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Women in Labor: How Birthing Practices Reflect Society's View of Women

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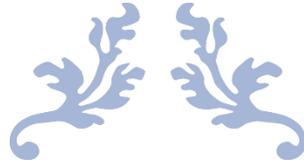
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WOMEN IN LABOR: HOW BIRTHING PRACTICES REFLECT SOCIETY'S VIEW OF WOMEN

An Analysis of the Shift from Midwifery to Doctor/Hospital Births in the American
South, from 1900 to the Present



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Midwifery is considered an archaic profession, with few people thinking of midwives as an alternative to doctors. Most believe that midwives were replaced by doctors as science provided more knowledge about how the human body works and that midwives were less adept at birthing than doctors. This, however, is not true in the slightest. This belief is the product of nearly a century's worth of propaganda and misinformation spread by American health officials to take the power of reproduction away from women. More specifically, the propaganda campaign was used to take power away from the minority midwives who served their communities and to give that power to white doctors. In 1900, more than 50% of babies were delivered at home by midwives; by 1950, 80-90% of babies were delivered by doctors in hospitals (Dawley, 3). This rapid period of change benefited doctors, state health departments, and pharmaceutical manufacturers, not mothers and babies.

Nowhere are the true motives of the campaign for obstetrics clearer than in the poor black communities of the Southern United States in the early 20th century. The accusations against the 'granny' midwives by public health officials were built on racism and sexism, not facts, and the change was detrimental for mothers and babies. White obstetricians barely cared about the mortality rates among their white patients, and their indifference towards black women was outmatched only by their fears of uncontrolled black reproduction. The term 'granny' midwife itself was used to paint a picture of an elderly woman guided by superstition rather than by medical knowledge.

Midwives were immensely important to the communities they served. In the South, many black midwives of the late 1800s and early 1900s took up their profession after having a spiritual call to midwifery, describing in their diaries and to their biographers that they received visions from God (Maxwell, 4). Midwifery was a religious practice as much as a medical one, as the

midwives would use the mothers' beliefs to help soothe them. Superstition may have had midwives putting an ax or a knife under the mattress to cut labor pains or telling the mother to wear the father's hat, but recent medical studies do show that both faith and placebos can have a remarkable effect on pain, which the midwives put to good use. Midwives were also very respectful of the mother's beliefs, whether or not the midwife shared those beliefs, which put mothers at ease as well. This is something with which modern doctors still struggle.

Black midwifery was a family business; daughters followed mothers and grandmothers into the profession, learning at their elbows rather than from written texts (Maxwell, 7). Additionally, midwives would include a woman's female friends and relatives to help care for the mother during her labor (Wilkie, 279). They would massage the new mother's body with perfumed oils during her second stage of labor, before the contractions got too close together. This would calm the new mother and make the next stage of labor easier. Midwives would also care for the women's other children during the pregnancy and help satisfy the pregnancy cravings the mothers had, so to ensure all the mother's needs were met (Wilkie, 278). Pregnancy and birth were family affairs, and midwives were an extension of that family, providing the best care to mothers that anyone could give them.

However, political tides began shifting against midwives in the late 19th and early 20th centuries. Medicalization was on the rise, with more and more healthcare being shifted to doctors and hospitals, and doctors were eager to prove their importance and establish themselves as the health authorities in the country. Obstetricians especially wanted to prove their importance; they were a small field of men who went undervalued by other medical professionals for several reasons, not the least of which being that it was a field that only serviced women. Women, however, preferred to use midwives they knew had learned from experience in apprenticeship

rather than strange men with degrees from a medical school. Midwives were also considerably cheaper than doctors when they charged patients; midwives usually charged less than ten dollars for their services where a doctor would charge between ten and twenty-five dollars (source). Money was being lost by hospitals and pharmaceutical companies, which obviously could not stand.

To stamp out the competition, doctors and their allies in the health departments across the country began a propaganda campaign that was so successful that it endured until the 1980s. This effective libel was targeted primarily at midwives of the ethnic minority communities: the Irish, Italian, Eastern European, and Black communities (Maxwell, 11). Black midwives in particular were accused of providing abortifacients (Wilkie, 275) and of fussing unnecessarily over mothers (Wilkie, 278). News articles and pamphlets declared that midwives were dirty and backward, which made them responsible for the high rates of infant and maternal mortality. In the early decades of the 20th century, the Bureau of Census released reports of birth and death statistics that had a significant impact on the public perception of midwifery (US Census). The report showed that infant mortality rates had significantly decreased between 1900 and 1915, and doctors used this data to insist that it was because more babies were being delivered by doctors. In actuality, the medical advances of antiseptic and antibacterial regimens between the two censuses were responsible for doctors killing less babies through bad medical practices (Thompson, 6). Despite their training at medical schools, doctors were usually not well-trained in birthing in this time period- obstetric training for physicians started in about 1820 and it was not until 1850 that we have a record of a medical student actually attending a live birth, and the training had not advanced much by the 1920s, when the campaigns against midwives were taking off (Thompson, 5).

The new medical profession had a significantly easier time targeting the poor Black midwives of the South; conditions in the areas the midwives served were particularly bad for black farming families. The majority of these people were living in poverty and substandard housing, which created many health issues (Maxwell, 9). It was later discovered that many of the issues mothers and infants faced in these regions were caused by contaminated water supplies, but doctors seized the opportunity to blame midwives (Maxwell, 12). This rhetoric was picked up by a women's health advocate, Laurie Jean Reid, a white Public Health Service nurse. She stated in her presentation to the Mississippi State Medical Association that the midwives were "illiterate, ignorant, negro women, without the knowledge of the first principles of ordinary soap and water cleanliness, and who are daily attending at the birth of some precious baby" ("The Plan of the Mississippi State Board of Health for the Supervision of Midwives," 1921). Reid argued that these midwives should be regulated because their own standards were unsuitable, describing the "uneducated negro midwife, who goes to the average poor family with her lack of knowledge, but multiplicity of superstitions, her insistence on a clean bed, but her equal determination to have as she terms it 'all de mess on de flo'" ("The Plan of the Mississippi State Board of Health for the Supervision of Midwives," 1921). Reid inflamed the Medical Association with her use of racial and class prejudice to make white medical officials feel as though they had to step in, for the good of black mothers and babies. Doctors pounced upon this belief: The Journal of American Medical Association published these statements by Dr. Charles W. Kollock in 1910:

"[He] spoke of the large negro population in South Carolina, among whom eye diseases are rife and who are eminently careless in all health matters. He urged strict laws and education for these people. He quoted the number of births in Charleston from July 1 to Dec. 31, 1909, that of 213 whites 155 were attended by physicians and 58 by midwives. Out of 225 colored births 30 were attended by physicians and 195 by midwives. He mentioned that those midwives were not only

ignorant, conceited, dirty, but very superstitious, and that more stringent laws should govern them” (“What Can be Done for the Prevention of Blindness”, 1910: 1816).

Dr. Joseph DeLee of Chicago made similar statements and said that women only went to midwives because of the lack of respect paid to obstetricians, claiming that “when the women demand a better standard of service and cease employing midwives better service will be provided” (“The Midwife Problem and Medical Education”, 1911, p. 1786). Non-medical sources, like Harper’s and Good Housekeeping, also painted ugly caricatures of midwives. Harper’s published an article in 1930 that quoted granny midwives in their colloquial speech as a deliberate attempt to make them sound uneducated: one midwife, Aunt Elizabeth, was quoted in the article as saying she could get “near about six dollars fo’ ketchin’ one bebbly.” Good Housekeeping published an article in 1914 that praised the new innovations in pain relief made by doctors and hospitals, noting the ‘safety’ and ‘comfort’ of the hospitals as compared to midwives (Thompson, 8).

Another crucial part of the campaign against midwives was the Sheppard Towner Act of 1921. Under this Act, Congress approved funding for local and state health programs to combat the “midwife problem.” It was based on the findings of the National Children’s Bureau’s study from the 1910s into the causes of infant mortality. While the study found the most common denominator in infant deaths was poverty, the Children’s Bureau claimed that it was the lack of ‘skilled care’ that caused infant death (Levy, “Maternal and Infant Mortality” 1919). This statement would be true if referring to midwives as the skilled care and doctors as the lack: infant mortality in hospitals was four times greater than it was in midwife-assisted deliveries at home (Maxwell, 14). In 1923, Polish midwives in New Jersey had 22 maternal deaths per 10,000 live births vs. doctors with 87 deaths per 10,000 live births; Italian midwives in Philly had 8.5

maternal deaths per 10,000 live births vs. doctors with 74.6 per 10,000 (Dawley et al 2016, 578-579). The Sheppard-Towner Act, however, was created to help get rid of the lay midwives responsible for most of the healthy births in the country at the urging of state medical associations and national medical journals.

The best weapon against midwives was creating stricter licensing and birthing legislation. Healthcare programs used the money from the Sheppard-Towner Act to create midwifery regulations. From the 1890s to 1930, all but ten of the states in America had passed legislation restricting midwife licensure, which all midwives were required to have when practicing (Thompson, 8). Some states required midwives pass written examinations, others had age limits of when midwives had to retire, and many had fees to renew licenses, all of which were designed to prevent midwives from legally performing their jobs. These regulations were specifically targeted at “foreign-born [and] racial groups” (Maxwell, 16). Additionally, all states required births to be reported by those attending the birth, so if an unlicensed midwife was helping women, she would be caught when she reported the births. If she did not report the births, she would be subject to heavy fines as well as punishment for working without a license (Bonaparte, 175). Laurie Jean Reid, the white Public Health nurse and women’s health advocate, was among the many health officials that used all of these new state laws and standards to reduce the midwife populations to a number that could be managed by medical staff (Maxwell, 89). Dr. T.L.W. Bailey wrote in the 1928 issue of the Journal of South Carolina Medical Association that:

I am registrar for my district and I became interested in this mortality of midwives, and I have ten midwives in my territory. I gave notice to them that if they would come to my office at a certain time I would give a series of obstetrical lectures. They came, and came regularly. I am sure that that little work did a great deal of good because they were practically instructed-instructed in such a way that these poor, ignorant midwives could understand (Simpson, 1928, p. 31).

He also wrote that there were too many midwives in one area, and that it would be best for the state of South Carolina if they got rid of most of the midwives and trained the rest. A Dr. Manton stated in his JAMA article that the number of women and babies treated by midwives had to be reduced, saying that because their “hands were indescribable, [their] clothing was filthy [and] the condition of [their] bags beggars description” midwives could “slay and kill without one word of protest” (Woods 1910, p. 462). Manton claimed that the regulations would “control these carriers of disease and death” (Woods 1910, p. 462). Like Reid, Drs. Bailey and Manton used incredibly racist descriptions of midwives and classist judgements to prove that the granny midwives of the South had to be controlled or outlawed by these new regulations.

In the South, as midwives were edged out, doctors were increasingly faced with the issue of who was going to deliver the black babies formerly handled by the granny midwife. White doctors did not want to deliver the babies of poor black women; they merely wanted control over black birthing rates and practices (Bonaparte, 173). 1921 saw the first midwife training program, in which the Sheppard-Towner Act money was used to help registered nurses and physicians travel to the rural areas, where the distance between homes and towns made it impossible for one physician to serve a community. These officials would then re-educate the lay midwives and the new nurse-midwives on hygiene methodology. This was part of the licensing programs as mentioned above as well as one of the many ways to ban midwives from practicing (Thompson 12). Courses and schools for midwifery that were later developed with Sheppard-Towner funding were expensive, took a long time to complete, and usually required a literacy test, all of which were obstacles for the poor Black women who had been midwives previously (Thompson, 13). Black women were eventually integrated into these programs, about fifteen years later in 1936, but the white nurse-midwives were paid better and promoted faster (Dawley et al 2016,

580). The few traditional midwives that remained were being forced to meet health department standards in order to get licensed and continue practicing (Maxwell, 90). Less than half of the midwives who attempted to get licenses would be approved after their state-mandated educational programs (Maxwell, 97).

The new nurse-midwives were not trained to do much outside of a regular delivery. They were taught to keep the birthing room clean and prepared, the stages of labor, and under what circumstances to call a doctor to help them, but not how to help with pain or how to handle common problems like hemorrhaging (Maxwell, 17). Black nurse-midwives were heavily regulated and inspected by white doctors and nurses while also going unrecognized for their good work with mothers and babies (Maxwell, 20). They were often called ‘mammies,’ a term that usually referred to domestic servants and harkened back to the slave era, further diminishing their worth to other medical professionals (Maxwell, 18). Their official titles, nurse-midwives, was used to delegitimize lay midwives while also demarking that they were lesser than nurses and doctors (Burst, 1).

Black mothers did not benefit from this change. Health officials were aware that poverty was the greatest cause of both maternal and infant mortality, for a number of reasons: lack of access to good medical care, difficulty with maintaining good hygiene due to insufficient living conditions, and mothers working late into their pregnancy. The majority of poor black women worked in cotton fields in addition to keeping up with their housework and taking care of their elder children. Nevertheless, programs directed to black mothers in the South were focused on the practices of black midwives instead of bettering conditions for the mothers (Maxwell, 101-102). In addition, black mothers were often not financially capable of paying for the services of health professionals, and many would give birth unassisted or with the help of friends, relatives,

or neighbors (Maxwell, 146). Those who did get the new nurse-midwives were not always safe either, as the nurse-midwife was only trained to handle certain situations. She would have to call the doctor if there was a complication, including hemorrhaging, and it would take considerable time for the doctor to arrive because of the distance between him and the patients (Maxwell, 146). This reflects a lack of concern from the doctors for this group of patients, who were similarly devalued by a white-run society for being black, female, and poor.

As mentioned earlier, doctors did not have the same knowledge or respect for their patients. Death records show that there was little or no change to maternal death rates in most of the United States until the late 1930s, more than ten years after doctors started forcing midwives to stop practicing, which helps demonstrate that the shift from midwifery to doctors was not done for women's best interests (Thomasson, 79). Doctors liked to utilize operative interventions, such as forceps and caesarian sections, which were intended to help in childbirth. However, increased operative intervention also meant higher likelihoods of contracting an infection or complications from anesthetic drugs. Midwives and nurse-midwives also used forceps, but with far less frequency: a study from the JAMA's November of 1932 publication found that 13.8% of hospital births were assisted with forceps while only 4.5% of home births used forceps (Plass, 1932). Dr. Joseph DeLee, an outspoken advocate against midwives, said that the use of sedatives, episiotomies, and forceps, which he called the "prophylactic forceps operation," was "...rounded method for relieving pain, supplementing and anticipating the efforts of Nature, reducing the hemorrhage, and preventing and repairing damage" (De Lee, p. 34). It actually may have exacerbated the danger for mothers, increasing risk of infections, damage to the cervix and perineum, hemorrhaging, and infant injury or death (Thomasson, 87). This method, like most operative interventions of the time, was easier for doctors and cost more than a natural delivery.

Doctors' willingness to use dangerous, expensive procedures gives more evidence that their invasion of the birthing room was more for their benefit than for the benefit of mothers and babies.

In 1940, almost two decades after the beginning of doctors' control of birthing, poor black women were still giving birth at home. 90% of nonwhite women in Alabama were having midwife-assisted births in 1940, a number that was cut in half by 1960 to 45%. In 1980, the percentage of nonwhite women giving birth at home finally began to resemble white women throughout the country (Maxwell, 194). These numbers indicate that while doctors were ushering their white patients into hospitals for supposedly 'safer' births, they were not making the same 'efforts' for their black patients. Black mothers remained in the care of nurse-midwives for a very long while.

Black nurse-midwives used their position to provide the best care they could for their communities. Even during the strictest periods of regulation, these nurse-midwives would use some of the traditional childbirth rituals to help calm the mothers they served: herbal treatments, traditional birthing positions, a knife or an ax under the bed to cut pain (Maxwell, 102). The nurse-midwives would use different methods to get the traditional methods past the regulators, including "a bag to go and bag to show," having one bag for inspection and another for deliveries, or having a bag with hidden compartments so they could use herbal remedies (Craven, 340). By combining the medical and the traditional, nurse-midwives won the respect and trust of the mothers in their communities. As such, mothers felt much safer delivering at home with the nurse-midwife than in a hospital, even when the option was available to them, which became a problem for doctors as hospitals continued to proliferate.

The Maternity Center Association, a union of doctors, nurses, and midwives, wanted to open a nurse-midwifery education program for nurses between 1921 and 1923. Their reasons for starting such a program were the same as the stated reasons of the anti-midwife movement: better care for mothers and babies, more hygienic practices, and better training for midwives. Doctors and state officials, however, feared well-educated nurses would be harder to eliminate than previous midwives. The Maternity Center Association (MCA) did get their schools eventually, since nurses were increasingly alone with birthing women at home births, which could prove fatal to the mother and/or the baby. In 1925, after a successful launch of a similar program in Kentucky, the MCA opened their program in New York City (Dawley 2003, 88). In the 1930s, graduates of this program worked their way into the health departments of Southern states, where they worked with the black nurse-midwives just coming out of their own training. The MCA's program and other programs like it did not often admit black women, however, which meant its effects on the black nurse-midwives were minimal (Dawley 2003, 91).

There were several changes to the medical industry in the 1940s that began changing the landscape of birthing care once again. During World War II, many young servicemen and their wives found themselves unable to pay for adequate prenatal care. The government developed the Emergency Maternity & Infant Care program in 1943 to help combat this problem (Dawley 2003, 90). Similarly, labor unions won the right to health insurance from employers, which made hospital care much more affordable for many blue-collar workers. When the war had ended, there was what many refer to as a 'hospital boom,' or a large number of new hospitals being constructed in a short amount of time. This had hospitals cropping up in areas previously serviced by singular doctors and practices. The sudden demand for more doctors in hospitals

coinciding with the post-war baby boom led to a shortage of obstetricians and an increase in nurse-midwifery programs to fill the vacuum (Dawley 2003, 90).

Postwar women, mostly white women found themselves significantly changed by their experiences during the war, and many of them now wanted to have control over their birthing process. They turned to the MCA, who gladly educated them on pregnancy, labor, and birth (Dawley 2003, 92). These women also became intrigued by the new idea of ‘natural childbirth’ proposed by Dr. Grantly Dick-Read, a British doctor. Dick-Read believed that the drugged labors and operative interventions of doctors were keeping mothers from the “fullest realization of motherhood” (Simonsen, 137). The popularization of natural childbirth began shifting power back to mothers as early as 1947. However, this shift did not affect most of the women of color at this time, who were seen by many of the white male experts as “dangerous influences” on the white working mother with their “decidedly matriarchal” families (Simonsen, 145).

While white women were regaining some control and choice over what happened when they gave birth, black women were struggling with a deeply insidious problem in their birthing experiences. As medicalization and hospitals were thriving, so too was eugenics, the idea of only allowing certain people to reproduce in order to create a better population. The United States began to embrace this idea in the first decades of the 20th century and it made its way into the birthing room through several avenues (Thompson, 16). The first was the enforcement of anti-miscegenation laws through the reporting of birth statistics; midwives, nurse-midwives, and doctors were all required to register the births they attended and to be truthful on the birth certificate, which allowed officials to know if a biracial child was born. The next and more enduring avenue was forced sterilization. Starting in the 1929, white officials feared that families of color would drain public resources, and they took steps to ensure this would not happen.

Doctors began performing involuntary sterilization procedures on people of color, more than 2,000 a year between 1929 and 1941. In the South specifically, the numbers are staggering: the Eugenic Commission of North Carolina sterilized 5,000 black people, women and men, between 1933 and the early 1960s. One South Carolina hospital recorded that every sterilization they performed in 1955 was on a black woman (Thompson, 18). The laws that allowed this to happen were only seen unfavorably after it became clear that the Nazi party in Germany had been using American eugenics movements for inspiration, but the practice of forced sterilization continued long beyond that and still happens today. Patients were either coerced into getting sterilized by their doctors, who urged many of them to get the more expensive and more dangerous procedure of a complete hysterectomy rather than a tubal ligation, or were sterilized without their consent (Thompson, 19). Many sterilizations would take place while mothers were recovering from giving birth, when they were in no state to be signing consent forms, and removed any power the mother had over her future child-bearing.

In recent decades, midwives have been returning to American child-bearing as an alternative to hospital births. They are not as many or as prevalent as they had been, and they do not serve the same clientele as they had in the past. Certified midwives attend around 8% of births in the United States (Johantgen, 74). White women are the majority of home births, about 66% more than black or Hispanic women, and less than 4% of these new midwives are black while less than 2% are Hispanic (Thompson, 20). The cause for this seeming reversal of midwife racial dynamics is the same as the cause for the original dynamic: money. Most insurance companies will not pay for midwifery services or home births, which means all costs are out of pocket. A hospital birth may cost around \$12,000 and a home birth may cost less than \$2,500, but the insurance company will not cover the latter (Thompson, 22). Midwifery practices

struggle to stay afloat, especially those who do service women of color, because of the insurance companies' refusal to work with them and state regulations that bar midwives from attending births, even with certification.

Among nurse-midwives, numbers are slightly better. The American College of Nurse-Midwifery did a survey in the late 1970s that found only 10% of their graduates were women of color, proving to its board a point that its students and professors had been trying to impress for about thirty years: there were not enough resources for women of color to attend their programs (Dawley 2016, 583). It still took until 1992 for a Midwives of Color Committee to be formed, and this Committee worked very hard to create resources for the women of color who wanted to study at the college. This Committee and its progeny, Diversity and Inclusion Task Force, still help minority students at ACNM. Registered nurses in general are becoming more diverse, with the entering graduates of nursing programs being 12% black and 5% Hispanic (Thompson, 20). While these numbers make the future look promising, they do not change the fact that the majority of black women are being forced to use racist, sexist services within the healthcare system when they give birth.

In 2008, the celebrity Ricki Lake co-produced the documentary *The Business of Being Born*, which took a hard look at obstetric services within the United States and the alternatives many women had not heard of when making their birth plans. This documentary explored the history of how birthing moved from home to hospital and from herbs to pharmaceuticals, but it largely ignored the issues of race within this history. The creators focused on how white women's births were handled by doctors, who used unethical drugs and practices on them, without touching on the neglect, falsities, and crimes committed against women of color. When looking at the present, the documentary included a black mother using a white midwife, but the

majority of the mothers using midwives or interviewed about their hospital experiences were white, and all of the doctors and midwives were white, with the one exception of a struggling midwife-run clinic in New York City. *The Business of Being Born*'s race-blind approach is symptomatic of most modern midwife movements and much of the historical studies on the midwifery subject.

This white-washing of midwifery does a severe injustice to the black women who were victimized over the course of American history. Black midwives took care of black mothers and babies in this country with more success than white doctors until they were forced out of their professions by lies and malice. This allowed for decades of cruelty and indifference to be inflicted black mothers and babies, the effects of which are still incredibly present today.

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