the boundaries in which midwives could operate. Prior to the late 19th century, virtually no state-level statutes focused on midwifery (Rooks, 1997). Therefore, changes in state legislation can demonstrate the impact physicians and maternal healthcare lobbyists likely had in shifting the authoritative knowledge base of birthing work.

I should also note that lay midwifery was an unlicensed practice targeted in some southeastern state legislative statutes beginning in the early 20th century (see Lee, 1996). However, political lobbyists and health professionals did not initially target lay midwives. Prior to 1907, some southeastern states (North Carolina, South Carolina, Georgia, Florida, Alabama, and Mississippi) required that a person wishing to practice medicine must pass a licensing board examination, register with a state board (and a county board in some instances), and pass a medical examination. I looked at these states due to their proximity to South Carolina and to note if there were any distinct differences in medical practice acts in regards to midwifery practice only.

Although there often was no specific mention of midwifery, physicians targeted unlicensed medical practice; typically physicians were more concerned with individuals who administered medical advice such as charlatans, Christian Scientists, and quacks in the late 1800s and early 1900s. Such practitioners represented a bastardization of good medicine, so many physicians sought to eradicate their practice while also educating the general public. As a result, midwives, chiropractors and osteopaths were often excluded from the auspices of the medical practice acts. As time passed, medical practice acts began to explicitly state that some of the

stipulations regarding medical practitioners were not applicable to certain practitioners such as osteopaths, lay midwives, and chiropractors (*American Medical Directory*, 1906: 867). Such statutes serve as important indicators of changes over time in the political climate regarding licensed versus unlicensed practitioners.

Physicians seeking to remove illegal practitioners (including lay healers) from medical practices sometimes used medical publications to oust these practitioners. In some instances, some county societies reported the names of illegal practitioners as a blacklisting measure within *JSCMA* to ensure punitive actions for offenders of illegal medical practice. Such writings suggest white physicians' impact on the dissolution of lay healing practices in South Carolina. Midwives were lay healers and as was earlier stated, many physicians felt that midwives were inadequate medical care providers and were responsible for the continued high infant mortality rates in South Carolina (Wilson, 1928: 206; Smith, 1926: 73-4; Fry, 1911:18). Moreover, most licensed medical professionals were white during the early 20th century (Beardsley, 1987).

Upon my examination of *JSCMA*, I found that legislative statutes on midwifery governance were published in the Sanitary Codes printed by within annual reports of the South Carolina Bureau of Child Hygiene and Public Health Nursing. Physicians writing in this journal about how to improve obstetrics in South Carolina argued that these codes could be used as means of eliminating the midwife in South Carolina with educational requirements therein.

The State Board of Health, October 22, 1919, amended its sanitary code, with reference to the practice of midwifery, adopting rules and regulations very similar to those in force in New York State. There are probably several thousand midwives in South Carolina of one kind or another. Elimination by education is the best way to accomplish the desired end ("Better Obstetrics in South Carolina," 1920: 4).

As a result, Sanitary Codes provided an additional source of relevant material which I coded for the presence or absence of exclusionary language within regulations of midwifery practice. Once midwifery regulation was formalized in 1936 and published in 1937 within the South Carolina

medical practices, supervision of midwives was the State Board of Health's responsibility. Both physicians and licensed nurses supervised midwifery care based on licensure stipulations such as requiring midwives to take ten hours of coursework from trained nurses and supervision by physicians if the birthing process lasted longer than twenty four hours (Sanitary Codes, 1937: 61-2).

Measurement and Operationalization of Medical Practice Acts

I recorded the frequency of exclusionary language and the years it appeared within the medical practice acts. Regulation of grannies was hidden in the guise of the professionalization of medicine via legislation in two distinct ways: (a) legal statutes requiring lay midwives to follow particular laws in order to practice in South Carolina and (b) according to Rooks (1997) and Fraser (1998), physician authoring of and advocating for bills for the licensure of midwifery or for making midwifery illegal.

I examined the medical practices acts of South Carolina and using the following criteria:

- (a) Is there an explicit mention of midwifery care or midwives?
- (b) Does the medical practice act allow unlicensed midwifery?
- (c) Are midwives exempt from the provisions of the medical practice act? If so, are there particular conditions for the exemption?
- (d) Does the medical practice act require a license in order to practice midwifery?
- (e) Are there requirements for medical schooling from an accredited medical institution and/or nursing school in order to practice midwifery?
- (f) Does the medical practice act impose a financial punitive action (e.g. fines) taken against unlicensed medical practitioners?
- (g) Does the medical practice act impose a jail sentence against unlicensed medical practitioners?

(h) Is supervision required in order to practice midwifery?

Of the aforementioned criteria, (d), (e), (f), (g), and (h) I consider to be types of regulation of granny midwifery.

Therefore, I coded text within legislative statutes that contain instances of legislative prosecution accordingly. In my review of the literature regarding legislative statutes governing the practice of medicine, as well as the history of the medicalization of birth and the professionalization of medicine, I found that most midwives were restricted from the following: dealing with severe birth complications (such as those requiring emergency Cesarean sections), working without the supervision and/or assistance of an obstetrician or other physician, and working without obtaining additional formal education regarding child birth delivery (Rooks, 1997; Lay, 2000; Fox and Worts, 1999; Wolfson, 1986). Consequently, I expected to find instances in which midwives were legally required to be supervised by a licensed physician, in addition to prohibitions against unlicensed practitioners.

Weaknesses of Data

Medical journal articles contain weaknesses as a source of data for my analyses. For example, some of the cases that are reported by doctors lack specific detail such as the race/ethnicity of an attending midwife (although most midwives who practiced in the South were African American; see Rooks, 1997; Katz Rothman, 1993; Weitz and Sullivan, 1992; Beardsley, 1987). For example, a physician writing in *JAMA* does not fully describe the ethnic background of the midwives in the following illustration.

A great many women in city and country are delivered by midwives; much would be gained if the medical profession could educate the public so that these women would learn the necessity of placing themselves under medical supervision during pregnancy, even if they continue to be delivered by midwives (Fry, 1911: 18).

In addition, some editorials do not list an author so it is difficult to determine if the piece was authored by a physician or some other medical practitioner (see Table 4 for a count of physician authored articles). Another weakness is that some opinions are later rescinded, particularly if more research (typically experimentation) has been done regarding the medical subject (e.g. usage of forceps versus natural birth). Therefore, if a particular physician criticized a treatment recommended by a midwife or used by midwives but later stated within the same article that the treatment was effective, this can prove problematic for analysis purposes in noting if a physician was criticizing a midwife or not. An additional weakness is that some journal articles are incomplete due to the fragile nature of old bound journals.

Moreover, *JAMA* is a medical journal dedicated largely to internal medicine; consequently, its number of articles focusing on maternal and infant healthcare may be limited. Nevertheless, I chose this journal based upon its national influence of medical care and physicians. *JSCMA* is a medical journal for the entire state of South Carolina and its focus on maternal and infant healthcare may also be limited given that the medical society published articles on medical issues that were prominent during the time period (such as pellagra as a public health concern).

Relevant legal statutes can be problematic as well. Sometimes legislative statutes such as medical practice acts are published every two years. Consequently, other changes may have occurred in the intervening year in which medical practice acts are not published. As I will discuss in Chapter VI, Sanitary Codes though published annually, did not often publish midwifery regulations within. Consequently, more records may exist that better document midwifery regulation in South Carolina during the time period of my study. And, as Rooks (1997) and Weitz and Sullivan (1992) argue, it is difficult to determine precisely how midwifery regulation occurred within the U.S. because states regulated it differently. In addition, and for the

case of South Carolina, some counties differed in their midwifery licensure requirements as well. I detail the latter in Chapter VI in my discussion of the Sanitary Codes as well.

Analytical Techniques

I employed exploratory qualitative analysis using the qualitative software program Atlas.ti to parcel out themes of persecution in texts within medical journal articles. Briefly, exploratory qualitative analysis involves the use of text as a means of identifying both predetermined themes and unknown themes within different media forms such as journals, tape recordings, or transcripts. Since my study is principally qualitative, I allowed the data to reveal certain trends in addition to looking for evidence of racist and sexist bias and the theme of inter-occupational conflict. I also expected to find instances in which my themes would be completely absent from the analyzed literature.

Atlas.ti is a program designed by Thomas Muhr for textual analysis of various verbal and nonverbal data such as interview transcripts, field notes, diaries, historical or political documents, scanned brochures, tape recordings, video tapes, and photographs (Prein, Kelle, and Bird, 1998: 199; see also Muhr, 1991). The program permits the researcher to code pre-determined categories within text for analysis and for the purpose of my thesis, allowed me to code text based upon my three themes. In addition, Atlas.ti assists researchers in answering hypothesized research questions. In other words, this program works as a more complex word processor in that it groups sections of text according to my predetermined and emergent themes which were identified as codes. In addition, Atlas.ti can help to identify frequencies of codes within small and large sections of text. If there is overlap between codes, the program can identify the overlapping codes separately as well as together for analytical purposes. Lastly, Atlas.ti aids researchers by allowing them (or providing the flexibility) to interpret the data rather than being forced to use scientific designations for each code (see www.atlasti.de for further information).

Description of Codes for Analysis

I created the following preliminary codes for analysis of text taken from medical articles with the understanding that each of these codes can overlap with one another or exist independently of one another when coding text of *JSCMA* and *JAMA*.

Preliminary Codes for Analysis of Medical Articles:

Theme: Racism

- (a) race: mention (neither positive or negative in which an author or authors state the race of a midwife without censure or praise)
- (b) racist-md: comments made by physicians about ignorance of blacks in general
- (c) racist2-md: exclusionary racist phrases about who can and cannot practice medicine
- (d) racist3-md: derogatory comments made about physicians to discredit care by black women like “darkie” or “foolish negro woman” (no specific mention of granny midwifery for that is a different category/code) or derogatory comments made by physicians specifically about grannies

Theme: Sexism

- (a) sexist-md: sexist comments made by physicians about women’s bodies and why medical men should treat women
- (b) cultdom: comments regarding the weaknesses of women or other cult of domesticity ideology
- (c) sexistmw-md: sexist comments made by physicians regarding why midwives should not assist births such as an inherent incompetence and that medical men are innately more competent
- (d) pathwmb: comments made by physicians or other health practitioners concerning the pathological nature of the womb
- (e) pathpreg: pregnancy viewed as a pathological condition and that labor pain was unnecessary for women to endure
- (f) medbirth: push for hospital births/record keeping; notion that birth was an unnatural process requiring the presence of a physician or trained and licensed medical professional

Theme: Inter-Occupational Conflict

- (a) authknow: language used by and notions stated by physicians and other health professionals in which medical knowledge is based upon licensure and examination
- (b) interoccup: legislative language that outlaws midwifery care or lay midwifery care (There are instances in which doctors in medical society meetings discuss current medical legislation for their respective counties and some of these discussions involved changes to medical practice acts.)
- (c) interoccup2: comments by physicians indicating how midwives usurp their place in the medical hierarchy
- (d) interoccup3: mds are better at obstetrical care or call to teach obstetrics
- (e) critlay: criticism of lay obstetrical notions/superstitions
- (f) mwreg: doctors and other professionals advocating for regulation of midwives
- (g) critmw: comments made by physicians or other health practitioners that are criticisms of midwifery practice
- (h) mdarrog: doctors being arrogant about who can and cannot practice medicine (no mention of midwives)
- (i) profmed: professionalization of medicine commentary in regards to making physicians become licensed following certain stipulations.
- (j) classist: arguments that provide disparaging commentary about midwives not rising above a particular social station
- (k) mwprob: specific usage of the term midwife problem
- (l) mw: mention of a midwife (neither positive nor negative)
- (m) lay: general mention of lay practitioners (or laity)
- (n) infmort: mention of concern re: infant mortality in which midwives are considered as contributors to infant mortality or that they can help reduce infant mortality
- (o) illegal: concern with illegal practitioners of unregulated schools
- (p) matmort: mention of or concern with maternal mortality
- (q) critmd: criticism of obstetrical care administered by doctors

(r) mwy: some doctors used the term midwifery to describe ‘birthing work’ rather than criticizing midwifery as a practice.

Exploratory qualitative analysis assists qualitative researchers in noting particular patterns or themes within sets of data. In addition, this research process allows researchers to note when emergent themes or patterns occur. When I noted emerging themes in my texts for *JSCMA* and *JAMA*, I created more codes to encapsulate these newer themes. I initially began with these 28 codes and upon my analysis of the texts, the number of codes increased and I noted social conditions that impacted midwifery abrogation which I had not previously taken into account such as a heavy reliance on midwifery education as a means of regulating midwives (code: mwteach). Appendix 1 details the final version of codes used in my analyses reflected in Chapters IV and V. In the following chapters, I detail how my themes of racism, sexism, and inter-occupational conflict were reflected in my texts as seen in Tables 5, 6, and 7. Table 3 illustrates the number of related and unrelated articles I found per decade within *JSCMA* and *JAMA*.

More specifically, in Chapter IV, I examine how physicians’ professional writings used racist arguments to discredit blacks’ mental and sanitary abilities, criticisms of black women participating in birthing work, and how physicians viewed black people’s influence on the health status of America. Also, in this chapter I discuss how sexism was reflected in physicians’ writings about women in general and their wombs, women practicing medicine, and women’s participation in birthing work. In Chapter V, I discuss the theme inter-occupational conflict by detailing how physicians wrote about the presence and negative contributions of midwives in birthing work, and what arguments physicians made for the elimination of the granny midwife. In Chapter VI, I examine how medical practice acts and sanitary codes produced an exclusionary shift in midwifery regulation from 1900 to 1940 in South Carolina legislative statutes.

CHAPTER IV

RACISM AND SEXISM IN BIRTHING WORK

I argue that between 1900 and 1940 a growing acrimony towards midwifery care, as evidenced within physician sentiments in *JAMA* and *JSCMA*, assisted in the abrogation of granny midwives. To reiterate, early Census records counted 548 midwives in South Carolina in 1890; merely twenty years later, there were only 125 midwives (*U.S. Bureau of the Census*, 1890; *U.S. Bureau of the Census*, 1910). Unfortunately, numbers solely accounting for midwives in South Carolina were only available for these two years because comparable sources were not available.¹⁴ Table 2 details the number of midwives for the U.S. and South Carolina. Given that these statistics shifted over time, I examined *JAMA* and *JSCMA* for physicians' sentiments regarding midwives. As stated earlier in Chapter III, I analyzed texts extracted from sampled issues within *JAMA* and *JSCMA*. I used these texts to reveal if patterns (the presence or absence of themes preconceived and otherwise) existed in physicians' statements. In order to target chronological/historical patterns within this forty year time period, I analyzed the texts by placing my textual data in four decades: 1900-1910, 1911-1920, 1921-1930, and 1931-1940 for both medical journals. Later, I looked for chronological patterns in physicians' comments about midwives within the journals and differences in the absence or presence of themes between the journals for each of the four decades.

In this chapter, I discuss whether there was a progression of physician acrimony towards midwives as rooted in racist commentary and sexist commentary. In addition, I investigate how professional writings illustrate changing perceptions about granny midwives as evidenced within physicians' arguments about blacks, black healers, women, and midwives. I also discuss how

¹⁴ Census records during the time period of my study published counts of midwives sometimes included unlicensed nurses in their totals rather than providing a sole accounting of midwives.

sexism as a social problem in American society shaped beliefs about women in general, women in medicine, and how physicians viewed the female womb as a pathological entity. My discussion demonstrates how some decades contained a larger number of texts that reflected one or more themes than others.

Following my understanding of both hooks (1981) and Hill Collins (2000) that the racist-sexist conditioning of American society colors the experiences of black women, I expected that physicians' sentiments about black women would reflect racist and sexist attitudes. My analysis also investigated whether an interdependence between racism and sexism existed within midwifery criticism in physicians' professional writings. Finding such a result would point to the impact race and sex had on how physicians viewed grannies in birthing work. Before examining the intersection of racism and sexism in physicians' professional writings, I examined my texts from *JSCMA* and *JAMA* for how physicians viewed granny midwives.

Racism and the Medical Doctor

I expected physician sentiments to reveal more racist overtones towards black healers as the years progressed between 1900 and 1940 in *JSCMA* and *JAMA* based upon my review of midwifery literature and the social climate of this time period. However, as I examined the codes encapsulated within the racism theme in my texts, many comments tended to be demeaning opinions about blacks more generally rather than outright racist comments about granny midwives (see Table 5 for the frequency of racist themes in the two journals combined). More specifically, comments about blacks that held elements of ostracism and racial exclusion persisted throughout the decades of examination. Sometimes such statements came in the form of debasing comments about the continent of Africa and its inhabitants, vituperative comments about blacks providing healthcare, criticisms of spiritual beliefs held by blacks, and questioning the physical and mental abilities of blacks overall. Because grannies served as the main healthcare providers

for both blacks and whites in rural areas (typically those of the poorer classes) in southeastern states such as South Carolina and tended to be black women, I argue that examining physicians' views of blacks assists in understanding their advocacy for the elimination of black women (as grannies) from birthing work (Lee, 1996 uses a similar strategy in outlining why granny midwives suffered social persecution).

In examining both medical journals for racist sentiments about blacks in general, *JAMA* and *JSCMA* during 1900-1910 had one text apiece containing a racist overtone (see Table 5, code: racist). After 1910, only *JSCMA* began to publish a higher frequency of articles containing racist texts; in some instances, these articles indicated sexist leanings as well. Again, focusing on the code: racist, the period between 1911 and 1920 provided the highest incidence of racist commentary by physicians (n=3) (see Table 5, code: racist). (In fact, all of these texts occurred in *JSCMA*; see Table 6. There were no texts coded 'racist' during this decade in *JAMA*; see Table 7). Within this decade, medical professionals espoused opinions about blacks and offered criticisms of various aspects of black culture. For example, according to some white male physicians in *JSCMA*, Africa represented a barbaric land filled with savages who should be unable to develop treatment advancements.

Dr. Robert P. Harris in his work on Obstetrics says: 'We do not know, with certainty, when Caesarean Section was first resorted to. It was practiced among uncivilized nations, notably Uganda, in Central Africa. This fact was brought to light by Robert W. Felkin, F.R.S.E., of Scotland, who witnessed the performance of a gastrohysterotomy, in 1879, by a native operator, upon a young woman, which resulted favorably to her and her child. How old this operation is in Africa it is impossible to determine. It is remarkable that the African barbarian should be so far in advance of the Chinese and Japanese in operative obstetrics. It was practiced by the Greeks after the death of the mother, and Pliny mentions that Scipio Africanus and Mantius were born in this way. These children thus born were dedicated to Apollo, whence arose the practice of things sacred to that Diety, being taken under the special protection of the family of the Caesars (Lunney, 1915: 6).

Dr. Harris's comments are particularly salient because Central Africa was the origin of many South Carolina black midwives who participated in birthing work. Moreover, as Heywood (2002) and Lee (1996) stated, black granny midwives as well as their historical predecessors successfully delivered children without physician interference despite an implicit racist belief that 'barbarians' are incapable of administering sufficient obstetrical care. This section of text was coded for racist and racistmd since Dr. Harris castigates blacks and black healers.

The third decade of my data held three racist comments made by doctors about blacks; however, these comments were more specifically directed towards midwives (see codes: ifmtrace and racist). Consequently, I discuss such racist commentary about midwives in a later chapter in order to discuss the inter-relationships between the race and inter-occupational conflict themes. However, I noted continuing further into my examination of later decades of my data that physicians who discussed collaborating with midwives included racist commentary about blacks in their remarks. Dr. Dreher, in *JSCMA* in 1931 sought to assist midwives but advocated eugenics arguments as well. Noting instances in which doctors used eugenics arguments illustrates the negative racial climate that blacks endured and what arguments physicians espoused to foster this movement.

Some time ago, a lady, sent by the government, dropped into my office and asked for my cooperation in rounding up the old midwives and teaching them some of the elementary modern principles of hygiene and antiseptics. I heartily recommended her work, and promised every assistance. I told her, however, that she and the government were short on one feature. That while, teaching them how to bring young Hami-ites safely into the world, she should also post them on legitimate preventive measures, to keep a lot of them out (Dreher, 1931: 332).

Noticeably, Dr. Dreher echoed the sentiments expressed by his fellow medical colleagues such as Dr. Harris in previous decades as well as some of the opinions of the American medical establishment. Physicians largely perceived that midwives required medical tutelage in order to

provide quality service for their patients; moreover, some felt that midwives lacked an even “elementary” knowledge of hygiene and antiseptics. However, Dr. Dreher goes one step further by advocating that midwives should also teach contraceptive efforts to their “Hami-ite” patients. Hamite is a Biblical term used to describe the origin of blacks as an undesirable and ‘cursed’ race of people that lived in a licentious manner (see <http://www.umsl.edu/~cfh/abstracts/ham.html> for a further discussion of how blackness is perceived as sinful). In addition, innate sinful behavior was believed to plague members of this ethnic group. Not only does Dr. Dreher call members of the black race “the nigger” and “the great bugbear in the path of birth control,” but he also denigrates other non-white ethnic groups for contributing to the poor health record of America.

You have often heard the ‘nigger’ as the great bugbear in the path of birth control. That they breed like rabbits, and no desire for a change. That, with birth control on one side of the hedge, and the negro, on the other, spawning their millions, the Caucasian race will eventually be put out of business. I do not ‘shoo’ this spook light aside. It is more than a ghost. The Chinese and Jap menace on the Pacific Coast was met by exclusion and gentlemen agreements. It is far different with the negro. It is useless to deplore the misfortune of bringing him in as a slave, for pillage and gain. But for that, the problem would present no special difficulties for centuries to come. It cannot be met like that of the Chinese and Japs. They are here, not only in great and increasing numbers, but here to stay. All physicians in the South know that poor negro women, with 5 or more children, when a link snaps in the chain in maternity, frequently approach us for ‘breeding medicine’. But my experience is that the numbers of these ignorant and willing overbreeders are rapidly increasing. In my town, I noticed a decided tendency towards smaller families among the better and more educated classes (Dreher, 1931: 331).

Other than Dr. Dreher’s comments, the last two decades of my data did not reflect persisting racist statements by doctors about blacks in general. In fact, the third decade had only one instance reflecting this code while the fourth decade did not have any text reflecting the code racist.

In addition to castigating blacks for their medical ineptitude, doctors also felt that blacks' spiritual beliefs were hindrances to healthcare administered by licensed physicians. Historically, blacks on slave plantations in South Carolina viewed illness as the result of spiritual warfare and such beliefs persisted in some black communities beyond Emancipation. On plantations, whites questioned and denigrated blacks' spiritual customs. Racist disregard persisted among whites to the point that Western medical practitioners considered these spiritual beliefs to be a hindrance to medical treatment administered by licensed health professionals. When examining my texts from *JSCMA* and *JAMA*, I did not find evidence of such opinions during the first decade of my study's time period (see code: racistmd in Table 5). Professional writings by physicians after 1910 did occasionally reflect such opinions. As stated earlier, white slave masters possessed such beliefs about black laborers and healers so to discover that such perceptions were largely absent in the professional writings of white male doctors is particularly significant. Although there is minimal evidence of censure, there are some historical similarities. Much like white male doctors during slavery, white male doctors writing in *JSCMA* and *JAMA* argued that they should receive higher regard than black lay healers. Between 1911 and 1920, physicians and other licensed health professionals questioned black medicinal practices on the basis of being rooted in archaic and worthless religious drivel. While treating black patients, doctors believed the occult and its beliefs served as the origin of medical ignorance among blacks. For example, in *JSCMA* (code racistmd in Table 6),

The belief in witchcraft and the agency of occult forces has by no means died out. It is very common when a negro becomes ill in any unusual and to him inexplicable way to imagine himself tricked and even to be able to say who perpetrated the job. This state of mind of course sets up a vicious circle and the unhappy ducky is liable to fall a victim to his own imaginings (Furman, 1916: 114).

Notably, "the unhappy ducky" considers spiritual victimization as the cause of his maladies rather than seeing ill health as a physical problem. Considering that some physicians viewed blacks as

uninformed about medical illnesses, doctors directed similar criticisms towards lay healers such as grannies. Granny midwives suffered such criticism because they, as well as other black lay healers, grounded their practices in spiritual beliefs germane to blacks, particularly regarding their connection between their work and God. In addition, many grannies felt that nature and God were solely responsible for the birthing process rather than surgical intervention. As I discuss later, some physicians condemned midwives for allowing women to endure labor pains without analgesics or to push unnecessarily (prematurely) during the birth process.

In contrast, one physician admitted to the expertise of root doctors and other black lay healers within *JSCMA*. As Savitt (1978) indicated, whites as slave owners distrusted black medicine, yet relied upon black healers for diagnosing and treating the health problems of both the black and white populace. Here again is another instance in which despite a general distrust of black medicine, whites could view black medical practices as beneficial. During the second decade of my data did I discover one instance in *JSCMA* reflecting respect for black medical care (see code abraamd1 in Table 6).

Now as to the object of all this: In a previous editorial it was suggested that some paper or papers be prepared for the State Association which would treat of some of the medical superstitions of the laity-especially of the root doctors and the negroes. Undoubtedly many of these people have knowledge of some potent remedies for various complaints, and there is no reason why we regular medical men should not observe them and investigate the materials used. We do not know all there is to know about medicine by any means, and from these empirical practitioners we may learn something of great value to the world at large. Let us get after their secrets if they possess any worth having, and then we can do our own experimenting with their drugs (“Editorials: The State Association Meeting”, 1911: 90).

Interestingly, despite doctors noting that the healing remedies of root doctors and black lay healers may possess “something of great value”, physicians sought to usurp “their secrets”, “their drugs”, and use them for self-interested purposes (1911: 90). This instance of reliance is not uncommon because as Holmes (1992) reports, many white male doctors worked alongside granny

midwives to obtain obstetrical training during the early 20th century. This text was the only one within *JSCMA* that reflected the code abracmd. *JAMA*, on the other hand did not have any instances in which doctors expressed a respect for black lay healers. This absence may be due in part to the heavy reliance on root healers among blacks in the South. Additionally, *JAMA* was a national publication and largely published commentary from northeastern states.

I noted the aforementioned because it is important to detail when the absence of a theme occurs; in this case, it was racism. Moreover, though it was the only instance, it did stand in stark contrast to what I was finding in my analyses of the second decade of my data regarding the code racistmd. Continuing my analysis of the second decade of my study investigating the code racistmd, I found that socio-religious beliefs of blacks suffered censure by medical professionals, particularly if such beliefs impeded the delivery of “standard” medical care by attending physicians. Dr. Furman, a South Carolina physician, while reporting a case he attended in *JSCMA*, clearly stated his general opinion of blacks and also managed to tout the authority and influence of medical men on American law.

The room was jammed with men and women, some singing, some exhorting and one fat ‘revrunt’ was kneeling by a chair at the door praying and sweating fervently. I commanded silence but without avail. Then I got provoked and grabbed the fat preacher by the collar with both hands and yanked him loose from that chair and out of the door. This decided action produced instant calm and I announced that as a doctor I was supported by the strong arm of the law and that I would indict the last mother’s son of them if that room wasn’t cleared of men instantly. Then the door and windows of that shack belched buck niggers. One elderly mamma who seemed to be a special high priestess of the occasion opined that patient was permeated with some sort of Divine Essence though she didn’t express it in exactly those words, and that it would be obviously sacrilegious to throw such obstacles as low down common doctors medicine in the way of the salvation of a human soul (Furman, 1916: 115).

This quote is not only symbolic of the manner in which physicians viewed black folk medicine (including granny midwifery) but also reflects the understanding doctors possessed about their

access to and reliance upon law as it related to medical practice. Given this understanding, Dr. Furman used coercive language to implement his will for the room to be “cleared of men instantly” (1916: 115). Dr. Furman, like some other medical practitioners of this time period, observed folk healers or the “one elderly mamma who seemed to be a special high priestess of the occasion” with condescension (1916: 115). Dr. Furman also detailed that this “elderly mamma” noted that “common doctors medicine” was “low down” (1916: 115). As time passed, such censure was no longer as evident within *JSCMA* or *JAMA*. *JSCMA* had no text illustrating this theme in the third decade or fourth decade. In comparison for the last two decades, *JAMA* did not possess text in which physicians discussed the socio-religious beliefs of blacks and their relation to medicine. Rather, medical professionals’ primary concerns centered on reducing mortality rates nationally and some examined how race factored into such alarming rates.

Infant Mortality and the ‘Black Influence’

Rooks (1997), Mathews (1992) and other midwifery researchers argued that national concerns with infant and maternal mortality rates contributed to a reduction in the number of and an intense scrutiny of lay midwives. Rooks (1997), Weitz and Sullivan (1992), and Holmes (1992) found that black midwives experienced social persecution and were viewed as competition for doctors. Given these previous researchers’ findings, I expected that physician sentiments over time would reflect a concentrated racist overtone about grannies’ influence on maternal and infant mortality rates, more particularly from 1900 to 1930 since according to Weitz and Sullivan (1992), physicians no longer focused on lay midwifery after 1930 because the profession ceased to exist. Neither *JAMA* nor *JSCMA* published articles during the four decades discussing how the black midwife affected infant mortality rates in the United States. My texts revealed that physicians did express racist attitudes; however, most of these comments were not directed towards granny midwives. Rather, racist comments focused on how blacks in general affected

the picture of American health. More specifically, there were 40 texts addressing infant mortality in *JSCMA* and *JAMA* from 1900 to 1940 (see Table 5 for ifmt); some of these texts discussed the link between race and infant mortality.

Prior to the 1920s, only *JSCMA* included text (n=1) in which doctors spoke about the contribution of blacks to infant and maternal mortality rates (see code: ifmtrace in Table 5). *JAMA*, on the other hand, did not possess any such text during this time period. Rather than focusing on the link between the black populace and infant mortality rates, physicians, such as Dr. Holt of South Carolina, saw the actual state of infancy and confinement of new mothers as largely responsible for infant and maternal deaths during and after the birthing process. Dr. Holt writing in *JSCMA* argued that "...infancy itself [is]the period in which the organism has the feeblest resistance to adverse conditions. The younger and more delicate the infant, the greater the perils that surround it...The fundamental causes of infant mortality, as we may call them, are mainly the result of three conditions---poverty, ignorance and neglect" (1910: 684-5). In confinement, Dr. Holt argued that many new nursing mothers suffered from poor nutrition; consequently new infants also suffered from poor nutrition. Moreover, Dr. Holt stated "the inability to escape the consequences of bad surroundings, such [as] excessive heat in summer or cold in winter" also contributed to infant and maternal mortality rates (Holt, 1910: 685). And since grannies largely serviced rural areas, I expected significant mention of their impact on infant and maternal mortality rates in rural populations. Yet, Dr. Reed-Mendenhall in *JAMA* argued that the cause of infant and maternal mortality rates within rural populations was due to neglect, namely "neglect of the childbearing woman" ("University Extension Work for the Prevention of Infant Mortality", 1915: 79).

Beginning in 1921 and continuing into 1940, some physicians offered explanations for why blacks contributed to infant and maternal mortality rates (see code: ifmtrace in Table 5). I found four such texts in *JAMA* (n=1) and *JSCMA* (n=3) that focused on race and infant mortality

(out of 160 texts during this time period). Within *JSCMA*, “Dr. Price pointed out that the high infant mortality was largely due to negro deaths; that the negroes used very little milk; and that it was his opinion that the milk supply contributed little to the high infant mortality” (Smith, 1926: 74). Interestingly, Dr. Emge reported in *JAMA*, in his examination of mortality rates of blacks, that continuing into the 1930s, blacks continued to suffer from high maternal mortality rates in the South, particularly in comparison to whites and blacks in the North.

Let me say in passing that the Negro population of all states has a higher mortality rate than the white population. This, no doubt, explains the alarmingly high maternal mortality rates in certain Southern regions where the proportion of Negro births is highest. Negro births in the Southern states fall for the most part into rural districts and are accompanied by a far greater mortality than in the Northern states, where the colored population concentrates in towns and cities. The situation evidently will have to be remedied through some social scheme sponsored by constituted authority and made effective through medical cooperation. If the number of Negro physicians and public health nurses is not sufficient to cope with the problem, then some other way will have to be devised, preferably through a combination of public health forces and county medical societies (Emge, 1940: 821).

Dr. Emge not only demonstrated the link between high infant mortality rates and race, he also noted that infant deaths among the black populace were preventable. Furthermore, he proposed that if black doctors and nurses were not responsible for find ways “to cope with the problem,” then more public community health initiatives need to occur. Within *JAMA* in the fourth decade, a study detailing birth and infant mortality rates based on race stated, “The highest infant mortality rates after New Mexico were: Arizona, 103; South Carolina 86.1; Georgia 78.9; and North Carolina, 77.4. The report points out that the two Western states have large numbers of nomadic Mexicans and Indians and the Southern states have large Negro populations” (“Birth and Infant Mortality Rates Rose in 1934”, 1935: 290). This editorial piece does not wholeheartedly attach blame to blacks for high death rates among the American populace; however, the consistent theme of higher rates of infant mortality among the southern black

populace was present. While I was only able to find one instance of such opinions in *JAMA* over all four decades, *JSCMA* contained three instances. Overall, during the forty year period of my study, there were only five texts that reflected links between race and infant mortality (again see code ifmtrace) and one that explicitly linked maternal mortality to race in *JAMA* (see code: matmtrace in Table 7).

The low presence of texts labeling blacks as primary cause of high infant mortality rates demonstrated that physicians used other arguments in addressing high infant and maternal mortality rates. As Litoff (1990), Rooks (1997) and others found, physicians in the United States focused on reducing rates of infant mortality and maternal mortality through medical lobbying for better prenatal and postnatal care of mothers and their infants. Rather than laying the blame at the feet of the black race, doctors touted that maternal and infant deaths could be prevented in both country and urban districts. For example, in *JSCMA* during the second and third decade (code: ifmtrace in Table 6), doctors argued that though blacks contributed to high rates of infant mortality and maternal death rates, such morbid circumstances were preventable. A physician writing in *JSCMA* in the second decade stated,

I suppose every Physician in country practice encounters the same difficulties we do; if so, there are in S.C. several hundred preventable Maternal deaths every year and even more preventable deaths of Infants. These cases are usually Negroes tis true... (Klugh, 1917: 764).

Dr. Klugh, in the quest to reduce infant and maternal mortality, emphasized that maternal and infant deaths are preventable rather than permanent fixtures in American health. And, in relation to granny midwifery care, Dr. Klugh does not link midwifery care to the high number of maternal and infant deaths despite grannies practicing primarily in country/rural areas. However, he did attribute the high rates of infant and maternal mortality to blacks in South Carolina. Yet, his statements do not include a derision of the black race nor does he speak of inadequate healthcare practices among blacks. Such statements are in contrast to my earlier discussion of findings

regarding physicians' sentiments towards blacks as patients and within maternal and infant healthcare. The second decade of my study did not reveal any other texts with similar sentiments. In the fourth decade of my study and continuing my investigation of text coded ifmtrace, Dr. Smith in *JSCMA* provided a contrasting opinion about the relationship between blacks and high maternal and infant mortality rates. Most importantly, Dr. Smith noted other causes contributed to these "preventable deaths" rather than just the race of the individual.

It will probably be stated that our large negro population raises the mortality rate. This will not answer the question, because the negroes are a part of our population, and conditions which affect our population generally under which they are allowed to exist should be corrected if possible. A large percentage of the cause of deaths in infants is due to preventable diseases and preventable conditions. There are a number of conditions which affect infant mortality, notably among them being: housing conditions, pre-natal influences, food and milk supplies, etc., the correction or improvement of which will prevent disease (Smith, 1926: 74).

Similar opinions that explicitly argued against race as a contributing factor to infant mortality, such as Dr. Smith's, were not present within *JSCMA* or *JAMA* after the third decade of my study. Instead, the two texts (one in *JSCMA* and one in *JAMA*) during this time period coded ifmtrace largely attributed infant mortality rates in the U.S. to the black populace solely. Finding little evidence of this phenomenon is still significant in that it demonstrates that physicians' actions towards and opinions of midwives as discussed in midwifery research are not necessarily germane to South Carolina. In addition, such evidence demonstrates that physicians' acrimony towards midwives was not fully rooted in midwives' contributions to infant mortality in regards to their care. In fact, doctors did continue to suggest other causes for infant mortality and preventative efforts but turned to problems associated with birth registration by physicians and midwives. Later in Chapter V, I more fully discuss what physicians stated in this regard in relation to inter-occupational conflict within birthing work.

Broadly, members of the medical profession viewed physicians, nurses, and midwives as principally responsible for reported infant and maternal mortality rates because of lax birth registration procedures (Rooks, 1997 and Litoff, 1990). By lax, Rooks (1997) and Litoff (1990) stated that physicians and midwives oftentimes neglected to report infant births and deaths. I expected that in discussions of infant mortality that physicians might make comments about how black midwives did not provide an adequate accounting of births and deaths. My code ifmtmw encapsulates comments made by physicians attributing infant mortality rates to midwives; so, as a result, I looked within those texts coded ifmtmw for mention of comments directed towards **black midwives**. However, in my examination of *JSCMA*, I did not find an explicit mention of how black midwives did and did not report births during the forty year time period in any text coded ifmtmw. Instead, I found criticism of physicians' reportings of birth (see beginning in the third decade of my study (code: ifmtmd in Table 6) in addition to links of midwives contributions to infant mortality (see ifmtmw in Table 5). *JAMA* did include text in the second decade that I coded ifmtmd; however, this text did not address birth reportings. As printed in *JAMA*, "[t]he blame for the present large mortality and morbidity of childbirth cannot be laid solely at the door of the doctor or of the midwife; they are both involved, and no one who knows the facts could say that improvements in the teaching of both are urgently called for" ("Lowering Infant Mortality by Better Obstetric Teaching", 1920: 1783). In this instance, physicians understood that better obstetrical teaching was necessary for both practitioners of birthing work in order to lower infant mortality rates. In addition, midwives and doctors were held accountable for these rates.

Turning my attention to other documents coded ifmtmd, I found that Dr. Atmar Smith, a South Carolina physician, heavily criticized South Carolina birthing work practitioners in *JSCMA* for consistently high rates of infant and maternal mortality and named birth reporting as part of the problem.

He said, with a feeling of shame, that of all the states
in the United States, South Carolina is the blackest

spot in the nation so far as infant mortality goes. He said it was a deplorable fact that his home city, Charleston, had the highest infant mortality, not only of any city in the United States, but of any city in North America. Statistics show that South Carolina at the present time has the highest infant mortality of any state in the Union. The infant mortality for South Carolina in 1924 was 109 per 1,000 births. The same for the United States generally was 72. Infant mortality in South Carolina appears higher because of poor birth reporting as many physicians and midwives fail to report births, and as practically all deaths are reported, the percentage is higher than it would be if all births were reported... This may be true, but if the medical profession did report every birth, it would not correct entirely the high mortality, as for instance: Charleston, where births generally are reported (the U.S. Registration Area gives Charleston a record of over 90 per cent of reporting births, which is high), notwithstanding this, has the highest infant mortality of any city, town, or village, not only in South Carolina, but in the United States in cities of over 50,000 inhabitants (Smith, 1926: 73-4).

In order to more fully understand what physicians stated about infant mortality in South Carolina, I examined text for the code: ifmt and found 40 texts exhibiting this code. Within this investigation, I found that other physicians commented on the disheartening state of infant health in South Carolina during the second decade of my study. Dr. Simpson in the same decade in *JSCMA* stated,

Since no state is greater than its people, and since the infants of today are citizens of tomorrow, the South Carolina Pediatric Association thought it wise to present as its paper before this Society some facts and figures taken from absolutely authoritative sources regarding the shameful position occupied by our beloved South Carolina; namely that of having the highest infant mortality of any state in the whole United States (Simpson, 1928: 27).

Considering this “shameful position,” it is no wonder that physicians actively worked within public health organizations such as the South Carolina Pediatric Association to reduce infant mortality (1928: 27).

As printed in *JSCMA* in 1925, South Carolina experienced

a marked lowering of the infant mortality rate from 114.5 to 94.4 per thousand births and notwithstanding an increase of births. It may be a coincidence but it will be recalled that the secretary in his report to the House of Delegates at the Spartanburg meeting urged that the major part of the association for the ensuing year might well be the lowering of the infant and maternal mortality rate than the highest of any state in the union. The State Health Department, especially the bureau of child hygiene has done extraordinary work but this is a colossal undertaking which can only be accomplished by the unanimous support of every doctor in the state (“Infant Mortality Rate in South Carolina Falls At Last,” 1925: 231).

In comparison to other high national averages, South Carolina represented the bleaker side of infant mortality in the U.S.

From the United States Bureau of the Census for the year 1924 the comparative figures show that South Carolina’s infant mortality was 102 for every 1,000 registered live births. The next nearest state was Delaware with an infant mortality of 95. Maryland was the second nearest at 86, while Iowa had the lowest rate at 55. In a survey made in 1923 by the American Child Health Association covering 86 of the most important cities of all the states, we find that Charleston, S.C., the city chosen in South Carolina, had an infant mortality of 150; (Simpson, 1928: 28).

The South Carolina Medical Society is yet another organization that galvanized to assist in diminishing infant mortality in South Carolina. Dr. Simpson in *JSCMA*, stated

Some months ago, at a meeting of this Society, attention was called to the high percentage of infant mortality as pertaining to the City of Charleston. Feeling keenly the seriousness of this situation as affecting the prestige of this community, a very strong committee was appointed to investigate conditions that maintain here and report their findings (Smith, 1926: 73).

Dr. Smith advocated for necessary investigations of factors leading to infant mortality and that mortality rates speak to the “prestige of [a] community” (1926: 73). His arguments fall in alignment with Lantos (1994) who pointed out that physicians use mortality rates as indicators of

a population's health. Dr. Smith in another text spoke about a committee drawn up to investigate infant mortality in Charleston.

As a special order of business, the consideration of the Report of the Committee on Infant Mortality in Charleston was taken up. This report was made by the following committee appointed to investigate the high infant mortality in this city: Dr. G. McF. Mood, Chairman; Dr. J. M. Green, and Dr. M. W. Beach (Smith, 1926: 47).

Given these opinions, some physicians began offering explanations for infant mortality in South Carolina and these explanations were found in some of my text coded ifmt during the third decade of my study (*JSCMA*, n=18). Dr. Cathcart found that since “high infant mortality is an existing condition, not a theory, and will be lowered by the correction of conditions that cause preventable diseases. Poor reporting of births will not account for all” (Cathcart, 1926: 113). Physicians also cited a lack of sanitary knowledge among laymen and laywomen as partially responsible for infant mortality in South Carolina. Here again, I expected some racist mention of blacks' knowledge of healthcare but did not find any texts indicating this theme. For example, “Dr. Robert Wilson pointed out that the high infant mortality was a community problem and was a reflection on the sanitary intelligence of the people. He stressed the laymen's responsibility in matters of this kind” (Smith, 1926: 74). Physicians during the third decade of my study, understanding infant mortality as a pervasive health problem, spoke of the work of public health agencies and the enforcement of the Sheppard-Towner Act as potential means of reducing infant mortality (see code: stact in Table 6).¹⁵ In *JSCMA*, doctors noted,

[t]here is no phase of public health work receiving more attention at the present time than maternity and infant hygiene and the health of the child of pre-school and school age. The increasing emphasis upon this phase of health work has been largely due to the financial aid of the Federal Government under the provisions of the Shepard-Towner bill, in co-operation with the respective states. When it is known that the death rate among mothers in child birth has

¹⁵ Such texts were coded both ifmt and stact in order to account for the presence of text relating to both codes.

not decreased during recent years and that the mortality among infants less than one year of age is alarmingly high, it is logical that special emphasis be placed upon this important phase of health work (Leathers, 1923: 518).

And, by the end of the third decade, physicians writing in *JSCMA* continued to credit the Sheppard-Towner Act with reduced rates of infant mortality in South Carolina (again, see code: stact in Table 6).

One of the most satisfactory reports that we have is that of Infant mortality, which in 1928 showed 3721 deaths and in 1929 showed 3,184—a decrease of 537 deaths, or 14 per cent. We believe this decrease is largely due to the efforts made under the Sheppard-Towner Act for the protection of maternity and infancy, and that the work done for the past seven years in the Bureau of Child Hygiene, which was a campaign of education, is just commencing to show results (Haynes, 1930: 38).

Within Dr. Haynes' statements, there is no mention of a black influence on infant mortality. Rather, again, the Sheppard-Towner Act is touted as being largely responsible for changing maternal and infant health in South Carolina. In addition, education is another facet responsible for reducing mortality rates. In my examination of texts taken from *JAMA*, I found similar statements advocating for physician participation in reducing infant mortality. This participation ranged from improved reporting of infant births and deaths to being members of committees geared towards dealing with infant mortality as a public health problem rather than as an isolated health issue.

Examining texts linking infant mortality rates to either doctors or midwives (codes: ifmtmd, ifmtmw in Table 5, 6, and 7), *JAMA* in comparison to *JSCMA* possessed more texts highlighting the impact of physicians' and midwives' reporting on mortality rates during the second decade of this study in 4 out of 63 texts (6%) (see codes: ifmtmd and ifmtmw under health reform in Table 7). During the beginning of the second decade of my study, some physicians writing in *JAMA* voiced a need to look at birth registration as an indicator of disparate mortality rates among new mothers and infants. For example, Dr. George B. Young in a reprint of

conference notes about infant mortality in *JAMA* stated “[c]omplete and accurate registration of births is absolutely necessary before any real beginning can be made to study the causes and the means of preventing infant mortality” (“Municipal Measures Against Infant Mortality in Chicago”, 1911: 1786). Although I am primarily concerned with South Carolina, discussing how physicians in cities in other states examined mortality rates can show how infant and maternal concerns became a national concern in physicians’ professional writings. Moreover, this concern is salient because, as I have earlier indicated, South Carolina was the bane of the American healthcare system in the early 20th century, particularly in regards to infant and maternal healthcare. And, Weitz and Sullivan (1992) and Litoff (1990) found that advocates in northern cities, by voicing strong concerns about maternal and infant mortality, garnered federal attention. *JAMA* included discussions of cities such as Baltimore with alarming mortality rates drew national attention; consequently, the Federal Children’s Bureau made efforts to ascertain contributing factors to infant mortality rates. For example, during the second decade,

The federal Children’s Bureau has started an investigation to ascertain the cause of the death rate among infants in Baltimore. The mortality every year reaches about 2,000. Twelve agents who have had special training will undertake the investigation, and have obtained from the health department statistics concerning every baby born in Baltimore during 1915, each one of whom will be visited. Miss Emma Lundberg, child welfare expert of the federal bureau, is directing the investigation (“Infant Mortality Probe”, 1916: 662).

In 1915, when the American Association for the Study and Prevention of Infant Mortality met, the topics under discussion as factors when studying infant mortality in the U.S. were “[e]ugenics; effect of the economic standing of the family on infant mortality; infant welfare nursing in small cities, towns and rural districts; institutional mortality; midwifery conditions; and treatment and prevention of respiratory diseases” (“Prevention on Infant Mortality”, 1915: 811). So, rather than linking midwives to infant mortality rates, doctors were discussing how the

aforementioned factors contributed to infant deaths in *JAMA*. When examining later decades in *JAMA*, most of the articles discussing infant mortality spoke about society meetings rather than including physicians' statements about the state of infant mortality in the U.S.

Finding contradictory evidence within doctors' statements published in *JAMA* and *JSCMA* about the black influence on infant and maternal health is significant for two reasons. As time progressed, racist beliefs about the black populace contributing to infant and maternal mortality rates lessened. I expected this trend to persist rather than desist. In addition, physicians noted the relevance of birth reporting and also the fact that shoddy treatment by physicians in rural districts were other contributing factors to infant mortality ("University Extension Work for the Prevention of Infant Mortality", 1915: 79). Although physicians did not lay high infant mortality rates at the feet of midwives, as Hill Collins (2000) and hooks (1981) explained, whites placed the social positioning of black women as the "other;" this positioning was also the case for granny midwives in birthing work.

Blacks in Birthing Work

Black birth attendants such as granny midwives did suffer some physician criticism in the form of racist sentiments. During the first decade of my data I found one instance in 63 texts in which physicians within *JAMA* espoused negative opinions about blacks and included mention of granny midwives; this virtual silence is surprising, since black midwives comprised most of the midwife populace and tended to the larger black populace of South Carolina (see Table 7 code: racist which overlapped with the code critmw for the following example). Within *JAMA*,

Dr. Charles W. Kollock, Charleston, ...spoke of the large negro population in South Carolina, among whom eye diseases are rife and who are eminently careless in all health matters. He urged strict laws and education for these people. He quoted the number of births in Charleston from July 1 to Dec. 31, 1909, that of 213 whites 155 were attended by physicians and 58 by midwives. Out of 225 colored births 30 were attended by physicians and 195 by

midwives. He mentioned that those midwives were not only ignorant, conceited, dirty, but very superstitious, and that more stringent laws should govern them (“What Can be Done for the Prevention of Blindness”, 1910: 1816).

In essence, Dr. Kollock argued that, since blacks are “eminently careless in all health matters”, it seems to be no wonder that physicians labeled black midwives “ignorant, conceited, dirty, [and] very superstitious” (“What Can be Done for the Prevention of Blindness”, 1910: 1816).

Kollock’s comments mirrored the sentiments of other medical officials who felt that midwives contributed to blindness among infants. Some physicians used infant blindness as another platform to discredit granny midwives. Despite a lack of text within both *JSCMA* and *JAMA* clearly indicating a racist opinion of granny midwives, black healthcare practices did receive censure. As stated earlier, many of the racist comments about blacks were general statements reflected within the first twenty years of my data. However, a significant shift occurred regarding the thematic content of racist comments during the second half of my data. More specifically, comments by physicians and other health professionals about blacks participating in birthing work made mention of their distrust of blacks in medicine.

Not only were Africans and their descendants castigated for their ‘blackness’, but also for their pain management techniques in birthing work. I found that *JSCMA* during the third decade of my study held two texts coded racistmd in which doctors criticized blacks in birthing work (see Table 6). As mentioned in my earlier discussion of the code racistmd, sometimes racist comments expressed by physicians also discussed black participants in birthing work. Moreover, these texts are deserving of a different discussion separate from physicians’ racist commentary on blacks in medicine since my project is concerned with how medical doctors viewed granny midwives’ participation in birthing work.

Since the earliest mother gave birth to her first-born, has all woman-kind prayed for relief from the travail of labor. And since the first obstetrical attendant had his heart wrenched by the agonizing cries of pain at this his first case has there ever been a challenge to medicine to seek and find a painless method of parturition.

From the earliest times and amongst scattered peoples, progress was made---Progress never universally enjoyed and which was very slight. As illustrative of this, recall the crude obstetrical chair of certain African tribes, the squatting posture preferred by many of our own negro women, the initial dose of castor oil, which many women insist, makes labor quicker and easier. Other methods might be mentioned. To most women alleviation of pains of childbearing means either less severe agony or quicker progress of labor (Guess, 1925: 267-8).

Noticeably, Africans and ‘negroes’ used crude means during the birthing process including birthing apparatuses and medicines. Consequently, a responsibility is placed upon the **male** obstetrical attendant to rescue women from the ‘travails of labor’ rather than continue a reliance on archaic obstetrical practices.

On occasion, physicians writing in these journals discussed supervising midwives in conjunction with midwife education. And, within these discussions, black midwives were sometimes mentioned which I discuss in the following paragraph. Both *JSCMA* and *JAMA* contained texts that advocated for the supervision and training of midwives (see codes: mwsuper and mwteach in Tables 6 and 7 under the inter-occupational conflict theme codes). Yet, what did physicians specifically state about black midwives’ participation in birthing work; and, was their commentary racist? To reiterate, most of the midwives practicing in the southern states (almost 90 percent) were black women (Holmes, 1992; Logan, 1989). And investigating both medical journals for text coded mwsuper and mwteach, I noted instances in which physicians recommended forms of medical regulation for black midwives. For example, in an effort to circumvent midwives from practicing and using techniques and tools deemed archaic, physicians assigned licensed nurse Mary Ruth Dodd to teach and supervise black midwives in the Sea Islands of South Carolina as printed in *JSCMA*. What made physicians choose Ms. Dodd to instruct black lay midwives rather than physicians teaching grannies themselves? Ms. Dodd was a suitable instructor for two reasons. One, northern schools were the basis of her medical instruction; two, she also was a black woman.

As printed in *JSCMA*,

Classes for the training of midwives have already been under instruction, and especial attention is being given to the instruction of Negro midwives. One of these classes has been under tutelage in Beaufort county and the islands on the coast. The instructor is a trained nurse of marked ability, well trained in good hospitals in the North, and capable of vastly improving the midwifery situation for her race (“Better Obstetrics in South Carolina”, 1920: 4).

‘Especial attention’ for the instruction of granny midwives seems to imply that black midwives required more tutelage than their white counterparts in practicing quality midwifery. And, considering that whites during this time period held little regard for lay healers, it is no wonder that a licensed professional’s supervision was deemed necessary. In addition, considering that many whites during the time period of my study perceived blacks as a lesser race, one could surmise that whites teaching ‘lower races’ was beneath them. The aforementioned text was the only example in which there was a form of racist commentary as it related to the regulation of black midwives. Analyzing text extracted from *JAMA* for the codes *mwsuper* and *mwteach* did not yield racist commentary. As I discuss in Chapter V, physicians advocating for midwifery supervision and training did not single out black midwives but rather argued that midwives as a whole required supervision and proper tutelage.

Continuing my discussion of physicians’ commentary of midwives, in contrast to *JSCMA*, *JAMA* yielded texts highlighting the vitriol doctors directed towards immigrant and black midwives as participants in birthing work. In particular, towards the end of the first decade, *JAMA* contained one text pertaining to what was commonly known as the ‘midwife problem’ that **specifically** mentioned black midwives (see code: *mwprob* in Table 7); yet these texts did not contain a blatant racist opinion of black midwives but rather discrediting comments about midwives in general. To reiterate, midwives nationally in the U.S. were viewed as purveyors of infant and maternal deaths. During the second decade, state medical boards in *JAMA* examined the national impact of midwives on birth rates and found that informal midwife training was

inadequate. Again, although I am focused on South Carolina, *JAMA* also reported how physicians in other states like Louisiana viewed black midwives.

The State Board of Medical Examiners has recently made an extensive study of the midwifery problem. The report states that ‘midwives attended approximately 50 per cent. of the births in this country,’ nevertheless the investigations prove that ‘with few exceptions the midwife is dirty, ignorant and totally unfit to discharge the duties which she assumes.’

Reports show they are practicing in all states, mostly among immigrants and negro women. The board concludes that the first thing necessary is to insist on their being better trained, and a school for them has been opened in New Orleans (“Report on Midwifery”, 1916: 1786).

This “Report on Midwifery” details how physicians from other states wrote about the ‘dirty, ignorant and unfit’ midwife in medical journals and such sentiments are similar to those expressed in *JSCMA*. Granny midwives oftentimes served the black populace; yet, these women were deemed inadequate birth attendants. These examinations and their subsequent commentary in part may have affected the presence of grannies in birthing work.

Doctors versus Midwives: Who Delivers Black Babies?

Criticism directed towards midwives encouraged women (white and black) in South Carolina and other southeastern states to utilize the services of physicians. Continuing in my examination of the second decade of my data, I found that physicians castigated granny midwives by pointing out their ineptitude and ignorance in comparison to seasoned and educated white medical professionals. Examining text coded granny, I found that doctors writing in *JSCMA* argued, “[we] are sometimes entertained with several ‘Old Dippers’ of the community, who have come to see and encourage the patient; by telling of a similar case which they waited on, where the woman would have died, had she not put a pillow under her hips or given her pepper tea,

‘Conceited old grannies’ these are” (Smith, 1918: 128).¹⁶ Here, not only were grannies considered ‘conceited’ but the treatments used during the birthing process were maligned.

Of note is the fact that despite physician advocacy for midwifery training and overtly suggesting that pregnant women should have physician-assisted births, physicians treated black women less favorably than white women (see earlier discussion of Beardsley, 1987 in Chapter I). *JAMA* did not yield any texts showcasing differences in obstetrical treatment between black and white women by physicians as it related to conditions associated with infant and maternal mortality. However, out of 40 texts during the fourth decade of my data, *JSCMA* provided one illustration out of two texts coded race that discussed how health statistics for the black and white female populaces differed (see Table 6; code: race). Dr. Guess, a South Carolina physician, noted in his study of toxemia that white and black health statistics varied greatly due to treatment.

Deaths from toxemia of late pregnancy and those from septicemia, were one-half again as frequent in the colored women as in the white, while deaths from hemorrhage in the colored were three times those in whites. Does the relative morality from toxemia indicate better prenatal care for the whites? It should, but it does not, because of the total number of women who died, only five received what by any standard could be termed adequate prenatal care.

The probable explanation is that more white women received medical care after the toxemia had developed, and so more of them were saved from death, than was the case with colored women. Twenty of the 100 women who died of late toxemia were never treated by a physician, probably when the disease was far advanced. Thus the doctor did not have a chance in one-third of these cases, and likely in many of the other two-thirds he had little better chance, and doubtless these facts apply to colored women nearly twice as frequently as they do to white women (Guess, 1936: 142).

Dr. Guess, in an implicit sense, identified a lack of adequate prenatal care for black women. However, he neglected to mention why black women did not receive medical care after toxemia developed. If doctors were so interested in decreasing rates of maternal and infant mortality,

¹⁶ Old Dipper is another moniker given to granny midwives and physicians used the term when discussing grannies.

what prevented them from treating black women with potentially terminal conditions? An interesting picture developed. On the one hand, physicians and other health officials argued that blacks and whites should utilize physician services. Unfortunately, some black women who chose physicians as their medical practitioners suffered (Beardsley, 1987). Yet on the other hand, some physicians actually opted to not treat black patients. This discussion is relevant to this study because Barbara Katz Rothman (1993), Lee (1996) and Weitz and Sullivan (1992) noted that oftentimes white male physicians relegated the care of black patients to granny midwives. And, if physicians provided unwanted clientele to granny midwives, why were midwives criticized by white male physicians as inadequate birth attendants? In addition, many blacks, despite technological advances, continued to distrust white medicine and practitioners. This distrust is certainly understandable given the fact that many black women died as a result of inadequate medical care as administered by white male physicians (Beardsley, 1987). Therefore, how could black women receive necessary treatment since the medical profession maligned black healers and midwifery care as inadequate, arcane, and unequal to that of physicians? On the other hand, how could black women obtain medical treatment when many white male physicians turned away black female patients? These questions are deserving of further research.

Another compounding element to the presence (or absence) of blacks in birthing work between 1900 and 1940 was that restrictions from medical practice were not limited to granny midwives. In fact, racist separatism was appropriate foreground for the treatment of granny midwives by the largely white and male medical establishment. Examining both *JAMA* and *JSCMA* during the forty-year time period of my study, I expected to find that both journals published text indicating a racist bent towards black participants in medicine (code: racistmd) as reflected within printed medical society membership requirements. *JAMA* did not possess such text; however, I found within the *JSCMA*, during the third decade, an explicit example of how blacks were excluded from membership in the Medical Society of South Carolina. Although this

text was a singular instance, such text merits some discussion. Roper Hospital, a prominent hospital in Charleston, South Carolina accepted only white patients and only white physicians could practice within these hallowed halls provided they had been approved by the South Carolina Board of Censors. The South Carolina Medical Society resolved and published this ‘separatism’ in its by-laws in *JSCMA*.

“BE IT RESOLVED: That in the future the privileges of the Roper Hospital be granted only to members of the Medical Society of South Carolina and to such **other white members** of the medical and dental professions to whom the Board of Commissioners, with the approval of the Board of Censors, may grant the privileges. RESOLVED, further, **that any white member** of the medical and dental professions may apply to the Board of Censors of the Medical Society of South Carolina for the privileges of the Roper Hospital and if approved, shall be granted the privileges of the hospital by the Board of Commissioners of the Roper Hospital” (“Society Reports”, 1929: 472; *emphasis mine*).

As I outlined earlier in Chapter II, granny midwives were practitioners in the medical profession along with other lay healers. More importantly, physicians as members of Boards of Health and County Society members used their voices to limit who could and could not practice medicine. Since doctors stated that blacks were careless, restricted from professional medical groups, and prohibited from practicing within white establishments, granny midwives suffered the brunt of racist criticism because of their blackness as well as their practices.

Of the 375 texts for the time period of 1900-1940 from both *JSCMA* and *JAMA*, only two texts (less than 1%), both within *JSCMA* (and none from *JAMA*), specifically addressed granny midwifery (see code: granny in Tables 5, 6, and 7). In addition, both of these documents are within the second decade of my study despite my expectation of a more defined trend of articles with specific commentary about granny midwifery care. Criticisms of the treatments midwives used are discussed later in Chapter V because such arguments were essential facets of arguments physicians posed for the removal of granny midwives from birthing work and such arguments

demonstrate an intersection between racist and sexist biases. Moreover, treatments exercised by midwives fostered an oppositional ground on which physicians as well as other licensed health professionals felt a need to claim ownership. Sexism was merely one of several measures to ensure their position in the medical hierarchy.

Sexism and the Medical Doctor

According to many physicians as well as some American ideologies during the early 20th century, a woman's sex predetermined many aspects of her life such as her academic ability and occupational choices. Furthermore, social expectations based upon a woman's class assisted in the furtherance of sexual boundaries for women. Consequently, unequal social and economic power structures developed (Schur, 1983) and were reflected in the occupational and domestic spheres for women, including within the area of birthing expertise. Using the codes encapsulated within my sexist theme, I examined my data from 1900 to 1940 in order to find any evidence of sexist biases among doctors towards granny midwife participation in birthing work (as expressed in professional writings). Such biases would illustrate how women (specifically black women) who chose to occupy the medical occupation experienced condemnation. To my surprise, I found relatively few instances in which criticisms of midwives were overtly rooted in sexism. Instead, physicians who engaged in sexist commentary in medical journals tended to focus on the womb, on the necessity of male participation in birthing work, and to argue that the domestic sphere should encompass all of women's lives.

In essence, the womb served as the center of sexist commentary. To reiterate, physicians labeled the pregnant womb as a pathogenic entity (code: pathwmb) that necessitated medical governance during birth, a stance that supported physicians' move towards the medicalization of birth (see codes: sexist, sexmd, and mdbirth in Tables 5, 6, and 7). Over time and due to successful argumentation, other licensed medical professionals (such as nurses) and society

embraced the pathogenic womb perspective as well (Schur, 1983; Lay, 2000). Prior to the 1900s, some physicians laid groundwork for the fostering of this sexist regard of the womb. For example, Dr. Moultrie, a highly venerated physician, cultivated the understanding that doctors were necessary birth attendants and helped pave the way for male occupancy and domination in birthing work in South Carolina. Dr. Hines, in *JSCMA* during the first decade of my study (see code: sexmd and in this instance overlapped with code: mdbirth), demonstrates his appreciation of Dr. Moultrie's efforts.

Moultrie was born and educated in England and settled in Charleston in the year 1733, where he practiced for 50 years. He soon became very popular and was one of the first to break through the prejudice against men attending women in labor...The year after his death was distinguished by the death of several women in childbirth. While he lived they felt themselves secure of the best assistance in the power of man and of art in case of extremity (Hines, 1907: 131).

Explicit and implicit within this paragraph are varying degrees of sexist commentary. On the one hand, Dr. Moultrie is lauded as helping men to overcome sexist prejudice against their participation in birthing work. To reiterate, historically, men were prohibited from birthing rooms. Some of the reasons behind their exclusion were spiritual while some women viewed birth as a time for women to bond together to assist the new mother in delivering her child and that a male presence would be interference (Ehrenreich and English, 1973; Hoch-Smith and Spring, 1978). However, Dr. Moultrie, on behalf of male physicians, re-directed this sexist exclusion by advocating that the "best assistance" can only come "in the power of man" during the birthing process (1907: 131). As a result, he laid the groundwork for the premise that males were necessary occupants of birthing rooms in extreme situations. Implicitly, without a qualified male birthing attendant, new mothers would feel insecure about the birthing process. What is most interesting is that within Dr. Hines' praise of Dr. Moultrie, the reader does not have the opportunity to know if those women who perished during childbirth after Dr. Moultrie's demise

were the victims of a lack of a male attendant or if other causes were at fault such as pre-existing conditions. *JSCMA* held one other text that reflected physicians' sexist regard in the first decade.

Physicians, particularly prominent obstetricians such as Joseph DeLee, who wrote during the first decade of my study, regarded the womb as a pathological entity and that consequently, pregnancy was a pathological condition requiring the supervision of a physician. Such sentiments were coded as pathwmb (see Table 5). Dr. Manton, in *JAMA*, printed DeLee's sentiments.

Pregnancy, being, according to the books, a physiologic process through which most women pass without untoward event, the practitioner in the past has presumed too much on 'Nature's' ability to take care of the gravida, and has therefore shirked responsibility. But the effect of the growing ovum on the maternal organism differs in different individuals, and it is wrong to assume that a process which may be normal in one is necessarily normal in all. As a matter of fact, of which we are all cognizant, the border-line between health and disease in pregnancy is often a shadowy one, and unless the patient's health is closely supervised during the whole period of uterogestation serious complications may arise, which, in their culmination, may prove of gravest import to the mother, child, or both, with resulting discomfiture, mortification and regret to the physician. It is an old adage, but true, that 'he who cures a disease may be the skillfullest, but he who prevents it is the safest physician' (Manton, 1910: 461).

JSCMA, during the first decade of my data, held three out of 30 texts (10%) containing physician commentary on pathogenesis of pregnancy (see Table 6, code: pathpreg). *JAMA* contained two out of 63 texts (3%) indicating physicians viewing pregnancy as a pathogenic occurrence (see Table 7, code: pathpreg). During the second decade, I found one out of 59 texts (less than 2%) reflecting pregnancy as pathogenic in *JSCMA*. *JAMA*, on the other hand, had 2 out of 63 texts (3%) illustrating pregnancy as pathogenic. The third decade shows a more defined increase in *JSCMA* because there were 12 out of 70 texts (17%) reflecting this sentiment. *JAMA*, by contrast, contained no texts echoing this sentiment. Within the fourth decade, *JAMA* does contain four out of 41 texts (almost 10%) in which physicians state that pregnancy is pathogenic whereas *JSCMA* has two out of 40 texts showing this belief. Some doctors even went so far as to

advise that some diseases of pregnancy could be avoided by either avoiding or terminating pregnancy.

Dr. Wilson in *JSCMA*, during the fourth decade of my data, illustrates this point by discussing eclampsia.

Regardless of theories, one fact is certain. Eclampsia is a disease of pregnancy, and limited to pregnant women. Its cause is pregnancy, whether it be the result of a disturbance of metabolism, an endocrine imbalance, a toxemia resulting from absorption of fetal products, or one resulting from disordered liver function. It ultimately goes back to the state of pregnancy. Its ultimate prophylaxis would be the avoidance of pregnancy, its more immediate prophylaxis the termination of pregnancy (Wilson, 1940: 86).

Some physicians writing in *JAMA* in this same time period were even more direct in their condemnation of the womb in its pregnant state as a pathogenic entity. “Zeigler and Austin consider the vagina of a woman in labor as potentially infected in that it may contain pathogenic bacteria. According to them the so-called normally sterile vagina in the adult female does not exist” (“Vaginal Antisepsis and Puerperal Morbidity”, 1940: 808). In essence, once females become adult, their vaginas are no longer sterile and pregnancy exacerbates the possible level of pathogenesis. In essence, pregnancy, according to some physicians, became an abnormal phase of a woman’s life.

Investigating text extracted from *JAMA* revealed two out of 63 texts in the first decade and only one out of 41 texts in the last decade in which physicians explicitly did not attach pathology to pregnancy (see code abptprg in Table 7). One of these texts from the first decade in particular focused on defining childbirth. It stated, “childbirth is a physiologic act which occurs in the regular course of Nature, and neither signifies nor entails disease or ailment in the usual and ordinary use of those terms” (“Pregnancy, Childbirth, Sound Health, and Insurance”, 1910: 1669). Yet, some physicians rather than only stating that pregnancy was not pathological, some also intimated that it was a natural occurrence.

JAMA provided two out of 41 texts (almost 5%) of doctors understanding that pregnancy was a normal, rather than abnormal, occurrence in the last decade. (Previously, there were two texts in the first decade in which doctors stated that pregnancy was a natural event).

Subsequently, I coded the following text abngpg (see Table 7).

As a result of certain tendencies manifested in some leading maternity hospitals, apparently a comparatively small group of superobstetricians are being educated who cannot help being permeated with the idea that pregnancy is an abnormal process and must be treated as such. Rather a knowledge of the subject should be inculcated into the minds of the student and intern body which will make them realize their proper function as guides and supervisors rather than as operators (Kosmak, 1936: 1437).

Dr. Kosmak's comments challenged a wide-spread belief among obstetricians and other licensed health professionals that doctors are largely responsible for bringing children into the world. Instead, Kosmak argues that physicians are "guides and supervisors" (1936: 1437). Kosmak continues his arguments by stating, "One must remember that pregnancy is not a disease, that it usually pursues a fairly normal course, that occasionally it develops pathogenic aspects, that accidents in labor are comparatively rare, that adequate antepartum care will avoid such subsequent trouble" (Kosmak, 1936: 1438). So, pregnancy in Kosmak's opinion is not necessarily a pathological process and "adequate antepartum care" assists in preventing obstetrical complications. Because Kosmak's statements reflected pregnancy as a natural occurrence and that it is not pathological, I coded this text as both abngpg and abtpgrg.

JSCMA did not present any text detailing physicians not pathologizing pregnancy (code: abtpgrg) until the last decade of my data. In this one instance, Dr. McCord sought to disabuse obstetricians of the idea that pregnancy was a biological condition desirous of treatment.

At the fear of being considered rather irregular, I might say that it is my personal belief that what obstetrics in America needs more today is a little more patience, a little more faith in a kind Providence and a little more trust in the individual woman. I do not know why the idea has become so wide

spread that, regardless of what ails a woman, if she happens to be pregnant we should treat the pregnancy; do something about the pregnancy. I know of practically no disease that a woman may have, plus a pregnancy, that she is not better off if you treat the disease and absolutely ignore the pregnancy (McCord, 1934: 159).

Dr. McCord's statements, like Dr. Kosmak's, were contradictory to the comments of other physicians writing in *JSCMA* considering the pathology of pregnancy was an argument used to convince women to use licensed physicians rather than midwives.

The Womb as the Realm of Mental Instability

Schur (1984) argues that sexist arguments espoused by men outlaid that the womb is the center of mental illness. Such comments, particularly about the nature of a woman's womb and its relation to mental (in)stability, occurred solely during 1931-1940 than in the previous decades (code: sxment in Table 5, n=2). So, how did physicians view the womb prior to 1931? During this time period, physicians voiced their opinions about the womb and pregnancy as pathological (pathwmb, n=7; pathpreg, n=26) and laced their commentary with tenets of the cult of domesticity (code: cultdom; n= 10). In particular, some physicians espoused commonly held ideas about the inadequacy of the female form in addition to what occupational spheres women could occupy. Outlining how physicians followed the similar sentiments of greater American society regarding the roles of women, I argue, demonstrates how granny midwives operated outside of their correct sphere. And, such an examination provides an understanding of how and why women that worked outside of the appropriate sphere received social sanctions by males. Before detailing solely arguments physicians used in conjunction with the tenets of the cult of domesticity, it is important that this discussion illuminate the inter-relationships that existed among these codes. *JSCMA* and *JAMA* encompassed some texts which demonstrated inter-relationships between these codes (pathpreg, pathwmb, and cultdom) during the forty year time period of my study. For example, out of 122 texts, four texts (3%) within the second decade

demonstrated that doctors reiterated concerns about the civilized woman's ability to endure the pathogenic process of pregnancy (codes: cultdom and pathpreg).

Dr. Edgar in *JSCMA* argued that class impacted women's ability to handle childbirth.

Many, possibly the majority, of the upper, highly civilized class of women are physically and mentally unfit to suffer an approach to spontaneous labor, by reason of their low resistance to the shock of labor. Hence these women have pathologic labors---are themselves neuropathic.

Unless guarded from too much suffering by analgesia and anesthesia, or perhaps surgical means, women of this class experience a profound physical and psychic shock in their first confinements from which some never fully recover, or they readily succumb to some intercurrent condition, as proved by numerous mental and physical wrecks dating from the birth of the first child.

Shock from pain of labor in the highly civilized neurotic woman must, moreover, be reckoned with in general childbed mortality. Painless labor in these cases is a life-saving measure. Shock produced by the first stage of labor in these patients is a fact, not a theory (Edgar, 1916: 739).

Women possessing a higher socioeconomic status were automatically classified as unable to endure the pain of childbirth and as having innate mental debilities; consequently their labors became pathological unless aided by painkillers or anesthesia. So, beyond further advocating for the necessity of surgical hands and supervision, physicians argued that women were incapable of handling childbirth without succumbing to an "intercurrent condition" and the womb was directly linked to mental problems. In contrast, I located one article in which a physician argued **against** pelvic pathology as the cause for mental illnesses. Dr. Gibson in *JAMA* wrote that "[t]he pelvic pathology is not the cause of the psychosis but may act as the exciting cause of an attack in a woman of neuropathic stock" ("Pelvic Disease and Manic Depressive Insanity", 1916: 1113).

Continuing my examination of text coded as sxment and investigating if such text reflected an inter-relationship with the codes pathwmb and/or pathpreg, I found that Dr. Boling writing in *JSCMA* in the third decade contended that sometimes more precautionary measures

should be taken in regards to dealing with the womb, even in the case of hysterical women. “But let me caution you against the hysterical woman. These women have a lot of pelvic symptoms, but if there is no pathology in the pelvis when you open it, close it and leave it alone, because any operative procedure will make it worse instead of better. Surgery has nothing to offer unless there is some definite pathology to account for the symptoms” (Boling, 1923: 568). Dr. Boling’s statement represents one example of a distinct departure from the previous treatment perspectives doctors employed at the beginning of the 20th century. Dr. Boling pushed for a less invasive approach in regards to treating what may appear to be womb pathology (code: pathwmb). Physicians largely argued that the womb required surgical treatment for most gynecological and obstetrical procedures (Schur, 1983; Rooks, 1997). However, Dr. Boling does not veer too far off the course of patriarchal supervision of the womb. He still advocated that insanity is indirectly tied to womb problems. And, unfortunately, he still called for surgical procedures as long as the presence of a pathogenic element could be located within the womb. His statements reflect an intersection between the codes pathwmb and sxment.

The fourth decade of my data also reflected some physician sentiments about the connection between pathology of the womb (particularly in a pregnant state) and mental illness. Such sentiments are important because they illustrate an intersection between a belief that pregnancy is a pathological state which lends itself to women experiencing different forms of mental illness (codes: pathpreg and sxment). In an examination as to why women experienced miscarriages due to dysmenorrhea, some physicians in *JAMA* addressed the mind as a cause. “The onset of dysmenorrheal [sic] after a few years of painless menstrual periods may have its origin chiefly in the psyche or in an adenomyosis of the uterus...The mental reaction of the patient may be determined after a number of conversations” (“Multiple Miscarriages”, 1935: 339). My other text reflecting such attitudes also came from *JAMA* in the fourth decade of my

study. Doctors asked for a deeper examination of how the psychoses affect pregnancy while studying the impact delirium had on reproduction.

Contrary to other reports, only 3.6 per cent of the cases were classified as deliriums directly attributed to the toxic-exhaustive factors of reproduction, although such factors were frequently precipitating causes in the development of rather typical manic-depressive reactions, particularly of the depressive type. Probably this difference in diagnosis may be attributed to the increasing recent tendency away from the belief that a specific psychosis occurs in the pregnant and postpartum states and toward the conception that the physical and psychic problems of childbirth do not determine the type of psychosis but merely act as exciting or precipitating agents (“Psychoses in Pregnancy and Childbirth”, 1940: 1226).

In this editorial, this unnamed physician did not discredit the belief that the womb served as the center of mental illness; rather, he argued that childbirth is not only a physical problem but a “psychic problem” as well. Here again is another reference to the state of pregnancy and childbirth as a problem rather than a natural occurrence. And, this argument is extended towards proposing that childbirth also is tied to some form of psychosis as well. As I stated earlier, instead of sexist commentary addressing the presence of granny midwives in birthing work, physicians used such commentary when they wrote about the womb and its consequent maladies including mental illness and pathology. This discussion of physicians’ professional writings supplements literature on the medicalization of birth and how pregnancy began to be viewed as a pathological condition (see Ehrenreich and English, 1973; Wertz and Wertz, 1977, Rooks, 1997; Litoff, 1990; Schur, 1983).

As I have previously addressed, at the end of the 19th century and continuing into the 20th century, doctors considered the womb a contentious creature and the origin of female neuroses and psychoses. Physicians wrote that such conditions required the supervision of a male attendant for gynecological and obstetrical treatment (see Ehrenreich and English, 1973; Lee, 1996; Fox and Worts, 1999). Such beliefs metamorphosed into labeling pregnancy as a potentially pathogenic or naturally pathogenic state as well. Consequently, I examined texts

within both *JSCMA* and *JAMA* to see if physicians' writings echoed beliefs that the womb and pregnancy are pathogenic. I found that within the first decade of *JAMA* and *JSCMA*, text that had a co-occurrence of the codes pathwmb and pathpreg only occurred once. In particular, DeBovis' writings argue that the womb becomes pathological as a result of a "woman moving about" during the birthing process (Mayer, 1907: 541-2). The second, third, and fourth decades of my data did not reveal the co-occurrence of these sentiments by physicians.

"Woman's Place is in the Home"

As Giddings (1994) states, American women (both black and white) in the early 20th century were subjected to the tenets of the cult of domesticity. With this understanding, I analyzed my text from both journals in order to address and illustrate how physicians' statements reflected the cult of domesticity ideology. Moreover, I wanted to know if physicians' sentiments were related to women's participation in birthing work. Examining data from both journals, some texts illustrated physicians' belief that women's bodies are fragile. During the first decade, Dr. Clarke writing in *JAMA* stated, "[p]rolonged mental strain, to which young females are habituated in our public schools and higher educational institutions, tends to render functionless the genitalia..." (Clarke, 1900: 469). However, not until the second decade did I find the sole instance in which physicians linked the assumed fragile nature of the female form to a woman's ability to practice medicine (see codes: sexmd and cultdom in Table 7). Dr. Brunson in *JSCMA* argued, "[w]e do think that in many particulars the profession is not suited to females, because of their inability to stand the physical strain of the practice—the long rides over the country, irregular hours, night work, etc. We do not think them well suited to stand these. However, if they want to make the attempt, let them do so. It is a matter that will regulate itself" (Brunson, 1911: 442). Physicians' advocacy for such strategic placement was multi-faceted. Firstly, physicians wanted to secure their positions within birthing work. In the next chapter (Chapter V),

I will further explicate how this perspective fostered inter-occupational conflict within birthing work and its relation to the abrogation of granny midwives. Secondly, a woman's place was at home or in what Paula Giddings (1994) identified as the domestic sphere.

Physicians, on occasion, in seeking to further establish their expertise voiced their opinions about women's roles such as viewing women's place as guardians of the home. Doctors writing in *JAMA* during the first decade felt that "[y]oung married women [who] wish no offspring, and finding themselves mothers, they shirk the vitally important duty of committing themselves to the highest interest of the child (McAlister, 1900: 210). In other words, women should understand their importance and necessity in the rearing of children rather than "seeking to return to her former employment in the office, storeroom or mill, or her wish to place the immediate care of the child into the hands of a skilled nurse" (McAlister, 1900: 210). Other text during this decade focused on how young women attending educational institutions were victims of "[p]rolonged mental strain" which consequently "tends to render functionless the genitalia" (Clarke, 1900: 469).

During the second decade, out of 122 texts overall, there were four instances (3%) and during the third decade, there were two instances out of 79 texts overall (almost 3%) in which doctors commented on the proper realm of women (see code: cultdom in Table 5). Some statements reflected physicians' advocacy for women to not work at all or limit their activities to "sacred duties of wifhood"(Brunson, 1911: 439). Dr. Brunson, for example, while discussing what jobs women should occupy, offered compelling arguments that women should not remove themselves from their domestic responsibilities despite choosing to work in the occupational sphere. "Now, in reasoning thus we do not mean to imply that woman should forsake the domestic sphere for which she is preeminently fitted and over which she has long presided, not at all. The sacred duties and responsibilities of wifhood and maternity cannot be neglected by

woman without irreparable loss to mankind. The home is the cradle of the nation. Its influence is formative and directive” (Brunson, 1911: 439). Dr. Brunson continued by arguing that,

...A true womanly woman who, with unselfish soul and lofty purpose, so controls and directs the affairs of a home as to create an atmosphere of wise contentment and peace, and so moulds [author spelling] the plastic souls of nascent youths as to guide their expanding minds into channels of pure and worthy thought, is doing a work that is second to none in this world. And from this noble work which is fundamental to all others, nobody in his right mind would for a moment attempt to dissuade woman. In this she occupies a sphere that is peculiarly her own, a sphere which no other can fill. Here she has wrought her greatest work and has proved herself to be a tremendously potent factor in the development of the human race (Brunson, 1911: 439).

When the opportunity arose, doctors sometimes disparaged women for attempting to part from their sphere and linked gynecological and obstetrical ills to female disobedience. Dr. Moore’s comments in the 1920s in *JSCMA* reflected such ideas.

A woman who is pregnant can have any disease any other woman can have, plus the complication of pregnancy. Secondly, there is a type of pathology which is peculiar to pregnant women. You have all varieties of problems to meet when you are practicing prenatal care or practicing obstetrics. There is an economic problem, the problem of the working mother. That touches every other problem. Women are touching every business, every industry, every profession. The minute they enter work they entangle the relationship of mother with that job. So we have a big economic problem and a big social problem in prenatal care (Moore, 1928: 229-230).

Although I did not find any instances in which doctors felt women working outside of the home served as probable explanation for womb illnesses in the last decade of my study, Dr. Moore’s sentiments fell into alignment with male proponents of the cult of domesticity. In addition, women who opted to work outside of the home contributed to a “big social problem” (1928: 230).

Race and Woman's Role

Paula Giddings (1994) adroitly distinguishes between the social lives of black and white women and pointedly remarks on the fact that black women, because of their status, could not possibly meet the expectations of the cult of domesticity. Due to her arguments, I expected some professional commentary by physicians, particularly within medical cases in which they attended black women, to speak on how the physical constitutions of black women allowed them to deal more tolerably with labor pains as well as other more toiling work inside and outside of the home in comparison to white women. But, like their white female counterparts, these difficult labor pains necessitated the presence of a male physician (see discussion of medicalization of birth in Chapter II and my analysis of the code: mdbirth). In addition, I expected to find instances that demonstrated the intersection between race and sex as it related to women's social responsibilities inside and outside the home. Contrary to my expectations, however, my texts did not include any physician commentary about the physical constitutions of black women in comparison to white women during labor; nor did physicians comment on how black women should adhere to the tenets of the cult of domesticity.

A Male Medical Expert is Necessary in the Birthing Room

Physicians arguing for supervision of the womb encapsulated their arguments within sexist ideas about the womb and a women's capabilities prior to and after the birthing process. Such arguments served as pillars for the medicalization of birth (see Chapter II for reference to medicalization of birth). The first decade of my data held two of 63 texts from *JAMA* (3%) in which doctors related why pregnant women needed male assistance (see code: mdbirth in Table 7). Dr. Halberstadt, in *JAMA*, argued that the usage of pain medication meant that labor pains were an unnecessary facet of the birthing process.

Where is the man who as physician or surgeon in his legitimate province could stand coldly by and see with indifference the

writhing of a human being in broken or continued pain without offering to him an anodyne or anesthetic? Yet that same man exhibits stolid and heartless indifference when he becomes an accoucheur and has in his sole charge a helpless woman in the agonizing throes of labor, earnestly beseeching him to save her of her anguish or give to her immediate relief in death (Halberstadt, 1901: 1170).

Dr. Shelly, in a similar sense, argued that physicians are fully responsible for the care of new mothers and that not doing so is a lack of professionalism.

Dr. E. T. Shelly, Atchison, Kas., said that the physician owes it to the expectant mother and to himself to give her the best professional attention he is capable of bestowing. As a necessary part of such attention he should, during the pregnancy, give her such guidance as her condition calls for, and to furnish it in a permanent and accessible form. The author spoke of the desirability of supplying the prospective mother gratuitously with an easily understood original pamphlet issued by the physician himself, and giving her such information as in his opinion she ought to have in order to pass through her ordeal as comfortably and safely as possible. He outlined such a pamphlet (Summers, 1906: 1056).

Continuing my examination of *JSCMA* and *JAMA*, I found in the second decade of my data contained approximately 9% or eleven out of 122 texts within *JSCMA* (n=3) and *JAMA* (n=8) in which medical doctors opined that new mothers were incapable of administering proper care of their infants (see code: mdbirth in Tables 6 and 7). Again, physicians, as printed in *JAMA*, worked to create an interdependent relationship between themselves and their female clientele. Apparently, female physiology and her progeny required the necessity of male interference.

No mammal mother is so completely incapacitated for carrying out the duties necessary to protect and nourish her young during the first few days after parturition as is civilized woman. On the first day after birth, the mother is usually absolutely dependent on the ministrations of others. The infant shares this dependence. Even the natural food supply of the parturient mother is extraordinarily small, for the total fuel value of the colostrums is insufficient during the first few days, even under the most favorable circumstances. These statements by careful students of the physiology of the new-born infant, expressing facts long appreciated by pediatricians, serve to raise a number of questions of practical as well as of theoretical importance.

(“The Nutrition of the New-Born Infant”, 1916: 1466).

Physicians also felt that new mothers required medical advice after delivery; again, physicians arguing for medical involvement relayed that assisting mothers with medical advice was a responsibility of the medical profession. Within *JSCMA*, physicians stated, “It is hardly to be supposed that any woman will refuse to nurse her baby from purely selfish considerations, once she is informed of the enormous advantages that it confers upon her child. It is obviously the duty of the medical profession to further this by every means at their command” (Brunson, 1911: 118).

Some doctors in *JSCMA* even claimed that medical supervision by obstetricians aided in the reduction of pregnancy complications such as eclampsia.

Complications of childbirth, according to Dr. Grace L. Meigs of the children’s bureau, caused in the United States, in 1913, more deaths among women from 15 to 44 years of age than any disease except tuberculosis. At least 15,000 women die each year from such complications, and during the last ten or fifteen years no substantial decrease can be found in the death rate from childbirth. According to Dr. Meigs, speaking before the Council of Jewish Women in Washington, D.C., the chief reason for such mortality is that women and their husbands do not yet realize that every woman needs, and has a right to, skilled care at the time of the birth of her children (“Needless Maternal Mortality Following Childbirth”, 1916: 1608).

Obstetrics served an integral medical arena in which men began to turn the tides of male exclusion from birthing rooms. Continuing in my examination of the second decade, doctors in *JAMA* and *JSCMA* specializing in obstetrics or whose statements reflected a push for obstetrics as a specialty (code: pfobst) sought to place men in birthing rooms; consequently, these rooms soon became surgical rooms under their direction, further separating midwives from birthing work (see Table 5). For example, Dr. Fife writing in *JAMA*, reported on a conference about obstetrics:

Dr. J. Whitridge Williams, Baltimore: ... One of the greatest advantages in modern obstetrics is the development of prenatal care. Further development of obstetrics lies in supervision of the woman after confinement, but this

prenatal and postnatal service involves the work of the obstetrician, the podiatrist and the social service worker. The crux of the matter is the proper education of doctors to be competent obstetricians. We have just begun to understand in this country what the obstetrician is. It is much more than a 'man midwife'...The 'man midwife' has disappeared and the 'accoucheur' is disappearing: what we want is the scientific obstetrician (Fife, 1916: 56).

Herein lies the relationship between the professionalization of medicine, particularly obstetrics (code: pfobst) and the medicalization of birth (code: mdbirth). The medicalization of birth situated the birthing room as a place that necessitated scientific assistance by competent members of the medical establishment. Such assistance included medical supervision of the birthing process as well as scientific advice given prior to, during, and after the delivery. Fife's comments demonstrate that physicians advocated for the medicalization of birth via calling for obstetrics as a field to improve its teachings of prenatal care primarily to firmly entrench themselves within birthing rooms. One of the ways doctors successfully accomplished this task was by arguing that their competency far outweighed the talents of traditional birth attendants such as the man midwife.

Physicians also monitored the (un)sanitary habits of women and used resultant medical problems as fodder for arguments for male involvement in birthing work. For example, in an editorial in *JAMA* addressing pregnancy problems, one physician spoke of the habits of young women regarding their wombs. "The habits of these young women are not so sanitary as they should be; as a rule they neglect their bowels; the colon bacillus very often gains entrance into the vagina, and the uterus and its appendages thus become infected" ("Etiologic Factors in Vomiting of Pregnancy, and How to Overcome Them", 1915: 49). Implicit within these statements is women's irresponsibility in regards to personal health, which thereby indicates a need for physicians' guidance. In the third decade of my data, there were seven out of 79 texts (almost 9%) in which doctors continued to promote the need for medical men to find solutions for the

pathological pains of childbirth (see Table 5, code: mdbirth). Moreover, as printed in *JSCMA*, “[s]ince the earliest mother gave birth to her first-born, has all woman-kind prayed for relief from the travail of labor. And since the first obstetrical attendant had his heart wrenched by the agonizing cries of pain at this his first case has there ever been a challenge to medicine to seek and find a painless method of parturition” (Guess, 1925: 267-8). Consequently, doctors believed that the birthing process required supervision and urgently pressed new mothers to utilize physician care. Such sentiments were also present within *JSCMA* during the third decade. In *JSCMA*, some physicians viewed medical supervision as a preventative measure for complications of pregnancy.

Progress has been made in combating the toxemic eclampsia of pregnancy not so much by means of measures to cure the condition after it has developed as by preventing its occurrence thru a vigilant supervision of pregnancy in order to detect early the danger-signs which put the physician on his guard against it (Peters, 1921: 116).

Also within the third decade of my study, I found an example in *JSCMA* of physicians persisting in arguments about their necessity to womankind when discussing maladies among women.

If there is any one thing a Southern man has a right to be proud of, it is his treatment of women. It is true of all walks of life but is especially true in Medicine. The sufferings that are peculiar to women were unnoticed, certainly uncured until a group of gifted Southern men taught the world a new branch of Medicine. The names of Ephraim McDowell, Mattauer, J. Marion Sims, Thomas A. Emmett, Nathan Bozeman, J. C. Nott, and T. Gaillard Thomas are dear to us all (Rucker, 1925: 331).

Dr. Rucker, in his admiration of his obstetrical predecessors, argues that his forebears were heroes for womankind due to their assistance in “sufferings...peculiar to women” (1925: 331). Also, Dr. Rucker’s commentary has a taint of paternalism in that the southern medical man’s treatment of women should be praised or easing the “sufferings that are peculiar to women”

(1925: 331).

Moreover, physicians lauded themselves as the primary educators in the areas of prenatal and postnatal health. Some doctors' statements included critiques of other physicians who did not take their role in the health of new mothers and infants seriously. In addition, some of these physician critiques berated women for not heeding their superior wisdom. Dr. Rhett writing in *JSCMA* argues,

Reiss states that 'it plainly rests with the obstetrician to take up his rightful role as the mother's educator in breast feeding.' If mothers were properly advised, during the prenatal period especially, he believes that fully 95 per cent of them could and would nurse their babies. No one is in a more advantageous position to impress the mothers with the importance of breast feeding than is the obstetrician. In addition to usual instructions as to prenatal care he should assure the mother of her ability to nurse, and insist that it is the infant's inalienable right to be breast fed, and that every mother who fails to make every reasonable effort is derelict, and is robbing her child of its best opportunity for maximum growth and development. If these facts are indelibly impressed on the mother's mind, when the infant arrives, she feels that she must institute and maintain breast feeding at all hazards (Rhett, 1922: 253-4).

Dr. Rhett not only laid responsibility at the foot of the obstetrician for educating women about breastfeeding but also made it a point to show that within breastfeeding education, their instructions should be "indelibly impressed on the mother's mind" (1922: 254). In articles published in *JSCMA*, physicians in South Carolina lobbied for women to consciously seek out better obstetrics as provided by physicians and used titled medical professionals to accomplish their goals. Although I have used this quote elsewhere in my analysis, it is particularly relevant for this discussion. "After considering the resolution passed by the S.C. Medical Association, we are in accord in the following statement of the duties of the County Health Director:

...(e) To disseminate among the womanhood of our land saner ideas of motherhood, inducing them to appreciate and obtain better obstetrics" (Barton, 1930: 268). Even the language within

this call for action purports that women need ‘saner ideas of motherhood’, implying that what women had been using was disreputable and illogical. Considering that men so intently encouraged their participation in birthing work, it comes as no wonder that granny midwives and other lay midwives began to lose favor within the American populace. And, as Lee (1996), Fraser (1998) and others asserted, granny midwifery practices were deemed sub-par in comparison to modern medicine.

Many of the considerations physicians held about birth, women, and the physician’s necessary role in the delivery rooms of South Carolina and America overall persisted into the last decade of my study. Dr. Guess, a South Carolina obstetrician who authored a large proportion of obstetrical pieces for *JSCMA*, noted in 1937 that as long as women relied on physician-assisted births, even class would no longer have an impact on the health of women.¹⁷

As I write, patient after patient comes to mind, where the greatest benefit I rendered her during the antenatal period was to reestablish calmness in outlook, to banish unreasonable fears, and to make it possible for her to enter labor reassured that she would not be allowed to suffer unnecessary pain, and with a profoundly trusting confidence that I would make everything all right. It is a child-like faith almost like that of which religious leaders speak, and it is effective in actually lessening the discomforts of labor, and in preventing accidents and in making meddlesome interference less likely... The pain differential between the more civilized woman and her who is lower in the social scale is definitely lessened, and they react to labors more nearly alike (Guess, 1937: 202).

Noticeably, Dr. Guess’s sentiments reflected a paternalistic attitude toward women in the South that continued into the last decade of my data. As noted earlier, southern men viewed their treatment of women in the South as noteworthy (see Rucker, 1925). Medical men truly perceived their skills as adroit in comparison to meddling midwives. He writes as though without his

¹⁷ Although Dr. Guess was oftentimes quoted in *JSCMA*, many of his obstetrical pieces were not opinion pieces but rather descriptions and discussions of obstetrical procedures.

comforting presence, women in labor were lone children suffering in pain. Some physicians did not cease at mentioning and constructing the social confines of women and these constrictions' relation to childbirth but also discussed the relationship of the cult of domesticity to occupational choices women should make.

Summary of Racist and Sexist Analysis

Physician sentiments as expressed within journal articles from 1900 to 1940 reflected racist and sexist commentary. Some decades either in *JSCMA* or *JAMA* only showed a slight presence of these themes (namely racism) whereas others reflected higher incidents such as the pathology of the womb and pregnancy. Although I expected physician sentiments to reflect a racist bent specifically towards granny midwives, I found that physicians tended to comment on blacks in general. Such comments by physicians included derision of Africa and its inhabitants, debasing spiritual beliefs of blacks, and questioning the mental and physical abilities of blacks overall. When physicians wrote professionally about black healers in racist terms, their commentary centered on seeing the link between spiritual belief and black healing practices as evidence of medical ineptitude. Consequently, some white physicians felt that blacks were victimized as a result of adhering to these spiritual customs or edicts.

I also found slight evidence of racist commentary by physicians as it related to the health status of southern Americans and the United States overall within *JAMA* and *JSCMA*. I had expected that since Lee (1996), Fraser (1998), and others noted that granny midwives were considered to be contributors to infant and maternal mortality rates that physicians would comment about this phenomenon. And yet, I found minimal evidence within either journal indicating this pattern. Instead, much of the racist commentary present in articles during the first half of the forty year time period that discussed infant and maternal mortality rates, particularly in South Carolina, claimed that blacks were largely responsible for mortality rates. And during the

second half of my data, physicians turned to examining other causes for infant mortality rates and remarking upon the contribution of mistakes or a lack of birth registrations by doctors and midwives. Some doctors criticized the techniques for managing patients' pains as well as the archaic obstetrical practices of black lay healers in birthing work. As a result, doctors furthered their cause of creating a hierarchy in birthing work by arguing that white male physicians were better caretakers for pregnant women and their unborn infants. Moreover, in this caretaker role, physicians felt that granny midwives would be more effective if they were supervised by individuals deemed suitable by the medical establishment.

My data also revealed other unexpected racist commentary in regards to practitioners and participants within birthing work. Physicians remarked that prenatal care differed for black and white women and that oftentimes it was either due to the fact that blacks opted not to use physician services or the services provided had fatal consequences. I expected to find texts showcasing how grannies were excluded from birthing work; yet, my data were silent in this regard. So, the social situation of granny midwifery censure included racist attitudes about the medical aptitudes of blacks coupled with formal exclusions from medical organizations.

Sexism, I expected, would be reflected in the writings about granny midwives by white male physicians. Yet, I found relatively few texts that included criticisms of granny midwives rooted in sexism; indeed, I found very few texts dealing explicitly with granny midwives at all. Instead, I found sexist commentary that demonstrated patriarchal views of the womb as a pathogenic entity, and about women's participation in birthing work, and viewpoints that stressed the necessity of a male presence in the birthing room. Within texts from *JSCMA* and *JAMA*, doctors espoused notions of male superiority and that male obstetricians were heroes to the weaker female sex. In addition, some doctors argued that because of the social roles prescribed for women, practicing medicine should be solely left in the hands of (white) male physicians. Some sexist commentary even extended to physicians deeming it necessary to inform women

how to care for their newborn infants. These arguments aided physicians in creating an interdependent relationship between themselves and their female clientele and set forth an acceptance of male occupancy in birthing rooms in the South as well as nationally. I found it interesting that some doctors even went so far as to criticize those physicians who did not take seriously their treatment of new mothers and infants. Even further, some South Carolina physicians created resolutions within local medical societies that addressed the need for doctors to fulfill their responsibilities towards being the principal educators for women.

Based on the writings of Giddings (1994), Hill Collins (2000) and hooks (1981), I expected to find that physicians' censure of granny midwives would reflect an intersection between race and sex. I did find some instances in which there were clear intersections of racist and sexist commentary as a means of maligning midwifery as a practice; however, I did not find in either journal physician arguments about blacks demonstrating an intersection between race and sex in relation to women's roles in the domestic sphere and the public sphere. In addition, I did not find texts with commentary about the physical constitutions of black women during pregnancy and in general. As I continued my examination of my data from *JSCMA* and *JAMA*, I noticed when physicians employed racist and sexist contentions, they furthered physicians' abilities to label themselves as knowledgeable experts in birthing work. In addition, such arguments also enabled physicians to usurp the place of midwives and other lay healers within birthing work. The next chapter details how physicians within their professional writings viewed the presence of midwives in birthing work, the arguments they used to substantiate their medical expertise, and how physicians wrote about midwifery regulation and the role physicians played in elevating obstetrics.

CHAPTER V

INTER-OCCUPATIONAL CONFLICT IN BIRTHING WORK

Drawing from the works of Starr (1982), Abbott (1988), and Lay (2000)), I argued that physicians viewed granny midwives as “unwelcome interlopers” in the field of birthing work, and that this would be reflected in medical journals. In addition, the research of midwifery researchers such as Rooks (1997), Fraser (1998), and Holmes (1992) found that granny midwives experienced criticism of their practices by physicians which oftentimes came in the form of contentions for midwifery abrogation. Consequently, physicians and midwives who were practitioners of birthing work underwent an occupational struggle. As the field of obstetrics gained popularity both within the medical profession as well as with U.S. women, physicians occupying positions of power and influence sought to eliminate practitioners of birthing work deemed unsuitable and incapable of administering medical care for new mothers and their infants. As I have earlier stated, there was some evidence of physicians using medical journals like *JSCMA* and *JAMA* as a platform to criticize midwives and lay out arguments for midwifery abrogation.

In this chapter, I detail how physicians’ writings about who was permitted to practice in birthing work and general medicine demonstrated inter-occupational conflict. I also report several instances of unexpected results within my data, such as other mechanisms of midwifery abrogation. My texts revealed how doctors successfully made claim to being experts in birthing work by establishing authoritative knowledge in the field of obstetrics as evidenced by text coded within the theme of inter-occupational conflict and also text coded under health reform within my data from 1900 to 1940. Coupled with the professionalization of medicine, physicians and other

licensed health professionals continued to discredit the age-old practice of midwifery in favor of modern technological obstetrical procedures.

Physicians as Experts in Birthing Work

According to Starr (1982) and others (Rooks, 1997; Leavitt, 1987; Litoff, 1990; Reed and Roberts, 2000), the professionalization of medicine, beginning in the late 1800s and continuing into the 1900s, assisted licensed health professionals in establishing authoritative knowledge both within American law and within the field of medicine by obtaining legal protection. As stated earlier, physicians used what Lay (2000) terms authoritative knowledge as a means of substantiating themselves as veritable experts in birthing work by using the American legal system to regulate medical practice beginning in the late 1800s and continuing into the early 1900s. Consequently, I coded arguments espoused by physicians in either journal that encouraged the legal community to establish the physicians' role in governing American medical care. Over time, physicians, as well as other healthcare lobbyists, advocated for medical practice regulation and, in effect, for the routing of other healers—such such as granny midwives—believed to be illegitimate practitioners . I later describe in detail how physicians used authoritative knowledge to castigate lay midwifery.

Investigating both journals, during the first decade (1900-1910), five out of 93 texts (5%) addressed physicians' need to claim authoritative knowledge (see Table 5, code: authknow). These texts contained opinions about the medical authority of licensed physicians versus unlicensed practitioners. Some of these texts contained statements in which doctors discredited unlicensed health practitioners as well as those individuals who dispensed purported cures for a variety of ailments. Moreover, those forces (namely media outlets) who touted the competency of these unlicensed physicians also came under attack by the medical establishment. For

instance, some physicians in *JSCMA* placed blame on newspaper advertisements for contributing to the medical victimization of the “gullible public.”

It is remarkable indeed what a shameless influence can occasionally be wielded in newspaperdom by a little paltry persuasion in the shape of advertising patronage... This time this paper inferentially and virtually champions, editorially and otherwise, the blood-sucking vampires who prescribe patent dopes across the counters of drug and other stores, and spread drug and alcohol addictions and hopeless invalidism broadcast through the land. It rises, too, to protect that blushless gang of highway robbers who advertise themselves blatantly as ‘eyesight specialists’, offering to ‘examine eyes free’, and selling the innocent and gullible public, at prices of from five to fifty dollars, glasses which they procure for fifty cents (“About the Medical Practice Act”, 1907: 440-1).

Depicting those treated by competing practitioners as victims greatly aided physicians’ ploys to de-legitimize those healers considered to be charlatans and quacks. As I detail later, attributing exploitation to the actions of people purporting to be healers continues into the latter decades of my data when physicians began discrediting the work of midwives and other lay healers.

In order to address and combat the activities of charlatans and quacks, doctors in South Carolina as well as within other states posed varying arguments about the inadequacy of medical regulation. Continuing in my examination of the first decade of my data, I found that, in his quest for economic gains for members of the medical profession, Dr. J. Madison Taylor felt imperatively that physicians should use the law as a means of substantiating their expertise.

Within *JAMA*, he states:

Finally, let me ask what is the position of the medical profession as an entity in the national councils. How far does the influence of medical thought reach in national or state legislation? How much of good could this influence exert on the welfare of the nation, on national or on sectional economics?... If each reputable physician in America were a member of the American Medical Association and fulfilled his duty in local and centralized organizations, not only would the power of medical opinion become invincible, but individual self-respect would reach a high plane. Not only so, but, individual values being thus raised, proportionate

earnings would follow. The public is perfectly willing to pay well for value received, and they would quickly become content to pay more for better service not only in times of exigency for personal attention, but for the knowledge that through and by intelligent watchfulness of local and national interests they would be better served, better protected and that future needs would be anticipated and met (Taylor, 1905: 1661-2).

Dr. Taylor not only advocated for medical lobbying by physicians but also for concentrated efforts by physicians to join the American Medical Association in order to assure their expertise. His comments also reflect that members of the medical profession possessed knowledge to secure and maintain control of medical credibility among the masses. Moreover, he urged his compatriots to understand their role in creating legislation for members of the medical profession as well as the impact of their legislative efforts on the health of Americans.

Promotion of medical practice acts was one of the first means I found in *JAMA* in which doctors sought to authenticate themselves as competent healers among the general public in professional writings (Table 7, code: mpa). Such advocacy also demonstrated an intersection between the codes: authknow and mpa. Initially, the construction of these acts ensured that practitioners had attended proper schools of medical instruction rather than just possessing a general layman's knowledge. And, more importantly, medical practice acts ensured that those individuals practicing medicine were under the auspices of a governing body. For example, in *JAMA* during the first decade of my data, doctors discussed the importance of the medical practice act.

The statute, in order to be effective, has denounced the public profession that he will cure or heal, and this may be proven without exacting evidence that he has actually undertaken to do so. The statute, when fairly construed, does not seem capable of a broader construction. Nor does the court deem this essential in order to sustain its constitutionality. The statutes do not attempt to discriminate between different schools of medicine or systems for the cure of disease. No method of attempting to heal the sick, however occult, is prohibited. All that the law exacts is that, whatever the system, the practitioner shall be possessed of a certificate

from the State Board of Medical Examiners, and shall exercise such reasonable skill and care as are usually possessed by practitioners in good standing of that system in the vicinity where they practice. This excludes no one from the profession, but requires all to attain reasonable proficiency in certain subjects essential to the appreciation of physical conditions to be affected by treatment. The object is not to make any particular mode of effecting a cure unlawful, but simply to protect the community from the evils of empiricism (“Construction of Practice Act,” 1905: 67).

As Lay (2000) noted, using licensure as a measure of professional legitimacy gravely affected lay healers like midwives. Of import is that one of the medical practice act’s goals was to “not make any particular mode of effecting a cure unlawful;” yet, creating stipulations for individuals to practice medicine, in effect, placed an eye of scrutiny upon “healers” who chose not to obtain certification by state boards (“Construction of Practice Act,” 1905: 67). Such scrutiny, depending upon state rulings, may have resulted in punitive action against uncertified individuals. Punitive action could come in form of fines and in extreme cases, incarceration. In my analysis of legislative statutes, particularly my examination of the South Carolina medical practice acts, imprisonment, monetary fines, and license suspension were the forms of punishment for noncompliance (see Chapter VI). Another interesting point is that the aforementioned text is the only document within my period of study that specifically stated that healing practitioners, “however occult, [were not] prohibited” from practicing as long as they adhered to regulatory practices (“Construction of Practice Act,” 1905: 67).

Within the latter decades of my data from both *JSCMA* and *JAMA* (1911-1940), there were 24 instances in which physicians sought to maintain positions of authoritative knowledge (see Table 5 under the inter-occupational conflict theme, code: authknow). However, their arguments not only discussed how and why medical doctors were better healers but also contained critiques of midwifery. And, as mentioned earlier, sometimes text from *JSCMA* and *JAMA* encapsulated more than one of my primary themes. Therefore, my analysis of

authoritative knowledge is further detailed in my discussion of the persecution of midwifery. In addition, I address the language of the South Carolina medical practice acts and Sanitary Codes in Chapter VI; and, in particular, I focus on how these legislative statutes reflected authoritative knowledge. It should also be noted that some physicians and legislative officers criticized medical practice acts.

Criticism of and Counter-Arguments for Medical Regulation

Turning to an examination of the code: medleg, when individuals (laymen and physicians) contested the construction of medical practice acts, physicians criticized them for their ignorance. For example, in *JAMA*, Dr. Dille argued for the necessity of state regulation of all professions, including the medical profession, as a protective measure.

It is under this classification that the state regulates trades, occupations and professions, notably those of plumbers, engineers, pilots, masters of ships, telegraph operators, druggists, pharmacists, lawyers and physicians. Some physicians question the propriety of such legislation. It is urged that the ignorant are inclined to look on such legislation as an attempt by the physicians in practice, to monopolize the business, and that under defective or poorly-executed laws the dishonest and incompetent succeed in getting certificates to practice, and their pretensions are made respectable thereby. My judgment is that the united efforts of the profession could not effect a repeal of the legislation on the subject. The necessity for such legislation is firmly fixed in the minds of most intelligent laymen, as the legislation on the subject in nearly every state in the Union from the earliest period to the present time shows. It would seem to be your duty to the public to assist in formulating such legislation and in making the same effective (Dille, 1900: 1395).

Couched within Dr. Dille's statements are two key elements to my analysis: statements substantiating the authoritative knowledge of physicians and the ability of members of the medical establishment to affect state legislation of medical practitioners. Dille (1900) pleaded for his fellow medical compatriots to encourage further effective legislation as a duty-bound

responsibility and obligation for the general public. And, Dille (1900) proposed further arguments for protection of the general public which consequently substantiated the authoritative knowledge of educated and licensed medical professionals.

This legislation is for the purpose of protecting the people from ignorance, incompetency and dishonest practices. A stranger or student coming into a community to practice medicine must file with the recorder of deeds evidence of the fact that he has satisfied the officers of the state that he is worthy of confidence, and qualified to practice medicine. In no other way could the public so readily ascertain these facts or obtain this protection (Dille, 1900: 1397).

In addition, he argued that the incompetent (those unregulated individuals) will continue to practice unless a concerted effort is made by members of the medical profession to promote well-executed laws. Other texts from this decade illustrated physicians advocating for the necessity of medical legislation as a means of preventing those deemed illegal practitioners from practicing medicine.

Lay (2000) wrote that the medical profession sought to wrest proprietary control of birthing work from midwives and were able to do so by perpetuating an ideology of legitimacy. Starr (1982) maintained that such dominance of the medical profession “spills over its clinical boundaries into arenas of moral and political action for which medical judgment is only partially relevant and often incompletely equipped. Moreover, the profession has been able to turn its authority into social privilege, economic power, and political influence” (1982: 5). As outlined above, many physicians stretched forth their hands of influence not only in the arenas of medical legislation but also among the general public by cautioning against the usage of unlicensed practitioners. Lay healers such as granny midwives practiced an art that had long gone unregulated or in those instances of regulation, states set unrestrictive regulations for midwifery practice (see Weitz and Sullivan, 1992). However, once physicians and other healthcare professionals began to view medical knowledge as an esoteric body of knowledge needing regulation, persecution (in the form of social criticisms) and prosecution (punitive actions taken

against offenders) of lay forms of healing began. More specifically, physicians who practiced birthing work successfully sought to establish and maintain positions of legitimate authority.

During the second decade of my data, there were 8 out of 122 texts (almost 7%) reflecting the code: medleg (see Table 5). However, six of these texts consisted of physician advocacy specifically for midwifery regulation which is a separate discussion (and is detailed later in this chapter). One text coded medleg within this decade focused on criticizing medical doctors for not developing better definitions of what constitutes medical practice in their arguments for the creation of medical practice acts (and is discussed later in this chapter), and the other text discussed physicians' role to mothers and their children and what types of legislation should be lobbied on their behalf. And, turning to an examination of the last two decades of my data, I noticed that the code: medleg continued to overlap with other codes. Consequently, I re-examined my data looking for these inter-relationships between codes and detail these overlapping codes in the following paragraphs as they relate to physicians arguing for medical regulation.

Initially, I coded instances in which lobbyists (physicians and legislators) pushed for legislation benefiting physician aims (again, see code: medleg) separately from statements encapsulating arguments for medical authoritative knowledge (code: authknow). However, physicians' legislative aims were sometimes couched in arguments seeking to establish that physicians possessed authoritative knowledge. Consequently, this interdependent relationship propelled me to examine my data for texts that reflected both codes. During the first decade of the 1900s, there were three texts out of 93 reflecting both a push for authoritative knowledge and legislation benefiting physicians. The second decade of my data yielded two out of 122 texts indicating this intersection. I previously used these quotations to address the construction of medical practice acts and how their purpose was beneficial for the professionalization of medicine. To reiterate, within these documents, doctors sought to use the American legislative

body to accomplish a governed medical body of men and women. The third decade of my data did not yield any texts in which physicians wrote about both authoritative knowledge and licensing; and, the fourth decade only had one out of 81 texts that showed this interaction. Despite a low presence in my texts, this intersection of coding is deserving of some attention because such statements illustrate how authoritative knowledge substantiated the need for licensed healthcare by trained health professionals. However, and more importantly, I realized that these two codes are reflections of one another rather than separate entities.

Doctors understood that in order to wrest jurisdictional control from traditional healers, such as granny midwives, legal advocacy and support was necessary. Again, one purpose of this thesis is to note if and how physicians lobbied for more restrictive medical governance of birthing work within medical journals and if legislative statutes illustrated physicians' advocacy for enforced regulation of medical practice. I argue that the professionalization of medicine served as base for physicians lobbying for the elimination of the midwife from birthing work. To this effort, my investigation of *JSCMA* and *JAMA* involved noting when physicians saw education as an indicator of one's ability to administer quality healthcare and used this notion to support the push for medical practice legislation (see codes: profmed, authknow and medleg in Table 5). Within *JAMA* during the second decade, Dr. George H. Matson and some other doctors made significant arguments in this regard. For instance,

Dr. George H. Matson, Secretary of the Ohio State Medical Board, Columbus, Ohio: Laws to regulate the practice of medicine are largely matters of education. Advancement in existing medical practice law should be anticipated the same as we anticipate progress in other educational laws. There should be no place for special privileges. The right to treat human ailments should be given only to those who by an educational test have been proved to be properly qualified. The best method of meeting present conditions is to provide for the regulation of all who in any way practice the healing art. Having begun with the restrictive plan which has led to multiple standards, we should now provide not only for present but also for future practices ("Annual Congress of Medical Education, Public Health and Medical Licensure",

1915: 681).

However, some legislative officials viewed the medical practice acts as troublesome, and pointed to a need for uniformity in the language and requirements within the acts. Additionally, this critique included mention of a lack of regulation for those who practiced other healing practices. Although there was not a large percentage of texts demonstrating this pattern, there was one instance in the second decade out of 122 texts overall that demonstrated this opinion (codes: medleg and mpa). The second decade deserves some discussion because physician lobbying (code: medleg) increased in comparison to the previous decade. As I stated earlier, there were eight instances in which doctors argued for legal governance of medicine in *JSCMA* and *JAMA* during the second decade in comparison to four texts from the first decade (see code: medleg in Table 5). Moreover, some legislative officials felt that such governance should be clearly stated for those individuals seeking to diagnose and treat.

Ex-Governor Hodges, Olathe, Kansas: My experience as a member of the legislature and as governor has demonstrated to me that the laws on the practice of medicine are a jumble of contradictions and confusions and are the products of minds scantily conversant with the fundamentals of a recognized science that differentiates between scientific investigation and primitive belief in witchcraft. Believing that there should be one educational standard for all who may treat the sick, a commission of three physicians and two laymen was appointed in Kansas to investigate this subject and draft a bill providing for a single educational standard for all persons desiring to treat the sick for compensation. The fact that certain cults and sects do not use drugs does not change the fact that they are practicing medicine, so long as they undertake to diagnose and treat human diseases and injuries. The man who assumes to have knowledge fitting him to treat human diseases should be required by the state to comply with definite educational conditions for the protection of the public. The state in appointing a board of examiners assumes an obligation for the protection of the health of its citizens and should see to it that the licenses which it issues to all men have a uniform manner ("Joint Session of the Council on Health and Public Instruction and the Federation of State Medical Boards", 1916: 683).

Despite such criticism, I found evidence of physicians encouraging their participation in medical legislation into the 1930s. Within the entire fourth decade of my data, there were four out of 81 texts (almost 5%) reflecting legislative advocacy (see Table 5, code: medleg). Dr. Harmon in *JSCMA* argued vociferously for legislation that benefited the medical profession as well as for physicians' participation in maintaining political control.

NOW is the time for the medical profession to stand up as one unit with a definite set purpose to see that the necessary constructive legislation is developed and maintained for the best interest and protection of our people. My most humble opinion is that, unless we take the initiative and carry out some such plan as outlined, we are fast headed for the political control of the practice of medicine, which we all know, would be most deplorable (Harmon, 1934: 140).

White medical men sought to firmly entrench themselves as medical experts, not only in birthing work but within society's view as well. And yet, what kinds of arguments, (if any) did female physicians espouse regarding the professionalization of medicine and medical legislation?

Female Physicians' Advocacy

Male physicians authored most of the texts extracted from *JSCMA* and *JAMA* that addressed the professionalization of medicine and the authoritative knowledge of medical doctors. I anticipated that the data would also reflect women physicians' contributions to the professionalization of medicine as well as their reliance on sexist/patriarchal notions to substantiate doctors as medical experts. The first, third, and fourth decades of my data did not provide any texts authored by female physicians. I found in my investigation of the journals that some female physicians' statements were included in county society notes. In particular, within *JSCMA*, I noticed Dr. Rosa Gantt, a female physician well-known in South Carolina, often

prepared secretarial reports that advocated for better obstetrics¹⁸. Consequently, I expected her statements would reflect these sentiments about the authoritative knowledge that physicians possessed but her statements did not include such commentary.

JSCMA provided one instance in the second decade in which a female physician, Dr. Mary Lampham, championed the authoritative knowledge of physicians and patriarchal ideology. This minimal occurrence was possibly due in part because women were often not welcome in state medical societies or as authors for state medical journals. (See Campbell and McCammon, 2005 for a discussion of how the medical profession excluded women in the late 19th and early 20th century.) In a discussion regarding how male physicians' treatment of women reflected racist and sexist conditioning among the medical establishment, she states,

You men have established all of these opportunities by your own effort. We have never helped you any, except indirectly. Let us suppose that a negro comes along and wishes admission to the foremost ranks, and he is rejected. I say the 'man who pays is the man who says'. When women have been wage earners and have paid their way as long as men have, then they will be given these opportunities. As it is, we are in the same position as the negro. We cannot pay, and, therefore, we cannot say, and we have to submit and take what is given us, just as the negro does (Brunson, 1911: 442).

Dr. Lampham, in an effort to state that women must be receptive to whatever the largely male medical establishment endorsed, proposed that women occupy the same societal and hierarchical position as blacks. In addition, her comments contain an interlacing of prejudicial bias in which unless a female or black member of society has paid dues, the ranks are not open. In essence, women who are members of the medical establishment should work their way up the ranks and be grateful for their opportunity to work alongside male doctors. Such prejudicial bias assisted

¹⁸ County society notes were oftentimes anonymous or were prepared by secretaries. Dr. Rosa Gantt was noted as an avid advocate for better obstetrics and frequent mentions of her name in connection with obstetrics existed in *JSCMA* during my period of study.

white male physicians in remaining at the top of the medical hierarchy and better positioned them in birthing work as well.

Birthing work served as an area in which doctors espoused their adroitness with delivery versus the careless hands of midwives. However, physicians, upon realizing that midwives and other lay healers continued to use their archaic ways while serving the female populace, sought to further affirm their hierarchical place within the American medical establishment. Consequently, doctors sought legislative governance of birthing work in the form of medical practice acts to protect the purveyors of future generations. Moreover, the cult of domesticity assisted medical professionals in viewing women with a patriarchal and sexist tint. However, beyond simply advocating for legal legitimacy of the white male medical establishment and legal illegitimacy of lay practitioners within medical journal articles, physicians also maligned midwives by publishing articles in which midwives were discussed in a persecutory slant.

Persecution of Midwives

As this research began, I expected texts uncovered in my investigation of *JSCMA* and *JAMA* would include numerous criticisms of midwifery, particularly granny midwives. To reiterate, the purpose of my project is to outline and discuss the manner in which physicians depicted granny midwives within *JSCMA* and *JAMA*. I expected that persecution of midwives is encapsulated in critical commentary by physicians about midwives, particularly granny midwives. In addition, I expected the data to provide me with more insights and subsequent emergent themes that demonstrated how physicians and other licensed health professionals perceived and reacted to lay midwifery practice, and most importantly granny midwifery.

I argued that a trend of antipathy towards midwives occurred in South Carolina during 1900 to 1940. Rooks (1997), Fraser (1998), Weitz and Sullivan (1992) and Mathews (1992) noted that midwives received significant amounts of censure by the medical establishment in the

early half of the twentieth century. Within my analysis of critiques that physicians used against midwives (code: critmw), the first decade revealed 21 out of 93 texts (almost 23%) in which physicians criticized midwives (see Table 5). During the second decade, there were 35 out of 122 texts (almost 29%) from both journals that provided criticisms of midwifery. The last two decades (1921-1930 and 1931-1940) included seven out of 79 and seven out of 81 texts respectively that illustrated physician critiques of midwifery. These percentages are significant in that they illustrate what midwifery researchers have argued; that being, midwives experienced physician criticism and now it can be stated that such criticism was evident within medical journals. Some of these critiques of midwifery ranged from solely defamatory remarks about its practice to the requests for the regulation and/or abrogation of midwives on grounds that they practiced in a meddlesome manner.

In my examination of text from both journals from 1900 to 1910, there were twenty out of 93 texts (almost 22%) that specifically mentions midwifery regulation (see Table 5, mwreg). From 1911-1920, there were 56 out of 122 texts from both journals that reflected midwifery regulation. The last two decades experienced a significant decline in the number of texts regarding midwifery regulation. The third decade had 16 out of 79 texts (almost 21%) and the last decade had 10 out of 81 texts (12%) reflecting midwifery regulation arguments by physicians.

I had not expected physicians to use what some consider to be improvements in midwifery care (e.g. midwife supervision, midwifery education) to eliminate midwives. Consequently, I begin my next discussion focusing on those comments that specifically criticized the practices of granny midwives and follow with a discussion of abrogation efforts espoused by physicians.

Granny Midwifery Persecution

Rooks (1997) and Beardsley (1990) noted that non-white midwives suffered various forms of criticism; some physicians criticized the mental capabilities of midwives while other physicians felt that black midwives were incapable of providing beneficial care because of their race. In order to ascertain physicians' comments about granny midwives, I examined text coded critmw to note specific mention of black midwives. During the first decade of my data, Dr. Lawton in *JSCMA* equated granny midwifery care to imbecilic behavior when discussing obstetrical care. In addition, there is a bit of an ageist element to his criticism.

The youth as he commences life's journey sees not the dangers and difficulties that await him. The past is a blank, the present a desert. 'Tis the future and only the future that sings the siren songs of enchantment and points the finger of Hope to the palace of Fame.

And especially is this the case in medicine. The few years he has spent in acquiring his medical education has metamorphosed him from a student to a Sena; from a medical ignoramus to a Marion Sims. The present which should be employed by the study of text books and a few good journals and by imbibing and digestion the little clinical experiences is oftentimes wasted. He is hoping to succeed without toil, and attain knowledge without application.

The old doctors with whom he comes in contact with are imbeciles or grannies. He is surprised that the people don't employ him more and is sorry for the poor deluded souls. More especially is this the case with the country physician (Lawton, 1908: 355).

Dr. Lawton began by providing an analogy about a youth moving further into his lifetime having similar processes as a neophyte in medical practice. This newly trained medical doctor perceived that medical education elevated or even crowned one as an expert. Herein, there is a criticism of doctors assuming they are experts without enough field experience. However, his critique of medical practitioners is not solely focused on doctors. I mentioned earlier that victimization was a platform that many physicians and other health professionals used to discredit midwifery care

and dissuade pregnant women from employing midwives as their birth attendants. Dr. Lawton's comments take this argument one step further by noting that contact with and *miseducation* by ineffective healers like midwives was a more frequent circumstance for "the country physician" (1908: 355). And, those individuals who employed these "imbeciles or grannies" were "poor deluded souls" (1908: 355).

Later in the same article, Dr. Lawton's sexist attitude towards women and female birth attendants is evident in his discussion of his first obstetrical case.

And then my first labor case! Who can forget his first labor case! That's the time to try a man's soul! That's sire fails when the grasshopper is a burden, when hours seem minutes, and minutes hours, when he wishes he had never seen a medical book, and curse the day wherein he decided to be a doctor. But who can ever forget his first experience? It is indelibly stamped on my mind. I may forget to eat or drink or sleep or breathe, but never shall I forget my first experience with a case in parturition. It was another of those dark, gloomy and peculiar nights. I have often wondered why women will select such nights for parturition... When I arrived she was in the throes of travail, and it was no time for an introduction. As I walked in she cried out, 'Doctor, do do something,' and gentlemen I felt like doing it. But I put on a bold front, pulled off my coat, rolled up my sleeves and called for hot water. I asked the midwife if she has a sterilized towel. Said she never had seen one, which I well believed. After thoroughly washing my hands, I made an examination and looked wise. If I had stuck my finger in a tub of lye soap, I could not have told the difference. But as the old Latin proverb says: 'fortune favors the fool.' For in about half an hour she gave birth to her first boy, followed by no complications, and Lawton got the credit (Lawton, 1908: 356).

Dr. Lawton's masculinist attitude (and medical inexperience) is obvious throughout his commentary. He depicted labor as an emotionally tiring experience for medical doctors while also criticizing the attending midwife. He stated that women purposefully select "dark, gloomy and peculiar nights" for parturition rather than understanding that Nature is not ruled by women (1908: 356). In essence, women's decisions were at fault for the travails of the attending doctor. And, he stated that assisting births makes doctors question their decisions to become medical

practitioners. It is interesting that Dr. Lawton continued to perform obstetrical procedures given his initial views on women and labor.

Vituperative physician sentiments were expressed not only in sole-authored pieces or editorials but also within convention and society reports during the first decade of my data. For example, Dr. Allen W. Freeman, as quoted in *JAMA*, in a discussion about the role of obstetrics and the impact of midwives at a county society meeting stated:

I suppose our experience in Virginia has been that of all other health departments on this subject. We have walked around and around it, looking at it, realizing its importance, but not feeling quite like attacking it; but I think it is time for somebody with Dr. Hurty's nerve to open up operations. There is no doubt that tens of thousands of women are being absolutely murdered by ignorant midwives. Every one who has ever practiced obstetrics knows how filthy and dirty, how officious and meddlesome these women are; and we know what a tremendous total of fatal and crippling illness they cause every year. If we try to get rid of the midwife, the public takes the attitude that we are trying to get a little more money for the average practitioner and do the poor working woman out of her \$3 or \$5 fee; but we should not let that keep us back: we must tell the people how many women these midwives are killing, and how much illness they are causing. I don't think people want to run the risk of being infected or killed by midwives; they run the risk because they don't know. The obstetrician and the health officers are the only people who apparently do know; and if we are going to be true to our duty, we must bring this information to them (Manton, 1910: 463).

What is significant about the above quote is that not only does it criticize midwives but it also includes a plea for the abrogation of midwives (code: abrogmw) by informing women about the morbid impact of midwifery practice. In addition, Dr. Manton maligned poor women for their hesitancy in choosing physicians they could ill-afford. Moreover, Dr. Manton (and many of his colleagues in later decades) clearly indicated the prevailing notion that "obstetricians and the health officers" possessed authoritative knowledge about medicine and were duty-bound to spare the uninformed general public from the negligence and ill-suited practices of midwives (1910: 463).

Dr. Manton provided a convincing argument that—because midwives are allowed to practice unregulated—female patients have to be concerned about septic infections.

The advent of septic infection in the lying-in woman has rarely an excuse, for the principles laid down by Holmes and Semmelweis, Pasteur and Lister, if carried out, make the occurrence of this disorder mostly preventable, so that the responsibility and blame for its presence must be borne by those who have the patient in charge. That the midwife, especially in congested districts, is generally accountable for the morbidity and mortality resulting from infection during and after labor, is evident from the reports of city boards of health. Miss F. Elizabeth Crowell, who personally visited 500 midwives in the Borough of Manhattan, New York City, found that of this number only fifty, or 10 per cent., could be qualified as capable and reliable, and those seen represented only about half of the practitioners in that borough.

We require that the physician shall have taken a prescribed course in a reputable medical school, the examinations of which he must have passed and later those imposed by a state board of registration, before he can legally enter into practice, and yet we permit, in many states without a question, an ignorant and dirty woman, such as depicted by Miss Crowell, ‘whose hands were indescribable, whose clothing was filthy, the condition of whose bag beggars description,’ to officiate in obstetrics, an important branch of medicine, and thus to slay and kill without one word of protest. Laws there are, which are enforced, for the protection of children, animals and birds, but the unfortunate mother and new-born babe are left unprotected to the mercy of the mercenary and indifferent. With all our vaunted philanthropy it would seem as if the times were ripe and civilization advanced enough for legislative control of these carriers of disease and death, and it should be the especial concern of every physician having the welfare of his community at heart constantly to urge, in season and out of season, either the elimination of the breed, or, what seems more desirable, the creation of educational standards and state examinations and a supervision of midwives by legislative enactment (Manton, 1910: 462).

Midwives, according to Dr. Manton in *JAMA*, were carriers of diseases and death. In addition, Dr. Manton described midwives as a “breed” worthy of elimination or at the very least required instruction in how to competently administer obstetrical assistance to new mothers and their infants (1910: 462). Moreover, Dr. Manton, like many other like-minded physicians, emphasized the importance of legal regulation of medical practice as a means of protecting those

in medical need while also advocating that physician should assist in the “legislative control of these carriers of disease and death” (1910: 462).

Continuing my discussion of what arguments physicians used to criticize midwives, Dr. Hayne, in *JSCMA*, declared that maternal and infant deaths persisted due to the lack of midwifery regulation and unskilled midwives in the second decade.

We can see that for South Carolina to have ten times as many women to die during parturition and pregnancy means that something is radically wrong with our system. We allow dirty, ignorant women to proclaim themselves capable of taking care of mothers at this time when they should have the most skilled care and attention.

There is no midwife law in South Carolina. No one, no matter how ignorant she may be is debarred from calling herself a midwife. They are neither licensed, nor inspected, nor do they know anything in regard to what is necessary to preserve life under these circumstances (Haynes, 1919: 340).

Dr. Hayne, like many of his colleagues in South Carolina and the United States overall, argued that ignorant, unskilled women were largely to blame for the health problems plaguing new mothers and their infants. Again, most midwives practicing in the southeast in the early 20th century were black; therefore his comments are related to a discussion of how physicians perceived granny midwives in South Carolina. In addition, he proclaimed that doctors can administer “the most skilled care and attention” (1919: 340). Here again is the presence of this notion that education and training ensured that physicians and other licensed health professions possess the necessary knowledge and authority to dispense medical advice to those in need. Dr. Hayne’s sentiments are an echo of Dr. Schwarz’s comments in *JAMA*; however, Schwarz offers a different slant in regards to midwifery regulation.

Dr. Henry Schwarz, St. Louis: . . . We all agree that we should try to prevent eclampsia rather than to cure it. I am sure that in the case of women who place themselves under medical supervision early in pregnancy, the frequency of eclampsia has been much reduced. A great many women in city and country are delivered by midwives; much would be gained if the medical profession could educate the public so that these women would

learn the necessity of placing themselves under medical supervision during pregnancy, even if they continue to be delivered by midwives (Fry, 1911: 18).

In essence, Dr. Schwarz rather than seeking to abrogate midwives, suggests that the general public should be educated and even if women opted to use a midwife that a physician's supervision is absolutely necessary. A consistent theme in each of the aforementioned remarks from the second decade of my data is the need for physicians to educate the general public as well as the midwife. Such educational efforts again perpetuate the viewpoint that doctors truly are far more competent than midwives. In essence, medical education and licensing standards are the hallmarks for medical competency rather than years of informal training and extensive experience.

Although I had expected to find in latter decades a specific denigration of granny midwifery, neither *JSCMA* nor *JAMA* used the term granny midwife in their criticisms of midwifery. And, noticeably during the second decade of *JSCMA* and *JAMA*, physicians and other health professionals began targeting lay healers, quacks, and charlatans. Despite this focus within both journals, I focused primarily on those articles that criticized lay healers who functioned as birth attendants but were not called midwives (critlay). The first specific critique of lay birth attendants occurred in *JSCMA* during the third decade of my data by Dr. Seibels, a prominent author in obstetrical topics in *JSCMA*.

The immediate and later care of the mother and infant are subjects seldom presented in scientific papers, and yet they form the most important phases in the reduction of infant and maternal morbidity and mortality with which we have to deal. Particularly is this true where the delivery has taken place at home, and especially is it important in the rural communities where the care of the two patients falls largely into the hands of the voluntary attendant. This attendant is only too often ignorant and inefficient and yet possessed of all the therapeutic courage of those who do not know. The infant is anointed with various concoctions, the least harmful of which is vaseline, and so on through the various home remedies until even axle grease is used; and not to mention the various teas that are forced down its

unwilling throat, is to open up a fertile field indeed. The mother too often is drenched with different nauseous mixtures, denied fresh air, nor permitted a cleansing bath 'for fear of catching cold in her womb'. It is generally difficult for the physician to avail himself of any more skilled services than those mentioned above, nor has he the time to give very much of his personal attention to the details of the immediate care. However, it is possible for him to correct many of the evils that exist by taking pains to educate both the patient and the nurse in the rudiments of post partum attention (Seibels, 1929: 295).

Dr. Seibels's commentary is vitriolic and illustrative on several accords. He maligned the treatment practices of these "too often ignorant and inefficient" attendants, critiqued home births, and placed the source of high rates of infant and maternal morbidity within rural communities attended by voluntary birth attendants (1929: 295). However, Dr. Seibels (like some of his other medical colleagues) situated physicians as heroes because only they can "correct many of the evils that exist" (1929: 295). Such commentary, espoused by physicians in both journals, slightly rose in the third decade and later declined in the last decade (n=4 and n=1, respectively in Table 5). *JAMA*, in particular, provided two instances in which physicians castigated lay birth attendants care of pregnant women. The first occurred during the second decade and the latter occurred in the last decade. Dr. Goodman, in discussing obstetrical maladies, stated, "[the] greatest of obstetrical calamities, rupture of the uterus, are of importance to the obstetrician, the surgeon, and the general practitioner. The most frequent causes of this condition are obstructions to the descent of the fetus, with neglect of the procedures necessary for delivery of the child, as in patients treated by midwives or by the laity..." (Goodman, 1911: 1260). Dr. Goodman's statements slightly differ from Dr. Seibels in that he castigates midwives and other voluntary birth attendants for their contributions to the "greatest of obstetrical calamities, rupture of the uterus" (1911: 1260).

Since I was unable to uncover texts containing negative criticisms of and actions by physicians towards granny midwives specifically, I focused on how midwifery regulation and

abrogation efforts of physicians contained criticisms of midwives overall. Physicians and other health professionals began their regulatory crusade against midwives by labeling them as a problem.

Midwife Regulation Efforts of Physicians and Other Health Professions

Although various researchers (Rooks, 1997; Litoff, 1990; Donnegan, 1978) differ in opinions about when doctors began using the term “the midwife problem”, *JSCMA* and *JAMA* published articles authored by physicians in which midwives were considered a ‘problem’ during 1900 to 1940. Beginning in the first decade of my data, *JAMA* had two out of 63 texts (3%) containing the terms ‘midwife problem’ (see code mwprob in Table 7). Interestingly, within discussions about midwifery in the United States, comparisons are made to the state of midwifery in Europe and other countries (see Rooks, 1997 for various federal studies that compared European infant mortality statistics to U.S. statistics as a means of determining the adequacy of maternal and infant healthcare in the U.S.). For example,

But the midwife problem is one which must have serious study. In many countries of Europe the midwife has not only legal restrictions but educational advantages. Her activity is recognized, and the government prepares her for work among the poor. Not so, to any degree at least, with us. We so often hear it stated that the midwife is here, and here to stay, that it must be true. That 40 or more per cent. of births are supervised by her lends confirmation. She is evidently more popular with the poorer classes than are our hospitals, maternities or relief societies which furnish free medical attention by women physicians. Yet we know that her ignorance often brings blindness to the baby and death to the mother. Preventive medicine means prevention of the effects of disease; elimination of cause, when possible (Woods, 1910: 1163).

Dr. Woods continued in his condemnation (within the same text) by relating how with physician action, the midwife problem can be effectively eradicated by reducing the number of women using midwives.

I am going to suggest, however, a side attack on the midwife problem. It is popular education of the persons who employ the midwife. We have in the Maryland Medical and Chirurgical Faculty a bureau in public instruction. Medical men and women go, at the request of philanthropic societies, among the poor and tell them about prevention. Last fall I addressed an audience of some sixty or more pregnant women under the auspices of a branch of the Women's Christian Association. I afterwards learned that a number of my audience canceled midwife retention, and entered hospitals. I have urged this popular education on our social workers in Baltimore, and mention it here only as suggesting a way of enlightening the ignorant poor who are quick enough to follow advice when they are convinced of its disinterestedness. They will not take such advice from physicians in this spirit (Woods, 1910: 1163).

JSCMA did not publish articles using the term “midwife problem” during the first decade, third and fourth decades of my data (see Table 6). However, during the second decade of my data, *JSCMA* published one text that discussed midwives as a problem. Within this text, Mary Dodd, a nurse, spoke about the midwife problem and pointedly spoke about the presence of black midwives in birthing work as problematic.

The midwife problem is a most difficult and gigantic one when we consider that twenty per cent of white mothers, and eighty per cent of colored, depend upon these dirty, ignorant Negro women, for care, at a time when they should have the most skilled attention. The midwife cannot be eliminated. She must be made the best of as a bad bargain. Registration of these women has been begun in those counties employing nurses, and classes have been formed. The instruction consists principally of what not to do, and rules for ordinary cleanliness. One hundred and seventy-five of these women are now under supervision. At the last meeting of the executive committee of our State Board of Health, a set of rules governing midwives was incorporated in our Sanitary Code, making this supervision compulsory (Dodd, 1920: 21).

Similar to Woods, in arguing for an alternative way to limit the negative impact of midwives, *JAMA* also published text containing the term “midwife problem” during the second decade. This

text came from a report on midwifery in which particular forms of action are suggested to combat the “problem”.

The State Board of Medical Examiners has recently made an extensive study of the midwifery problem. The report states that ‘midwives attended approximately 50 per cent. of the births in this country,’ nevertheless the investigations prove that ‘with few exceptions the midwife is dirty, ignorant and totally unfit to discharge the duties which she assumes.’ Reports show they are practicing in all states, mostly among immigrants and negro women. The board concludes that the first thing necessary is to insist on their being better trained, and a school for them has been opened in New Orleans (“Report on Midwifery”, 1916: 1786).

Within each of the above texts, different regulatory efforts were suggested such as education, supervision, and legislative rules as provided by the South Carolina State Board of Health (see codes: mwteach, mwsuper, mwleg in Tables 5, 6, and 7).

However, not all doctors who assisted midwives in their cases made virulent critiques. In fact, I discovered one instance in *JAMA* in which the attending physician only spoke of coming to the case after the midwife had assisted the delivery of a child.

The pregnancy terminated October 17, 1899, about two weeks before the woman had anticipated. In the evening of October 15 the woman was seized with pain in the back and a discharge of water. A midwife, who called, declared that labor had not begun. During the 16th there was some pain and continual discharge of water. After midnight on the 17th, acute pain began and the child was easily delivered by the midwife at 7 a.m. October 17, the head presenting. The mother’s recovery was without incident. On the seventh day she was at work again on the trousers (Daniel and Cordes, 1900: 1081).

As I continued my analysis of *JSCMA* and *JAMA* from 1921 through 1940, I noted that the term “midwife problem” was not used when discussing midwives. Instead, physicians used adjectives such as “evil” and “ignorant” in their critiques of midwives. These adjectives (and others) were present in physicians’ arguments for midwifery regulation (as well as those detailed in my earlier

discussion of the code: critmw) and can be viewed in the following paragraphs in my discussion of midwifery regulation efforts by medical doctors.

As I stated earlier, through my review of *JAMA* and *JSCMA*, I realized that physicians held various opinions about how to relieve the American populace of the midwife. Consequently, I created codes to encapsulate these differing efforts (see mwcodes in **bold** in Tables 5, 6, and 7 within the inter-occupational conflict theme). One tool doctors employed as a means of ridding the profession of or at least restricting birthing work from those deemed to be unskilled birth attendants was enforcement of educational stipulations.

Education as a Tool for Abrogating Midwives

I found within the first decade, there were three texts out of 93 noting physician advocacy for midwifery education as a means of addressing the midwife problem (see code mwteach in Table 5). Physicians, in *JAMA* during the first decade of my data, while discussing national vital statistics versus those reported overseas in places such as Europe, declared that uneducated midwives were largely responsible for the U.S.'s deplorable state of health.

Midwives conduct labor cases in every state in the Union and an investigation a few years ago showed that not more than a dozen states had any law whatever regulating or restricting them and that even in the states where such laws existed, they were inadequately enforced. Midwifery is not so well regulated in this country as in Europe and yet the harm done is probably less, since midwives are not so numerous, it being more common here, except among the recent immigrants, to employ physicians to attend labor cases. The evils resulting from ignorant midwives are well known to physicians, but more education of the public and of the state legislatures will be required before midwifery is properly restricted. Its abolishment under present conditions is probably impossible.

...The present condition of our national vital statistics is a national disgrace. The Committee on Medical Legislation of the American Medical Association is carrying on a campaign for an adequate and uniform state law on vital statistics. Efforts are being made to extend the registration by adopting this model bill in a few states at a time. With more complete vital statistics, it will be

possible to show the damage wrought by ignorant attendants on parturient women and with these figures at hand, the campaign of education may then be extended and agitation for the proper training of midwives may be undertaken. The result of such regulation will unquestionably be an enormous improvement in the mortality and morbidity of obstetric cases (“Vital Statistic Legislation”, 1910: 490).

The author of this piece advocated that midwives were responsible for “evils” and that a “campaign of education” was a suitable means of fixing the midwife effect on U.S. vital statistics. In addition, state legislatures were brought to task for their negligence in successfully regulating and restricting midwifery. To reiterate, many physicians and other health lobbyists used legislation to restrict and regulate the practice of midwifery in order to secure their position of seniority in birthing work. Using arguments that educating the public would be a useful way to, at the very least, restrict the actions of midwives assisted physicians in reaching the upper echelons of birthing work.

One of the more interesting and unexpected findings about midwife opponents was that although many physicians were proponents of midwifery abrogation, some sought to educate women about the problems associated with midwife-assisted births as a means of tolerating (but also lessening) the midwife’s presence in birthing work while also contributing to better health outcomes for new mothers and their infants. Consequently, I coded such arguments *mwreg* as a means of identifying a form of midwifery regulation and *mwteach* as a means of identifying arguments used by physicians to educate women (pregnant and midwives) about maternity care. And, within my analyses, I detail whether physicians solely expressed tolerance of midwives, or if they specifically sought to reduce the midwife’s presence. Physicians writing in *JAMA* argued,

Dr. C. Hampson Jones, Baltimore: The midwife question is one in which we of Baltimore and Maryland have been much interested for many years; and I am glad to say that at a meeting of the last legislature we succeeded finally in passing a law which will enable us to improve the situation a great deal. For many sessions of the legislature, bills had been introduced which met defeat regularly; and only by the greatest care in drawing up this last bill, so as, while

being effective, yet not too strongly to antagonize the interests of the midwives, did we succeed in getting the bill through.

...Midwives undoubtedly cannot be abolished, and I don't know that it is at all desirable to abolish them, because they attend cases which physicians do not want to attend, and in which trained nurses can not be employed. The institution being a necessity; therefore, we should undoubtedly regulate it legally. The number of cases that would be treated by midwives can be considerably lessened, I believe, if special care is taken by the managers or superintendents of maternity hospitals to separate carefully pregnant women who are married from those who are not married; the fact that a woman is poor does not mean that she is blind to the association with a woman who is not of the same character (Manton, 1910: 463).

Within Dr. Jones' comments, he advocated that midwives were necessary in order to treat cases that doctors are disinclined to attend. However, Dr. Jones also noted that by regulating the birth attendants of both richer and poorer classes of women, midwife-assisted births can be significantly reduced. Also of import is that within the state legislature of Maryland, Dr. Jones and his colleagues worked to obtain a bill for their interests by not strongly "antagonizing" the interests of midwives. Overall, it is clearly evident that although midwives were considered a bane to the medical profession, Dr. Jones found them to be necessary participants in birthing work. Conversely, he also noted the importance of teaching married pregnant women not to use midwives because of their class position. This notion is of import because not only are midwives viewed as a nuisance within birthing work, physicians relegated poorer women to midwife care.. Moreover, Dr. Jones's comments align with Abbott's (1988) discussion of jurisdiction as determined by division of clientele.

As I have previously addressed, Abbott (1988) posited that particular groups of individuals can obtain occupational spaces in the medical profession by claiming jurisdiction. Midwives and physicians did obtain such 'spaces'; however, based upon a societal accreditation that medical doctors possessed medical expertise, physicians occupied elevated positions in the

medical hierarchy. Consequently, physicians were allotted particular activities within the profession. This process connects with Starr's (1982) conceptualization as to how physicians obtained and were able to enforce authority within the medical profession based upon their status and authoritative claim to medical knowledge. For the purpose of this thesis, such activities included defining birthing knowledge and who is suitable for practicing birthing work. Dr. Jones provides an interesting slant to this discussion because he posed that midwives occupy their space out of professional necessity rather than because of their skill level. So, physicians' dependency on midwives aligns with Starr's (1982) arguments about interdependence in the medical profession and the relationship between those occupying subordinate groups (midwives) and those occupying dominant groups (physicians). Moreover, despite this interdependent relationship, physicians still considered themselves medical experts in birthing work in comparison to midwives.

Arguments for midwifery education as an appropriate means of either tolerating the midwife or for her elimination continued on into the latter decades of my data from *JSCMA* and *JAMA*. Consequently, my following analyses will discuss both reactions physicians had to midwives. In a discussion about reform of South Carolina obstetrics in the second decade of my data, some doctors advocated that education was the best manner of midwifery abrogation. And, although I have used this quote earlier in my thesis, it is relevant here. "The State Board of Health, October 22, 1919, amended its sanitary code, with reference to the practice of midwifery, adopting rules and regulations very similar to those in force in New York State. There are probably several thousand midwives in South Carolina of one kind or another. Elimination by education is the best way to accomplish the desired end" ("Better Obstetrics in South Carolina", 1920: 4). The second decade had the highest number of texts out of all of the decades that included physician arguments for midwifery education (n=17, 18%, Table 5). Because some physicians explicitly mentioned abrogating midwives (code: abrogmw) via regulation of

midwifery education (mwteach), I noted that there were six texts reflecting this intersection.

For example, Dr. Baldy, writing in *JAMA* during the second decade argued,

This country contains several groups of foreigners who have been accustomed to the midwife, and until immigration ceases and these peoples are evolved into Americans, the midwife will be demanded. The question resolves itself into the proper education and control of the midwife. Results are obtained by meeting existing conditions and improving them. There is no state, city or town in the United States in which by the passage of laws it has been possible to eliminate the midwife. Any measurable degree of success has come only through education and control” (Fife, 1916: 56).

Dr. Baldy’s statements clearly illustrate the manner in which education could be used to control the midwife presence. Moreover, despite the fact that he (along with other physicians) wanted to completely eliminate the midwife, education (in Dr. Baldy’s opinion) served as the only way for midwifery abrogation to be successful.

In my investigation of data from the last two decades for both journals, I coded only two texts abrogmw and mwteach in the third decade, and there were no instances in the fourth decade of this inter-relationship between these codes. One text in particular that was coded abrogmw and mwteach shows the contradictory nature of physician sentiments (in this case Dr. Bailey) towards midwives and their education. I discuss this text later in this chapter as a means of illustrating how physicians negatively viewed midwifery schools. Some instances also existed in my data in which midwives themselves stated educational standards prevented them from practicing.

Prior to 1920, I did not find any instances within text coded mwteach that held mention of midwives explicitly stating that they no longer intended to practice due to educational requirements. However, Mary Dodd, a nurse hired to instruct granny midwives in the South Carolina Sea Islands, described several instances of her training experiences within *JSCMA* during the early 1920s. In one description Nurse Dodd quoted Susan Williams, a midwife, during

the second decade. I coded this text as mwteach as an illustration of the efforts made to regulate midwives by education; however, this midwife's statements are further relevant to this discussion because she serves as an example of how educational requirements forced a midwife to stop practicing birthing work.

Still at Hilton Head, drove five miles to a hall to instruct nine midwives. After instructing class, Mrs. Susan Williams said, after receiving instruction how to care for mother before baby's birth and baby after birth, she could not see well enough to wash out baby's eyes or attend to baby as instructed, she really felt it her duty to give up midwifery [sic], because she could not see how to cut the cord or wash out baby's eyes. She made this statement to the class. She also handed me her certificate given her by Mr. W. D. Brown, locla [sic] registrar (Dodd, 1920: 13).

Within these notes, Ms. Dodd provided commentary on the number of women she instructs as well as some of the necessary obstetrical procedures that grannies should employ while assisting births. However, and most significantly, a midwife humbly opted to no longer practice due to her failing eyesight leaving her unable to administer *newer* obstetrical procedures (application of silver nitrate to wash out the eyes) and even relinquished her certificate of midwifery. The impact of these training procedures cannot be overlooked.

As Lee (1996), Holmes (1992), and Fraser (1998) noted, physicians oftentimes employed black nurses to educate black midwives and those midwives unable to comply with midwifery educational standards had to cease practicing. *JSCMA* provided another text about educating granny midwives in South Carolina in the second decade. "One of these classes has been under tutelage in Beaufort [C]ounty and the islands on the coast. The instructor is a trained nurse of marked ability, well trained in good hospitals in the North, and capable of vastly improving the midwifery situation for her race" ("Better Obstetrics in South Carolina", 1920: 4). One can extrapolate that doctors assigned this nurse to teach black midwives since blacks populated many of the islands on the coast of South Carolina and because physicians did not want to serve the rural black populace. Again, given that doctors sought to reduce the number of "ignorant, negro"

midwives, midwifery education served as a means of “vastly improving the midwifery situation” for blacks (Manton, 1910: 463; “Better Obstetrics in South Carolina”, 1920: 4).

Some physicians even opined that midwifery schools should not be the sole training source for midwives. Looking at the third decade out of my data, I found 10 out of 79 texts (almost 13%) in which I found physician advocacy for midwifery education (see Table 5, code: mwteach) and in this decade, I found in *JSCMA*, a physician who advocated for personal hands-on training by doctors.

Dr. T. L. W. Bailey, Clinton: In reference to one thing that has come under my observation in regard to midwives, I would like to make a few remarks. I believe if local physicians were to take an interest in one little thing I don't believe it would give any physician any trouble and would be a great help to the midwives. I am registrar for my district and I became interested in this mortality of midwives, and I have ten midwives in my territory. I gave notice to them that if they would come to my office at a certain time I would give a series of obstetrical lectures. They came, and came regularly. I am sure that that little work did a great deal of good because they were practically instructed-instructed in such a way that these poor, ignorant midwives could understand. We are having too many midwives: Eight ignorant women in one locality waiting on women in confinement is too much. I wish this association could give authority to the local man at home they would cut down the number of midwives and have them to take a series of practical lectures and instructions four or five or six times a year, and keep these especially prepared, you might say, under the doctors of that locality, I believe we would get better results as a general thing throughout the state.

And I believe if we had a system of authority to cut the number of midwives down, it would be a great advantage. Out of the ten, eight of these women gave reports of deliveries during the year. The combined of course almost equally what the practitioners of that district were doing. I think it is well worth thinking of and I think if the home man would take enough interest just to bring their midwives together occasionally and give them, say four series of lectures in a practical way and teach it to them in such a way that they could understand it, it would be helpful to the State of South Carolina (Simpson, 1928: 31).

Dr. Bailey's remarks are a reflection of a considerable percentage of physician commentary focused on using midwifery education to regulate and reduce the number of

midwives in South Carolina. In addition, education was a useful gate-keeping mechanism considering that many granny midwives were older women from poor backgrounds so their access to education may have been limited. This limitation may also be present due to racist and sexist ideas prevalent in the South historically.

During the fourth decade of my data, I found five out of 81 texts (6%) from *JSCMA* and *JAMA* highlighting physicians pushing for midwifery education and training (see Table 5, code: mwteach). Dr. Guess in two separate documents in *JSCMA*, argues that midwifery training is a must for the State of South Carolina.

Perhaps, the best solution will come from a combination of State aid through the department of public health, together with a stipend for the physician who is called to render service to the destitute, combined with better training and supervision of midwives (Guess, 1936: 160-1).

Physicians delivered 17,058 white children and 3,013 colored children, while midwives delivered 2,422 white children and 17,025 colored children, almost a reversal of figures for white and colored. In Georgetown County only 49 births, both white and colored, were reported by physicians, whereas 425 were reported by midwives. If midwives are responsible for our high mortality rate, then they must either be better trained and supervised, and be made to report their cases when engaged so that some effort can be made to give such cases prenatal care, or else we may expect no great improvement (Guess, 1936: 141).

Overall, the second and third decades of my decade contained the largest number of texts of physician advocacy for midwifery education (n=17, 18%, and n=10, 12% respectively). Prior to 1910 and after 1930, the number of texts containing arguments for midwifery education were considerably lower (n=3, 3% and n=5, 6% respectively, Table 5).

I should note that not all physicians felt that education was an effective measure to eliminate the midwife. In fact, some physicians suggested that eliminating the midwife was preferable to teaching them because midwifery education only further perpetuated deleterious births. Such arguments I coded as abrogmw because of the overarching theme of abrogation and

detail in my analyses of these code that physicians advocated against midwifery education. For example, in *JAMA* during the first decade of my data,

At the meeting of the Conference of Jewish Women's Organizations, October 27, Dr. Alice Hamilton advocated the abolishment of midwives because they are not properly trained. She said that out of 500 licensed midwives in Chicago, scarcely 30 per cent. are capable and efficient, and one-third are willing to take criminal cases. In this country the license issued to a midwife means nothing. This practice is scarcely controlled at all. We give them the stamp of approval which only deceives those who do not understand ("To Abolish Midwives", 1910: 1652).

JAMA also provided another instance in which a physician was opposed to midwifery education. Dr. Joseph DeLee, writing in the second decade, in fact adamantly opposed teaching midwives. He viewed it as a further sully of the reputation of good participants in birthing work, namely licensed health professionals. Writing in *JAMA*, he states

I am opposed to any movement to perpetuate the midwife. She is a relic of barbarism, and her perpetuation demands a compromise between right and wrong. She is a drag on the progress of thez [sic] science and art of obstetrics, her existence stunting the one and degrading the other. The foreigner is becoming enlightened on the value of medical attendance and demanding it. The visiting nurse does an amount of maternity and prenatal work not fully recognized. There are thousands of young physicians who would take cases now cared for by midwives were it not considered undignified work, and also undignified to accept such a small fee for the service. In educating the midwife we assume the responsibility for her, we lower standards and compromise with wrong, and I for one, refuse to be particeps criminis (Fife, 1916: 56).

Not only does Dr. DeLee rebuff participating in midwifery education, he likens teaching midwives to participating in a criminal act. Yet, another observation can be made as well. Women were still using midwives because some young physicians perceived obstetrical work as "undignified" and unacceptable because only "small fee[s]" could be garnered for such medical services (1916: 56). DeLee, in his criticism, also clearly illuminated another reason why midwives were able to continue participating in birthing work despite some of the critical

onslaught of health professionals. Also, by labeling midwifery education as a crime, DeLee stated that physicians should not function as overseers to midwives. I found other texts in later decades in which physicians argued that educating midwives was an ineffective way of dealing with infant and maternal mortality rates. However, some of these arguments were used in conjunction with the promotion of obstetrical training and I discuss these texts in the following paragraphs.

Bettering Obstetrical Training for Doctors as a Tool of Midwifery Abrogation

Not only did doctors and other health professionals feel that education could be used to thwart midwives from practicing, some doctors also argued that better medical education would push pregnant mothers to choose nurses and doctors as birthing attendants. In order to note this form of midwifery abrogation, I examined text coded as abrogmw for physicians advocating for improvements in obstetrics as a means of reducing the number of midwives. None out of the four texts coded abrogmw in the first decade emphasized using physicians and nurses as birth attendants. However, Dr. Emmons in *JAMA* during the second decade argued that abrogation measures in Boston which included better obstetrical training of nurses and doctors was the most efficient in ridding America of the midwife.

Dr. Arthur B. Emmons, Boston: Nothing is being done in Massachusetts to eliminate the midwife. Our law registers physicians, and if a midwife wants to qualify before the board of licensure she must pass the examination. It is interesting to note that the daughter of one midwife has already taken a course in medicine and qualified as a physician. I believe that the plan which we have in Boston is an answer to the question of eliminating the midwife. WE [sic] have been working out a plan of holding prenatal clinics and conferences. From among the graduates of the lying-in hospital we select a number of young physicians who attend these patients, receiving from \$5 to \$10, depending on the section in which the women live. The follow-up work is done by the visiting nurse, and I am satisfied with our results from a medical point of view. I have worked the idea out with graduates in medicine with

the thought of its adoption in other parts of the country. Pennsylvania is leading this country in its requirements for medical licensure (Fife, 1916: 56).

Dr. DeLee, writing in a different article in *JAMA* during the second decade of my data, echoed similar sentiments and also noted that due to the lack of respect given to the field of obstetrics, women continued utilizing the services of untrained midwives.

Dr. Joseph DeLee, Chicago: The indictment of medical schools by Dr. Williams is true, but the principal cause is a matter of money. The public does not respect the obstetrician and will not pay him adequately. His standard is not so high as that of the surgeon. This lack of consideration for obstetrics extends through the hospitals and medical schools and the young men will not become either obstetricians or teachers but go into surgery and gynecology, which are better paid. The elevation of the standard of obstetrics in the opinion of the public first and in the schools afterward is the demand. When the women demand a better standard of service and cease employing midwives better service will be provided. This education of the women can be assisted materially in the women's clubs throughout the country. Maternity hospitals of high class must be established more universally in which nurses and physicians can be practically trained in obstetrics. This will naturally abolish the midwives ("The Midwife Problem and Medical Education", 1911: 1786).

In DeLee's opinion, only through the elevation of obstetrics as a respectable and effective medical profession could former patients of midwives see that midwives were no longer necessary medical practitioners (code: pfobst in Table 7). DeLee, in his advocacy for midwifery elimination, proposed that hospitals were far better training and birthing centers. In essence, he sought for improvement in maternity hospitals which would involve the use of nurses and physicians trained in obstetrical practice. And, he also proposed that medical education should focus on improving the field of obstetrics and educating women rather than midwives. Moreover, DeLee mimics Woods (1910) in that he advocates using women's clubs as a means of disseminating anti-midwifery sentiment.

Again, during the second decade of my data in *JAMA*, Dr. Yarros expounded upon the notion that hospitals would be the centers of highly efficient and adequate obstetrical care.

Dr. Rachelle S. Yarros, Chicago: The conclusions of Dr. Williams were true, but the public must demand good work and it will get it. The midwives, objectionable as they are, cannot at present be abolished, I believe; but if they are, then lying-in hospitals must be established where the expense is not great and the women educated to go to them in the instances, chiefly among the foreign population, in which they now demand midwives. As a measure of expediency and as an improvement over the midwife I recommend the education of the trained nurses to take care of normal cases, or to work as assistant with the obstetrician (“The Midwife Problem and Medical Education”, 1911: 1786).

Notably, Dr. Yarros like other physicians, argued for the betterment of obstetrical education for physicians and nurses as means of reducing the number of midwife-assisted births. In addition, placing birth within hospitals—which restricted access only to licensed health professionals (such as nurse and physicians)—also limited the practice of midwife. This process also known as the medicalization of birth also served as another avenue contributing to the elimination of midwives in that it gave doctors governance over the birthing process while also substantiating doctors as authorities on birthing knowledge. Understandably, if an authoritative knowledge base is placed in the realm of those who practice obstetrics, midwives would be considered outdated birth attendants. As discussed earlier, DeLee argued that bettering obstetrics rather than the midwife would have a greater impact on maternal and infant healthcare. However, not all physicians voiced these sentiments in their writings.

For example, in the third decade of my data within *JSCMA*, I found one sole instance in which a physician advocated that midwives should be utilized to provide instruction on better prenatal care (see code ababrgmw in Table 6). In essence, this physician viewed midwives, given their position and access to pregnant women as useful providers of medical information.

However, this medical information was given to them and approved by licensed medical practitioners.

Dr. L.A. Hartzog, Olar: We all realize the importance of instruction on prenatal care. We also realize the fact of the incompetency on the part of midwives in giving this instruction. Some time ago a pamphlet on prenatal instruction came under my supervision from one of my patients sent by a friend from another state that furnished these pamphlets to expectant mothers. That showed the effects it was having---that they were so enthused that this mother sent it on to one in this state. I think it would be a good idea if our State Board would print similar pamphlets and place them in the hands of midwives to give the expectant mothers (Simpson, 1928: 31).

Here, Dr. Hartzog not only maligned the intelligence of midwives but he also advocated that only by medical doctors providing pamphlets to midwives could expectant mothers experience better obstetrical care. And, implicitly, physicians were responsible for correcting the “incompetency on the part of midwives” (1928: 31). The last decade did not include any text relating the abrogation of midwives to better obstetrical training. However, I found that **other** codes revealed more statements by physicians addressing better obstetrical training as a means of substantiating doctors in birthing work and de-legitimizing midwives during the last two decades of my study.

For example, in my analysis of the code: critmw during the third decade of my data, I found a text illustrating a physician arguing for better obstetrical training as well as criticizing midwives. Dr. Shecut, in a discussion as to how to improve obstetrical teaching and the efforts of those in birthing work, advised in *JSCMA*, “This course of teaching will help them to learn the normal from the abnormal, and will be a great counteractor [sic] for the superstitions and false teachings of the old women and midwives” (1925: 116). Dr. Shecut, a licensed obstetrician maligned “the superstitions and false teachings of the old women and midwives” to further substantiate the authoritative knowledge of licensed doctors (1928: 31). In addition, his argument effectively de-legitimizes midwifery as a “real” practice.

During the fourth decade of my data, I found one out of five texts about midwifery education (code: mwteach) in which doctors advocated for better obstetrical training as a means of convincing pregnant women to use physicians and nurses for obstetrical care. This text is important because it still calls for the elimination of the lay midwife by instilling a need for better obstetrical care.

The development of more and still more teaching maternity hospitals for the better training of medical students, nurses, and midwives in the art of obstetrics and the intelligent cooperation of the lay public and the profession in the care of the expectant mother will do for obstetrics what preventive medicine has done in the general field of medicine (Riley, 1936: 1439).

Dr. Riley argued for his constituents to understand that obstetrics needed to become more preventative in a manner similar to those practicing general medicine. However, despite doctors vying for midwives to be educated and for obstetrical training to occur, some doctors felt that supervision was a far better way of dealing with the meddlesome midwife.

Supervision as an Effort of Midwifery Abrogation

Only *JAMA* had text (n=3, 3%) containing arguments for the regulation of midwives by supervision before 1910 (see code mwsuper in Tables 5 and 7). Again, though this study is principally focused on South Carolina, examining how other states regulated midwives via supervision is key to understanding what arguments physicians espoused. For example,

We have recently added to our Maryland laws one regulating the practice of midwifery. It requires ability to read and write, attendance on at least five cases of confinement, under capable supervision, and demonstration to the health board of ability to attend normal labor. It requires report, and forbids treatment of infantile ophthalmia. This law, and others similar, aims at making the midwife as harmless as possible, recognizing her standing, because she is necessity.

If that is the professional attitude toward her, it seems to me that we must go the full length of the situation, and

provide, as is done abroad, for education of the midwife up to her legal privileges. She has a unique place. Her patronage can never rise above a certain social line, and persons below this line do not know how to take care of themselves. Naturally, they become, in one sense or another, public charges. I do not mean that they must be supported; but I do mean that their ignorance leads to results from which intelligent men and women must save them. How and by what means the midwife is to obtain educational facilities I do not, at this time, at least stop to discuss. But, on the doctrine of her necessity in American life, it is worth thoughtful discussion, and such a group of men as make up this Section will soon have to grapple with it (Woods, 1910: 1163).

Here, Dr. Woods is arguing that midwives can only practice in Maryland based upon their ability to read and write, attend cases of confinement, and after having been under capable supervision. In other words, only by regulation can midwives be protected from “their ignorance”. There is a paternalistic taint to Dr. Woods’ statements because he feels that “intelligent men and women must save” midwives (1910: 1163).

Dr. Manton, also writing in *JAMA*, argued that midwife supervision should be enacted by legislation to staunch the number of women and infants treated by “an ignorant and dirty woman” (1910: 462).

We require that the physician shall have taken a prescribed course in a reputable medical school, the examinations of which he must have passed and later those imposed by a state board of registration, before he can legally enter into practice, and yet we permit, in many states without a question, an ignorant and dirty woman, such as depicted by Miss Crowell, ‘whose hands were indescribable, whose clothing was filthy, the condition of whose bag beggars description,’ to officiate in obstetrics, an important branch of medicine, and thus to slay and kill without one word of protest. Laws there are, which are enforced, for the protection of children, animals and birds, but the unfortunate mother and new-born babe are left unprotected to the mercy of the mercenary and indifferent. With all our vaunted philanthropy it would seem as if the times were ripe and civilization advanced enough for legislative control of these carriers of disease and death, and it should be the especial concern of every physician having the welfare of his community at heart constantly to urge, in season and out of

season, either the elimination of the breed, or, what seems more desirable, the creation of educational standards and state examinations and a supervision of midwives by legislative enactment (Manton, 1910: 462).

Continuing my investigation, the second decade of my data provided 7 out of 122 texts coded mwsuper (almost 6%). For example, in *JAMA*, Dr. Nicholson in a discussion about whether midwives should be eliminated or not, related that midwife-assisted deaths can be reduced only if midwives were supervised.

Dr. William R. Nicholson, Philadelphia: Without inspection of every case we cannot control the midwife. We have in Philadelphia five inspectors, graduates in medicine, who inspect every case after delivery has taken place. It seems to me that an association of this sort could do an immense amount of good if its members worked on a common ground. To me the question at issue is the benefit of the women now attended by the midwife. We do not believe that the midwife can be eliminated at present, and all we are doing is carrying out a police supervision---there is no other word for it. The women are brought to account for any infraction of requirements. We have saved the lives of babies and mothers, and improved obstetrics by our work, which may be regarded as a temporary expedient. I believe that if we had a certain number of English speaking, intelligent young women trained to care for women in labor, we would be able to get rid of a number of the midwives. We have nine such young women who have been in training from six to eight months. They attend lectures given by one of the inspectors, and must see and deliver twenty patients under inspection. This is an experiment which Dr. Baldy has given us permission to try out, and we believe that the result in a year or two will be good (Fife, 1916: 56).

Dr. Nicholson, in an effort to eliminate poorly trained birth attendants, argued that only true reduction of the midwife could occur if “English speaking, intelligent young women” were given lessons in obstetrics. What is implicit within Dr. Nicholson’s comments is the understanding that unless a midwife had received training approved by licensed inspectors, *untrained* midwives were a bane in birthing work. In addition, Dr. Nicholson expressed some prejudicial notions about midwives who are not English-speaking and who are too old and unintelligent. As previously

noted, in many northern urban areas, many midwives were foreign born and older women who routinely received castigation for their participation in American birthing work.

Critical judgments of midwives which included advocacy for midwifery supervision were present in the third decade of my data as well (n=3, almost 4%; see code mwsuper in Table 5 and 6). However these texts were only present in *JSCMA*. Such texts indicate that not only did physicians and other health professionals writing in these two medical journals focus solely on educating midwives, local, county, and state legislatures but rather began advocating for midwife supervision. For example, in an effort to obtain better reporting of infant births and deaths from birth attendants, physicians drew up a legal proposal to rid South Carolina of untrained midwives by calling for licensure and supervision.

A few suggestions are: First: Accurate and Prompt Registration of Births...Births must not only be reported but must be reported promptly and accurately by the ninth day of the month following birth or they do not count. Midwives report births more promptly than do some physicians. We understand that some physicians hold these birth certificates for several months before reporting them...

Third: Elimination of Uninstructed Midwives. The vast number of uninstructed midwives should be eliminated and only those who have taken and passed successfully the prescribed course of the State Board of Health should be allowed to practice midwifery. Here it is choosing the least of evils. Under the supervision of a health unit the death dealing liberties and chances taken by some of the most ignorant midwives can be eliminated. It is a question of what a midwife shall not do and how far she may go without calling in a physician. This particular point has been very strikingly demonstrated in my own county by the very efficient services of our public health nurse (Simpson, 1928: 29).

Interestingly, midwives are complimented yet also criticized within the lobbying of legislature for proper birth registration. In addition, midwives, specifically the “untrained” are an evil but those who are trained are the “least of evils” (1928: 29).

JSCMA provided, during this decade, one text illustrating a midwife’s reliance on and **acceptance of** physician supervision.

On June the 17th, I was called by a midwife to attend a young colored girl who was then in labor. It was the opinion of the midwife that the case was an exceedingly difficult one and as it was several miles in the country I asked Dr. Milton Block, a recent graduate of the Medical College in Charleston, now of Baltimore to accompany me. The delivery had already been completed when we arrived, however The midwife was in a great state of excitement and insisted that we make an immediate examination (Wilcox, 1925: 194).

This text not only demonstrates that some doctors did not attend cases in the country due to their geographic location; in addition, it brings to mind the question: could physicians' efforts to regulate midwives work to foster doubt or mistrust not only among the female American populace but also among midwives in birthing work? Here is yet another question that deserves further research.

JSCMA in the fourth decade provided five out of 40 texts (12.5%) reflecting physicians' advocacy for midwifery supervision as a form of regulation (see Table 6; code: mwsuper). *JAMA*, in comparison did not provide any text for the code mwsuper. Within these texts, I found one text reflecting midwifery supervision in which physicians used prenatal education and supervision as a means of regulating midwifery as a practice.

Dr. Robert E. Seibels (Columbia):...The policy of requiring the local medical society to request it before a clinic is inaugurated is a wise one and has resulted in a high degree of cooperation in the conduct of these clinics. They have not only provided examinations for many patients who in the light of past experience would not have had any, but they have permitted the physician to send to these clinics patients who otherwise would have been a drain on their office resources. They have provided prenatal care for the patients to be delivered by midwives and have given the county health department additional check on the midwives themselves ("Minutes of House of Delegates S.C. Medical Association, Continued", 1940: 234).

Some medical county commissions employed nurses as supervisors as well in order to determine if a doctor needed to supervise midwife-assisted births. So, granny midwives and their fellow sisters of birthing work had to suffer the scrutiny of two pairs of eyes as evidenced within *JSCMA*. I was unable to discover texts that reflected how county commissions wrote about

midwife supervision in the first and second decade of my data within *JSCMA*. However, I did find one instance in the third decade of my data in which *JSCMA* published a discussion in Greenville County, South Carolina about using nurses to supervise midwives.

Dr. DeWitt Kluttz, Greenville: I think a good idea would be to have the Association pay one-half, the County one-fourth and the State one-fourth to keep a negro nurse and a white nurse just to look after expectant mothers. The midwives were put through the same examination mentioned. The County Commissioners passed a law that made the midwife come in for examination and if they did not take it, they were put out. If they expected trouble they had to report it to this nurse and she went to examine the cas [author spelling] and, if she saw it was necessary, turned the case over to a doctor. If the doctor handled the case this allowed \$12.50 for him to look after the case. This small amount kept it from being a charity patient (Simpson, 1928: 31).

Here, Dr. Kluttz's advocacy for nurse supervision of midwives served two purposes. The first purpose was to ensure that midwives who experienced problematic births used the services of nurses and if necessary, the services of a physician. The second purpose of his advocacy supplied doctors with additional monies if they came to the aid of midwives. And, implicit within his advocacy is the understanding that midwives should not practice without licensed supervision.

And yet, some doctors felt that teaching, supervising, and regulating midwives would achieve the ultimate goal—removal of the midwife.

Physicians' Shifting Attitudes Towards Midwifery Abrogation

During my analysis of midwifery abrogation (code: abrogmw), I found that prior to 1910, neither *JAMA* nor *JSCMA* published articles that detailed conference discussions addressing midwifery regulation efforts. I examined these texts for conference discussions in order to find (a) more opinions expressed by physicians regarding midwives and (b) because such conversations would illustrate that midwifery regulation was multi-faceted rather than having what I expected which was a singular focus to eliminate the midwife. *JAMA* during the second

decade of the 1900s (primarily between 1911 and 1915), began publishing notes on conferences held about the state of midwifery. These conferences questioned the efficacy of the supervised midwife, whether doctors should seek to abolish the midwife, and whether education of the midwife provided a reduction of maternal and infant deaths. Within these notes, physicians argued for complete abrogation of midwives; however, some physicians continued to state that midwives were necessary practitioners of birthing work. Dr. Josephine Baker in *JAMA* speaks at length about what she felt her role was in regards to dealing with the presence of midwives in birthing work.

Dr. S. Josephine Baker, New York: My interest in the midwife is solely to make her as nearly as we can a fit person to give the mothers and babies their essential care; but it is an absolute impossibility to abolish her in the city at the present time. In New York, the mortality and morbidity of mothers and babies attended by midwives is in most instances, in proportion, less than that among those attended by physicians. We are coming to the better education of the medical student, but in the interim we are doing, just so far as we are able, that which seems the most efficacious and most nearly protects the mother and baby.

The midwife is being eliminated. We have in New York only half as many as there were seven years ago. It is probably that this elimination will come about by making the standards so high that none of the ignorant and untrained women can reach it. At present the women will practice whether you want them, whether licensed or not, and it is infinitely better to see that the care given by the midwives is at least adequate. In prenatal work my experience is that the midwife is one of our best cooperators in referring the mother to us for instruction; and, contrary to what has been said, the women do engage the midwife quite as early as women engage the doctor. We are having meetings with the midwives for purposes of instruction, and they are beginning to look on the health department, not as something to be feared, but as something which is a very definite help to them. Through such cooperation we believe we shall obtain reforms more effective than those obtained by radical measures (Fife, 1916: 56).

Dr. Baker's comments illustrate the contradictory slant by which physicians regarded midwives. Because of their employment by women from different classes, midwives continued to be a presence in birthing work during the time period of my study. Consequently, physicians and other licensed professionals had to discover a means of traversing the realms of birthing work alongside these women. Some physicians, like Dr. Baker, argued that it was more important to educate the midwife than to seek to eliminate her. Reason being, the lives of mothers and infants was a more pressing matter in birthing work than fully eliminating midwives (see total for abrogmw versus total for codes ifhealth and mathlth in Table 5). And, as Dr. Baker also pointed out, physicians were better able to solidify themselves as medical experts in birthing work by working in cooperation with midwives. Such *cooperation* enlisted midwives to trust and utilize the medical acumen of licensed health professionals rather than relying only on their own informal training. And, of further interest, Dr. Baker notes that midwives (more specifically, ignorant midwives) will be eliminated due to newly enforced rigorous standards. Lastly, Dr. Baker's comments align well with regulatory efforts that used education as a means to eliminate the midwife.

Dr. Huntington, like Dr. DeLee and other physicians, argued for the abrogation of midwives as well. What is interesting is that when some doctors reported that Europe and other foreign countries had better results with midwife-assisted births than the United States, Dr. Huntington found that results in other nations were unsatisfactory.

Dr. James Lincoln Huntington, Boston, sketched conditions in foreign countries where they have trained, supervised midwives, as in England and Germany, where the results are said to be unsatisfactory. America has no laws concerning midwifery, but they should be abolished and not licensed. The Boston lying-in hospital with out-patient service, assisted by the public and social workers, seems to have solved the problem ("Has the Trained, Supervised Midwife Made Good?", 1911: 1786).

In addition to calling for the abolishment of midwives, Dr. Huntington pointed out that Boston's lying-in hospital was successful in working to eradicate the midwife problem. Dr. Bacon also offered a contradictory point of view towards midwives. Initially, he begs for the elimination of the midwife. But, he counters these statements by advocating for more midwifery schools.

Dr. C. S. Bacon, Chicago: I believe if it is possible to abolish the midwives it would be well. In America each state can institute experiments and the whole country can profit by them. Whatever may be done in Boston or in Massachusetts, I believe, that in New York and Chicago the abolition of the midwife is absolutely impossible. As to midwife schools, if this matter is not to be allowed to go without any attention, there must be schools for midwives. It is doubtful whether the medical colleges can go into this work, but a university, which has its medical and other departments, can properly have a department of midwifery ("Has the Trained, Supervised Midwife Made Good?", 1911 : 1787).

Dr. Bacon, like other physicians during the second decade, viewed midwives as a problem but also as a necessity in birthing work. However, some physicians continued in their efforts to negate midwifery practice and used labor complications in midwife-assisted births as a foundation for further criticism of the midwife.

Midwifery Mishaps Necessitate Doctor's Aid

As outlined earlier, physicians used various arguments in order to secure a place-holding in birthing work. During my examination of my data, I discovered that some physicians used actual cases attended by midwives to de-legitimize these lay healers. My investigation uncovered a few arguments illuminating this point within *JAMA* and *JSCMA* within text coded critmw. For example, in *JSCMA* during the first decade of my data, Dr. Burgess, after having been called to deal with a midwife-attended birth, commented on the state of the woman's womb. "Doctor Burgess recalled his case of Caesarean Section reported a year or more ago. The case was in a dirty negro hut, some distance in the country. Wound was closed throughout with catgut. Later it

burst open and became infected with magots (sic)” (Pruitt, 1915: 62). Within this commentary, Dr. Pruitt indirectly criticized the attending midwife (which was more than likely a granny midwife given the location and race of the patient) for her technique in using catgut to close the wound. Again, the work of a midwife is considered inadequate and a physician’s assistance is paramount to ridding new mothers of maladies caused by the presence of a midwife.

In some instances, a midwife sought the assistance of a physician to assist in persisting obstetrical cases if she was unable to deal sufficiently with a patient. Although I used this text earlier to illustrate how midwifery supervision was accepted by midwives, the text is relevant for this discussion as well. Dr. Wilcox wrote such an accounting in *JSCMA* during the second decade of my data.

On June the 17th, I was called by a midwife to attend a young colored girl who was then in labor. It was the opinion of the midwife that the case was an exceedingly difficult one and as it was several miles in the country I asked Dr. Milton Block, a recent graduate of the Medical College in Charleston, now of Baltimore to accompany me. The delivery had already been completed when we arrived, however The midwife was in a great state of excitement and insisted that we make an immediate examination (Wilcox, 1925: 194).

Such an occurrence indicated a shifting of authoritative knowledge as well as demonstrated the amount of influence medical doctors held over midwives. In an effort to further discredit midwives, doctors used such instances to further substantiate their platform for their necessity for the general public, particularly pregnant mothers. The last decade of my data did not reveal any other texts reflecting such sentiments. Nevertheless, this discussion is of merit because physicians writing in *JSCMA* and *JAMA* used different platforms to discredit midwifery practice and pointedly noting instances in which midwives’ services were inadequate or unsatisfactory aided physicians in establishing themselves as the more credible practitioners in birthing work.

Summary of Inter-Occupational Conflict Analysis

JSCMA and *JAMA* reflected the theme of inter-occupational conflict in different ways. Physicians scrutinized midwives and labeled them problematic and as a hindrance to their participation in birthing work. Consequently, physicians writing in *JSCMA* and *JAMA* used various arguments for midwifery reform. For example, in both journals, some physicians sought to eradicate midwives by increasing licensure requirements. Some physicians opined that such regulation would limit and reduce the presence of midwives in birthing work. In addition, it would ensure that a more trained and knowledgeable woman would be participating in birthing work. And, hopefully, eventually the midwife would be eliminated. Other physicians sought to eradicate midwives by forcing them to undergo certain training seminars in order to weed out the “careless midwife”, while others believed that improvements in obstetrical education would convince pregnant women to enlist licensed nurses and doctors rather than midwives.

Noticeably, creating the notion that medical doctors are veritable experts in birthing work served as the main focus of midwifery regulation. And, though some physicians felt that educating the midwife was not a worthy cause, my study revealed that educating both the general female public and the midwife served as the most prominent form of midwifery regulation that physicians wrote about from 1900 to 1940. In addition, and similar to arguments espoused by physicians for increasing licensure requirements for midwifery practice was the belief that such regulation would either eliminate or reduce the number of practicing midwives in the U.S.

Midwifery supervision served as the second most prominent form of midwifery regulations advocated by physicians writing in *JSCMA* and *JAMA*. Physicians who argued that midwives required supervision either opined that a nurse supervisor was necessary and/or that doctors in order to protect pregnant women should be available to supervise complicated labor cases. In addition, *JAMA* contained instances in which doctors spoke of how efficacious programs in the North were able to successfully control the presence of the midwife by

introducing supervisory requirements within laws governing midwifery practice. Such commentary is important given *JAMA*'s impact on and medical relevance to physicians practicing in the U.S.

What is also interesting is that physicians offered contradictory views about midwives' participation in birthing work. On the one hand, some medical doctors such as Dr. Joseph DeLee viewed midwives as criminals and as a bane to the overall health of new mothers and their infants. On the other hand, some physicians like Dr. Mary Lapham, despite not wanting midwives to participate in birthing work, viewed midwives as a necessity, particularly when physicians did not seek to attend certain cases or travel to remote rural areas. Again, and specifically for the case of South Carolina, granny midwives largely proliferated in rural southern areas rather than within urban locales.

Many arguments that physicians espoused discredited the care of midwives by stating that midwives contributed to infant and maternal mortality rates and using actual cases as representation of the ill-advised care of midwives. And yet, physicians did not only use medical journals as a means of eradicating the midwife from birthing work. Some physicians also assisted lawmakers in lobbying for medical legislation to provide further strictures for practitioners of birthing work.

CHAPTER VI

LEGISLATIVE EFFORTS TO ABROGRATE GRANNY MIDWIVES

Given the arguments of Lay (2000) and Starr (1982), I expected legislation written and published during my study's time period (1900 to 1940) to include exclusionary language. In particular, I believed that there would be a significant shift in laws and regulations governing the practice of lay midwifery from unrestrictive to restrictive and/or prohibitive. Lay (2000), in her discussion of how legislation supported medical authority over women's bodies, details how physicians established biopower.¹⁹ Physicians instituted a definition of normal birth by discrediting midwifery practice and labeling normal births as hospital births supervised by an attending physician (2000: 173). Moreover, Lay (2000) points out how legislative policies such as medical practice acts and Sanitary Codes can provide "social and professional justification" for modernized views of the birthing process (2000: 173).

I found that physicians' professional writings, beginning in the early 1900s and continuing on to 1940, resonated with the themes of making medicine a more legitimate practice and advocating for the eradication of lay healthcare practices such as granny midwifery. Moreover, most of the commentary revealed that physicians wrote about different measures to regulate midwifery and using legislative bodies to support their arguments. For example, when discussing the purpose of statutes governing medical practice, physicians presented several discussions in regards to what language should be used and what goals they sought for the

¹⁹ Lay (2000) finds that despite Foucault's term biopower being problematic for studies of gender and power, the term is beneficial in understanding how medical professionals were able to control women's bodies within the birthing process. "Biopower takes two forms—disciplinary practices and regulatory power. Disciplinary practices represent the body within institutions and in everyday activities by creating desires, attaching individuals to specific identities, and establishing norms against which individuals and their behaviors and bodies are judged and against which they police themselves...Regulatory power is inscribed in the policies and interventions governing a population in which the body serves as the basis of biological processes affecting birth, death, the level of health and longevity and is the target of state societies" (Lay, 2000: 173).

medical practice. Namely, physicians sought to secure their place in American healthcare, protecting the general public from miscreants, and eradicating illegitimate practitioners. I initially expected that medical practice acts would be suitable for noting changes in midwifery regulation. I discovered, however, that most midwifery regulations were printed in the Sanitary Codes of the South Carolina Bureau of Health. Consequently, my analysis of shifts in legislation encompasses an examination of both medical practice acts and Sanitary Codes published during the forty year period of my study. In fact, the rules within the medical practice acts exempted “dentists, trained nurses, pharmacists, opticians, optometrists, [and] midwives” (*American Medical Directory*, 1921: 1386). This exemption extended over the entire forty year time period of my study.

To be clear, in 1920 the South Carolina State Board of Health incorporated “a set of rules governing midwives...in our Sanitary Code” (Dodd, 1920: 21). In my examination of *JSCMA*, I found no other legislative mention of midwives prior to 1920. U. G. Dubach (1916) found that state boards of health were designed to secure and promote public health. His research on national state boards of health found that like some other states, South Carolina’s Board of Health/Sanitary Codes “add to the list of diseases to be reported which are specified in the law,” “give power to make rules governing quarantine,” and are “granted to enact rules to prevent the introduction and spread of communicable diseases” (1916: 84). In addition, the board of health’s codes “should contain rules and regulations for the improvement of the sanitary and hygienic conditions of the State” (1916: 93). Ubach’s (1916) research is particularly salient given its year of publication and his inclusion of South Carolina within his commentary on state public boards of health.

The year 1906 marks the first publication of the *American Medical Directory*, which published medical practice acts for each of the states in the U.S and continued printing every three to four years. I should note that previous legislature existed regulating medical practice in

South Carolina. However, these laws made no mention of midwifery and, as Weitz and Sullivan (1992) found, most states did not regulate midwives until the 1920s. This document was important because physicians and other medical practitioners relied upon medical practice acts in order to understand what forms of education must be obtained and standards that should be adhered to in order to practice medicine. In addition, medical practice acts also informed medical doctors of the subsequent punishment for noncompliance. The medical practice acts for the State of South Carolina are printed in three to four year time spans and specifically are for the purpose “[t]o regulate the Practice of Medicine in South Carolina, to provide for a State Board of Medical Examiners and to define their duties and powers” (“South Carolina,” 1906: 867). Consequently, I examined the medical practice acts of: 1906, 1909, 1912, 1914, 1915, 1916, 1918, 1921, 1923, 1925, 1927, 1929, 1931, 1934, 1936, 1938, and 1940 (see Table 8). As I discussed earlier, *JSCMA* alerted me to the fact that the Sanitary Codes housed midwifery regulations. Moreover, I investigated language within the medical practice act; the acts did not discuss midwifery at length nor mention where midwifery regulations could be found.

The South Carolina State Board of Health published an annual report titled “Reports and Resolutions” as its first record. Within these reports, the South Carolina Sanitary Codes were published annually and are formally titled South Carolina State Board of Health Sanitary Codes of South Carolina. However, Sanitary Codes regarding midwifery regulation appeared in 1914. The other years in which the South Carolina State Bureau of Health published Sanitary Codes that included mention of midwifery regulations are as follows: 1915, 1928, 1929, 1932, 1934, 1935, and 1937.²⁰ Table 8 indicates the publication years of midwifery regulation in the Sanitary Codes and the South Carolina medical practice acts. During my review of these years, I

²⁰ I was able to procure these records from the South Caroliniana Library due to a personal investigation of Bureau of Health records at the Medical University of South Carolina Waring Library and through the efforts of the archivist, Roberta (Robin) Copp. The South Carolina State Board of Health also published Sanitary Codes in 1919; however, these Codes did not include mention of midwifery regulation. See email correspondence in appendices.

examined the medical practice acts and the Sanitary Codes for the presence or absence of the following:

- (a) Is there an explicit mention of midwifery care or midwives?
- (b) Does the medical practice act or Sanitary Code allow unlicensed midwifery?
- (c) Are midwives exempt from the provisions of the medical practice act or Sanitary Codes? If so, are there particular conditions for the exemption?
- (d) Does the medical practice act or Sanitary Code require a license in order to practice midwifery?
- (e) Are there requirements for medical schooling from an accredited medical institution and/or nursing school in order to practice midwifery?
- (f) Does the medical practice act or Sanitary Code impose a financial punitive action (e.g. fines) against unlicensed medical practitioners?
- (g) Does the medical practice act or Sanitary Code impose a jail sentence against unlicensed medical practitioners?
- (h) Is supervision required in order to practice midwifery?

Midwifery Regulation

Since I expected that Sanitary Codes and medical practice acts worked in tandem, I began my analysis investigating the earliest published medical practice acts. I then examined the Sanitary Codes and medical practice acts consecutively during the time period of 1900 to 1940. I used this method of analysis in order to discern whether the medical practice acts included similar midwifery regulation as printed in the Sanitary Codes. Language is significant in my investigation because I expected that changes in stipulations would reflect a stronger restraint of midwifery care. I began my review of each medical practice act with the aforementioned questions in mind.

South Carolina medical practice acts mentioned midwives in the *American Medical Directory's* first publication in 1906. During this year, the provisions of the medical practice act exempted midwives. This same stipulation holds true for the years 1909, 1912, and 1914. The year 1914 is particularly significant for my analysis of legislative statutes because the Sanitary Codes for South Carolina begin in 1914.

Within the 1914 Sanitary Codes, Rule 19 of Quarantine and Disinfection states, “whenever any nurse, midwife or other person not a legally qualified practitioner of medicine shall notice inflammation of the eye or redness of the lids in a newborn child under his or her care, it shall be the duty of such person to report the same to the local health authority, or in his absence, to any reputable physician, within twelve hours of the time the same is first noticed” (*Sanitary Codes*, 1914: 86). As mentioned in Chapter V, one of the many criticisms of lay midwives was their supposed contribution to eye infections among new infants because they did not use antiseptic procedures during birth and/or neglected to apply silver nitrate to an infant’s eyes after delivery. Noticeably, midwives were not prohibited from any other practices during this year. However, the year 1915 marked a turn of events.

In South Carolina, there was a marked concern regarding the deaths of mothers and infants, as reflected within *JSCMA* during the third and fourth decade of my data (see Table 6, codes ifmt and matmort). In comparison, *JAMA* during the second and fourth decade of my data contained texts reflecting interest in maternal and infant health (see Table 7, codes ifhealth and mathlth). Within these two decades of my study period, physicians and other health lobbyists argued that maternal and infant deaths should be checked for their causes, particularly if the death or deaths occurred during a midwife-assisted delivery (see discussion of midwifery persecution in Chapter V).

And in my examination of *JSCMA* texts within the second decade of my study period, I found one 1915 publication that listed a proposed amendment to the South Carolina medical

practice act that detailed midwifery regulation. This amendment proposed that every midwife should register with the Clerk of Court in her county, provide her age, length of time and place of practice, pay a fee of \$1, and pass an examination as provided by the State Board of Medical Examiners. The examination fee would be \$10 and once a midwife passed, she would be issued a midwifery certificate. If a midwife had pre-registered with the Clerk of Court, her fee would be \$0.50 (“Proposed Amendments to the State Medical Practice Act as will be Submitted to the Delegates of the South Carolina Medical Association at their Annual Meeting at Greenwood, S.C.,” 1915: 75-6).

My investigation of the medical practice acts of South Carolina did not contain this amendment for the year 1915 nor did I see explicit mention of these guidelines in the Sanitary Codes for 1915. Despite its absence, this observation is significant because an amendment of this nature would demonstrate a more direct link between physicians’ legal advocacy for midwifery regulation in their professional writings and legislative statutes that govern medical practice. In other words, viewing how physicians’ arguments for midwifery regulation resulted in a change in medical legislature would provide evidence of the impact of physicians’ professional writings. However, such was not the case. Rather, the Sanitary Codes proved to be a far more informative source regarding midwifery regulation in South Carolina.

Turning back to my examination of the Sanitary Codes, the 1915 Sanitary Codes stated “midwives shall not sign certificates of death for still-born children; but such cases, and still-births occurring without attendance of either physician or midwife, shall be treated as deaths without medical attendance, as provided for in section nine of these regulations” (*Sanitary Codes*, 1915: 93). The South Carolina Board of Health considered midwives as medical birth attendants, yet limited their authority in regards to signing death certificates. Moreover, if a patient died, the South Carolina State Board only accepted death certificates signed by physicians.

[T]he medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state cause of death, so as to show the course of the disease or sequence of causes resulting in the death, giving first the name of the disease causing death (primary cause), and the contributory (secondary) cause, if any, and the duration of each (*Sanitary Code*, 1915: 94).

Herein lies an example of Abbott's (1988) contentions about how professions are created and sustained. A legal jurisdictional claim allowed physicians to claim ownership of medical knowledge. Moreover, this ownership further substantiated that only physicians—not lay healers—could define or determine death. Starr's (1982) conceptualization of how those (in this case physicians) are able to occupy authoritative positions is particularly helpful in my analysis of Sanitary Codes and medical practice acts. Starr (1982) elucidates that individuals society considers as professionals (again meaning physicians) are titled with “superior competence” (1982: 11-12). This titling thereby helps to make clients/patients and other practitioners dependent upon their expertise. So, the South Carolina Sanitary Codes stating who could sign death certificates demonstrated a dependency on physician expertise and a legal jurisdictional claim as well. These Codes do not specify what types of patients or if such conditions extended to women and their infants in delivery rooms. Given the Sanitary Codes lack of specificity, I assume that such regulations applied to the general populace regardless of the nature of death.

Stipulations for who could sign birth certificates differed from those for death certificates. Both physicians and midwives were allowed to file and sign birth certificates since it was their duty as the birth attendant. “[I]t shall be the duty of the attending physician or midwife to file a certificate of birth, properly and competently filled out, giving all the particulars required by this act, with the local registrar of the district in which the birth occurs, within ten days after date of birth” (*Sanitary Codes*, 1915: 97). Similar to 1914 regulation regarding the reporting of eye infections among newborns, midwives, nurses, and “other persons [who were] not legally

qualified practitioners of medicine were required to report eye inflammation to a local health authority or physician” (*Sanitary Codes*, 1915: 97). Again, Starr’s (1982) and Abbott’s (1988) works are salient in my examination of South Carolina medical legislation. Physicians’ “superior competence” set a benchmark for medical regulations that supported this notion of competence while also discrediting the expertise of others, including midwives. So, not only was midwives’ birthing knowledge discredited, physicians legally held the right to supervise midwifery care.

Lay’s (2000) discussion regarding how authoritative knowledge is created is relevant to my analyses of birthing stipulations as well. She states that when authoritative knowledge is socially accepted, tools, procedures, or theories result (Lay, 2000: 21). As I argued earlier, the professionalization of medicine aided doctors in becoming viewed as authorities in medical care. Given this designation, it is no surprise that medical legislation reflected how society attributed authoritative knowledge of medicine (including birthing work) to physicians.

As with earlier medical practice acts, the years 1916, 1918, 1921, 1923, 1925, and 1927 continued to exempt midwives from stipulations of practice within the South Carolina Medical Practice Acts. Sanitary Codes regarding midwifery regulation, as previously noted, were not printed for these years. I am unable at this point in time to discern why such was the case despite my archival research regarding these records. The Sanitary Codes begin to discuss midwifery regulation again in 1928.

The 1928 Sanitary Codes included the same 1914 requirement for midwives in regards to reporting eye inflammations. As mentioned in my analysis of *JSCMA*, the South Carolina State Board of Health advocated for better maternal and infant healthcare and instituted a number of state-wide projects to decrease maternal and infant mortality rates. One of these projects was the establishment of the Bureau of Child Hygiene and Public Health Nursing. During the late 1920s, this Bureau took a yearly accounting of the effectiveness of maternal and infant healthcare activities, such as child healthcare conferences as well as other public health interventions such as

tuberculosis clinics. Included in the Bureau's reports were counts of midwife classes and the number of midwives. The first report of the Bureau of Child Hygiene and Public Nursing appeared in 1928. The establishment of this Bureau and a publication of its records are particularly important because their origins coincided with the national campaign for maternal and infant health. To reiterate, part of the campaign included midwifery reform and providing states with monies for midwifery education. Examining the reports of the South Carolina Bureau of Child Hygiene and Public Health Nursing assists in noting South Carolina public health efforts geared towards midwifery regulation and/or its elimination. Moreover, if the treatment of midwives shifted due to physician advocacy in *JSCMA*, more exclusionary language may be present in the Sanitary Codes.

During this year and within the Sanitary Codes, Laura Blackburn (a midwife supervisor) reported on the regulatory efforts of the South Carolina Board of Health and one of the main thrusts of the Bureau was to round up the midwife. (See earlier discussion of midwifery supervision in Chapter V for review of Ms. Blackburn's efforts as printed in *JSCMA*.)

State Efforts to Round Up the Midwife

I argued that from 1900 to 1940 physicians used arguments rooted in racist and sexist commentary in their professional writings in support of the elimination of the midwife. In addition, the threat of inter-occupational conflict within birthing work would also serve as a base for physicians' statements for midwifery abrogation. I found that some physicians and other licensed health professionals (chiefly nurses) sought to supervise and teach midwives in an effort to circumvent birth complications, maternal mortality, and infant mortality. Moreover, their arguments would be illuminated in changes within medical legislation. Prior to 1928, the Sanitary Codes did not report the efforts of the Bureau of Child Hygiene and Public Health Nursing.

Beginning in 1928, Ms. Blackburn began reporting on the state of midwifery in South Carolina.

At the present time the only two counties in which the Midwives are untaught and unsupervised are Lexington and Greenville, and in Greenville, Miss Dalton is now engaged in rounding them up and organizing classes. In Lexington County the work was begun several years ago by Miss Blackburn but discontinued at the request of the County Medical Society (*Sanitary Codes*, 1928: 90).

Of further import is that Ms. Blackburn notes that physicians are in “sympathy with the work [of midwifery regulation] and are very cooperative” (*Sanitary Codes*, 1928: 90). Training courses tended to last for a month and some were held at historical black colleges such as Voorhees in Denmark, South Carolina. In addition, within Ms. Blackburn’s notes, she mentions how many of these training courses used educated black midwives.

To assist Miss Malone this year, Nurse Hilda Warren, a colored graduate midwife of Bellevue Hospital, was employed. With her help much work was done. Eighteen (18) patients were delivered in the hospital, 13 in homes and six were brought to the hospital for after care. Five others who had been delivered by local doctors or midwives were given post-partum care in their homes (*Sanitary Codes*, 1928: 91).

Yet another surprising element within Ms. Blackburn’s notes is the reported receptivity of midwives to formal educational training. “The midwives came from 27 counties. This was due to the efforts of the staff and county nurses. The general attitude of the midwives toward their work was excellent and things ran even more smoothly this year than they did last” (*Sanitary Codes*, 1928: 91). I noted previously in Chapter V an instance in which a midwife was amenable and understanding of midwifery training by a black nurse supervisor. Moreover, she accepted that the newer version of midwifery was better than what she had been taught by her predecessors. Here again within the *Sanitary Codes* is another formally trained black midwife assigned to reform lay midwives into licensed midwifery and what appears to be a general acquiescence by lay midwives (see earlier reference to Miss Mary Dodd as discussed within *JSCMA*). However, such reports should receive scrutiny given that the South Carolina State

Board of Health and many South Carolina physicians sought to either eliminate or reduce the number of practicing midwives. Nurses employed by the state **needed** to establish their efficacy in rounding up and better training midwives in order to stay employed and as a means of demonstrating that South Carolina's maternal and child healthcare was improving.

Some attention must also be paid to the fact that these midwives knew they were under observation. Anthropologist Marie Campbell in *Folks Do Get Born*, an anthropological study of granny midwives on the Georgia Sea Islands, described anecdotal instances of midwives complying with midwife bag inspections and behaving well under the supervision of white nurses. Upon leaving the presence of their nurse supervisors, many granny midwives removed newer implements from their midwife bags and replaced them with their old implements and medicines. Although Campbell (1946) is speaking of granny midwives on the Sea Islands of Georgia, it would not be a far stretch to assume that midwives in South Carolina exhibited similar behaviors considering that South Carolina and Georgia geologically share the Sea Islands and the granny midwifery school of South Carolina was located in the Sea Islands.

In order to further establish the ineptitude of *untrained* midwives, the Board of Health appointed nurses as acceptable instructors. Consequently, staff and county nurses taught classes and demonstrated various methods for attending births.

The demonstrations consisted of bed making, bed baths, bathing of baby, baby's tray, enemas, douches, preparation for delivery, delivery, post-partum care, temperatures, etc. Supplies were made, such as newspaper pads, bed pans, bags, etc., and the simple solutions were taught. An effort was made to make these demonstrations so simple that they would be applicable to any home, no matter how poor, that the midwife might enter in her work. They were taught to use newspaper in every available way and the simplest equipment was used (*Sanitary Codes*, 1928: 91).

Graduation exercises oftentimes included awards to the midwife with the best bag and plays that demonstrated the differences between the old midwife and the more highly trained and educated midwife. For example, once midwife classes were reviewed to see if some midwives delivered

“insufficient service or [had] physical disabilities,” midwifery supervisors inspected the midwife bag (1928: 91). Midwives suffered punitive action if they failed to comply with standards for their midwifery bags. For example, “. . .if [the bag was] found incomplete or in bad condition the midwife is suspended until she has corrected what is wrong” (1928: 91). So, noncompliance to certain midwifery standards served as a gate-keeping mechanism. Other methods of gate-keeping included nurses appointed by the Bureau of Child Hygiene conducting reviews of midwifery standards of care. Similar to other forms of evaluation (e.g. checks to see if a midwife’s bag is in poor condition), noncompliance with midwifery standards involved license (or certificate, depending upon the county) suspension. Also, nurses revoked midwifery certificates if midwives provided “insufficient service or [had] physical disabilities” (*Sanitary Codes*, 1928: 92). Some counties held specific standards for their midwives, such as Laurens County where “midwives were required to review the entire course of ten lectures and demonstrations” (*Sanitary Codes*, 1928: 92).

Nurses responsible for training midwives used other methods to establish the inadequacy of old forms of midwifery. One graduation activity, in particular, contained the prevailing element of lay midwifery criticism.

A Playlet entitled “The Old Order Passeth,” written by Miss Blackburn, with the assistance of those at the Institute, was acted at the graduation exercises, by the midwives themselves. They played their parts most creditably and showed to the audience the difference [between] the old and the new midwife (*Sanitary Codes*, 1928: 91).

Not only were midwives expected to participate in teaching exercises but to also participate in castigation of their former practices in a theatrical setting. In addition, since a licensed midwife wrote the lines for this performance, an underlying element of authoritative knowledge of birthing work being held only by licensed professionals is present. As indicated previously, many granny midwives surreptitiously disobeyed their nurse supervisors and state midwifery regulations once they were no longer under direct supervision. Midwives acting in these plays at the Midwifery

Institute may have *truly* been performing once again in regards to receiving the approval of their professional licensed counterparts. Again, some midwives opted to practice under new forms of midwifery regulation in order to remain in midwifery practice. In other words, and using the works of Lay (2000), Starr (1982), and Abbott (1988), granny midwives understood that participating in birthing work entailed bowing to the authoritative knowledge of physicians and nurse midwife supervisors and to legislative stipulations governing midwifery practice.

What is equally of import is the fact that nurses also occupied a higher position than midwives in the medical hierarchy. By employing nurses as midwife supervisors, the South Carolina Board of Health made it apparent that midwives were no longer authorities within the field of medicine. And, in order to handle the medical problem of birth, nurses as well as physicians held a legitimized claim to jurisdiction in birthing work. As Lee (1996), Fraser (1998), and Mathews (1992) found, these newly enforced standards of care also provided the public alongside midwives with an understanding that nurses and physicians deserved to occupy dominant hierarchical positions in birthing work while lay midwives occupied subordinate positions. And, despite the medical practice acts exempting midwives from its provisions, the South Carolina State Board of Health ensured their governance of midwifery.

The 1929 Sanitary Codes did not include any regulations about midwives or efforts to eliminate midwives; rather the Sanitary Codes contained records of organized midwifery training classes and midwifery reviews. However, pertinent statistics were discussed in this year's publication as well as those which followed until 1936. These statistics provide a picture of the number of midwives practicing as well as how many women were able to complete midwifery training given the standardization of midwifery care. During this time period, the Codes published the following statistics: In 1929, there were 2,033 midwives and 3,588 doctors (*Sanitary Codes*, 1929: 67).

In regards to statistics focusing on midwives, the Bureau of Child Hygiene and Public Health Nursing reported:

Midwife classes organized:

No. of Midwife Classes Organized.....120
No. Class Meetings Held.....120
No. New members.....128
No. Old members.....158
No. Completing course during year..... 77

Midwife classes reviewed:

No. midwife classes reviewed.....749
Attendance.....6,822
No. Certificates Withdrawn.....111 (*Sanitary Codes*,1929: 68).

I expected to find evidence of a reduction in the number of midwives practicing in the State of South Carolina due to the presence of midwifery regulations, midwifery education, and midwifery supervision. Previously, I discussed the punishment that noncompliant midwives received, which included license supervision and certificate revocation. Examining the 1929 Codes demonstrates that 111 midwifery certificates were withdrawn meaning that 111 midwives no longer practiced due to noncompliance. In addition, further investigating these statistics, there is a marked difference between the number of new members joining midwifery classes (128), the number of old members (158) and the number of midwives that actually completed the course (77). My analyses of *JSCMA* and *JAMA* revealed that midwifery education served as one of the main tools used by physicians to regulate the presence of midwives in birthing work. These statistics further support my finding by illustrating how midwifery supervision and midwifery education were slightly effective institutional roadblocks to women seeking to practice midwifery in South Carolina.

Moreover, the theme of authoritative knowledge is prevalent both in regard to the number of women granted a passing grade for the course and the number of women whose certificates were withdrawn. Also, physicians continued to occupy their positions as medical authorities as a result of their interdependent relationship with the South Carolina legislative body. Nurse

Blackburn as well as other South Carolina midwifery supervisors substantiated their authoritative stances by ridiculing the old ways of midwifery while touting newer advanced forms of birthing technology. Also, only licensed health professionals possessed knowledge of these more effective birthing strategies which thereby created an interdependent relationship between midwives and their licensed counterparts.

Starr (1982) maintains that such interdependence advances physicians' and licensed health professionals' jurisdiction in healthcare. Moreover, these regulations fostered a cultural understanding that birth required medical management rather than lay midwife attendance (Schur, 1983). Lay (2000) writes that society considered physicians and nurses as medical experts due to social, economic, and in the case of the Sanitary Codes and medical practice acts, political backing. And such regulations create a system in which medical knowledge is linked to "formal education, abstract standards, and hierarchical relationships among practitioners" (Lay, 2000: 32).

Examining the medical practice acts for 1929 and 1931, midwives continued to be exempt from the provisions. Turning back to my analysis of the Sanitary Codes, similar to 1929, the 1932 Sanitary Codes did not provide regulatory measures for midwives within the Codes; however, the Codes indicated the impact of an annual midwife meeting. Such meetings or conventions, as I discussed in Chapter II, aid in detailing the legal scope of practice as agreed upon by the state and the profession (particularly birthing work). I argue, using Weber's conceptualization of the impact of law on society, that the midwife meetings were held to discredit traditional approaches to healing (old historical ideas) in order to "point in the direction of conduct that various interests promote" (Gerth and Mills, 1965: 63). For the purpose of my analysis, physicians sought to promote their interests by legal advocacy, and medical regulations reflected the efficacy of physician efforts.

Also, the year 1932 marked another publication of records which focused on “get[ting] information to the public that will result in the reduction of the amount of illness and the number of deaths among infants and children and their mothers, and the stimulation of a general interest in the positive cultivation of health, helping to bring about that time when everybody will realize that the mere avoidance of disease, though a step in the right direction, is not enough” (*Sanitary Codes*, 1932: 46). Again, using Weber’s conceptualization of the sociopolitical impact of law, the State Board of Health using legislative regulations assisted physicians and nurses in maintaining their “material and ideal interests” (Gerth and Mills, 1965: 63). Revisiting the work of Hill Collins (2000) and Schur (1984), social realities are constructed and people are categorized based upon the creation of an *other*. As I have previously argued, doctors viewed granny midwives as the other and subsequently these women became interlopers and social pariahs in birthing work. Consequently, physicians and other licensed health professionals sought to eliminate these women by education and supervision. Within this 1932 publication, considerable attention was given to educating and supervising midwives. More specifically, September, 1932 was an important month in regards to addressing midwifery in South Carolina.

The first State meeting for midwives occurred in conjunction with a conference instructing nurses how to teach and supervise midwives (*Sanitary Codes*, 1932: 49). State Field Nurse and Midwife Supervisor Miss Blackburn again reported the state of midwives in South Carolina and detailed her review of 174 midwife classes with an attendance of 1,447 to the Bureau of Child Hygiene and Public Health Nursing. To address the need for midwifery tutelage, “Miss Blackburn conducted a two weeks’ institute for midwives at which twenty-four women were given instruction” (*Sanitary Codes*, 1932: 50). Unfortunately the report did not include statistics indicating the number of midwives who passed the midwifery classes and received certificates. Midwives possessing the best midwife bags or a “very good appearance” in their midwife uniforms received prizes (*Sanitary Codes*, 1932: 50). As Rooks (1997) pointed out,

physicians used defamatory remarks about the appearance of midwives and their archaic ways of treatment in order to dissuade women from using midwives. Rewarding midwives for their adherence to standardized midwifery protocols served as another means of reducing the authority and presence of lay midwives. Case in point, unlike previous years, the 1932 Sanitary Codes mention physicians' and nurses' success in reducing the number of midwives in South Carolina.

We are glad to report that the number of midwives in the State has been reduced to about 3,000 from over 6,000 ten years ago. This means that many of the most incompetent have been eliminated and those in active practice now are, on the whole, cleaner and more intelligent (*Sanitary Codes*, 1932: 51).

And, to further advocate for the proper training of midwives, the report mentions a decline in maternal and infant deaths and in particular mentions a reduction in black maternal and infant death rates.

Federal figures for the year 1930 are not yet available, but a tabulation made by this office of our State figures on maternal and infant deaths reveals a substantial reduction in each case from the 1929 rates. It is interesting to note that from 1919 to 1928, the last year for which we have figures tabulated separately for white and colored, there was a decided reduction in the colored rates for both infants and mothers although there was an increase in both rates for whites. This would seem to indicate that the instruction of midwives, who deliver most of the negro mothers, has not been without value to the State (*Sanitary Codes*, 1932: 51).

Here, the author used data from previous decades as a means of attributing reductions in infant and maternal mortality among blacks. In addition, the author implied that midwifery as a practice is now worthy to South Carolina due to regulation efforts such as midwifery education. This discussion is linked to my analysis of *JSCMA* concerning infant mortality rates in Chapter V. In this analysis, I reported that some physicians in South Carolina oftentimes attributed higher mortality rates to the black populace. And, based upon my review of literature concerning midwife abrogation during the early 20th century, I argued that physicians advocated that lay midwives such as grannies contributed to infant mortality rates and used racist arguments about the competency of blacks to discredit lay midwifery care. Yet, the aforementioned paragraph

demonstrates that physicians later viewed trained granny midwives as a valuable asset to South Carolina for both whites and blacks.

Although the medical practice act for 1934 continued to exempt midwives from its provisions, the Sanitary Codes for this year did include information about midwives. The publication noted that the Narrative Report of the Bureau of Child Hygiene as printed in the Sanitary Codes contained information about other methods of midwifery regulation. The Bureau required midwives to distribute health literature to their patients and clinics. Similar to 1932, an annual State Midwives' meeting occurred and midwives received praise as well as rewards for having satisfactory midwife bags. One startling difference in this State meeting involved a discussion of further standardizing midwifery care. The Bureau also mentioned the impact that the State Midwives Institute had on the state of midwifery care in South Carolina. In particular, "a younger, more intelligent midwife is coming forward at this school and even those who are older go back to their communities and have a great influence on the women of their communities" (*Sanitary Codes*, 1934: 34).

Consistent with my previous analysis of *JSCMA*, some licensed health professionals wanted to improve midwifery care not by ridding South Carolina of midwives; rather, these officials proposed increasing educational standards and licensing stipulations to develop more proficient midwives. Moreover, the State reported in the Sanitary Codes that "2 graduate nurses...took the course to become midwives and several practical nurses. This is the ultimate goal in Midwifery, the trained Nurse Midwife" (*Sanitary Codes*, 1934: 34). And yet, having such a goal has an under-girding argument for the abrogation of lay midwives or those women serving as birthing attendants without proper midwifery schooling. In contrast, the medical practice act of South Carolina for 1934 continued to exclude midwives from its provisions. This persistent silence is particularly interesting given that the Sanitary Codes explicitly mentioned methods of midwifery regulation and protocol.

Medical practice acts and state boards of health were designed to secure and promote public health (Ubach, 1916). And, the board of health's codes "should contain rules and regulations for the improvement of the sanitary and hygienic conditions of the State" (1916: 93). So, as Ubach (1916) found in his research on state health boards, the state of South Carolina (like other states) assigned a group of individuals to determine medical regulation. This group of individuals was largely composed of licensed medical doctors. Therefore, physicians were better able to situate themselves as veritable experts in medicine and, for the purpose of this project, in birthing work despite the medical practice act not outlining midwife regulation.

In 1935, State Field Nurse Blackburn provided an annual report on South Carolina midwives. In her report, she lauds that "2,604 midwives were supervised," "129 midwife groups were inspected," and that an outside instructor "Dr. Bartlett, professor of Public Health, University of Michigan" was invited to attend two midwife classes and "she was delighted at the progress the midwives had made" (*Sanitary Codes*, 1935: 26). Again, the report did not contain the number of midwives who passed the classes so I was unable to discern how effective such instruction was on eliminating untrained or lay midwives in South Carolina. Miss Blackburn, in her efforts to improve midwifery practices, "visited Florida's State Midwives Institute [and] sent Nurse Trezevant to study for one week under Miss Ely, to help in [the Midwife] Institute" (*Sanitary Codes*, 1935: 27). The State meeting for midwives included similar portions to other county midwife meetings and the Midwife Institute such as award ceremonies for the "best equipped bag" and the county with the largest number of midwives. Ms. Blackburn noted that some women attended previous institutes and the activities of the 1935 Midwife Institute.

As participants, midwives in attendance received Chase doll demonstrations.²¹ In addition, graduation included the annual play demonstrating the inefficacy of the old midwife

²¹ Chase dolls (also known as Sanitary Dolls) were used in hospitals and by nurses to teach obstetrical care. See <http://nursingald.com/uploads/newsletters/CT052000.pdf> (page 16) for a complete history of the doll's evolution and uses.

versus the new midwife (*Sanitary Codes*, 1935: 27). This Institute also included an inspirational and instructive program which was a slight variation from previous midwifery training meetings because of the addition of the inspirational portion. And, the Sanitary Codes also explicitly mentioned black midwives in its reports of midwifery training sessions such as midwife institutes and meetings.

In particular, one event salient to my investigation of granny midwifery as discussed in Miss Blackburn's records was The One Week's Institute. This Institute, patterned after the State Institute, occurred in Berkeley County, which historically had a large black populace. Within this county, midwifery instruction happened at "a colored school and clinic" and, as participants in the program, midwives received "lectures by doctors and nurses and Chase doll demonstrations" (*Sanitary Codes*, 1935: 27). The Prenatal Conference "at the Colored Clinic, Pineville" was a result of this Institute which included further instruction of practicing black midwives (1935: 27).

What makes The One Week Institute relevant to my study? My project examines how physicians, using their professional writings and medico-legal influence, sought to eliminate granny midwives in South Carolina. The One Week Institute occurred in a predominantly black county and involved physicians and nurses serving as midwifery supervisors and teachers. Miss Blackburn notes that the Institute showcased a need for improvements in midwifery care, primarily among black midwives. Since many midwives lacked access or the ability to attend the Institute, they might have been subject to a license suspension or revocation of a midwifery certificate if their absence was revealed. In addition, since birthing work at this point was legally governed, midwives could either comply with regulation or cease practicing midwifery. As Lay (2000) noted, physicians and other licensed health professionals served as gatekeepers of birthing work and used legal and social credibility as a platform for medical authority. And, health officials created even more institutes to address the need for improvements in midwifery care in South Carolina. For example, one-day County Institutes began because of the utility of the Chase

doll for proper demonstration of birthing procedures and because many midwives (black and white) lacked access or the ability to attend the State Institute. More importantly, health officials such as Miss Blackburn sought not only to improve midwifery care but to also change the practicing midwife in South Carolina.

Miss Blackburn in her report commented on the need to rely on a different type of midwife. “Our aim for this year has been to interest and train a younger, more intelligent woman to work as a midwife in isolated sections of the State, to replace those old midwives who are dying out... We already feel the influence of the midwife in a community, who has been to the State school” (*Sanitary Codes*, 1935: 28). Health officials understood that providing midwifery training to younger women would aid in achieving their goal of “the trained Nurse Midwife” since grannies due to their age would cease to practice (*Sanitary Codes*, 1934: 34). In addition, health officials such as Miss Blackburn acknowledged the prudence of their actions in regulating midwifery by commending the impact of educated and trained midwives. While waiting for the demise of older midwives, the untrained midwife’s presence was considered a bane to public health.

One of our greatest problems is the lack of workers in the field, to supervise and stimulate the midwives, and the lack of finances to carry on the work. There is a rising up to replace the older midwives who have died, but who did have some instruction, a woman who has had no instruction, no equipment, and who hides her work. To check this requires greater personnel and better traveling facilities. Our problem is also the lack of prenatal examinations (*Sanitary Codes*, 1935: 29).

This observation is noteworthy on several accounts. First, such statements serve as evidence that health officials acknowledged that some older midwives continued their practice. Second, Miss Blackburn’s comments indicated that midwifery regulation efforts were not as successful as I initially perceived, given financial constraints as well as a lack of suitable midwifery instructors and supervisors. As I indicated earlier, physicians’ and other licensed health officials’ efforts to reduce and/or eliminate midwives via midwifery education and this

form of regulation were described in Miss Blackburn's report. Her report included organizing five midwifery classes, 78 new members enrolled in midwifery classes, and she reviewed 129 midwifery classes. Third, this Code illustrates that health officials did acknowledge that older midwives "did have some instruction" which is in direct conflict with my assumption that granny midwives were viewed as ignorant practitioners of birthing work (1935: 29).

Midwives once again were exempt from provisions outlined in the medical practice act for 1936. The Sanitary Codes for 1937 provided the most detailed stipulations for midwifery practice in South Carolina (see Figure I in Appendices). More specifically, these codes detailed not only all birthing procedures that midwives should implement but also the fines that could be incurred for noncompliance. Previous codes mentioned only that certificates would be suspended for noncompliant midwives. In the last two relevant years of the South Carolina medical practice acts, 1938 and 1940, midwives continued to be exempt from stipulations outlined in the acts. Since midwife regulations were not present in the medical practice acts, I investigated how each of the medical practice acts regulated unlicensed practitioners. Laws in the years 1906, 1909, 1912, 1914, 1916, 1918, 1921, 1923, 1925, 1934, 1936, 1938, and 1940 imposed either a monetary fee ranging from \$100 to \$500 or a 30-day jail sentences for those individuals who practiced without license. I felt that it would be important to specify how the medical practice acts treated unlicensed practitioners. Originally, I assumed that since granny midwifery was an unlicensed medical practice, midwives would be included in such provisions for unlicensed health practitioners. However, as Litoff (1990) and Weitz and Sullivan (1992) noted, it is difficult to locate legislative statutes governing midwifery for the late 19th and early 20th century because there were no federal regulations prior to 1920. And, after 1920, states were given charge of midwifery regulation rather than the federal government which led to different national midwifery regulations.

Summary of Legislative Efforts to Abrogate Granny Midwives Analysis

Health officials regulated midwives in South Carolina using Board of Health guidelines provided in the Sanitary Codes rather than including this occupation within the medical practice acts. In fact, the rules within the medical practice acts exempted “dentists, trained nurses, pharmacists, opticians, optometrists, [and] midwives” and these rules did not shift throughout the entire time period of my study (*American Medical Directory*, 1906: 1386). During the first two decades of the 1900s, midwives were not as restricted in their practice. In fact, the only significant restriction was that midwives were not allowed to sign death certificates. However, as time passed, midwifery regulations became more stringent. My analysis of the Sanitary Codes and the reports of midwife supervisor Laura Blackburn revealed that women practicing midwifery without a license or certificate (again depending on the county) might suffer similar consequences as unlicensed practitioners such as monetary fines, license suspension or revocation. In addition, the Sanitary Codes for 1938 provided a full explication of the prohibited and accepted activities of midwives. In previous years, the Sanitary Codes did not provide such detail.

Midwife institutes also became a larger presence in South Carolina from 1900 to 1940. In fact, some of these institutes occurred in predominantly black cities and counties. One could surmise that placing these institutes in these places was a strategic means of dealing with and improving the midwife situation among blacks and South Carolina as a whole. Moreover, reporting that midwives attending these institutes and adhering to newly instated stipulations demonstrated to the medical establishment that the midwife problem was being addressed and reduced by midwife supervisors.

The accounting of the state of midwifery in South Carolina also supplements my analysis of how physicians viewed midwives, licensed and unlicensed, and demonstrates further how midwives occupied the lower rung of the occupational hierarchy of birthing work. For example, the Codes and notes therein from the State Midwife Supervisor Miss Blackburn imparted how

nurses viewed midwives and the nurses' roles in ridding South Carolina of the older, ignorant midwife. In addition, Miss Blackburn's notes on the state of midwifery in South Carolina correspond well with the notes from Miss Mary Dodd, a black registered nurse and midwife supervisor. As I stated in Chapter VI, Miss Dodd was appointed a midwife supervisor of black midwives and she provided her accounting of her training and supervising experiences. Each of these nurses discussed midwifery classes taught, the demeanor of the women who sought their expertise, and the effectiveness of training sessions. Miss Blackburn's notes are also beneficial to my study given her description of the numbers of midwives in attendance at certain midwifery institutes as well as the number of midwives that faced license suspension or revocation. Moreover, the goal of these training meetings and resulting midwife institutes was to not only reduce the number of older midwives but to also change the midwife to a nurse midwife. Given my analyses presented in this chapter and the previous two, I reached some conclusions about my project and what further research is needed.

CHAPTER VII

CONCLUSIONS AND SOCIOLOGICAL SIGNIFICANCE OF STUDY

This research project began with a series of research questions about what physicians writing in *JSCMA* and *JAMA* between 1900 and 1940 would reveal about their views of granny midwives. I drew many of my assumptions from my literature review of midwifery research and granny midwifery research and theories about racism and sexism and inter-sectionality of racism and sexism. In addition, reviewing Starr's (1982) and Abbott's (1988) seminal works regarding the professionalization of medicine, I expected that physicians used their professional writings as a platform for the abrogation of midwifery. And, if not proposing the complete elimination of this centuries-old practice, doctors, at least, would provide arguments outlining the necessity of a reduction of midwives in birthing work. Using racism, sexism, and inter-occupational conflict as themes under which I created codes and allowed other codes to emerge, I expected that physicians within both medical journals would advocate for the abrogation of granny midwifery. Moreover, I expected critical commentary about granny midwifery as a practice in general, racist and sexist commentary about grannies' participating in birthing work, and the threat of inter-occupational conflict within birthing work to serve as primary arguments used by doctors to advocate for midwifery abrogation.

And yet, I found that the landscape of the midwifery abrogation, particularly as it related to granny midwives, was quite different from my original expectations. To reiterate, I assumed that doctors would seek the outright abrogation of midwives from birthing work using arguments couched in racist and sexist commentary. What I found instead was that physicians primarily wrote about forms of midwifery regulation as a means of eliminating the midwife (see Table 5, prevalent codes *mwreg* and *mwteach* and the codes *mwregis* and *mwsuper*). And, in regards to

racism, my analysis revealed a historical disregard for black medicine from its African origins to the practices of what Dr. Kollock termed “ignorant” and “superstitious” black midwives. Texts I coded as racist tended to focus more on the medical practices of blacks and the black populace in general than on granny midwives.

In addition, though I expected many articles denoting physician censure (or criticizing arguments or statements about granny midwives by physicians), I found few illustrations. For example, despite my expectation that doctors writing in professional medical journals would use racist arguments about granny midwives, I found only one specific instance of granny midwifery criticism with a racist element. As noted in Table 5, racist commentary by physicians in their professional writings—at least in articles about other birth attendants, women’s health, and so on—was relatively rare from 1900 to 1940.

As previously noted, this silence was surprising but a significant finding nevertheless. Although researchers such as Fraser (1998), Lee (1996), and Mathews (1992) argued that physicians’ intolerant arguments aided in the demise of granny midwives, my research demonstrates that professional writings did not reflect a strategic effort to target black midwives specifically. Rather, physicians using racist commentary maligned blacks as a whole rather than just those who participated in birthing work. This subtle attack had its ramifications as Fraser (1998) and others found in their research. Castigating the black race set a platform for granny midwifery abrogation in that it afforded white medical doctors the title of veritable medical experts and pushed the notion that whites were naturally superior to blacks in regards to general and medical intelligence. Re-examining the comments of Dr. Dreher, blacks were nothing more than “bugbears” and “niggers” who hindered the medical attendance of white physicians, and further, were “overbreeders” (Dreher, 1931: 331). Because granny midwives were black, such criticisms extended to them as well.

My analysis of sexism within *JSCMA* and *JAMA* reflected a similar oblique condemnation rather than a more forthright attack on granny midwives. Physicians used sexist commentary to degrade females in general rather than speaking about midwives' participation in birthing work. Physicians' statements did not demonstrate a prevailing sexist opinion of women as practitioners which I expected would serve as another facet of their efforts for midwifery abrogation. Rather, physicians lauded themselves as heroes to the weaker female sex. Such criticisms served to further support physicians' arguments discrediting female practitioners, including granny midwives, in birthing work. Arguments in which physicians offered suggestions that women's wombs were naturally pathological and required the presence of a male physician prior to, during, and after the birthing process also contributed to the notion that female practitioners within birthing work were unnecessary and a hindrance to the health of pregnant mothers and their newborns. Again, these arguments set the framework for white male doctors to claim authoritative knowledge in birthing work.

I found other noteworthy findings (though somewhat rare) within my analysis of *JSCMA* and *JAMA* that were unexpected in their relationship to my themes of social persecution and prosecution. Regarding inter-occupational conflict, physicians criticized their own colleagues in regards to their dealings with new mothers and their infants. In particular, physicians in South Carolina castigated their colleagues in discussions concerning legislation affecting maternal and infant healthcare for not taking their rightful places as health educators for women. In regards to the themes of racism and sexism, given the applicability of hooks (1981) and Hill Collins (2000) discussion of the racist-sexist conditioning of black women, the lack of a co-occurrence of racist and sexist codes in physicians' critiques of midwifery was surprising as well. One possible explanation for this silence could be the presence of pressing health epidemics such as pellagra in South Carolina and tuberculosis in the U.S.

Turning back to other expectations of my study as they relate to the theme of inter-occupational conflict, I anticipated that physicians would view midwives as interlopers in birthing work and consequently argue that their presence was a threat to pregnant mothers and their unborn children. My analysis of writings that express inter-occupational conflict does support my research expectations. Out of the three themes, inter-occupational conflict was the most prevalent during the forty year time period (see codes under the inter-occupational conflict theme in Table 5). And of further note is that despite my belief that doctors using my theme of inter-occupational conflict would argue for midwifery abrogation, my texts revealed something very different. I found that doctors used arguments for midwifery education, midwifery supervision, midwifery legislation, and sometimes one or a combination of all of these actions as a means of reducing the number of practicing midwives. This finding is truly surprising considering the fact that physicians used what some would term improvements in midwifery care as a means of dealing with the “midwife problem.” In fact, some doctors deemed it particularly important for a national campaign to educate the midwife to reduce her impact within birthing work and on the American female populace. A number of physicians acknowledged the necessity of midwives in order to treat those patients doctors were unable to reach due to locations or time; a few physicians were simply unwilling to treat certain classes of patients.

Doctors, like Dr. DeLee, argued that midwifery education was pointless since midwives were “relics of barbarism” and doctors should “refuse to be particeps criminis” (Fife, 1916: 56). Like her colleague Dr. DeLee, Dr. Yarros advocated for improvements in obstetrical training, the development of lying-in hospitals, and highly trained nurses as a means of improving the livelihoods of new mothers and their infants. Out of all the arguments physicians used to eliminate the midwife, midwifery education was the predominant form of midwifery regulation seeking this end.

When physicians did use racist and sexist commentary in their rebuke of midwifery care, they did so to elevate their medical expertise over midwives and other unlicensed health practitioners. Overall, racist and sexist commentary as expressed by physicians worked to substantiate that doctors held authoritative knowledge in birthing work and that lay practitioners like granny midwives were no longer acceptable, socially and legally. Examining Table 5, the largest proportion of texts possessing elements of authoritative knowledge came from both journals from 1900 to 1920 (code authknow). This finding is significant because it falls in alignment with my argument that the professionalization of medicine (which began in the early 1900s) aided physicians' arguments for midwifery abrogation while also situating them at the forefront of medical expertise.

To reiterate, *JAMA* in the first decade published such physician sentiments in conference notes for the prevention of infant blindness. In these notes, Dr. Kollock of Charleston, South Carolina argued that in South Carolina, “[o]ut of 225 colored births 30 were attended by physicians and 195 by midwives. He mentioned that those midwives were not only ignorant, conceited, dirty, but very superstitious, and that more stringent laws should govern them” (“What Can be Done for the Prevention of Blindness”, 1910: 1816). And moving into the second decade, *JSCMA* published physician commentary on how midwives contributed to problems with “woman’s fate.”

Dr. Klugh observed that

In...over a series of 150 cases of labor in 6 years of country practice I was struck by the fact that with few exceptions the infant and maternal deaths were those previously attended by a Midwife. I lose one or two maternal cases every year, besides several infants from the midwife’s ignorance. I believe some of these complications are caused by the midwife’s ignorance of the different stages of labor. She has her patients strain and bear down during the first stage of labor causing displacement of the Foetus, and exhaustion of the patient[.] I suppose every Physician in country practice encounters the same difficulties we do; if so, there are in S.C. several hundred preventable Maternal deaths every year and even more preventable deaths of Infants.

Dr. Klugh concluded his observations by mentioning that blacks—be they the general black populace or black midwives—are responsible for contributing most of these cases.

For example, re-examining *JSCMA* during the fourth decade of my study, Dr. Dreher's comments illustrate how a physician used racism to substantiate his authoritative knowledge. Moreover, Dr. Dreher's comments highlight that some physicians held onto racist beliefs about blacks during my period of study.

Some time ago, a lady, sent by the government, dropped into my office and asked for my cooperation in rounding up the old midwives and teaching them some of the elementary modern principles of hygiene and antiseptics. I heartily recommended her work, and promised every assistance. I told her, however, that she and the government were short on one feature. That while, teaching them how to bring young Hami-ites safely into the world, she should also post them on legitimate preventive measures, to keep a lot of them out (Dreher, 1931: 332).

There are some other patterns deserving attention as well. Criticism of midwives (as represented by the code critmw) was most prevalent within *JSCMA* and *JAMA* between 1900 and 1920. Of the two journals, *JAMA* contributed a higher percentage of texts during this time period given its weekly publication rather than *JSCMA*'s monthly publication (see Table 7). This finding is consistent with my arguments as supported by midwifery researchers that physicians did criticize midwives and that such criticisms were present in physicians' professional writings at the beginning of the 20th century. Moreover, this finding showcases the prevalence of a national criticism of midwives.

Comparing both journals in an examination of physicians' statements concerning midwifery regulation, I found that *JSCMA* had a larger number of texts detailing forms of midwifery regulation (code: mwreg) and criticism of midwives (code: critmw) during 1911-1930 as compared to *JAMA*. This finding is most significant given the influence of the maternal healthcare movement on physicians' and midwives' participation in birthing work. Additionally,

according to Rooks (1997), physicians during this time period began a more concentrated effort to abrogate midwives.

Rooks (1997) and Leavitt (1983) argued that concerns with maternal and infant health also contributed to scrutiny of midwives. Consequently, I expected that physicians' professional writings would reflect concerns with maternal health and infant health during the time period of 1911-1930. However, examining both *JSCMA* and *JAMA*, I found that the latter decades (1921-1940) held a larger number of texts discussing infant health and maternal health (24% and 58% respectively, codes ifhealth and mathlth); yet, texts that included criticisms of midwives were less common during this time period (almost 9% for both decades). As I discussed in Chapter V, physicians began to turn away from seeing midwives as responsible for infant mortality and sought to discover other contributing factors (see Table 6 for frequency changes for the code ifmtmw).

Sociological Contribution of the Study

Despite physicians' writings not fully reflecting some of my initial expectations and revealing unexpected patterns from 1900 to 1940 in *JSCMA* and *JAMA*, my project is another sociological contribution to midwifery research for several reasons. Firstly, previous midwifery researchers had not investigated professional writings for themes of racism, sexism, and inter-occupational conflict and how they can be inter-related in regards to addressing midwifery abrogation. Secondly, examining how physicians used medical publications for legislative advocacy is an important addition to midwifery research. Thirdly, noting how midwifery legislation shifted over time demonstrates how an occupation once touted as honorable and given a high degree of social respect became considered an illegal practice. Fourth, seeing how birthing knowledge began to be defined by more formalized midwifery regulations provides an example of how the professionalization of medicine named physicians and other licensed health

professionals (such as nurses) as medical experts in American society. Such findings provide fodder for future research analyses.

My analysis of midwifery regulation for the state of South Carolina begs for a more in-depth analysis of the South Carolina Bureau of Health regulations. As I discussed in Chapter VI, the year 1937 was the only year that provided clear protocols to which midwives adhered. Midwifery care protocols are particularly salient for understanding more clearly how over time the rules and regulations for South Carolina midwives shifted. Moreover, another possible research project involves examining physicians' statements within *JSCMA* for evidence of inter-occupational conflict with faith healers and root doctors. Some black women operated in this capacity throughout the South. Katrina Hazzard-Donald, a sociologist who studies old black male and female healers, noted that midwives sometimes used other titles (such as root healers, hoodoo women) to disguise their roles as birth attendants (Conversation at April 2006 PCA/ACA conference, Atlanta, Georgia). And, some grannies opted to function in these other roles as means of holding onto their clientele in the face of negative attention they received from members of the medical profession.

The *Woman's Medical Journal* is another medical source in which opinions espoused by doctors about midwives in birthing work could be analyzed. In particular, examining whether white female physicians writing in medical journals used similar or dissimilar arguments to those stated by their white male counterparts in regards to the presence of midwives in birthing work would provide a more illustrative picture of how physicians used their professional writings to abrogate midwives. Yet another research project could entail a historical quantitative analysis examining longitudinally whether a reduction in the number of midwives directly coincided with reduced infant and maternal mortality rates in South Carolina and nationally, net of other variables such as better prenatal care. More research is needed about midwives in the state of South Carolina, in particular in regards to those women who accepted midwifery regulation,

midwifery teaching, and midwifery supervision. The Penn Center would serve as an excellent source because its inception was as a black midwifery training school²². Noting shifts in the regulation of these newly licensed black midwives would provide midwifery researchers more knowledge about the historical state of midwifery in South Carolina. The Center may house the notes of noted black midwife supervisors Mary Dodd and Hilda Warren. Their notes may provide more insight about how licensed black midwives viewed their unlicensed counterparts.

Such future research projects highlight the contribution of my study and its focus on how the professional writings of physicians substantiated authoritative knowledge. Moreover, the results of this study reinforce the need for midwifery researchers to note the importance of professional writings of physicians in efforts toward midwifery abrogation. Examining further the manner (or manners) in which black medical doctors and nurses contributed to the elimination of the granny midwife is yet another point of investigation.

²² The Penn Center is a historical museum dedicated to the study of black life in South Carolina and is located in the Sea Islands of South Carolina. It is also the site of the first black midwifery school in South Carolina.

Table 1. Infant Mortality Rates, U.S. and South Carolina, 1900-1940²³

		Decades				
		1900	1910	1920	1930	1940
Infant mortality rates--- U.S. (per 1,000 births)		*	*	89.9	62.1	41.2
Infant mortality rates--- S.C. (per 1,000 births)		**	**	115.8	88.7	68.1

* In my examination of the Historical Abstracts of the United States, infant and maternal death rates were not estimated prior to 1915. See <http://www.census.gov/statab/hist/HS-13.pdf>. While there are estimates available, no comparable sources are available.

**Prior to 1920, national infant mortality rates were reported in 1915 (99.6), 1916 (100.0) , 1917 (96.1), 1918 (105.8), and 1919 (88.7). See earlier reference in Chapter II regarding South Carolina birth reporting.

²³ U.S. Department of Commerce
 1943 *Vital Statistics Rates in the United States 1900-1940*. Washington: United States Printing Office.

Table 2. Count of midwives in U.S. 1900-1940²⁴ and South Carolina, 1900-1940²⁵

	Decades					
	1900	1910	1920	1930	1940	
U.S. midwives and untrained nurses* (aggregate)	109,000	133,000	157,000	198,000*	115,000*	
number per 10,000 population	14.3	14.5	14.9	16.1	8.7	
S.C. midwives and untrained nurses (aggregate)	1,581**	1,582	1,249**	1,526	1,429	
number per 10,000 S.C. population	11.8	1,515,409	1,683,724	1,738,765	7.5	

* Beginning in 1930, the U.S. Census began combining the number of practical nurses with the number of midwives.

** Census records for this year counted unspecified nurses and midwives separately.

²⁴ United States, Bureau of the Census.
1975 *Historical Statistics of the United States, Colonial Times to 1970*. Washington: Government Printing Office.

²⁵ United States, Bureau of the Census.
1902 *Twelfth Census of the United States, Taken in the year 1900: Population Part II*. Washington: Government Printing Office.

1914 *Thirteenth Census of the United States, Taken in the year 1910: Population, Occupation Statistics*. Washington: Government Printing Office. 653

1922 *Statistical Abstract of the United States, 1921*. Washington: Government Printing Office. www2.census.gov/prod2/statcomp/documents/1921-06.pdf.

1933 *Fifteenth Census of the United States: 1930, Population Occupations by States*. Washington: Government Printing Office. 983.

1943 *Sixteenth Census of the United States: 1940, Population, The Labor Force*. Washington: Government Printing Office. 975.

Table 3 Frequency of related and unrelated articles

JAMA and JSCMA, 1900-1940

		1900-10	1911-20	1921-30	1931-40
Type of articles					
Related articles--- JSCMA		31	26	36	20
Unrelated articles--- JSCMA		64	30	12	34
Related articles--- JAMA		38	27	2	7
Unrelated articles--- JAMA		577*	89	34	55

*As I discussed in my methodology chapter, initially I attempted to review all articles from each decade. Upon my secondary review and sampling procedure, the numbers following this decade of *JAMA* were significantly reduced.

Table 4

Number of Physician Authored Articles, JAMA and JSCMA: 1900-1940

	1900-10	1911-20	1921-30	1931-40	Total
JSCMA*	22	11	29	18	80
JAMA**	16	7	0	3	26

* In 1900-10, there were 4 editorial articles and 6 anonymous authored articles; 1911-20 had 3 editorial articles and 12 anonymous authored articles; 1921-30 had 8 anonymous authored pieces; and 1931-40 had 2 anonymous authored pieces.

** In 1900-1910, there were 23 anonymous authored articles; in 1911-20, there were 20 society notes articles; in 1921-30 there were 2 anonymous authored pieces; and in, 1931-40 there were 4 anonymous authored articles.

Table 5

Frequency of Codes by Theme, JAMA and JSCMA: 1900-1940

	Decades				
	1900-10	1911-20	1921-30	1931-40	Total
Prevalent Codes					
abrogmw	4	13	3	0	20
authknow	5	6	12	6	29
critmw	21	35	7	7	70
ifhealth	0	3	10	19	32
ifmt	1	4	18	17	40
mdbirth	2	11	7	12	32
medleg	4	9	6	4	23
mwreg	20	56	14	7	97
mwteach	3	17	10	5	35
pathpreg	5	3	12	6	26
Totals	65	157	99	83	404
Themes					
Racism					
abracmd1	0	1	0	0	1
ifmtrace	0	1	2	2	5
matmtrace	0	0	0	1	1
rac3md	0	1	0	2	3
race	0	2	2	2	6
racexmd	0	1	0	0	1
racist	2	3	1	0	6
racistmd	0	2	0	0	2
Sexism					
abcult	1	4	0	0	5
abngpg	2	0	0	2	4
abtprg	2	0	0	2	4
abptwmb	2	0	0	0	2
absxmd	1	2	0	1	4
cultdom	4	4	2	0	10
negpreg	1	0	2	4	7
pathpreg	5	3	12	6	26
pathwmb	1	4	2	0	7

Table 5, continued

Sexism cont.	1900-10	1911-20	1921-30	1931-40	Total
sexist	5	0	1	1	7
sexmd	3	7	6	2	18
sxment	0	1	1	2	4
Inter- occupational Conflict					
ababrgmw	0	1	0	2	3
abcrmw	5	3	4	4	16
abmdbth	0	2	0	0	2
abocc2	0	0	1	1	2
abocc3	0	2	0	0	2
abrogmw	4	13	3	0	20
authknow	5	6	12	6	29
btwkleg	0	0	0	1	1
class	1	1	1	2	5
crbhatte	0	0	0	3	3
critlay	0	1	4	1	6
critmw	21	35	7	7	70
granny	0	2	0	0	2
homebth	0	0	0	1	1
hospbth	1	0	1	4	6
ileg	0	1	3	0	4
inocc2	1	3	2	0	6
inocc4	1	0	1	0	2
inoccab	1	0	0	0	1
iocc3sex	0	2	0	0	2
laity	2	1	0	0	3
mdarrog	1	0	3	4	8
mdbirth	2	11	7	12	32
mdpwr	4	0	2	2	8
medleg	4	8	6	4	22
mpa	1	1	4	0	6
mpaprob	0	0	3	0	3
mw	11	0	1	0	12
MWLEG	1	6	0	0	7
MWNUMB	0	0	0	1	1

Table 5, continued

Inter-occupational Conflict cont.	1900-10	1911-20	1921-30	1931-40	Total
mwprob	2	2	0	0	4
mwreg	20	56	16	10	102
MWREGIS	0	1	3	0	4
MWSUPER	3	7	3	5	18
MWTEACH	3	17	10	5	35
mwpy	3	1	0	2	6
pfobst	0	1	0	0	1
profmed	1	5	2	2	10
Health reform					
abifmtmd	0	0	0	2	2
abifmtmw	0	0	0	2	2
bthctrl	0	0	0	2	2
bthregis	0	0	0	3	3
critmd	0	2	4	8	14
critmdlg	0	0	0	1	1
critmom	0	0	0	1	1
crmdmed	0	0	0	2	2
crpfmed	1	0	0	0	1
ifhealth	0	3	10	19	32
ifmt	1	4	18	17	40
ifmtfin	0	0	0	1	1
ifmtmd	0	1	3	1	5
ifmtmw	0	3	6	1	10
mathlth	0	2	9	28	39
matmort	0	0	8	21	29
matmtmd	0	1	0	5	6
matmtmw	0	1	0	6	7
obstreg	1	0	0	4	5
stact	0	0	2	2	4
Criticism of midwifery in healthcare					
critmw	21	35	7	7	70
granny	0	2	0	0	2

Table 5, continued

Criticism of midwifery in healthcare cont.	1900-10	1911-20	1921-30	1931-40	Total
ifmtmw	0	3	6	1	10
matmtmw	0	1	0	6	7
Total number of texts	93	122	79	81	375
Total number of related articles	69	53	38	27	187

Codes in **BOLD** are forms of midwifery regulation

Table 6
Frequency of Codes by Theme: JSCMA 1900-1940

	Decades				
	1900-10	1911-20	1921-30	1931-40	Total
Prevalent Codes					
critmw	4	12	7	6	29
ifhealth	0	0	10	11	21
ifmt	0	0	18	12	30
mathlth	0	0	9	13	22
matmort	0	0	8	14	22
mwreg	0	25	14	6	45
mwteach	0	6	10	4	20
pathpreg	3	1	12	2	18
			Themes		
Racism					
abracmd1	0	1	0	0	1
ifmtrace	0	1	2	1	4
matmtrace	0	0	0	0	0
rac3md	0	1	0	2	3
race	0	1	2	2	5
racesxmd	0	1	0	0	1
racist	1	3	1	0	5
racistmd	0	2	1	0	3
Sexism					
abcult	0	4	0	0	4
abngpg	0	0	0	0	0
abptprg	0	0	0	1	1
abptwmb	0	0	0	0	0
absxmd	0	1	0	1	2
cultdom	2	3	2	0	7
negpreg	0	0	2	1	3
pathpreg	3	1	12	2	18
pathwmb	1	2	2	0	5
sexist	0	0	0	1	1
sexmd	2	1	6	2	11
sxment	0	0	1	0	0

Table 6,continued

Inter- occupational Conflict	1900-10	1911-20	1921-30	1931-40	Total
ababrgmw	0	1	0	0	1
abcrmw	0	1	4	4	9
abmdbth	0	0	0	0	0
abocc2	0	0	1	1	2
abocc3	0	2	0	0	2
abrogmw	0	2	3	0	5
authknow	1	2	11	3	17
btwkleg	0	0	0	0	0
class	0	0	1	2	3
crbhatte	0	0	0	3	3
critlay	0	0	4	0	4
critmw	4	12	7	6	29
granny	0	2	0	0	2
homebth	0	0	0	0	0
hospbth	0	0	1	2	3
ileg	0	1	2	0	3
inocc2	1	0	2	0	3
inocc4	1	0	0	0	1
inoccab	1	0	0	0	1
iocc3sex	0	2	0	0	2
laity	1	1	0	0	2
mdarrog	0	0	3	4	7
mdbirth	0	3	7	5	15
mdpwr	4	0	0	0	4
medleg	0	2	2	1	5
mpa	0	1	0	0	1
mpaprob	0	0	0	0	0
mw	6	0	1	0	7
MWLEG	0	3	0	0	3
MWNUMB	0	0	0	0	0
mwprob	0	1	0	0	1
mwreg	0	25	14	6	45
MWREGIS	0	1	3	0	4
MWSUPER	0	3	3	5	11
MWTEACH	0	6	10	4	20
mwyt	0	0	0	0	0

Table 6, continued

Inter-Occupational Conflict cont.	1900-10	1911-20	1921-30	1931-40	Total
pfobst	0	0	0	0	0
profmed	0	1	0	1	2
Health reform					
abifmtmd	0	0	0	2	2
abifmtmw	0	0	0	2	2
bthctrl	0	0	0	2	2
bthregis	0	0	0	3	3
critmd	0	0	4	4	8
critmdl	0	0	0	0	0
critmom	0	0	0	0	0
crmdmed	0	0	0	0	0
crpfmed	0	0	0	0	0
ifhealth	0	0	10	11	21
ifmt	0	0	18	12	30
ifmtfin	0	0	0	0	0
ifmtmd	0	0	3	1	4
ifmtmw	0	0	6	1	7
mathlth	0	0	9	13	22
matmort	0	0	8	14	22
matmtmd	0	0	0	2	2
matmtmw	0	0	0	5	5
obstreg	0	0	0	0	0
stact	0	0	2	0	2
Criticism of midwifery in healthcare					
critmw	4	12	7	6	29
granny	0	2	0	0	2
ifmtmw	0	0	6	1	7
matmtmw	0	0	0	5	5

Table 6, continued

Total number of texts	30	59	70	40	199
Total number of related articles	31	26	36	20	113

Codes in **BOLD** are forms of midwifery regulation

Table 7

Frequency of Codes by Theme: JAMA 1900-1940

	Decades				
	1900-10	1911-20	1921-30	1931-40	Total
Prevalant Codes					
abrogmw	4	11	0	0	15
authknow	4	4	1	3	12
critmw	17	23	0	1	41
mdbirth	2	8	0	7	17
medleg	4	6	4	3	17
mwreg	20	31	0	1	52
mwteach	3	11	0	1	15
			Themes		
Racism					
abracmd1	0	0	0	0	0
ifmtrace	0	0	0	1	1
matmtrace	0	0	0	1	1
rac3md	0	0	0	0	0
race	0	1	0	1	2
racexmd	0	0	0	0	0
racist	1	0	0	0	1
racistmd	0	0	0	0	0
Sexism					
abcult	1	0	0	0	1
abngpg	2	0	0	2	4
abptprg	2	0	0	1	3
abptwmb	2	0	0	0	2
absxmd	1	1	0	0	2
cultdom	2	1	0	0	3
negpreg	1	0	0	3	4
pathpreg	2	2	0	4	8
pathwmb	0	2	0	0	2
sexist	5	0	1	0	6
sexmd	1	6	0	0	7
sxment	0	1	0	2	3

Table 7, continued

	1900-10	1911-20	1921-30	1931-40	Total
Inter-Occupational Conflict					
ababrgmw	0	0	0	2	2
abcrmw	5	2	0	0	7
abmdbth	0	2	0	0	2
abocc2	0	0	0	0	0
abocc3	0	0	0	0	0
abrogmw	4	11	0	0	15
authknow	4	4	1	3	12
btwkleg	0	0	0	1	1
class	1	1	0	0	2
crbhatte	0	0	0	0	0
critlay	0	1	0	1	2
critmw	17	23	0	1	41
granny	0	0	0	0	0
homebth	0	0	0	1	1
hospbth	1	0	0	2	3
ileg	0	0	1	0	1
inocc4	0	0	1	0	1
inoccab	0	0	0	0	0
iocc3sex	0	0	0	0	0
laity	1	0	0	0	1
mdarrog	1	0	0	0	1
mdbirth	2	8	0	7	17
mdpwr	0	0	2	2	4
medleg	4	5	4	3	17
mpa	1	0	4	0	5
mpaprob	0	0	3	0	3
mw	5	0	0	0	5
MWLEG	1	3	0	0	4
MWNUMB	0	0	0	1	1
mwprob	2	1	0	0	3
mwreg	20	31	0	1	52
MWREGIS	0	0	0	0	0
MWSUPER	3	4	0	0	7
MWTEACH	3	11	0	1	15

Table 7, continued

	1900-10	1911-20	1921-30	1931-40	Total
Inter-Occupational Conflict cont.					
mwy	3	1	0	2	6
pfobst	0	1	0	0	1
profmed	1	4	2	1	8
Health reform					
abifmtmd	0	0	0	0	0
abifmtmw	0	0	0	0	0
bthctrl	0	0	0	0	0
bthregis	0	0	0	0	0
critmd	0	2	0	4	6
critmdl	0	0	0	1	1
critmom	0	0	0	1	1
crmdmed	0	0	0	2	2
crpfmed	1	0	0	1	2
ifhealth	0	3	0	8	11
ifmt	1	4	0	5	10
ifmtfin	0	0	0	1	1
ifmtmd	0	1	0	0	1
ifmtmw	0	3	0	0	3
mathlth	0	2	0	15	17
matmort	0	0	0	7	7
matmtmd	0	1	0	3	4
matmtmw	0	1	0	1	2
obstreg	0	0	0	4	4
stact	0	0	0	2	2
Criticism of midwifery in healthcare					
critmw	17	23	0	1	41
granny	0	0	0	0	0
ifmtmw	0	3	0	0	3
matmtmw	0	1	0	1	2

Table 7, continued

Total number of texts	63	63	9	41	176
Total number of related articles	38	27	2*	7*	74

Codes in **BOLD** are forms of midwifery regulation.

* These two decades in JAMA did not provide a large number of articles to draw from despite their larger number of corresponding primary documents.

Table 8

South Carolina midwifery regulation, 1900-1940

		Sanitary Codes	Medical practice acts
Publication years			
1906			X
1909			X
1912			X
1914		X	X
1915		X	<i>proposed amendment in JSCMA</i>
1916			X
1918			X
1921			X
1923			X
1925			X
1927			X
1928		X	
1929		X	X
1931			X
1932		X	
1934		X	X
1935		X	
1936			X
1937		X	
1938			X
1940			X

Table 9

Infant Health and Maternal Health, Frequency of Texts

JSCMA and JAMA 1900-1940

	Decades				
	1900-10	1911-20	1921-30	1931-40	Total
ifhealth--- <i>JSCMA</i>	0	0	10	11	21
mathlth--- <i>JSCMA</i>	0	0	9	13	22
ifhealth--- <i>JAMA</i>	0	3	0	8	11
mathlth--- <i>JAMA</i>	0	2	0	15	17
ifhealth--- <i>JSCMA</i> and <i>JAMA</i>	0	3	10	19	32
mathlth--- <i>JSCMA</i> and <i>JAMA</i>	0	2	9	28	39

APPENDIX

Appendix 1A. Description of All Codes for Analysis of Medical Journal Articles

Theme: Racism

- (a) abracmd1: comments made by physicians that did not castigate black healers
- (b) ifmtrace: comments made by physicians that discussed infant mortality rate in relation to blacks
- (c) matmtrace: comments made by physicians that discussed maternal mortality rates in relation to blacks
- (d) rac3md: comments made by physicians that discredited healthcare of black women
- (e) race: comments made by physicians that discuss race without censure
- (f) racesxmd: comments made by physicians that are both racist and sexist
- (g) racist: made by physicians that are a blatant criticism of blacks
- (h) racistmd: comments made by physicians about black healers

Theme: Sexism

- (a) abcult: comments made by physicians that are not rooted in the cult of domesticity ideology
- (b) abngpg: comments made by physicians that view pregnancy as a natural occurrence rather than an unnatural or negative experience for women
- (c) abptprg: comments made by physicians that do not link pathology to pregnancy
- (d) abptwmb: comments made by physicians that do not link pathology to the womb
- (e) absxmd: comments made by physicians that do not reflect sexist sentiment
- (f) absxment: absence of comments made by physicians that link mental disorders of women to womb ailments
- (g) cultdom: comments made by physicians that reflect the cult of domesticity ideology
- (h) negpreg: comments made by physicians that view pregnancy as a negative and unnatural occurrence

- (i) pathpreg: comments made by physicians that viewed pregnancy as a pathological condition and that labor pain was unnecessary for women to endure
- (j) pathwmb: comments made by physicians or other health practitioners concerning the 'pathological' nature of the womb
- (k) sexist: comments made by physicians that viewed women in a debasing manner and as inferior to men
- (l) sexmd: comments made by physicians when discussing obstetrical cases about the need for male physicians
- (m) sxment: comments made by physicians that link mental disorders of women to womb ailments

Theme: Inter-occupational Conflict

- (a) ababrgmw: comments made by physicians that do not call for the abrogation of the midwife
- (b) abcrmw: comments made by physicians that did not criticize midwifery care
- (c) abmdbth: comments made by physicians that did not advocate for the medicalization of birth
- (d) abocc2: comments made by physicians that do not indicate how midwives usurp doctors' place in the medical hierarchy
- (e) abocc3: comments made by physicians that do not state that doctors are better at obstetrical care or call to teach obstetrics
- (f) abrogrmw: comments made by physicians that clearly argue for the elimination of midwives
- (g) authknow: comments made by physicians advocating that medical knowledge is only possessed by medically trained and licensed practitioners.
- (h) btwklbg: actual cases in which midwives were prosecuted for practicing without a license
- (i) class: comments made by physicians signifying their socioeconomic status
- (j) crbhatte: comments made by physicians that criticize birth attendants (voluntary)
- (k) critlay: comments made by physicians that criticize lay obstetrical notions/superstitions
- (l) critmw: comments made by physicians or other licensed health practitioners that are criticisms of midwifery

- (m) granny: comments made by physicians in which a granny was mentioned
- (n) homebth: comments made by physicians about home births
- (o) hospbth: comments made by physicians advocating for hospital births
- (p) ileg: comments made by physicians addressing the presence of illegal practitioners in healthcare
- (q) innoc4: comments made by physicians that concern inter-occupational conflict within the medical field in general
- (r) innocab: comments made by physicians that do not discuss inter-occupational conflict between midwives and doctors
- (s) iocc3sex: comments made by physicians about the unnecessary presence of women practicing medicine
- (t) mdarrog: comments made by physicians that state that trained doctors are the medical experts (no mention of sexism or racism)
- (u) mdbirth: comments made by physicians that labeled birth as an unnatural process requiring medical attention and the presence of a physician
- (v) mdpwr: comments made by physicians advocating for more legislative power in the development of medical legislation
- (w) medleg: comments made by physicians (or legal officials) for legal advocacy
- (x) mpa: comments made by physicians addressing medical practice acts
- (y) mpaprob: comments made by physicians addressing how medical practice acts are problematic
- (z) mw: comments made by physicians in which the term midwife is used (no criticism)
- (a1) mwleg: comments made by physicians that advocate for midwives to be legally regulated
- (b1) mwnumb: comments made by physicians that advocate for midwives to be counted as a means of regulation
- (c1) mwreg: comments made by physicians that advocate for midwifery regulation
- (d1) mwregis: comments made by physicians that advocate for registration as a means of regulation

(e1) mwsuper: comments made by physicians that advocate for supervision as a means of regulation

(f1) mwteach: comments made by physicians that advocate for midwifery teaching as a means of regulation

(g1) mwyt: comments made by physicians about midwifery (this term was used to describe birthing work in the early 1900s)

(h1) pfobst: comments made by physicians that advocate for the professionalization of the field of obstetrics

(i1) profmed: comments made by physicians that advocate for the professionalization of medicine

Theme: Health Reform

(a) abifmtmd: comments made by physicians that do not link infant mortality rates to doctors

(b) abifmtmw: comments made by physicians that do not link infant mortality rates to midwives

(c) bthctrl: comments made by physicians about their role in controlling women's reproduction

(d) bthregis: comments made by physicians about the importance of registering births (code can be linked to the mdbirth code)

(e) critmd: comments made by physicians criticizing the medical profession as a whole

(f) critmdl: comments made by physicians criticizing medical legislation

(g) critmom: comments made by physicians criticizing mothers as being responsible for the maternal and infant health

(h) crmdmed: comments made by physicians criticizing their colleagues for bad medical practice

(i) crpfmed: comments made by physicians criticizing the professionalization of medicine

(j) ifhealth: comments made by physicians addressing infant health as a pressing problem in relation to obstetrics

(k) ifmt: comments made by physicians about infant mortality in relation to doctors and midwives

- (l) ifmtfin: comments made by physicians about infant mortality and its link to those who are financially disadvantaged
- (m) ifmtmd: comments made by physicians that link infant mortality rates to doctors
- (n) ifmtmw: comments made by physicians that link infant mortality rates to midwives
- (o) mathlth: comments made by physicians about maternal health and the physician's role
- (p) matmort: comments made by physicians about maternal mortality rates and the physician's role
- (q) matmtmd: comments made by physicians that link maternal mortality rates to doctors
- (r) obstreg: comments made by physicians that advocate for better regulation of obstetrics (no distinction for midwives or doctors)
- (s) stact: comments made by physicians that discuss the Sheppard-Towner Act

Appendix 2A. Text Citations from JAMA

- 1900 “Surgical Obstetrics.” *Journal of the American Medical Association*. 34(11).507.
- 1900 “Medical Review: Surgical Obstetrics.” *Journal of the American Medical Association*. 34(14). 866.
- 1900 “American Gynecological Society: Gynecology in the Last Quarter.” *Journal of the American Medical Association*. 34(21). 1337-9.
- 1905 “Medicolegal: Construction of Practice Act and What Violates It.” *Journal of the American Medical Association*. 44(1). 67.
- 1905 “Medicolegal: Pregnancy and Miscarriage Not to be Anticipated.” *Journal of the American Medical Association*. 44(5). 418.
- 1905 “American Practitioner and News, Louisville: Observations in Obstetrics.” *Journal of the American Medical Association*. 44(21). 1717.
- 1906 “American Association of Obstetricians and Gynecologists: Uterine Fibroids in Pregnancy.” *Journal of the American Medical Association*. 47(14). 1126-8.
- 1906 “St. Louis Medical Society.” *Journal of the American Medical Association*. 46(17). 1309-10.
- 1910 “Medical News: Illinois: Chicago---To Abolish Midwives.” *Journal of the American Medical Association*. 55(19). 1652.
- 1910 “Medicolegal: Pregnancy, Childbirth, Sound Health and Insurance.” *Journal of the American Medical Association*. 55(19). 1669-70.
- 1910 “Medical News: Indiana—Prophylaxis Against Blindness.” *Journal of the American Medical Association*. 55(22). 1900.
- 1910 “Medical Economics: Infant Mortality and Birth Registration.” *Journal of the American Medical Association*. 55(23). 1999-2000.
- 1910 “American Academy of Medicine: The Division of Child Hygiene and the Reduction of Infant Mortality in the City of New York.” *Journal of the American Medical Association*. 54(1). 72-3.
- 1910 “American Academy of Medicine: Discussion on Papers of Drs. Darlington and Gerstenberger, and Mr. Gunn.” *Journal of the American Medical Association*. 54(1). 73-4.

- 1910 "Medical Economics: Vital Statistic Legislation a Necessity for Suppression of the Midwife Evil." *Journal of the American Medical Association*. 54(6). 490.
- 1910 "Infant Mortality and Its Reduction Especially in New York City." *Journal of the American Medical Association*. 54(9). 682-91.
- 1910 "South Carolina Medical Association: What Has Been Done for the Prevention of the Increase of Blindness, and What Can Be Done." *Journal of the American Medical Association*. 54(22). 1814-6.
- 1910 "Medical Economics: Legislative Notes-Maryland." *Journal of the American Medical Association*. 54(10). 811-2.
- 1910 "Medicolegal: U. S. Supreme Court on Constitutionality of Practice Acts, Especially on Exceptions." *Journal of the American Medical Association*. 55(6). 524-5.
- 1910 "Medical News, Chicago---Birth Returns." *Journal of the American Medical Association*. 55(9). 784.
- 1911 "Michigan State Medical Society: The Need of a Better-Developed 'Obstetric Conscience.'" *Journal of the American Medical Association*. 57(17). 1393.
- 1911 "Has the Trained Midwife Made Good? Shall Midwives be Licensed or Abolished?, Society Proceedings: American Association for the Study and Prevention of Infant Mortality." *Journal of the American Medical Association*. 57(22). 1787.
- 1911 "The Midwife Problem and Medical Education, Society Proceedings: American Association for the Study and Prevention of Infant Mortality." *Journal of the American Medical Association*. 57(22). 1786.
- 1915 "Surgery, Gynecology and Obstetrics, Chicago: Treatment of Second Degree of Pelvic Contraction." *Journal of the American Medical Association*. 64(10). 859.
- 1915 "American Association for Study and Prevention of Infant Mortality :University Extension Work for the Prevention of Infant Mortality." *Journal of the American Medical Association*. 64(1). 78-80.
- 1915 "Medical News, General: Prevention of Infant Mortality." *Journal of the American Medical Association*. 65(9). 811.
- 1915 "Missouri State Medical Association: Etiologic Factors in Vomiting of Pregnancy, and How to Overcome Them." *Journal of the American Medical Association*. 65(1). 49.

- 1915 "Medical News, Chicago: School of Instruction for Midwives." *Journal of the American Medical Association*. 65(1). 36.
- 1915 "Medical Education and State Boards of Registration: Medical Cults Under Control of Medical Board." *Journal of the American Medical Association*. 65(6). 550.
- 1915 "Medical News, New York: Enforcement of Vital Statistics Law." *Journal of the American Medical Association*. 65(9). 808.
- 1915 "Medical News, Oregon: New Birth Registration Law." *Journal of the American Medical Association*. 65(10). 886.
- 1915 "Medical News: Midwives." *Journal of the American Medical Association*. 66(1). 40.
- 1915 "Annual Congress of Medical Education, Public Health, and Medical Licensure: Society Proceedings." *Journal of the American Medical Association*. 66(9). 681-3.
- 1916 "American Journal of Obstetrics and Diseases of Women: Pelvic Disease and Manic Depressive Insanity." *Journal of the American Medical Association*. 67(15). 1113.
- 1916 "The Medical Society of the State of Pennsylvania: Conservative Treatment of Puerperal Sepsis." *Journal of the American Medical Association*. 67(19). 1396.
- 1916 "Medical News, District of Columbia: Needless Maternal Mortality Following Childbirth." *Journal of the American Medical Association*. 67(22). 1608.
- 1916 "Medical News, Illinois: Baby Week." *Journal of the American Medical Association*. 66(9). 662.
- 1916 "Medical News, Maryland: Infant Mortality Probe." in *Journal of the American Medical Association*. 66(9) 662.
- 1916 "The Death Rate and the Birth Rate." *Journal of the American Medical Association*. 66(18). 1388-9.
- 1916 "Joint Session of the Council on Health and Public Instruction and the Federation of State Medical Boards." *Journal of the American Medical Association*. 66(9). 682-5.
- 1916 "The Nutrition of the New-Born Infant." *Journal of the American Medical Association*. 66(19). 1466-7.
- 1916 "Medical News: Report on Midwifery." *Journal of the American Medical Association*. 67(23). 1786.

- 1916 "Medical News: Prevention of Infant Mortality." *Journal of the American Medical Association*. 67(15). 1103.
- 1916 "American Journal of Obstetrics and Diseases of Women and Children, York, PA.: Acidosis in Uterine Pregnancies." *Journal of the American Medical Association*. 67(23). 1696.
- 1920 "Surgery, Gynecology and Obstetrics, Chicago: Transplanting Uterus in Vesicovaginal Fistula." *Journal of the American Medical Association*. 74(18). 1284.
- 1920 "Medical News: Chicago—Midwives Fined." *Journal of the American Medical Association*. 74(9). 609.
- 1920 "Medical News: New Jersey---Infant Mortality Rate." *Journal of the American Medical Association*. 74(1) 38.
- 1920 "Medical News: Midwives Fined." *Journal of the American Medical Association*. 74(14). 894.
- 1920 "Medical News: Reduction of Motherhood Casualties." *Journal of the American Medical Association*. 74(14). 959.
- 1920 "Medical News: Illegal Practitioners Fined." *Journal of the American Medical Association*. 74(17). 1172.
- 1920 "Medical News: Sheppard-Towner Bill." *Journal of the American Medical Association*. 74(17). 1176.
- 1920 "Medical Record, New York." *Journal of the American Medical Association*. 74(17). 1192.
- 1920 "Medical News: Medical Bill Now Law." *Journal of the American Medical Association*. 74(18). 1263.
- 1920 "Lowering Infant Mortality by Better Obstetric Teaching." *Journal of American Medical Association*. 74(26). 1783.
- 1920 "Rural Obstetrics." *Journal of the American Medical Association*, 95(2). 1996.
- 1930 "Annual Congress on Medical Education, Medical Licensure and Hospitals, Twenty-Sixth Annual Meeting, held in Chicago, Feb. 17, 18 and 19, 1930." *Journal of the American Medical Association*. 94(17). 1325-7.
- 1935 "Birth and Infant Mortality Rates Rose in 1934." *Journal of the*

- American Medical Association.* 105(4). 290.
- 1935 "Medical Licensure Statistics For 1934." *Journal of the American Medical Association.* 104(17). 1505-20.
- 1935 "Queries and Minor Notes: Multiple Miscarriages." *Journal of the American Medical Association.* 104(4). 339-340.
- 1935 "Medical News: South Carolina—Graduate Courses in Obstetrics." *Journal of the American Medical Association.* 104(2). 129.
- 1936 "Infant Mortality Higher in Rural Areas." *Journal of the American Medical Association.* 106(22). 1928-9.
- 1936 "Annual Congress on Medical Education, Medical Licensure and Hospitals, Thirty-Second Annual Meeting, held in Chicago, Feb. 17 and 18, 1936: Undergraduate Education in Obstetrics." *Journal of the American Medical Association.* 106(14). 1204-7.
- 1936 "Proceedings of the Kansas City Session: Minutes of the Eighty-Seventh Annual Session of the American Medical Association, Held at Kansas City, May 11-15, 1936: Section on Obstetrics, Gynecology and Abdominal Surgery." *Journal of the American Medical Association.* 106(23). 1993-2010.
- 1940 "Vaginal Antisepsis and Puerperal Morbidity." *Journal of the American Medical Association.* 115(9). 808-9.
- 1940 "Psychoses in Pregnancy and Childbirth." *Journal of the American Medical Association.* 115(14). 1226.
- Adair, Fred L.
1936 "Undergraduate Obstetric Education." *Journal of the American Medical Association.* 106(17). 1441-2.
- Barrow, William H.
1940 "The Patient and the Art of Living." *Journal of the American Medical Association.* 114(8). 715-8.
- Bovee, J. Wesley.
1900 "Arrhythmia Cordis Complicating Fibromata Uteri." *Journal of the American Medical Association.* 35(5). 277-81.
- Carstens, J. H.
1910 "The Uselessness of Local Treatment in Puerperal Sepsis." *Journal of the American Medical Association.* 55(6). 475-7.
- Clarke, Augustus P.
1900 "Anteflexion of the Uterus: Its Causes and Treatment." *Journal of the American Medical Association.* 35(8). 468-70.

- Daily, Edwin F.
 1940 "Intramural Postgraduate Education in Obstetrics and Pediatrics." *Journal of the American Medical Association*. 115(17). 1436-7.
- Daniel, Annie Sturges and Cordes, Louise.
 1900 "Case of Fatal Fetal Ichthyosis." *Journal of the American Medical Association*. 35(17). 1081-4.
- DeLee, Joseph B.
 1934 "Obstetrics Versus Midwifery." *Journal of the American Medical Association*. 103(5). 307-311.
- Dille, John I.
 1900 "Regulation of the Practice of Medicine." *Journal of the American Medical Association*. 34(22). 1395-1400.
- Duff, John Milton.
 1900 "Parturition as a Factor in Gynecologic Practice." *Journal of the American Medical Association*. 35(8). 465-8.
- Edgar, J. Clifton.
 1916 "Painless Labor" in *Journal of the American Medical Association*., 67(10). 739-741.
- Emge, Ludwig A.
 1940 "Present Trends of Socialization of Medicine in Relation to Maternal Welfare." *Journal of the American Medical Association*. 115(10). 819-822.
- Favill, Henry B., Bracken, Henry M., Rankin, Watson S., Cannon, Walter B., Woodward, William C., Green, Frederick R.
 1915 "Proceedings of the San Francisco Session: Minutes of the Sixty-Sixth Annual Session of the American Medical Association, Held at San Francisco, June 21-24, 1915---Subcommittees." *Journal of the American Medical Association*. 65(1). 97.
- Fife, Charles A.
 1916 "The Midwife, Society Proceedings: American Association for Study and Prevention of Infant Mortality." *Journal of the American Medical Association*. 66(1). 55-6.
- Fry, Henry D.
 1911 "Vaginal Cesarean Section." *Journal of the American Medical Association*. 56(1). 16-9.
- Herman, Charles.
 1910 "Reducing Infant Mortality in Large Cities" in *Journal of the American*

Medical Association. 54(20). 1628.

Goodman, Charles.

1911 "Cervical Implantation of the Placenta with Rupture of the Uterus." *Journal of the American Medical Association.* 57(16). 1260-2.

Halberstadt, A. H.

1901 "Advances in Obstetrics During Last Half Century." *Journal of the American Medical Association.* 36(17). 1167-70.

Helmhoz, H. F. and Hoffman, Walter.

1916 "An Analysis of the Mortality for 1915 in the Infant Welfare Stations of Chicago." *Journal of the American Medical Association.* 67(22). 1567-9.

Hornbogen, A. W.

1916 "Michigan State Medical Society: Insanity in Pelvic Diseases in Women." *Journal of the American Medical Association.* 67(10). 767.

Jonas, A. F.

1900 "A Case of Chronic Inversion of the Uterus: Spontaneous Reduction After Three Years." *Journal of the American Medical Association.* 34(1). 23-4.

Jones, D. W.

1910 "Mississippi State Medical Association—A Plea for Asepsis in Labor" in *Journal of the American Medical Association.* 54(19). 1568.

Koehler, Gottfried and Drake, C. St Clair.

1911 "The Prevention of Infant Mortality." *Journal of the American Medical Association.* 56(1). 20-6.

Kosmak, George W.

1936 "The Training of Medical Students in Obstetrics." *Journal of the American Medical Association.* 106(17). 1435-7.

Linthicum, G. Milton

1910 "Some Public Health Problems." *Journal of the American Medical Association.* 54(23). 1835-1840.

Manton, W. P.

1910 "The Role of Obstetrics." *Journal of the American Medical Association.* 55(6). 459-463.

Markoe, J. W.

1916 "Posture in Obstetrics." *Journal of the American Medical Association.* 67(15). 1066-1072.

- McAlister, Alexander.
 1900 "Infant-Feeding." *Journal of the American Medical Association*. 35(4). 209-10.
- McGehee, J. W.
 1930 "Obstetrics and the General Practitioner." *Journal of the American Medical Association*. 94(1). 51.
- Oviatt, C. W.
 1905 "Wisconsin State Medical Society: Aseptic Obstetrics." *Journal of the American Medical Association*. 45(1). 66-7.
- Pietri, A.
 1910 "An Intraperineal Tear." *Journal of the American Medical Association*. 54(10). 793.
- Riley, R. H.
 1936 "The Public Health Aspect of the Teaching of Obstetrics." *Journal of the American Medical Association*. 106(17). 1438-40.
- Senn, N.
 1905 "Medical Affairs in the Heart of the Arctics." *Journal of the American Medical Association*. 45(22). 1647-51.
- Sigerist, Henry E.
 1935 "The History of Medical Licensure" in *Journal of the American Medical Association*. 104(13). 1057-1060.
- Summers, John E.
 1906 "Medical Society of the Missouri Valley: The Expectant Mother." *Journal of the American Medical Association*. 46(14). 1053-1056.
- Taylor, J. Madison.
 1905 "Economics of Medical Organization." *Journal of the American Medical Association*. 44(21). 1660-2.
- Wolverton, W. C.
 1911 "Opsonotherapy in a Case of Puerperal Sepsis." *Journal of the American Medical Association*. 57(16). 1287.
- Woods, Hiram
 1910 "The Role of Ophthalmology in Preventive Medicine." *Journal of the American Medical Association*. 55(14). 1162-6.

Appendix 3A. Text Citations from JSCMA

- 1906 “Editorial: Medical Legislation—How to Get It.” *Journal of the South Carolina Medical Association*. 2(4). 153-4.
- 1906 “Editorial: ‘Medical Legislation.’” *Journal of the South Carolina Medical Association*. 2(November). 261-3.
- 1907 “About the Medical Practice Act” *Journal of South Carolina Medical Association*. February(9). 440-2.
- 1907 “Advantages of Immigration in the South.” *Journal of South Carolina Medical Association*. January(8). 371-2.
- 1907 “County Reports: Oconee.” *Journal of the South Carolina Medical Association*. 3(4). 194-5.
- 1907 “The Proposed Amendments to the Medical Practice Act.” *Journal of the South Carolina Medical Association*. January(8). 390-7.
- 1907 “Editorial: Advantages of Vital Statistics.” *Journal of the South Carolina Medical Association*. September(4). 171-2.
- 1907 “Medical Legislation---More Practical Politics.” *Journal of the South Carolina Medical Association*. February(9). 437-8.
- 1908 “Miscellaneous Business.” *Journal of the South Carolina Medical Association*. 4(1). 30.
- 1911 “Editorials: The State Association Meeting.” *Journal of the South Carolina Medical Association*. 7(3). 87-91.
- 1915 “Proposed Amendments to the State Medical Practice Act as Will Be Submitted to the Delegates of the South Carolina Medical Association at Their Annual Meeting at Greenwood, S.C.” *Journal of South Carolina Medical Association*. 11(3). 72-6.
- 1915 “Minutes of the House of Delegates—Sixty-seventh Annual Meeting of the South Carolina Medical Association, Greenwood, S.C., April 20, 1915---Concluded.” *Journal of the South Carolina Medical Association*. 11(6). 189-201.
- 1915 “Minutes of the House of Delegates—Sixty-seventh Annual Meeting of the South Carolina Medical Association, Greenwood, S.C., April 20, 1915---Concluded.” *Journal of the South Carolina Medical Association*. 11(6). 152-170.
- 1915 “Society Reports.” *Journal of the South Carolina Medical Association*. 11(2). 57-62.

- 1917 “Editorial: Medical College Open to Women:---Public Health Chair---Special Lectures.” *Journal of the South Carolina Medical Association*. 12(12). 36.
- 1919 “Editorial: Law Governing Midwives.” *Journal of the South Carolina Medical Association*. 15(3). 383-4.
- 1919 “The Development of a Bureau of Child Hygiene.” *Journal of the South Carolina Medical Association*. 15(5). 496-7.
- 1920 “Better Obstetrics in South Carolina.” *Journal of the South Carolina Medical Association*. 16(1). 4-5.
- 1921 “Minutes: Minutes House of Delegates.” *Journal of South Carolina Medical Association*. 17(6) 153-7.
- 1921 “South Carolina Birth Registration Urgent Necessity.” *Journal of South Carolina Medical Association*. 21(7). 138.
- 1922 “Minutes: Report of State Board of Health.” *Journal of the South Carolina Medical Association*. 18(8) 243-5.
- 1922 “Maternal Mortality in South Carolina.” *Journal of the South Carolina Medical Association*. 18(7). 184-5
- 1925 “Infant Mortality Rate in South Carolina Falls At Last.” *Journal of the South Carolina Medical Association*. 21(10). 231.
- 1929 “Society Reports: Proceedings of the Regular Meeting of the Medical Society of South Carolina, Held at Roper Hospital, Tuesday Evening, June 25th, at 8:30 O’Clock.” *Journal of South Carolina Medical Association*. 25(7). 472.
- 1929 “Society Reports: Report of Councilor—First District.” *Journal of South Carolina Medical Association*. 25(8) 498.
- 1929 “Society Reports: Report of Councilor of the Sixth District.” *Journal of South Carolina Medical Association*. 25(8). 500-1.
- 1929 “The A.M.A. Journal Passes the One Hundred Thousand Mark.” *Journal of South Carolina Medical Association*. 25(10). 534.
- 1930 “Society Reports: Anderson County Medical Society.” *Journal of South Carolina Medical Association*. 26(10). 268.
- 1930 “Society Reports: Annual Report of State Board of Health South Carolina.” *Journal of South Carolina Medical Association*. 26(2). 37-8.

- 1939 "South Carolina Birth Registration Campaign March 5-11 Inclusive." *Journal of South Carolina Medical Association*. 35(1). 41.
- 1940 "Minutes of House of Delegates S.C. Medical Association, Continued." *Journal of South Carolina Medical Association*. 36(8). 233-9.
- 1940 "Spectacular Fall of the Infant Death Rate in South Carolina." *Journal of South Carolina Medical Association*. 36(6). 166.
- Ashmore, W. Frank.
1911 "The Importance of Maternal Nursing." *Journal of the South Carolina Medical Association*. 7(4). 117-9.
- Bailey, T. L. W.
1907 "The Care of the Infant." *Journal of the South Carolina Medical Association*. September(4). 189-190.
- Baker, Mary R.
1906 "Our Medical Law." *Journal of the South Carolina Medical Association*. 2(4). 168-170.
- Baker, S. C.
1906 "Are We Doing Our Full Duty by the Laity?" *Journal of the South Carolina Medical Association*. 2(October). 212-5.
- Ball, R. W.
1937 "Maternal and Child Health Work in South Carolina." *Journal of the South Carolina Medical Association*. vol., no. 6-10.
- Banov, Leon.
1923 "The Drugless Healer." *Journal of the South Carolina Medical Association*. 19(3). 445-6.
- Black, H. R.
1910 "Report of Caces [sic]." *Journal of the South Carolina Medical Association*. 6(5). 197-201.
- Bland-Sutton, John.
1911 "Right Sided Abdominal Pain in Women." *Journal of the South Carolina Medical Association*. 7(8). 317.
- Boling, John R.
1923 "A Brief Series of Uterine Suspension Cases with Follow Up Results." *Journal of the South Carolina Medical Association*. 19(8). 567-9.
- Brunson, Sophia Dr.
1911 "The Woman Physician." *Journal of the South Carolina Medical Association*. 7(10). 437-443.

- Bunch, Geo.
1916 "The Use and Abuse of the Uterine Curette." *Journal of the South Carolina Medical Association*. 12(4). 233-7.
- Carroll, F. Julian
1908 "The Physician as a Political Factor." *Journal of the South Carolina Medical Association*. 4(9). 454-6.
- Cathcart, R. S.
1926 Minutes: Minutes of the House of Delegates." *Journal of the South Carolina Medical Association*. 22(?). 113.
- 1926 "Address of the President of the South Carolina Medical Association." *Journal of the South Carolina Medical Association*. 22(?). 80-1.
- Cornell, Wm. P.
1922 "Pediatrics." *Journal of the South Carolina Medical Association*. 18. 331-2.
- Croft, T. G.
1908 "The Value of the County Medical Society." *Journal of the South Carolina Medical Association*. 4(1). 15-8.
- Dodd, Ruth A.
1920 "Extracts From the Reports of a Colored Nurse---Work Among the Midwives." *Journal of the South Carolina Medical Association*. 16(1). 11-4.
- 1920 "Annual Report of Bureau Child Hygiene." *Journal of the South Carolina Medical Association*. 16(1). 20-3.
- Dotterrer, Thomas D.
1930 "Infant Mortality in South Carolina." *Journal of the South Carolina Medical Association*. 26(11). 277-81.
- Dove, W. Banks.
1920 "New Medical Practice Act." *Journal of the South Carolina Medical Association*. 16(3). 56-60.
- Draher, F. H.
1909 "Some Reflections on Practical Obstetrics." *Journal of the South Carolina Medical Association*. 5(7). 317-8.
- Dreher, T. H.
1931 "Birth Control Among the Poor." *Journal of South Carolina Medical Association*. 27(1). 329-332.

- Dunn, Halbert L.
 1940 "Birth Registration in South Carolina." *Journal of South Carolina Medical Association*. 36(1). 14.
- Furman, R. B.
 1908 "A Case For Diagnosis." *Journal of the South Carolina Medical Association*. 4(8). 415.
- 1916 "Ignorance, Superstition, Quackery." *Journal of the South Carolina Medical Association*. 12(4). 113-5.
- Geiger, Chas. B.
 1910 "Clarendon." *Journal of the South Carolina Medical Association*. 6(1). 47-8.
- Guerry, Le Grand.
 1907 "Responsibility of the Physician in Cases of Carcinoma of the Cervix and of the Breast." *Journal of the South Carolina Medical Association*. 3(2). 67-9.
- Guess, J. D.
 1940 "Observations on the Conduct of Labor." *Journal of South Carolina Medical Association*. 36(9). 241-4.
- 1940 "State Meeting of the South Atlantic Association of Obstetricians and Gynecologists." *Journal of South Carolina Medical Association*. 36(10). 318.
- 1939 "Obstetrics and Gynecology: Annual Meeting of the South Atlantic Association of Obstetricians and Gynecologists." *Journal of South Carolina Medical Association*. 35(3). 73-4.
- 1937 "Obstetrics and Gynecology: Facts and Fancies." *Journal of the South Carolina Medical Association*. 33(3). 69-70.
- 1937 "Obstetrics and Gynecology: The Relationship of Antenatal Care and Alleviation of Pain in Labor." *Journal of the South Carolina Medical Association*. 33(8). 201-2.
- 1936 "Obstetrics and Gynecology: Facts and Reflections Obtained From a Study of the Report of the Committee on Maternal Welfare." *Journal of the South Carolina Medical Association*. 32(5). 141-3.

- 1936 "Obstetrics and Gynecology." *Journal of the South Carolina Medical Association*. 32(6). 159-161.
- 1935 "Obstetrics and Gynecology." *Journal of the South Carolina Medical Association*. 31(11). 223.
- 1925 "Obstetrical Analgesia." *Journal of the South Carolina Medical Association*. 21. 267-271.
- Harmon, Samuel E.
 1934 "The Political Campaign. The Doctor and the People." *Journal of the South Carolina Medical Association*. 30(7). 139-140.
- Haynes, James A.
 1920 "Annual Report of the State Health Officer." *Journal of the South Carolina Medical Association*. 16(1). 23-6.
- 1919 "Annual Report of the State Health Officer." *Journal of the South Carolina Medical Association*. 15(1). 335-341.
- Hines, E. A.
 1940 "Report of the Secretary-Treasurer." *Journal of South Carolina Medical Association*. 36(7). 170-1.
- 1935 "Report of Secretary-Treasurer: South Carolina Medical Association." *Journal of the South Carolina Medical Association*. 31(7). 144.
- 1925 "Report of the Secretary for the Fiscal Year 1924, Ending December 31." *Journal of the South Carolina Medical Association*. 21(7) 173-80.
- 1907 "A Brief Summary of Obstetric Progress." *Journal of the South Carolina Association*. 3(3). 130-2.
- Kirkpatrick, W. L.
 1908 "Intra-Uterine Rigor Mortis." *Journal of the South Carolina Medical Association*. 4(1). 42.
- Klugh, G. F.
 1917 "Improvement of Rural Obstetrics with Special Reference to the Midwife" *Journal of the South Carolina Medical Association*. 13(12). 764.

- Knowlton, A. B.
 1907 "Cancer of the Uterus—Our Responsibility to Woman." *Journal of the South Carolina Medical Association*. 3(2). 69-74.
-
- 1906 "Perineal and Cervical Infection as Factors in the Production of Gynecic Surgery." *Journal of the South Carolina Medical Association*. Nov (6). 278-9.
-
- 1905 "Imperative Surgery." *Journal of the South Carolina Medical Association*. 1(10). 134-5.
- Land, J. N.
 1930 "Conservative Gynecology." *Journal of South Carolina Medical Association*. 26(4). 125-7.
- Laughinghouse, Chas. O'H.
 1929 "Bureau of Health Education." *Journal of South Carolina Medical Association*. 25(12). 595.
- Lawton, W. H.
 1908 "Notes of Abortion and Its Treatment." *Journal of the South Carolina Medical Association*. 4(7). 355-9.
- Leathers, W. S.
 1923 "The Public Health Program of the New South." *Journal of the South Carolina Medical Association*. 19(6). 513-9.
- Lunney, John.
 1915 "A Case of Caesarean Section Not Hitherto Reported." *Journal of the South Carolina Medical Association*. 11(1). 5-7.
- Mayer, O. B.
 1907 "Obstetrics and Pediatrics: Puerperal Autoinfection from the Bacteriologic Standpoint." *Journal of the South Carolina Medical Association*. March(10). 541-2.
- McCord, James R.
 1934 "The Conservative Treatment of Eclampsia." *Journal of the South Carolina Association*. 30(8). 159-161.
- Moore, Oren.
 1928 "Some Problems of Prenatal Care." *Journal of the South Carolina Medical Association*. 24(10). 229-231.

- Mullaly, Lane.
 1906 "Obstetrics and Gynecology: Present Day Methods of Conducting Labor Cases and the Results Obtained." *Journal of the South Carolina Medical Association*. 2(8). 248.
-
- 1905 "Puerperal Eclampsia." *Journal of the South Carolina Medical Association*. 1(9). 69-72.
- Parker, Edward F.
 1915 "President's Address, 1915—Greenwood, S.C." *Journal of the South Carolina Medical Association*. 11(5). 140-1.
- Peters, Lindsay.
 1921 "Treatment of Eclamptogenic Toxemia of Pregnancy with Special Reference to Its Surgical Aspects." *Journal of South Carolina Medical Association*. 17(5). 116-122.
- Rankin, W. S.
 1921 "Relation of Public Health to the Medical Profession or The Relation of Social to Curative Medicine." *Journal of the South Carolina Medical Association*. April. 93-9.
- Robinson, William J.
 1911 "Scientific Medicine Versus Quackery: Should Ignorant Laymen be Permitted to Treat the Sick?" *Journal of South Carolina Medical Association*. 135-6.
- Rhett, Wythe.
 1922 "Breast Feeding." *Journal of the South Carolina Medical Association*. 18(8). 252-6.
- Ross, Clyde F.
 1910 "Early Symptoms and Early Diagnosis of Uterine Carcinoma" *Journal of South Carolina Medical Association*. 6(7). 324-6.
- Ross, Robert A.
 1933 "Late Toxemia of Pregnancy: An Analysis and an Evaluation of Treatment." *Journal of South Carolina Medical Association*. 29(8). 193-7.
- Rucker, M. Pierce.
 1925 "Parturition A Surgical Procedure." *Journal of South Carolina Medical Association*. 21(issue unavailable). 331-6.
- Salters, Leland B.
 1910 "A Case of Combined Intra and Extra-Uterine Pregnancy." *Journal of the South Carolina Medical Association*. 6(2). 83-5.

- Seibels, R. E.
 1940 "Report of the Committee on Maternal Welfare." *Journal of South Carolina Medical Association*. 35(4). 202-4.
-
- 1933 "Obstetrics and Gynecology." *Journal of South Carolina Medical Association*. 29(4). 110-1.
-
- 1929 "Post Partum Care." *Journal of the South Carolina Medical Association*. 25(1). 295-300.
-
- 1928 "Puerperal Sepsis." *Journal of South Carolina Medical Association*. 24(10). 239.
-
- 1922 "Obstetrics and Gynecology." *Journal of the South Carolina Medical Association*. 18(7) 200-1.
- Shaw, H. L.
 1908 "Puerperal Eclampsia with Report of Cases." *Journal of the South Carolina Medical Association*. 4(12). 612-4.
- Shecut, L. C.
 1924 "Ante-partum Care." *Journal of the South Carolina Medical Association*. 20(5). 114-6.
-
- 1909 "Some of the Functional Neuroses with Report of Case of Hysterical Amaurosis." *Journal of the South Carolina Medical Association*. 5(9). 408-413.
- Simpson, W. E.
 1928 "Infant Mortality in South Carolina." *Journal of South Carolina Medical Association*. 24(2). 27-32.
- Smethers, A L.
 1934 "Pain-killers in Obstetrical Patients." *Journal of the South Carolina Medical Association*. 30(2). 34-6.
- Smith, D. H.
 1925 "Placenta Praevia, with Special Reference to Treatment." *Journal of the South Carolina Medical Association*. 22(11). 36-8.
-
- 1918 "A Consideration of the Proper Management of Obstetrical Engagements in Sparsely Settled Districts." *Journal of the South Carolina Medical Association*. 14(5) 127-9.

- Smith, W. A.
 1929 "Society Reports: Proceedings of the Regular Meeting of the Medical Society of South Carolina, Held at Roper Hospital, Tuesday Evening, May 28th, at 8:30 O'Clock." *Journal of South Carolina Medical Association*. 25(8). 474-5.
- Smith, W. Atmar.
 1926 "Society Reports." *Journal of the South Carolina Medical Association*. 22. 47.
- 1925 "Minutes." *Journal of the South Carolina Medical Association*. 23. 72-4.
- Tyler, G. T.
 1924 "Gynecological Contributions to Obstetrical Difficulties." *Journal of the South Carolina Medical Association*. 20(7). 165-9.
- Walker, D. E.
 1921 "Observations on the Etiology and Treatment of Enteroptosis." *Journal of South Carolina Medical Association*. 17(11). 290-292.
- White, Joseph A.
 1911 "Preventive Medicine: What It Has Done and What It can Do if the State Will But Recognize Its Obligations to the Public." *Journal of the South Carolina Medical Association*. 7(8). 295-300.
- Wilcox, J. McL.
 1925 "An Unusual Obstetrical Condition." *Journal of South Carolina Medical Association*. 21(8). 194.
- Wilson, G. Fraser.
 1924 "Special Points on the Delivery of Normal Cases." *Journal of the South Carolina Medical Association*. 20(6) 139-141.
- Wilson, H. L.
 1910 "Lister Versus Midwife." *Journal of the South Carolina Medical Association*. 6(1). 42-3.
- Wilson, Lester A.
 1940 "Eclampsia." *Journal of South Carolina Medical Association*. 35(4). 83-7.
- 1928 "The Conduct of Labor and the Use of Anesthetics." *Journal of South Carolina Medical Association*. 24(9). 206-8.
- 1928 "The Conduct of Labor and the Use of Anesthetics." *Journal of the South Carolina Medical Association*. 24(9). 206-8.

1925 "Pueperal Infection." *Journal of the South Carolina Medical Association*. 21. 215.

Wilson, Robert

1920 "Report of the State Board of Health." *Journal of the South Carolina Medical Association*. 16(6). 141-2.

Yarros, Rachelle S.

1917 "Medical Aspects of the Social Hygiene Movement." *Journal of the South Carolina Medical Association*. 13(12). 637-641.

Appendix 4A: Sanitary Code Citations

- 1914 “Reports of State Officers, Boards and Committees.” Pp. 78, 86 in *State Board of Health--Sanitary Code*. Columbia: Gonzales and Bryan State Printers.
- 1915 “Reports of State Officers, Boards and Committees.” Pp. 91-7, 115, 123 in *State Board of Health--Sanitary Code*. Columbia: Gonzales and Bryan State Printers.
- 1928 “Narrative Report of the Bureau of Child Hygiene and Public Health Nursing for the period of Jan. 1, 1928 to Jan. 1, 1929.” 88-93. Pp. 111, 119 in *State Board of Health--Sanitary Code*. Columbia: Printed under the Direction of the Joint Committee on Printing of the General Assembly of South Carolina.
- 1929 “Reports of State Officers, Boards and Committees--Bureau of Child Hygiene and Public Health Nursing.” Pp. 61-70. in *State Board of Health--Sanitary Code*. Printed under the Direction of the Joint Committee on Printing of the General Assembly of South Carolina.
- 1932 “Reports of State Officers, Boards and Committees. Report of the Bureau of Child Hygiene and Public Health Nursing, Oct. 1, 1930 to Oct. 1, 1931.” Pp. 46-5 in *State Board of Health--Sanitary Code*. Printed under the Direction of the Joint Committee on Printing of the General Assembly of South Carolina.
- 1933 “Reports of State Officers, Boards and Committees. Report of the Bureau of Child Hygiene and Public Health Nursing, Oct. 1, 1931-Oct. 1, 1932.” Pp. 53-61 in *State Board of Health--Sanitary Code*. Printed under the Direction of the Joint Committee on Printing of the General Assembly of South Carolina.
- 1934 “Reports of State Officers, Boards and Committees. Report of Bureau of Child Hygiene July 1, 1932 to May 15, 1933.” Pp. 29-35 in *State Board of Health--Sanitary Code*. Printed under the Direction of the Joint Committee on Printing of the General Assembly of South Carolina.
- 1935 “Reports of State Officers, Boards and Committees. Annual Report State Field Nurse and Midwife Supervisor, July 1933-June 1934 Inclusive.” Pp. 26-30 in *State Board of Health--Sanitary Code*. Printed under the Direction of the Joint Committee on Printing of the General Assembly of South Carolina.
- 1937 “Reports of State Officers, Boards and Committees. Rules and Regulations Governing Midwives in the State of South Carolina.” Pp. 60-3 in *State Board of Health--Sanitary Code*. Printed under the Direction of the Joint Committee on Printing of the General Assembly of South Carolina.

Appendix 5A: Medical Practice Acts Citations

- 1906 “South Carolina” Pp. 867-8 in *American Medical Directory*. Chicago: American Medical Association.
- 1909 “South Carolina” Pp. 1063-4 in *American Medical Directory*. Chicago: American Medical Association.
- 1912 “South Carolina” Pp. 1128-9 in *American Medical Directory*. Chicago: American Medical Association.
- 1914 “South Carolina” Pp. 1337-8 in *American Medical Directory*. Chicago: American Medical Association.
- 1916 “South Carolina” Pp. 1408-9 in *American Medical Directory*. Chicago: American Medical Association.
- 1918 “South Carolina” Pp. 1452-3 in *American Medical Directory*. Chicago: American Medical Association.
- 1921 “South Carolina” Pp. 1385-6 in *American Medical Directory*. Chicago: American Medical Association.
- 1923 “South Carolina” Pp. 1465-6 in *American Medical Directory*. Chicago: American Medical Association.
- 1925 “South Carolina” Pp. 1463-4 in *American Medical Directory*. Chicago: American Medical Association.
- 1929 “South Carolina” Pp. 1337-8 in *American Medical Directory*. Chicago: American Medical Association.
- 1931 “South Carolina” Pp. 1457-8 in *American Medical Directory*. Chicago: American Medical Association.
- 1934 “South Carolina” Pp. 1505-6 in *American Medical Directory*. Chicago: American Medical Association.
- 1936 “South Carolina” Pp. 1509-1510 in *American Medical Directory*. Chicago: American Medical Association.
- 1938 “South Carolina” Pp. 1561-2 in *American Medical Directory*. Chicago: American Medical Association.
- 1940 “South Carolina” Pp. 1645-6 in *American Medical Directory*. Chicago: American Medical Association.

Appendix 6A. Email correspondence with Roberta (Robin) Copp

From : Roberta Copp <RCOPP@gwm.sc.edu>Sent : Friday, July 28, 2006 2:31 PM
To : <alicia.d.bonaparte@Vanderbilt.Edu>Subject : referred by Mary Morgan of SC State
libraries {SpamScore: sss}

Dear Ms. Bonaparte;

In response to your query, the first codes regulating midwives were passed in 1936 - published in 1937. There is no mention of midwifery in the 1915 or 1919 volumes. Before 1936, midwives were not licensed, but came under the supervision of the Bureau of Child Hygiene and Public Health Nursing, a bureau within the State Board of Health. If you would like the annual reports of this bureau from 1929-1936, please email me your postal address so that I may send you a photo copy services order form. The South Caroliniana Library is a closed stack, non-circulating library; we do not participate in interlibrary loan.

Attached is a list of researchers, should you decide to pursue that route. If there is any other way I may be of assistance, please do not hesitate to let me know.

Sincerely,

Robin Copp
Curator of Published Materials
South Caroliniana Library
University of South Carolina
Columbia SC 29208

>>> "Bonaparte, Alicia Dionne" <alicia.d.bonaparte@Vanderbilt.Edu> 07/26 2:24 PM
>>>

Greetings,
Greetings,

My name is Alicia D. Bonaparte and I'm a doctoral candidate working on my dissertation. I've previously spoken with Mary Morgan at the SC State library in regards to locating the Sanitary Codes of South Carolina volumes. More specifically, I'm looking for references regarding midwifery regulation during the first 4 decades of the 1900s. Mary was able to locate volumes 1928 and 1937 and informed me that there is no mention of midwifery regulation in volume 1928; however, she did find midwifery regulation in 1937. I would like to request information regarding midwifery regulation in the volumes that you all hold at the South Caroliniana (sp?) location. If such a request cannot be completed, can I ILL the bound volumes you all hold?

Please respond at your earliest opportunity.

Warmest regards,

Alicia D. Bonaparte, M.A.

"Truth without compassion is brutality"--an unlikely sage
Bonaparte, Alicia Dionne
Doctoral Student, Dept. of Sociology
Vanderbilt University
Email: alicia.d.bonaparte@Vanderbilt.Edu

Figure 1: Rules and Regulations Governing Midwives in the State of South Carolina

Section 1. All midwives shall register with the local registrar and also at the County Health Department.

Section 2. Requirements for Registration.

(1) In order to secure a Certificate of Registration a midwife shall first demonstrate her ability to read and write. She shall have reasonable clear vision, average intelligence, and good general health. She shall obtain from the Health Officer or a private physician each year a certificate stating that she is free from communicable diseases.

(2) Every midwife shall be successfully vaccinated against smallpox, inoculated against typhoid fever, and have a negative Wasserman test for syphilis.

(3) Before becoming eligible to register, all midwives are required to attend a course of instructions of at least ten lessons to be given to midwifery classes in the counties by either State or County nurses. At the conclusion of this course certificates may be granted to those whom the instructor considers competent to register. No certificate will be issued until this course has been completed. These certificates are valid for one year only, and shall be renewed each year by the County Health Officer, and may be withdrawn at the discretion of the County Health Officer. A fee of twenty-five cents shall be charged for the issuance of each certificate and for each renewal, said fee shall be paid to the County Health Officer or nurse and disbursed by them in defraying expenses of State Midwife Institutes. The midwife shall also be required to attend a State Institute for instructing midwives unless excused by the County Health Officer.

(2) Midwives shall report to the Public Health Nurse of their community whenever requested to do so.

Sec. 4. Regulations.

(1) A midwife, before attending a woman in confinement, shall wash her hands and arms with warm water and soap; and afterwards wash in quart of warm water containing a teaspoonful of Lysol, or carbolic acid, or other antiseptic.

(2) She shall keep herself clean, and also her patient, bed, clothing and all that comes in contact with her.

(3) She shall not pass her fingers or any instrument into the birth canal of the woman for the purpose of examination or for any other purpose.

- (4) A midwife shall endeavor to secure the assistance of a physician if the child is not born after twenty-four hours of labor.
- (5) A midwife shall not give drugs of any kind to hasten or increase labor pains, but may give castor oil or other laxative as needed.
- (6) She shall not give an injection of any kind into the birth canal without orders from the doctor, but may use an enema of warm water into the bowels to produce a movement.
- (7) If the child's hands come down, the child is lying in cross position and cannot be born alone. The midwife shall immediately send for a physician and inform him as to the condition observed.
- (8) If the child's feet or buttocks are born first, it will be smothered in a few minutes unless the head comes out immediately. In such a case the midwife should lift the body of the child by the feet and hold it up. This will make the delivery of the head quicker. Delay will almost certainly mean the death of the child.
- (9) If the mother has a spasm, or bleeds either before or after the child is born, the midwife shall send at once for a physician. She shall do likewise if the mother is very weak or her labor is slow. If the mother shows signs of fever, send for the physician at once without waiting until she is worse.
- (10) Every midwife shall report all births she attends within ten days on the blanks furnished her. Unfading black ink (writing fluid) is to be used. These reports shall be made to the local registrar.
- (11) As soon as the child is born, two drops of a 1 per cent solution of nitrate of silver shall be dropped into each eye.
- (12) Every case of 'baby's sore eyes' or reddening of the eyelids shall be reported at once to a physician.
- (13) The cord shall be dressed at once with a clean dry dressing. No grease is to be used.

Sec. 5 Penalty. Any person violating any of the above rules or regulations shall, upon conviction, be punished as provided in Section 2314, Vol. II, Code of Laws of South Carolina, 1922. (This section provides that any one failing to comply with any of the rules or regulations of the Executive Committee of the State Board of Health shall, upon conviction, be fined not to exceed \$100.00 or Imprisoned not to exceed thirty days.)

Approved and promulgated by the Executive Committee of the South Carolina State Board of Health, July 14, 1937 (*Sanitary Codes*, 1937: 60-3).

Figure 2.

An account describing the forms of medicines that a granny midwife used in South Carolina as reported to Dr. Furman in *JSCMA*

“I fetch dis chile fuh you to look at um, please suh, an’ lemmy know wha’ de mattah ail um an’ geeum subscription (1). I bin try my homes remedy onum an’ wah’ dissent an’ datten ecvise, but stedda he recroot up he peah fuh git wusser ontell it look lack he gwine dead (2). No, suh, he ent my chile (3). He was give me by my secunts cousin Manda Ludd younges’ gal Angeline, wha’ dead wid de tarryfide fevah when bin in he tree week old (4). He evah been a weezly chile fum de fuss breat ontell all bofe he two eye bin shet (5). I low it muss be wurrum wha’ ail um, an’ I geeum some wurrum puhfume, but it ent seems t o reach de complain’ (6). Ole aun Fibby Simmon, de granny oomans wha’ stay longside de big road—I speck you must’ be shum—ecvise me futtuh geeum road root tea an’ bade he two leg een mullein leaf bild down wid life mulastin (7). She say how he gut de yaller trash, an’ dat he’ll sho dead he go troem (8). Ole Mis’ Ann low he plaguenin wid de ingestion of de stumick an’ de dropsy, an’ gimme some calmous an’ tinchywine fuh geeum, an’ de swellin’ bate down ontell he look lack he gwine swage way to nuttin (9)” (Furman, *JSCMA*, 1908, 4(8): 415). (granny)

Translation:

1. I’m bringing this child for you to see, please sir, and let me know what is the matter with him, and give him a prescription.

2. I was trying my home remedies on him/her and what this and that advised, but he kept on coughing up and he appeared to get worse until it looked like he would die.

3 No, Sir, he isn't my child.

4. He was given to me by my second cousin, Manda Ludd's youngest daughter, Angeline who died of terrified fever when (bin in he) three weeks old.

5. He's always been a sickly child from his first breath until both of his eyes were shut.

6. i figure (allow) it must be worms that's ailing him, and i gave him worm perfume, but it didn't seem to help him. (reach the complaint)

7. Old aunt Fibby Simmon, the granny woman that stays near the main highway---i expect you must be show 'em (shum might be some)---advised me to give him road root tee and bathe both of his legs in mullein leaf boiled down with life everlastin.

8. She says he has the yellow thrash, and that he'll die for sure if he goes through it.

9. Old Miss Ann believes that he's sick with indigestion of the stomach and dropsy and she gave me some calamus and turpentine to give to him and the swelling abated down until he looked like he was going to waste away to nothing.

WORKS CITED

- Abbott, Andrew.
1988 *The System of Professions*. Chicago: University of Chicago Press.
- Alexa, Melina and Zuell, Cornelia.
2000 "Text Analysis Software: Commonalities, Differences, and Limitations: The Results of a Review." *Quality and Quantity*. 34(3). 299-321.
- Alho, Olli
1988 *The Religion of Slaves: A Study of the Religious Tradition and Behavior of Plantation Slaves in the United States, 1830-1865*. Helsinki: Academia Scientarium Fennica.
- Apple, Rima D.
1990 *Women, Health, and Medicine in America*. New York: Garland Publishing, Inc.
- Auerbach, Elizabeth S.
1968 "Black Midwives in Mississippi: The Professionalizing of a Folk Role." *Human Mosaic*. 3(1). 125-132.
- Baer, Hans A.
1982 "Toward a Systematic Typology of Black Folk Healers." *Phylon*. 43(4). 327-343.
- Baer, Hans A., and Yvonne Jones.
1992 *African Americans in the South: Issues of Race, Class, and Gender*. Athens: The University of Georgia Press.
- Ball, Charles.
1837 *Slavery in the United States: A Narrative of the Life and Adventures of Charles Ball, A Black Man*. (internet source: <http://docsouth.unc.edu/ballslavery/ball.html>)
- Barker, Kristin K.
1993 "Birthing and Bureaucratic Women: Gender, Professionalization, and the Construction of Medical Needs, 1920-1935." Ph.D. Dissertation, Dept. of Sociology, University of Wisconsin, Madison, WI.
- Beardsley, Edward H.
1990 "Race as a Factor in Health." Pp. 121-140 in *Women, Health, and Medicine in America*. Edited by Rima D. Apple. New York: Garland Publishing, Inc.
1987 *A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South*. Knoxville: The University of Tennessee Press.

- Beoku-Betts, Josephine A.
 1994 "She Make Funny Flat Cake She Call Saraka: Gullah Women and Food Practices Under Slavery" Pp. 211-231 in *Working Toward Freedom: Slave Society and Domestic Economy in the American South*, edited by Larry E. Hudson, Jr. Rochester: University of Rochester Press.
- Berkenkotter, Carol and Huckin, Thomas N..
 1995 *Genre Knowledge in Disciplinary Communication: Cognition/Culture/Power*. Hillsdale: Lawrence Erlbaum Associates.
- Bogdan, Janet Carlisle.
 1990 "Childbirth in America, 1650 to 1990. Pp 101-120 in *Women, Health, and Medicine in America: A Historical Handbook*, edited by Rima D. Apple. New York: Garland Publishing.
- Borgatti, Steve.
 "Introduction to Grounded Theory". (internet source: <http://www.analytictech.com/mb870/introtoGT.htm>).
- Borst, Charlotte G.
 1995 *Catching Babies: The Professionalization of Childbirth, 1870-1920*. Cambridge: Harvard University Press.
- Brown, Phil.
 2000 *Perspectives in Medical Sociology*. Prospect Heights: Waveland Press, Inc.
- Brown, Ras Michael.
 2002 "Walk in the Feenda": West-Central Africans and the Forest in the South Carolina-Georgia Lowcountry." Pp. 289-317 in *Central Africans and Cultural Transformations in the American Diaspora*, edited by Linda Heywood. New York: Cambridge University Press.
- Buchan, William.
 1815 *Domestic Medicine, Advice to Mothers, and Domestic Midwifery*. Charleston, S.C. (bound together in Waring Historical Library of Medical University of South Carolina-Charleston).
- Campbell, Karen and Holly McCammon.
 2005 "Elizabeth Blackwell's Heirs: Women as Physicians in the United States, 1880-1925." *Work and Occupations*. 32(3). 290-318.
- Campbell, Marie.
 1946 *Folks Do Get Born*. Rinehart and Co., Incorporated.

- Conrad, Peter
2000 "Medicalization and Social Control" Pp. 104-129 in *Perspectives in Medical Sociology*, edited by Phil Brown. Prospect Heights: Waveland Press, Inc.
- Daly, Mary.
1990 *Gyn/ecology: The Metaethics of Radical Feminism*. Boston: Beacon Press.
- Davis, Sheila P., and Cora A. Ingram.
1993 "Empowered Caretakers: A Historical Perspective on the Roles of Granny Midwives in Rural Alabama" Pp. 191-201 in *Wings of Gauze*, edited by Barbara Bair and Susan E. Cayleff. Detroit: Wayne State University Press.
- De Vries, Raymond G.
1985 *Regulating Birth: Midwives, Medicine, and the Law*. Philadelphia: Temple University Press.
- Donnegan, Jane B.
1978 *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America*. Westport: Greenwood Press.
- Donnison, Jean
1977 *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*. New York: Schocken Books.
- Dougherty, Molly C.
1978 "Southern Lay Midwives as Ritual Specialists" Pp. 151-164 in *Women in Ritual and Symbolic Roles*, edited by Judith Hoch-Smith and Anita Spring. New York: Plenum Press.
- DuBois, W. E. B.
1979 *The Souls of Black Folk*. New York: Penguin Books. Originally published in 1903.
- Dula, Annette
1994 "Bioethics: The Need For A Dialogue With African Americans" Pp. 11-23 in *"It Just Ain't Fair": The Ethics of Health Care for African Americans*, edited by Annette Dula and Sara Goering. Westport: Praeger.
- Dula, Annette and Sara Goering.
1994 *"It Just Ain't Fair": The Ethics of Health Care for African Americans*. Westport: Praeger.
- Ehrenreich, Barbara, and Deidre English.
1973 *Witches, Midwives, and Nurses: A History of Women Healers*. Old Westbury: The Feminist Press.

- Finkelman, Paul.
1989 *Medicine, Nutrition, Demography, and Slavery*. New York: Garland Publishing.
- Fox, Bonnie and Diana Worts.
1999 "Revisiting the Critique of Medicalized Childbirth: A Contribution to the Sociology of Birth." *Gender & Society*. 13(3). 326-346.
- Gerth, H. H. and C. Wright Mills.
1965 *From Max Weber: Essays in Sociology*. New York: Oxford University Press.
- Giddings, Paula.
1994 *When and Where I Enter: The Impact of Black Women on Race, and Sex in America*. New York: Morrow.
- Fraser, Gertrude Jacinta.
1998 *African American Midwifery in the South: Dialogues of Birth, Race, and Memory*. Cambridge: Harvard University Press.
- Graves, Jules O.
1960 *A Manual for Midwives*. Jacksonville, Florida: Florida State Board of Health.
- Gruter, Margaret and Robert D. Masters.
1986 "Ostracism as a Social and Biological Phenomenon: An Introduction." *Ethnology and Sociobiology*. 7. 1-10.
- Hanlon, John J.
1964 *Principles of Public Health Administration*. St Louis: C. V. Mosby.
- Hatch, Nathan O.
1988 *The Professions in American History*. Notre Dame: University of Notre Dame Press.
- Hazard-Donald, Katrina.
2006 American Culture Association/Popular Culture Association conference. Section on Black Healers. April 4, 2006. Private conversation.
- Hill Collins, Patricia
2000 *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York: Routledge.
- Heywood, Linda W.
2002 *Central Africans and Cultural Transformations in the American Diaspora*. New York: Cambridge University Press.

- Higgs, Robert
1977 *Competition and Coercion: Blacks in the American Economy, 1865-1914*. Cambridge: Cambridge University Press.
- Hobbs, S. H. Jr.
1927 "Births Attended by Midwives." *North Carolina State Board of Health Education*. 42. 26-9.
- Hoch-Smith, Judith and Anita Spring.
1978 *Women in Ritual and Symbolic Roles*. New York: Plenum Press.
- hooks, bell.
1981 *Ain't I A Woman: Black Women and Feminism*. Boston: South Press.
- Holmes, Linda Janet.
1992 "Midwives, Southern Black." Pp. 258-260 in *Encyclopedia of Childrearing: Critical Perspectives*, edited by Barbara Katz Rothman. Phoenix: Oryx Press.
- Hudson Jr., Larry E.
1994 *Working Toward Freedom: Slave Society in Domestic Economy in the American South*. Rochester: University of Rochester Press.
- Jones, Jacqueline.
1985 *Labor of Love, Labor of Sorrow: Black Women, Work, and the Family from Slavery to Present*. New York: Basis Books, Inc.
- Kelle, Udo.
1998 *Computer-Aided Qualitative Data Analysis*. Thousand Oaks: SAGE Publications.
- Kemble, Frances.
1992 *Journal of a Residence on a Georgian Plantation in 1838-1839*. Savannah : Library of Georgia.
- Lafaille, Robert.
1995 "Computer Programs for Qualitative Research." *Historical Social Research*. 20(173). 91-97.
- Lantos, John D.
1994 "Race, Prenatal Care, and Infant Mortality" Pp. 67-74 in "*It Just Ain't Fair*": *The Ethics of Health Care for African Americans*, edited by Annette Dula and Sara Goering. Westport: Praeger.
- Lay, Mary M.
2000 *The Rhetoric of Midwifery : Gender, Knowledge, and Power*. New Brunswick: Rutgers University Press.

- Levine, Robert A. and Campbell, Donald T.
 1972 *Ethnocentrism: Theories of Conflict, Ethnic Attitudes, and Group Behavior*. New York: John Wiley & Sons, Inc.
- Leavitt, Judith Walzer.
 1987 "The Growth of Medical Authority: Technology and Morals in Turn-of-the-Century Obstetrics." *Medical Anthropology Quarterly* 1(3). September. 230-255.
- 1986 *Brought to Bed: Childbearing in America 1750 to 1950*. New York: Oxford University Press.
- 1983 "Science Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century." *The Journal of American History*. 70(2). 281-304.
- Lee, Valerie.
 1996 *Granny Midwives and Black Women Writers*. New York: Routledge.
- Litoff, Judy Barrett.
 1996 "Forgotten Women: American Midwives at the Turn of the Twentieth Century." Pp. 425-441 in *Childbirth: Changing Ideas and Practices in Britain and America 1600 to the Present*, edited by Phillip K. Wilson, Ann Dally, and Charles R. King. New York: Garland Publishing.
- 1990 "An Historical Overview of Midwifery in the United States." *Pre- and Peri-Natal Psychology*. 5(1). Fall. 5-22.
- Littlefield, Daniel C.
 1981 *Rice and Slaves: Ethnicity and the Slave Trade in Colonial South Carolina*. Urbana: University of Illinois Press.
- Loeks, Meria.
 1993 "Midwifery and the Law." Pp. 254-258 in *Encyclopedia of Childbearing: Critical Perspectives*, edited by Barbara Katz Rothman. Phoenix: Oryx Press.
- Logan, Onnie Lee.
 1989 *Motherwit: the story of an Alabama midwife*. New York: Dutton.
- Lops, Vonda R.
 1988 "Midwifery: Past to Present." *Journal of Professional Nursing*. 4(6). 402-7.
- Lorde, Audre.
 1984 *Sister Outsider: Essays and Speeches by Audre Lorde*. Freedom: The Crossing Press.

- MacGaffey, Wyatt.
 1986 *Religion and Society in Central Africa: The Bakongo of Lower Zaire*. Chicago: The University of Chicago Press.
- Masters, Robert D.
 1987 "Ostracism, Voice, and Exit: The Biology of Social Participation." *Ethology and Sociobiology*. 7. 231-247.
- Mathews, Holly F.
 1992 "Killing the Medical Self-Help Tradition Among African Americans: The Case of Lay Midwifery in North Carolina, 1912-1983." Pp. 60-78 in *African Americans in the South: Issues of Race, Class, and Gender*, edited by Hans A. Baer and Yvonne Jones. Athens: University of Georgia Press.
- Miller, Joseph C.
 2002 "Central Africa During the Era of the Slave Trade, c. 1490s-1850s." Pp. 21-70 in *Central Africans and Cultural Transformations in the American Diaspora*, edited by Linda M. Heywood. New York: Cambridge University Press.
- Mitford, Jessica.
 1992 *The American Way of Birth*. New York: Dutton/Penguin Books.
- Moss, Kay.
 1992 *Southern Folk Medicine, 1750-1820*. Columbia: University of South Carolina Press.
- Muhr, Thomas.
 1991 "ATLAS/ti: A Prototype for the Support of Text Interpretation." *Qualitative Sociology*. 14(4/2). 349-371.
- Mullin, Michael.
 1992 *Africa in America: Slave Acculturation and Resistance in the American South and the British Caribbean, 1736-1831*. Urbana: University of Illinois Press.
- North Carolina.
 1988 *North Carolina Vital Statistics*. Vol. 1. Raleigh: North Carolina Department of Environment, Health, and Natural Resources, Division of Statistics and Information Services.
- Numbers, Ronald L.
 1988 "The Fall and Rise of the American Medical Profession." Pp. 51-72 in *The Professions in American History*, edited by Nathan O. Hatch. Notre Dame: University of Notre Dame Press.

- Osofsky, Gilbert.
 1969 *Puttin' On Ole Massa: The Slave Narratives of Henry Bibb, William Wells Brown, and Solomon Northup*. New York: Harper & Row, Publishers.
- Postell, William Dosite.
 1951 *The Health of Slaves on Southern Plantations*. Baton Rouge: Louisiana State University Press.
- Prein, Gerald, Udo Kelle, and Katherine Bird.
 1998 "An Overview of Software." Pp. 190-210 in *Computer-Aided Qualitative Data Analysis: Theory, Methods, and Practice*, edited by Udo Kelle. Thousand Oaks: SAGE Publications.
- Pringle, Elizabeth W. Allston and Cornelius O. Cathey.
 1961 *A Woman Rice Planter, by Patience Pennington*. Cambridge: Belknap Press of Harvard University Press.
- Pringle, Rosemary
 1998 *Sex and Medicine: Gender, Power, and Authority in the Medical Profession*. Cambridge: Cambridge University Press.
- Radcliffe, Walter.
 1989 *Milestones in Midwifery and the Secret Instrument: The Birth of the Midwifery Forceps*. San Francisco: Norman Publishing.
- Rawick, George.
 1972 *The American Slave, vol. XI*. Westport: Greenwood Publications.
- Reed, Alyson and Joyce E. Roberts.
 2000 "State Regulation of Midwives: Issues and Options." *Journal of Midwifery & Women's Health*. 45(2). March/April. 130-149.
- Reid, Margaret.
 1989 "Sisterhood and Professionalization: A Case Study of the American Lay Midwife." Pp. 219-238 in *Women as Healers: Cross-Cultural Perspectives*, edited by Carol Shepherd McClain. New Brunswick: Rutgers University Press.
- Robinson, Sharon.
 1984 "A Historical Development of Midwifery in the Black Community: 1600-1940." *Journal of Nurse-Midwifery*. 29(4). 247-50.
- Rooks, Judith Pence.
 1985 *Midwifery and Childbirth in America*. Philadelphia: Temple University Press.

- Rose, Willie Lee (ed.)
 1976 *A Documentary History of Slavery in North America*. New York: Oxford University Press.
- Rothman, Barbara Katz.
 1993 *Encyclopedia of Childrearing: Critical Perspectives*. Phoenix: The Oryx Press.
- 1991 *In Labor: Women and Power in the Birthplace*. New York: W. W. Norton & Co.
- Savitt, Todd L.
 1978 *Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia*. Chicago: University of Illinois Press.
- Schur, Edwin M.
 1983 *Labelling Women Deviant: Gender, Stigma, and Social Control*. New York: Random House.
- Schwalm, Leslie A.
 1997 *A Hard Fight for We: Women's Transition from Slavery to Freedom in South Carolina*. Urbana: University of Illinois Press.
- Shryock, Richard Harrison.
 1967 *Medical Licensing in America, 1650-1965*. Baltimore: Johns Hopkins.
- Sinkler, Anne Whaley LeClercq.
 2001 *Between North and South : The Letters of Emily Wharton Sinkler, 1842-1865*. Columbia: University of South Carolina Press.
- Smith, Claudine Curry and Millie H. B. Roberson.
 1993 *Memories of a Black Lay Midwife from Northern Neck Virginia*. Lisle: Tucker Publications.
- Smith, Margaret Charles and Linda Janet Holmes.
 1996 *Listen to Me Good: The Life Story of an Alabama Midwife*. Columbus: Ohio State University Press.
- Sollars, Werner.
 1997 "The Curse of Ham; or 'Race' and Biblical Exegesis Lecture". (internet source: <http://www.umsl.edu/~cfh/abstracts/ham.html>). Original source *Neither Black Nor White Yet Both: Thematic Explorations of Interracial Literature* (New York and Oxford: Oxford University Press, April 1997).
- Southeastern Council on Nurse Midwifery.
 1974 *Mimeograph Report on Maternal-Infant Health*. Jackson: University of Mississippi.

- Sowell, Thomas.
1983 *The Economics and Politics of Race*. New York: William Morrow and Company, Inc.
- Speert, Harold.
1980 *Obstetrics and Gynecology in America: A History*. Baltimore: Waverly Press, Inc.
- Stacey, M.
1981 "The Division of Labour Revisited, or Overcoming the Two Adams" Pp. 172-190 in *Practice and Progress: British Sociology 1950-1980*, edited by P. Abrams, R. Deem, J. Finch, and P. Rock. London: Allen & Unwin.
- Starr, Paul.
1982 *The Social Transformation of Medicine*. New York: Basic Books.
- Sterk, Helen M., Carla Hay, Alice B. Kehoe, Krista Ratcliffe, and Leona G. VandeVusse.
2002 *Who's Having This Baby: Perspectives on Birthing*. East Lansing: Michigan State University Press.
- Sterling, Dorothy.
1984 *We Are Your Sisters: Black Women in the Nineteenth Century*. New York: W. W. Norton & Company.
- Sullivan, Deborah and Weitz, Rose.
1988 *Labor Pains: Modern Midwives and Homebirth*. New Haven: Yale University Press.
- Susie, Debra Anne.
1988 *In the Way of Our Grandmothers: A Cultural View of Twentieth Century Midwifery in Florida*. Athens: University of Georgia Press.
- Tatum, Beverly Daniel.
1997 "Why Are All the Black Kids Sitting Together in the Cafeteria?": *And Other Conversations About Race*." New York: Basic Books.
- Trochim, William K.
2006 "Qualitative Approaches: Grounded Theory" (internet source: www.socialresearchmethods.net/kb/qualapp.php)
- Ubach, U. G.
1916 "Quasi-Legislative Powers of State Boards of Health." *The American Political Science Review*. 10(1). 80-95.
- United States, Dept. of Labor Force, Occupation, Industry, Employment, and Income.
1903 *Twelfth Census of the United States 1900: Population—Occupations*. Washington: United States Government Printing Office.

- United States, Dept. of Labor Force, Occupation, Industry, Employment, and Income.
1913 *Thirteenth Census of the United States 1910: Population—Occupations*.
Washington: United States Government Printing Office.
- United States, Dept. of Labor Force, Occupation, Industry, Employment, and Income.
1923 *Fourteenth Census of the United States 1920: Population—Occupations*.
Washington: United States Government Printing Office.
- United States, Dept. of Labor Force, Occupation, Industry, Employment, and Income.
1933 *Fifteenth Census of the United States 1930: Population—Occupations*.
Washington: United States Government Printing Office. 79.
- United States, Dept. of Labor Force, Occupation, Industry, Employment, and Income.
1943 *Sixteenth Census of the United States 1940: Population, volume III
Labor Force Occupation, Industry, Employment, and Income, Part 1:
United States Summary*. Washington: United States Government
Printing Office. 237.
- United States, Dept. of Vital Statistics.
1943 *Vital Statistics Rates in the United States 1900-1940*. Washington:
United States Government Printing Office. 1943.
- Ulrich, Laurel Thatcher.
1990 *A Midwife's Tale: The Life of Martha Ballard, Based on Her
Diary, 1785-1812*. New York: Alfred A. Knopf.
- Walker, Alice.
1989 *The Temple of My Familiar*. San Diego: Harcourt Brace.
- Wallace, Ruth A. and Alison Wolf.
1995 *Contemporary Sociological Theory: Continuing the Classical
Tradition*. Englewood Cliffs: Prentice Hall.
- Warren, David C.
1972 "Legitimization of Nurse-Midwives." *Health Law Bulletin*.
33. 1-4.
- Webber, Thomas L.
1978 *Deep Like the Rivers: Education in the Slave Quarter Community
1831-1865*. New York: W. W. Norton & Company, Inc.
- Weitz, Rose and Deborah Sullivan.
1992 "Midwife Licensing." Pp. 245-247 in *Encyclopedia of Childbearing:
Critical Perspectives*, edited by Barbara Katz Rothman. Phoenix: The
Onyx Press.
- Wertz, Richard W. and Wertz, Dorothy C.
1977 *Lying-In: A History of Childbirth in America*. New Haven: Yale
University Press.

- White, Deborah Gray.
1999 *Ar'n't I a Woman?: Female Slaves in the Plantation South*. New York: W. W. Norton & Company, Inc.
- Williams, James Earl.
1972 *Plantation Politics: The Southern Economic Heritage*. Austin: Futura Press.
- Wilson, Philip K., Ann Dally, and Charles R. King.
1996 *Childbirth: Changing Ideas and Practices in Britain and America 1600 to the Present*. New York: Garland Publishing.
- Wolfson, Charles.
1986 "Midwives and Home Birth: Social, Medical, and Legal Perspectives." *Hastings Law Journal*. 37. 909-976.
- Wood, Peter.
1974 *Black Majority: Negroes in Colonial South Carolina from 1670 through the Stono Rebellion*. New York: W. W. Norton & Company, Inc.