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INTENTION FROM GOD: MIDWIVES AND PROFESSIONAL PHYSICIANS IN LATE NINETEENTH-CENTURY ALABAMA

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"There was an intention from God because that was God's program for the women to have babies. It was the midwife or nothin."

Onnie Lee Logan, midwife in Sweet Water, Marengo County, Alabama

In Alabama, toward the end of the nineteenth century, professional physicians routinely expressed grave concerns about the practice of traditional midwifery. Midwives, they claimed, were incompetent, ignorant, and unclean. They ridiculed and derided midwifery for its supposedly superstitious and dangerous practices and sought to improve public health in Alabama by standardizing or regulating the practice of midwifery. Members of the Medical Association of the State of Alabama and *The Alabama Medical and Surgical Journal*, the most powerful and influential physicians in the state, regularly presented papers on the midwifery issue during the years 1886 to 1918. These governing bodies in the medical field were deeply concerned with elevating the standards and rigor of the medical profession in Alabama, and they saw unregulated midwives as a threat to their efforts.

Yet midwives in nineteenth-century Alabama were an integral piece of public healthcare, due to high levels of rural poverty, racial segregation, and general mistrust of professional doctors. Alabama was (and remains today) one of the most rural and poor states in the country. In the context of late nineteenth-century transportation, physical difficulties interfered with country doctors' ability to get around and attend births. Most rural women, black and white, could not even afford to have a physician attend their birth. Furthermore, high levels of racial segregation and racism meant that many white doctors simply refused to attend black patients. In the words of Onnie Lee Logan, an Alabama midwife who practiced in Marengo County,

I cain't remember a doctor go in a place my whole time in the country to deliver a black baby. I don't remember a single doctor not a single time deliverin a black baby at home. Not one. ...Not on my whole life. Not in my whole life. Cause if they sent for him the baby woulda been there and probably some of em walkin befo' he got there.[1]

"On the Road." Midwife on her way to a birth, carrying her kit. Greene County, Georgia, November 1941. Photographer Jack Delano. Courtesy of Library of Congress.

In practice, then, midwives attended most births – women would call them right before or just as soon as they went into labor, knowing they were close by, and it wouldn't take them long to arrive. There was also the fact that late nineteenth- and early twentieth-century Alabamians of both races did not fully trust professional physicians yet. The field was still recovering from its early nineteenth-century reputation, and doctors were only just learning how destructive treatments like bloodletting and purging had been. Many women, both black and white, preferred the presence of their familiar friends and neighbors to the unfamiliar and unknown technological complexity of a doctor-attended birth. Although it frustrated physicians,

midwives continued to attend births in high numbers throughout the end of the nineteenth and into the twentieth-century. The statistics of midwife-attended births in Alabama may even be higher than records show, given physicians' difficulties in getting local healthcare practitioners and midwives to report each birth and register it.

Historians who have investigated the transition from traditional midwifery to professional obstetrics aptly describe a transfer of power and authority from midwives to physicians. Analysis of this historical transition in Alabama reveals a more complex situation in which physicians in Alabama continued to rely on midwives in practice, while publicly and professionally denouncing them in the literature. Racism, rural poverty, and general mistrust of professional medicine in Alabama created a situation in which both black and white women in rural areas continued to rely heavily on midwives, while physicians routinely and publicly worked to discredit them.

Although many historians have explored the history of the transition from American midwifery to professional obstetrics,[2] not much research has been devoted to Alabama in particular. Howard L. Holley, in his comprehensive history of medicine in Alabama, devotes limited page space to early professional obstetrics and a few passing remarks to the ignorance of midwives, acknowledging the issue as a concern of early professional Alabamian physicians. Legal scholar Stacey Tovino includes Alabama as a case study in her comparative analysis of midwifery legislation in the United States. Charlotte Borst's work on midwives in Wisconsin at the turn of the nineteenth century provides helpful comparisons and contrasts to the situation in Alabama. Perhaps the most in depth work on this historical moment in Alabama is found in the two published oral histories of Alabama midwives, *Listen to Me Good: The Story of an Alabama Midwife and Motherwit: An Alabama Midwife's Story*.[3] These volumes, along with scholarly research on the history of African American midwifery in the Southeast region more generally, form a crucial foundation upon which this paper builds.

As noted by Judy Barrett Litoff, historical research on midwifery is challenged by the dearth of written information produced by the midwives themselves.[4] Many of these women were either illiterate or emphasized oral communication, meaning that much of what is known comes from the often-hostile observations of contemporary physicians. Nevertheless, the contemporary rhetoric in the professional medical community illuminates and enriches understanding of this moment in medical history. Therefore, the other important source of information necessary to an understanding of this historical moment in Alabama comes from physicians, in the form of medical journals and the transactions of the state medical association.

Continuous change and profound transformation characterized the medical profession throughout the second half of the nineteenth century. Following dramatic advances in bacteriology and other sciences, Alabamian physicians strove to consolidate authority, trust, and standardized public healthcare. Eventually, these efforts would result in a near-total authority vested in the professional physician. In the field of American obstetrics, this process caused a drop in midwife attended births from 50% to 15% during the period 1900 to 1930.[5] Professionally organized physicians used technological interventions to attract women with the promise of a smooth, painless, and relatively risk-free labor. Yet midwives continued in high numbers as birth attendants in certain areas of the country. 80% of all midwife-attended births in 1913 occurred in the South, "where physicians had always been extremely scarce and the population had the highest percentage of black, poor, and rural citizens."[6] Despite the ascendance of specialized obstetrics at the turn of the nineteenth century, parturient women continued relying on midwives for healthcare when physicians could not, or would not attend to them. This process was contingent on developments in medical obstetrics and how they affected the transition away from midwifery in Alabama.

Technological and scientific advances in medicine, both obstetric and otherwise, assimilated slowly in Alabama. According to Howard Holley, "medical practice in the second half of the nineteenth-century did not differ too greatly from that of earlier days."[7] Forceps were commonly used but still a matter of discussion in the 1886 issue of

The Alabama Medical and Surgical Journal (AMSJ).[8] Much more debate revolved around the new practices of using anesthesia and antiseptics during labor.[9] Although these would eventually become cornerstones of medical authority in the birth chamber, during the late nineteenth century their efficacy and appropriateness was still somewhat unknown. Physicians continued to disagree and debate how to effectively manage labor; the literature reflects this and reveals a great deal of uncertainty.

In fact, it is possible that women were at a higher risk from physician-attended or hospital births due to the prevalence and misunderstood nature of puerperal fever – an infectious disease caused by introducing bacteria into the vagina during labor. Despite the fact that bacterial science had determined the infectious etiology of puerperal fever, in the second half of the nineteenth century, "[t]he reluctance with which physicians surrender traditional ideas and methods was again demonstrated. … The therapeutic value of bloodletting and purging in the treatment of puerperal fever was still being stressed."[10] Indeed, in the 1886 issue of the AMSJ, Job Thigpen of Greenville recorded his use of bleeding to treat puerperal fever.[11] Alabamian physicians resisted using antiseptic techniques of sterilization, and women who gave birth in hospitals, urban areas, or crowded clinics remained at higher risk due to the greater prevalence of bacteria. In addition, doctors also tended to intervene and use more instruments during labor than midwives,[12] increasing further the possibility that harmful bacteria would be introduced. Even by the 1930s, when medical obstetrical advancements had become more widely accepted, three independent studies explicitly found that high rates of infant and maternal mortality in the United States were caused by physician error, intervention, and exposure to hospital environments.[13] Despite frequent claims to the contrary in the medical literature, the idea that midwives posed a greater risk to health during birth attendance at the turn of the twentieth century is simply untrue.

Some wealthy, urban women did choose physician-attended births, but the scarcity of doctors in the country meant that it was unlikely or impossible for rural women to do so. On the one hand, there were not enough doctors to go around. In the words of Onnie Lee Logan, "[a] doctor was impossible for him to keep up with all these cause women was havin babies like cats havin kittens durin these times with no prenatal care whatsoever."[14] Alabama was a frontier state, and the first cities settled had been decimated by malaria and yellow fever.[15] In the late nineteenth century it remained rural and lacked an effective network of public healthcare. Famous physicians like Jerome Cochran would work to change this so that by the early twentieth century the foundations had been laid for public healthcare in the state, but the process was slow and arduous.[16] Calls for improvement in licensure, examination, and efficacy of county health officers permeate the medical discourse from the 1880s to the early 1900s. There was a logistical and organizational dilemma to resolve before doctors would become widely available in rural areas. Due to the distance and onerous nature of transportation in the late nineteenth century,[17] doctors charged high rates for travel into the country, posing a significant financial barrier for rural families. In 1894, Dr. Halle Tanner Dillon Johnson, the first female doctor licensed by the Alabama Medical Society, "reported that families living far from town could not afford medical care because physicians charged two dollars per mile for a visit—plus the cost of medicine—and demanded cash or reliable assurances of payment before coming."[18] Black families were either too wary or too shrewd to even ask a white doctor to come, knowing that he would either fail to arrive or would treat them with discrimination. Logan explains: "The white doctors at this time—…I don't think they paid too much attention to the black families then, because the spirit of the white people then didn't go out for the black people. They thought that we was—as they used to call us—animals. We were like animals. So, they didn't have any feelin for us."[19]

Beyond the cost of travel, physicians charged fees for obstetrical care that many families in Alabama simply could not afford, while midwives were available to perform the attendance for exchange or for free. In 1837 physicians charged up to $20 for obstetrical engagements;[20] by the late nineteenth century, average country doctors were barely eking out a living, not allowing them to drop costs for attending births out in the country.[21] In contrast,

midwives often attended births either for exchange in goods or for no compensation at all. Midwives would also perform tasks beyond the childbirth event itself, such as cooking, cleaning, and sometimes making sure the family had enough to eat.[22] According to Logan, speaking about the generation before hers, “Now the midwives in those days—let me tell you about the midwives in those days. When they go on a delivery, they didn't just go on a delivery. They do the cookin and the washin. ...My mother wasn't paid hardly anything alot a times. If she was paid at all they might give her co'n, chicken, greens outa the garden if we didn't have any and such like that. There wasn't any money to pay em."[23] Midwives offered a healthcare system founded on informal networks of community and family, not financial transaction. This made them not only available but also appealing to rural and poor families.

> “White families engaged physicians in an official capacity and relied on African-American midwives to provide the actual labor of healthcare.”

Midwives’ physical proximity, willingness to attend births even without financial compensation, and extra steps to provide support and care to parturient women made them more available and appealing than physicians. This situation was enhanced for black women, who faced open discrimination and racism from white physicians: "You know why the blacks avoided the white doctors? Because, honey, they avoided the whites period. ... The doctors thought the black person was mostly too filthy for him to put his hands on. They talk to em just like they was a dog that didn't have human sense. They did not want that kinda treatment. They didn't deserve that kinda treatment because they was human beings."[24] Black women made active choices to involve caregivers that they could trust and who would treat them well during their labor.

Yet white women displayed preferences for midwives as well. Logan explains: “Fact a business, alot a white families years ago didn't do nothin but use midwives. And most midwives at that time was black. ...And it wasn't only white sharecroppers that my mother delivered for. There was white people that owned property. You don't call em sharecroppers the ones that own property."[25] When white babies were involved, there would usually be a doctor present at the labor, but he would frequently be attended by a midwife. Logan described the way this scenario usually played out in her mother’s work as a midwife: The doctors mostly time they are there to deliver that baby and get goin. They're not go'n clean up any of it. They will have Mother there with the doctor knowin Mother's go'n do the cleanin up afterwards. This would be the white families. Mother would do whatever need to be done. Sometimes she would get the house all cleaned up. Mother all settled and baby all settled. See the doctor's not go'n bathe that baby, not go'n dress that baby or nothing like that. That's go'n be the midwife. The doctor would fill out the birth certificate. It happened alot a times that the baby was born befo' the doctor got there. So, you see it was white and black alike that used midwives. It was never hard to get a midwife unless she was already on another case. All you had to do was to go down and pick her up.[26]

Even when doctors were officially present at childbirth, then, African-American midwives still performed most or all of the labor. The doctor attended in an official capacity, but his presence did not extend beyond the labor event. White families engaged physicians in an official capacity and relied on African-American midwives to provide the actual labor of healthcare. Black families learned not to count on doctors altogether, instead relying on long-established networks of familial and neighborly support and ancestral knowledge to maintain a healthy community.[27]

Of course, physicians did not openly acknowledge that they relied on midwives to deliver black babies in rural areas, but the reality can be inferred from the oral histories of midwives themselves and sociocultural realities of racism during the Jim Crow era. Physicians neglected the black community in their healthcare practices – labor attendance was no exception. Charlotte

Borst argues that this stems from "a double standard of obstetrics tied to a very gendered and culturally defined professional ideal. The standards of scientific, male professionalism were presumed to be absolutely essential for white women, but a black female midwife, properly supervised by the state, was considered adequate for black women."[28] Racist and ethnic stereotypes contributed to the idea that a delicate, white American woman required more attention during childbirth, while immigrant and black women could give birth more easily, "a sure indication of a cruder, more animal-like character."[29] The dehumanization of black people during the Jim Crow era in Alabama meant that white physicians did not respond to the needs of black parturient women, forcing them to count on the informal networks of midwives to stay healthy during childbirth.

For these reasons, before the advent of a fully specialized and technologized field of obstetrics, physicians in Alabama relied on midwives to attend high numbers of births, counting on them to bring healthy babies into the world in areas and communities they could not or would not access. Many parturient women still mistrusted modern medicine and did not yet fully acquiesce to the supremacy of the physician in childbirth attendance. Yet while midwives performed the labor of childbirth attendance, professional medical organizations openly debated how to license, censor, and erase their practices. Not only did these physicians disregard the fact that the state of public health in Alabama was largely dependent on the uncompensated and unacknowledged labor of midwives, but they themselves did not necessarily perform cleaner or safer childbirth than the midwives. Their rhetoric proceeded from an ancient, gendered, and racist stereotype that ran contrary to actual midwifery practice and presence. The medical literature of the period provides a window into the rationales and arguments used by physicians to argue for licensure and eventual elimination of midwives in the state of Alabama.

Perhaps the most obvious reason for physicians' concern about the state's reliance on midwives was a genuine consideration for the state of public health in Alabama. Physicians and public health officials claimed that "the high rate of infant and maternal deaths during childbirth was directly related to the use of untrained midwives,"[30] and they believed that licensing and controlling the practice would solve the problem. They argued that midwives' lack of basic obstetrical education linked directly to high maternal mortality and argued for the establishment of examinations and certificates to regulate the practice midwifery in the state. In 1890, at the annual conference of the Medical Association of the State of Alabama, in a session titled "The Education of Midwives," the presenter argued that "a large majority of the midwives in Alabama are extremely ignorant of even the most elementary principles of obstetric practice…a higher standard of efficiency amongst them is very greatly to be desired."[31] They then presented an ordinance for the examination of midwives, to be adopted by the association. They directly connected concerns about midwifery with a lack of standardized and regulated midwifery education.

Yet in the late nineteenth century, even professional physicians often lacked a basic clinical understanding of obstetric practice. Far from the elite education associated with pre-medical and medical training today, "[f]or most American doctors who sought a medical education between the end of the Civil War and approximately 1890, medical school was not a post-college degree program. Indeed, most medical students had little or no college preparation, and many had not graduated from high school. The medical school curriculum was minimal."[32] When it came to obstetrics, a lack of clinical or practical education seems particularly concerning: most obstetrics courses were taught as lectures, and graduates of medical schools often had never attended or even witnessed a live birth.[33] In fact, despite continuing efforts to

improve standards and rigor in medical education, a 1910 report conducted by the education reformer Abraham Flexner found the two top schools in Alabama unsatisfactory.[34] Some of the concerns Flexner raised included lax acceptance requirements and an unbalanced ratio of lectures to clinical instruction.[35] Those general practitioners and early obstetric specialists who lacked practical experience yet performed physician-attended births at the time escaped castigation in the medical

discourse. Despite their lack of experience, these physicians' professional status and adherence to the practice of rational, scientific medicine protected them from the kind of public denunciation directed at midwives. This double standard indicates that other reasons motivated top physicians of the day to spill so much ink over the need for licensing and controlling midwives. A non-academic, faith-based practice predicated on learning by experience, traditional midwifery was epistemologically dissimilar to an obstetric approach to childbirth. Midwives in Alabama were older black women who had learned the trade from their mothers and grandmothers, and from giving birth themselves. They explicitly linked practices of midwifery to their faith, and often referred to their work as a calling. Oral histories by rural Southern midwives, limited as they are, are full of stories in which midwives describe being called to the work by the Lord, and not being ready to stop until the Lord lets them know.[36] Midwives learned by apprenticing to someone more experienced, usually a relative. Knowledge was passed down orally and through direct experience at the childbirth event. The skills necessary to successfully bring healthy babies into the world were not considered scientific or technological and birth was viewed as a natural process rather than a pathological episode in need of medical intervention. For these reasons, midwifery and early professional obstetrics viewed childbirth in completely different ways.

One fundamental distinction between the epistemologies of midwife care and physician care is found in the latter's emphasis on speed, action, and intervention. Physicians believed that these three factors lay at the heart of an effective and successful medical practice. C.H. Fort of Tuskegee spoke at the Medical Association's 1881 meeting of the appropriate stance of the birth attendant: "he should be ready, willing and zealous in his endeavors to assist nature in every way in this her sore hour of need and distress; ever having a firm reliance in his resources, relying upon true knowledge and power; like the pilot before the storm he is ever anticipating danger, and thus is prepared for any emergency, believing and realizing that delay and timidity are always bad."[37] Nineteenth-century physicians prioritized action and intervention in the birth chamber, largely because at that point they were almost always called in to a labor when something had gone wrong and lives were in danger: "[t]hey were called at a particular time in the drama, they joined an already established social scene with its own pattern of emotions and relationships, and they were expected to do something terribly important but also quite exact: stop the convulsions, get the baby out."[38] Their general medical training and the nature of their role in obstetrics combined to encourage an active, interventionist approach to birth attendance. Midwives, by contrast, attended the majority of births in which nothing went wrong; lacking any technological or surgical skills they learned to prioritize patience and maternal agency to ensure a smooth and uneventful labor. This often meant that they spent more time with the mother and played a more passive role in the birth, more akin to witnessing it than managing or directing it. Margaret Charles Smith, an Alabama midwife who practiced in Greene County, exemplified this emphasis on maternal agency, patience, and behavioral soothing: "Only when she has used her powers of discernment to determine what the mother really wants to do will Mrs. Smith reply, 'If you can go, go as soon as you can.' ...Holding her hand and rubbing her back, she offers comfort, telling her having that baby won't be as hard as she thinks."[39] Onnie Lee Logan shared similar priorities in her midwifery practice, and clarified the way this distinguished her work from that of official healthcare practitioners: I tell you one thing that's very impo'tant that I do that the doctors don't do and the nurses doesn't do it because they doesn't take time to do it. And that is I'm with my patients at all times with a smile and keepin her feelin good with kind words. The very words that she need to hear it comes up and come out. And that means a lot. Most of the doctors when they do say somethin to em it's so harsh. They already had contractions, and then with a ugly word to come out not suitable to how they're feelin. Some of em say that if they wasn't strapped down there they would get down and come home. A lot a women are left totally alone. And plenty of them have had their babies right by themselves. Well see I don't leave my patient like that. I'm there givin her all the love and all the care and I be meanin it and they know I mean it. It's from my heart and they can feel me. You see what I mean? ...What she's

"Aunt Sally. " Midwife named Sally. Gees Bend, Alabama, May 1939. Photographer Marion Post Walcott. Courtesy of Library of Congress.

goin through with I'm goin through right along with her.[40]

Midwives' emphasis on soothing touches, kind words, and encouraging behavior takes on new significance in light of contemporary research that finds birth attendant behaviors and attitudes to be either as powerful or more powerful than pharmaceutical pain relief or technological interventions in producing positive birth experiences.[41] Midwives and physicians relied on different sets of skills and tools to ensure positive birth outcomes; these different practices were not ontologically incompatible, yet in the struggle for consolidation of professional authority physicians highlighted their epistemological differences, reinforced the supremacy of their birth practices, and denied any value in those of the midwives. The professionalization process occasioned this because "the professional practitioner must master a body of knowledge unique to the field within a formal setting, and then have the autonomy to decide when and under what circumstances to apply this knowledge."[42] In order to establish professional medical authority, it was crucial that physicians establish a special body of obstetric knowledge in order to master and then pass on to new trainees. Professional authority would have been undermined by the admission that an alternative and viable set of practices existed outside of scientific medicine. In prioritizing the organization of modern

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medicine into specialties, physicians had to neutralize the competing authority of the midwifery practice, which they often accomplished by using their professional and public governing bodies as platforms to denounce midwifery practice and fight for its assimilation into the new field of obstetrics. Yet another factor remains which must be examined in order to explain and understand the level of denigration and vehemence toward midwives in nineteenth-century medical discourse: the role of race. The deeply ingrained white supremacy of Southern culture associated black people with filth, squalor, ignorance, stupidity, and sloth. Pseudo sciences like phrenology provided a rational discourse of support. For white Alabamians, the association of these qualities with black people would have seemed natural, rational, scientific, and inherently true. In an 1898 session of the Medical Association of the State of Alabama, physician David Leonidas Wilkinson explicitly tied race to the "especially hazardous"[43] status of midwives: "Their morality is frequently on a par with their ignorance. Most of them are negresses, whose sole claim to midwifery is that they have borne children, in filth and squalor; that these children have lived. Therefore, they say: 'I am competent.'"[44] Despite the positive collaborative relationships that sometimes formed between white physicians and black midwives, where the former had to acknowledge at least the individual competence of the latter, discourse in the medical literature reverted to racist stereotypes when discussing midwives. Indeed, the absolute crux of a double standard against midwives appears in the practice of white professional physicians who denigrated black midwives and yet relied on them to attend the births of families

living in rural poverty that they refused to attend: “[i]n the rural south, African-American midwives reported that physicians encouraged them to deliver babies. Indeed, Louvenia Taylor, who practiced in rural southern Alabama, reported that she was 'forced' by physicians to become a midwife. ...Taylor reports that the doctors begged her to get a license and help them out."[45] Black midwives were denounced in the medical literature because of their race, and then exploited in practice for the very same reason. Alabamian midwives existed in a sociocultural realm far from the anxieties and goals of early professional physicians. These women emphasized their calling by the Lord and prioritized intuition, spirituality, and community health where physicians prioritized professional development, material gain, and individual achievement. The vast cultural distance between these types of practice and the overwhelming power of white supremacist ideology made it nearly inconceivable for early professional physicians to officially and professionally praise the knowledge, birthing experience, wisdom, or authority of illiterate older black women. Although a few physicians did put aside the hegemonies of rational scientific medicine and white supremacy to recognize the value in traditional midwifery, they did not represent the official, public, professional discourse in medical literature at the time. The transition from midwives to professional obstetric specialists in America, scholars have found, met little organized resistance. Midwives lacked any professional organization, and in fact many may not have identified themselves as midwives per se. They had no governing body, no form of standardization or licensure, and their approaches to birth attendance did not align with those of professional physicians. However, as examination of this historical moment in Alabama reveals, a more complicated transition took the place of a straightforward transfer of power from midwives to physicians. In fact, midwives comprised an integral network of community healthcare for far longer in Alabama than in many other parts of the country, due to rural poverty, racism, and mistrust in professional medicine. In actuality, many Alabamian physicians relied heavily relied on these informal caregivers to supplement their healthcare practice in the poorest and most rural parts of the state. Furthermore, white supremacy and racial segregation meant that many physicians neglected the black population entirely, making black women even more dependent on midwives for healthcare. In nineteenth century Alabama, marginalized women without money or options would give birth with a midwife present or with no one at all. Midwives attended births for which they might receive no financial compensation and would assist in ways that went beyond the event of childbirth itself. In a time before public health, before welfare, and before adequate transportation in many parts of the state, midwives comprised an essential and informal network of caregiving in Alabama that supplemented the practice of rural doctors who could not or would not attend. However, as the rise of professionalism put pressure on the medical community to standardize obstetrical healthcare, practitioners in Alabama could not publicly or professionally defend the midwives or their behavior due to the intersecting ideologies of white supremacy and rational medical science. At the time, midwives in Alabama were almost exclusively older black women. Physicians did not look past this aspect of their identity, and continued to rely on negative stereotypes of ignorance, uncleanliness, and incompetence to argue for their licensure and eventual erasure. Further, midwives and physicians relied on completely different skillsets and tools to ensure positive birth outcomes. Professional physicians were trained to use surgical tools, prioritize speed, and intervene, while midwives relied on maternal agency, patience, and comforting behavior. These two epistemologies were not inherently incompatible, as midwives and physicians often worked together to improve birth outcomes. But physicians were committed to constructing a professional authority in the field of obstetrics that required establishment of their practices and approaches as superior. Racism and professionalism prevented physicians from publicly acknowledging the value of midwives and the extent to which they relied on them, even as they did in practice do so.

ENDNOTES

1 Onnie Lee Logan and Katharine Clark, Motherwit: An Alabama Midwife's Story (New York: E.P. Dutton, 1989), 58-59.

2 For thorough and extensive research on the history of this transition in the United States, see American Midwives by Judy Litoff (Westport, CT: Greenwood Press, 1978), Brought to Bed: Child-Bearing in America by Judith Walzer Leavitt (New York and Oxford: Oxford University Press, 1986), and Lying-in: a History of Childbirth in America, by Richard and Dorothy Wertz (London: Collier MacMillan Publishers, 1977).

3 Listen to Me Good is the oral history of a rural African-American midwife named Margaret Charles Smith. Ms. Smith practiced in Greene County, Alabama, during the twentieth century. Ms. Smith was aided by Linda Janet Holmes in recording and publishing her oral history. Motherwit is the oral history of a rural African-American midwife named Onnie Lee Logan. Ms. Logan practiced in Marengo County, Alabama, during the twentieth century. Ms. Logan was assisted by Katherine Clark in recording and publishing her oral history.

4 Judy Barrett Litoff, "Forgotten Women: American Midwives at the turn of the Twentieth Century," The Historian vol. 40 no. 2 (Feb 1978): 239.

5 Charlotte Borst, Catching Babies: The Professionalization of Childbirth, 1870-1920 (London and Cambridge: Harvard University Press, 1995), 1.

6 Logan and Clark, xi.

7 Howard Holley, The History of Medicine in Alabama (University, Alabama: The University of Alabama Press, 1982), 175

8 Joseph Eve Allen, "Remarks on the Abuse of the Obstetric Forceps," *The Alabama Medical and Surgical Journal*, vol. 1 (July-December 1886), 307-313.

9 John Kimbrough, "The Use and Abuse of Anaesthetics in Midwifery," "When Not to Give Chloroform in Parturition," *The Alabama Medical and Surgical Journal*, vol. 1 (July-December 1886), 156

10 Holley, 171.

11 Job Thigpen, "Treatment of Puerperal Eclampsia," *The Alabama Medical and Surgical Journal*, vol. 1 (July-December 1886): 315.

12 Judith Walzer Leavitt, "'Science' Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century," Journal of American History vol. 70, no. 2 (Sep. 1983): 286.

13 Debra Anne Susie, In the Way of Our Grandmothers: A Cultural View of Twentieth-Century Midwifery in Florida (Athens and London: The University of Georgia Press, 1988), 1.

14 Logan and Clark, 58.

15 Holley, 6.

16 See chapter twelve, "The Development of Public Health in Alabama" from The History of Medicine in Alabama Howard Holley.

17 Steven M. Stowe, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth Century American South," Bulletin of the History of Medicine vol. 64, no. 4 (Winter 1990): 558.

18 Margaret Charles Smith and Linda Janet Holmes, Listen to Me Good: The Life Story of an Alabama Midwife (Columbus: Ohio State University Press): 20.

19 Logan and Clark, 56.

20 Holley, 38.

21 Holley, 177.

22 Litoff, 237.

23 Logan and Clark, 52.

24 Logan and Clark, 58.

25 Logan and Clark, 59-60.

26 Logan and Clark, 60.

27 Logan and Clark, 56.

28 Borst, 157.

29 Susie, 7.

30 Holley, 26.

31 "The Education of Midwives," Transactions of the Medical Association of the State of Alabama: Organized 1847—Session 1890 (Montgomery, Ala.: The Brown Printing Co., Printers and Binders, 1890), 114.

19

32 Borst, 93.

33 Ibid.

34 Holley, 94.

35 Holley, 98-99.

36 Many stories attesting to this can be found in Motherwit by Onnie Lee Logan and Katherine Clark (New York: E.P. Dutton, 1989), Listen To Me Good by Margaret Charles Smith and Linda Janet Holmes (Columbus: Ohio State University Press), Folks Do Get Born by Marie Campbell (New York and Toronto: Rhinehart & Company, Inc., 1946), and In the Way of Our Grandmothers: A Cultural View of Twentieth-Century Midwifery in Florida by Debra Anne Susie (Athens and London: The University of Georgia Press, 1988).

37 C.H. Fort, "Our Duties and Remedies to Woman During Gestation and in the Lying-in Chamber," Transactions of the Medical Association: Organized 1847—Session 1881 (Montgomery, Ala.: Barrett & Brown, Steam Printers and Book Binders, 1881), 310.

38 Stowe, 555.

39 Smith and Holmes, 13.

40 Logan and Clark, 140.

41 Ellen D. Hodnett, "Pain and women's satisfaction with the experience of childbirth: a systematic review," American Journal of Obstetrics and Gynecology, vol. 186 (2002): 160.

42 Borst, 22-23.

43 David Leonidas Wilkinson, "Alabama's Need of More Stringent Midwifery Laws," Transactions of the Medical Association of the State of Alabama: Session 1898, (Montgomery: The Brown Printing Co., State Printers and Binders, 1898), 98.

44 Ibid.

45 Borst, 18.