The ‘Last Midwife’ that Never Was

Gender, Race, and Birth in Durham’s Medical Establishments, 1900-1989

Bailey Griffen

A thesis submitted in partial fulfillment of the requirement for honors in the Department of History,
Duke University
Durham, North Carolina

Under the Advisement of Professor Sarah Deutsch

April 21, 2023

Dedication

To the mothers and midwives who have birthed each generation. And the networks of support that aided them along the way.
To the bodies and brains who have contributed to the knowledge we take for granted.
And to all the voices yet to be heard.

Abstract

Across the twentieth century American South, childbirth moved from the privacy of the home and the hands of the midwife to a space governed by capital interests, medical hierarchies, and public policy: the hospital. This thesis offers a historical analysis of the actors—doctors, lay practitioners, patients, and policymakers—who shaped birthing conventions in Durham, North Carolina by drawing on legal, medical, and oral histories. Durham provides a unique case study as, unlike other cities in the South, its industry flourished in the postbellum period and became a bastion of erudition with the growth of Duke University and its medical center in an otherwise rural state. At the same time, the fact that Durham's midwives were predominantly Black women meant that Duke's response to the national discourse surrounding the "midwife problem" was intimately tied to the racism of the Jim Crow South. These lay midwives became easy scapegoats for the high infant and maternal mortality rates that plagued the state. They became the victims of strict regulation through medical licensure. However, in the mid- to late-twentieth century a new, paraprofessional form of nurse-midwifery emerged as a reputable medical discipline first arising as a form of public health outreach and eventually as a means of addressing the heightened frustration with the impersonal nature of obstetricians. This revival in the 1960s and onwards was in many ways a continuation of the erasure of the tradition of Black lay midwifery, if by appropriation rather than repudiation. While this periodization shows the shifting methods by which the medical profession staked a claim to legitimacy, its aim to consolidate power remained unchanged.

Acknowledgements

That my name is the only one cited on this thesis feels remiss. It belies the whole team of people whose presence kept me going these past nine months, either because they held me accountable to making Perkins a regular part of my routine or because they took me far away from it! I credit my research to the former and my sanity to the latter. I cannot adequately acknowledge all of these people without rivaling the word count of my three chapters, but here is an ode that just begins to express my gratitude.

First, I am forever indebted to my advisor, Dr. Sarah Deutsch. This project truly would not have been possible without the generosity with which you shared your wisdom, passion, and time. The idea behind this thesis sprouted in your class, Family Rights/Human Rights, and since then, you have helped this idea grow into the paper it is now. I am sorry that I delayed your retirement (and made you spend more time on Ancestry.com than you could have ever wanted) but I mean it when I say I don't know what I would have done without your confidence in my goals and your undying support to make sure I could execute them. More than just an advisor, you are an inspiration.

Second, I owe a sincere thanks to all of my peers who braved reading drafts of my work when it was in its most bare bone forms. Your feedback brought me back to shore when I was floundering in murky waters, and even encouraged me to navigate paths I wouldn't have thought to explore of my own accord. You have been the best of lifeboats amidst what, at times, felt like a raging tempest. Our seminar is testament to the fact that even the most seemingly individual of endeavors are strengthened through teamwork. With this, I am forever appreciative of Nancy Beaujeu-Dufour, Lily Brown, Patrick Duan, Melody Gao, Isabel Lewin-Knauer, Jack Palmer, Nellie Sun, and Lisa Zhao.

And to our fearless leader, Dr. Philip Stern, I don't know how you put up with our collective angst, but I couldn't be more thankful that you did. I have never had a professor with such a sincere commitment to making his students' scholarship the best it could possibly be. Your faith in our respective journeys and friendly nudges to make it to the finish line do not go unseen.
To Isabel, no words express how much I appreciate the bond we built over endless hours spent in the thesis room. I am in awe of your diligence and intellect every day. This paper would not be what it is without your candor and wisdom, but more importantly, in you I have found a forever friend.

To my cheerleaders and confidantes outside of the classroom, thank you for putting up with my torrent of emotions and erratic schedule, and making senior year fun along the way. A special thanks to my roommates—Aspen Martin, Helen Xiao, Tanner Mercer, and Russ Hunter—for letting me talk your ear off about midwifery. Even if it was to your chagrin, you did not make this known (at least, most of the time). Another shoutout goes to Liz Maydew, Marissa Dulas, and Sophie Holtzman for exploring Durham's coffee shop scene and various library hideouts with me. You made sure work didn't feel like work, and that fun was, well, always fun. Duke would not be Duke without you and the countless others whom I love dearly and deserve more thanks than words can afford. I look forward to the many adventures ahead.

I cannot say a proper thanks without mentioning the exceptional resources housed in the Triangle area. I am lucky to have been in such close proximity to the wealth of stories that exist in Duke University Medical Center Archives and the Rubenstein Library. Navigating these collections would have been impossible without the assistance and commendable patience of Rachel Ingold, Rebecca Williams, and Kelly Wooten.

And I owe another thanks to the people who were kind enough to share their stories with me. To Dianne Barre and Gabriella Ross, you embody the strength and warmth I aspire to possess.[1] I will always carry tremendous respect for your vulnerability and belief in the power of narrative to incite change. Anyone would be fortunate to cross paths with you.

Dr. Jeffrey Baker, Dr. Nicole Barnes, and Dr. Wesley Hogan are three others who have provided me sage advice and nurtured my belief in the importance of using the history of medicine to elevate the voices of those all too often written out of the dominant record. From instilling enthusiasm towards the subject to teaching me best practices, you all have helped shape my journey writ large and this thesis, in particular.

To the grants that funded the initial stages of my research: the Department of Gender, Sexuality, and Feminist Studies' Gender and Race Research Award and the Human Rights Center's Summer Research Grant. This thesis would not have been possible without your faith in my idea.

And finally, to my parents and brother, thank you for being you. You all have seen me through the highs and lows and loved me all the same. Mum and Dad, you taught me the joys of learning from an early age and fostered a genuine sense of curiosity. Winslow, watching Duke unfold through your unjaded eyes has been the best reminder of the privilege and possibilities that exist as an undergraduate. You are my younger brother, but I look up to you, not least in your work-life balance and joie de vivre.

[1] For the sake of privacy, I have changed the names of the women who were kind enough to share their stories. However, I could not be more grateful for the wisdom these women shared.

TABLE OF CONTENTS

Figures and Tables

Preface

Studying history opened my eyes to medicine and science. It sounds counterintuitive but it was through a humanistic lens that I first grasped what I had learned in laboratory classes since grade school. Or at least, that what I learned was part of a bigger story. One that situates equations and theories lauded as infallible into the social, political, and economic contexts in which they are shaped. In other words, the 'objective' label conferred to the quantitative disciplines belies the motives, biases, and contradictions of the people who wrote them. And the very languages in which they are written, whether written or oral, hold implicit biases that shape the way we make sense of our world. What I have come to love about the discipline of history is that, at its core, it speaks to human behavior. And does so by elevating individual voices and putting them in conversation with others. Thus, it exists at both the level of the individual and the network of individuals that constitute a larger whole, and in the most intimate or impersonal of moments. Since the perspective of one person will necessarily be different than that of another, there are always more stories to be told.

Surrounded by peers on the pre-medical track, and having myself entertained the possibility of pursuing clinical work, it was courses in the History of Medicine that I found most powerful. They help diagnose the sociopolitical factors that impact perceptions of health, not just biological symptoms of disease. I came to this topic, then, invested in engagement with a discourse that weds the biological sciences, social sciences, and the humanities. And in a moment when this conversation feels particularly pertinent to the field of obstetrics and gynecology with the overturning of *Roe v. Wade* less than a year in the past. This most recent assault on reproductive justice encouraged me to consider how the perspective of the medical

professional mediates the relationship between patient and public policy, and how the stories these practitioners embrace inform their role in this arbitration.

The more I read on the topic of reproductive justice, the more I realized that the stories I had internalized on the subject were all too reductive. Reproductive rights are not just the 'right to choose,' but also the ability to access adequate care during pregnancy and the postpartum period. And the hospital births I had associated with the golden standard of care bely a darker history, one which points to the fallacy in equating the hospital with the best quality of obstetric practice. In the three chapters that follow, I invite the reader to reconsider their own preconceptions of childbirth and the medical knowledge privileged in shaping it. I do this by bringing new voices to the table that often remain invisible in the historical record. While there will always be more voices that need a place at the table, I hope this proves a foundation upon which future scholars may build.

Introduction

Three generations of Dianne Barre's family had given birth under radically different circumstances. In the 1940s, her grandmother gave birth to Dianne's mother in their North Carolina home. The community midwife joined the rest of the family to assist with the delivery, as was typical of black families during the mid-twentieth century in the American South. Several decades later, Dianne's mother delivered Dianne in an ambulance in transit to the hospital. While Dianne arrived before her parents had made it to their destination, the family had planned to welcome each of their five children into the world from a delivery room overseen by a licensed obstetrician. By the time that Dianne prepared to deliver her own daughter in Chapel Hill, in 1993, she expected to do so in Durham Regional Hospital. While the thirty years between Dianne's own birth and the delivery of her daughter had maintained medical institutions as the principal site of childbirth, it had added additional professionals to the roster, including the hospital's own midwife.[1]

None of these women's birthing stories is unique. Nationally, fewer than five percent of women delivered their children in a hospital at the turn of the twentieth century.[2] This number witnessed a dramatic increase throughout the century, but one which materialized more slowly in the country's black communities. While nearly fifty percent of African American women used a midwife to deliver their children as late as 1929, only 1.77 percent of white women did the same.[3] In this context, Dianne's grandmother's use of midwives represents no anomaly; childbirth in the hospital only became ubiquitous across social strata by the mid-twentieth

---

[1] Oral History Interview with Dianne Barre, 2023.

[2] Judith W. Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986), 133.

[3] S. H. Hobbs, "Births Attended by Midwives," *The University of North Carolina News Letter,* April 27, 1927, https://newspapers.digitalnc.org/lccn/2015236560/1927-04-27/ed-1/seq-1/#words=midwifery.

century following stringent public health campaigns to end a practice government and medical professionals deemed dangerous.[43] But by the 1970s, feminists protested what they saw as the medicalization of childbirth: the lack of humane contact during and their own loss of control over the process. Hence, Dianne joined many of her contemporaries in seeking out a more personalized version of care within the confines of the medical institution. Hospital supervised midwives seemed to be the answer.

While the pattern of demise and revival in the recent history of midwifery seems simple, there are many elements of this story that are more complicated than they appear. Even as national trends suggested homogenous desires in the delivery room, the different contexts in which expectant parents prepared to welcome a child meant that they came to the table with different expectations based on the differential treatment hospitals offered along class and racial lines. Moreover, the history of midwifery has not just evolved on its own terms. It has been shaped by a confluence of actors, from the obstetricians who sought to monopolize the practice of childbirth to the policymakers who came to identify midwifery with poor maternal outcomes and thus sought to vilify it.[5] These evolving dynamics epitomize medical historian Paul Starr's definition of medicine as a "world of power where some are more likely to receive the rewards of reason than are others."[6] For this reason, my thesis will look beyond the story of midwifery, instead, placing it in conversation with the other players implicitly and explicitly exerting authority on birthing practices: regulatory bodies, like departments of health; obstetricians; and,

---

[4] Richard Wertz and Dorothy Wertz, *Lying-In: A History of Childbirth in America* (New Haven: Yale University Press, 1989).

[5] Gertrude Jacinta Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge: Harvard University Press, 1998); Jenny Luke, *Delivered by Midwives: African American Midwifery in the Twentieth-Century South* (Jackson: University Press of Mississippi, 2018); Wertz and Wertz, *Lying-In: A History of Childbirth in America.*

[6] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 4.

later, insurance companies. In elucidating the ambivalent relationship between these stakeholders, and the evolution of such relationships in response to a dynamic social, political, and economic milieu, what emerges is a story of that is neither specific to midwives nor obstetricians, but pertinent to both.

Just as the medical profession sought to consolidate its authority over practices of care by tightening its foundation in reason and empirical knowledge and proving its propensity to heal on a national scale, obstetricians in Durham did the same. They fortified their profession's legitimacy by drawing comparisons with those who failed to uphold the same rigorous standards: lay midwives who lacked the same academic training. This juxtaposition transcended political and scholarly discourse, which manifested in medical licensure and journal articles, and seeped into the public conscience. In practice, midwives confronted draconian regulations which placed them firmly at the bottom of a medical hierarchy in which doctors occupied the top rung. Even if midwifery had not disappeared entirely, it existed on conditions set by the medical institution, whether through the voice of the region's largest medical centers—Duke, Lincoln, and Watts—or the city's Department of Public Health.

When women across the country began to protest the hyper-medicalized births normalized by the hospital, midwifery made a comeback, but only within the medical institution as nurse-midwifery. This new occupation's very diction connotes allegiances to the medical establishment *and* the tradition of midwifery. The term characterized professionals with advanced degrees in nursing but alleged partiality to a holistic and personable code of care. At least in Durham, nurse-midwives bore little resemblance to the lay-midwives who had preceded them as compared with the nurses and doctors under whom they worked.

Durham's obstetricians sought to eliminate the lay midwife from the beginning of the twentieth century to its close, even when the two practices appeared harmonious. This first took the form of regulation in the 1910s and 1920s, when it became evident that midwives occupied an important niche yet one which obstetricians refused to extend to the city's Black women on the same scale. Midwives only remained an acceptable form of care for the most marginalized, and even then, public health policy shaped them into an image they deemed more professional through education and surveillance by health departments. Yet, this was largely ignored by the white, middle-class and their doctors. As obstetricians began to increase the breadth of their practice, bureaucratic rhetoric relegated midwifery to the past only to be resurrected when hospitals and their staff encountered patients' critiques of the shortcomings of their care and reminisced about the personable character of home births and midwifery. What resulted, the legalization of nurse-midwifery and a reversion to more traditional practices, was inseparable from an attempt to fortify obstetrics when its legitimacy came under attack from a vocal part of the desired market. I, then, argue that the relationship between obstetricians and midwives has always been one in which the former attempts to claim its authority by eclipsing the latter, even when biomedicine appears to concede the benefits of midwifery. Whether through plain displays of supervision or more covert attempts of maintaining presumptive superiority via assimilation into the medical establishment, the field of obstetrics mirrors larger power dynamics whose tactics are modulated by social and economic contexts.

In 2021, anthropologist Dána-Ain Davis and medical doctor Karen Scott analyzed black women's experiences within medical institutions before, during, and after birth to recommend

"quality-improvement strategies that would now take into account Black women's experiences."[7] To do so, they built on Davis' conception of obstetric racism: the confluence of "obstetric violence and medical racism" which "delineates particular forms of exploitation that are historically created and structure Black value as it is constituted in the engagements of Black women within biomedical and healthcare infrastructure."[8] While Davis envisioned this framework as a means to analyze the racial disparities that shape access to assisted reproductive technology, or the lack thereof, other scholars interested in the social and historical responses to black reproduction and motherhood have built on its foundation.

Jennifer Nash is one such scholar. While her work focuses on black motherhood as symbolic, she acknowledges the increasing attention Black maternal and infant health have received amongst medical and lay audiences since 2010, from CDC reports which acknowledge the abhorrent juxtaposition between white and black health outcomes in the delivery room to conversations on Capitol Hill. This attention, she argues, stems from "both state actors and nonprofit organizations invested in eradicating—or at least downplaying—the crisis."[9] As in twentieth century systems of care, the motivations of private and public actors bleed into biomedical care. To borrow the words of Davis once again, this leaves us with "a prompt to investigate the felt intuition and situated knowledge of reproductive experiences and medical encounters" as black women continue to confront "particular forms of exploitation that have been historically created."[10]

---

[7] Karen A. Scott and Dána-Ain Davis, "Obstetric Racism: Naming and Identifying a Way Out of Black Women's Adverse Medical Experiences" *American Anthropologist* 123, no. 3 (September 2021): 681-684. https://anthrosource-onlinelibrary-wiley-com.proxy.lib.duke.edu/doi/full/10.1111/aman.13559.

[8] Dána-Ain Davis, "Reproducing while Black: The crisis of Black maternal health, obstetric racism and assisted reproductive technology" *Reproductive Biomedicine & Society Online* 11, (November 2020): 56-64. https://www-sciencedirect-com.proxy.lib.duke.edu/science/article/pii/S2405661820300228.

[9] Jennifer C. Nash, *Birthing Black Mothers* (Durham: Duke University Press, 2021), 71.

[10] Scott and Davis, "Obstetric Racism."

I interpret this appeal as one which first, seeks to mobilize the past to elucidate the present and second, does so by elevating the voices of those most often written out of the medical record. The Black Mamas Matter Alliance corroborates the former point in publishing their series of recommendations regarding obstetrical racism. Teaching the history of "medical apartheid in America," they argue, is a paramount step towards reproductive justice.[11] The second point aligns with the shortcomings of countless histories of medicine written by physicians reliant on medical archives which necessarily reproduce their own viewpoints.[12] Experiences which may be either life-altering or quotidian for the patient are reduced to stories of innovation and technological progress; their social and cultural implications go unnoticed. In the case of maternity, historian of medicine and women's studies, Judith Leavitt, notes that the "history of childbirth had traditionally been written as a history of medical advances" despite the fact that parturition marked the first part of motherhood, traditionally, a woman's life purpose.[13]

True to Leavitt's claim, scholars have produced a plethora of research on childbirth and reproductive health, before and after the woman enters the delivery room. With the publication of *Brought to Bed,* Leavitt herself proved a pioneer in the genre of women's health history, allowing for the analysis of obstetric and gynecological care through a social lens. Although hard to overstate the significance of Leavitt's contribution, the book's focus on females "binding together in their common cause" overlooks the heterogeneity of pregnant women and their unique needs conferred by a diversity of backgrounds. A similar critique can be made of Dorothy and Richard Wertz's seminal book on the social history of childbirth, *Lying-In: A History of*

---

[11] Sunshine Muse, "Setting the Standard for Holistic Care of and for Black Women" *Black Mamas Matter Alliance* (April 2018): 1-27. https://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf.

[12] Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, 2008), 8.

[13] Leavitt, *Brought to Bed,* 3.

Childbirth in America. While Wertz and Wertz provide a sweeping discussion of the evolution of birthing practices over the course of three centuries in American history, their broad temporal and geographic scope prevents them from analyzing some of the nuances that differentiated the experience of birth across different social strata, especially in regards to race.[14] The same can be said of Laura Ettinger's history of the development of nurse-midwifery during the twentieth-century: a story which spends little time contextualizing the convergences and divergences between these paraprofessionals and their lay predecessors.[15] These macro histories present an invaluable foundation but one which merits a closer look. To do otherwise, "would ignore the complexity of black women's experiences of pregnancy and childbirth, which are shaped not simply by violence and coercion by patriarchal institutions but also by the multifaceted ways in which gender interacts with interlocking systems of race, class, age, ability, sexuality, and nation."[16]

Scholars, especially in recent years, have heeded the call to diversify the stories we tell regarding medicine and its history. In her formative book *Medical Apartheid,* Harriet Washington analyzed the chasm that exists between the quality of care available to white versus black patients by illuminating the roots of medical mistrust, arguing that this complete rupture in health care, or apartheid, stems from the fact that "American medical researchers remain a racially homogenous group."[17] If the lack of diversity amongst researchers inevitably taints the knowledge they produce, can the same not be said for the practitioners who apply such findings to the human corpus?

---

[14] Wertz and Wertz, *Lying-In: A History of Childbirth in America,* xvi.

[15] Laura Ettinger, *Nurse-Midwifery: The Birth of a New American Profession* (Columbus: The Ohio State University Press, 2006).

[16] Julia C. Oparah and Alicia D. Bonaparte, *Birthing Justice: Black Women, Pregnancy, and Childbirth* (Boulder: Paradigm Publishers, 2015), 3.

[17] Harriet A. Washington, *Medical Apartheid,* 13.

Prioritizing this intersectionality has been the goal of twenty-first century academics interested in the study of reproductive health as a social, political, and medical phenomenon. For example, Leslie Reagan addressed this need in her work *When Abortion Was a Crime*, understanding doctors as a liaison between the public and impersonal needs of the state and the private, human relationships with patients, people who both refused to deliver lifesaving abortions and risked their careers to do so.[18] Since then, Dorothy Roberts' *Killing the Black Body* has grappled with similar questions about how the practitioners inform the care patients receive, particularly when it comes to reproductive health.[19] Seeking to engage with the nuances of gender, race, and their overlap, Roberts historicizes reproductive injustices, from the procreation required of enslaved females on the plantation to the coercive promotion of Norplant for poor black women.[20] Beyond the scope of each of these books, however, was discourse regarding women who *did* carry children to term. That which exists is important, yet insufficient.

Feminist activist scholar Julia Oparah and sociologist Alicia Bonaparte compiled oral histories to commemorate the experiences of Black women in labor to understand the diverse conceptions of reproductive justice that move beyond the binary of the choosing to conceive, on the one hand, or to terminate a pregnancy on the other, and the comparable paradoxes that pervade the delivery room.[21] Oparah and Bonaparte let the testimonies of women, so often excluded from scholarly discourse, speak for themselves.

---

[18] Leslie Reagan, *When Abortion Was a Crime* (San Francisco: University of California Press, 1998).

[19] Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Vintage Books, 199).

[20] Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty;* Sasha Turner, "Home-grown slaves: women, reproduction, and the abolition of the slave trade, Jamaica 1788-1807" *Journal of Women's History* 23, no. 3 (2011): 39-62. DOI: 10.1353/jowh.2011.0029.

[21] Oparah and Bonaparte, *Birthing Justice;* Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.*

Anthropologist Gertrude Jacinta Fraser's ethnography of midwives in Green River County, Virginia addressed the same archival gap that perpetuates the silence of practitioners trained outside of the medical establishment and the minority patients they tended in her ethnography *African American Midwifery in the South*.[22] Rather than present a comprehensive history of midwifery, analogous to the histories written by Leavitt or Wertz and Wertz, however, Fraser locates her study in a specific geographic space within the mid- to late-twentieth century. Fraser's work is one to which I am deeply indebted for both its content and methodology. The former dissects the practice of midwifery in the American South, and its subsequent regulation, into three categories of analysis: its commentary on the relationship between medicine and the minority body, its account of what constitutes 'authoritative knowledge,' and the power of collective memory. In her research, the focal point becomes the patient experience and its impact of community conscience regarding birth and birthing attendants. Here, the tension between midwifery and obstetrics remains acute but is one we must disentangle as "a cultural and social resource whose destruction has impoverished us all."[23]

As Ettinger, Leavitt, Regan, and Wertz and Wertz privilege providers while Oparah, Bonaparte, and Fraser highlight the women they tended, my aim in this thesis is to wed the narratives of such women with those of their providers as they existed, and continue to exist, in tandem. In doing so, my thesis will allow histories that have been told as disparate and divergent realities to exist simultaneously. By reading through the contradictions that arise, we can better understand the ambivalent interactions between patient and provider that persist today. As I put this multitude of voices in conversation and move beyond the sole act of birth to cover the care

[22] Gertrude Jacinta Fraser, *African American Midwifery in the South* (Cambridge: Harvard University Press, 1998).

[23] Fraser, *African American Midwifery in the South,* 8.

that enables or prevents it—from abortion and birth control to perinatal care—I had to define a scope that allowed the degree of depth this story warrants. First, is an acknowledgement that while reproductive health, by definition, encompasses goals as distinct as fertility to contraception, delivery remains the chief concern of this thesis. I will address abortion, birth control, and sterilization as they are relevant to obstetric care and when policies regulating or implementing such practices present a notable parallel to the control of prenatal and maternal health. Second, is the use of Durham, North Carolina as a confined space that lends itself to more intimate analysis of encounters between midwives, obstetricians, policymakers, and mothers-to-be.

Durham's historical profile makes for an apt site to study the appropriation of midwifery by the medical establishment. While firmly located within the American South, the city earned a reputation for its vibrant black business culture and community. The production of brightleaf tobacco in Durham into the twentieth century meant that the city became the epicenter of southern industry and the fastest growing area in an otherwise rural and underdeveloped state.[24] With its booming economy and successful businessmen, Durham supported a strong intellectual environment. In 1892, Trinity College, now Duke University relocated to Durham from Randolph County. Less than three decades later, the Duke family who helped to fund the university proposed the addition of a medical school and hospital system. By October 1930, Duke University Medical Center had opened its doors to patients and medical students alike.[25]

---

[24] Jeffrey J. Crow, Paul D. Escort, and Flora J. Hatley Wadelington, *A History of African Americans in North Carolina* (Chapel Hill: The University of North Carolina Press, 1992), 107.; James F. Gifford, *The Evolution of a Medical Center: A History of Medicine at Duke University to 1941* (Durham: Duke University Press, 1972), 3.

[25] Davison, Wilburt C. *The Duke University Medical Center (1892-1960): Reminisces of W. C. Davison, Dean of the Duke University Medical School, 1927-1960* (Durham: Duke University, 1967), 19.

The goal of this teaching hospital, then, rested on its ability to improve the health of Durham's residents through the means of "scientific health instruction."[26] But as we have now seen, instruction and education never articulate an objective truth. Rather, as Matthew James Crawford writes in his study of the commodification of antimalarial drugs, "in modern science, certain places and spaces, such as the field or the laboratory, bestow epistemic authority and credibility to the knowledge produced at those sites."[27] The teaching hospital is no exception. It even offers insight into the way the labels we use to legitimize medical knowledge affect patient health. Trying to reconcile political motives with the purported aims of medicine, disability studies scholar Majia Nadesan notes that "governmental regimes are constituted in relation to matrices of knowledge and technology that make forms of life visible and subject to intervention."[28] Durham presents a setting in which knowledge rendered legitimate amongst dominant medical and political discourse is both produced and applied. However, other forms of knowledge, notably the experience of the lay midwife, existed concurrently. Residents of Durham had access to hospitals and midwives alike by the middle of the twentieth century, thus the city truly provides a landscape in which the conversation enables the truths of two voices, often considered mutually exclusive, to enter the same dialogue.[29]

On a methodological level, Durham invites thoughtful analysis because of the archives housed at Duke University, Duke University Medical Center, and the Durham County Library. In

---

[26] Gifford, *The Evolution of a Medical Center,* 12.

[27] Matthew James Crawford, *The Andean Wonder Drug: Cinchona Bark and Imperial Science in the Spanish Atlantic, 1630-1800* (Pittsburgh: University of Pittsburgh Press, 2016), 25.

[28] Majia Holmer Nadesan, *Governmentality, Biopower, and Everyday Life* (New York: Routledge, 2008), 115-6.

[29] Leavitt, *Brought to Bed,* 133.; Economic barriers and the racism that kept hospitals segregated as late as 1965 meant that proximity to a hospital did not always translate to access. However, the prevalence of medical institutions in Durham as compared with other regions of North Carolina meant that access was far more widespread here than elsewhere in the state. This follows national trends in which urban women, regardless of class, more quickly transitioned to hospital births than their rural peers. And the increasingly widespread use of the automobile also played a role in increasing the number of women who could reach a hospital before delivery.

particular, I spent ample time sifting through the logbooks and records of Duke's Department of Obstetrics and Gynecology as well as the Rubenstein Library's files on the Duke Endowment and Lincoln Hospital, the black hospital it helped fund. I am forever grateful for the city's commitment to preserving its history, even if this history is incomplete. To fill these gaps, I have identified newspaper articles and pamphlets and books circulated within lay circles to gain a better grasp of the patient perspective. While these are by no means comprehensive portraits of the public conscience, or the myriad voices that constitute it, this in conjunction with the oral histories conducted with doctors, patients, and midwives, offers the most dimensional reconstruction of the political, social, and medical history of childbirth, and its regulation, in twentieth-century Durham.

Chapter one identifies the various birthing practices in vogue in Durham by the turn of the twentieth century and how these changed over the next three decades. What emerges is a mounting condemnation of midwifery as obstetricians tried to negotiate their authority within systems of care and adopted racist logic to do so. As medical innovations promised relief to the ill and infirmed across the board, policymakers and Progressive Era reformers concluded that leveraging biomedicine during labor could help mitigate the abhorrent rates of maternal mortality that plagued the American South. The ensuing regulations on medical education and professional licensure coincided with precipitous drops in the number of midwives who remained in practice.

However, such a decline in midwifery was only feasible with public cooperation and an obstetric alternative to home births. Thus, chapter two analyzes the founding of Duke University Medical Center and its Department of Obstetrics. Its primary focus addresses how the introduction of a nationally venerated medical institution pushed midwifery into obscurity. It argues that this tension was no coincidence, but rather, testament to the mid-century fears of

racial extinction on a macro level and increasing partiality towards commodification within the medical establishment. While Durham's medical centers remained segregated, the tendency towards hospital births did not discriminate between racial lines, even if outcomes differed between black and white women.

Although black women dealt with the worst of the institutionalization of reproductive care, middle-class white women began to express grievances with the low quality of care they believed they received in the hospital. In the midst of the rebellious spirit of the 1960s and 1970s, such women began to speak out against their indifferent obstetricians and question their claim to authority as a predominantly male occupation. In response, medical institutions—the practitioners themselves and the insurance companies writing their paychecks—turned to midwifery to harken back to a compassionate and personable birthing experience. Yet, in a capitalist system, this personalized vision was reserved for those who could pay. Birthing was once again commodified and made to benefit a select few.

Chapter 1
Mitigating 'The Evil of the Moment': From Midwives to Male Obstetricians, 1900-1929

On April 27, 1927, the University's Editorial Board brought the conversation of childbirth to their readers with a headline that read "Births Attended by Midwives."[1] Patrons of the University of North Carolina-Chapel Hill's newsletter would not have had to do so much as flip the page to note the discourse concerning maternal and infant care that seemed to permeate the most disparate reaches of American society by the mid-twentieth century. While the prominent placement of the article signified the gravity at stake in defining who could attend the births of North Carolina's mothers, the article's diction conveys a comparable conviction that only one side of the debate, that of the professional physician, harbored merit.

The opinion-piece—although it gives little room for readers to contemplate an alternative perspective—concludes that the only way to improve maternal health outcomes, and thus the health of the state, lay in the termination of the practice of midwifery. The authors' proposition for eradicating the alleged "evil of the moment" proved twofold.[2] On the one hand, the country could invest in increasing accessibility to erudite physicians, allowing their empirical obstetric knowledge to naturally overpower his "ignorant, untrained, incompetent" female counterpart. Alternatively, implementing laws and licensure could directly bound the domain in which the midwife practiced.[3] While the article deemed the latter solution the most pragmatic given the

---

[1] S. H. Hobbs, "Births Attended by Midwives," *The University of North Carolina News Letter,* April 27, 1927, https://newspapers.digitalnc.org/lccn/2015236560/1927-04-27/ed-1/seq-1/#words=midwifery.

[2] Hobbs, "Births Attended by Midwives."

[3] Hobbs, "Births Attended by Midwives."; The authors of the newsletter cited an additional means of addressing the "midwife problem" as proposed in medical discourse, but quickly wrote it off as impossible. This entailed inaction, letting the doctor and midwife proceed without intervention. However, this particular op-ed deemed this plan "unworthy of consideration."

prevalence of midwifery in the American South, it did not fail to inform its readers that the coexistence of doctors and midwives merely proved a transitional period that would inevitably lead to the "practical abolition" of an antiquated practice.[4] The path looked ambiguous, but the end goal did not: midwifery no longer had a place in North Carolina by the end of the 1920s. The "midwife problem," which had saturated the most prestigious medical journals since the turn of the century, had finally permeated the conscience of the southeastern reaches of the state, at least in its academic circles. Extrapolating public opinion from university discourse presents ample limitations, but ultimately, the elite circles reading publications circulated by revered institutions were those making the policy-level decisions which seeped down to the most quotidian experiences. In the case of this thesis, that of birth.

What prompted this poignant assault on midwifery? Why did the state, from its most revered scholars to its governing agencies, privilege the physician over the practitioners who had witnessed births since the state itself had existed? Although some dissenters joined the chorus of voices condemning midwifery, legislation and media dating back to the first three decades of the twentieth century suggests that, at a societal level, midwifery garnered a negative reputation and one which merited the demise of the practice.

In this chapter, I define the economic and social milieu that targeted midwifery on a national level, and then, analyze why these factors proved particularly acute in Durham, North Carolina. As medicine, and especially medical education, adopted more rigor across the country, physicians had increasing concerns over potential competitors, including the midwife. Doctors combatted such vexations with a convincing perspective that modernity meant progress and progress came through the kind of scientific and technological innovation they produced.

---

[4] Hobbs, "Births Attended by Midwives."

Concomitantly, the state assumed a more regulatory role, one in which it held the responsibility to intervene in the private lives of its citizens.[5] These two factors led to a relationship between the law and medical care which is hard to parse apart and place on a binary of good and bad. Rather, what emerges is a web of relationships that altered the landscape of birthing, a shift emanating from structural changes but resulting in consequences felt by the individual in the most intimate of spaces.

The shift away from midwifery would have seemed an implausible change for North Carolinians before the twentieth century. These women built on community relationships, passing knowledge down from daughter to mother and laterally between neighbors. Future midwives prepared to oversee births by watching older women in the community, oftentimes relatives, deliver children through relationships that emulated the practical learning acquired from the apprenticeship, as it was called in other professions.[6] Through the intimate relationships this system encouraged, the midwife gained repute; for her, success became her ability to put the mother at ease.

The Granny Midwife, in Name

The midwife's practice transcended racial groups in the otherwise segregated South. Midwives, although predominantly African American women, traveled to the homes of birthing mothers, black and white alike, to deliver the next generation of kin in the community.[7] Thus, the delivery room embodied contradiction. On the one hand, it was here that families recognized the

---

[5] Jenny Luke, *Delivered by Midwives: African American Midwifery in the Twentieth-Century South* (Oxford: University Press of Mississippi, 2018), chapter one.; Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast industry* (New York: Basic Books, 1982).
[6] Darline Turner, "Queen Elizabeth Perry Turner," in *Birthing Justice: Black Women, Pregnancy, and Childbirth*, edited by Julia C. Oparah and Alicia D. Bonaparte (Boulder: Paradigm Publishers, 2015), 21.
[7] Turner, "Queen Elizabeth Perry Turner," 21.

expertise of black midwives, at least implicitly if not explicitly. The midwife's proficiency in maternal and infant care manifested in the fact that she became a ubiquitous caretaker during such a pivotal life event, suggesting that nobody else was better suited for the role.[8] This stemmed from the importance of midwifery established on the plantation in the antebellum South. Following the end of the slave trade in 1808, procreation became the primary means by which slave owners acquired new laborers. Thus, the women capable of ensuring that slaves delivered healthy babies garnered a semblance of reverence from both their kin whose children they ushered into the world and their masters, for whom they helped churn a profit by assisting in the production of the next generation of slaves.[9] Although the process of conception and birth, then, reads as a means of total corporeal and occupational control of the enslaved, these midwives also helped their fellow slave women exert agency over their fertility. This is best exemplified in Jenny Luke's research which details African American midwives' use of cotton root as an emmenagogue, allowing slave women to time their conception.[10] Simultaneously, midwives who accumulated positive maternal and infant outcomes during birth, caught the attention of their slave master who would then rent them out to assist with the births of black and white women in the community. Midwifery, at once, held a venerable status in black and white communities, if for different, oftentimes antithetical, reasons.

---

[8] Alicia Bonaparte, "Physicians' Discourse for Establishing Authoritative Knowledge in Birthing Work and Reducing the Presence of the Granny Midwife," *Journal of Historical Sociology* 28, no. 2 (June 2015): 166-194. https://doi-org.proxy.lib.duke.edu/10.1111/johs.12045.

[9] Elizabeth Grainger, "Granny Midwives: Matriarchs of Birth in the African American Community, 1600-1940," *The Birth Gazette* 13, no. 1 (December 1996): 9-13. https://www.proquest.com/docview/203168652?accountid=10598&parentSessionId=XgRic1AVeDWcMj7xQqpiTS3GQz41MnBckxAzv3WaHUU%3D&pq-origsite=summon.; Deirdre Owens, *Medical Bondage,* 10.; Dorothy Roberts, *Killing the Black Body* (New York: Vintage Books, 1997), chapter one.

[10] Luke, *Delivered by Midwives,* chapter one.; Leslie Reagan, *When Abortion Was a Crime* (Berkeley: University of California Press, 1997), 90-91: Perhaps it is no surprise, then, that the association between abortion and midwives persisted well into the twentieth century, and that the illegalization of abortion and the regulation of midwives occurred concomitantly.

The nomenclatures used to describe African American midwives itself epitomizes the practice's contradictory perception. On the one hand, these women had been critical parts of the South's slave economy for their expertise but on the other hand, the white patriarchal hegemony that dominated Southern life, even in the wake of emancipation, consistently undermined their expertise. Writing in 1918, South Carolina obstetrician Dr. Sims, described African American midwives as "conceited old grannies."[11] The term 'Granny midwife' was a common one to describe birthing attendants in the American South. However, Sims' use of the term to characterize such practitioners in a derogatory light, depicts the negative connotations associated with their title. "Granny" denotes an older woman, one who is as easily painted as senile as she is with wisdom. Placing the modifier "conceited" before such a depiction further undermines her authority and replaces it with unfounded confidence.

We can further analyze the use of this term through Dorothy Roberts' analysis of the "derogatory icons of Black women" which have pervaded American culture since its founding.[12] Among such stereotypes exist the "Granny" or "Mammy" caricature. This image's cursory reverence for the older black woman's inherently maternal nature belies an expectation of both passivity and inferiority. Her value derived from her alleged willingness to "g[i]ve all without expectation of return," especially when it came to domestic duties in her master's home.[13] While the 'Granny' cared for the white youth on the plantation, these same southerners constructed

---

[11] D. H. Smith, "A Consideration of the Proper Management of Obstetrical Engagements in Sparsely Settled Districts," *Journal of the South Carolina Medical Association* 14, no. 5: 127-129. https://onlinelibrary-wiley-com.proxy.lib.duke.edu/doi/full/10.1111/johs.12045.; Deirdre Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: The University of Georgia Press, 2017): It is worth noting that Sims has been celebrated as the Father of American Gynecology, yet, much of his knowledge regarding female anatomy and his 'innovative' solutions of common gynecological problems came from experimentation on enslaved women with the assistance of fellow slaves, essentially acting as medical assistants. Thus, it is particularly ironic that he would be so demeaning of their erudition and experience.

[12] Dorothy Roberts, *Killing the Black Body,* introduction.

[13] Dorothy Roberts, *Killing the Black Body,* introduction.

'Granny' as inept at caring for her own children.[14] The 'Granny' image reinforced a perception in which the black women only won praise for her acquiescence, otherwise, her alleged incompetence could invoke harm. The charged racial history of the parlance through which midwifery has been articulated, speaks to the practice's contradictory status that long preceded its formal regulation.

The Granny Midwife, in Practice

While most lay midwives in the antebellum South, and in the half century or so preceding the Civil War, delivered children in the homes of their clients, these women cannot be seen as caricatures of a wholly private enterprise. They often made their livelihoods tending to the births of women in the community. And while many of these mothers were people with whom they had preexisting ties, it still proved a means to support their livelihoods and those of their families. The granddaughter of Queen Elizabeth Perry Turner, a midwife who worked in North Carolina from the 1910s to 1940s, recalls her grandmother's fee of two or three dollars for the women who could afford to pay for her services and the chickens, textiles, or food she accepted from those who could not.[15] While Turner did not strictly rely on the arrangements of a purely capitalist system, it was this same flexibility that allowed her to make a living for herself *and* operate from a place of compassion for those in her community. Overall, a more savvy businesswoman than the term 'Granny Midwife' allows one to believe.

The same can be said of the African American women registered as midwives in Durham's City Directory throughout the early part of the century. While their life stories are hard

[14] Roberts, *Killing the Black Body.*
[15] Roberts, *Killing the Black Body.*

to piece together from the demeaning statistics to which the state attempts to relegate them, the little information we have does paint a picture of women residing in stable homes and engaging in the city's industry. Almost across the board, the women from the 1929 Directory who identified themselves as practicing midwives lived in homes owned by the head of the household, often their husbands if not themselves. Owning a home necessitates some semblance of financial stability and, again, these lay midwives must have found more success than the ineptitude evoked by the title of 'Granny' insinuates.[16]

Although these women clearly straddled the private and public sectors more equivocally than scholarship has acknowledged, the quotidian duties midwives fulfilled inside the birthing mother's home epitomized what Jenny Luke defines as "micro-level of care."[17] Beyond the economic system they adopted, asking for monetary fees versus other forms of payment based on the client's socioeconomic situation, midwifery care itself embodied a more holistic and individualistic form of care. They stayed by the laboring woman's bedside before and after delivery, helping with chores around the house—including cooking and cleaning—having learned the skills needed to assist in childbirth through apprenticeships with older midwives, oftentimes relatives. Apart from these relationships built on tutelage, midwives often did not interact with other midwives and the practice typically included the friends and family in her

---

[16] U.S. City Directories, 1822-1995, indexed database and digital images, *Ancestry.com*, page 46, Midwife entry; citing *Durham, North Carolina, City Directory, 1928* (Durham: 1928), https://www.ancestrylibrary.com/imageviewer/collections/2469/images/12409729?treeid=&personid=&rc=&usePUB=true&_phsrc=nuK12&_phstart=successSource&pId=716503861. After locating the midwives from the City Directory, the U.S. Census proved helpful in painting a clearer image of the lives of the aforementioned midwives: Fifteenth Census of the United States. Population Schedule, 1930. Prepared by Ancestry.com. https://www.ancestrylibrary.com/imageviewer/collections/6224/images/4608282_00299?treeid=&personid=&rc=&usePUB=true&_phsrc=qDg3&_phstart=successSource&pId=77139285 (accessed Oct 21 2022).

[17] Jenny Luke, *Delivered by Midwives*, introduction.

community.[18] Her services lay deeply embedded within existing fraternal relationships and thus transcended a solely capitalist transaction.

Even as the economic landscape of the country shifted, as late as 1910, midwives attended nearly half of all births across the United States.[19] If this statistic paints a portrait of the relative prevalence of midwifery across the country, a 1914 report ranking public health efforts by state suggests an even more abundant practice in North Carolina. In comparing "child hygiene," the report relegated North Carolina to the bottom tier of maternal and infant care given its score of zero on the subsection which measured states by their supervision of midwives.[20] The low grade indicates that midwife regulation occurred infrequently, if at all. Childbirth still happened at the behest of the midwife.

Of course, this woman's identity proved heterogenous, as did the frequency with which it was regulated, as it crossed geographic and ethnic lines. Northern regions moved away from lay midwifery at a faster rate than the southern states, and most of those whose practices remained existed within immigrant communities.[21] While interesting in their own right, the nuances of these practices and the ways in which they were eventually regulated by the state are beyond the scope of this thesis. What is of note, however, is that as hospital births became less taboo, midwifery persisted on the margins of society, coloring the image of the practice writ large. Ironically, prior to the turn of the twentieth century, hospitals existed as places for the indigent; there, the poor sought care financed by charitable patrons.[22] Given this association, those who

---

[18] Judy Barrett Litoff, *American Midwives: 1860 to the Present* (Westport: Greenwood Press, 1978), 41.
[19] James Burrow, *Organized Medicine in the Progressive Era: The Move Toward Monopoly* (Baltimore: John Hopkins University Press, 1977), 117.
[20] Charles Chapin, *A Report on State Public Health Work Based on a Survey of State Boards of Health* (Providence: American Medical Association, 1915), 207.
[21] Litoff, *American Midwives,* 41.; Luke, *Delivered by Midwives,* chapter 2.
[22] Starr, *The Social Transformation of American Medicine,* 147.

had the means avoided maternity hospitals because of the stigma that came along with them, and only five percent of all births across the United States in 1900 occurred within the hospital. But as the social and political milieu shifted, so too did social experience of birth: by the end of the 1930s, this number had climbed to over fifty-percent, and over seventy-five percent for women living in urban areas.[23] Gertrude Fraser aptly claims that the regulation of midwifery evolved out of a "national search for order," an assertion bolstered by the xenophobia at the turn of the twentieth century, and the fact that the image of the hospital increasingly became a means of controlling chaos, biological or social.[24]

Trends in Treatment: How Economic and Social Pressures Shaped a Burgeoning Profession at the Turn of the Century

Previous scholarship argues that the Progressive Era remains the most decisive part of the United States' medical history.[25] Of course, this depends on the lens through which you understand the implications of the past on present paradigms of care, be it technological innovations, shifts in delivery of care, or something in between. For the latter, and particularly the nascent field of obstetrics' desire to outpace lay midwifery, such a statement rings true given the economic and social environment of the Progressive Era and its tangible effects on medicine. The ensuing milieu, in many ways, defined what Americans would come to associate with medicine: both what existed within the label and what became excluded. The boundaries that

---

[23] Richard Wertz and Dorothy Werz, *Lying-In: A History of Childbirth in America* (New Haven: Yale University Press, 1989), 132-3.
[24] Gertrude Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge: Harvard university Press, 1998), 49.
[25] James Burrow, *Organized Medicine in the Progressive Era: The Move Toward Monopoly* (Baltimore: John Hopkins University Press, 1977), 154.; Beatrix Hoffman, "Health Care Reform and Social Movements in the United States" *American Journal of Public Health* 93, no. 1 (January 2003): 75-85. doi: 10.2105/ajph.93.1.75.; Starr, *The Social Transformation of American Medicine,* 145.

defined the discipline struggled to accept lay midwifery even though it had been a fundamental component of reproductive care since America's founding and remained one across the globe. I argue social norms bred this debarment, rather than genuine interest in improving health outcomes equitably across the population. Admittedly, separating the two is a tall task, if even possible at all.

The American Doctor's Financial Strife

Contrary to public perception, medicine did not always constitute a lucrative career choice. Many American doctors practicing around the twentieth century struggled to make ends meet.[26] Concurrently, the United States shifted towards an increasingly hyper-capitalist culture in which success and profit worked as analogs.[27]

Even in the nineteenth century the physician never attained the same degree of reverence as he had in Europe in the preceding centuries. Much of this resulted from the significantly lower quality of medicine in the United States as compared with England and the Continent, regions in which medicine had existed as an esteemed course of study in countries' most prestigious universities. Across the Atlantic, doctors at best, utilized what they had learned from their European peers and at worst, fumbled to treat illnesses and injuries of which they knew little. Although true across the nation, the southern states lagged behind their northern counterparts. Historians have described North Carolina as medically impoverished through the early 1900s: the state had not had formal medical establishments until the Civil War when the Confederacy invested in them to care for wounded soldiers, and given that most residents lived in rural areas,

[26]Starr, *The Social Transformation of American Medicine*, 105.
[27] Starr, *The Social Transformation of American Medicine*, 240.

the majority of the populace still lacked access to such facilities, and instead, continued to rely on a system of care that still resembled a "cottage industry."[28] This lack of care attracted national attention after World War I, given the concern that many conscripted men were disqualified from military service upon mandatory medical examinations.[29] Not only did this present a national security concern, but it struck the American ego.[30] Midwifery became an easy scapegoat and the doctor the hero able to use the medical innovations characteristic of the late-nineteenth and early-twentieth centuries.

As this period saw the caliber of American medicine improve, physicians faced new economic challenges. Novel technologies extended patients' lives and helped prevent disease before symptoms manifested, which proved a welcome development on a personal level but not for the pocketbooks of doctors who had fewer ailments to address. Furthermore, as the image of the American doctor assumed a venerable status in tandem with innovations that led to better health outcomes, men saw the profession as an increasingly viable option. In the nineteenth century, the lack of medical training programs in the States meant that people lacked experience and easily fed into the discourse of the incompetency and quackery rife within the profession or those who could afford it went to Europe for their medical education. Of course, the latter meant the profession rejected all but those who came from upper-middle class families; medicine had a higher barrier to entry for all but the most elite citizens. This changed during the late 1800s as schools established medical programs which began to crop up all over the country, opening the

---

[28] Thomas Duffy, "The Flexner Report—100 Years Later" *Yale Journal of Biology and Medicine* 84, no. 3 (September 2011): 269-276. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178858/. James F. Gifford, *The Evolution of a Medical Center: A History of Medicine at Duke University to 1941* (Durham: Duke University Press, 1972).; Phoebe Ann Pollitt, *African American Hospitals in North Carolina: 39 Institutional Histories, 1880-1967* (Jefferson: McFarland & Company, 2017), 4.

[29] Starr, *The Social Transformation of American Medicine,* 193.

[30] Barbara Gutmann Rosenkrantz, *Public Health and the State: Changing Views in Massachusetts, 1842-1936* (Cambridge: Harvard University Press, 1972), 2; Starr, *The Social Transformation of American Medicine,* 193.

field to people with a more diverse array of socioeconomic and geographic backgrounds. This, however, increased supply, thus breeding competition amongst doctors who already worked in a lower-paying field.[31] While no longer a condemned profession and, it can even be argued, that the pendulum swung towards veneration, economic pressures weighed on America's doctors. And they identified childbirth as a place to make profit.

Hygiene and Xenophobia: The Parents of Public Health

A second notable shift in American medicine during the Progressive Era stemmed from the epoch's emphasis on social reform designed to quell vexations posed by reorganization of the country's social fabric. The demographics of the nation shifted as immigrants relocated to the United States like never before. Within the existing social sphere, change was also on the horizon. African American men had secured the right to vote with the Union's victory in the Civil War while women fought for the same citizenship status, a fight they won by 1920. Both threatened white male hegemony. The insecurity new socio-political changes engendered manifested in parts of society as unsuspecting as the healthcare system.[32]

The roots of public health trace back to the genesis of public health departments in the 1850s. The first State Board of Health was that of Louisiana in 1855. Twenty-four years later the National Board of Health came to fruition in the nation's capital. This followed recurring outbreaks of cholera and yellow fever in the wake of the Civil War. As Yale doctor Charles Edward Amory Winslow defined public health as a matter of hygiene at its core.

---

[31] Burrow, *Organized Medicine in the Progressive Era,* 106.
[32] Burrow, 99.

> Promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventative treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.[33]

Illness, according to Winslow, represents a failure on the part of the individual. Ignorance allows people to continue to engage in unhygienic behaviors which leads to environments amenable to pathogens. The solution, then, became control of the individual and his daily practices, even those that seemed beyond the purview of the medical discipline. This manifested in stringent regulations of practitioners, interventions at the school level, and new standards of sanitation. North Carolina adopted these recommendations with a State Laboratory of Hygiene, established in 1905 to monitor environmental sanitation. Three years earlier, nurses began to work in schools, and their position became one under the jurisdiction of the Board of Education beginning in 1911.[34] Health care no longer fit within the bounds of treating physical ailments, it permeated every facet of society.

As Winslow mentions, this grew out of a desire to improve health outcomes by implementing a higher standard of care but also addressing the environmental factors that allowed people to fall ill in the first place. While a noble cause, the execution proved less altruistic. It conferred the government the legitimacy to endorse "social machinery" used to control individual behavior. Nothing exists in a vacuum and thus seemingly unrelated ideologies of the dominant discourse quickly pervaded such efforts of control. In a period of American

---

[33] Starr, *The Social Transformation of American Medicine*, 180.
[34] Starr, 188.

history rife with xenophobia with an influx of immigrants and a diversified citizenship, it is not hard to imagine how health care became a site of power but under the guise of goodwill.

Hamlet to City: Durham Meets the Twentieth Century

While few scholars have looked at how Progressive Era ideals shaped Durham's health care landscape, the metamorphosis the region underwent at the turn of the century includes what scholars have cited as catalysts for reforming systems of care: changing economics and social demographics, which were intimately intertwined. In the latter half of the nineteenth-century, while other southern towns floundered in the aftermath of the Union's 1865 victory, Durham witnessed an economic boom with the cultivation and manufacture of brightleaf tobacco.[35] Census data makes the changes of this new epoch visible: while Durham had been a small town of fewer than 200 residents around the outbreak of the Civil War, it housed a population of just over 5,000 by 1900.[36] Thirty years later, this number had swelled to 52,036.[37] Many of these residents came to the area in search of work, moving from rural areas to this urban center. Implicit in this shift was the degradation of tight-knit networks of family and friends.[38] As such community structures had enabled home-based models of care, Durham required a new, institutionalized model to suit city life.

The city's ill health pronounced this need. Although Durham had entered a new epoch of prosperity and innovation, the tobacco industry did not foster a comparable sense of health. In

---

[35] James Gifford, *The Evolution of a Medical Center: A History of Medicine at Duke University to 1941* (Durham: Duke university Press, 1972), 3.; Stephen Massengill, *Images of America: Durham, North Carolina* (Charleston: Arcadia Publishing, 1997), 7.
[36] Gifford, *The Evolution of a Medical Center,* 3.
[37] US 1930 City Directory: https://www.ancestrylibrary.com/imageviewer/collections/2469/images/11238731?ssrc=&backlabel=Return&pId=1146278049.
[38] Wertz and Wertz, *Lying-In,* 102.

fact, environmental conditions hindered worker's physical well-being.[39] This shortcoming germinated the parvenu Duke family's interest in local philanthropic efforts as it was their marketing and production of tobacco that had changed Durham's economic and social topography.

While these tobacco tycoons became a symbol of Durham's booming industry, they were not alone in finding a financial mecca in Durham, if on a different scale. African Americans who settled in Durham in pursuit of economic opportunities, helped cultivate a thriving black-middle class and the largest black-owned business at the time: the North Carolina Mutual Life Insurance Company in 1898.[40] And while the area did gain repute for its strong black community, this same characteristic contributed to racial tensions as black success challenged the racial hegemony that had been the foundation for the southern social order for so long.[41] Moreover, class tensions that existed between workers and industry elites, like the Duke family, exacerbated social friction. Ultimately, Durham's successful veneer concealed the underlying conflict.

These contradictions are legible when considering the city's health. The 1892 City Directory celebrates Durham's health as "unquestioned," and a model for the rest of the state, despite the lack of tangible evidence that follows the assertion given the city's struggle to prevent morbidity and mortality.[42] The subtext here is twofold. First, the privileged voices shaping the directory—those with the power of the pen—saw a correlation between health statistics and a region's perceived status. They had a motive to paint the city as a salubrious site.

---

[39] Gifford, *The Evolution of a Medical Center,* 3.

[40] Jeffrey Crow, Paul Escott, and Flora Hatley Wadelington, *A History of African Americans in North Carolina* (Chapel Hill: The University of North Carolina, 1992), 107.

[41] Leslie Brown, *Upbuilding Black Durham: Gender, Class, and Black Community Development in the Jim Crow South* (Chapel Hill: University of North Carolina Press, 2008), 13.

[42] 1892 Durham City Directory, 32. https://www.ancestrylibrary.com/imageviewer/collections/2469/images/11272164?ssrc=&backlabel=Return&pId=1146278049.

Second, they did not care to understand the experiences of the population writ large, conveying a distinct tear in the social fabric. This was either deliberately avoided or subconsciously overlooked. By 1930, similar social divisions manifested in the hegemonic perception of Durham's health status read through the City Directory. The Directory opens with a local history whose brevity does not sacrifice hubris. Reminiscing about the antebellum South and the valor of Confederate soldiers, this telling of Durham's past credits the city's affluence to James Buchanan Duke, patriarch of the Duke family, as he "turned the vision of his great genius into the cigarette field," which became "the common property of mankind."[43] On a more palpable level, the stark contrast in death rates along racial lines is testament to this. Compared with the 8.3 white deaths per 1,000 residents, the black community witnessed an exorbitant 17.9.[44] To add insult to injury, the black death rate is tucked away in a set of parentheses, a futile effort which all but writes the statistics out of the sentence.

Durham, like the rest of the United States, entered the twentieth century with an ambition to subvert any image of its ties to antiquity. And this seeped into the hopes it had to alter its health profile. While the turn of the century saw hyperbolic descriptions of statistics related to the populace's wellbeing, by 1930 this was reflected in measures of explicit control perhaps most notable in its "well organized Board of Health…charged with the supervision of health conditions in the entire county."[45] Statistics did not merely relay information about the community, they allowed regulatory bodies to apply this information.

---

[43] 1930 Durham City Directory, 8. https://www.ancestrylibrary.com/imageviewer/collections/2469/images/11238732?ssrc=&backlabel=Return&pId=1146278049.

[44] 1930 City Directory, 12.

[45] 1930 City Directory, 11.

Learning the New American Medicine: Creating Legitimate Knowledges

National xenophobia helped shape the Progressive Era's emphasis on public health initiatives and public consciousness regarding wellbeing, in general. Similar political and social discourses sculpted the rhetoric on which such rhetoric claimed credibility. Translating such knowledge into policy predicated upon three assumptions. First, the belief that part of what made populations vulnerable to malady was modifiable. Second, this modifiable variable would permit better health if controlled. Third, the State had the best idea of who should operate the "social machinery." Oftentimes, this consisted of a combination of federal actors in conjunction with trained physicians. This then begs us to ask why the government and the doctor became the preeminent authorities on population health and hygiene when the former is seemingly relegated to politics and the latter had, for many centuries in American history, struggled to attain legitimacy. This merits analysis in the story of midwife regulation given that she became the target of regulation based on attestations that her practice lacked erudition and thus had the propensity to harm, not heal.

Bureaucratic Authority, from Medical Societies to State Boards of Health

North Carolina was the twelfth state to establish a State Board of Health when it did so on February 12, 1877.[46] The sub-committees it subsequently founded follow the same trajectory of the nation's public health interests. 1913 saw the enactment of the law on Model Vital Statistics which put $10,000 towards enforcement of medical record-keeping each year. This meant that by 1917, the state had a census that was ninety-six percent complete. The methods behind this metric are perhaps less important than the fact that the state found this a worthy cause

[46] 1930 City Directory, 1.

to fund.[47] In 1919, maternal and infant health received comparable financial support with the State Board of Health's commitment of $12,000 per year to be put towards the Bureau of Public Health Nursing and Infant Hygiene.[48]

Nationally, legislation like the Sheppard-Towner Act of 1921 evinced that the government included infant and maternal mortality as a significant part of their public health agenda. The law attempted to combat high rates of mortality, especially in rural areas, by distributing funds for states to fortify the care available to pregnant women, from prenatal care clinics to education campaigns run by traveling nurses.[49] While the actors implementing such changes suggested that organizations like the State Board of Health existed outside of the purview of politics, the narrative that unfolded on the ground suggests another story.[50] And public perception towards the Sheppard-Towner act provides evidence of this. On the one hand, the legislative branch showed enough support for the idea of bettering maternal health care that the Bill passed in the Senate. However, this followed nearly a decade of debate during which organizations and individuals alike vocalized their condemnation of the Bill. Perhaps surprisingly, the American Gynecological Society—now the American Gynecological and Obstetrical Society—saw this as a step towards socialized medicine, a move that would infringe on their autonomy and hinder their private practices.[51] Furthermore, the American Medical Association only begrudgingly provided tentative support of the Bill when its authors assured

---

[47] North Carolina State Board of Health, *Twentieth Biennial Report of the North Carolina State Board of Health-Ninth Biennial Report* (Raleigh: Bynum Printing Company, 1924), 12. https://digital.ncdcr.gov/digital/collection/p249901coll22/id/257317.

[48] North Carolina State Board of Health, *Twentieth Biennial Report,* 18

[49] Katherine Madgett, "Sheppard-Towner Maternity and Infancy Protection Act (1921)," In *The Embryo Project Encyclopedia,* May 18, 2017. https://embryo.asu.edu/pages/sheppard-towner-maternity-and-infancy-protection-act-1921; Wertz and Wertz, *Lying-In,* 155.

[50] North Carolina State Board of Health, *Twentieth Biennial Report,* 22.

[51] Jan Wilson, *The Women's Joint Congressional Committee and the Politics of Maternalism, 1920-30* (Champaign: University of Illinois Press, 2007): 52.

them that the funds the Sheppard-Towner Act provided states could only go towards prevention and education. In other words, the legislature had to quell the AMA's fears that the care they and the members of their network provided would become obsolete. Finally, men who had been neutral or disdainful of the Bill when initially proposed in the 1910s, finally lent support. Considering that women won the right to vote in 1920, the time suggests a tactical move to garner female support where it had not mattered before.[52] This meant addressing problems that previously seemed far removed. Each actor's decision built upon the environmental context in which they found themselves: senators desires' to remain in office or the AMA's desire to retain their share of the market. Here, the commodification of healthcare rises to the surface. And, as a commodity, its place in the political system comes to light.

This elucidates a seeming contradiction: why did organizing medical bodies like the American Gynecological Society of the American Medical Association prioritize medicine as a commodity over a tool to improve health on individual and community levels? Why does this power struggle become particularly visible in discussion of maternal and infant care? To answer this question we must look to the inception of these two societies and governing bodies with similar roles. In his book, *The Social Transformation of American Medicine* Paul Starr answers with a Marxist framework: "The structure of medicine can be more adequately explained as a mirror of the development of capitalism."[53] Of course, this assumes that capital is the core of power struggle, which while incomplete, proves true when considering the birth of medical societies which divided medicine into distinct specialties, bringing physicians together around

---

[52] Wertz and Wertz, *Lying-In,* 209-10.; Wilson, *The Women's Joint Congressional Committee and the Politics of Maternalism, 1920-30,* 28, 32.
[53] Starr, *The Social Transformation of American Medicine,* 16.

common goals and in adherence to more rigorous standards that conferred a degree of legitimacy.

Political power must have been implicated in this process given the fact that, during the early twentieth century, regulation of health delivery and education took place on a state level.[54] The societies that developed on a local level took shape and continued to evolve said shape as they attempted to back Progressive efforts of reform. Medical societies, which essentially acted as professional guilds, allowed professionals to bond over common goals; a historically disparate and independent profession now coalesced under a series of umbrellas. Their newfound cohesion enabled the formation of an influential political body which could advocate on the behalf of like-minded professionals.[55] While such a movement relieved internal economic and political competition, it created new struggles between doctors and external bodies. While eventually the law became an ally rather than a competitor, those who already suffered from the control of the dominant discourse, faced an exacerbated struggle to make it above the lowest social strata, or at least, maintaining autonomy. This conversation was a particularly poignant one in the realm of childbirth as it represented a lucrative field for the physician and had direct impacts on the vital statistics used to determine the health and well-being of a population. This came across in the exponential growth of licensing acts and examination boards, but perhaps more pertinent to the conversation of obstetrical care, in the increasingly regulated education and certification of providers.[56] These defined whose knowledge lent itself to legitimate forms of care. Often, such labels privileged the doctor and pushed those without the same biomedical training to the

---

[54] James Burrow, *Organized Medicine in the Progressive Era: The Move Toward Monopoly* (Baltimore: John Hopkins University Press, 1977), vi.
[55] Burrow, 17.
[56] Burrow, 64.

periphery of the evermore explicit healing discipline, at best, and banished them from the practice altogether, at worst.

Regulating Medical Education in the School System

Part of what catalyzed a reframing of medicine beginning with the total upheaval of previous forms of medical training in favor of a standardized medical curriculum, stemmed from the spirit of the Progressive Era. Perhaps it was this period that left the most profound legacy on the borders that define the medical practice today. If teaching and education work to produce—and reproduce—knowledge, it comes as no surprise that the existing system of medical education would play a large role in defining this new era in American medicine. Surely this was the case, as the 1910 Flexner report evinces. However, before we look at what this upheaval of medical training entailed, it is vital we understand the forces that fueled it. The answers are endless, but the two biggest that merit mention are a new confidence in American progress, culture of controlling competition in the name of profit, and privilege of scientific knowledge as an objective framework through which to view the world.[57] If we take the latter at face value, it is no wonder that practical experience and apprenticeship would fall short of the science class and laboratory time medical students had at the university. Altogether, we see a new definition of what constitutes legitimate medical care, and the sites at which the knowledge could be acquired.

The Flexner Report epitomizes this shift. The Report marked the formal embrace of biomedical knowledge as truth. As such, the physician's reputation predicated on his adherence to the rational scientific ethos. This was not an altogether novel idea but rather one modeled after

[57] Burrow, 154-5.

the European medical profession, and particularly, Germany's system of medical education.[58] This pedagogy made its way to the United States with the American-born doctors who traveled to the Continent for training before returning home to the States to establish practices born out of the European school of thought. Three of these doctors—William Welch, William Osler, and Frederick Gates—first pushed the shift towards the scientific and laboratory methods taught in the European academy as a foundational part of the culture at Johns Hopkins University's physician training programs. Recognizing their devotion to the medical practice, John D. Rockefeller solicited their advice for his philanthropic endeavors. Consequently, the three preeminent members of the Hopkins' staff convinced him of the need to enhance the caliber of medical education in the United States. This task fell to Abraham Flexner, an educator without any prior experience in the medical field. What he lacked in medical expertise he, allegedly, made up for in his myriad accolades from the prestigious Johns Hopkins and Harvard universities.

With the blessing of Welch, Osler, Gates, and Rockefeller, Flexner traveled to Europe to survey the pedagogies employed in medical schools there. His work won the praise of other wealthy white Americans, like Henry Pritchett, then head of the Carnegie Foundation. Flexner's account of European medical schools proved so captivating to men like Pritchett that the Carnegie Foundation turned their agenda to address health care practices in the United States, beginning with the overhaul of its pedagogy. The Foundation asked Flexner to travel to every medical school across the United States and Canada and rank them based on the gold standard set by European universities and adopted at Johns Hopkins. Flexner's subsequent report classified them as equivalent in quality to the medical education received at Hopkins, inferior but

---

[58] Thomas Duffy, "The Flexner Report—100 Years Later" *The Yale Journal of Biology and Medicine* 84, no. 3 (September 2011): 269-276. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178858/.

salvageable, and inferior without hope of improvement. The poor laboratory facilities and lack of student exposure to clinical practice meant that most schools found themselves in this bottom rung. Thus, he recommended that of the 155 medical schools reviewed for his report, only thirty-one should continue to educate the next generation of doctors.[59] While the number was reduced to seventy-six, not thirty-one, the Flexner Report has set the precedent for medical education in the United States through the modern-day.[60]

Defining an outcome on a binary of good and bad proves reductive, and considering the legacy the Flexner Report had on the experience of patients and practitioners alike is no exception. On the one hand, it meant that, given the financial resources, patients now had access to doctors with a more robust knowledge of the human body, a marked change from the thirty to forty percent of doctors who failed literacy tests in 1909.[61] On the other hand, it precluded vast swaths of people from having their expertise legitimated. This disproportionately affected the marginalized: African Americans, women, and the poor. Scholars like James Burrow have spoken to the toll this took on the patient. More so than tending to the needs of their patients, doctors' work now centered around their ability to cultivate a reputable image.[62] And such an image entailed their scientific erudition. The profession traded an affective relationship for a professional one. The patient suffered in the process, but so too did the practitioners who did not conform to the elite profile of the Hopkins Circle. Such a narrative is lost in most scholarship

---

[59] Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (The Carnegie Foundation, 1910), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2567554/pdf/12163926.pdf.

[60] Claire Johnsons and Bart Green, "100 Years After the Flexner Report: Reflections on Its Influence on Chiropractic Education" *The Journal of Chiropractic Education* 24, no. 2 (Fall 2010): 145-52. doi: 10.7899/1042-5055-24.2.145.

[61] James Burrow, *Organized Medicine in the Progressive Era: The Move Toward Monopoly* (Baltimore: John Hopkins University Press, 1977), 31.

[62] Burrow, *Organized Medicine in the Progressive Era*, 154.

which continues to hold the doctor to the empirical standards set by biomedicine and its inflexible classroom curriculum. Midwives, who had long been associated with the ignorant, impoverished, black, female profile—however right or wrong the image—the Report implicitly condemned, faced repudiation on incomparable levels.[63] Even though they had treated women for years, their practical experience no longer matched the sterile hands of the school-educated doctor guided by papers on what to expect in the delivery room. This increasingly professionalized discourse in conjunction with increasingly stringent licensure, solidified a hierarchy of knowledge that transcended the classroom. This gradation proves pertinent in Durham, given its status as a burgeoning center of education and medical research.

Durham's Health Care Landscape at the Turn of the Century

By the turn of the century, two hospitals tended to the city's sick and injured: Watts and Lincoln Hospital. The former admitted white patients while the latter cared for Durham's African American residents. Such racial segregation persisted despite the relative affluence of the city's black community and attestations that, unlike its Southern neighbors, North Carolina championed an ethos of "progress and alleged opportunities for blacks…without a white antebellum aristocracy."[64] And the disparities between Watts and Lincoln Hospital challenge any claim that the city was *separate but equal*.

[63] Burrow, *Organized Medicine in the Progressive Era*, 114.
[64] Jeffrey J. Crow and Paul D. Escort, and Flora J. Hatley Wadelington, *A History of African Americans in North Carolina* (Chapel Hill: The University of North Carolina Press, 1992), 128.

The City's White Hospital: The Birth of Watts

Resembling an intermediary of the community care that characterized nineteenth century America and the architecture of the medical establishment as evident in the hospital, Dr. George Watts founded Watts Hospital, Durham's first hospital, at the beginning of 1895. In line with the hospital's role before the twentieth century, Watts functioned as a place where those unable to afford a doctor to see them in the privacy of the home found privately funded charitable care.[65] The original building resembled a cottage that could cater to twenty-two patients before demand outpaced supply and merited the opening of a larger site. Watts' second, more institutional home opened in December of 1909 after a $217,000 investment in a plot of land on the outskirts of the city in West Durham.[66] The finished product boasted a capacity of forty-five patients and any infants born to the women in the maternal war, notably separated from the rest of the residents in the infirmary.

The building's architecture conveys the domestic influence of the hospital's operation as the complex afforded more space to work associated with the home than that of a hospital: a laundry house, dining room, and two separate kitchens—one for staff and one for clients—dwarfed the two-story patient pavilion. The pavilion's profile completed the domestic feel with marble and tile finishes and ample balcony space for patients to enjoy. Considering the popular conceptions of the hospital at the time as a relic of the almshouse, the focus on patient comfort can be read in several different ways.[67] Perhaps it exemplified the desire to establish an

---

[65] P. Preston Reynolds, *Watts Hospital of Durham, North Carolina, 1895-1976: Keeping the Doors Open* (Durham: The Fund for the Advancement of Science and Mathematics Education in North Carolina, 1991), 7.
[66] Ibid, 9.; "Watts Hospital (1909-1980)," Open Durham, Preservation Durham, accessed 17 Oct., 2022, https://opendurham.org/buildings/watts-hospital-1909-1980-north-carolina-school-science-and-math.
[67] Beatrix Hoffman, "The American Hospital: Charity, Public Service or Profit Centre?," in *The Political Economy of the Hospital in History*, edited by Martin Forsky, Margarita Vilar-Rodríguez, and Jerònia Pons-Pons (Queensgate: University of Huddersfield Press, 2020), 222.

institution whose appeal would extend beyond the poor as medicine celebrated the beginning of a new era. Alternatively, the hospital's congenial feel may have stemmed from Watts' desire to nurture a "Christian and Christ-like manner" within his hospital's walls.[68]

By 1911, part of this "manner" included separation of the races but also of the sexes. This year marked the completion of a patient pavilion that would house all female patients. Additionally, the hospital invested in the construction of Wyche House, the geographic demarcation of the inception of the Hospital's nurse training program.[69] The architecture reads the gender divide inherent to the medical profession: men became doctors while females could support them through nursing careers. Not only did patients merit segregation, but so too did the professionals who looked after them.

Between the emphasis on educating professionals on site and investing in technological advances, like laboratory and x-ray equipment, Watts Hospitals demonstrated a keen desire to garner equal status to hospitals in the northeast, those seen as champions of modernity. It is noteworthy that many of these technological innovations, in Watts and amongst its northern peers, came about in the operating room. At Watts, surgery and obstetrics became analogous—they even shared a physical space, a joint room for surgical procedures and deliveries.[70]

Despite its early successes, Watts struggled to maintain its standing as a venerable medical establishment given its proximity to Duke University, then Trinity College, which attempted to enter the medical landscape, and enjoyed the hearty funds of James B. Duke's endowment in manifesting this aspiration into reality.[71] This, in conjunction with legally

---

[68] First annual report of Watts Hospital as cited in Reynolds, *Watts Hospital of Durham, North Carolina, 1895-1976*, 50.
[69] Reynolds, *Watts Hospital of Durham,* 8.
[70] Reynolds, 11.
[71] Reynolds..

mandated desegregation in the 1960s, would ultimately force Watts to close by the end of the century. Yet it remains an important actor in health care delivery, especially for the white men and women living in Durham during the early- and mid- twentieth century.

Institutionalized Care in the Black Community: The Conception of Lincoln Hospital

Although George Watts had proposed the addition of a wing to treat African American patients in 1900, his idea succumbed to the construction of an entirely separate hospital for Durham's black residents. Lincoln Hospital filled this need following its inception in 1901 and grew to accommodate 50 patients by 1924, despite the fact that its square footage proved significantly smaller than the compound that constituted neighboring Watts Hospital and tended to a smaller demographic. Not only does the architecture negate the need to offer the same quality of care to black and white patients, but the racism of early-twentieth century Durham permeated the literal brick and mortar—or rather, wood—of the hospital structure. The cornerstone dedicated at the hospitals' opening read provides an apt example.

> With grateful appreciation and loving remembrance of the fidelity and faithfulness of the N**** slaves to the Mothers and Daughters of the Confederacy during the Civil War, this institution was founded by one of the Fathers and Sons: BN Duke, JB Duke, W. Duke. Not one act of disloyalty was recorded against them.[72]

The abhorrent paternalism on the part of the Duke family to the implicit acknowledgement of the historic relationship of healing between African Americans and white women, or "Mothers and Daughters of the Confederacy." Even in an institution designed for the African American community, they could not escape the presence of their white neighbors—an omnipresence acknowledged at the entrance to Lincoln Hospital. Furthermore, the unequal basis of this

[72] "Lincoln Hospital (1901-1924)," Open Durham, Preservation Durham, accessed 17 October 2022, https://www.opendurham.org/buildings/lincoln-hospital-1901-1924.

relationship was again perpetuated by defining blacks as “slaves” and whites as people with jurisdiction. Here, we see an inherent contradiction: the white man forced segregation but simultaneously demanded thanks, for the African Americans were cast as agentless actors even within the confines of an institution purportedly constructed for their benefit. The Duke Family who held the financial power to manifest this sentiment in the physicality of Durham’s health care scene squelched any means of questioning the impossible incongruencies that riddled race relations in Durham, particularly in the realm of health and healing. Within the context of the hospital, African Americans lacked the autonomy to treat patients of their own accord—authoritative white folk often had the final say—but also to receive treatment equivalent to their white peers.

Buying into the medical establishment, like in the case of Lincoln Hospital, left black patients under the jurisdiction of white doctors and their biomedical authority. The amicable and personable relationship established between mother and midwife disappeared. And the discourses that arise from the study of Lincoln Hospital foreshadow the themes at play in the conversation that arises vis–á-vis midwifery regulation and the movement towards the medical establishment writ large. Regulating a community-based practice and bringing it under the purview of an establishment defined by the dominant discourse forced agency from black midwives towards white practitioners. Thus, this movement reads as a story of the consolidation of power amongst the affluent and educated, white, male elite.

Implicit in consolidation, however, is a need to assert authority because of a multiplicity of authority figures. Lincoln Hospital’s occupational hierarchy conveys the contradiction of exerting power and creating a stringent social order. Successful black businessman John Merrick oversaw Lincoln Hospital as the president of its Board of Directors, yet he still worked in a space

permeable to the white medical gaze.[73] Here, we must grapple with the fact that he did assume agency and wielded his power to incite positive change in Durham's African American community, but that the city's white male doctors still wielded influence over what he could and could not do. This struggle to acknowledge the strength of the oppressed while recognizing the oppression he faced each and every day becomes a challenge, but one we must endeavor to respect. Lincoln Hospital, here, proves a microcosm that reflects broader shifts in the medical field during the early part of the twentieth century. A similar confluence of factors became a repressive force from which midwifery regulation was not immune. And understanding these factors, those which contributed to the zeitgeist of the day, becomes critical in understanding why midwife regulation came to the forefront of Durham's public health during the first couple of decades of the twentieth century.

It proves ironic that as the medical profession in North Carolina sought to proselytize the population to care in the hospital, it refused to benefit those most dependent on care in the home and the kinship networks that supplied it: women largely excluded from the medical practice and the African Americans who had a robust tradition of lay midwifery. Thus, doctors and policymakers questioned the feasibility of displacing midwifery altogether, prompting prolific responses to the "midwifery question" in medical literature. The next section will analyze this national debate and the parallel changes in Durham's regulation of midwifery that the voracious rhetoric likely prompted.

---

[73] The 'medical gaze' is a term which can be credited to Michel Foucault, speaking about the ways that power is omnipresent, and not derived from a single source. This intricate web of relationships ultimately allows for the complex ties between medical institution(s), the state, and individual practitioners and patients. Even those whose titles convey a sense of authority, are subject to external and internal regulation, enabled by a system in which individuals are made visible. This includes the production of population statistics and the literal observation of the patient within a medical establishment. The doctor is also perceived via his or her licensure and compliance to federal policy. Thus, Foucault presents a helpful framework to understand the nuanced power that exists within the healthcare sector and seeps into society writ large.: Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage Books, 1973).

Constructing Legitimacy in Durham's Medical Landscape

While Durham did not have a university of its own prior to 1930, the conversations about opening a medical school meant that the policymakers and financiers in the city likely had reason to engage with literature that would not have been as prevalent in a less academic culture. The Duke family and other members of Durham's elite, including George Watts, had affirmed education and healthcare as the focal points of their philanthropic efforts.[74] By the 1920s, the Duke Endowment published reports whose sole purpose was to analyze the state of health in the Carolinas and the impact of the Duke family's donations in this sector: "The major objective of the Hospital Section of the Duke Endowment, as pointed out and emphasized in previous reports, is to bring about a better distribution of well-trained physicians."[75] While it is impossible to know who read what medical literature in order to contribute to this endeavor, the intellectually-minded leaders in the city meant it is possible they had read the journal articles communicating the purported severity of the "midwife problem." Moreover, the tangible policies and demographic shifts that are documented suggest that this discourse, if not read verbatim, had a palpable impact on the city's consciousness.

Academic Assaults on Midwifery: Literature on the "Midwife Question"

Speaking to the visibility of infant and maternal mortality during the Progressive Era and the increasing professionalization of the doctor, Judy Liftoff places the genesis of medical literature debating the "midwife problem" in the 1910s. But mentions its duration through the

---

[74] Gifford, *The Evolution of a Medical Center,* vii.
[75] W. S. Rankin, *The Duke Endowment Annual Report of the Hospital Section, 1928* (Charlotte: The Duke Endowment, 1928).

1930s.[76] This conversation commenced upon the publication of Dr. J. Whitridge Williams "The Midwife Problem and Medical Education in the United States" in 1911.[77] The article reports on a survey Williams conducted on behalf of the Study and Prevention of Infant Mortality which had recently launched a Committee on Midwifery. Having sent questionnaires to fifty physicians at various American medical schools, Williams concluded that poor maternal mortality and the low standard of medical education were intimately intertwined. He claimed that even his students at Johns Hopkins, "the best body of medical students ever collected in this country," had not had apt experience to prepare them for overseeing a delivery.[78] For Williams, allowing the persistence of midwifery, then, would only further undermine the obstetrician's already ambiguous claim to legitimacy. For doctors, the midwife obscured their path to repute. But this was merely the first-step of a process that also required the improvement of medical rigor, pertinent in the Flexner era and to the Durham story. And myriad articles followed.[79]

Beyond the various arguments crafted to degrade the midwife's practice, the prolific nature of such writing suggests the significant impact it had on the profession. In 1923, the *American Journal of Public Health* published an oral dialogue between Dr. Julius Levy and Dr. M. Pierce Rucker.[80] Rucker wrote a review of Levy's study on midwifery to which Levy responded with his qualms. Levy proposed that mere abolition of midwifery would do little to

---

[76] Judy Barrett Litoff, *The American Midwife Debate: A Sourcebook on Its Modern Origins* (New York: Greenwood Press, 1986), 6.
[77] Ibid, 7.
[78] J Whitridge Williams, "Medical Education and the Midwife Problem in the United States," *The Journal of the American Medical Association* 113, no. 1 (January 1912): 1-7: doi:10.1001/jama.1912.04260010003001.
[79] Many of these have been thoughtfully deposited in Litoff's work: Judy Barrett Litoff, *The American Midwife Debate: A Sourcebook on Its Modern Origins* (New York: Greenwood Press, 1986).
[80] M. Pierce Rucker, "The Relation of the Midwife to Obstetric Mortality, with Especial Reference to New Jersey," *The American Journal of Public Health* 13, no. 10 (October 1923): 816-822. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1354653/?page=6**.

improve health outcomes and, instead, favored her "active supervision."[81] In his work, he deemed public health education targeting midwives as the ultimate solution:

> In discussing what can be accomplished by public health education in the reduction of infant mortality, I am reminded of a definition of scientific training as given, I believe, by Matthew Arnold who said, 'scientific training consists of learning what to look for and where to look for it," and so I believe that public health education for the reduction of infant mortality, to be effective, must be directed to those things that really bear a very direct and pertinent relationship to infant mortality and must be so given that it can really [a]ffect these factors.[82]

While Levy's hostility towards midwifery paled in comparison to that of his peers, even his argument in its favor built on an assumption of biomedicine's veracity. Levy hoped that by bringing midwives into the purview of an empirical system, they could help alleviate high maternal mortality rates for which others had made them targets of blame. He believed that, with supervision, these midwives could help bring women back into the home and out of the workplace because "it interferes with mothering and maternal nursing."[83] Levy recognized the unique propensity to instill the values of public health's 'scientific' recommendations to the mother. Such recommendations, he thought, could act as a vehicle to shape social conventions, whether subconscious or not. Even when acting with the best of intentions, Levy's voice in the midwife debate shows the subjectivity inherent in even the most purportedly objective of methods, and the social norms that shape them.

Less measured than Levy, Rucker wrote a fervent response that rejected any form of midwifery: "There will be a midwife problem as long as there is a midwife, and there will be

---

[81] Rucker, "The Relation of the Midwife to Obstetric Mortality," 816-822.
82 Julius Levy, "Reduction of Infant Mortality by Economic Adjustment and by Health Education," (speech delivered at the National Conference of Social Work, Atlantic City, New Jersey, June 5, 1919).
[83] Levy, "Reduction of Infant Mortality by Economic Adjustment and by Health Education."

midwives as long as there is an element of ignorance and superstition in the population."[84] Not only did the midwife derive from benightedness, she had no place in an enlightened world. However, Rucker's adamance on this stance also confers her some agency as there would be nothing for him and his colleagues to fear had she not had something they envied, be it authority, trust, or demand. Between Rucker and the chorus of other voices postulating amendments to the 'midwife problem,' it is evident that midwifery practice abounded and harbored concern. While medical journals offer a clear window into the professional's perspective, policy and census data help reconstruct a better image of the tangible effects such discourse had on the lives experience.

Policy in Praxis: The Official Rhetoric on Midwifery

By 1917, midwifery officially acquiesced to the government's attempts to surveille the medical landscape. This year marked the first time that North Carolina required midwives to register as members of the occupation.[85] While this may seem an innocuous amendment, its consequences threatened the foundations of midwifery. First, it represented the professionalization of a domain historically characterized by an intimate relationship between the expectant mother and the midwife coaching her through her child's birth. Professionalization antagonizes such a personal relationship, favoring efficiency in lieu of connection. Although in its nascent phase, Concurrently, Licensure is one of the primary examples as this bureaucratic system allowed the state to survey a discipline that had traditionally operated within the private relationship formed between mother and midwife. This is not to say that midwives could not

---

[84] M. Pierce Rucker, "The Relation of the Midwife to Obstetric Mortality, with Especial Reference to New Jersey," *The American Journal of Public Health* 13, no. 10 (October 1923): 816-822. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1354653/?page=6**.

[85] Sarah Mobley, "Midwives," in *Encyclopedia of North Carolina,* edited by William S. Powell (North Carolina Press, 2006), https://www.ncpedia.org/midwives.

embody the qualities of a successful practitioner and businesswoman, but that this definition had not been reduced to the fruits of a transactional relationship. And it had never been subject to the critical eye of the state to the degree which licensure would require. This brings us to the second change inherent in the requisite of licensure. Oftentimes, anonymity carries negative connotations—it becomes synonymous with the invisibility of individuals that fall outside of the bounds of convention and the privileges that conforming to these narrow yet accepted boundaries bestow. However, an alternative is that visibility, when understood as a prerequisite of surveillance, allows the governing class to assert control over something that could otherwise remain autonomous precisely because of its anonymity.[86] Licensure assured that midwives lost this privilege: the state extended its gaze to regulate this practice and the 9,000 midwives who registered as members of the occupation in 1917.[87] By writing these women into state records, however demeaning these statistics may have been, a new form of knowledge arose as these women became products of the maternal and infant birth and death rates that were simultaneously examined by state officials working for the State Board of Health and its Bureau of Vital Statistics. Here a contradiction arises. Just as the state created the subject of the midwife in its own system, making her a visible actor in the profession of care, her identity as a community-based provider diminished; she was at once perceptible and increasingly obscured. This paradoxical identity also affected the patient. The expectant mother found increasing recognition in state statistics at the same time she lost the individualized care of the midwife as the professional physician assumed responsibility for her treatment. We will explore this shift in more depth throughout this paper, but even the diction foreshadows the power dynamics

[86] Michel Foucault, *The Punitive Society: Lectures at the College de France, 1972-1973*. Translated by Graham Burchell. New York: Picador, 2013.
[87] Sarah Mobley, "Midwives," in *Encyclopedia of North Carolina,* edited by William S. Powell (North Carolina Press, 2006), https://www.ncpedia.org/midwives.

underlying such changes: midwives offer "care" while obstetricians provide "treatment." Not only does the former system seem genuine next to the transactional nature of the latter, but the physician-patient relationship connotes a need to correct a condition that deviates from the standard of health. Ironically, the expectant mother is pathologized even though childbirth is, by definition, a natural process.

We see this discourse manifest in the documents kept by public health workers in North Carolina—here, the state's incipient bureaus and its developing medical societies ally with new metrics of organization and record-keeping to fortify its regulation of medical care. These tools allegedly implemented to promote the health of North Carolinians bely the mechanism of power fueled by this new construction of knowledge. Most pertinent to our story are the State Board of Health's biennial report and the annual report published by the Bureau of Vital Statistics.

Analysis of the Board of Health's biennial reports offer insights whose importance is twofold. One, it provides a window into the health of the state writ large and its one hundred counties. Two, it paints a multidimensional image of the values of those in power as we see how they defined health and the environmental factors that promoted or hindered their subjective definition of such. Interestingly, the Biennial Report of the North Carolina State Board of Health, in its review of monumental state legislation vis-à-vis public health in the 1910s, fails to mention the regulation of midwifery. Instead, its entry for 1917 applauded the State for its efforts in maintaining accurate birth records.[88] Perhaps the move did not seem noteworthy, but this seems remiss given the attention afforded to other laws that affected maternal and child health. More viable options emerge threefold. First, midwives had already been implicitly regulated and thus the legal confirmation of this did not create waves of change in practice. Second, midwives no

[88] North Carolina State Board of Health, *Twentieth Biennial Report,* 12.]=

longer retained the status of healers they had once been and, to push them further to the periphery, the legislation that validated their existence was not to be circulated to the wider public. Finally, the regulation and licensure of practitioners had become so normative that to do so hardly merited mention.

Reading through the Census: The Palpable Effects of Policy

Determining the precise prevalence of midwifery in any region presents a challenge because of the fact that lay midwives did not always report births and the people to whom they tended typically constituted those already on the geographic and social margins; it was not until the 1940s that the completion of a birth certificate became part of her state-sanctioned duties.[89] Furthermore, the rates of hospital births that scholars have cited showcase a wide range of numbers, even when bound to the same region.[90] What is evident is that between 1900 and the close of the 1920s, the practice of midwifery had been curtailed but not obliterated in Durham. According to census data from the turn of the century, there were both black and white lay midwives practicing in Durham. By 1930, white midwives had disappeared from reports of the area's lay midwives. And the number of African American midwives are few and far between. It follows that UNC's 1927 article celebrated Durham as a poster child of obstetrical care given

[89] Fraser, *African American Midwifery in the South,* 46.

[90] In her dissertation, Nancy Rushing claimed that North Carolina was one of the states with the highest rates of births attended by lay midwives, claiming that the number was as high as 4,000 home births per 34,000, or roughly 11 percent of births had a midwife rather than a doctor. Admittedly, up to 80 percent of these were attributed to African American women. However, as cited in the newspaper article at the beginning of this chapter, statistics published at the time of observation, in 1925, found that midwives oversaw as many as thirty percent of births in the state.: Editorial Board, "Births Attended by Midwives," *The University of North Carolina News Letter,* April 27, 1927, https://newspapers.digitalnc.org/lccn/2015236560/1927-04-27/ed-1/seq-1/#words=midwifery.; Nancy Rushing, "Midwifery and the Sources of Occupational Powe," PhD diss. (Duke University, 1988).

that only forty-eight percent of African Americans and fewer than two percent of white Durhamites solicited the assistance of a midwife during labor.[91]

Conclusion

The first three decades of the twentieth century saw substantial changes to the medical field across the United States. This shift permeated every facet of society as it clung to the notion that the entire system of care in America was not worthy of maintaining a happy and healthy population. On the surface, a noble enterprise, but what is often left out of this narrative, are the practitioners and patients who suffered in the process. As the medical field cultivated a more standardized identity, it excluded the practitioners who did not conform to the period's dominant discourse. Thus, the midwife—typically an African American woman—was replaced by a white man. Her holistic care for the patient was replaced by an capitalistically-minded man attempting to climb the professional ladder and accrue capital, just as his profession did on a macro level. The result oftentimes concluded in treatment that problematized the female body in order to prioritize the pocketbooks, financial and political, of the physician, the hospital, the American Medical Association, and the State. But if this understanding was based in books and quantitative analysis rather than the experiences of the patients behind each diagram and every number, there is no doubt that such a shift reflected the economic, political, and social dynamics of the day. In this chapter we can reflect on this on a macro level, while chapter two centers the conversation more locally, tracing the genesis of the Duke University Medical Center and its interactions with Durham as a microcosm of the field in which these broader dynamics interacted.

---

[91] Editorial Board, "Births Attended by Midwives."

Chapter 2
‘A Special Breed of Angel’: Midwifery and Durham’s Medical Establishments, 1930-1959

By 1953, Durham County had relegated midwives to a figment of the past. At least, this is how the *Durham Morning Herald* described it in a Sunday morning paper printed that spring. The bolded headline spanning the top of the page made it near impossible for readers to ignore that the “practice of midwifery has been terminated.”[1] What remained ambiguous, however, was the candor of this bold assertion. Were midwives truly “now gone forever” as the *Herald* claimed?

Fig. 1. Twenty-one midwives posing for a picture in front of the Durham County Courthouse in 1923. Here, they received instruction from Health Superintendent Jesse Epperson and public health nurse Hulda Covert in the wake of state regulation of lay midwifery beginning with licensure requirements in 1917.

The article begins by citing the robust practice of Durham’s lay midwives up until the 1920s, even adopting a venerable tone to describe them. The associated photograph depicts the twenty-one midwives practicing in the County in 1923: one white

[1] “Practice of Midwifery Has Been Terminated in Durham County,” *Durham Morning Herald,* April 26, 1953. https://www.newspapers.com/image/790434905/?terms=midwife&match=1. (accessed November 19, 2022).

and twenty black women stand in front of the County Courthouse donning matching dresses and white smocks and caps.[2] Their uniforms imply conformity to a strict professional dress code that contradicts the amateur connotation "granny midwives" had garnered in the first couple of decades of the twentieth century. Similarly, the photograph's setting on the steps of a local courthouse, intimates an association between the once autonomous lay midwives and the regulatory logic of local government. The two additional figures who pose for the picture—public health nurse Hulda Covert and Health Superintendent J. H. Epperson—intimate the stratified nature of this relationship. Covert and Epperson stand one step above the midwives, physically replicating their authoritative status in the medical hierarchy, a hierarchy in which midwives had been forced to occupy the bottom rung of the health profession.[3]

The *Herald's* article, the accompanying photograph, and their respective contradictions highlight the nuances of midwife regulation in the mid-twentieth century. The consolidation of institutions of care, with both the birth of Duke University Medical Center and the heightening influence of public health departments in Durham, eclipsed the role of the lay midwife. In this sense, she became nothing "but a legend."[4] However, the veracity of this statement must be called into question considering the number of articles the *Herald* published between the 1940s and early-1960s in reference to Durham's bygone tradition of lay midwifery.[5] That newspaper

---

[2] "Practice of Midwifery Has Been Terminated in Durham County, " *Durham Morning Herald.*

[3] Vicente Navarro, "Social Class, Political Power, and the State and Their Implications in Medicine." *International Journal of Health Service* 7, no. 2 (1977): 274. https://www.jstor.org/stable/45140170.: Sociologist, political scientist, and longtime Professor of Health and Public Policy, Vicente Navarro, argues that the health sector's intimate ties to capitalism means that the duties and responsibilities distributed to various members of the health profession reproduce class, gender, and racial hierarchies. White men occupied the top of the ladder as doctors and relegated minority women often supported the rest of the field as janitorial and housekeeping staff. Midwifery proves no exception to this gradation.

[4] "Practice of Midwifery Has Been Terminated in Durham County."

[5] George Lougee, "When the Obstetrician Was Not Called," *Durham Morning Herald,* November 6, 1949. https://www.newspapers.com/image/786547558/?terms=midwife&match=1.; "Last Midwife Here to Lose Permit Jan. 1," *Durham Morning Herald,* August 5, 1952.

articles, oftentimes recycling indistinguishable copies of the same paragraphs and photographs, consistently reminded the public of the midwife's absence from Durham, draws attention to the motives behind such incessant messaging. While Durham's Health Department could only justify its decision to stop renewing midwives' licenses at the close of 1952 after "medical science, expanded hospital facilities and educational advancement…[had] reached the citizenry," the nostalgia towards the midwife still goes unexplained.[6] Part of this tolerance, I argue, became permissible when the midwife began to more closely emulate the standards of institutionalized medicine when forced to operate within the confines of the law, and specifically, under the supervision of the Department of Health; it lacked autonomy. And midwifery, like public health nursing which expanded during the mid-twentieth century, offered some semblance of care for Durhamites for whom so-called modern medical institutions remained out of reach because of financial and racial barriers. In both instances, midwifery's lay roots were rejected in order to cultivate a practice that resembled Flexner-era medicine.

In Durham, Duke epitomized the possibilities of innovation and relied on the veneration of science to attain legitimacy comparable to that of its northern peers; the university and its newly minted medical establishment quickly replaced the value of the local.[7] Not only did Duke aspire to cultivate the professional image of revered medical schools like Hopkins, it also helped institutionalize care in its southern city. As maternal and infant mortality had been on the public health agenda at a national level, Duke had to tackle this problem too. It helped offer the obstetric solutions to the "midwife problem," and a successful one at that, according to the

---

https://www.newspapers.com/image/790409480/?terms=midwife&match=1; Lougee, "Midwife—A Special Breed of Angel;" "Practice of Midwifery Has Been Terminated in Durham County."

[6] "Last Midwife Here to Lose Permit Jan. 1;" "Practice of Midwifery Has Been Terminated in Durham County," *Durham Morning Herald.*

[7] Robert Durden, *The Launching of Duke University, 1924-1949* (Durham: Duke university Press, 1993), 23-4.

Herald-Sun's 1953 publication. However, this headline belies reality that the systemization of medicine in Durham, catalyzed by the Duke University Medical Center, excluded the people whose knowledge it rejected: largely, the uneducated and indigent, African Americans, and women. And when it could not provide for these groups, the breadth of its shadow left few people who could—a pattern that occurred across the country as medicine became commodified and standardized.

This chapter reconciles the claim that midwifery had no place in modernity given its foundation in the personal rather than the institutional with the fact that the practice *did* continue under the watchful eye of doctors and public health officials alike. Both operate on the assumption that lay midwifery, as it had existed, proved inferior to the scientific knowledge generated in the academy, government, or hospital. At its core, this discrepancy can be understood as a manifestation of racism, especially as described by Robert W. Terry's three-pronged definition of racial discrimination and its application to medicine. First, is the propensity for white individuals to make and enforce decisions as played out in Duke University and Durham's Department of Health. Second, is the establishment of standards of care that define normalcy in relation to the white body.[8] And finally, is the differential conference of the benefits of said standards of care.[9] As the medical profession had rejected lay midwifery on the grounds that it built upon inferior knowledge than that offered in the institution, it did not conceive of a

---

[8] Although beyond the scope of this thesis, it is worth noting that although the white body has been used to define normalcy, it is often the minority body that is abused in pursuit of medical treatments and scientific knowledge. Deirdre Owens' *Medical Bondage: Race, Gender, and the Origins of American Gynecology* speaks to this in the context of Dr. Marion J. Sims' invention of the vesicovaginal fistula. Dorothy Roberts' *Killing the Black Body* and Harriet Washington's *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* expand this conversation beyond gynecologic procedures to include theft of Black bodies for use in cadaver labs to the infamous Tuskegee Syphilis Study.

[9] W. M. Byrd and L. A. Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," *Journal of the National Medical Association* 93, no. 3 (March 2001): 13S. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2593958/?page=3.

way to offer the obstetric care it lauded across the population. Instead, midwifery regulated by the establishment became the only form of service available to women excluded from Duke's supposed health care panacea.

Obscured by the Hospital: The Birth of Duke University Medical Center

Many historians have noted that the early-twentieth century marked the professionalization of American medicine.[10] Paul Starr asserts that the competency conferred to physicians "had to be reconstructed around the claim to technical competence, gained through standardized training and evaluation."[11] Durham was no exception, and the story of the County's midwives only corroborates this. As the physician sought to gain legitimacy and professional success on an individual level and the discipline endeavored to garner the same prestige it held in Europe and in esteemed American universities, like Hopkins, the doctor and his field both hoped to erase practices associated with a less innovative past.[12] For the South, this included the lay midwife, preyed upon by stringent legislation and public health practices which moralized behaviors that transcended the clinic.[13] Perhaps it is no surprise, then, that the increasing institutionalization of medicine only reinvigorated the assault on midwifery, if by different forms.

---

[10] James Brodley, III and A. McGehee Harvey, *Two Centuries of American Medicine, 1776-1976* (Philadelphia: W. B. Saunders Company, 1976).; Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987).; Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982).; Wertz and Wertz, *Lying-In: A History of Childbirth in America* (New Haven: Yale University Press, 1989).

[11] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 18.

[12] Durden, *The Launching of Duke University, 1924-1949,* 24.

[13] Crow, Escott, and Wadelington, *History of African Americans in North Carolina* (Raleigh: North Carolina Office of Archives and History, 1992).; Historians have analyzed adm

Across the South health administrators conflated lay midwives with ignorance and a lack of hygiene. In the late 1920s, a Georgian public health administrator wrote of the importance of educating the lay midwives still allowed to practice: "Clean, sterile, and dressed in white, midwives were symbolically cleansed of their race."[14] Only in adopting the logic of white supervisors in the health department could Black midwives earn some degree of repute. Wearing a uniform, officials claimed, would distance the midwife from her "dirty" habits; her image in addition to her intellect was alleged evidence of the midwife's inferiority.[15] The blatant racism behind official discourse shows the unabashed collusion between the medical hierarchy of knowledge and racism. In Durham, not only was this sentiment reflected by the public conscience in articles like that published in *The Herald*, but it also imbued the city's physical architecture when Duke University Medical Center opened its doors on July 20, 1930.[16] To understand the alleged extinction of the midwife would be impossible without first appreciating one of the actors driving her away: the medical institution.

Conceiving the Duke University Medical Center

Duke University Medical Center's first admit had been years in the making. Whispers of a new medical school first emerged in the 1890s given the poor health of North Carolina's population and the lack of infrastructure to address the problem.[17] However, what the proposal possessed in passion, it lacked in funding. Not only had the project lacked adequate financial support but it too lacked consensus on where to direct the funds once raised. Compelling

---

[14] "Midwife Activities in Mississippi," 1928, Georgia State Board of Health as cited in Molly Ladd-Taylor, "'Grannies' and Spinsters': Midwife Education under the Sheppard-Towner Act," *Journal of Social History* 22, no. 2 (1988): 267. https://www.jstor.org/stable/pdf/3788221.pdf.

[15] Ladd-Taylor, "'Grannies' and Spinsters': Midwife Education under the Sheppard-Towner Act," 267.

[16] Wilburt C. Davison, *The Duke University Medical Center, 1892-1960* (Durham: Duke UP, 1960), 2.

[17] Durden, *The Launching of Duke University, 1924-1949,* 347.

arguments fought for the use of philanthropic donations from the Rockefeller Foundation in the construction of a medical school in Charlotte or Chapel Hill. However, Dr. Watson Rankin, the State Health Officer, felt that funding a hospital in Durham would have greater impact.[18] The relatively small and rural community of Durham could benefit from more places to turn to receive medical care. It was through increasing the accessibility of biomedicine to those outside of the country's greatest urban centers, that Rankin hoped to fortify health at the state-level. While metropolises, like the District of Columbia, boasted one doctor for every 275 residents by the end of the 1920s, for every one of North Carolina's 2,281 physicians, there were 1,210 lay people who might request their care.[19] Rankin, like other Durham elites, believed that the first step towards a healthier populace lay in the hospital and promoted a "professional element" only possible with highly-trained physicians.[20]

> The purpose of a community or county hospital is to…develop a medical profession that will serve efficiently, not only the few patients confined in the hospital, but the many patients in the community at large. It is only when a hospital exercises its full influence in the development of an efficient medical service that it ceases to be merely a building for the care of a few sick people and becomes an important factor in the life of the whole community.[21]

Rankin claims that the hospital, far more than a sole thread in a larger web of care, should exist as its protagonist. Likewise, the hospital's role should extend beyond the treatment of ailments to the control of community life. Rankin saw prevention where others could read control. But as scholars like Barbara Rosenkrantz have argued, this statement is unsurprising during a period in

---

[18] Wilburt C. Davison, *The Duke University Medical Center, 1892-1960* (Durham: Duke UP, 1960), 2.
[19] *The Duke Endowment Tenth Annual Report of the Hospital Section, 1934*, 13.
[20] Ibid, 12.
[21] Watson Rankin, *The Small General Hospital: Prepared for the Trustees of the Duke Endowment* (Charlotte:1932), 10, https://babel.hathitrust.org/cgi/pt?id=mdp.39015006666468&view=1up&seq=16.

which public health became a priority in the field of health care, conflating hygiene, sanitation, and health with mortality.[22] Such interwoven sentiments allow us to make sense of the decline of midwives alongside the growth of Durham's hospital scene, especially when the city finally received the financial resources it needed to support the endeavor.

This aid came in the form of James Buchanan Duke's pledge of four million dollars towards the establishment of "the best medical center between Baltimore and New Orleans" as written in his will.[23] Duke also hoped this generous philanthropic act would offset local gripes that fueled the class tensions between the Duke family and the working class residents who manned the family's factories.[24] The fact that Durham "numbered more productive poor in her population than any other city in the state" gave merit to such an aspiration.[25] Hence, beginning in 1924 the Duke Endowment published statistics that reflected local morbidity and mortality. It tracked the Endowment's contribution to hospitals across the Carolinas, of which the Duke University Medical Center comprised just one benefactor, if the largest.[26]

What differentiated Duke's hospital from the few dispersed across the Carolinas and the two already established in Durham, Lincoln and Watts, was a fervent desire to emulate the prestige of other university medical centers, especially Johns Hopkins given its praise in the Flexner Report. To ensure the incipient institution could meet such lofty expectations, North Carolina health officials; William Preston Few, President of Trinity College (now Duke University); and members of the Duke family looked to faculty at Johns Hopkins itself to help

---

[22] James Burrow, *Organized Medicine in the Progressive Era: The Move Toward Monopoly* (Baltimore: The Johns Hopkins University Press, 1977).; Barbara Rosenkrantz, *Public Health and the State: Changing Views in Massachusetts, 1842-1936* (Cambridge: Harvard UP, 1972), 2.
[23] Wilburt, *The Duke University Medical Center,* 4.
[24] James Gifford, *The Evolution of a Medical Center: A History of Medicine at Duke University to 1941* (Durham: Duke UP, 1972), 37.
[25] Gifford, 8.
[26] Gifford, 16.

them turn dreams of an esteemed hospital into reality using the same gold standard Flexner had established in his report regarding medical education in the decade prior.[27] At Duke, education and medicine were inextricably linked for the former and meant better results for the latter. This, they hoped, would in turn enhance the university's regard writ large.[28] In Duke's quest to contend with older institutions, the "granny midwife," characteristic of the South, had no place.

Hopkins' influence on Duke's burgeoning hospital permeated everything from its pedagogical approach towards medicine to the resumes of the doctors it employed. In fact, the majority of the Medical Center's original staff came from jobs at Hopkins with the hope that they, as pioneers, would have the opportunity to raise the standards of medical care in a region less familiar to such privileges.[29] Internal reflections from the Medical Center written later in the twentieth century convey Duke's enduring adherence to Flexner with retrospective appreciation of the "brisk professionalism" of some of Duke's earliest health care workers, a quality which afforded them the job.[30] While Duke aspired to establish a medical center that could offer residents of the Carolinas the rigorous scientific background needed to excel in the profession, the Medical Center's first doctors moved to Durham from around the country. Herein, we see the first perceptible difference between the physician and the midwife: Durham imported the former while the latter was ingrained in the region's history.

Another stark contrast emerged between the two when it came to the transactional relationship between obstetrician and patient in the hospital as compared with the intimate one fostered between midwife and mother in the home. Physicians wanted efficient births and a

---

[27] Davison, 348.
[28] Davison, 351.
[29] Davison, 47.
[30] Davison, 63.

paycheck.[31] In fact, these motives led the hospital to emphasize patients' ability to pay over the severity of their illness or injury. Just one year after the Hospital opened, they instigated a policy which charged patients a flat rate of six or nine dollars depending on the kind of bed they booked with the intent of ensuring patients paid their fees on the front end, lest they forgo treatment. The Medical Center begrudgingly accepted patients who could not pay this steep fare by offering a sliding scale that asked between $3.50 and $4.50 per day—a number still far outside the reach of many of Durham's residents.[32] The perceived financial losses from these so-called "charity patients" led to the opening of Duke's Private Diagnostic Clinic, a place in which doctors offered the best care to the most affluent, and placed pressure on Lincoln and Watts to accept more charity patients.[33] Within the professionalized and institutionalized medical establishment, the patient experience became a commodifiable service.

While saying that midwifery represented the opposite would be misleading, its relationships predicated on exchanges that felt more personable and less corporate. The means of paying the midwife epitomizes this difference. Furthermore, births in the home encouraged the presence of the extended family and friends—to support the birthing mother emotionally and to provide assistance with household tasks—while many hospitals barred anyone but the mother from the birthing room until the 1960s, perpetuating the demographic shift that brought people to the country's cities and dispersed them from their kin.[34] This isolation left women who could not afford to pay for a stay in the hospital without friends and family to help with the delivery process barred from practice that quickly became social convention. Returning to Terry's

---

[31] Wertz and Wertz, *Lying-In: A History of Childbirth in America*, 133.
[32] Gifford, *The Evolution of a Medical Centre*, 93.
[33] Gifford, 95.
[34] Wertz and Wertz, 102, 157.

framework of the concurrent manifestations of racism, while knowledge deemed superior helped Duke establish quality care for Durham's elites, the most marginalized members of society, neither benefited from the rising standards of obstetric care nor had the same access to the lay midwives they had always trusted. This was exacerbated by the knowledge produced by the Duke University Medical Center's status as a medical school and teaching hospital.

Duke's Foray into Obstetrics

The Duke Department of Obstetrics and Gynecology opened just one year after the rest of the Medical Center and as in the other departments, its first chair, Dr. Francis Bayard Carter, came to Duke as a student of the Hopkins school of thought: one that taught that a strong foundation in basic science and time in the laboratory were the hallmarks of a good physician.[35] In an interview conducted at the end of his career, Carter credits his desire to join the growing Duke faculty to the autonomy he would have as a young physician, only having graduated from medical himself in the mid-1920s. This enabled him an unprecedented opportunity to build a system of practicing and teaching medicine and training community health workers that would not have been possible in a location with a more established medical institution and the regulations such a bureaucracy by nature imposes. Throughout his career, he prioritized teaching future doctors as a faculty member of Duke's medical school.[36] Here, he passed his affinity for medical innovations and the sterility of the hospital to the next generation.[37] Thus, while the Duke Department of Obstetrics and Gynecology undoubtedly touched its maternity patients, it

---

[35] Thomas Duffy, "The Flexner Report—100 Years Later" *The Yale Journal of Biology and Medicine* 84, no. 3 (September 2011): 269-276. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178858/.
[36] Interview with F. Bayard Carter. *Duke Ob/Gyn.* DUMC-TV, Durham, 1967, https://www.youtube.com/watch?v=KdBFdnUHzrs.
[37] Interview with F. Bayard Carter.

had an equal impact on those who never made it there through its influence on obstetric pedagogy.

Although the men behind the construction of the Duke University Medical Center, particularly those invested in the Department of Obstetrics and Gynecology, saw their work as a catalyst for mitigating North Carolina's maternal and infant mortality rates, aspirations far surpassed reality in the hospital's early years. When the Department first opened, North Carolina ranked forty-sixth in maternal mortality, making it one of the most dangerous places for a woman to have a child, statistically-speaking.[38] One's prospects of survival were better or worse depending on one's race: 4.14% of obstetrics patients in black hospitals died during delivery compared with 1.36% of those in white hospitals.[39] This shadow followed Carter into the Duke's medical center, a space conducive to the spread of infectious disease. There, the mortality rate amongst obstetric patients between 1931 and 1933 swelled to a shocking thirteen percent, a number greatly credited to infections of the bloodstream following delivery or abortion.[40] The prevalence of maternal morbidity and mortality, even in the alleged safe haven of the hospital, led Carter to reflect on pregnancy as "the worst disease" by the end of his career; no longer a process, pregnancy became pathologized.[41] Infants fared even worse. Their mortality rates increased by fifty percent as births moved to the hospital in the 1920s, a trend which did not reverse until antibiotics were introduced to the delivery room in 1936.[42] Even when the hospital

---

[38] Interview with F. Bayard Carter.
[39] *The Duke Endowment Tenth Annual Report of the Hospital Section, 1934*, 77-8.
[40] Gifford, 138.
[41] Interview with F. Bayard Carter.
[42] Wertz and Wertz, *Lying-In,* 161, 164.

pushed midwives backstage, maternity remained a killer—the medicalization of pregnancy and birth exacerbated risk, it did not mitigate it.[43]

Unlike the midwives who had assisted in the natural process of childbirth, the institutionalization of medicine brought with it a discourse that pathologized delivery. It became a process that merited intervention by a well-trained, male physician.[44] This doctor, the obstetrician, leveraged his erudition to protect mothers-to-be through the perils of labor. When discussed as a site rife with dangers, the obstetrician garnered increasing authority—he could conquer the perils of nature on behalf of the helpless woman delivering. The doctor's capacity to control nature simultaneously fortified the doctor's legitimacy and made the hospital a commendable place for delivery while inadvertently undermining practitioners who did not have access to the newest medical technology. It also reinforced the image of the fragile female hysteric in need of saving.[45] Perhaps it is no surprise, then, that the 1910s and 1920s saw a drastic increase in the number of cesarean sections and use of sedative drugs across the United States.[46] In the context of Duke, such surgical procedures jump out as one of the most perilous parts of childbirth with nearly ten percent of those undergoing the procedure not making it out alive in 1933.[47]

Rather than consider the hazards of constant pathologization, medical professionals promoted new technology as the zenith of modernity. A notable example was the introduction of Twilight Sleep, the pinnacle of childbirth's medicalization. A mixture of scopolamine and

---

[43] Wertz and Wertz, 161: A White House Conference convened in 1933 to address the country's poor maternal and infant outcomes cited the two primary culprits of increasing rates of mortality as a lack of adequate prenatal care and excessive intervention during birth. The latter proved a marked difference from the conventions of midwifery.
[44] Wertz and Wertz, 161.
[45] Wertz and Wertz, 93-4.
[46] Wertz and Wertz, 139, 150.
[47] *The Duke Endowment Tenth Annual Report of the Hospital Section, 1934*, 79.

morphine, doctors administered this sedative to women hoping to evade the pains associated with labor.[48] Unlike the use of forceps, which midwives could learn to use, Twilight Sleep presented an amenity unique to the hospital.[49] Before long, other 'commodities' joined the ranks of Twilight Sleep to appeal to expectant middle- and upper-class mothers. Hospitals advertised the hotel-like sojourn the mother would experience away from her home: a staff to cook and clean on her behalf.[50] Births within the hospital became a marketable experience rather than an intimation of a patient's destitution, as the almshouse and the first maternity hospitals had.[51] Accordingly, eighty-eight percent of all American births occurred inside a hospital as of 1950.[52] Offering an expectant mother some semblance of escape—either from her corporeal reality or her domestic duties—marked the physician different from the midwife. However, not everyone could afford these luxuries and differences in childbirth appeared along class and racial lines.[53]

Racial Segregation within the Hospital

One of the most prominent barriers in affording maternal care lauded as a lifesaving necessity was one's race. While Duke Hospital committed to treating Durham's black and white residents, in name, the segregation of wards along racial lines exemplifies how Jim Crow

---

[48] Lauren MacIvor Thompson, "The politics of female pain: women's citizenship, twilight sleep and the early birth control movement," *Medical Humanities* 45, no. 1 (2019): 67-74. https://mh-bmj-com.proxy.lib.duke.edu/content/45/1/67.: Although beyond the scope of this paper, it is of note that the genesis of Twilight Sleep fed into many of the racist ideologies that shaped how doctors perceived their patients' pain. While Twilight Sleep was offered as a remedy for upper-class white women seen to be fragile, many obstetrical procedures were practiced on enslaved black women who weren't so much as offered anesthesia.

[49] Amy Hairston, "The Debate Over Twilight Sleep: Women Influencing Their Medicine," *Journal of Women's Health* 5, no. 5 (1996): 489-499. http://doi.org/10.1089/jwh.1996.5.489.

[50] Leavitt, *Brought to Bed,* 202.

[51] J. Rogers Hollingsworth and Ellen Jane Hollingsworth, *Controversy about American Hospitals: Funding, Ownership, and Performance* (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1987), 44.; Leavitt, *Brought to Bed,* 177.

[52] Leavitt, 181.

[53] Leavitt, 65.

permeated the hospital. Moreover, only Durham's wealthiest black residents could afford to fulfill the requirement to pay medical fees out of pocket, making the institution out of reach for most.[54] While African Americans who could pay for medical services out of pocket could be admitted to Duke Hospital, most of them could not. Even the ones who could fund a stint in the Medical Center received significantly worse treatment than their white peers. This racial discrimination manifested materially in the DUMC's lack of infrastructure for black patients can be seen by looking at a comparison of the number of beds dedicated to them versus those dedicated to white patients. When the Hospital opened, it had 416 beds and 50 bassinets yet only six of these beds were left aside for African Americans in need of inpatient care by 1943.[55] Across the state, the African American population constituted thirty percent of North Carolina's population, but only sixteen percent of the hospital beds in the state were set aside for them. This number, though egregious, fails to problematize the fact that many of these beds were concentrated in urban centers, and fifty-five of Durham's one hundred counties had no hospitals with beds for black patients.[56] Even if they could afford care outside of the home, North Carolina failed to offer medical services to the state's black community.

Thus, while the number of urban women delivering in hospitals increased from five percent to seventy-five percent between 1900 and 1939, this statistic neglects the experience of African American women who continued to rely on the midwife, on financial and institutional accounts.[57] The North Carolina Health Bulletin, published in 1939, cites that 89.5% of white

---

[54] Walter Campbell, *Foundations for Excellence: 75 Years of Duke Medicine* (Durham: Duke University Medical Center Library, 2006), 174.
[55] Phoebe Ann Pollitt, *African American Hospitals in North Carolina: 39 Institutional Histories, 1880-1967* (Jefferson: McFarland & Company, 2017), 13.
[56] Pollitt, 16.
[57] Wertz and Wertz, 133.

births occurred in the hospital compared to 35.3% of black births.[58] As mentioned, even the third of black mothers who delivered in the hospital had radically different experiences because of the color of their skin. This leads to a contradiction as the hospital hoped to medicalize all births, regardless of the mother's race, but a discriminatory and blatantly racist culture pervaded its practices.

Ubiquitous and quotidian displays of racism even transcended the walls of Lincoln Hospital and manifested in its operations and health outcomes. Its fatality rate was nearly twice that of other black hospitals in the state, as it now admitted only the region's most underprivileged: Durham's Black working class.[59] Lincoln's new patient demographic exacerbated the financial strife felt on the heels of the Depression, so that by 1934, Lincoln teetered on the verge of ruin, prompting Duke to intervene in accordance with the Endowment's commitment to the local hospital itself and the more grandiose goal to improve the health of all North Carolinians.[60] The ensuing attention Lincoln garnered from Duke left many of Lincoln's previously all-Black staff upset with the constraints on their practice, leading the entire staff to resign. Filling their roles were white transplants, many of whom had trained at Duke Medical School. In addition to their clinical responsibilities, they were charged with overseeing their Black assistants.[61]

The introduction of physicians born out of Duke's earliest years, led to an evermore paternalistic relationship between Duke and Lincoln, one which embodied the legitimacy conferred to those who ascribed to purportedly modern research, science, and technology. Even

---

[58] Pollitt, 16.
[59] Campbell, *Foundations for Excellence*, 76.
[60] *The Duke Endowment Tenth Annual Report of the Hospital Section, 1934*, 44.
[61] *The Duke Endowment Tenth Annual Report of the Hospital Section*, 76-77.

amongst accredited physicians, the white doctor held authority over the Black doctor, a hierarchy exacerbated by American medical education. The two percent of physicians who were Black during the mid-twentieth century had no option but to attend Black medical schools which tended to lack the same resources and reputation of historically white institutions, like Duke.[62] As with Leonard Medical School, which had educated many of the initial Lincoln doctors, Black medical schools closed at disproportionate levels following the publication of the Flexner Report. Again, even when privileged knowledge identified a practice as insufficient, it failed to propose a solution to those most in need.[63] While perhaps most acute when examined through the lens of race, this imperialistic relationship was not unique to Lincoln and Duke but also appeared in the relationship between university-backed doctors to those who sought to practice independently as mediated by the law.

Cultivating Conventions of Care: institutionalization of Medical Practice in Durham

With the financial and authoritative backing that came with intimate ties to the Duke Endowment, Durham hoped a decidedly empirical and laboratory-based approach to obstetrics could seep into the community writ large. This worked through both explicit and implicit mechanisms. The first leveraged the existing, paternalistic relationship between Duke and

---

[62] Byrd and Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," 20S.

[63] Earl H. Harley, "The Forgotten History of Defunct Black Medical Schools in the 19th and 20th centuries and the Impact of the Flexner Report," *Journal of the National Medical Association* 98, no. 9 (September 2006): 1425-1429.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569729/?page=1.; "Delivery Room Records, 1957-1964," Lincoln Hospital (Durham, N.C.) Records, 1901-1998, Box 14, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC. (hereafter cited as "Lincoln Delivery Room Records"): An oral history conducted in January 2023 with Gabriella Ross (whose name has been changed to protect her privacy) suggested that, during her childhood in the mid-twentieth century, Lincoln Hospital was known for its predominantly Filipino staff, including doctors. By 1959, most of the obstetricians who appear in Lincoln's Delivery Room Records have Spanish surnames, corroborating this narrative. While no secondary scholarship exists on the employment of Filipino doctors by Lincoln Hospital, this is worth further research given the implications it has on conceptions of race in Durham.

Lincoln. On a macro level this meant that relatives of the Duke family and Duke medical faculty, including Dr. Bayard Carter, sat on Lincoln's Board of Trustees but also that Duke physicians oversaw the day to day work of the doctors working with Lincoln's black demographic.[64] Legal documents formally refer to this relationship as one in which "professional work is supervised by an advisory committee composed of five white physicians."[65] Not only had the black physicians working at Lincoln had to jump through the myriad hoops that it took to become a black doctor in the Jim Crow South but even this near impossible path toward professionalism did not allow them autonomy on the other side.[66] We can see this in both the legal stipulations they had to follow and the rhetoric they adopted in Lincoln's reports. Outside of the hospital, Duke's influence can be understood by examining government documents, as this sentiment would have emulated the environment in which public policies were conceived, and popular voices as seen in newspapers, a medium which simultaneously reflects and shapes the opinions of its readership. This imperialistic slant of medicine in twentieth-century Durham largely paralleled national public health discourse which simultaneously promoted health education and new standards of care without making such standards universally accessible.

While Duke University Medical Center made no effort to care directly for Durham's most indigent, it did not shy away from dictating how vulnerable communities needed to improve behaviors and how failure to adhere to such advice inevitably led to poor health. This contradictory messaging riddles much of the prolific public health propaganda conceived of in the mid-1900s. While departments of health opened in the earlier decades of the century, their reach increased during this period and used community outreach and media campaigns to do so:

---

[64] *Thirty-Eighth Annual Report.* Durham: Lincoln Hospital, 1938, 12.
[65] *Thirty-Eighth Annual Report,* 12.
[66] Campbell, *Foundations for Excellence*, 77.

"The power of the bureaucratic state came to depend in large measure on its capacity to administer rather than take life."[67] Their messaging became accessible to the masses, even if the care they promoted was not. The examples abound but given their geographic proximity to Durham, I will analyze a film produced by the Georgia State Department of Health and the Frontier Nursing Service. Understanding the national rhetoric and action concerning public health helps to illuminate the breadth of implications of Duke's obstetric consolidation.

Hygiene and Morality in the Delivery Room

Public health departments across the American South executed various tactics to assimilate midwifery as a means of community outreach and education in the name of state-sponsored boards of health. In 1953, Georgia's Department of Public Health had released a video meant to educate midwives on what physicians deemed proper obstetrical training. The video praises former "granny" midwife Mary Francis Hill on her ability to adapt to working under a doctor: sterilizing obstetrical instruments the way he asked, completing birth certificates, and attending regular training through the Board of Health.[68] While on the surface the tone appears congenial, and Hill seems the hero of the story, the jovial music belies Hill's loss of autonomy. No longer contingent on her ability to deliver babies in her clients' homes and treat the mother-to-be holistically, Hill's worth derived from her ability to conform to a standardized procedure, one considered superior by white male obstetricians and bureaucrats in the department of public health. On a more literal level, the video will not let us fail to see that midwifery had not in fact

---

[67] Gertrude Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge: Harvard University Press, 1998), 51.

[68] Georgia Department of Public Health, *All My Babies,* preserved in the United States National Film Registry by the Library of Congress (Atlanta: Georgia Department of Public Health, 1953), YouTube video, https://www.youtube.com/watch?v=KGaW3yhfKN0.

perished in the mid-twentieth century South, even if the nomenclature disguised a new denotation. No longer the enemy, midwifery, when appropriately assimilated under the jurisdiction of an established medical institution and the educated people who ran it, became a means of filling the shortcomings of the professionalization of medicine: it sought to extend the establishment's services to the rural folk who no longer lived in propinquity to the evermore urban concentration of medical facilities. Here, arises a contradiction in which midwifery was abhorred and merited supervision but yet it proved a necessity.

Similarly, Mary Breckenridge, the founder of the Frontier Nursing Service (FNS) in Kentucky, produced a documentary, *The Trail of the Pioneer,* to garner public support for her school of nurse-midwifery.[69] Building off of the model established in England, Breckenridge thought that the institutional training of nurses specialized in obstetrics would yield a practitioner capable of providing maternal care for destitute communities in Appalachia who otherwise had no option but to use the "granny" midwife.[70] In addition to FNS, the Maternity Care Association operated in New York to serve the city's immigrant community and ran. Graduates of both schools earned the title of "nurse-midwife," a person with a license and credentials to work with a physician during the birthing process. The title of this role's seemingly antithetical nomenclature illustrates the tension between the abhorrence of midwifery but also the need to distribute maternal care more equitably. Like the Georgia Department of Health, supervision and institutionalization proved apt means of dealing with midwifery when it could not be abolished altogether. However, when it came to the FNS, Breckenridge showed none of the same tolerance towards the lay midwives—she attempted to distance the women in her organization from the

---

[69] Laura Ettinger, *Nurse-Midwifery: The Birth of a New American Profession* (Columbus: The University of Ohio State Press, 2006), 45.
[70] Ettinger, 74.

caricature of the lay midwifery as much as possible and refused to serve anyone but the white woman: "The one great thing for us all to remember is that we pure blooded Americans must stand solidly together, whether we come from the South or the North, for we Americans are the inheritors of this wonderful country, and we are very distinct from the foreign born element which is overpowering us in the great cities."[71] As self-proclaimed "inheritors" of the United States, FNS feeds on nativist insecurities and a sense of white entitlement. This excerpt from *The Trail of the Pioneer,* a documentary created by FNS' founder to garner public and professional support and charitable donations, highlights the relationship between reproduction and power. Notably, MCA had few black practitioners and FNS remained explicit in its unwillingness to hire anybody of color.[72] Instead, Breckenridge wrote letters to the country's most revered obstetricians in pursuit of endorsements and professional assistance from those she associated with good repute in the field of childbirth given their connections to established universities.[73] Ironically, in Breckenridge's attempt to offer care to those she felt the medical establishment left behind, she perpetuated the perspective of the exclusionary medical profession. The genesis of nurse-midwifery in New York and Kentucky turned its back on traditional lay midwifery because of its connotations with African American care.

Durham's institutionalization of midwifery proved less explicitly xenophobic than Breckenridge's, but still led to disparate lived experiences for black and white mothers and their infants. This became evident in chapter one as Durham began to require licensure of its lay midwives and earlier in this chapter as we saw the physical interaction of lay midwives and the government in the image portraying the handful of practitioners donning matching white outfits

---

[71] *The Trail of the Pioneer* as quoted by Ettinger, *Nurse-Midwifery,* 45.
[72] Ettinger, *Nurse-Midwifery,* 46, 91.
[73] Mary Breckenridge to Dr. Bayard Carter, September, 1950, MC.0031, box 1, folder 1, Francis Bayard Carter Papers, Duke University Medical Center Archies, Durham, NC.

in front of Durham County's Courthouse. However, by the 1930s and 1940s this became obvious in the day to day, from the identity of the health care workers on the ground to the conventions they adhered to. As Harry Marks wrote in the context of medical research, science became an intellectual *and* moral category.[74]

One such example lies in the explicit condemnation of midwifery by the Duke-supervised administration at Lincoln. In their 1938 report they scapegoated midwives for the disparities in black and white maternal and infant health outcomes with 94.2 deaths per one thousand live births in the black community and 52.2 deaths per one thousand live births amongst whites. Condemning these disparities, the reports assure the reader of a simple fix:

> Lincoln Hospital has recognized the hazards involved in the delivery of such a large number of N**** babies by midwives. Here again ignorance and poverty play an important role. Many mothers do not realize the danger attendant upon childbirth, and many who are informed are too poor to have a private physician. Therefore, for the past five years we have been trying to educate mothers of the importance of pre-natal and post-natal care.[75]

Lincoln administrators acknowledged the barriers to receiving the care they deemed necessary for expectant mothers; "ignorance and poverty" were once again at fault for the risks of childbirth outside of the walls of the medical institution. However, these same authors identified these dangers as unique to the African American community, assuming midwifery only remained in black communities. Their solution was to educate mothers on caring for themselves during pregnancy and their infants after birth.

---

[74] Harry Marks, *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900-1990* (Cambridge: Cambridge University Press, 2000), 7.
[75] Ibid, 13.

Realizing that Lincoln lacked the capacity to care for all of the Black women in Durham, the city employed public health nurses to educate midwives using the logic of the medical establishment. It is no coincidence that as Georgia launched its campaign to educate midwives, fourteen public health nurses served Durham and the four surrounding counties' most rural residents. A 1951 feature article in the *Durham Morning Herald* suggested that these women committed to "spreading the gospel of better health," using their degrees from accredited nursing schools to act as registered nurses and educational supervisors. The latter included visiting "aged" midwives to ensure they visited patients with the white uniforms and proper equipment that the Department of Health had insisted they use.[76]

An additional role of such public health nurses included the referral of new mothers to Well Baby Clinics, particularly common at Lincoln Hospital. Such clinics constituted a joint effort between medical professionals and local governments, Duke Hospital and the Public Health Department, in the case of Durham.[77] Each clinic provided a space for infants to receive routine medical care and for mothers to learn "proper diets, the purpose and preparation of foods and the essential clothing necessary for her and the new baby."[78] Prevention took center stage in the field of obstetric and pediatric care and this was inherently intertwined with lifestyle, as in clothing or diet. The connection between health and morality became more apparent with the "baby reunions" and "baby competitions" used to promote these clinic days. Not only were

---

[76] Walter Carroll, "Public Health Nurse—In the Fight to Prevent Disease: Mrs. Sessoms Has Important Teaching Job," *Durham Morning Herald,* November 11, 1951, https://heraldsun.newspapers.com/image/789097383/?clipping_id=116377134&fcfToken=eyJhbGciOiJIUzI1NiIsInR5cCI6IkpXVCJ9.eyJmcmVlLXZpZXctaWQiOjc4OTA5NzM4MywiaWF0IjoxNjgyMTM0MTQ4LCJleHAiOjE2ODIyMjA1NDh9.iIAvJQr1b_znXdpddqckA9ztE5Wo-awPuOVQ8X_Egbw.

[77] "Women's Auxiliary Letter," August 16, 1955, box 6, Administrative Office Files Folder, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, N.C.

[78] "Analysis of Lincoln Hospital Services," 1954, box 8 folder 1, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, N.C.

mothers whose babies had been delivered in Lincoln welcomed back to fraternize with their peers, but they also accommodated referrals from public health nurses who found women who had delivered their children with midwives in their home.[79] Given the allegedly insufficient training public health nurses thought these women received regarding care of their newborn children, Lincoln invited them in for check-ups with open arms. While the day entailed a schedule of revelry and learning, it concluded with a speech from a member of the North Carolina Board of Health, a revered actor in Durham's medical landscape.[80] In the mid-twentieth century, the midwife debate—while addressed with different solutions—showed a clear alliance between local bureaucracy and Duke's growing institutions.

The subtext here is that midwives failed to teach mothers how to foster a healthy environment for their children. Hence, public health outreach and Well Baby Clinics in the hospital had to continue to remedy the ills of midwifery.

Academic Abhorrence of Midwifery

Part of this judicial-medical relationship, in Durham and across the nation, was regulated by medical associations and their political engagement. Engaging with medical societies' views regarding midwifery, then, allows us to see the ambivalence that plagued the profession and its many contradictory responses to the "midwife problem." This comes as no surprise given that the doctors setting the status quo directly competed with others who dedicated their livelihoods to professional care, even though lay practitioners like the midwife had become less threatening since the hospital became a more familiar and trustworthy institution to the majority of urban

---

[79] *Lincoln Hospital: Thirty-Eighth Annual Report, 1938,* North Carolina Collection, University of North Carolina at Chapel Hill. https://docsouth.unc.edu/nc/lincoln38/lincoln38.html.
[80] *Lincoln Hospital: Thirty-Eighth Annual Report.*

dwellers. What remains striking, however, is that despite the authority that medical associations and reputable hospitals had been able to consolidate over the course of the century, by the mid-1950s, the vexations provoked by medical knowledge made and practiced outside of the establishment persisted, conveying some semblance of insecurity. In the case of obstetricians, this manifested in the content highlighted in the American College of Obstetricians and Gynecologists'(ACOG) agenda for their December 1959 Executive Board Meeting.

Both the Meeting's opening and closing remarks alluded to the prevalence of the "midwife problem" in 1959. The first document for the Executive Board to discuss was the report from the College's Committee on Maternity Nurses. Although obstetricians had asserted their capabilities in the delivery room, here they acknowledge the merits of having professionals focused less on the medical nuances of childbirth but rather on the personal experience of the laboring mother. This had been part of the midwife's role during childbirth before her expungement from a position of legitimacy. Rather than welcome her and her more personable approach to delivery back into the limelight, obstetricians favored a discipline over which they already had the upper hand via the medical hierarchy: the nursing profession. The Committee on Maternity Nurses would report back to the ACOG that having nurses who specialized in maternity would behoove the entire profession. However, the stipulations that followed included a recommendation that "the ACOG should stimulate the addition of a national association of obstetrical and gynecological nurses within their own framework."[81] Medical associations allowed the white men in charge of the medical establishment to continue to assert their control. By asking maternity nurses to adopt this system, they ensured that their mechanisms of power

[81] "ACOG Agenda Material for Executive Board Meeting," December 11, 1959, MC0031, Box 4, Francis Bayard Carter Papers, Duke University Medical Center Archives, Durham, North Carolina. (hereafter cited as "ACOG Agenda Material")

held jurisdiction over a less established and less scientifically oriented practice, and notably, one that had historically been run by women.

The midwife question differed because of the connotation of midwifery as an autonomous practice, not governed by medical associations and legislation. This comes through in the final point on the ACOG's meeting agenda relaying information from the Committee on Nurse Midwifery's meeting held several months prior. Nurse-midwifery existed with the non-unanimous blessing of a select number of obstetricians who supported the MCA, FNS, and the nurse-midwives both institutions graduated. However, the thought of allowing the practice to exist in the mainstream, not just tend to the country's most vulnerable and isolated, caused strife. Even though nurse-midwives needed a nursing degree from a recognized institution, just the name "nurse-midwifery" gave members of ACOG, the discipline's governing body, pause. Although "it [was] a belief of the Committee that there [was] a need in the general organization of obstetrical care in America for nurses with at least an additional twelve months of approved special training," any sort of midwifery, a nurse-midwife or otherwise, "produced a very unsatisfactory reaction from the majority of the physicians of the country."[82] Thus, the Committee concluded that the nomenclature from the archaic practice should not seep into the doctrine of the medical profession. Rather, nurses with additional maternity training should be called "certified obstetrical assistants." The practice of lay midwifery, moreover, remained a practice to which the ACOG wanted to "go on record as unalterably opposed."[83] Nurse-midwifery existed within the confines of the medical establishment, lay midwifery did not despite the best attempts of state licensure. Even as physicians realized that their impersonal

[82] "ACOG Agenda Material."
[83] "ACOG Agenda Material."

practices had become too sterilized for the liking of America's women, and they needed to circle back to a demeanor once written off as unprofessional, harkening back to their predecessors who had worked in this vein, proved unpalatable. Despite doctors' best efforts, and their cooperation with the apparatuses of the state, midwifery and less institutionalized forms of maternal care continued outside of the hospital.

Sowing the Seeds of Resistance: Behind Duke's Shadow

Childbirth in the middle of the twentieth century comprised many paradoxes. On the one hand, moving labor out of the home and into the hospital finally showed the health outcomes that medical professionals had promised by the 1940s and 1950s.[84] While infant death had increased in the initial decades of hospital births, the mid-century saw a precipitous decline. Doctors credited this to better medical education, routinization, and the introduction of new antibiotics.[85] But along with this standardization came procedures dictated by improving efficiency; the patient's humanity became all but an afterthought as birth became a medical emergency in need of expert intervention.[86] Not only did this fail to acknowledge the patient's experience in the medical understanding of childbirth but it also gave rise to a rigid hierarchy within the hospital. Consequently, the middle of the century saw both the solidification of the hospital as the site of birth but also witnessed voices of protest to the new status quo, from mothers and doctors alike.

---

[84] Wertz and Wertz, *Lying-In,* 164.
[85] Werz and Wertz, 164.
[86] Wertz and Wertz, 167.

Mid-Century Lay Midwives: Fact and Fiction

Durham, like the rest of the country, saw a decline in infant and maternal mortality and morbidity and a dramatic increase in the number of births that occurred in the hospital. With the opening of the DUMC in 1930, the number of doctors in Durham increased by fifty-five percent in the first five years.[87] And while the effects permeated Duke's hospital, the consequences rippled across the city's other networks of care. In Lincoln Hospital, for example, the number of births recorded in the building's maternity ward grew considerably. Between 1931 and 1940, the number of births remained below 150. However, by 1945 Lincoln delivered 267 babies and 463 just two years later, in 1947.[88] The number of births remained around 400 through the 1950s, reaching 529 in 1959.[89]

Along with the change in the quantity of births at Lincoln, new protocols changed the experience of the birthing process. While it is hard to reconstruct these shifts, comparing the documentation of births in the early-1900s to that of the mid-1900s, provides insight into the Hospital's changing priorities. While the birthing logs from the 1920s contained scant information—just the mother's case number and her name—organized with no discernible pattern, by 1930 the logbooks cited which kinds of obstetrical tools had been used, the name of the attending doctor and nurse, as well as any abnormalities observed in the perinatal period.[90] A similar shift in the level of detail recorded about each birth is legible in the delivery room records kept by Duke's Department of Obstetrics. Here too, the increasing interventions used to care for laboring mothers can be seen with the striking number of cesarean sections that began to litter

---

[87] The Duke Endowment. *The Duke Endowment: Fifteenth Annual Report of the Hospital Section, 1939.* (Charlotte: The Duke Endowment, 1939), 18.
[88] "Lincoln Delivery Room Records."
[89] "Lincoln Delivery Room Records."
[90] "Lincoln Delivery Room Records."

the pages of the delivery records in the 1940s and became more and more numerous each year.[91] On a national scale, the medicalization and standardization of birth as a hospital-based experience led to a drastic reduction in maternal deaths: while one in every 500 women died during childbirth in the mid-1930s, by the mid-1950s the rate fell to one in 2,000.[92] These statistics were perceived as testament to the increasing use of doctors during labor.

Public conversations about childbirth went so far as to say that midwife was all but obsolete given the prevalence of medicalized births. Of course, records from Lincoln in 1938 suggest otherwise as do the subtext of local newspaper articles. While the 1953 article cited at the beginning of this chapter and other Durham newspapers relegated lay midwives to no more than a memory of bygone times, what goes unsaid offers analysis as rich as the diction they employ; articles that perpetually addressed the "midwife problem," attest to its persistence. Problems need not be solved if they no longer exist. I argue that while midwifery was certainly affected by the growth of the hospital, especially an influential medical system like Duke, reporting its annihilation is a demeaning oversimplification, and was likely a response to the "midwife problem" in of itself. Journal articles published by doctors in the middle of the century spoke to the persistence of lay midwifery in the South. While the growth of the hospital had made the end of midwifery a possibility, this end goal had not been reached: "Although great strides have already been made in safeguarding mothers and infants, opportunities still exist for further progress, particularly in the rural areas of the South. Fortunately, the prospects are that the situation will continue to improve as the public health and hospital building programs go

---

[91] "Obstetric Delivery Logs," 1932-1949, AR.0049, Department of Obstetric and Gynecology Records, Duke University Medical Center Archives, Durham, North Carolina.

[92] Jeffrey Nall, *Feminism and the Mastery of Women and Childbirth: An Ecofeminist Examination of the Cultural Maiming and Reclaiming of Maternal Agency During Childbirth* (Palo Alto: Academica Press, 2014), 53.

forward."[93] Yet, in Durham the public heard a different story, one in which public health initiatives and the hospital had left little room for "progress," at least according to the voice of the public and the authoritative declarations to which they were exposed.

1938 marks the last year that the Durham City Directory included "midwifery" as an occupation by which you could identify residents. Sarah Johnson, in 1938, became the last of the three black midwives who had been listed in 1935 to make a public appearance in the census data.[94] However, to assume that the practice itself disappeared with its recognition in the directory would prove remiss. Midwives practiced in Durham after 1938 because, only twenty years later, Durham stopped issuing licenses to midwives in 1953. To mark the end of the legal practice of midwifery, the *Durham Herald-Sun* published a tribute to the profession's last member: Mrs. Estell Laws, a local black woman.[95] Nearly two decades after the profession no longer merited mention in official demographic documentation and the medical practice made a concerted effort to undermine home births, Mrs. Estell Laws wins public admiration as the last of her kind. This leaves the reader to wonder why the charismatic-looking woman featured in the paper needed to retire, and the historian to question how to reconcile the genial tone of the article aligns with hegemonic forces that had once ardently condemned Laws' profession.[96] Even before her forced retirement, her appearance in the City Directory portrays North Carolina's attempt to obscure her identity as a midwife, legal regulation was not enough. This invisibility of midwifery per demographic accounts accessible to the general public that came nearly twenty years before

---

[93] Paul Jacobson, "Hospital Care and the Vanishing Midwife," *The Milbank Memorial Fund Quarterly* 34, no. 3 (July 1956): 253-262. https://www-jstor-org.proxy.lib.duke.edu/stable/3348527?seq=2.

[94] Durham, North Carolina, City Directory, 1935 (Durham, NC.: n.p.. 1938), page 339, entry for "Midwives," *Ancestry.com*, https://www.ancestry.com/discoveryui-content/view/1146396800:2469?tid=&pid=&queryId=0e6ea8130004e5908570bb1c5d3dc5da&_phsrc=fQN2&_phstart=successSource.

[95] "Last Midwife Here to Lose Permit Jan. 1."

[96] "Durham's Last Midwife," *The Durham Morning Herald,* 07 August, 1952 (accessed 19 November, 2022).

the codification of its extinction in the eyes of the law, conveys a power in shaping public perception through records and stories that fail to narrate a whole truth.

While Laws exists in the Durham City Directory and Federal Census entries, her profession is notably absent. Identified as a black resident of Durham for at least the past five years, the rest of the entry portrays her in a different light than the *Herald* article's professional feature. According to the 1940 Census, thirty-five year old Laws left school after the third grade and had no job or source of income to her name.[97] Rather, she relied on her husband James Laws, a stoker whose education had not surpassed an elementary level, to support her and their three-year old son.[98] The location of their rental home in a neighborhood surrounded by African Americans, Russian immigrants, and white working-class laborers, suggests that their financial situation was less than sound.[99] However, *The Durham-Herald* offers an alternate reality. It shows a smiling Laws wearing a nursing uniform and glasses, a portrait which showcases a friendly yet wise woman. The content of the feature adds to this image by portraying her as a savvy businesswoman who "has the field [of midwifery] to herself" and a kind-hearted citizen who adopted "the first baby she ever delivered" after his birth mother died. The syntax is vague enough that the mother's cause of death remains a mystery; the fact that Laws kept the baby and went on to deliver two hundred and eighty-seven other children over the course of her ten year career, suggests she was not implicated in the mother's death.[100] However, it is noteworthy that

---

[97] U.S. Federal Census, 1940, entry for "Estelle Laws," *Ancestry.com,* https://www.ancestry.com/discoveryui-content/view/154788360:2442?tid=&pid=&queryId=977581361100db72afe1472b98074bae&_phsrc=HHY2&_phstart=successSource.

[98] U.S. Federal Census, 1940, entry for "James Law," *Ancestry.com,* https://www.ancestry.com/discoveryui-content/view/154788356:2442.

[99] U.S. Federal Census, 1940, entry for "Estelle Laws," *Ancestry.com,* https://www.ancestry.com/discoveryui-content/view/154788360:2442?tid=&pid=&queryId=977581361100db72afe1472b98074bae&_phsrc=HHY2&_phstart=successSource.

[100] "Durham's Last Midwife," *The Durham Morning Herald,* 07 August, 1952 (accessed 19 November, 2022).

public mention of midwifery is followed by some story of mortality. A follow-up article nearly six months later again extols Laws as a "proficient" practitioner while simultaneously commending Durham for differentiating itself from other part of the South in which Laws would have practiced in good company.[101] Laws and her predecessors "have done a good job—their record is clean. American history will list their calling among the significant occupations which passed from the scene in the 20th century."[102] The admirable spirit in which midwifery is recalled marks a stark contrast to the harsh condemnation of the practice found in earlier journalism and even contemporary medical discourse. However, even the article defines midwifery as a figment of the past, something antithetical to progress and modernity. Thus, it is a practice with no place in Durham given the city's purported status as "a medical center with ample doctors and hospital facilities."[103] According to the article, midwives existed as an archaic steppingstone that preceded the hospital. As midwifery shrunk in Durham, public perception of it could show some semblance of gratitude for what the profession did well given that its threat to the medical establishment dwindled.

Escaping Duke Health: Private Practice outside of the Hospital

Just as the hospital's power solidified, some of the doctors within the hospital expressed grievances at their own lack of autonomy. This side of the story elucidates the gender dynamics that occurred within the medical establishment as well as the financial conflicts which changed the landscape of care in the middle of the century. Pertinent to the conversation of reproductive and maternal care is the career of Dr. Eleanor Easley, a Duke-trained physician who founded the

---

[101] "Practice of Midwifery Has Been Terminated in Durham County," *Durham Morning Herald,* April 26, 1953. https://www.newspapers.com/image/790434905/?terms=midwife&match=1. (accessed November 19, 2022).
[102] "Practice of Midwifery Has Been Terminated in Durham County."
[103] "Practice of Midwifery Has Been Terminated in Durham County."

Durham Women's Clinic while still maintaining ties with Duke's hospital and medical school. While not as alternative as lay midwifery, and still embedded in the medical establishment, this institution proves an interesting case study in the gendered analysis of hierarchies within American medicine as both providers and patients in the Clinic constituted women seeking means of evading the male-dominated hospital setting while still reaping the benefits of a biomedical approach to care.

An Ohio native born in 1907, Easley became the first female graduate of Duke's four-year medical school in 1934. She remained in Durham for the duration of her career, becoming the first female resident to work at Duke University Medical Center.[104] During this time, she later remarked, "being a women physician was considered barely one stage more desirable than leprosy. Nobody wanted us. I saw I couldn't afford to make many mistakes and needed to have *good* training."[105] Unlike midwives, Easley's skin color and association with a prestigious university allowed her through the door and into the medical establishment. However, once inside she still had to fight in order to prove her worth, which meant acquiescing to definitions of competency as defined by the medical establishment: publishing papers, delivering healthy babies, and easing the pains of childbirth. While this was true of male physicians, Easley had to meet and exceed such expectations. It was only through hard work and diligence that she could overcome the stigma associated with her gender in a field that had been dominated by men. Gender discrimination even affected Easley's most intimate interpersonal relationships; her husband, a member of Duke's medical faculty, protested having his wife also become a colleague.

---

[104] "Eleanor Easley," Medical Center Library, accessed 19 November, 2022, https://exhibits.mclibrary.duke.edu/duke-women/women/easley-eleanor/.
[105] "No Time to Retire" article, 02 July, 1982, MC0061, Box 1, Folder 42, Eleanor B. Easley Papers, Duke University Medical Center Archives, Durham, North Carolina.

This rang true for Easley who claimed her reputation solidified in the wake of World War II.[106] It was during this time that she became the first practitioner, along with Dr. Richard Pearse, to establish a medical partnership in the state of North Carolina with the formation of the Durham Women's Clinic in 1941.[107] Moving outside of the hospital's hierarchy allowed Easley a degree of autonomy while retaining the legitimacy afforded by association with the medical establishment. The obstetricians at the Clinic had admitting privileges at Watts Hospital but would send at-risk patients to Duke Hospital given that all of the Clinic's doctors had appointments as clinical associates or clinical associate professors at Duke through the mid-twentieth century.[108] By extension, this meant that Easley and her colleagues at the Durham Women's Clinic oversaw the obstetric care of black women at Lincoln Hospital. Despite these continuing responsibilities within the University's hospital system, a later colleague of Easley's, Dr. Philip Pearce, attributes his desire to work with Easley in her private practice to the power dynamics made more prominent in the hospital schema: "I felt that being at Duke, to be in the hierarchy system, I would always sort of feel like I was under someone's thumb, and that did not appeal to me."[109] A clear association is drawn between working in Duke Hospital and a loss of independence as a practitioner. While these are Pearce's words and not Easley's we can only imagine that this sense of inferiority would have only been heightened for the female Easley.

Easley merits mention in discussion of the dynamic conversation between the medical establishment and the professions excluded from the discipline because her path represents a compromise of the two. The extent to which a compromise can be made on one's own terms,

---

[106] "No Time to Retire."
[107] "Eleanor Easley," Medical Center Library, accessed 19 November, 2022, https://exhibits.mclibrary.duke.edu/duke-women/women/easley-eleanor/.
[108] Philip H. Pearce, "Philip H. Pearce Oral History Interview," *Duke University of Obstetrics and Gynecology*, 2007, https://medspace.mc.duke.edu/concern/documents/g158bh80x?locale=pt-BR.
[109] "Philip H. Pearce."

however, is another question. This degree of autonomy allowed the Durham Women's Clinic to show up for its female clientele in a personal and conscientious manner that was not feasible in the hospital setting. Her practice's personalized care offered an alternative to the standardized birthing plans at Duke and Lincoln Hospitals. And while this connection appealed to her clients, it created tension between her private practice and Duke's medical empire. Economic factors mattered more as the Clinic's relationship with Duke became less amicable and, instead, began to breed competition. Pearce acknowledged this in the interview at the end of his career when speaking of his ambivalent relationship with Duke. As a graduate of the university and its medical school he felt allegiances to the Medical Center. However, when a "different chairman of the department" took over and told Pearce and Easley they "would be buried" unless they merged with the Duke system, Pearce's perception of the institution changed.[110] It became one which cared about the authority over people rather than the people themselves. In turn, Easley and Pearce had to reorient themselves and, in doing so, emulated some of the impersonal nature of the Hospital.

Conclusion

From the 1930s through the 1950s, the systems of medical care in Durham changed drastically. After the Duke University Medical Center opened in 1930, the county's most affluent had access to the technological advances and professional minds born out of the Hopkins school of thought and promoted as the gold standard of care via the Flexner Report and medical societies that sought standardization. In adopting more stringent expectations regarding medical treatments, the practitioners that lacked the resources to these same innovations—both material

[110] "Philip H. Pearce."

and ideological—struggled to prove their legitimacy. Obstetric care in Durham epitomizes this contradiction in which, on the one hand, the midwives outside of the medical establishment found themselves labeled as charlatans. Explicit discourse and implicit actions painted the midwife as a hindrance to childbirth rather than a help, from the institutional reports that publicly condemned the practice to the creation of alternative public health services created to make it defunct. On the other hand, the same hegemony that undermined midwifery barred those who benefited most greatly from the practice from accessing her successor: the obstetrician. The capacity to care for North Carolina's black population in a hospital setting was far below what the population merited. This was because of segregation in the state's most prestigious hospitals and the discrimination that bled into the material realities of those designed specifically for African Americans. Without offering a sufficient alternative, North Carolina's most distinguished voices in healthcare vilified those who did not subscribe to their biomedical standards.

However, reading this story as one of defeat negates the legacies of those who persisted against all odds and their valiant attempts to subvert the gendered and racial dynamics inherent in the hospital's hierarchy. While the Duke University Medical Center consolidated authority and monopolized the field of medicine during the mid-twentieth century, not everyone submitted to its jurisdiction despite what the historical record shaped by the Hospital would like us to believe. Black lay midwives, even if scant in number, continued to offer their services through the 1950s and a small subset of doctors recognized the autonomy they as professionals and their clients as patients could attain in the setting of private practice. Carving out areas of care between the home and the hospital allowed for a compromise between the kind of lay care deemed incomprehensive and the institutional care that had to answer to bureaucracy before

considering a patient's needs and wants. Here, we can examine the extent to which doctors with one foot in the medical establishment and one foot outside of its complete control, were able to exercise agency for themselves and, in turn, their patients; the connection between the practitioners privileged by society and the people they treat—or do not—becomes clear.

Chapter 3
'Beautiful, Lofty People': A New Outlook for 'Modern Midwifery,' 1960-1989

Less than a quarter-century after the Triangle's newspapers had bid an ambivalent adieu to the area's lay midwives, Phyllis Tyler of *The Independent Weekly* featured "Beautiful, Lofty People," a 1982 profile of the newest member of Durham Women's Clinic's staff: Nancy Carreras, a certified nurse midwife. As a Scottish native and nursing-school graduate, her background hardly emulated the prototypical "Granny midwife" who had inhabited the papers' pages in the decades prior. As the headline of Tyler's feature article promised, since the 1970s Durham witnessed the burgeoning of a new kind of midwifery, one intimately intertwined with the medical establishment. Unlike the legislation of the 1920s and 1930s that spoke to the ills of midwifery and the rhetoric of the 1950s that guaranteed its demise, Tyler highlights a newfound energy surrounding the genesis of midwifery.[1] How did a practice forced into extinction make a resurgence, and one supported by the very actors who had vilified it? I argue that the answer lies in the analysis of the identities of the women who became nurse midwives and the policies governing the field. As a white-dominated profession certified by and practiced in the very medical establishments that had defamed midwifery, this new branch of obstetric professionals offered an opportunity for doctors to respond to their patients' disenchantment with medicalization's dehumanization by providing a more personal component of care. Yet, the rapport fostered between a mother-to-be and her nurse midwife still operated under the

[1] Phylis Tyler, "Beautiful, Lofty People," *The Independent Weekly,* August 26, 1982. Eleanor B. Easley Papers, Box 1, Folder 42, Duke University Medical Center Archives.

jurisdiction of medical associations and hospital bureaucracies. The appropriation of midwifery saved the hospital but failed to resurrect the "Granny midwife."

The plethora of contradictions in Tyler's article point to the plethora of questions we must grapple with to understand the resurgence of midwifery in Durham in the 1960s and beyond. While rooted in feminist and anti-capitalist attitudes, nurse-midwifery also aligned with the institutionalization that the medical establishment had perpetuated over the course of the century. And while this appropriation may have seemed benign to Carreras' patients at the Durham Women's Clinic, the consequences were less neutral for those who no longer had access to the same "Granny midwives" as their mothers and grandmothers and could not afford the luxury of having a midwife and obstetrician working on the same team. Then, the story of midwifery's resurgence becomes one of class, gender, and race, and its consequences were felt differently by different groups of women. While nurse-midwifery addressed the grievances of middle- and upper-class women, particularly white women, it proved less advantageous for Durham's poor and marginalized groups.

The Birth of Discontent: Counterculture and the Women's Health Movement

While Kentucky's Frontier Nursing Service and New York's Maternity Center Association had introduced nurse-midwifery to the United States by the middle of the twentieth century, the practice garnered heightened interest by females across the country in the 1960s and 1970s. Rather than present a public health solution to the limited care available to those in Appalachia and the East Coast's poor immigrant communities, respectively, nurse-midwifery began to attract attention from white middle-class women no longer content with gender discrimination in the medical field and increasingly empowered to highlight such inequities.

Such a shift was only plausible against the backdrop of the decades' counterculture characterized by rebellion and the rejection of authority.[2] This sentiment encompassed social movements from civil rights to second-wave feminism, but in the field of healthcare, it was the liberal feminists' calls for reform rather than those of the more radical groups that found common ground with policymakers that ultimately translated into policy.[3] Thus, the acceptance of nurse-midwifery and concurrent rejection of lay midwifery and other community-based forms of care parallels broader social and political contradictions.

Civil Stirrings: Civil Rights, Reproduction, and the Moynihan Report in the 1960s

One of the most salient paradoxes of the 1960s was the widespread faith in expert opinion to resolve social ills alongside the rejection of the oppressive hierarchies upheld by existing hegemony. President Lyndon Johnson's Great Society promised to tackle the racial and socioeconomic inequalities that plagued the nation by leveraging the wisdom of venerated academics. Like his fellow liberals, Johnson believed that social scientists possessed the knowledge to guide policy decisions.[4] This belief manifested in the 1965 publication of the contentious Moynihan Report. In line with his administration's legislative commitment to civil rights, Johnson appointed the then Syracuse professor, Patrick Moynihan, to analyze the roots of black poverty following the passage of the Civil Rights Act and just before the Voting Rights Act.[5] The Report concluded that the disintegration of the nuclear family unit and its middle-class

---

[2] Mark Kurlansky, *1968* (New York: Random House Trade Paperbacks, 2005), xvii.; Wetz and Wertz, 218.
[3] Sheryl Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control* (New York: Praeger, 1978), 7.
[4] Daniel Geary, *Beyond Civil Rights: The Moynihan Report and Its Legacy* (Philadelphia: The University of Pennsylvania Press, 2015), 19-20.
[5] Geary, 20-29.

values lay at the core of the economic disparities that perpetuated racial inequality.[6] To treat what the Report had diagnosed, it cited the need for a male breadwinner to support his household and decreased reliance on welfare programs, which Moynihan believed prompted indolence. While analysis of the torrent of different responses to the Moynihan Report are beyond the scope of this thesis, two of its primary critiques by the public are of importance to our story. First, it provoked criticism of technocratic policies that allowed academics to prescribe solutions to problems from which they were far removed.[7] This pushback against self-proclaimed experts in the context of civil rights inspired other groups, like feminists, to question the status quo and the foundations of authority.[8] Second, its differential reception within the African American community, on the basis of class, gender, and race, problematizes an assumption of homogeneity within racial groups.[9] The source of several of these divisions stemmed from the Report's discourse regarding reproductive health and the woman's role within the family.

Although the Moynihan Report promised to address racial economic disparities first and foremost, many of its most fervent opponents *and* proponents responded to the Report's discussion of women's agency in reproduction, or the lack thereof. Finding a correlation between poverty and large families, Moynihan recommended voluntary birth control programs to encourage family planning. Demographers, like Hopkins' Margaret Bright, complained that Moynihan should have taken a stronger stance on this matter and encouraged welfare programs to make birth control a requisite for eligibility.[10] Lay Americans took these social scientists'

---

[6] Geary, *Beyond Civil Rights,* 88.; Kevin Mumford, "Untangling Pathology: The Moynihan Report and Homosexual Damage, 1965-1975," *Journal of Policy History* 24, no.1 (February 2012). https://doi.org/10.1017/S0898030611000376.
[7] Geary, 100.
[8] Kurlansky, xviii, 312.
[9] Geary, 157-9.
[10] Geary, 107.

suggestions to heart, leading many to believe that sterilization offered an apt solution to economic disparities and the more general threats posed by the counterculture.[11] However, while a 1965 poll of African American men showed that over one-fifth of them would favor a policy of forced sterilization, many African American women showed public contempt for policies they identified as coercive and oppressive.[12] While African American women contested the nonconsensual assaults on their abilities to procreate, feminist groups conceived the women's health movement to condemn their inability to prevent pregnancy—because of the hurdles in accessing abortions and birth control—and the discrimination they faced from doctors when pregnant.

The Feminist's Call to Arms: The Women's Health Movement of the 1970s

Just as government-sponsored family planning efforts targeting minority women peaked in the 1970s, this decade saw white feminists focus their efforts on their lack of access to the quality of care they craved, whether abortions, birth control, or gynecologic and obstetric care. Many of the white feminists writing at the inception of the women's health movement focused their efforts on their grievances with the professionalization and impersonalization of medical care. This transcended the doctor-patient relationship and included its mediation by the law. Legislation prohibited access to procedures like abortion while defining the spaces and actors that constituted acceptable care through licensure. Health care, in this context, was no longer a private, community matter but was regulated by the most public institution of all, the

[11] Geary, 106.

[12] Geary, 140.: In 1970, African American poet June Jordan published "Memo to Daniel Pretty Moynihan" voicing justified disdain for the implications of Moynihan's Report. In another public display of resistance, civil rights activist Pauli Murray coined the term "Jane Crow" to articulate the discrimination she felt as an African American woman subject to both the pervasive racism and sexism of the mid-twentieth century.

government. Moreover, it suggests the ease with which politics pervaded medical practice and the ways in which medical policy has been used to achieve social objectives, even if this means adopting seemingly antithetical practices.

While white feminists began to repudiate the political and economic motives of the care they received, embedded with the patriarchal perspectives of the time, the first iterations of these critiques prioritized gender discrimination without so much as mentioning the intersectional implications of the state of women's health care. Feminist authors like Suzanne Arms and Barbara Ehrenreich wrote histories of birthing practices which neglected to mention the place of race in these stories.[13] However, more recent scholarship which analyzes the feminist movement from a historical perspective maintains the race divisions that created different definitions of reproductive rights. Asserting that women of color desired "health care for the poor, child-care, and welfare rights in addition to anti-sterilization abuse efforts" unlike the white feminists who sought access to abortion and contraception, historical scholarship on reproductive health still tends to draw a binary in which white women and minority women have disparate objectives, overlooking the points of similarity and the nuances within groups deemed homogenous by race. While I do not question that many of the middle-class feminist calls for reproductive choice negate the experiences of less privileged women, my research considers the more dimensional framework proposed by sociologists Saraha Brubaker and Heather Dillaway. They identify three distinct problems with the medicalization of childbirth that oftentimes, but do not always, overlap: the usurpation of authority from the woman into the hands' of the practitioner, the

---

[13] Suzanne Arms, *Immaculate Deception: A New Look at Women and Childbirth in America* (Boston: Houghton Mifflin, 1975); Barbara Ehrenreich and Deirdre English, *Witches Midwives, and Nurses: A History of Women Healers* (Old Westbury: The Feminist Press, 1973): It is worth mentioning that Ehrenrecih has written seminal pieces on female medical care, some of which do mention race. However, this particular edition which speaks to midwives, has a notable lack of any discussion of race, or African American women's role in lay midwifery.

setting, and the prevalent use of medical technology.[14] By examining medicalization, particularly when it comes to reproductive care, through these three different lenses we are more equipped to understand the multitude of struggles that merit protest and the ways in which they may converge and diverge at different moments; it allows us to move beyond a reductive binary.

One of the most prominent actors driving the women's health movement was the Boston Women's Health Book Collective, Inc. One of its founders, Judy Norsigian, writing about the movement nearly half a century later, credits its genesis to the subversive culture of the 1960s. She and her colleagues had gotten their start as proponents of the civil rights and anti-war movements.[15] They were also of the generation inspired by Betty Friedan's 1963 *Feminine Mystique.* As Friedan questioned the demeaning notion that a woman's purpose lay in childrearing and domestic work, the Boston Women's Health Collective undermined the exploitative and inattentive work of men in the public sector, particularly when coupled with the intimacy and vulnerability of the medical arena—a moment in which the most private relationships, ones which dealt with the corporeal, became public in a clinical setting governed by impersonal and universal policies.[16] In response, the Collective launched a series of educational workshops to broaden the reach of the small-scale health seminars to women across the country and published their seminal book, *Our Bodies, Ourselves,* in 1970. Three years later, they signed with the reputable publishing house Simon & Schuster, bringing the women's health movement closer to the conscience of the American mainstream.[17] Offering information on

---

[14] Sarah Jane Brubaker and Heather Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," *Sociology Compass* 3, no. 1 (January 2009). https://doi.org/10.1111/j.1751-9020.2008.00183.x.
[15] Judy Norsigian, "Our Bodies Ourselves and the Women's Health Movement in the United States: Some Reflection," *American Journal of Public Health* 109, no. 6 (June 2019). doi: 10.2105/AJPH.2019.305059.
[16] Stephanie Coontz, *A Strange Stirring* (New York: Basic Books, 2011), 34.
[17] Stephenson Heather and Kiki Zeldes, "'Write a Chapter and Change the World' *How the Boston Women's Health Book Collective Transformed Women's Health Then—And Now*," *American Journal of Public Health* 98, no. 10. doi: 10.2105/AJPH.2007.132159.

women's health issues as written by ordinary females, the book operated on the principle that "there were no 'good' doctors and we had to learn for ourselves."[18]

While *Our Bodies, Ourselves* had an impressive influence on the general public, selling over three million copies by the close of the twentieth century, books with more concentrated audiences shared the sentiment of the Collective.[19] Two of these books, Barbara Ehrenreich's 1973 *Witches, Midwives, and Nurses: A History of Women Healers* and Suzanne Arms' 1975 *Immaculate Deception: A New Look at Childbirth in America* built on the core tenets of *Our Bodies, Ourselves,* but paid special attention to the sexism that permeated obstetrics.[20] Ironically, their critiques of "birth's machine age" and the obstetricians of the mid- to late-twentieth century, adopt some semblance of the technocratic and xenophobic institutional logic they endeavored to critique.[21] Most notably, while Ehrenreich and Arms both voice the merits of midwifery—and Arms even dedicated her text to "the midwives"—their nostalgic history of a bygone time when medicine was "part of our heritage as women, our history, our birthright," they solely offer a white, Eurocentric story that offers no mention of African or African American midwifery.[22] These three texts of the women's health movement convey the appropriation that began to happen when addressing the sexism within the delivery room. While revolutionary in their pushback against the medical patriarchy, these books suggest the subtle ways in which Black women were excluded from the women's health movement, and the extent to which their pivotal role in childbirth was hastily erased from mainstream feminist discourse.

---

[18] Boston Women's Health Collective, *Women and Their Bodies: A Course* (Boston: New England Free Press, 1970).
[19] Miriam Schneir, *Feminism in Our Time: The Essential Writings, World War II to the Present* (New York: Vintage Books, 1994), 352.
[20] Suzanne Arms, *Immaculate Deception*.
[21] Suzanne Arms, *Immaculate Deception*, 87.
[22] Arms, *Immaculate Deception*; Ehrenreich and English, Arms and Ehenreich, *Witches, Midwives, and Nurses*.

Given this debarment at the outset of the movement, it is no surprise that a similar disregard for minority women shaped the medical establishment's response to feminist discontent, particularly in the delivery room.

The Women's Health Movement Meets Durham: Race, Gender, and the Birth in the 1960s and 1970s

Durham adopted the spirit of the women's health movement relatively early. In 1974, the city opened its own Women's Health Cooperative founded on the belief that "it should be a woman's right to weigh cost and service factors before choosing a doctor or other health worker."[23] Durham's Women's Health Cooperative grew out of the local chapter of the Young Women's Christian Association (YWCA), a group meant to empower young women to fulfill their potential outside of the domestic sphere through education, work, and volunteering and active in Durham since 1920.[24] In 1976, the Cooperative became one of the first campaigns around which the previously segregated organization promoted conversation across racial lines.[25] Like the Boston Health Collective, the Durham Women's Health Cooperative felt that women had the potential to know more about their bodies than a male gynecologist or obstetrician ever could. Thus, the women behind the Cooperative occupied themselves by compiling lists of resources regarding abortion and birthing services in Durham and hosting self-exams for women

[23] "Durham YWCA Women's Health Cooperative" Pamphlet, n.d. R.L.11616, box 36, 1976-1978 YWCA Programs Folder, YWCA of Durham Records, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC. (hereafter cited as Pamphlet, YWCA of Durham Records).
[24] "The Open Door of the YWCA" Pamphlet, R.L.11616, box 35, YWCA Programs Folder, YWCA of Durham Records, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.; "YWCA," *Open Durham,* Preservation Durham, December 1, 2006. https://www.opendurham.org/buildings/ywca.
[25] Pamphlet, YWCA of Durham Records.

to explore their bodies.[26] They believed that shifting the locus of knowledge and authority regarding reproductive health was a means to liberate Durham's women.

Despite its rejection of the traditional hierarchy that dominated Durham's hospitals and clinics, the YWCA favored reform within these institutions rather than a radical restructuring of the delivery of care. The examples of this abound, but two are particularly germane to the question of childbirth in the 1970s. First, in May of 1976, the director of the Women's Health Cooperative, Suzi Woodard, exchanged correspondence with one of Durham's few female doctors at the time: Dr. Bailey Webb, a pediatrician who had graduated from Duke's medical school in 1946.[27] In these letters Webb expressed her concern that the Cooperative violated legislation that ensured only those with the appropriate licensure provided medical services. Woodard responded by outlining the other physicians and lawyers with whom the Cooperative collaborated, to build credibility by adopting the rhetoric of the medical establishment, before explaining that the Cooperative's services solely constituted community outreach that gave female patients the knowledge to act as "informed, assertive decision-makers instead of helpless victims of an often patronizing system" when visiting the doctor.[28] The doctor never came into question as a valuable part of the medical system, rather accepting his infallible authority proved the point of conflict.

Consistent with their qualms with twentieth century medicine's knowledge hierarchy over all else, the Cooperative rarely challenged the other two prongs of Brubaker and Dillaway's threefold constitution of the medical profession: setting or the application of medical

---

[26] Pamphlet, YWCA of Durham Records.

[27] "Dr. Bailey Daniel Webb Obituary."*Find A Grave,* accessed April 21, 2023, https://www.findagrave.com/memorial/29681165/bailey-daniel-webb.

[28] Correspondence between Dr. Webb and Durham Women's Health Cooperative, May 24, 1976, R.L.11616, box 36, 1976-1978 YWCA Programs Folder, YWCA of Durham Records, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.; Pamphlet, YWCA of Durham Records.

technology.[29] However, the second example of the Cooperative's collaboration with the medical establishment is the closest it came to doing so: in the spring of 1978, they circulated a questionnaire amongst their members asking about these women's respective perceptions of midwifery. Two nurse-midwives, Linda Glenn and Debbie Clendenim, in Durham's neighboring Chatham County hoped to open a practice within Chatham Hospital but they recognized their success depended on proving to the Hospital that there was adequate demand for such a service. To do so they advertised the merits of nurse-midwifery in local papers and solicited feedback from their readers. For Glenn and Clendenim, midwifery fit into the physical space of the hospital but with a more sparing use of technological intervention. Notably, much of their advocacy for nurse-midwifery built on its proximity to the medical institution. Glenn and Clendenmin asserted their professional credibility as graduates of nursing school who not only made it through the general curriculum but spent additional time studying obstetrics and passing a nationally accredited licensing exam. Moreover, a primary objective of their 1978 outreach lay in the mitigation of stigma surrounding midwifery; "they want to get people away from the popular but totally inaccurate image of the granny mid-wife who delivers at home without drugs or knowledge of medicine," a feature in the *Chatham County Herald*, and distributed at the Durham Women's Health Cooperative, explained.[30] Despite this clear association with medical doctors, Glann and Clendenim cited their work as nurse-midwives offered patients a unique opportunity for continuity of care and emotional support.[31]

---

[29] Brubaker and Heather Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences."

[30] "Chatham Hospital Considering Midwives," *The Chatham County Herald,* May 31, 1978, YWCA Records, box 63, *Chatham County Herald* from May 31, 1978. R.L.11616, box 59, 1976-1978 OB-GYN Articles Folder, YWCA of Durham Records, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.; Pamphlet, YWCA of Durham Records. (hereafter cited as "Chatham Hospital Considering Midwives," YWCA Records)

[31] "Chatham Hospital Considering Midwives," YWCA Records.

At the Durham Women's Clinic, Dr. Eleanor Easley had instigated a similar initiative. As *The Independent Weekly* article attested to, Easley had invited Nancy Carreras to join the Durham Women's Clinic to spearhead the city's first nurse-midwifery program in 1967. In search of fortifying the Clinic's pre-natal education, Easley found herself captivated by Carreras' personable approach to pregnancy upon their introduction at a conference hosted by the American College of Nurse-Midwives. Soon after, she hired Carreras to lead educational programs for expectant mothers. While unable to deliver babies herself, Carreras helped coach mothers through what they could expect on their due dates. According to Carreras, her primary job as a nurse-midwife lay in creating a space for women to assume an active role in the maternity care they received within an establishment that had increasingly privileged doctors' credentials over pregnant women's lived experiences of their bodies. In her words, "'it's malarky to tell a pregnant woman, 'just leave everything to us.'" Rather, Careers worked to carve out a space for women to both cry and revel in the experience of pregnancy, validating the wide spectrum of emotions she had seen childbirth evoke. While this sentiment—the hope to legitimize firsthand knowledge and allow this to work in tandem with professional expertise—contradicts the institutionalized sentiment of doctors in the twentieth-century, we must be wary of the extent to which Carreras and her seemingly progressive peers wished for doctors to cede their claims to mastery, whether conscious or not.[32] As with the nurse-midwives in Chatham, Carreras made clear that as a midwife, her role is part of the ensemble. The obstetrician takes center-stage. By encouraging expectant mothers to "'shop around for [their] babies' doctor,'" Carreras implies that modern midwifery will not emerge as an alternative to obstetrics, but rather an accomplice. And not just a henchman for the family doctor but the specialized and

[32]Tyler, "Beautiful, Lofty People," Eleanor B. Easley Papers.

increasingly commodified profession. After all, the diction she employs does little to belie its obvious capitalist connections: Carreras speaks as the product of an era in which the supply of doctors allowed for patients, if only those with the resources, to operate out of preference rather than availability. Second, she states her role as one of an educator and mediator. Unable to deliver on her home, or see patients outside of the Durham Women's Clinic, Carreras and her colleagues would collaborate with, rather than threaten, obstetricians. Nurse-midwifery became the handmaiden to modern medicine, and it separated itself from the 'Granny midwife" of the past.

Treating Dissonance: Official Responses to Critiques of the Medical Domain in the 1970s and 1980s

By 1982, Carreras worked alongside one other nurse-midwife and five of the Clinics' obstetricians. An article published by the *Duke Chronicle* that same year claimed that although Durham witnessed "increased demand from middle-class women for midwifery service[s]," Carreras and her colleagues at the Women's Clinic remained the only place in Durham where a woman could request the presence of a midwife during childbirth.[33] The article offered opposing perspectives on midwifery, which at once increased its demand but did so whilst rooted in professional's inclinations to condemn the practice. The professionals and policymakers who shaped medical policy conveyed this discordance, as *The Chronicle* expressed to young, academic members of the Durham community. On the one hand, the article celebrated Duke alumna Debbie Frank who had gone on pursue graduate study in nurse-midwifery as well as the

[33] Susan Deaton and Alison Seevak, "The Midwife: Old-fashioned Care Offers New Alternative." *Aeolus: The Chronicle's Weekly Magazine,* 77, no. 132 (April 1982): https://dukelibraries.contentdm.oclc.org/digital/collection/p15957coll13/id/22285/rec/1.

latest North Carolina legislation which legitimized nurse-midwifery as a valid practice. On the other hand, *The Chronicle* cited Duke professors and obstetrician Dr. Allen Killam's reservations towards the seeming increase in legal leniency towards paraprofessionals in a clinical setting. An assistant professor of nursing at the medical school proposed an additional explanation behind Duke's refusal to adopt its own midwifery program, as the Durham Women's Clinic had done, claiming that it strayed from the institution's interest in high-risk cases which attracted the most reputable doctors and thus a venerable reputation for the University and its hospital.[34]

The lack of unanimity amongst Durham's professionals regarding the place of midwifery in the medical establishment paralleled the incongruencies that existed at the national level discourse. While most scholarship written on nurse-midwifery offers a linear history of the profession, analyzing its acceptance and resistance in Durham complicates this narrative.[35] Understanding the moments in which nurse-midwifery was accredited, rejected, or begrudgingly acknowledged, elucidates the perceived merits and shortcomings of nurse-midwifery. This section, then, looks at the rhetoric surrounding nurse-midwifery in academic and policy circles in the wake of the women's health movement to appreciate why it became a viable means by which traditional medical authorities undermined by the women's health movement could pose a thoughtful response. Midwifery, once the problem, became a means of reconciliation.

---

[34] Deaton and Seevak, "The Midwife: Old-fashioned Care Offers New Alternative."

[35] The scholarship that gives a history of nurse-midwifery: Laura Ettinger, *Nurse-Midwifery: The Birth of a New American Profession (*Columbus: The Ohio State University Press, 2006); Jenny M. *Delivered by Midwives: African American Midwifery in the Twentieth-Century South (*Jackson: University Press of Mississippi, 2018); Deborah K. McGregor, *From Midwives to Medicine: The Birth of American Gynecology (*New Brunswick: Rutgers University Press, 1998).

Creating a Space in the Hospital: The American College of Nurse-Midwives and Schools for Prospective Nurse-Midwives

While nurse-midwives featured prominently into health care options of poor, urban New Yorkers and white working-class women in the rural South as early as 1918, these women did not operate under a standard set of protocols and regulation laid out by the medical societies that governed most specialties in the twentieth century and would come to guide the work of women like Durham's Carreras and Chatham's Glenn and Clendenim. Public health nurses, frustrated with their inability to exist as an entity distinct from the nursing profession, coined the universal definition of the nurse-midwife as a professional who "combines the knowledge and skills of professional nursing and midwifery." When the National Organization of Public Health Nurses and the American Nurses Association both refused to grant nurse-midwifery autonomy within the nursing profession, in both name and practice, the most fervent proponents of nurse-midwifery devised their own American College of Nurse-Midwifery in November of 1955. Just one month later they published the first edition of the *Bulletin of the American College of Nurse-Midwifery.* Although founded by women shunned from existing medical societies, the Association's operations—from the committees which established a shared mission and set of standards to the publication of scholarship that disseminated this foundational philosophy—adopted the logic of the traditional medical hegemony.[36] It follows that the educational path towards nurse-midwifery followed that of the nursing profession; rigorous training in certified schools proved a requisite of both professions as dictated by their respective regulatory bodies.[37] Education and legal regulation worked in concert to ensure conventional rules of behavior

[36] Black Hawk Hancock, "Michel Foucault and the Problematics of Power: Theorizing DTCA and Medicalized Subjectivity." *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 43, no. 4 (July 2018). https://doi.org/10.1093/jmp/jhy010E

[37] Ettinger, *Nurse-Midwives;* Wertz and Wertz, *Lying-In.*

upheld contemporaneous moral and political values.[38] As fears of nursing shortages sparked concern amongst public health officials at the University of North Carolina-Chapel Hill at the end of the 1960s and beginning of the 1970s, this same network of pedagogical and juridical regulation and accommodation catalyzed the prevalence and professionalization of nurse-midwifery.[39]

Just as academics in the Durham-Chapel Hill area established commissions to research a perceived decline in nursing personnel across North Carolina, the institutions certified to train nurse-midwives proliferated. While the temporality of these two phenomena are likely no more than coincidental, Durham's medical professionals quickly took advantage of the growth of schools for nurse-midwives, especially after the programs grew out of esteemed universities and university hospitals. Johns Hopkins' was the first such teaching hospital to launch a program when it welcomed students in 1956. University systems, including the California public schools, Emory, and Yale followed suit through the end of the twentieth century, with most programs launching in the 1970s.[40] While none of the universities in North Carolina adopted such a program, the Durham Women's Clinic cultivated a close association with Yale's nurse-midwifery program. By 1982, the other two nurse-midwives practicing at the Durham Women's Clinic in addition to Carreras were Yale graduates, and the Clinic routinely accepted enrolled

---

[38] Starr, *The Social Transformation of American Medicine,* 3-5.

39 Legislative Research Commission. *Report on the Shortages of Nurses and Other Medical Personnel in North Carolina* (Raleigh: North Carolina General Assembly, 1967) in the North Carolina History of Health Digital Collection, Health Sciences Library, University of North Carolina at Chapel Hill, Chapel Hill, NC. https://archive.org/details/reportonshortage00nort/page/2/mode/2up.

[40] Helen Varney Burst and Joyce Thompson, "Genealogic Origins of Nurse-Midwifery Education Programs in the United States." *Journal of Midwifery and Women's Health* 48, no. 6 (December 2003). https://doi.org/10.1016/S1526-9523(03)00348-9.

students to work in Durham for their field work.[41] However, these nurse-midwives could not have been more different than the lay midwives North Carolina had known earlier in the century.

While demographic information describing the identities of the women working as nurse-midwives by the 1970s is hard to come by, if feasible at all, it is likely that they were predominantly white given the racial disparities that persisted in medical education writ large and the feature articles describing them.[42] While medical schools across the country developed affirmative action programs to increase the number of Black students attending medical school, by the early-1970s, less than three percent of medical students were Black. More than fifty percent of these students attended historically Black medical schools, like Howard in Washington, D.C. or Meharry in Nashville, Tennessee; at predominantly white medical schools, the number of Black students enrolled tended to number less than two percent.[43] The statistics showed worse racial disparities at southern medical schools, like Duke and the University of North Carolina-Chapel Hill, which were slow to integrate.[44] And in the newspaper articles

---

[41] Easley papers, "Beautiful Lofty Women"

[42] Theresa Ann Sippe, Judith Dullerton, and Kerri Durnell. "Demographic Profiles of Certified Nurse-Midwives, Certified Registered Nurse Anesthetists, and Nurse Practitioners: Reflections on Implications for Uniform Education and Regulation." *Journal of Professional Nursing* 25, no. 3 (June 2009): 178-185). https://doi.org/10.1016/j.profnurs.2009.01.002. : Today, over ninety-five percent of nurse-midwives are white. And almost ninety percent of these practitioners have more than a Bachelor's degree.

[43] Jeff Magalif, "Black Students Comprise 2.8 Per Cent of Enrollment at U.S. Medical Schools," *The Harvard Crimson.* May 17, 1971. https://www.thecrimson.com/article/1971/5/17/black-students-comprise-28-per-cent/ (accessed April 21, 2023).; "A Half-Century of Progress of Black Students in Medical Schools." *The Journal of Blacks in Higher Education*, no. 30 (Winter 2001): 28-31. https://doi.org/10.2307/2679066.

[44] "A Half-Century of Progress of Black Students in Medical Schools;"; Jean Spaulding, "Jean Spaulding Oral History Interview," *Women in Duke Medicine Oral History Exhibit*, 2006, https://medspace.mc.duke.edu/pdfjs/reduced?file=%2Fdownloads%2F3197xm44h%3Flocale%3Den&locale=en: In an oral history interview with Dr. Jean Spaulding, she describes the blatant racism she faced in the medical school as the first female African American to graduate from Duke University School of Medicine. Having come from Columbia University, Spaulding remembers moving to Durham as a trip back a hundred years." Although the university was in the midst of addressing racial issues made visible by the takeover of the Allen Building in 1969, she remembers members of the medical school's admissions committee questioning why they should give her a spot in the class because she was a woman who would inevitably get pregnant and have babies. Even after overcoming the odds and matriculating, Spaulding remembers having professors whose cars were decorated with stickers of the Confederate flag and working in histology labs in which tissues were labeled as "white" or "colored." Beyond her minority status, Spaulding was one of just six females in her class of one hundred.

celebrating the genesis of nurse-midwifery in North Carolina, all of the women featured are white. Moreover, the authors of such articles went to great lengths to divorce nurse-midwifery from granny-midwifery. Not only did Carreras' feature assert that "the granny-midwives in [North Carolina] died off," but academic scholarship suggested similar differences between the State's history of midwifery and its experience of it by the late-twentieth century.[45]

Two certified nurse midwives, Judith Bourne Rooks and Susan Fischman, pursuing advanced degrees from the University of North Carolina's School of Public Health surveyed the practices and practitioners of nurse-midwifery in the United States between 1976 and 1977 as part of their graduation requirements.[46] The titles following their names at the beginning of the article, CNM, MPH, and DrPH, already convey the assimilation of nurse-midwifery into the medical establishment—it became a title used to convey authority and communicate the completion of years of training and education in the discipline—a marked departure from the naivety that the term "granny midwife" conjured. The content itself shared a similar sentiment; the final sentence of the study defined nurse-midwifery as:

> Blending practices and concepts from English midwifery, American nursing, and American medicine, current nurse-midwifery practices are well-suited to meet the needs of women who want few children, want to be intelligent participants in their own maternity care, and want to be cared for in systems which guarantee access to specialized services when needed.[47]

Without mention of the lay midwifery which prevailed in North Carolina no less than seven decades prior, Rooks and Fischman indisputably position nurse-midwifery as a facet of the

---

[45] Tyler, "Beautiful, Lofty People," Eleanor B. Easley Papers.

[46] Judith Rooks and Susan H. Fischman, "American Nurse-Midwifery Practice in 1976-1977: Reflections of 50 Years of Growth and Development," *American Journal of Public Health* 70, no. 9 (September 1980): 990. DOI: 10.2105/ajph.70.9.990.

[47] Rooks and Fischman, 990.

medical system, founded upon the erudition of technology and predominantly white institutions. And yet, it still promised a less medicalized birth than that condemned by the feminists of the women's health movement—it offered the best of all worlds. Rooks and Fischman credit this new conception of midwifery by the public with its marked rise in the 1970s, increasing from 275 practicing in the United States in 1963 to 1,723 nurse-midwives by the time they published their article in 1977.[48] As medical professionals, from New Haven to Durham to Chapel Hill, embraced nurse-midwifery as a non-threatening means to combat the hypermedicalization of childbirth, policymakers underwent a similar change of heart.

Legitimizing Nurse-Midwifery through the Law: House Bill 695 and the Midwife Regulation Act, the Early-1980s

By 1977, North Carolina was one of six southeastern states that employed eighteen percent of the country's nurse-midwives, the largest concentration of such professionals outside of the Northeast.[49] Accordingly, North Carolina law had had to renege on its past ban on the practice of midwifery, adopting the medical rhetoric which saw nurse-midwifery as wholly distinct from the granny midwives the State had outlawed just two decades before. This manifested first in House Bill 695 presented during the 1981 session of the North Carolina General Assembly and later in the Midwifery Practice Act of 1983.[50]

---

[48] Rooks and Fischman, 991.

[49] Rooks and Fischman, 994.

[50] Midwifery Practice Act, § 90-178 (1983); *An Act to Study and Regulate the Practice of Midwifery in North Carolina,* H.B. 695, Chapter 676 (1981).; North Carolina General Assembly, *Journal of the House of Representatives of the General Assembly of the State of North Carolina (*Winston-Salem: Winston Printing Company, 1981), In the North Carolina State Documents Collection, State Library of North Carolina, Raleigh, NC. https://digital.ncdcr.gov/digital/collection/p16062coll9/id/37720/rec/1.

The former, the House Bill, presents a curious contradiction given its stringent definition of the bounds defining acceptable midwifery practice while considering that this could occur outside of the confines of the hospital, a statement never alluded to in the rhetoric surrounding midwifery by academics and doctors. The State Legislature asserted that only those with a "permit granted by the Department of Human Resources and also being under the supervision of a physician licensed to practice medicine" could assume a role in the delivery room. The Legislature reserved eligibility for such licensure to those "who [had] been certified Nurse Midwives by the American College of Nurse-Midwives.[51] The State and medical societies worked together to define the bounds of legitimate medicine—a boundary drawn based on allegiances to the university's principal role in disseminating biomedical knowledge and offering practical experience. The hospital, like the medical societies, like the American College of Nurse-Midwives, cultivated a distinct hierarchy of knowledge in which the professor held authority over his pupils and the doctor over the midwife. The only departure from this logic was in the Bill's brief acknowledgement of lay midwifery—the first time public writing related nurse-midwifery to lay midwifery since the 1950s.[52] Along with the North Carolina Board of Medical Examiners, the North Carolina Board of Nursing, the North Carolina Commission for Health Services and obstetricians and public health officials operating within the state, the Bill tasked the Secretary of the Department of Human Resources to compiling research on the safety of births outside of the hospital. The results were to be presented two years later at the 1983 Session of the General Assembly.[53]

---

[51] *An Act to Study and Regulate the Practice of Midwifery in North Carolina,* H.B. 695, Chapter 676 (1981).
[52] Katy Dawley and Helen Varney Burst, "The American College of Nurse-Midwives and Its Antecedents: A Historic Time Line," *Journal of Midwifery and Women's Health* 50, no. 1 (December 2010): 16-22. https://doi.org/10.1016/j.jmwh.2004.09.011.
[53] *An Act to Study and Regulate the Practice of Midwifery in North Carolina,* H.B. 695, Chapter 676 (1981).

Including lay midwives as stakeholders necessary to make thoughtful recommendations regarding midwifery, North Carolina's General Assembly grants these women more agency than had been seen to date. First, the diction suggests that lay midwives still existed within North Carolina, even if their practice was invisible in the eyes of the law. Otherwise, it would have been impossible to solicit the opinions of such women. Second, while their mention reads as little more than an afterthought, the fact lay midwives were included alongside governing bodies and medical practitioners with presumed authority implies that lay midwives had some semblance of wisdom to offer in determining the efficacy of out-of-hospital delivery. It is impossible to know what exactly liberated the lay midwife from an exclusively ignorant depiction in bureaucratic circles in 1981. One possibility is that these women constituted part of the citizenship with "strong interest in out-of-hospital delivery," and which the General Assembly wanted to better understand.[54] Regardless, by the onset of the 1980s, North Carolina policymakers had realized that hospital births did not have as universal appeal they did amongst professional circles earlier in the decade, especially in the wake of the women's health movement which proposed that childbirth and the hospital were not inevitably bound together. As with medical diagnosis and scientific discovery within the university, the government turned to empirical studies to address their questions: calling upon an esteemed member of the state government, the Secretary, to make recommendations based on methodical research.

This research on midwifery, then, informed the conception of the 1983 Midwifery Practice Act. While the 1981 House Bill had contemplated the possibility of legalizing out-of-hospital births, the Midwifery Practice Act dismissed this chance to exercise maternal autonomy during the birthing process. In many ways, the Act narrowed the domain of nurse-midwives. It

---

[54] *An Act to Study and Regulate the Practice of Midwifery in North Carolina,* H.B. 695, Chapter 676 (1981).

offered a new definition of midwifery as providing neonatal care, excluding that which could be construed as the role of a doctor or nurse. Instead, the Act listed specific scenarios in which the midwife could legally participate. These responsibilities included the physical assessment of the newborn and the administration of vitamin K and eye prophylaxis immediately following delivery. Most of the midwife's tasks, according to this Act, included educating the mother on "interconceptional care." Twice the Act mentioned the midwife's duty to instigate conversations on family planning with their clients. And despite the skills that more closely paralleled social work than medical practice, the Act required all licensed midwives pay annual fees to the North Carolina Medical Board. While midwifery practice remained highly regulated and subordinate to other medical and paramedical professions, as it had in the mid-twentieth century, North Carolina leveraged the power of the law to formally place midwifery into the medical establishment but at the bottom of its hierarchy.

Analyzing the evolution of North Carolina's legal regulation of midwifery conveys the ties between medicine, the state, and social hegemony. This legal facet of midwifery's history subverts the notion that the medical practice can be divorced from politics and policymaking, particularly in the twentieth century United States. Moreover, examining the "web of entanglements" and contradictions that facilitate dynamic state and federal policies, offers a reflection of the political, social, and economic factors that drive apparent "sites of contradiction and conflict."[55] Examining the legislation that altered the place of midwifery in North Carolina suggests the ways in which the transformation of medical practice helped shape the judicial reality, while examining the socio-medical landscape of the 1980s suggests how the law, in turn,

[55]Majia Nadesan, *Governmentality, Biopower, and Everyday Life* (New York: Routledge, 2008), 4.

reinforced broader social and economic endeavors through medicine. With midwifery, as with other fields of medicine, the networks of care inform the law and vice versa.

The Handmaiden: Modern Midwifery's Role in the Economic and Social Discourse Surrounding Reproductive Health

Just as the Midwifery Practice Act advertised midwifery as a means of increasing health literacy in North Carolina, nurse-midwives across the country reflected upon their work as a means of community outreach more so than obstetric practice. The same scholarship on nurse-midwifery that came out of the University of North Carolina-Chapel Hill's School of Public Health in the late 1970s, applauded nurse-midwives as "leaders in maternal and child nursing and public health."[56] And forty-nine percent of the nurse-midwives the study surveyed had never used their degrees to work in clinical practice, primarily out of the lack of jobs available or the scant salaries such jobs paid. Instead, nurse-midwifery practice included "a broad spectrum of women's health care," with the greatest number of nurse-midwives providing family planning services.[57] Most of these services occurred in the hospital, but a 1977 survey conducted by the American College of Nurse-Midwives showed the other institutions employing these women, from public health agencies to private practices to prepaid health plans.[58] Considering the profound influence that politico-medico discourse had in shaping nurse-midwifery, it seems unsurprising that the profession assumed a role that addressed the economic and social dialogues that had enveloped medical practice by the end of the twentieth-century.

---

[56] Rooks and Fischman, "American Nurse-Midwifery Practice in 1976-1977: Reflections of 50 Years of Growth and Development," 991.
[57] Rooks and Fischman, 992.
[58] Rooks and Fischman, 992.

Economic Incentives: Increasing Profit, Decreasing Costs

The economic catalysts of nurse-midwifery exist as seeming opposites. Their point of reconciliation, however, lay in the response to the financial incentives of medical institutions; the goal, increasing profit, proved the same even if the methods to get there diverged. The commodification of nurse-midwifery appealed to middle- and upper-middle class women's plights as expressed in the women's health movement. Ironically, just as white feminists rebelled against the commodification of medical practices in traditional obstetric practices, the medical system lured them back in by commodifying the "natural" birthing practices for which they advocated.[59] As the number of nurse-midwives in practice increased, the demographics of their clientele shifted from poor women without the ability to pay for physicians or reach a hospital to those intrigued by the new commodities offered surrounding neonatal care. This was most typical in private practices, like the Durham Women's Clinic and comparable Clinics in the Northeast which attracted "well-educated, healthy, and highly motivated middle-class women."[60] Midwifery, once a threat, now allowed holistic care to become a commodifiable part of a capitalist system.[61] Nancy Carreras alluded to this in describing the appeal of nurse-midwives, like herself, to the Durham Women's Clinic's prospective patients: "I tell [expectnat women] they must not be intimidated by health-care personnel. You shop around for your butcher or your fish-monger—why shouldn't you shop around for your baby's doctor? I even tell [these women], 'If your doctor doesn't listen to you, that's reason enough for changing doctors.'"[62]Nurse-

---

[59] Brubaker and Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences;" Ruzek, *The Women's Health Movement,* 63.

[60]Carol Wood Nichols, "The Yale Nurse-Midwifery Practice: Addressing the Outcomes." *Journal of nurse-Midwifery* 30, no. 3 (June 1985): 159. https://doi.org/10.1016/0091-2182(85)90281-2.

[61] Ruzek, *The Women's Health Movement,* 63.

[62] Phylis Tyler, "Modern Midwifery," *The Independent Weekly,* August 26, 1982. Eleanor B. Easley Papers, Box 1, Folder 42, Duke University Medical Center Archives.

midwives, like Carreras, offered an emotional alternative to mass medicalization scorned by the women's health movement and the counterculture of the late-twentieth century. This appeal was then advertised by medical practices to present a desirable commodity for expectant mothers, advertising a product to a buyer the same way that a "butcher" or "fish-monger" would. This commodification transcended the Durham Women's Clinic: in 1971 only ten percent of American hospitals offered birthing and parenting classes for which women could pay while this was a near-universal service offered in hospitals and medical practices across the country by the beginning of the 1980s.[63] And by the 1990s, prominent insurance companies, like Kaiser Permanente, offered nurse-midwives to their clients free of charge. In Durham, she even constituted a full-time member of Kaiser's obstetric staff by the close of the century.[64]

At the same time, nurse-midwifery offered a means for medical practices, particularly hospitals, to save money by cutting their expenses—not just through attracting consumers. Mitigating obstetric financial losses had been a continual point of conversation amongst medical actors in Durham since the 1970s. Internally, Durham University Medical Center fixated on the costs of its obstetrical services epitomized by a 1974 report titled "A Study of Obstetrical Financial Losses." The document's self-proclaimed goal included determining contemporary costs of the abortions and deliveries occurring in an inpatient setting and proposing means of decreasing such costs.[65] Following national discourse that obstetric departments in hospitals operated on a deficit, the proponents of the study worried that Duke's Department of Obstetrics and Gynecology could have annual losses as high as one million dollars with each patient

---

[63] Ruzek, *The Women's Health Movement,* 222.

[64] Oral History Interview with Donna Barnes.

[65] John Richard Stanko, *A Study of Obstetrical Financial Losses at Duke University Medical Center* (Durham: Duke University M.H.A. Thesis, 1974), ii. David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.

causing an average of $251 in losses.[66] The main concern on the part of Dr. Stuart Sessoms, the Hospital's director, was that patients received care at a discounted rate for which they did not qualify in order to lure patients into the hospital, a tactic necessary in a bygone era when the medical establishment was still acquiring trust and legitimacy.[67] The recommendation, then, made by the supervising committee highlighted the importance of employing someone whose sole job it would be to screen Medicare and Medicaid patients on the basis of need.[68] While this particular report bears no mention of midwifery or nurse-midwifery, it conveys that medical establishments were beginning to see the need for practitioners outside of the physician to assist in an administrative capacity, especially as finances were concerned. Ironically, just as their solution offered more personalized care for patients, the discourse catalyzing this formed on the basis that patients were merely consumers promising pay, whether from personal accounts of those of their insurance companies, rather than people in need of care.

This vexation was felt outside of Duke University Medical Center and within other hospitals in the geographic vicinity. This most clearly comes through in the tone adopted by the Duke Endowment, the fund providing aid to many of North Carolina's medical facilities. At the time that the Hospital published its report on the financial profile of the Department of Obstetrics in 1974 supported 174 hospitals across North and South Carolina, a remnant of the Duke family's zealous affinity for philanthropy as a means to leave their parvenu behind in the nineteenth century and usher in the twentieth century with repute.[69] As mentioned in chapter one, the provision of healthcare became an obvious way to do so because it aligned with the family's

---

[66] Stanko, 2, 50.
[67] Stanko, 51.
[68] Stanko, 54.
[69] James F. Gifford, *The Evolution of a Medical Center: A History of Medicine at Duke University to 1941* (Durham, Duke University Press, 1995) 11.

need for a robust working class to man their factories while simultaneously offering a solution to the deplorable one to 1,250 patient to doctor ratio in the state in 1890.[70] However, one-hundred years later, the fund initially established to offer medical services to Durham's indignant struggled to reconcile their moral duty to the Southern institutions they had come to bolster with their a fiscal fear of excessive spending. At least, that is what the tone of the Endowment's records from the latter part of the twentieth century convey.

Each year the Endowment published statistics meant to measure the relative success of each one of the hospitals Duke supported. The results were measured against the average of all the hospitals, whether this be in terms of average percentage of beds occupied to the gross cost of each inpatient per day. However, the metric used shifted. In 1960, the emphasis of the report was on patient outcomes. Fatality rates introduced the rest of the hospital's profile while the number of stillbirths or abortions as a percentage of total obstetrical patients followed.[71] In the 1970 report, it was almost exclusively a financial summary that was used to profile each hospital. This included the expenses incurred and income generated by each patient as well as minutiae that hypothesized why profit may have been drained, tracking everything from the number of days charity patients remained inpatient to the number of hospital employees working relative to the number of patients.[72] The metric of success for the hospital seemed to shift from one judged by its propensity to deliver quality care to its ability to deliver any care in the least expensive way possible. And this is not mere conjecture. In 1976, Lincoln and Watts hospital, two of the sites

---

[70] Gifford, 15.

[71] Clinical Service Comparisons: October 1, 1960-September 30, 1961, Box HCCD 16, Misc. Clinical Comparative Hospital Statistics Folder, The Duke Endowment Archives, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.

[72] Comparative Operational and Departmental Indicators: October 1, 1975-September 30, 1976, Box HCCD 16, 1975-1976 Hospital Statistics Folder, The Duke Endowment Archives, David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.

the Endowment had subsidized from its inception, had to merge as neither could make it on its own. Thus marked the founding of the Durham County General Hospital, now Durham Regional Hospital, the result of Lincoln and Watts' merger.[73] Admittedly, the financial contexts of both hospitals cannot be adequately understood without remembering that the Civil Rights Act of 1965 would have made both of their goals obsolete: black patients, in theory, had healthcare options outside of Lincoln while Watts could no longer cater to a solely white clientele. Neither fared well with this shifting demographic.[74] Private institutions cared about their profits and it showed.

Thus, when Amy MacDonald, a nurse-midwife from Chapel Hill, proposed expanding a midwifery program to Duke University Medical Center in the 1990s, it comes as no surprise that she pitched her program, Centering Pregnancy, as a cost-effective way of caring for indigent patients. The program, a part of the Durham County Department of Public Health, sought to provide classes for pregnant mothers. Led by one of the three employed midwives, a cohort of women due around the same date would gather to speak to their shared experiences of pregnancy and fears of motherhood.[75] At the end of the day, the program was a tool used by the Health Department to reach women who may not have otherwise had sufficient prepartum care; the program brought in experts in a plethora of fields, offering everything from vouchers to allow for the purchase of nutritious foods at the Durham Farmer's Market to help securing housing. The impetus behind such holistic provisioning of maternal care was Durham's high infant mortality rate. When midwives assumed control of the sterile relationships Medicaid patients and women

---

[73] "Watts Hospital (1909-1980)." *Open Durham,* Preservation Durham, January 2, 2013, accessed April 21, 2023. https://www.opendurham.org/buildings/watts-hospital-1909-1980-north-carolina-school-science-and-math.

74 Preston Reynolds, *Watts Hospital of Durham, North Carolina, 1895-1976: Keeping the Doors Open* (Durham: N.C. Fund for the Advancement of Science and Mathematics Education in North Carolina at the North Carolina School of Science and Mathematics, 1991).

[75] Antoinette Milligan-Barnes Oral History Interview, 2022.

of color had with physicians all too often, the no show rate for obstetrical appointments dramatically decreased.[76] Writing grants to win Duke's cooperation with the Program, MacDonald emphasized two claims. First, that nurse-midwifery lowered neonatal mortality by thirty-three percent and second, that it reduced the burden of cost for hospitals by nearly thirteen percent.[77] Liking this success rate, Duke absorbed the Centering Program into its orbit. A cost-effective means of offering education and care to new mothers, nurse-midwifery became embraced rather than scorned.

Midwifery and Reproductive Politics: Abortion, Contraception, and Forced Sterilization

Beyond the financial factors, midwifery became a handmaiden in the medical profession's campaigns to assert control over reproduction as the practice's domain extended beyond childbirth to education and family planning. To neglect this part of the story would be remiss given that the focal point of our story has been North Carolina, a state with one of the most appalling assaults on reproductive rights. Its institutions, overseen by the North Carolina Eugenics Board in collaboration with the State Department of Public Health, enabled more sterilizations than forty-eight other states, most of which occurred after eugenics came into question at the conclusion of the second world war.[78] Although sterilizations declined after President Johnson's War on Poverty asserted the importance of the government in molding the nuclear family, the government exercised reproductive control via birth control through the end

---

[76] Antoinette Milligan-Barnes Oral History Interview, 2022.

[77] Amy MacDonald, Vanessa Lancaster, Barbra Roberman, and Deborah Meyer-Smith, "A Proposal to Expand the Nurse-Midwifery Service at Duke University Medical Center" submitted to the State of North Carolina's DHHS, Division of Women's and Children's Health (Durham: Duke University Medical Center, 2000), AR.0180, box 1, folder 6, Duke Midwifery Service Records, Duke University Medical Center Archives, Durham, NC.

[78] Randell Hansen and Desmond King, *Sterilized by the State: Eugenics, Race, and the Population Scare in Twentieth-Century North America* (New York: University of Cambridge Press, 2013), 242-3.

of the twentieth century.[79] Both neoliberals who thought that promoting a small, normative family would help alleviate social inequities and Republicans who feared widespread dependence on welfare, saw family planning as a tactic to further their aims.[80]

Historians who have researched the eugenics campaigns of the twentieth century claim the success of these programs required the coordination of doctors and state legislatures.[81] This claim, however, negates the cooperation of those on the receiving end; while forced sterilizations, by definition, offered no opportunity for women to resist hysterectomies, their ambivalent reception of other forms of contraception merits examination. Medical ethicist Harriet Washington explains that although some members of the Black community viewed contraception as a form of racial genocide, a significant number of Black women embraced the protection it conferred.[82] Although addressed by few scholars, nurse-midwifery's foray into family planning merits discussion given the trust it garnered amongst patients and practitioners alike.[83] Scholars have oft acknowledged that the expansion of medical jurisdiction translated to the consolidation of social control through medicine.[84] As nurse-midwifery became more deeply entrenched in this system, it too played an evermore prominent role in social engineering.

---

[79] Hansen and King, 245.

80 Geary, *Beyond Civil Rights*; Hansen and King, 246.

[81] Hansen and King, 270.

[82] Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial times to the Present* (New York: Harlem Moon, 2006), 200-201.

[83] Leslie Reagan, *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1967-1973* (Berkeley: University of California Press, 1997), 95-97, 122: Interestingly, while nurse-midwifery hasn't been discussed in the context of forced sterilization and family planning, historian Leslie Reagan drew a parallel between the anti-abortion movement and the assault on midwives, claiming that both were driven by the medical establishment in order to consolidate their sense of authority. Her work focuses on Chicago where many midwives were condemned for providing illegal abortions, oftentimes without evidence.

[84] Brubaker and Heather Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences.;" Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception,* trans. A.M. Sheridan (New York: Vintage Books, 1973).

Just as the women's health movement had been informed by feminist's conscience rejection of the sociopolitical milieu, cultural context elicited response's that preyed on the vexations of those existing within the medical establishment, often those privileged by traditional hegemony. Because the archive has been written and preserved by these same authorities—the doctors who leave their notes and the policymakers who laud their policies—it is hard to discern the extent to which nurse-midwifery facilitated coerced birth control amongst underprivileged women in North Carolina and the end of the twentieth century. By putting several of the stories left in the archives in conversation, however, we can paint a more complete picture.

In 1972, the revered *American Journal of Public Health* published an article co-authored by five physicians and two certified nurse-midwives: "The Nurse-Midwife as a Family Planner." The article's primary conclusion was that the number of obstetricians in the United States was inadequate to "deliver family planning services to 5,000,000 medically indigent women" and thus required additional practitioners to help with the cause. Nurse-midwives, they found, presented an expedient solution because of the comparatively lower salaries expected in the profession. Considering that most family planning programs, especially those offered at discounted prices or free of charge, targeted "the medically indigent in the ghettos and rural areas," medical institutions or local governments had to carry the costs.[85] Bringing nurse-midwives into family planning not only advanced attempts to regulate reproduction but did so with the lowest possible financial burden.

This sentiment reverberated two years later in a speech delivered to members of the Duke and University of North Carolina communities in November of 1974. While articles like that in

---

[85] S. G. Kohl, G. Maljzlin, M. Burnhill, J. Jones, G. Solish, S. Okrent, and E. Pendleton, "The Nurse-Midwife as a Family Planner," *American Journal of Public Health* 62, no. 11 (November 1972): 1448-1450. doi: 10.2105/ajph.62.11.1448.

the *American Journal of Public Health* allow us to draw inferences about the role of midwifery, this speech drew an explicit connection between nurse-midwifery and population control. Speaking to this young, educated North Carolina audience, Germaine Greer spoke to the grave threat of overpopulation and its negative implications for health at a population level. The solution she offered privileged the midwife and her ability to earn the trust of her clients, especially in foreign cultures: "Contraception and abortion must become part of the lore of the country transmitted to the people by their own: by a familiar midwife rather than by an American whose white coat smells of antiseptics."[86] It was the alleged separation of midwives from the medical establishment that allowed them to best support it. Although unclear the extent to which midwives forced sterilization or pushed contraception on their clients, it becomes obvious that they had a large role in family planning efforts of the 1970s and 1980s, and that the trust they fostered with the patient became a relationship of which the medical establishment, in the United States or abroad, could take advantage.

Finally, the marginalized clientele of many nurse-midwives allowed for medical exploitation in one additional way, and all while under the guise of community outreach. In Durham, this story reached a precipice during the 1990s when community outreach became a central part of Duke Medical Center's focus. In 1989, North Carolina had one of the largest rural populations in the United State and they initiated programs to close the gap in the healthcare delivery provided in rural versus urban communities.[87] A component of these efforts included

---

[86] Miram Ehtesham and Melina Smale. "Overpopulation and Hunger: Cause and Effect." *The Duke Chronicle* 70, no. 51, November 8, 1974. https://dukelibraries.contentdm.oclc.org/digital/collection/p15957coll13/id/53596/rec/18 (accessed April 21, 2023).

[87] Mary Elizabeth Burkett, "The Tertiary Center and Health Department in Cooperation: The Duke University Experience," *Journal of Perinatal and Neonatal Nursing* 2, no. 3 (1989): 11-19, AR.0180, box 1, folder 6, Duke Midwifery Service Records, Duke University Medical Center Archives, Durham, NC

perinatal outreach programs in five counties within a thirty to seventy-five mile radius.[88] Such a program led to "the development of the existing relationship between Duke University and the health department's prenatal clinics," which included Centering Pregnancy, the campaign firmly founded on the merits of nurse-midwifery. Then, it is perhaps surprising that one of the goals of Duke's newfound perinatal programming was to provide more accessible alternatives to the lay midwife as a document circulated amongst the administration stated. The fact that nurse-midwifery became a solution to the lay midwife is a telling admission of their distinctions, especially in terms of their perception within the medical establishment.

The ulterior motive driving Duke's push for community outreach was that it gave the teaching hospital a population to serve as a classroom for obstetrical residents. The Medical Center saw the venture as mutually beneficial: it would "create a milieu for the education of future health care professionals in the context of delivering quality child health care in rural communities."[89] Although less abhorrent than during Sims' time, the rhetoric draws parallels to the use of indigent black and immigrant obstetrical patients as a means of experimentation during the incipient years of American obstetrics and gynecology. While nurse-midwives provided education to under-resourced communities, it becomes clear that this beneficence was not relegated to the women on the receiving end; the relationship such outreach programs fostered between rural communities and Duke's medical institution created a supply of patients that gave medical residents the experiences they needed to thrive in the profession. More than birthing assistants, nurse-midwives became handmaidens of larger political visions and mechanisms of capital gains.

---

[88] Burkett, "The Tertiary Center and Health Department in Cooperation."
[89] Burkett, 14.

Conclusion

If mid-twentieth century North Carolina saw a palpable disdain for midwifery, this could no longer be said just several decades later. In fact, policymakers, physicians, and those with purchasing power even seemed to usher midwifery back into the medical landscape, at varying paces, in the years following the 1970s. However, the extent to which this new practice—one characterized by community outreach and intimate ties to the state government and the private health practices operating within its jurisdiction—can be seen as a successor of midwifery is contestable. On the one hand, this new nurse-midwifery served as an extension of the medical establishment in a way that lay midwifery never had. And thus, it professionalized in a way that led many of the similarities between them to end with nomenclature. On the other hand, the medical establishment attempted to leverage the more individualistic and personable qualities of midwifery to appeal to those who were disillusioned with authority and the people forced to submit to an elite minority. Ultimately, this appropriation made nurse-midwifery part of the medical establishment that could reinforce the status quo and do so without protest because of its facade of congeniality.

Epilogue

While our story began with a young woman giving birth in her home in the presence of a midwife, decades later when her granddaughter Dianne Barre prepared for her own delivery, there was no question that the baby would enter the world from inside Durham Regional Hospital.[1] By 1993, Dianne's prenatal experience—routine check-ups with doctors, nurses, and certified nurse-midwives—proved no anomaly. Kaiser Permanente, the insurance plan she received as an employee of the University of North Carolina-Chapel Hill, promised that none of these appointments would require her or her husband to pay out of pocket.[2] What understanding the insurance policies and attending birthing classes could never have prepared her for, however, was the self-described traumatic experience that the delivery itself entailed.

When Dianne's water broke ten weeks ahead of her due date, she was rushed to Durham Regional Hospital where doctors met her with a torrent of medications. With the exception of an antibiotic, these came without the courtesy of an explanation of their commercial names or medical uses; she melded into one of the many cases to be treated by the ensemble of medical practitioners who quickly decided the infrastructure at Durham Regional proved inadequate to treat her and her premature daughter. The doctors transferred them to a more acute facility at the well-funded University of North Carolina Medical Center in Chapel Hill.[3]

---

[1] "Duke University Health System Timeline," Duke University Medical Center Archives, Duke University Medical Center, accessed April 2023, https://archives.mc.duke.edu/duhs_timeline.: Now known as Duke Regional Hospital, this institution opened its doors on October 3, 1976. It offered care for those who had been displaced following the closure of Lincoln and Watts Hospitals. As of 1998 it operated as part of the Duke University Health System. It proved the last major acquisition of the twentieth century by Duke University Medical Center and foreshadowed the establishment of the Duke University Health System later in the year.

[2] Dianne Barre, in discussion with the author, Durham, North Carolina, January 30, 2023.

[3] Dianne Barre Oral History Interview.

If Dianne's experience at Durham Regional was one of mayhem, her experience at UNC was one of heartache. The doctors there administered copious drugs despite her providers at Durham Regional had already done so. But her vexations lacked the credibility of the doctor's pen. The obstetric staff continued to prescribe medications before discharging her a week later. Her daughter remained in the ICU. It came as a shock, then, when Dianne used a lunch break to visit her infant child and was told she "was gone." Immediately, Dianne's thoughts jumped to the worst case scenario: she saw all the dreams of what motherhood had in store, those which had been so palpable mere hours before, evaporate into a world incongruent with her present reality. And although it turned out that her child had not died and this chapter had not closed as soon as it had started, it was hard to shake the feeling of loss.[4]

While Dianne was at work, Kaiser determined it would no longer pay for the exorbitant medical fees at UNC. UNC, unwilling to accept no pay for its services, transferred Dianne's daughter back to Durham Regional Hospital. While the two hospitals' finance departments negotiated the transfer with Kaiser, nobody thought to inform the patient's mother of the situation, no less solicit Dianne's thoughts on the situation. Rather, changes in the financial situation merited scripted actions be taken without consideration for the humans implicated by these procedures. And despite the emotional strife this transfer caused, Dianne is one of the lucky ones, for Duke Regional Staff discharged her ultimately healthy infant four weeks later. She went on to mature into a healthy young woman who now considers starting a family of her own. But the toll the lack of communication had on Dianne and her husband has been hard to shake.

[4] Dianne Barre Oral History Interview.

Dianne's delivery occurred in the 1990s, but even today we see the harrowing disparities in maternal and infant health outcomes. In 2021, the maternal mortality for black women like Dianne was 2.6 times greater than for that of their white peers.[5] While the overall mortality rates are lower across the board, this discrepancy is no better than it was in the mid-twentieth century. This forces us to consider that time does not directly translate to progress and that medical breakthroughs only treat the symptoms of infirmities enmeshed in political, economic, and social discourse.

In the history of childbirth in Durham, the class, gender, and racial dynamics bubbling under the surface of a purportedly harmonious city become apparent. Not only was discrimination baked into the physical architecture of institutions of care, but it was similarly maintained through the dissemination of knowledge which privileged empiricism and technological intervention over an intimate, material experience of the body. As medical professionals in the American South still sought to garner legitimacy in the eyes of the public at the beginning of the twentieth century, they questioned the credibility of all others who promised to deliver care. In the universal and thus lucrative domain of birth, lay midwives became an easy scapegoat. This assault became all the easier given its alignment with the racist logic that saturated the legal rhetoric and social hierarchies of the Jim Crow South.

Policy that vilified midwifery, and even rendered it extinct, only reversed course when the authority of the medical doctor again came into question—but this time because of the

---

[5] Donna L. Hoyert, "Maternal Mortality Rates in the United States, 2021," *NCHS Health E-Stats,* Center for Disease Control and Prevention, Accessed April 2023. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-; "Working Together to Reduce Black Maternal Mortality." Health Equity. Center for Disease Control and Prevention. Accessed April 2023. https://www.cdc.gov/healthequity/features/maternal-mortality/index.html. 2021.htm#:~:text=In%202021%2C%20the%20maternal%20mortality,for%20White%20and%20Hispanic%20women.

perceptible breadth of his influence, rather than his lack thereof. The anti-war, civil rights, and feminist movements of the mid-twentieth century questioned the grounds on which authoritative voices claimed power, a sentiment from which doctors were not immune. Only when midwifery became a means of addressing the technocratic and impersonal critiques of a cold and sterile discipline was it accepted by medical and public health professionals. And even then, so called modern midwives had to adopt the logic of the medical domain, from stringent policies on licensure to standardized pedagogical approaches. The result: nurse-midwifery, a practice appropriated by doctors and policymakers to advance their own political and economic agendas.

In illuminating this story of rejection and periodization, I do not intend to define medicine as maleficent, but rather, question our predisposition to accept it as objective fact. Telling a medical history that draws on a wealth of different perspectives—from that of the academic doctor to the lay practitioner to the patient herself—we can move beyond the binary of good and bad, progress and regression to a more nuanced portrait of the social, political, economic, and corporeal diagnoses that medicine seeks to treat. When we fail to look beyond the doctor's pen and the State's policies, we are more prone to accepting these reductive fallacies. Instead, what emerges from the dialogue of a multiplicity of voices is a story of both vulnerability and strength.

Further work is needed to remedy the parallel power dynamics that create the historical archive, those which privilege quantitative analysis and authoritative voices over alternative reflections of the multitude of truths that exist in tandem even if—or, especially if—they narrate different histories. The same dismissal of Dianne's articulation of her delivery in favor of the textbook prescriptions favored by her obstetricians operates at various levels in the historical

record when written documents receive attention at the expense of the voices never chronicled in this way.

Expanding our conception of knowledge and immersing ourselves in its contradictions allows us to adopt a more holistic approach to reproductive justice from both a contemporary and historical lens. While this thesis adopts birth as its focal point, we can see this need evolve in countless medical contexts. While medicine has been a story of victory for some, it has been a story of abuse for others. Only when we acknowledge both sides can we hope for justice.

Bibliography

Archival Primary Sources

Arms, Suzanne. *Immaculate Deception: A New Look at Women and Childbirth in America.* Boston: Houghton Mifflin, 1975.

Bradfield's Regulator Co. "Young Mothers." *News & Observer* (Raleigh, NC), December 27, 1911. North Carolina Newspapers.

Chapin, Charles. *A Report on State Public Health Work Based on a Survey of State Boards of Health.* Chicago: American Medical Association, 1915.

Department of Obstetrics and Gynecology Records. Duke University Medical Center Archives, Durham, NC. https://archives.mc.duke.edu/xml?faids=collection-132.xml#preferredcitation.

Duke Endowment Archives, 1902-2018. David M. Rubenstein Rare Books & Manuscript Library, Duke University, Durham, NC. https://archives.lib.duke.edu/catalog/dukeend#using-these-materials.

Duke Midwifery Service Records. Duke University Medical Center Archives, Durham, NC. https://archives.mc.duke.edu/xml?faids=collection-687.xml#preferredcitation.

Eleanor B. Easley Papers, 1928-2000. Duke University Medical Center Archives, Durham, NC. https://archives.mc.duke.edu/xml?faids=collection-307.xml#preferredcitation.

Francis Bayard Carter Papers, 1930-1976. Duke University Medical Center Archives, Durham, NC. https://archives.mc.duke.edu/xml?faids=collection-169.xml.

Lincoln Hospital (Durham, NC) Records, David M. Rubenstein Rare Books & Manuscript Library, Duke University, Durham, NC. https://archives.lib.duke.edu/catalog/lincolnhospital.

Stanko, John Richard. *A Study of Obstetrical Financial Losses at Duke University Medical Center.* Thesis (M.H.A.), 1974. David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.

Young Women's Christian Association (YWCA) at Duke University Records, Circa 1923-1985. David M. Rubenstein Rare Book and Manuscript Library, Duke University, Durham, NC.

Digitized and Printed Primary Sources

Amy G. MacDonal Oral History Interview, 2022. Duke University Medical Center Archives, Durham, NC. https://archives.mc.duke.edu/xml?faids=collection-709.xml.

Antoinette Milligan-Barnes Oral History Interview, 2022. Duke University Medical Center Archives, Durham, NC. https://archives.mc.duke.edu/xml?faids=collection-707.xml.

Boston Women's Health Collective. *Women and Their Bodies: A Course.* Boston: New England Free Press, 1970.

Carroll, Walter. "Public Health Nurse—In the Fight to Prevent Disease: Mrs. Sessoms Has Important Teaching Job," *Durham Morning Herald,* November 11, 1951, https://heraldsun.newspapers.com/image/789097383/?clipping_id=116377134&fcfToken=eyJhbGciOiJIUzI1NiIsInR5cCI6IkpXVCJ9.eyJmcmVlLXZpZXctaWQiOjc4OTA5NzM4MywiaWF0IjoxNjgyMTM0MTQ4LCJleHAiOjE2ODIyMjA1NDh9.iIAvJQr1b_znXdpddqckA9ztE5Wo-awPuOVQ8X_Egbw.

Charles B. Hammond Oral History Interview, 2004. Duke University Medical Center Archives, Durham, NC. https://medspace.mc.duke.edu/concern/documents/9s161655t?locale=es.

Deaton, Susan and Alison Seevak. "The Midwife: Old-fashioned Care Offers New Alternative." *Aeolus: The Chronicle's Weekly Magazine,* 77, no. 132, April 14, 1982. https://dukelibraries.contentdm.oclc.org/digital/collection/p15957coll13/id/22285/rec/1.

Department of Commerce—Bureau of the Census. *Fifteenth Census of the United States: 1930 Population Schedule* (Durham: United States Federal Census, 1930), p. 40, Jennie Clay name; digitized in "1930 United States Federal Census," *Ancestry,* https://www.ancestrylibrary.com/imageviewer/collections/6224/images/4608282_00299?treeid=&personid=&rc=&usePUB=true&_phsrc=qDg3&_phstart=successSource&pId=77139285.

The Duke Endowment. *The Duke Endowment: Fifteenth Annual Report of the Hospital Section, 1939.* (Charlotte: The Duke Endowment, 1939).

"Durham's Last Midwife." *The Durham Morning Herald,* August 7, 1952.

Hill's Durham City Directory (New York: Hill Directory, Co., 1928), p. 438, Midwife occupation; digitized in "U.S. City Directories, 1822-1995," *Ancestry,* https://www.ancestrylibrary.com/imageviewer/collections/2469/images/12410121?treeid=&personid=&rc=&usePUB=true&_phsrc=nuK12&_phstart=successSource&pId=716503861.

Hill's Durham City Directory (New York: Hill Directory, Co., 1928), p. 438, Midwife occupation; digitized in "U.S. City Directories, 1822-1995," *Ancestry,* https://www.ancestrylibrary.com/imageviewer/collections/2469/images/12410121?treeid=&personid=&rc=&usePUB=true&_phsrc=nuK12&_phstart=successSource&pId=716503861.

Ehtesham, Miriam and Melina Smale. "Overpopulation and Hunger: Cause and Effect." *The Duke Chronicle* 70, no. 51, November 8, 1974. https://dukelibraries.contentdm.oclc.org/digital/collection/p15957coll13/id/53596/rec/18 (accessed April 21, 2023).

"England Overrun with the Medical Profession." *Raleigh Times.* January 31, 1908. North Carolina Newspapers.

"Exchange Nurses Arrive." *InterCom* (Durham, NC), March 1, 1966. North Carolina Newspapers.

Flexner, Abraham. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching.* New York: The Carnegie Foundation, 1910.

Hobbs, S. H. "Births Attended by Midwives." *University of North Carolina News Letter* (Chapel Hill, NC), April 27, 1927. North Carolina Newspapers.

Jean Spaulding Oral History Interview, 2006. Duke Medicine Oral History Exhibit. Duke University Medical Center Archives, Durham, NC. https://archives.mc.duke.edu/xml?faids=collection-255.xml.

Joint Legislative Committee on New Licensing Boards. *North Carolina Midwifery Licensing Act: Licensure/Fees.* By Senator Robert C. Atwater, et al. Senate Bill 662, Durham, NC: North Carolina Senate, 2011, https://www.ncleg.gov/Files/Library/studies/2011/st11901.pdf (accessed December 7, 2022).

"Last Midwife Here to Lose Permit Jan. 1." *Durham Morning Herald,* August 5, 1952. https://www.newspapers.com/image/790409480/?terms=midwife&match=1.

Legislative Research Commission. *Report on the Shortages of Nurses and Other Medical Personnel in North Carolina.* Raleigh: North Carolina General Assembly, 1967. North Carolina History of Health Digital Collection, Health Sciences Library, University of

North Carolina at Chapel Hill, Chapel Hill, NC. https://archive.org/details/reportonshortage00nort/page/2/mode/2up.

Levy, Julius. "Reduction of Infant Mortality by Economic Adjustment and by Health Education," (speech delivered at the National Conference of Social Work, Atlantic City, New Jersey, June 5, 1919).

Lewis, Malcolm. "Program Launched to Help Midwives in Comeback Role." *Carolina Time* (Durham, NC), November 26, 1966. North Carolina Newspapers.

Lincoln Hospital: Thirty-Eighth Annual Report, 1938. North Carolina Collection, University of North Carolina at Chapel Hill. https://docsouth.unc.edu/nc/lincoln38/lincoln38.html.

Lougee, George. "Midwife—A Special Breed of Angel." *Durham Morning Herald,* April 27, 1 964. https://www.newspapers.com/image/791562895/.

North Carolina State Board of Health. *Biennial Report of the Bureau of Vital Statistics.* Raleigh: Edward & Broughton Printing Co., 1916-1917.

North Carolina General Assembly. *Journal of the House of Representatives of the General Assembly of the State of North Carolina.* Winston-Salem: Winston Printing Company, 1981. In the North Carolina State Documents Collection, State Library of North Carolina, Raleigh, NC. https://digital.ncdcr.gov/digital/collection/p16062coll9/id/37720/rec/1.

Occupational Folklife Project. Library of Congress American Folklife Center, Washington, DC. https://www.loc.gov/item/2021655200/.

Philip H. Pearce Oral History Interview, 2007. Duke University Medical Center Archives, Durham, NC.

"Practice of Midwifery Has Been Terminated in Durham County." *Durham Morning Herald,* April 26, 1953. https://www.newspapers.com/image/790434905/?terms=midwife&match=1.

"President Taft Settles Vexed Question by Modifying His Recent Order." *News & Observer* (Raleigh, NC), December 27, 1911. North Carolina Newspapers.

"Public Health Nurse." *Carolina Times* (Durham, NC), July 25, 1942. North Carolina Newspapers.

Rucker, M. Pierce. "The Relation of the Midwife to Obstetric Mortality, with Especial Reference to New Jersey." *The American Journal of Public Health* 13, no. 10, October 1923: 816-822. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1354653/?page=6.

Ruzek, Sheryl. *The Women's Health Movement: Feminist Alternative to Medical Control.* New York: Praeger, 1978.

Sezer Aksel Oral History Interview, 2007. Duke University Medical Center Archives, Durham, NC. https://medspace.mc.duke.edu/concern/documents/h415p9881?locale=es.

The Duke Endowment. *The Small General Hospital,* by Watson Smith Rankin, H. Eldridge Hannaford, H. P. Van Arsdall. Charlotte: Trustees of the Duke Endowment, 1928.

Tinsley, J. A. "A Study of Maternal and Child Welfare Work in North Carolina." *Journal of the National Medical Association* 24, no. 1 (1932): 13-15. Accessed December 7, 2022. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2625207/?page=2.

W. Allen Addison Oral History Interview, 2017. Duke University Medical Center Archives, Durham, NC. https://medspace.mc.duke.edu/concern/documents/kh04dq181?locale=es.

Williams, Whitridge, "Medical Education and the Midwife Problem in the United States," *The Journal of the American Medical Association* 113, no. 1 (January 1912): 1-7: doi:10.1001/jama.1912.04260010003001.

"Wilson County Midwives Meet." *Wilson Daily Times* (Wilson, NC), June 17, 1921. https://afamwilsonnc.com/2019/05/10/midwives-and-granny-women/.

Secondary Sources

"A Half-Century of Progress of Black Students in Medical Schools." *The Journal of Blacks in Higher Education*, no. 30 (Winter 2001): 28-31. https://doi.org/10.2307/2679066.

Bonaparte, Alicia. "Physicians' Discourse for Establishing Authoritative Knowledge in Birthing Work and Reducing the Presence of the Granny Midwife." *Journal of Historical Sociology* 28, no. 2 (June 2015): 166-194. https://onlinelibrary-wiley-com.proxy.lib.duke.edu/doi/full/10.1111/johs.12045.

Bordley, James, and A. McGehee Harvey. *Two Centuries of American Medicine, 1776-1976.* Philadelphia: W. B. Saunders Co., 1976.

Brodsky, Phyllis L. "Where Have All the Midwives Gone?" *The Journal of Perinatal Education* 17, no. 4 (2008): 48-51. Accessed December 7, 2022. https://doi.org/10.1624/105812408X324912.

Brown, Leslie. *Upbuilding Black Durham: Gender, Class, and Black Community Development in the Jim Crow South.* Chapel Hill: University of North Carolina Press, 2008.

Brubaker, Sarah Jane, and Heather E. Dillaway. "Medicalization, Natural Childbirth and Birthing Experiences." *Sociology Compass* 3, no. 1 (January 2009): 31-48. https://doi.org/10.1111/j.1751-9020.2008.00183.x.

Burrow, James G. *Organized Medicine in the Progressive Era: The Move Toward Monopoly.* Baltimore: The Johns Hopkins University Press, 1977.

Burst, Helen Varney and Joyce Thompson. "Genealogic Origins of Nurse-Midwifery Education Programs in the United States." *Journal of Midwifery and Women's Health* 48, no. 6 (December 2003): 464-472. https://doi.org/10.1016/S1526-9523(03)00348-9.

Byrd, W. M., L. A. Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey." *Journal of the National Medical Association* 93, no. 3. (March 2001): 11S-34S. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2593958/?page=15.

Campbell, Walter E. *Foundations for Excellence: 75 Years of Duke Medicine.* Durham: Duke University Medical Center Library, 2006.

Coontz, Stephanie. *A Strange Stirring: The Feminine Mystique and American Women at the Dawn of the 1960s.* New York: Basic Books, 2011.

Crow, Jeffrey J., Paul D. Escott, and Flora J. Hatley Wadelington. *A History of African Americans in North Carolina.* Chapel Hill: The University of North Carolina Press, 1992.

Davison, Wilburt C. *The Duke University Medical Center, 1892-1960.* Durham: Duke University Press, 1960.

Dawley, Katy and Helen Varney Burst. "The American College of Nurse-Midwives and Its Antecedents: A Historic Time Line." *Journal of Midwifery and Women's Health* 50, no. 1 (December 2010): 16-22. https://doi.org/10.1016/j.jmwh.2004.09.011.

"Dr. Bailey Daniel Webb Obituary."*Find A Grave,* accessed April 21, 2023, https://www.findagrave.com/memorial/29681165/bailey-daniel-webb. Bailey Webb, died 24 November 2004.

Duffy, Thomas P. "The Flexner Report—100 Years Later." *Yale Journal of Biology and Medicine* 84, no. 3 (September 2011): 269-276. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178858/.

"Duke University Health System Timeline." Duke University Medical Center Archives. Duke University. Accessed April 2023. https://archives.mc.duke.edu/duhs_timeline.

"Eleanor Easley." Women in Duke Health," n.d., Duke University Medical Center Library and Archives, Durham, NC. https://exhibits.mclibrary.duke.edu/duke-women/women/easley-eleanor/.

Ehrenreich, Barbara. *Witches, Midwives, and Nurses: A History of Women Healers.* Old Westbury, NY: The Feminist Press, 1973.

Ettinger, Laura E. *Nurse-Midwifery: The Birth of a New American Profession.* Columbus: The Ohio State University Press, 2006.

Foucault, Michel. *The Birth of the Clinic: An Archaeology of Medical Perception.* Translated by A.M. Sheridan Smith. New York: Vintage Books, 1973.

Foucault, Michel. *The Punitive Society: Lectures at the College de France, 1972-1973*. Translated by Graham Burchell. New York: Picador, 2013.

Fraser, Gertrude J. *African American Midwifery in the South: Dialogues of Birth, Race, and Memory*. Cambridge: Harvard University Press, 1998.

Gamble, Vanessa N. *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945.* New York: Oxford University Press, 1995.

Gifford, James F. *The Evolution of a Medical Center: A History of Medicine at Duke University to 1941.* Durham: Duke University Press, 1972.

Greene, Christina. *Our Separate Ways: Women and the Black Freedom Movement in Durham, North Carolina.* Chapel Hill: The University of North Carolina Press, 2005.

Hancock, Black Hawk. "Michel Foucault and the Problematics of Power: Theorizing DTCA and Medicalized Subjectivity." *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 43, no. 4 (July 2018): 439-468. https://doi.org/10.1093/jmp/jhy010.

Hansen, Randall and Desmond King. *Sterilized by the State: Eugenics, Race, and the Population Scare in Twentieth-Century North America.* New York: Cambridge University Press, 2013.

Harley, Earl H. "The Forgotten History of Defunct Black Medical Schools in the 19th and 20th Centuries and the Impact of the Flexner Report." *Journal of the National Medical Association* 98, no. 9 (September 2006): 1425-1429. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569729/?page=1.

Heather, Stephenson, and Kiki Zeldes. "'Write a Chapter and Change the World' *How the Boston Women's Health Book Collective Transformed Women's Health Then—And Now*." *American Journal of Public Health* 98, no. 10 (October 2008): 1741-1745. doi: 10.2105/AJPH.2007.132159.

"History." *Durham Women's Clinic*, accessed December 12, 2022. https://www.durhamwomensclinic.com/history.

Hoffman, Beatrix. "The American Hospital: Charity, Public Service or Profit Centre?" In *The Political Economy of the Hospital in History,* edited by Martin Forsky, Margarita Vilar-Rodríguez, and Jerònia Pons-Pons. Queensgate: University of Huddersfield Press, 2020.

Hoyert, Donna L. "Maternal Mortality Rates in the United States, 2021." *NCHS Health E-States.* Center for Disease Control and Prevention. Accessed April 2023. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#:~:text=In%202021%2C%20the%20maternal%20mortality,for%20White%20and%20Hispanic%20women.

Johnson, Claire, and Bart Green. "100 Years after the Flexner Report: Reflections on Its Influence on Chiropractic Education." *The Journal of Chiropractic Information* 24, no. 2 (October 2010): 145-152. https://doi.org/10.7899/1042-5055-24.2.145.

King, Helen. *Midwifery, Obstetrics and the Rise of Gynaecology: The Uses of a Sixteenth-century Compendium.* London: Routledge, 2007.

Kluchin, Rebecca C. *Fit to Be Tied: Sterilization and Reproductive Rights in America, 1950-1980.* New Brunswick: Rutgers University Press, 2009.

Kohl, S. G., G. Maljzlin, M. Burnhill, J. Jones, G. Solish, S. Okrent, and E. Pendleton. "The Nurse-Midwife as a Family Planner." *American Journal of Public Health* 62, no. 11 (November 1972): 1448-1450. doi: 10.2105/ajph.62.11.1448.

Kub, Joan, Pamela Kulbok, and Doris Glick. "Cornerstone Documents, Milestones, and Policies: Shaping the Direction of Public Health Nursing 1890-1950." *The Online Journal of Issues in Nursing* 20, no. 2 (May 31, 2015). https://doi.org/10.3912/OJIN.Vol20No02Man03.

Korstad, Robert R. *Civil Rights Unionism: Tobacco Workers and the Struggle for Democracy in the Mid-Twentieth-Century South.* Chapel Hill: The University of North Carolina Press, 2003.

Ladd-Taylor, Molly. "'Grannies' and Spinsters': Midwife Education under the Sheppard-Towner Act." *Journal of Social History* 22, no. 2 (1988): 255-275. https://www.jstor.org/stable/pdf/3788221.pdf.

Lay, Mary. *The Rhetoric of Midwifery: Gender, Knowledge, and Power.* New Brunswick: Rutgers University Press, 2000.

Leavitt, Judith. *Brought to Bed: Childbearing in America, 1750-1950.* New York: Oxford University Press, 1986.

"Lincoln Hospital (1901-1924)." *Open Durham*. Preservation Durham, last modified January 2, 2013. https://www.opendurham.org/buildings/lincoln-hospital-1901-1924.

Litoff, Judy Barrett. *American Midwives, 1860 to the Present.* Westport: Greenwood Press, 1978.

—----------. *The American Midwife Debate: A Sourcebook on its Modern Origins.* New York: Greenwood Press, 1986.

Luke, Jenny M. *Delivered by Midwives: African American Midwifery in the Twentieth-Century South.* Jackson: University Press of Mississippi, 2018.

Madgett, Katherine. "Sheppard-Towner Maternity and Infancy Protection Act (1921)." In *The Embryo Project Encyclopedia.* May 18, 2017. https://embryo.asu.edu/pages/sheppard-towner-maternity-and-infancy-protection-act-1921.

Magalif, Jeff. "Black Students Comprise 2.8 Per Cent of Enrollment at U.S. Medical Schools." *The Harvard Crimson.* May 17, 1971. https://www.thecrimson.com/article/1971/5/17/black-students-comprise-28-per-cent/ (accessed April 21, 2023).

Marks, Harry. *The Progress of Experiment: Science and Therapeutic reform in the United States, 1900-1990* (Cambridge: Cambridge University Press, 2000).

May, Elaine Tyler. *America and the Pill: A History of Promise, Peril, and Liberation.* New York: Basic Books, 2010.

McGregor, Deborah K. *From Midwives to Medicine: The Birth of American Gynecology.* New Brunswick: Rutgers University Press, 1998.

Meckel, Richard. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929.* Ann Arbor: University of Michigan Press, 1998.

Mobley, Sarah. "Midwives." In *Encyclopedia of North Carolina,* edited by William S. Powell, 2 006. https://www.ncpedia.org/midwives.

Morgen, Sandra. *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990.* New Brunswick: Rutgers University Press, 2002.

Mumford, Kevin J. "Untangling Pathology: The Moynihan Report and Homosexual Damage, 1965-1975." *Journal of Policy History* 24, no.1 (February 2012): 53-73. https://doi.org/10.1017/S0898030611000376.

Nadesan, Majia Holmer. *Governmentality, Biopower, and Everyday Life.* New York: Routledge, 2008.

Nash, Jennifer C. *Birthing Black Mothers.* Durham: Duke University Press, 2021.

Navarro, Vicente. "Social Class, Political Power, and the State and Their Implications in Medicine." *International Journal of Health Service* 7, no. 2 (1977): 255-292. https://www.jstor.org/stable/45140170.

Nichols, Carol Wood. "The Yale Nurse-Midwifery Practice: Addressing the Outcomes." *Journal of nurse-Midwifery* 30, no. 3 (June 1985): 159-165. https://doi.org/10.1016/0091-2182(85)90281-2.

Norsigian, Judy. "Our Bodies Ourselves and the Women's Health Movement in the United States: Some Reflection." *American Journal of Public Health* 109, no. 6 (June 2019): 844-846. doi: 10.2105/AJPH.2019.305059.

Ordover, Nancy. *American Eugenics: Race, Queer, Anatomy, and the Science of Nationalism.* Minneapolis: University of Minnesota Press, 2003.

Owens, Deirdre C. *Medical Bondage: Race, Gender, and the Origins of American Gynecology.* Athens: The University of Georgia Press, 2017.

Pollitt, Phoebe Ann. *African American Hospitals in North Carolina: 39 Institutional Histories, 1880-1967.* Jefferson, NC: McFarland & Company, Inc., 2017.

Reagan, Leslie J. *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973.* Berkeley: University of California Press, 1997.

Reynolds, Preston. *Black America Series: Durham's Lincoln Hospital.* Charleston: Arcadia, 2001.

Reynolds, Preston. *Watts Hospital of Durham, North Carolina, 1895-1976: Keeping the Doors Open.* Durham: The Fund for the Advancement of Science and Mathematics Education in North Carolina, 1991.

Rice, Mitchell F., and Woodrow Jones, Jr. *Public Policy and the Black Hospital: From Slavery to Segregation to Integration.* Westport: Greenwood Press, 1994.

Roberts, Dorothy. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.* New York: Vintage Books, 1997.

Rooks, Judith Bourne and Susan H. Fischman. "American Nurse-Midwifery Practice in 1976-1977: Reflections of 50 Years of Growth and Development." *American Journal of Public Health* 70, no. 9 (September 1980): 990-996. DOI: 10.2105/ajph.70.9.990.

Rosenkrantz, Barbara Gutmann. *Public Health and the State: Changing Views in Massachusetts, 1842-1936.*

Rushing, Nancy Elizabeth. "Midwifery and the Sources of Occupational Power." PhD diss., Duke University Department of Sociology, 1988. Rubenstein Rare Books & Manuscript Library. Duke University. Durham, North Carolina.

Schneir, Miriam. *Feminism in Our Time: The Essential Writings, World War II to the Present.* New York: Vintage Books, 1994.

Sipe, Theresa Ann, Judith Dullerton, and Kerri Durnell. "Demographic Profiles of Certified Nurse-Midwives, Certified Registered Nurse Anesthetists, and Nurse Practitioners: Reflections on Implications for Uniform Education and Regulation." *Journal of Professional Nursing* 25, no. 3 (June 2009): 178-185). https://doi.org/10.1016/j.profnurs.2009.01.002.

Smith, David Barton. *The Power to Heal: Civil Rights, Medicare, and the Struggle to Transform America's Health Care System.* Nashville: Vanderbilt University Press, 2016.

Solomon, Miriam. *Making Medical Knowledge.* Oxford: Oxford University Press, 2015.

Starr, Paul. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry.* New York: Basic Books, 1982.

Thomas, Karen K. *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935-1954.* Athens: The University of Georgia Press, 2011.

Turner, Darline. "Queen Elizabeth Perry Turner: 'Granny Midwife,' 1931-1956." In *Birthing Justice: Black Women, Pregnancy, and Childbirth,* edited by Julia C. Oparah and Alicia D. Bonaparte, 20-24. New York: Routledge, 2016.

Washington, Harriet A. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present.* New York: Harlem Moon, 2006.

Watts, C.D., and F.W. Scott. "Lincoln Hospital of Durham, North Carolina. A Short History." *Journal of the National Medical Association* 57, no. 2 (March 1965): 177-183. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2610830/?page=6.

"Watts Hospital (1909-1980)." *Open Durham,* Preservation Durham, January 2, 2013. https://www.opendurham.org/buildings/lincoln-hospital-1901-1924.

Wertz, Richard W., and Dorothy C. Wertz. *Lying-In: A History of Childbirth in America.* New Haven: Yale University Press, 1989.

Wilkinson, Patrick. "The Selfless and the Helpless: Maternalist Origins of the U.S. Welfare State." *Feminist Studies* 25, no. 3 (1999): 571-597. https://doi.org/10.2307/3178657.

Wilson, Jan. *The Women's Joint Congressional Committee and the Politics of Maternalism, 1920-30.* Champaign: University of Illinois Press, 2007.

"Working Together to Reduce Black Maternal Mortality." *Health Equity*. Center for Disease Control and Prevention. Accessed April 2023. https://www.cdc.gov/healthequity/features/maternal-mortality/index.html.

"YWCA." *Open Durham,* Preservation Durham, December 1, 2006. https://www.opendurham.org/buildings/ywca.