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BIRTH AS BATTLEGROUND: HOW THE DEBATE BETWEEN MODERN OBSTETRICS AND TRADITIONAL MIDWIFERY WAS RACIALIZED IN THE U.S. (1900-1950)

M. S. THESIS

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BİR MÜCADELE SAHASI OLARAK DOĞUM: ABD'DE MODERN KADIN DOĞUM VE GELENEKSEL EBELİK ARASINDAKİ TARTIŞMA NASIL IRK SÖYLEMİ ÜZERİNDEN YÜRÜTÜLMÜŞTÜ (1900-1950)

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To my mother to whom I will be forever indebted,
Sayısız şey borçlu olduğum anneciğime,

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This thesis was written in 2020 during the global Covid pandemic. To add to the stress of this unprecedented global outbreak, I was also pregnant. During the time that it took me to write this thesis, we had our first baby, Omer Selahaddin. All the things I learned while researching birth history came in handy, but of course, as any mom will tell you, nothing will ever prepare you for birth. I want to take this opportunity to send my love and utmost respect to my midwife and all the midwives, nurses, and doctors and medical staff who handle the special event that is birth with the utmost care, compassion, and kindness.

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SUMMARY

This thesis is about the transformation in the U.S. between the 1900s and1950s when women went from giving birth at home with midwives to delivering babies in the hospital setting attended by physicians. The research focuses on the role of race in the rhetoric against midwives during this period. Historical document analysis was the methodology used for this project. Primary documents of all sorts ranging from official government reports to peer-reviewed journal articles, oral histories, visual accounts, illustrations, paintings, women's magazines, works of fiction from this period were gathered and analysed. Empirical evidence from several studies that look at the safety of birth assisted by doctors vs. midwives from this period was included to demonstrate that, contrary to the doctors' claims from this time, doctor-attended births were not safer for women due to several reasons. These reasons include the inadequacy of medical training, doctors' lack of practical experience, and their tendency to intervene when unnecessary. I conclude that the swift takeover of doctors was not due to medical advances providing better care to birthing mothers but rather was a result of an amalgamation of factors. These factors included the privately funded health care system, doctor's financial concerns, allure of science. However, arguably the most crucial factor was the xenophobia and racism of this particular moment in American history which white male physicians weaponized against the midwife community. Midwives were primarily poor, indigenous, immigrant, and black women of colour, some of the most marginalized individuals in American society.

Keywords: midwifery, midwives, American midwives, traditional midwifery, traditional knowledge, modern medicine, modern science, medicine, American history, whiteness, white supremacy, xenophobia, medical history, obstetrics, gynaecology, birth, childbirth, delivery, situated knowledge

BİR MÜCADELE SAHASI OLARAK DOĞUM: ABD'DE MODERN KADIN DOĞUM VE GELENEKSEL EBELİK ARASINDAKİ TARTIŞMA NASIL IRK SÖYLEMİ ÜZERİNDEN YÜRÜTÜLMÜŞTÜR (1900-1950)

ÖZET

Bu tez, A.B.D.'de 1900-1950 yılları arasında, Amerikalı kadınların neredeyse tümü evlerinde ebeler eşliğinde doğum yaparken, elli yıllık bir süre zarfında, yine neredeyse toplumdaki tüm kadınların doktorlar eşliğinde hastanelerde doğum yapmaya başladığı dönüşüm sürecini konu alıyor. Bu araştırma, bu hızlı dönüşüm sürecinde, doktorların ebelere karşı geliştirdiği ırkçı söylemin rolüne odaklanmıştır.Yöntem olarak tarihi belge analizi kullanılan projede, döneme dair resmi raporlardan, hakemli dergi makalelerine, sözlü tarih örneklerinden, görsel malzemelere, kadın dergilerinden, romanlara kadar çok çeşitli birincil kaynaklar incelenmiştir.

Tezin ilk bölümü araştırma sorusunu, teorik çerçeveyi, metodoloji ve literatür taramasını içeriyor. Burada araştırma sorusu ırk değişen doğum pratiklerini nasıl etkilemiştir olarak belirlenmiştir. Teorik çerçeve interdisipliner, yani disiplinler arası bir yaklaşımı benimsemekle beraber Bilim, Teknoloji, Toplum çalışmalarını merkeze koyan bir yaklaşımı esas almıştır. Burada da en temelde Sandra Harding'in çalışmaları dayanak olarak gösterilmiştir. Harding feminist ve post-kolonyal bir bakış açısından yazan seküler, batı, beyaz ve erkek merkezci bilim anlayışını eleştiren bir akademisyendir. Harding'in çalışmaları objektiflik gibi terimlerin dominant grup tarafından (bu durumda orta sınıf beyaz erkekler, tez özelinde 20.yy Amerikan kadın doğum doktorlarının büyük çoğunluğu) kendi amaçları doğrultusunda manipüle edildiğini savunur. Bu tezde de ebeler ve doktorlar arasındaki temel meselelerden bir tanesi ebelerin yetersiz olduğu iddiasıdır. Ancak doktorlar bunu ebelerin yaptıklarını eleştirmekten çok, kimlikleri ve kimliklerine dair stereotipler üzerinden yaparlar. Onlara göçmen oldukları, siyahi oldukları, yerli oldukları için cahil, batıl inançlı, pis ve kötü niyetli gibi sıfatlar yakıştırırlar.

Bu tez metodoloji olarak ise tarihi döküman analizini benimsemiştir. Farklı türde, yazılı, görsel, sözlü tarih, resmi devlet raporları, karikatürler, romanlar, popüler kadın dergileri gibi çoklu bir bakış ile bütüncül ve kapsamlı bir kanıya varmayı hedeflemiştir.

Literatür taramasının ortaya koyduğu önemli noktalardan biri Amerikan ebelik tarihine dair yapılan çoğu çalışmanın 1970'lerde ikinci dalga feminizm etkisi ile kadın çalışmaları (women studies) departmanlarından çıktığına dairdir. Bu çalışmalar genel itibari ile ebelere sempatik bir tavır takınırken, doktorları kadın düşmanlığı (misogyny) ile itham etmektedirler. Daha sonraları yapılan çalışmalar ise, doğum yapmakta olan annelerin doktorlar kadar (belki bazen onlardan daha fazla) bu dönüşümde rolü olduğunu, ve bu kadınların ebeler yerine doktorları kendi özgür iradeleri ile, çocukları doğumda ölmesin ya da zarar görmesin diye seçtikleri tezini savunur. Günümüze yaklaştıkça, ırk gibi sosyal faktörlerin bu dönüşümdeki önemini vurgulayan çalışmalar yapılmaya başlansa da, bu çalışmaların hepsi azınlık gruplarına odaklıdır. Yani Japon kökenli ebeler, Siyahi ebeler, yerli popülasyonun ebeleri gibi çalışmalar yapılsa dahi hiç bir çalışma doktorların beyazlığını merkeze alıp tüm bu azınlık gruplarının yaşadığı sorunları bu bağlamda bir bütün olarak incelememiştir. Bu tez buradaki boşluğu doldurmayı hedeflemektedir. Ayrıca bu dönüşüm sürecini Bilim, Teknoloji,

Toplum çalışmaları bağlamında analiz eden başka bir çalışmaya da rastlanmamıştır. Bu anlamda da yapılan araştırma orijinal bir katkı yapmayı hedeflemektedir. Bilim, Teknoloji, Toplum çalışmaları sadece sosyal değil teknolojik gelişmeleri de (anestezi, farklı jinekolojik aletler, teknikler geliştirilmesi vs) göz önünde bulundurup doğum sürecinin dönüşümünündeki rolünü analiz edebilmesi açısından da önemli bir katkı sağlamaktadır.

Tezin ikinci kısmı yirminci yüzyılda Amerikan toplumunu üç lens üzerinden tahlil etmeye ayrılmıştır: cinsiyet, ırk ve bilimsellik. İlk bölümde bu yüzyılda, dönüşen kadınlık ve erkeklik algılarına, ve kadınların tıp ve erkek doktorlarla olan sorunlu tarihine odaklanılmıştır. İkinci alt kısımda beyazlık olgusuna, ve ırkçılık ile mücadele hareketine değinilmiştir. Üçüncü kısımda ise bilimselliğin, modern bilim kavramının Amerikan toplumunda yükselen prestijine değinilmiştir. Bu üç konuya odaklanılma sebebi ise doktorların ebelere karşı kullandıkları sosyal imtiyazların (privilages) kimliklerinin bu 3 tarafına dayanıyor olmasıdır: erkek olmaları, beyaz olmaları ve geleneğin karşısında yeni, modern, seküler bilimi temsil ediyor olmaları.

Üçüncü bölüm ebeliğin tarihine kısa bir bakış olarak düzenlenmiştir. Burada kadınların şifacılık konusundaki geçmişine, farklı kültürlerde yüzyıllardır ebelere yapılan referanslara değinilmiştir. Modernite ve endüstriyelleşme sonrası ebeliğin de nasıl profesyonelleştiğini ve Amerika dışındaki pek çok endüstriyel toplumun ilk etapta ebeliği eleştirse de nasıl eğitim, denetleme ve çalışma mekanizmaları kurup, son tahlilde hastanelerde resmi kapasitede ebeleri sağlık sistemlerine entegre ettiği anlatılmaktadır.

Bir sonraki bölüm kadın hastalıkları ve doğum alanının bir tıp alanı olarak ortaya çıkışını, tarihsel köklerini ve özellikle Amerika'da nasıl önem kazandığını anlatmaktadır. Bu bölümde Amerikan doktorların dünyada ön plana çıkmasının arkasındaki karanlık bir gerçek olan köleler üzerinde yaptıkları son derece etik dışı deneylere değinilmiştir. Bunların en meşhur örneklerinden biri bugün tüm dünyada modern jinekoloji ve kadın doğum atası olarak bilinen J. Marion Sims adlı doktorun sağlıklı köle kadınlar üzerinde yaptığı ve kendi otobiyografisinde anlattığı deneylerdir. Bu bölüm son olarak Amerikan sağlık sisteminden, bu sistemin nasıl özel sigorta şirketleri üzerinden yürütüldüğünden bahsetmektedir. Bu durum kanunları etkileyip, politik lobisi güçlü olmayan ebeliğin son bulmasına neden olan faktörlerden biri olarak öne çıkmaktadır. Ebeliği resmi sağlık sistemine entegre eden diğer endüstriyel ülkelerdeki en büyük farklılık kamusal sağlık hizmeti vermeleridir. Böylece ebeler politik lobi faaliyetleri üzerinden özel sağlık sigortası şirketleri ile mücadele etmek zorunda kalmamış ve tamamen yok olma noktasına gelmemişlerdir.

Son bölümde doğumun nasıl bir hastalıkmışçasına 'medikalize' edildiğinden bahsederken, bunun gerekçelerinden biri olarak icat edilen yeni teknik, alet ve kimyasal ilaçlar gösterilmiştir. Doktorların argümanlarından biri olan, doktorlu doğumlar daha güvenlidir tezini incelemek için döneme ait ampirik, istatistiki çalışmalar derlenmiştir. Bunun sonucunda, doktorların argumanlarının aksine, bu geçiş süresi boyunca ebelerin bulunduğu doğumların istatistiki olarak kadın ve bebekler için daha güvenli ya da eşit derecede güvenli olduğu kanısına varılmıştır. Buna sebep olan şeyler arasında, dönemin tıp eğitiminin yetersizliği, doktorların tecrübe eksikliği, (tıp eğitiminin sadece teorik olmasından dolayı) ve ebelere nazaran doktorların gerekmediğinde dahi müdaheleci davranmaları sonucu ortaya çıkan

tehlikeler sayılmıştır. Bunu yapmalarının sebeplerinden biri de doktorlara karşı açılan malpraktis davaları sonucu doktorların fazla temkinli olma eğilimleri ve doktor olarak sürekli hastalık görmeye odaklı bir şekilde eğitim almaları gösterilmiştir.

Geleceğe dair araştırma önerileri bu dönemde hızla büyüyen bir meslek grubu olan Amerikan hemşirelerinin (çoğunluğu beyaz kadınlar olan) farklı ırklara mensup ebelere olan tavrı önerilmektedir. Cinsiyet üzerinden kurulması muhtemel bir fikir birliği varken ırk üzerinden çıkabilecek bir ayrışma ihtimali de bunu ilginç bir araştırma konusu yapmaktadır. Bunun yanı sıra sayıları çok çok az olmakla beraber bu dönemde siyahi kadın jinekoloji ve doğum doktorları vardır. Bu doktorların ebelere karşı olan tavrı da son derece ilgi çekici bir konu olmakla beraber ulaşabildiğim kaynakların hiç birinde böyle bir meseleye değinilmemiştir. Bu da araştırmacılar için ilginç bir diğer muhtemel konu olabilir.

Araştırmanın sonucunda, bu hızlı dönüşümün tıptaki ilerlermelerin doğum yapan annelere ebelerden daha iyi bir hizmet sunması sebebiyle değil, farklı toplumsal, ekonomik ve yapısal faktörlerin bir araya gelmesiyle yaşandığı kanısına varılmıştır. Bu faktörlerden bazılarının, Amerika'nın özel sağlık sistemi, doktorların finansal endişeleri, dönemin bilime karşı olan bakış açısı ve en önemlisi, çoğunluğu siyahi, yerli ve göçmen kadınlardan oluşan ebelere karşı toplumsal olarak zirve yapmış olan ırkçılık ve zenofobi (yabancı düşmanlığı) olduğu görülmüştür. Bu ırkçı tavrın, çoğunluğu beyaz erkeklerden oluşan doktorlar tarafından ebeleri itibarsızlaştırmak için kullanılması sonucunda, ebelik Amerika'da yok olma noktasına gelmiştir.

Anahtar Kelimeler: ebe, ebelik, Amerikan ebe, geleneksel ebelik, geleneksel bilgi, geleneksel tıp, tıp tarihi, Amerikan tıp tarihi, modern bilim, modern tıp, Amerikan tarihi, beyazlık, beyaz üstünlüğü ideolojisi, zenofobi, kadın doğum, jinekoloji, doğum

INTRODUCTION

Medicine, like war, is an extension of politics. The story of the old wife is not the story of an inferior practice losing ground with the advances of medical science and technology; rather, it is a story which concerns the politics of medicine-a story of control and access.

Mary Chamberlain (Chamberlain, 1981, 139)

1. 1 Statement of Problem

Birth is one of the very few things universal in the human experience. At first glance, childbirth seems like a purely or primarily anatomical event, but further consideration reveals that there are economical, legislative, sociocultural, gendered, and racial aspects of this universal process. It is a fascinating subject to study precisely because it cuts across all kinds of dividers like race, gender, class, geography, and others. This thesis will be looking at how birth practices changed in the United States of America between the 1900s and1950s, considering an amalgamation of factors such as industrialization and health care policy, but focusing on the influence of racism and xenophobia.

In the United States, up until the late 19th century, like in many other countries, most births took place at home and were attended by midwives. These midwives were almost always women of colour, and most were trained in an informal system of passing down knowledge from one woman to another within the community. In the rural south, for instance, African American midwives delivered both black and white babies. In the American West, there were midwives who had trained in Japan. The indigenous communities had their midwives in the reservations. Immigrant communities and communities of colour often lacked financial and geographic access to physicians and had internal systems dealing with minor diseases and birth. By the time we come to the 1950s, however, home births went from being the norm to being the anomaly, and midwives were marginalized and essentially outlawed within the span of a few decades.

The story of birth in this period and this particular country is worthy of investigation for several reasons. This history is vital because its implication far exceeds the local American case. As American obstetricians and gynaecologists were fighting to be the primary birth attendants, ruling out midwives, they were simultaneously becoming centre stage in obstetrics and gynaecology globally, thanks to the dangerous experimental operations they were performing on enslaved black women (Owens, 2017, p.6). Thus, modern obstetrics and gynaecology as we know it today trace their roots back to this period. American obstetrics and gynaecology were taking form as American midwives were disappearing. Secondly, taking an STS (Science, Technology, Society Studies) approach and considering many factors simultaneously illuminate not just past injustices but those that are still alive today. Racial health disparities and medical bias are still vital issues in the United States. A 2019 New York Times article details how black and indigenous women in the United States were three times more likely to die due to pregnancy or birth-related causes than white women (Rabin, 2019). Lastly, I chose to pay closer attention to race as a factor. Not only because it has been an underlying issue throughout American history, but also because, during the 20^{th,} with the advent and spread of mass communications systems like newspapers and advertisements, race took on a more prominent role at the forefront of public consciousness. Therefore, the transition of birthing practices in the first half of the 20th century U.S. cannot be understood if divorced from the discourse of race.

Chapter 1 gives a historical overview, focusing on the late 1800s and early decades of the 1900s. This chapter is designed to be a backdrop to the story of birth which will be more directly dealt with in the following chapters. It is split into three subsections. The first section looks at the issue of gender, shifting understanding of masculinity and femininity, and the gendered critique of American medicine. The second section is concerned with race and the social construction of race via scientific discourse. The last section is a brief look at how science was viewed by American society. These three subsections deal with the three aspects of doctors' identities that granted them an advantage over midwives sociologically. Doctors were (almost exclusively) white men of modern science, while midwives were women of colour practicing on tradition.

Chapter 2 follows the trajectory of midwifery, starting with female healers and midwives in ancient times and into modernity, lastly, ending on the story of American midwifery. Chapter 3 carries out a similar task in providing a brief history of obstetrics

and gynaecology as a medical field. However, it also deals with the problematic past of American obstetrics and gynaecology, and the unethical experiments carried out on (sometimes completely healthy) enslaved black women. The chapter ends on the story of how medicine was professionalized in America. Professionalization is an important aspect not to be overlooked in considering why the United States is particularly hostile to midwifery practice when many other industrialized countries found ways to integrate traditional midwives by training, licensing, and regulating them. This chapter gets into the details but suffices it to say here that it has a lot to do with how the American health care system is run by private health insurance, with no universal health care.

The last chapter looks at how this birth transformation issue is indicative of a broader transformation about what society values as a legitimate source of knowledge. It is divided into three sections also, and the first section is about how the idea of birth shifted from being seen as a natural life event to a medical event, a pathology. The second section looks at the argument that physician-attended births were safer than midwife-attended births. Through a comprehensive collection of empirical data from 1900 to the 1930s, it is challenging the assertion that physicians delivered babies more safely than midwives. The data suggests that this was not the case for the initial takeover period. Lastly, the chapter ends on rhetorical analysis, the issue of image and narrative building. Examples pulled from doctors' accounts, novels, and visuals point to P.R.'s importance in legitimizing medical professionals. These four short chapters aim to demonstrate how a myriad of factors influenced the swift shift in how women gave birth in America in the early 20th century and challenge the notion that it was simply the advancements in medical science that led to the disappearance of midwives.

1. 2 Research Question & Argument

This thesis will be concerned with the swift transition, roughly between the 1900s and-1950s, in the history of birth in America. During a few decades, women went from almost exclusively giving birth at home with midwives' help to giving birth at the hospital attended by physicians. The question that started this project for me was since race is a significant factor in American history and present day, could race have influenced the changing birth practices in the 20th century U.S.? This study's primary concern is using an STS (Science, Technology, Society Studies) approach to challenge

the seemingly banal conclusion that scientific advancement out won all other competing knowledge systems and traditional practices, simply on its merit. Anthropologist Gertrude Fraser puts it best: "[T]he erasure of these women's (the midwives) roles and skills in birthing should not be taken for granted as an inevitable outcome of medical progress and professionalization" (Fraser, G. J., 1998, p.2).

Researching this topic through the lens of STS is helpful for a critical reconsideration of history. Critically engaging the mainstream scientific advancement narrative reveals the many different aspects of this transition, such as the history of racial health disparities in the United States and the white supremacist rhetoric propagated and reproduced by white American physicians. This transition was so swift and effective in part because of the racialized rhetoric and policies used against midwives who were almost always poor, immigrant, or African American women of colour. Professionalized medicine was made up of mostly white males who had the financial ability and the political connections to cement their role in the American public health sector both legally and socially.

Leading obstetrician of the early 20th century, Joseph B. DeLee, framed the tension between doctors and midwives as a struggle of elevating science and called midwives "relics of barbarism" (DeLee, 1916, p. 407-415). This language of barbarism, dirt, and cleanliness, scientific vs. backward, and its likes by DeLee's contemporaries will be engaged in more detail further throughout the thesis. However, I bring it up here to give the reader a sense of rhetoric taken up by some of the leading figures in this debate.

After having reviewed the literature and the primary sources, **I argue that** in the case of birth in the United States in the 20th century, physicians takeover from midwives was a complex process, one which included concerns other than just the wellbeing of the birthing mother and the baby, the physicians did not necessarily have more knowledge about childbirth at the time of this takeover. As a result, contrary to their claims, they did not immediately improve maternal and infant mortality rates.

1. 3 Methodology & Theoretical Framework

I will be using **qualitative historical document analysis** as a methodology for this thesis. This method entails the close reading of oral, written, and visual sources, including but not limited to official state documents, reports, newspaper articles, medical journal articles, magazines, diaries, novels, oral histories, caricatures, and illustrations. I will also be surveying secondary sources for an overall trend amongst scholars on the issue. There are **limitations** to the chosen methodology at hand. The two that I am concerned with are **investigator bias and unwarranted selection.** As with most if not all historical research, this one too falls short in analysing all primary and secondary sources. Based on the researcher's interest, limited time, and limited access, a selection of materials was put together to provide the thesis's foundation. I did my best to make sure this body of work included seminal papers, books, and primary sources and was representative of the debate at hand. However, due to the aforementioned issues, there always remains the possibility that some important things were inevitably missed or left out.

As for the theoretical framework, due to the subject's multifaceted nature at hand, there were several possible theoretical frameworks that I could employ. I chose to work with science, technology, society studies (STS), and critical race theory, for reasons that will be made clear throughout the thesis. Still I maintain an interdisciplinary approach, benefiting from the history of medicine through which I focused on the development of obstetrics and gynaecology, professionalization and industrialization of medical procedures, as well as medicalization of birth; critical media studies through which I did a close reading of material from the period at hand, such as pamphlets, women's magazines, popular medical magazines, films, fiction; women's studies through which I studied birth as a gendered event, the shifting power relations within the birthing room and how they changed as birth moved away from the home into the hospital. Here I also benefited from the theoretical framework of intersectional feminists such as Bell Hooks who writes about the various tensions and shifting alliances between white women and women of colour.

STS will remain at the centre of my theoretical approach because it provides a holistic approach that allows me to consider several factors, including but not limited to industrialization, technical tools, chemical drugs, the role of economic systems, and

race and gender in this narrative. By focusing on theorists like Sandra Harding, whose work deals with post coloniality and issues of objectivity vs. diversity, and standpoint methodology, I hope to challenge how medical professionals devalued midwives' knowledge because it was outside of the secular, modern, western, and white notion of knowledge. Critical race theory alongside STS will be a lens that can bring everything into sharp focus. Visual and verbal narratives around midwives invoked the cultural moment's xenophobia and implicitly referred to racial stereotypes about black people, indigenous communities, and immigrants.

1. 4 Literature Review

There is a lively debate on the history of American midwifery. Much of the writings on the topic grew out of a surge of interest in women's history in the 1970s with the influence of the second-wave feminist movement. The scholars who were first to take up this issue wrote that male physicians had aggressively pushed female midwives out of the birthing rooms as primary birth attendants and are much more charitable to the traditional midwives. However, more recently, another stream of scholarship argued for giving women more agency in the historical recounting of these events. This group of scholars claimed that women who were giving birth were demanding physicians instead of midwives. This was due to the promise of this mystical new method: science in the face of widespread fear of losing one’s baby or life during labour.

Some of the books that proved to be useful and engaging for this thesis include Dorothy and Richard Wertz's 1978 book *Lying-In*. Written by a married couple of historians, the book established the legitimacy and value of historicizing childbirth. It inspired a new generation of scholars to research the intersections between reproduction, medicine, and feminism, emphasizing women's active roles in changing birth practices. The book is about the hospitalization of birth, midwives' struggles, and the re-emergence of the homebirth phenomenon in the late 70s. Following it, Judith Walzer Leavitt's 1986 title *Brought to Bed: Childbearing in America, 1750– 1950* was published. Leavitt's book includes personal accounts by mothers and their attendants, talks about the tension and power struggles between physicians, midwives, and birthing women. Leavitt writes as a white woman and as someone who hails from the history of medicine and women's studies, all of which influenced her work (Leavitt, 1986, 3-5). Some ten years after *Brought to Bed*, in 1995, Charlotte Borst, another

historian, took on the challenge of examining the issue from a qualitative statistical point of view with her book *Catching Babies: Professionalization of Birth*. In the book, Borst looked at the influence of gender and class but did not focus very much on race. The most striking assertion in Borst's book is that contrary to the earlier narrative, she argues that what pushed the midwives out was not the misogynistic doctors. Instead, it was the social change around valuing depersonalized science over artisanal skills and traditional knowledge. (Borst, 1995, p. 11) Borst writes that a lot of the early literature on the history of birth in America came out of "a critique of medical authority in general" and that a lot of the literature on birth grew out of a moment of high interest in women's studies in the 1970s (Borst, 1995, p. 8). It was not until Gertrude Fraser that someone dealt with race and its involvement in the history of black midwives. Fraser's books include interviews with the African American community of not just midwives but also community members who knew them, who gave birth in their presence. She talks about her ability to access these homes as a black woman from the Caribbean, wearing her hair naturally. (Fraser, 1998 p.8-9). She writes how the way she presented herself as a black woman differed from many in the community she studied, but her racial background still lent her more access than someone else may have had. (Fraser, 1998 p.9). The most interesting finding from her work is that people were both embracing the midwives and their authority, ability, and charisma in some cases; while at the same time seemed hesitant to do so because these old and traditional ways of doing things were now considered "backward" (Fraser, 1998 p.12).

After Fraser, other scholars took on the challenge of looking at birth history through a racial prism. One of the more interesting ones was Susan Smith, who wrote about Japanese American Midwives. These were women who were accepted and performed within the official legislation in their home countries but in America suddenly found themselves strangely at odds with normative whiteness and mainstream medicine (Smith, 2005, p 2-4). More recently, in 2019, Brianne Theobald published her first book, which deals with Native women and the theory of birth histories, titled *Reproduction on the Reservation.* Historians have been writing about U.S. governments' coercion tactics on indigenous populations, from forced sterilizations to taking indigenous children and placing them at boarding schools or foster systems.

Theobald puts all this context and talks about the adaptive strategies native women have come up with to survive and protect their children. Theobald writes, "Outside

reservation boundaries, physicians and especially obstetricians began to speak and write about "the midwife problem" in ways that resonated with a host of cultural anxieties. --- [T]he ignorant, immoral midwife who was evoked in Progressive Era medical literature and popular culture had a specific identity: she was almost always an immigrant (Theobald, 2019, p. 58). The last book I will mention by name here is Wendy Klein's 2019 book *Coming Home: How Midwives Changed Birth* which looks at midwifery's re-emergence starting in the 1970s. Birth moves back into the home just as fast as it moved outside of it, though only for a small demographic of middle-class, counterculture white women. In 1977, the executive director of the American College of Obstetricians called this phenomenon "anti-intellectual anti-science revolt" (Kline, 2019, p. 145).

Recent scholarship focuses on specialized historical accounts, focusing on the African American, Japanese American, and Native American midwives, and how a racialized rhetoric influenced their practices. Yet, no study has tried to present an overview of how these separate communities went through the same process with the common thread of race. Also, studies often focus on the "colour" of the midwives and how they were scrutinized with racialized language while disregarding the invisible colour in the discourse. The overwhelming whiteness of the medical professionals during this time played a role in this transitionary period. Another weakness in the literature is the lack of consideration for female doctors, both white and women of colour. Although their numbers were few and far between and their existence proved an exception in the medical community that established itself during this time. It would be interesting to investigate whether women had a different gender or race-based perhaps allegiance to these midwives. There were some white and some black women who, despite facing many difficulties, still managed to get their diplomas and later licenses to practice. There were also obstetricians amongst them. Their views on midwifery would provide a unique angle.

The unique contribution this thesis aims to make to the literature is its holistic approach through an STS lens. I look at this debate between traditional midwifery and modern obstetrics not just as a case in medical history but also as a case of racialized knowledge systems: one the one hand, the so-called rational, objective, modern (and by implication white) science, on the other hand, the so-called irrational, subjective, and premodern or traditional or as some doctors deemed it barbaric, uncivilized,

savage ways of knowing. The shift in birth practices did not primarily come from concerns around safer births for mothers and babies. Instead, it is a cultural, political, and epistemological shift that validates modern science (represented by white men) against traditional knowledge about birth (in this case, carried by non-white women).

Throughout this thesis, I will be referring to race and racism. When I write racism, I do not mean race-based personal prejudice. Racism as a political ideology was established and maintained for centuries by various formal institutions. African American scholar of race and gender Bell Hooks argues that racism is a political ideology and a system of oppression, not white people's personal prejudice. (Hooks, 1981/2000, p. 389). Throughout the rest of this thesis, I will give detailed examples of how racism was embedded into the very fabric of American medicine, but to give you an idea of how high the stakes are, I would like to bring your attention for a brief moment to the way doctors in America engage with race. In a recent example, a 2011 study showed that people of colour were less likely to receive pain medication (due to false assumptions about their pain tolerance being higher and their supposedly higher likelihood of drug abuse) (Mills et al., 2011, p. 752). Even more surprising was a 2016 study that showed half of a sample of 222 white medical students and residents endorsed or held beliefs such as black people have less sensitive nerve endings, literally thicker skin, and a type of blood that coagulates more quickly compared to white people (Hoffman et al. 2016, p. 4296).

These views have severe and even fatal real-world consequences. One such consequence is that in America, black mothers are three times more likely to die due to birth complications than white mothers (Martin & Montagne, 2017). This was true even when the data was adjusted to factor in education level and financial status. Thus, the disparity was clearly based on race (Martin & Montagne, 2017). In yet another chilling study, researchers concluded that black babies were less likely to die when cared for by black doctors (Greenwood et al., 2020, p. 21199).

The coming chapter will situate the story of birth transformation in the broader context of what was happening in the U.S. during this time, particularly paying attention to gender, race, and the rising popularity of science. The reason is that these three aspects are what gave doctors an advantage over midwives due to their race, gender, and the use of modern western science as opposed to traditional knowledge.

2. HISTORICAL CONTEXT OF THE LATE 19TH AND EARLY 20TH CENTURY U.S.

The history of birth in America is an intersection of multiple histories. There are various narratives interwoven through the lens of gender, race, and science. Therefore, it is essential to provide a holistic snapshot of the historical period during which this transformation of childbirth happened. Modernization, industrialization, changing gender dynamics, racial tensions are all surrounding issues without which it is impossible to understand the intricacies of how and why women suddenly started to give birth differently. This chapter in three subsections will provide a slightly more detailed look at what was happening in America, focusing on the end of the 19th century and the first decades of the twentieth century. First, I will write about gender, American women's condition, shifting understandings of masculinity and femininity, and the gendered critique of medicine. Then the second section will provide a broader look at race, focusing on the construction of whiteness as well as its convergence with citizenship, the rise of xenophobia, anti-immigrant movements, and the condition of black people. Finally, the chapter will end with a section on the role science played in people's lives during this period, some important events in American science history, and the rise of secular western science as the dominant epistemology. This chapter is designed to provide the reader with a snapshot of this period in the U.S. with three focal points: gender, race, and science, to provide a foundation for the rest of the thesis.

2. 1 Gender and the Shifting Notions of Femininity and Masculinity

The turn of the century was a time of significant changes for women. However, it is important to caveat this history with a word about intersectionality. Intersectionality, a term coined by Kimberlé Crenshaw, a law school professor at Columbia and UCLA, is the idea that issues like gender, race, and class are interconnected (Steinmetz, 2020). Therefore, it is crucial to notice that women of different racial backgrounds have not always been a unified front on matters of race and gender. African American studies and women's studies scholar, and self-proclaimed intersectional feminist, Bell Hooks argues that racial injustice is more fundamental for the American context than sexual injustice. Black and white women have always held different places in American society. In the 19th and 20th centuries, "few if any similarities could be found between

the life experiences of the two female groups" (Hooks, 1981/2000, p. 390). This is the framing I would like the reader to keep in mind as we delve into the issue of gender.

The 1920s was a time for ideas around women's sexuality started to change. An influential thinker was Sigmund Freud, who sought to break the taboos around sexuality and its role in people's psyche and life (Woloch 2002, p. 274). Men and women, mostly speaking of white men and women, started to mingle socially more than they used to without any supervision. This was partly because of the emergence of co-education, women entering colleges (Woloch 2002, p. 281-83), and partly was caused by the automobile's advent. However, it would not be until the contraceptive pill was invented that ideas around sexuality really shifted and what the feminists call "women's sexual liberation" really took hold. This social shift also presented a strange dichotomy. On the one hand, women were out in society working, dating, and having sexual relationships outside of marriage with less consequence than before. On the other hand, these behaviours were seen as signs of having low morals and associated with urbanization and immigrants (who were seen as catalysts for this negative cultural shift) (Cowan, 1976, p. 184). It would later be used against midwives of colour with accusations of performing illegal abortions for urban single immigrant women.

Another major event that pushed men and women into sharing social spaces was the First World War. Women replaced men temporarily in the workforce, in jobs that previously would be called inappropriate for women, like mechanical factory work (Kessler-Harris, 2003, p. 219). This was mainly for white women, as for black women, by the 1920s, they were mostly doing agricultural work, domestic work, or laundry. It would not be until WWII that similar industrialization would take place for black women. Despite the hardship imposed upon by the war, there was a relative level of prosperity in the nation even for working-class people, allowing young women to seek vocational training that could help them move up the socioeconomic ladder (Kessler Harris, 2003, p. 237-288). Traditional gender division of labour was dramatically affected by the war. The domestic sphere, assigned to women by society, was now seen as an active part of the war and referred to as the "home front." The public sphere, assigned to men in turn, was now seen as the place of military action (Standlee, 2010, p. 43-62; Milkman, 1987, p. 99-105). As the number of married women joining the workforce, men slowly lost their role as the sole breadwinner.

A significant area of activism for feminists during this time was reproductive rights. Abortion and birth control were two primary agenda items. Both were inaccessible and frowned upon, in most cases also illegal. It was a feminist activist named Margaret Higgins Sanger who first opened birth control clinics in the U.S. starting in 1916 (O'Dowd & Philipp, 2000, p. 33). She was the one who brought a civil lawsuit against the government in 1936 to allow doctors to send information and contraceptives to married patients via mail. She won the suit, and a year later, the American Medical Association announced it now recognized birth control as integral to medical education and practice (Temkin, 2007, p. 1741). Birth control for unmarried people did not become legal until 1972 in America.

Gender politics of therapy came into play in the obstetricians' takeover of birth as a procedure, but before this transformation happened, women already had a contentious relationship with professional medicine. Gender roles and perceptions also influenced women's relationship with doctors and medicine in general.. During the early 20th century, there was an idea of heroic (male) medicine especially embodied in the figure of the surgeon. It is apparent in Figure 1, the 1875 painting by the famous 19th-century painter Thomas Eakins, titled Gross Clinic. The scene depicts a room filled with obscure viewers and doctors hobbled over the patient while prominent surgeon Samuel Gross stands in the middle as the heroic doctor. The female nurse is seen as covering her eyes in the left bottom corner. Everyone is looking except her, not to be capable of even observing what is happening, let alone participating in assistance. This painting reflects the general notion that women were not fit for medicine, that it was too shocking for a lady. Another hotly debated issue from this period was the diagnosis of hysteria. Derived from the Greek word for womb, *hysteria* in the 19th century was considered a physiological illness, mainly affecting women. Later in the 20th century, it would come to be regarded as a mental disorder and eventually be dropped altogether in the latter half of the century. Colloquially the term came to signify women who were unable to control their emotions. Hysteria was heavily criticized by feminist scholars later (Gilman et al., 1993, p. 286).

Figure 2.1. Gross Clinic by Thomas Eakin, 1875 is an oil painting depicting surgeon Samuel Gross, famous for its shockingly candid portrayal of the blood and gore of surgery. Note the portrayal of the disgusted female figure in the left bottom corner, alluding to the common myth about women being unfit for medicine.

Source: Encyclopaedia Britannica. Retrieved February 23, 2021, from https://www.britannica.com/topic/The-Gross-Clinic

A vital gendered critique of late 19th and early 20th-century medicine was often referred to as "Rest vs West Cures." Put simply, these referred to the notion that women with psychological symptoms like depression were prescribed bed rest sometimes for months while men with similar ailments were suggested to take trips. Westwards (Stiles, 2012). These cures were made famous by Silas Weir Mitchell, who treated the likes of poet Walt Whitman, painter Thomas Eakins and the then-future president Theodore Roosevelt. Among his female patients was the author Charlotte Perkins Gilman. Afterward, Gilman wrote a seminal feminist short story called "The Yellow Wallpaper" (1892), where the narrator of the story, perhaps inspired by Gilman's experience, goes slowly mad during the prescribed bed rest in seclusion. Critiques of the rest cure deem it a symbolic case of 19th-century medical misogyny (Stiles, 2012). These narratives about women's supposed irrationality, inability to make sensible

decisions, and lack of control over their overflowing emotions were the backdrop of any argument advanced against the female healers and midwives deemed unprofessional and unfit to be trained in and practice medicine.

This thesis constantly refers to a tension between white male doctors and female midwives of colour. The intersection of race and gender and the tension between these two groups of people is therefore at the very heart of this study. When talking about race and gender, it is essential to recognize that while there are two separate issues at hand, they are also intertwined in ways that make it impossible to separate them. Bell Hooks argues that despite what she sees as the dominance of patriarchy in America, racial oppression takes precedence over sexual oppression, evidenced by the fact that patriarchy could not bond Indigenous men and black men with white men. On the other side, racism shadowed, she says, any alliance made between white women and black women (Hooks, 1981/2000, p. 390). Black and white women have an interesting dynamic where their comradery constantly shifts from their racial community to their fellow women and back. The following section will detail some of the significant events of this era as they pertain to the history of race relations and take a closer look at the issues faced by black women.

2. 2 Race and the Invisible Ubiquity of Whiteness

Harvard-educated black sociologist W.E.B. DuBois declared that the problem of the 20th century was the problem of the colour line (DuBois, Chandler (Ed.) 2014, p. 1). Though ever-present, the issue of race and racism came into their own during the 20th century. Many things were going on in terms of the social construction of race and interracial dynamics. It is crucial to first layout the foundation of the American ideas of Euro-American cultural superiority and white middle-class. This is to comprehend better the weight behind words like barbaric or racist stereotypes invoked to delegitimize the women of colour who were midwives. This century's xenophobic climate would prove to be a fertile ground for portraying midwives as ignorant, old, and dirty.

Racism, as a political ideology, was maintained for centuries by different institutions, and science was one of these institutions. It is illuminating to investigate the relationship natural sciences, medicine, and social sciences had with racism and xenophobia. The 19th century supported a dominant ideology of a type of social

stratification today known as "scientific racism." It is the idea that science empirically and objectively proves (all loaded terms) that some human communities are more evolved than others and thereby implies that the various placements of these racially different communities are justified on solid scientific grounds (Winston, 2020). E. Francis Galton, Darwin's cousin, is credited for creation of eugenics. (Allen, 1986, p. 225) It was considered a legitimate field of scientific study that argued for racial purity and sterilization laws to improve the race until the Nazis and WWII used these as justification. Sometimes referred to as Social Darwinism, this ideology of ranking races biologically was a popular idea. Harry Laughlin, the President of the American Eugenics Association, argued that to keep America America, the country had to increase the amount of Nordic and northern Europeans and reduce the number of Eastern Europeans, Asians, South Americans, and people of African descent (Wilson, 2002, p. 49).

Scientific racism was not an invention of the U.S.; it was already well established in Europe in the 18th century. Some scholars root this notion of a hierarchy of human races with the white Europeans at top broadly to the Enlightenment thinking. Specific examples from European scientists' views from this time include Swedish scientist Carolus Linnaeus book *Systema Naturae* in 1748, followed soon after by French scientist Henri de Boulainvilliers' work on the theory of race and conquest published in 1767 and British Edward Long's the history of Jamaica in 1774. All of them used scientific arguments to argue for Africans' inferiority and those with African ancestry (Owens, 2017, p. 21-22). German naturalist Johann Blumenbach (d. 1840) thought that the "ugly noses" of African babies were flat because their mothers were careless while breastfeeding and would press the babies' noses into this shape (Schiebiner, 2004, p. 135). Another common belief among Europeans regarding Africans was that black women in Africa had sex with apes. In the only book he published, one of America's founding fathers, Thomas Jefferson, claimed that black women preferred apes as sexual partners over black men in Africa (Owens, 2017, p. 22).

White Europeans who came to America inherited these notions of their superiority over other races, and as a result, late 19th and early 20th centuries witnessed the American nativist movement. It that was made up of white descendants of some of the earliest immigrants of the United States. These populations did not perceive themselves as immigrants but rather as rightful owners of the land (disregarding the

presence of the indigenous populations), and as a result, some were vocally anti-immigrant. People who would be considered white today, such as the Italians and the Irish and European Jews, faced discrimination. The anti-immigrant sentiments targeting these groups would only soften in the face of a major influx of formerly enslaved southern black people migrating to the northern U.S. in the 1920s to pursue jobs. This led to black people being targeted by racism and allowed the fair-skinned European immigrants to now be considered white (Jacobson, 1999, p. 8).

There was some irony in how black people were seen as more foreign than recently immigrated fair-skinned Europeans, considering that many black Americans who were descendants of people that were brought via the Atlantic Slave Trade and had been in America for as long as the very first Protestant white ancestors the nativist movements took pride in. To quickly note some basics about this chilling historical event, between the 1600s and 1880s, an estimated 12.5 million Africans were abducted and shipped to the New World; 10.7 million of which are thought to have survived the middle passage. Out of those, only about 388,000 were directly shipped to North America until the 1880s (Gates, 2014). Most were sent to South America (Gates, 2014). America fought a Civil War between 1861 and 1865 partly over slavery, and President Abraham Lincoln decreed all slaves (in states rebelling to the Federal Government) as freemen with the Emancipation Proclamation in 1863 (The Public Broadcasting Service, 1998). This means that the history this thesis is focusing on between 1900 and 1950s starts merely 37 years after emancipation.

By the time 1900s rolled around, much had changed for black people in America since the Atlantic Slave Trade, and yet much remained to be changed. Along with economic injustice, Southern states also presented the very imminent danger of white supremacist violence at the hands of the Klu Klux Klan (KKK), a self-proclaimed Christian organization with racial purity and white supremacy as their central ideology (Law, 2016, p. 126). They were not just after black people, but rather anyone who they felt threatened the purity of the white race, which included Catholics, Jews, Asian Americans, communists, and others (Law, 2016, p. 137). This is an important point that sometimes gets lost in narratives about racism. Historical accounts of race often centre people of colour and allow the culprit of white supremacy to remain invisible and not be held accountable. I want to focus on whiteness here as a central notion of American citizenship itself, a dynamic notion that means different things at different

times.

Reproduction was one of the central concerns of this racial superiority ideology, and interracial sex was taboo both during slavery and in the years following emancipation. Some states passed miscegenation laws that rendered having sexual relations between people of different races illegal. Their main crime being that the mixed-race individuals born from these relationships would lead to race degeneration (Frederick, 2016). One of the most common and horrific manifestations of this fixation was accusing black men of allegedly raping white women and lynching them as punishment. Whites believed black men to be feral and predatory (Law, 2016, p. 131), while white women were held as ultimate symbols of purity and bearers of the Anglo-Saxon race into the future. KKK or the others who were complicit in black men's lynching were not interested in giving people due process. Oftentimes even so much as gossip was enough for a black man to be lynched and brutally mutilated (Law, 2016, p. 131). The lynching was done publicly, and the bodies were left hanging to rot on tree branches to spread fear to all the black people. There is not an exact number of how many people were lynched. Even though black men suffered a lot due to claims of raping or having sex with white women, most of the interracial sexual violence was perpetrated by white men against black women. Plantations where slaves worked often had biracial children whose fathers were almost always the white slave owners (Owens, 2017, p. 40).

There were strange dichotomies around how whites saw black women. On the one hand, black women were hypersexualized. White men raped and showed sexual desire towards black women privately, but they were pronounced as ugly while white women were the standard of beauty. Thomas Jefferson wrote about how Indians were less savage than blacks and most evolved of all races were the whites, which was evident according to the third president of the United States, in the darker people's supposed ugliness (Owens, 2017, p. 22). Another dichotomy was that black women were seen as masculine while they were sexually targeted. They were perceived to be far from the lady-like fragility attributed to white women, in their capacity to bear a lot more pain during childbirth supposedly and in general or do the same work as black male slaves in the fields (Wood, 2010). These ideas would be important in obstetricians' treatment of black birthing mothers later on.

One of the key takeaways is that rationality was a racialized value that would later be used against women and people of colour when specific sectors like medicine are "professionalized." One of the most apparent manifestations of this racialization of certain values like being rational was the 1790 Naturalization Law: the most important law in defining citizenship. It defined who was eligible to be a citizen. It was "free white persons." Whiteness at this time had been written into all kinds of laws, so whiteness was not a new legal idea, but neither was it clearly defined and fixed. The definitions and the parameters of whiteness would constantly be shifting. Japanese immigrants, for example, were ambiguously categorized until 1922 when a Supreme Court case (Ozawa v. the U.S.) established that the Japanese were not white. In this way, reproduction was politicized, and the American-born children of these Japanese immigrants were denied citizenship on racial grounds. There are two ways to think about the reflexive assumption that citizens should be white: the U.S. was a settler democracy, and indigenous people and the slaves were seen as two racialized threats to this democracy. Secondly, there were underlying assumptions about whiteness and democracy. To make sure this system worked, it was decided that the citizens must be rational, upstanding, virtuous, wise, etc. At this time, all those virtues and characteristics are already explicitly assumed to be racialized. Whiteness is conjoined with the virtues needed for citizens.

It is common to find 19th-century medical texts asserting presumed scientific authority race-based anatomical differences, often accompanied by a heavy undertone of anti-black racism or white supremacy. Historian Walter Johnson said of the 19th-century medical journal "where race was daily given shape" (Owens, 2017, p. 19). What is the 21st century we have come to call scientific racism was the norm of 19th-century science. Many medical professionals propagated racist views and aided white supremacy to prevail over America. Samuel Cartwright, a prominent 19th-century doctor, argued black people had certain "peculiarities" like lower lung capacity, which conveniently was fixed by forced slave labour and mental disorders that made enslaved people run away from their enslavers (Cartwright, 1851, p. 691). Physician T.E. Murrell wrote about how a less developed cerebral cortex made black people "carefree" (Murrell, 1887, p. 820). While some other doctors of this era attributed features like less sensitive nerve endings to black people (Guillory, 1968, p. 209) (making them supposedly more resilient to pain), some physicians went so far as to

claim black people felt little to no pain during surgical operations (Pernick, 1986, p. 991). These beliefs had dire consequences for black people who were experimented on well into the 20th century, without their consent and sometimes even without their knowledge. One doctor wrote after hearing from other physicians how black people who had cholera lost all ability to feel, he decided to see it for himself and poured boiling hot water on the legs of a black person (Kollock, 1836, p. 329). In this way, doctors used their scientific authority to justify the inhumane treatment that black people were suffering from under slavery. In the same essay, Murrell openly argued that though one may look for various socioeconomic or circumstantial causes for the differences, he claims to exist between blacks and whites; these differences are only "accounted for … by some racial peculiarity" (Murrell, 1887, p. 817). Explicitly race was made out to be why the social placement of black people (as well as other non-whites) was justified on scientific grounds. Such texts also often provided a counter-image of why white people could not bear such rough circumstances by comparing white women to black women in labour, white children during play to black children. Another interesting question about the dichotomy of black women's role was how could races be biologically as divergent as the doctors claim if they used the exact same scientific findings based off of research on enslaved black women, for white patients? (Owens, 2017, p. 28).

It is clear from these examples that U.S. medicine has always had a complicated relationship with racism. Doctors used and abused the scientific authority they had to justify the social ills of American society. Early American medicine was rudimentary and decentralized. Therefore, the critique on its anti-blackness can be argued to be about the individuals and their prejudices. However, as American medicine matured and healthcare grew with its stakeholders: the policymakers, the insurance companies, caregivers, and of course patients, the issue of anti-black racism continued to grow. This is a section aimed to provide a snapshot of race relations between white and black Americans during the first half of the twentieth century to understand better how race may have played a role in shifting birth practices and the tension between white doctors and black midwives.

2. 3 Science, Its Allure and Rise to Prestige

The United States became a country around the same time as Europe was living through what came to be known as the Enlightenment era. Although, in theory, the U.S. was also a place for free scientific discovery, in practice, it was very rudimentary compared to established European institutions of science. However, the promise of a free world combined with the pushing away some scientists experienced in their own countries led to a major surge of scientists immigrating to the U.S. Broadly speaking lab science was in the cultural consciousness and the allure of scientific knowledge was picking up speed. Two cartoons from the popular magazine *Puck,* figures 2.2 and 2.3 show on the cover microscopes. Putting aside the actual message of these cartoons the repeated use of a microscope in such a medium and popular press reflects that by the late 19th-century lab instruments are not only recognizable to the ordinary people, but they are also friendly objects rather than mysterious or threatening (Hansen, 2019).

One of the underlying debates during this time, starting really with the Enlightenment, was the tension between various epistemologies. At the heart of this debate between maternity care lies a more profound tension around traditional knowledge's legitimacy versus modern western medicine. This thesis is about knowledge production and tension between different knowledge systems as much as it is about birth history. The validity of what the midwives knew about birth, how they acquired or passed down that knowledge all came to be questioned in the 20th century. It was a gradual process of a cultural takeover by the white western understanding of proper "objective" knowledge production. The dichotomies, midwife vs. physician, traditional vs. modern, all stem from a singular understanding of white western dominant epistemological hegemony. Some critical historians argue that the conventional history of medicine promotes a "myth" about "(male) science" automatically or naturally replaced "(female) superstition," which must be questioned (Ehrenreich & English, 1973, p. 2). I would add to Ehrenreich and English's argument that alongside gender, these epistemologies were also racialized and accordingly ranked, male and white going alongside each other and placing at the very top of the hierarchy.

This struggle between medical men and female healers, in this case, midwives, was a political and economic struggle with high stakes that determined which party would

monopolize health care and benefit from it financially and otherwise (Ehrenreich & English, 1973, p. 2). To that effect, science, and technology studies scholar Sandra

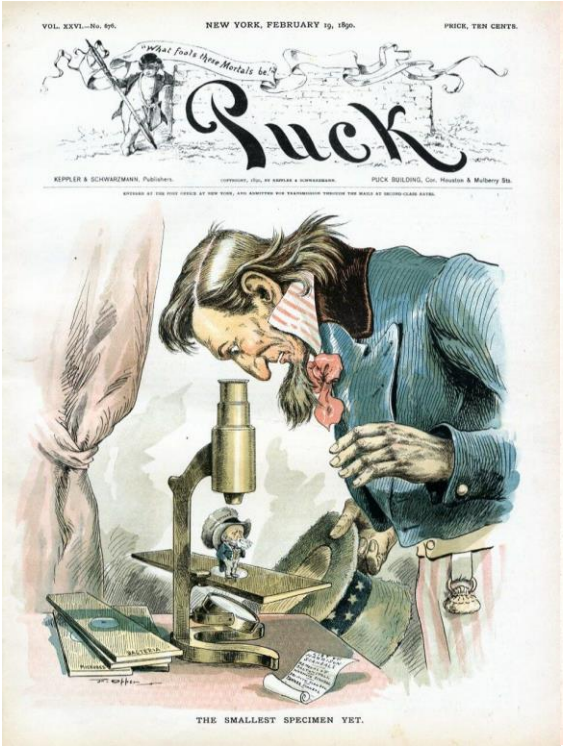

Figure 2.2 Cover page of Puck Magazine, 1890, Feb 19th

It depicts "Uncle Sam," the symbol of America, looking through a microscope. The particular political message is irrelevant here. What is relevant is that a popular magazine using scientific lab equipment like a microscope indicates that the general public was fairly familiar with it.

Source: HANSEN, B. (1999). New Images of a New Medicine: Visual Evidence for the Widespread Popularity of Therapeutic Discoveries in America after 1885. *Bulletin of the History of Medicine*, *73*(4), 629-678. Retrieved March 7, 2021, from http://www.jstor.org/stable/44446035

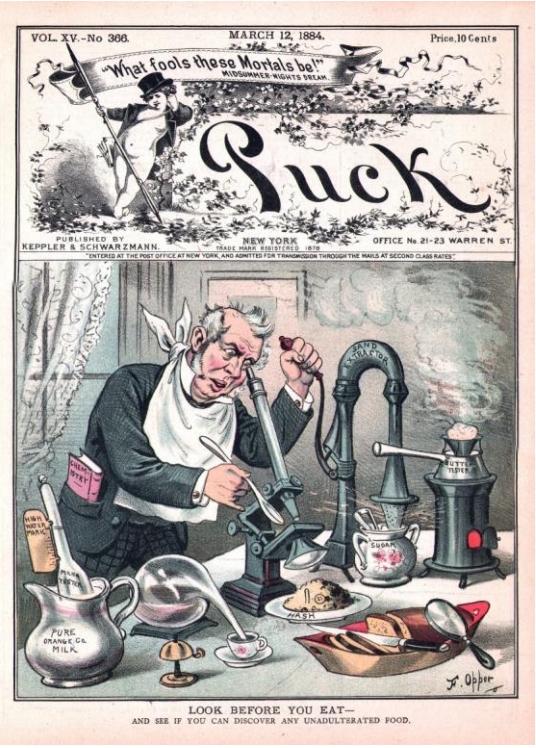

Figure 2.3. Cover page of Puck Magazine, 1884 March 12th

It depicts a microscope along with other lab equipment. Similarly, the point about food safety regulations is irrelevant here. The focus is still on the way science was making its way into the public consciousness as part of everyday life.

Source: Opper, F. B. (1884) Look before you eat / F. Opper. , 1884. N.Y.: Published by Keppler & Schwarzmann. [Photograph] Retrieved from the Library of Congress, https://www.loc.gov/item/2012645181/.

Harding argued that objectivity is a fraud notion that has a history of being weaponized by the dominant oppressors. Objectivity or one's incapacity for it was both gendered and racialized and used to dismiss women, black or indigenous peoples. These people were accused of subjectivity or self-interest (Harding, 2012, p. 32). Harding's solution to this problem: diversity, specifically the inclusion of those economically, politically, and socially oppressed (Harding, 2015, p. 35). Harding uses standpoint methodology, defining feature of which is that it proposes to start from the standpoint of the daily

lives of the oppressed groups rather than the dominant conceptual frameworks, "to obtain more objective accounts of nature and social relations" (Harding, 2015, p. 30). Both gender and the race of midwives contributed to the delegitimization of their practice. Therefore, standpoint methodology offers a valuable critique that even medicine which seems so impartial and depersonalized can be biased.

Starting with the gender question, Harding demonstrates how objectivity has been a name for a certain type of white protestant male status quo perspective. She writes, "Yet women have been presumed to be less capable of human rationality in general, and certainly of scientific rationality. And women's distinctive technical expertise in childcare, household, and agricultural contexts, for example, have been excluded from what counts as real technical expertise" (Harding, 2015, p. 55). In other words, we are not faced with women's incapacity to meet the expectations of modern rational humans. The problem is that this striving is an impossible one because modern rational humans are set out to be distinctly male. It is not that men happen to be the more rational ones, but rather that what men are and how men are, defines the perimeters of rationality. Later in this section, she writes about how poverty and high birth rates have long been misinterpreted to argue in favour of adopting standpoint methodology. For a long time, the literature on poverty and high birth rates assumed that high birth rates, caused by the irrationality, inability, and ignorance of poor women, caused poverty. Putting aside the one-sided nature of this argument that puts the onus entirely on women and their sexual and reproductive behaviour as if men were not involved in the affair, it was also simply wrong. Even though widespread popular discourse still advances this rhetoric, most recent literature on the subject showed that poverty leads to having many babies, not the other way around. It was the rational thing to do in a situation like this. Some of the reasons included high infant mortality rates, preference for boys (not just from a misogynistic point of view also from a pragmatic point of view of access to a free workforce in a labour-intensive environment), lack of free and accessible care for the ill, elderly, and domestic labour. Harding argues that for the literature to rectify its errors, researchers had to begin from "the daily lives of poor people, and especially poor women, to bring into focus the actual causal relations between poverty and 'overpopulation" (Harding, 2015, p. 62).

Harding also argues that even though this connection between development and gender is made by some others, it often has a blind spot: race. After briefly outlining the types

of labour women are asked to do and that are rendered invisible in the form of wage labour, domestic labour, sex work, volunteer work, and emotional work; she goes unto explain how the deficit of female emotional labour in the west is being substituted by women from the Global South. In turn, the deficit left in the societies these women come from is provided by the women who are left behind who work twice as hard. She writes that standpoint theory does not argue that knowledge produced by the oppressed is immune to criticism or is always right, and neither does standpoint theory argue that knowledge production about a particular group is limited to members of that group. Here she gives the example that the women's movement always wanted the involvement of men. It was not about pushing men out but rather pushing patriarchal notions out and inviting all people to look at the world through women's perspective (Harding, 2015, p. 40). In other words, how scientists and good science are asked and portrayed to be value-free. Strong objectivity for which she stands, instead of demands that the cultural commitments underlying knowledge production be investigated (Harding, 2015, p. 36).

Tracing the histories of ideas can be deeply illuminating. Harding does this for secular science. She argues here that" secularism is thus a moral and political project, not the absence of such projects as is usually assume" (Harding, 2015, p. 130). It is rooted very much in enlightenment thought and therefore brings with its binaries such as reason vs. dogma and progress vs. backwardness (Harding, 2015, p. 130). Here Harding borrows an argument from philosopher Shannon Sullivan who argues that there are three features of western secularism that mark it distinctively protestant: the first one is its focus on individualism as opposed to communal experience, second is its conceptualization of religious commitment as beliefs rather than daily practices and third is its insistence on assigning the religious experience to the private sphere (Harding, 2015, p. 135). Harding argues that given this particularistic approach western secularism has, and its imposition on other cultures and peoples comes at a cost for both people of colour in the west and those in the Global South. Harding points out that for many non-westerners, the secular stance signifies not tolerance but intolerance and disrespect for their cultures (Harding, 2015, p. 131). As for the racist consequences of secularism, Harding turns once more to Shannon Sullivan, who argues that religion and spirituality are important components of the lives of many people of colour, so secularism as a philosophy that is unwelcoming to religion and

spirituality ensures the continued whiteness of philosophy as a discipline as well (Harding, 2015, p. 135).

The fight over who attended births and helped women deliver babies is an interesting case study for the shifting dynamics of gender, race, and epistemology. This chapter looked at the social positioning of women of colour and their traditional knowledge and practice in contention with the domination of maleness, whiteness, and modern western science. This historical context aims to help the reader grasp why the midwives were fighting a losing battle with many strong forces working against them. This chapter also set the stage for the kind of multifaceted analysis this thesis hopes to put forth by considering broadly the many factors that were in play as doctors took over from midwives completely the business of attending births. The next section will take a step back and look at the history of traditional knowledge of illness and healing, women's role as healers and midwives, and how this role transformed with modernity.

3. A BRIEF HISTORY OF MIDWIFERY

In times that predate modern medicine, there were healers. Healers are a common theme across many cultures. Some feminist scholars retrospectively argued that women have disproportionately had undertaken this role, creating, and passing down knowledge, teaching each other how to deliver babies, or abort them, how to care for the old and the sick, cure ailments (Ehrenreich & English, 1973, p. 1). This model differed from medicine in a few distinctive ways. There was no standard model of training, no regulatory body, and no standardized payments. Midwifery was part of this long tradition of female lay healers. This chapter will outline a brief history of midwifery and female healers, then talk about the move into modernity and its influence on midwifery, ending with a section about American midwives.

3. 1 Birth Before Obstetrics: Female Healers and Traditional Knowledge

Before I go on any further talking about the history of midwifery, obstetrics, and gynaecology and get into a deeper analysis from various angles, I believe it is important to spend some time on the actual event of birth anatomically however briefly, to make the rest of this thesis clearer. To begin with, labour is divided into three stages. The first stage is called the active phase, the second is the emergence of the baby, and the third is the delivery of the placenta which is also called the afterbirth O'Dowd & Philipp, 2000, p. 139). During what is mostly referred to as a normal birth, a baby is delivered vaginally with the head of the baby emerging first and then his/her one shoulder and the rest of the body. Most babies are born facing the back of the mother. What drives labour are contractions of the muscles in the uterus contracting to push the baby through the birth canal. Until eventually, his/her head emerges and the rest of the body as well as the placenta. After this point, the uterus continues to contract to go from its present size, which is similar to a large watermelon to its original size, which is close to the size of an orange (PBS, 2008).

There could be any number of complications at any of these stages. If a baby is presenting not with his / her headfirst but rather sideways or with their feet first, this may cause a problem. Throughout history, there is textual evidence that as early as the first century A.D., people were aware of baby's birthing positions and tried various methods to try to turn the baby in the uterus so it would come with his/ her headfirst

(O'Dowd & Philipp, 2000, p. 139). If a baby is presenting with his/her headfirst, but they are facing the wrong direction, this could cause a problem. If a baby is in the birth canal but is not moving along fast enough, they could be oxygen-deprived, and this could lead to permanent brain damage. The worst outcome is when a birth is so traumatic that either the baby or the mother, or sometimes both, are unable to survive it. These are the kinds of high stakes that partially drove the medical innovations in the form of chemicals, tools, and surgeries. Many different cultures came up with their own version of forceps; some were to help deliver healthy babies, while others were designed to get a dead baby out of a mother's womb. Later in chapter 4, I will discuss in further detail the history and consequences of these medical tools and drugs being involved in the birth.

Many ancient cultures have references to midwives. Greece (800-500 BCE) was a place where midwives had high social standing. Soranus in Rome wrote his monumental text on obstetrics and gynaecology. A translation was made into Chinese as early as 1661 (O'Dowd & Philipp, 2000, p. 166). People in the Ottoman Empire used midwifery at all levels of the social strata, at the palace, as well as in the villages. Midwives had varying social standings depending on whom they served; the palace midwives were affluent as one might expect, being paid well, while the public midwives were paid only with some food and small gifts (Ergin et al., 2013, p. 809). While Native Americans also compensated midwives generously, sometimes with horses, blankets, food, or money. (Theobald, 2019, p. 31) Midwives were usually older women, many times post-menopause, with some kids of their own. Typically, they had no formal education and learned the craft from other traditional birth attendants. In most countries, they operated outside of the law (O'Dowd & Philipp, 2000, p. 168). The role of the midwife, as well as the title, differed from culture to culture. To give some examples, Senegalese called her "accoucheuse traditionelle," while people in Indonesia used the name "daya dukun buj" and many French-speaking nations referred to "matrons" O'Dowd & Philipp, 2000, p. 168).

Even just tracing the history of midwifery and female healers in Europe reveals that as early as 11th-century female healers had knowledge of many plants and animal-based remedies. *Liber Simplicis Medicinae*, the compendium of natural healing methods written by St. Hildegard of Bingen (A.D. 1098-1178), gives some idea of the scope of women healers' knowledge in the early Middle Ages. Her book lists the healing

properties of 213 varieties of plants and 55 trees, in addition to dozens of minerals and animal derivative" (Ehrenreich & English, 1979, p. 36). When we come to the 14th-16th century, Mary Chamberlain writes about women called "old wives" who are seen as "the custodians of communal medical knowledge" (Chamberlain, 1981, p. 3). This is also the period in European history when female healers were decreed witches. In the 14th century, the church declared that women who knew remedies and could treat ills without having studied had acquired this knowledge through "diabolical agency." In other words, they were allegedly inspired by the devil and were sentenced to death for this supposed crime (Gage, 1893, p. 104.)

Witch hunts almost always targeted poor women, peasants, and female lay healers (Ehrenreich & English, 1979, p. 35). There were a multitude of charges ranging from political opposition to religious heresy or lewdness but having 'magical healing powers' especially related to obstetrics was a repeated offense (Ehrenreich & English, 1979, p. 8). Midwives were therefore associated with witches. Witch hunters Kramer and Sprenger claimed, "No one does more harm to the Catholic Church than midwives" (Ehrenreich & English, 1979, p. 11). There was a strange dichotomy in place with regards to the attitude of the Catholic Church towards health care. The Church was not against medicine, especially for the upper class. Noblemen and the royals had their doctors. Feminist scholars, therefore, argued that "male, upper-class healing under the auspices of the Church was acceptable, female healing as part of a peasant subculture was not" (Ehrenreich & English, 1979, p. 11). In other words, women's knowledge of matters of illness, treatment, birth, and death were seen as magic as opposed to men's medicine.

Although two of the most popular historical interpretations of the witch hunts are that either the peasants who hunted and killed witches were insane or that those called witches were insane, Ehrenreich and English argue that the hundreds of years-long efforts against lay healers were a well-organized campaign run by the Church and the State (1979, p. 7). Women were being prosecuted for healing without having studied, but ironically, the gates of the university in Europe were shut for them, so they could not have studied there even if they wanted to (Ehrenreich & English, 1979, p.1). This was justified on the grounds that women lacked adequate intellect and were governed by their senses (Chamberlain, 1981, p. 44). When we come to 18th century England and Europe, with the influence of the enlightenment, knowledge came to be regarded

as something for a select few (namely male, white, and upper class) and institutionalized. “Knowledge without expertise became skilled deceit” (Chamberlain, 1981, p. 79).

Historically birth was a female affair. People thought birth was an all-female event and that men could not handle or should not have been present at birth. Something that was common in many of these communities was what scholars later named social childbirth (Carroll Smith-Rosenberg’s term), where several women would be present, including a midwife, birthing woman’s mother, or other older women from her family, as well as some friends and neighbours. This is how many midwives also learned the craft, women teaching other women. Feminist scholarship on birth history tended to focus on the gendered power dynamics at birth. The gendered power dynamics influenced the initial resistance to male obstetricians, as will later be explained. Interestingly though, when male doctors become the norm, the femininity of the midwives was pointed as a weakness. Women were said to be too sensitive for the medical profession.

There is a long history of the contested relationship between midwives and doctors. Many cultures recruited midwives from lower social standings compared to doctors, and their position with regards to the male obstetrician remained competitive at best and antagonistic at worst (O’Dowd & Philipp, 2000, p. 169). The first record of midwifery being regulated by the state via doctors is in 15th century Germany (O’Dowd & Philipp, 2000, p. 169). Although midwives overall never attained prestige as a group, few of them individually achieved to make a name for themselves. Most notably, it was the palace midwives. Loyse Bourgeois was one of the most famous among them. She delivered many royal babies successfully and wrote about a delivery, mentioning arguably for the first time in writing babies presenting facing back of the mother were born with ease and that this was the desirable position (which became standard practice to this day) (O’Dowd & Philipp, 2000, p. 169). Another notable midwife in the history of the practice was Madame Boursier Du Coudray, who was also from France. She wrote a textbook in 1773 describing the anatomy of the female reproductive system as well as illustrations of what to do if the baby was presenting in the breech position, in other words, with his/her feet coming down instead of headfirst (O’Dowd & Philipp, 2000, p. 172).

The term “man midwife” came to be used in English in the early 18th century. It was not until the 1720s that men were summoned for normal deliveries; until then, only if there were complications would doctors get involved. Thus, men likely had little to no experience of normal births, also given that medical education lacked a practical component and was limited to theoretical knowledge. Smellie and William Hunter, during the 19th century, started teaching men obstetrics. These early men midwives/ obstetricians were much more interventionist unnecessarily largely due to their poor training (O’Dowd & Philipp, 2000, p. 174). 1720 was when obstetrical forceps became widely available, and some historians attribute the takeover of birth attending by doctors largely to forceps. They were seen as an attractive new technology and were in demand; additionally, this was a time when women were seen as incapable of “operating machinery,” even those with no moving parts like the obstetrical forceps (O’Dowd & Philipp, 2000, p. 175).

3. 2 Midwifery into Modernity: Regulation, Training, and Professionalization

Midwives were primary birth attendants throughout the world until they came under “increasing scrutiny across the industrialized world at the beginning of the twentieth century” (Smith, 2005, p. 3). America became a strange example among other nations. Many other countries integrated midwives into professional healthcare services by training, regulating, and licensing them. Midwives in Europe started organizing. In 1900, more than a thousand midwives gathered in Germany for the first international meeting of midwives, joined by Danish, Dutch, Romanian, Russian, Swiss, and Australian as well as Hungarian midwives. They aimed to increase public recognition. By 1919 these efforts culminated in an organization titled International Midwives Union, which was the precursor to what is today known as the International Confederation of Midwives (Smith, 2005, p. 4). European midwives continued to hold meetings. Presently at the time of this thesis (2021), there are 143 member associations that represent 124 countries (The International Confederation of Midwives, n.d.). European health providers integrated the midwife into the prenatal care system. Through training, regulation, and professionalization, the midwife became a part of the medical care team.

Feminist scholars like Ehrenreich and English have argued that this elimination of midwifery meant that women were now “under the biological hegemony of the

medical profession" and that "the only roles left for women in the medical system were as employees, customers, or "material" (Ehrenreich & English, 1978, p. 25). There are certain hierarchies in the medical world that extend to its interaction with patients and their families. Doctors, nurses, hospitals occupy roles that carry various levels of prestige or their lack. The feminist critique of this hierarchy tends to focus on how doctors who hold the highest position also generally tend to be men. When we investigate the historical roots of this system, we see that those who remained outside of the university-trained and institutionalized professional medicine came to be called "illegitimate" practitioners." Chamberlain argued that these practitioners who were seen as illegitimate tended to be women. Therefore, she reads this as a gendered struggle for dominance at its core. Thereby calling modern medicine "masculine medicine" and going so far as to claim, "some of its most dominant features are reactions against healers' practice" (Chamberlain, 1981, p. 139). While other scholars argued that the regulations on midwifery that spread across various countries were not about the safety of women and children but rather were part of a broader phenomenon that encompassed medicalization of birth and banning of abortion, all of which can be traced back to the emergence of the modern state and its desire to control and regulate the population (Altay, 2017, p. 175).

Another similar argument was that professional medicine was used to advance imperialistic motives of the American government in the case of their treatment of the Native peoples living in reservations. The U.S. government's effort to intervene with indigenous birth practices was seen as an effort to meddle with the very structure of the native family and society (Theobald, 2019, p. 7). One example of such an intrusive intervention was the forced or coerced sterilization of Native American women on the reservations in the 1930s by the government (Theobald, 2019, p. 9). Another example was that the nuclear family unit with a mother, father, and their children were seen as the "most moral and civilized domestic arrangement" and was imposed upon the native families who had a different history, customs, and tradition (Theobald, 2019, p. 24).

The traditional midwife and her knowledge, as we moved into modernity, for one reason or another, was delegitimized. Many doctors claimed that the traditional midwife had no knowledge and had poor hygiene. The campaign against midwifery was not bound to the US. The most prominent Turkish obstetrician of the 19th century, Besim Ömer (1862-1940), who established the first maternity hospital and

professional midwifery training programs in the 1890s wrote on the topic of traditional midwives: “it has been a custom for women to inherit the task of midwifery from their mothers as if it is an estate, and one can hardly see the glimpse of knowledge, hygiene, talent and skill in any of these midwives. This situation is not only a disgrace but also a sin. I would like to cry when I encounter an older woman who pushes and throw young, healthy, and vigorous women into the grave with their filthy hands that infect these pure women’s wombs with the seeds of deadly diseases” (Besim Ömer, 1906, p. 4-5). While Besim Ömer presented harsh views about traditional midwifery, he was not altogether against it like many of his American counterparts were. Instead, he was a prominent advocate of training, regulating, and licensing midwives. Besim Ömer wrote articles in newspapers trying to persuade people to give birth at hospitals aided by both doctors and midwives. He wrote, “(Mothers) will find the peace and joy of being cared for in the clinic. A bed and blanket, a knowledgeable midwife and daily needs including milk and other things are among the supplies the clinic provides” (Kocatürk, 2020, p. 2).

A good case study showcasing how the problems of xenophobia and professionalization of medicine culminated in midwives of colour being targeted was the Japanese American midwives in California. There was a wave of Japanese immigration to the Western US between 1890 and 1924 (Smith, 2005, p. 34). This movement was partly influenced by the Chinese Exclusion Act of 1882, which barred the Chinese from entering the U.S. and created an opportunity for other kinds of cheap immigrant labour, and partly influenced by the Japanese government’s encouragement of emigration, which was seen as a solution to Japan’s overpopulation problem. As a result, a Japanese American community was formed, and Japanese midwives were part of this vibrant community (Smith, 2005, p. 35). While the Chinese, the Irish, the Italian, and European Jewish immigrants were portrayed via racist tropes such as being dirty and diseased races (as were the midwives in these communities), the Japanese were facing a different kind of xenophobia. Despite being much smaller in number than these aforementioned immigrant communities, they were seen as colonizers of the Japanese empire (Smith, 2005, p. 35).

Hospitalization of birth served different purposes for different communities. In the U.S., it was seen as part of a “civilizing mission.” The U.S. government officials who dealt with Native people often purported that Native healers were an obstacle in

assimilating Native populations. They saw the important role women played in the Native community and concluded that if Native women gave birth in the hospital and were convinced of its superiority, it could prove a way into convincing Natives to uphold "science over superstition" (Theobald, 2019, p. 57). It is important to note that Euro-American observers had complimented the skills of the Native midwife some years prior to the organized effort to abolish midwifery nationally and move birth to the hospital (Theobald, 2019, p. 58).

Hospitalization of birth was a widely seen phenomenon. While the U.S. government encouraged medicalized pregnancies and births in the hospital setting for many American women, including the Native women living in reservations (Theobald, 2019, p. 45), there were similar campaigns around the world. As Besim Ömer's example illustrates, hospital births were going from being an anomaly in the 19th century Ottoman Empire to being the norm. In fact, delivering babies in the hospital was seen as something only poor or those delivering babies out of wedlock would do, while most other women, rich and poor, would be giving birth at their homes aided by midwives (Kocatürk, 2020, p. 1). 19th century Egypt was going through a similar transition under Muhammed Ali's "New Order." The reforms were particularly influenced by a French obstetrician by the name of Dr. Antoine Barthelme Clot whose goal was to replace "backward indigenous practitioners with professionals in the image of his own training" (Ahsan, 2011, p. 22). Clot found the traditional midwife a "symbol of the whole complex of 'old-wives' medicine' with its magic potions, charms, and incantations, and he did everything in his power to undermine her persistent popularity" (Kuhnke 1990, p. 129)

In the UK, women were also swiftly moving to the hospital to deliver their babies. The percentage of mothers delivering their babies at hospitals went from a mere 20% in the 1920s to 64% in the 1950s, and by 1991, 99% essentially almost all women in the country were delivering at hospitals. However, the main difference was the integration of the midwives. In the early twentieth century, the British government set up clinics run by midwives with the help of junior medical residents all around the country (O'Dowd & Philipp, 2000, p. 28). In 1902 the UK passed the first effective Midwives' Act and set up a Central Midwives' Board, thereby established a State Certified Midwife position which was sought by midwives globally from around the world as it was the only certificate of its kind (O'Dowd & Philipp, 2000, p. 176). While in the

United States, midwife-attended births went from a rough %50 in the 1900s to 15% in the 1930s (Kline, 2019, p 2). Later, they forged midwifery with nursing, creating the professionally trained nurse-midwife model (Apay, 2014, p. 18).

While the European midwives benefited from the public health care model that integrated them into its ranks by training, regulating, and licensing them, many American doctors and leading figures disapproved of improvements that would prolong the total demolishing of midwifery (Theobald, 2019, p. 62). While there was the brief federal campaign titled Sheppard Towner Act which was a similar effort to that in Europe, ultimately, it was underfunded and thus short-lived (Theobald, 2019, p. 62). The privately-owned health care system in America and the influence of special interest lobbying over legislators were partly responsible for this difference (Smith, 2005, p. 43). The American midwife was often a poor woman of colour, which meant that they were not a strong social group in terms of their economic capital or political connections. Medicine and nursing were, in contrast, dominated by middle-class white people, who established national organizations like the American Medical Association (Smith, 2005, p. 43). Additionally, "the demographic composition of these doctors, in terms of gender, class, and race, closely mirrored those characteristics of influential individuals at the state level, giving the doctors greater credence and support" (Dalton, 2009, p. 17).

3. 2 The American Midwife and How She was Pushed into Obscurity as a Figure

Midwifery was actively practiced all throughout the United States as well as everywhere else well into the 19th century. Before medicine was well established in the country, there were many healers, midwives, and doctors that prescribed it to different schools of thought. One of the most interesting communities of healers was the enslaved Africans who brought knowledge from their ancestral lands and communities, passed it down, and even possibly added to it while working on the cotton fields of these plantations. In oral histories allowed for stories from the era of slavery to live on via memories passed down to children and grandchildren. In one such incident, one slave woman recounted how she used roots and tree barks to make teas to treat various ailments, to treat babies that would not stop crying, she would make a syrup out of rats' veins (Yetman, 1999, p. 230). In comparison, Native

American women used an old method known to traditional Native midwives, ingesting peyote, which reportedly eased their labour pains (Theobald, 2019, p. 88).

Although publicly white doctors denounced the methods of traditional black healers and midwives, there were also reported cases of them using these traditional methods and recipes and sometimes taking the credit for it as well. In one such incident, a slave man recounted how his grandmother, who was such a slave nurse with traditional herbal recipes, not only treated the other slaves and attended many births at the plantation for almost forty years but also attended to the patients of the slave owner who was also a doctor. The white owner would whip the woman not to tell her so-called secrets, a euphemism for her traditionally rooted pharmaceutical and medical knowledge (Wyant Howell, 1997, p. 24-25).

These slave midwives later continued what came to be known as the "granny midwife" tradition. Black women who passed down ancient knowledge about birth would help women, both black and white, give birth. However, the United States had an uncharacteristically high infant mortality rate which was blamed on these traditional midwives (I will delve deeper into the infant mortality rate and birth safety argument in the coming chapters.) Officials suggested training and registering monitoring midwives as a solution to the infant mortality problem. Yet, physicians opposed this fearing that improvement on midwifery lead it to become a permanent rival to their practice they instead advocated for its termination (Matthews, 1992, p. 64). They also argued that midwives had to be eliminated because almost all of them were "ignorant, untrained, incompetent women," and they could not be trained like their European counterparts because they were "far below the European midwife in intelligence and no training under the sun could make her a competent obstetrics attendant" (Matthews, 1992, p. 68). The Children's Bureau officials claimed that black midwives were untaught and unclean, unlike foreign midwives in different countries (Smith, 2005, p. 46).

As the rules for registration got stricter and training got more inconvenient having moved to city centres and required midwives to be younger than 60 and literate and economically able to pay for their room and board for a duration of two weeks the numbers dwindled (Matthews, 1992, p. 72). One of the main arguments against midwives was that they performed abortions which at the time were illegal in the

United States. In fact, abortion state laws were only repealed in some states 1970s onwards (O'Dowd & Philipp, 2000, p. 30).

After 1900, more and more American-born white women started to give birth at hospitals. Meanwhile, midwifery in America was becoming seen as a "backward" and foreign practice of America's marginalized communities, such as those in poverty, black people, indigenous people, Hispanic people, Mormons, and so on (Smith, 2005, p. 41). Midwives continued to serve their communities in different regions. North and Midwest of the country were dominated by European immigrant midwives, while the South was dominated by black midwives, the Southwest by Mexican Americans, and Pacific Coast and Hawaii by Japanese Americans (Smith, 2005, p. 41). It is important to note that these immigrant communities where midwifery was thriving had often long-standing cultures of midwifery. Lilian Wald, prominent social welfare and public health figure from 20th century New York went on record in 1915, saying, "Perhaps nothing indicates more impressively our contempt for alien customs than the general attitude taken toward the midwife" (Smith, 2005, p. 45).

Historians estimate that by 1910 about half the babies nationwide were delivered by midwives, but by the time 1939 rolled around, that number was down to 9% of all births (Smith, 2005, p. 41). Notably though, by this time, 80% of practicing midwives were black, and while only 9% of all babies in America were delivered by midwives when broken down by race, a different truth emerged: 3% of white babies were delivered in the presence of midwives while that number was as high as 50% for black babies (Smith, 2005, p. 41). As more and more white American women turned away from midwifery, it became increasingly more associated with immigrants, racial/ethnic minorities, and women of colour, and thus became increasingly more vulnerable to criticism (Smith, 2005, p. 41).

Midwives were not criticized just based on the basis of their skills in birth assistance. Part of what was called to question was the moral standards of these women. This fits in well with a larger narrative about immoral, urban, poor, immigrant women of colour. Midwives were blamed for performing abortions which at this time were both illegal and perceived largely as immoral by American society. (Smith, 2005, p. 49) Another way midwives were targeted was that they were said to be working with

“instinct, superstition, and experience” in contrast to the medical knowledge (Smith, 2005, p. 53).

Doctors presented the demise of traditional midwifery as a victory for modern health care, but they failed to make obstetricians easily accessible for populations in the US. In 1989 North Carolina (a prominent location for traditional midwifery earlier in the century) had only four obstetricians for 1500 births every year (Matthews, 1992, p. 76). It would take a few more decades and the interest of an educated, affluent suburban white woman to rekindle midwifery in America (Matthews, 1992, p. 73). It is important to understand that middle-class white Americans who partook in the healthcare reform movement were more interested in medicalizing birth than professionalizing midwifery (Smith, 2005, p. 44). Interestingly, medical communities’ interest in pressuring midwifery differed regionally within the U.S. as well. In the Western U.S., where Japanese American midwives operated, California state officials did little more than just provide licensing, and the medical community’s pressure was not massive. This was in part due to the Japanese midwives having been trained in Japan formally, but partly it was in line with a history of portraying Asian Americans as a model minority in contrast to other minorities. In 1925, a California health officer went on record saying that the Japanese were not a public health threat because they were used to taking orders, unlike the supposedly unruly Mexican populations (Smith, 2005, p. 57). Another reason why California was easier on midwives was arguably because they were attending a small number of births and not the births that “mattered the most -- white babies” (Smith, 2005, p. 58).

Doctors at this time did not have hospitals or equipment at their disposal in rural areas thus, their practice resembled very much to that of midwives, but the doctor was a powerful male figure who represented the advancement of new science (Borst, 1995, p. 7). The story of puerperal fever is an example of this. It was a condition first described in 1662 by Thomas Willis which killed thousands of women giving birth at hospitals until the late 18th century. Oliver Wendell Holmes published a paper in 1843 detailing how the doctors passed this disease patient to patient because they would not sanitize, properly wash their hands, moving from dissecting cadavers to delivering babies (O’Dowd & Philipp, 2000, p. 18). Between the 1900 and 1930s, pregnancy-related causes took up to 15% of all deaths for women aged 15-44, mostly due to puerperal fever (Health Care Daily Online, 2015). Mortality crises led to the creation

of the nurse-midwife inspired by their European counterparts and led in large part by Mary Breckinridge. She founded the Frontier Nursing Service and served the poor white communities in the Appalachian Mountains (Health Care Daily Online, 2015). These efforts were met with resistance from the medical community and did not result in midwifery becoming mainstream. The physician-backed governmental bodies heightened their control over the midwives with the "long-term goal of elimination" (Zook, 2005). Midwives were made to get permission slips from licensed doctors to perform deliveries. This meant that their homes, bags, and even their moral character were open to scrutiny. Their experience or knowledge was not valued, and they were not allowed to carry herbs or bibles as they used to in order to comfort the labouring women (Zook, 2005)

Although physicians and nurses often saw and talked about midwives as threats to their own "legitimate" practice, midwives were many times operating in places where no other alternative care was available. One Georgia public health nurse who worked in the 1940s admitted that under the circumstances, she could not work as well as these midwives often did (Smith, 2005, p. 46) It was noted that many midwives cared for labouring women beyond the most immediate anatomical level, carrying bibles, herbs, and oils to comfort the labouring women psychologically and ease the labour pains. All these practices were deemed inappropriate by official regulatory bodies, and they were not allowed to carry these things in their bags (Zook, 2005). Famous novelist Toni Morrison said of the knowledge of midwives that it "was discredited, because it was held by discredited people" (Smith, 2005, p 47)

Another aspect of the story of midwifery in America had to do with the post-slavery economy of the Southern United States. Recently emancipated former slaves were still the backbone of the agriculture-based Southern economy. They provided the cheap intensive labour that was essential to the Southern U.S. As detailed earlier, even though slavery was abolished, racism and white supremacist violence was still a major problem for black people living in the South. Black lives were not valued, and the medical community was no different in its mistreatment of black people than the rest of society. However, the massive influx of black people moving to Northern states coupled with the high infant mortality rates made black health and its influence on the Southern economy into a national concern (Smith, 2005, p. 45).

Midwifery is a historically rooted, cross-cultural female practice. Like many other aspects of daily life, 19th-century industrialization also affected midwifery and how women give birth. While many industrialized countries like the U.K. or Japan integrated midwifery into professionalized medical care, creating training programs, licensing mechanisms, and regulatory bodies, the U.S. went on a different trajectory. While many ethnically and racially diverse non-white communities, including indigenous people, descendants of formerly enslaved black people or recent immigrants from Europe or Japan, utilized the knowledge and skills of their own community's midwives, white middle-class people, and the majority-white medical establishment as well as the official government policies increasingly pressured midwives in America and rendered this tradition obsolete.

This chapter outlined a brief history of midwifery starting in ancient times, partly in an effort to showcase that despite the smear campaign against midwives, which tried to portray them as incompetent and ignorant, midwives historically demonstrated knowledge of pregnancy and birth, some of which was later confirmed in medical findings by researchers and physicians. While individual works portrayed how different minority communities in the U.S. were affected by this anti midwifery movement, this thesis tried to unify these narratives by putting whiteness as its focal point. Connected to the demise of midwifery was the rise of obstetrics and gynaecology as an established medical field. The next chapter outlines a brief history of how the field came about and its complicated relationship with race and economics. These ulterior motives of various actors in the story challenge the notion that medicine replaced midwifery simply on merit-based grounds.

4. AMERICAN OBSTETRICS AND GYNAECOLOGY

This chapter will go through the history of obstetrics and gynaecology as a medical field. The ethically questionable experimental surgeries performed on enslaved black women will be discussed next. Lastly, the chapter will close off with an account of the professionalization of medicine in America and its relationship to race and class.

4. 1 General History of the Field

While obstetrics is a fairly new medical field with a history that goes back only a few centuries, knowledge about the female reproductive system is dated back to ancient cultures. (McGrew, 1985, p. 122). There is evidence that as early as ancient Egypt, people had some knowledge of the female reproductive system, its parts like the ovaries, its various diseases, and potential remedies; they tried ways to induce birth and perform abortions (O'Dowd & Philipp, 2000, p. 3). Discovered in 1889 and housed in University College of London, UK, the Kahun Gynaecological Papyrus dated 1825 BC, is one of the oldest medical texts. It has detailed record of various illnesses mostly related to the womb, and how to treat them. (Smith, 2011, p. 54) Generally the treatments make references to the use of massage techniques and oils, no surgical intervention is mentioned. (Smith, 2011, p. 54) Even before the invention of writing, birth and female fecundity show up in the ancient record in the form of art. There are cave paintings of pregnant women or women giving birth in various positions attended by others, as well as little statues of women like Venus of Willendorf, which is thought to symbolize fecundity (O'Dowd & Philipp, 2000, p. 3).

The roots of the medical field of obstetrics and gynaecology can possibly be traced back to near present India; it is thought to have moved westward reaching Greece, and Italy. One of the most famous doctors from this area was Soranus of Ephesus, who wrote some twenty medical books, one of which was his textbook on gynaecology (O'Dowd & Philipp, 2000, p. 6). Although Soranus was writing about female anatomy, this was still centuries before doctors would get involved in delivering babies. So, he gave his opinion on the qualities of a good midwife, that she has to have a 'good memory, love her work, be respectable, be sound of limb, robust and' have short nails (O'Dowd & Philipp, 2000, p. 6).

In 1492 Spanish Inquisition drew Muslims, Jews, and Protestants away into distant lands, and with them, they took their knowledge of medicine throughout the European continent and beyond. Human anatomy was one of the areas where European scientists made great strides through the spread of cadaver dissections. One of the people whose dissections led to a famous discovery was Gabrielis Falloppius, who was an Italian scientist that described the connection between the ovaries and the uterus, named after him the Fallopian tubes (O'Dowd & Philipp, 2000, p. 9).

When we come to the 16th century, Eucharius Rosslin publishes a book which was translated to English with the name *The Byrth of Mankynde* in 1540, and it would remain the most popular textbook on midwifery until the late 17th century (O'Dowd & Philipp, 2000, p. 10). The major obstetrics-related event of the 17th century was the invention of the forceps, but they were kept a secret by the inventor's Chamberlin family at the time and would not be used commonly for some time. Also important were major jumps in the medical knowledge on microbiology and anatomy of reproduction (O'Dowd & Philipp, 2000, p. 11). The 18th century was seen as the Age of Reason, and this was also the century when scientific obstetrics began. It was not just a time of great science but also of great economic opportunity for some of the early obstetricians in Europe made themselves sizable fortunes (O'Dowd & Philipp, 2000, p. 14).

The 19th century was a time of many advances in obstetrics and gynaecology. Some historians of medicine call this period a time of "much unnecessary but some beneficial surgical assault" (O'Dowd & Philipp, 2000, p. 16). What is left out is that many of these 'surgical assaults' were carried out on the bodies of enslaved black women who bore the brunt of the experimental surgeries without even anesthetics. I will get into more detail about this in the following section. Some doctors during the 19th century routinely, without hesitation, advocated for interventions during labour. Dr. Pinard of France was an advocate of inducing labour (Induction is a starting labour by using medication before contractions naturally come and start the labour.) This was to prevent 'disproportion,' he said. In other words, he argued that women should not wait until birth naturally started but rather should be administered medicine to start birth before its time because the babies might get too big to be born vaginally. Many more advancements took place in this century, including experimentations on caesarean section and other gynaecological surgeries, but the full scope is beyond this chapter,

so I will move on giving the rest of this brief overview before moving unto the American obstetrics and gynaecology.

In the 20th century, pregnancy was now detected faster with more accuracy, and once detected, it was monitored more closely with blood and urine tests and blood pressure readings. Early pregnancy tests were done using animals and took weeks to give a result, but in 1943 Kupperman test was introduced, and it gave a result in under 2 hours (O'Dowd & Philipp, 2000, p. 21).

One common theme across cultures is that until fairly recently, the birth was almost always an entirely female endeavour. Occasionally some cultures allowed husbands into the room to cut the umbilical cord, which is still practiced in some cultures today (O'Dowd & Philipp, 2000, p. 3). It was not until the 18th century that men, as doctors and surgeons, became routinely involved in the process; up until then, the birth was seen as a non-medical, natural part of life, and calling a surgeon was seen as a last resort when things took a turn for the bad (Gellis, 1991, p. 97-99). In the mid-18th century, male surgeons, and physicians such as William Smellie began to promote the normalcy and the necessity of their role in regular births, but it was met with some resistance from the public (Fores, n.d.). A great example is a caricature by Scottish illustrator Isaac Cruikshank from a 1793 pamphlet, figure 4.4. (Fores, n.d). The pamphlet was cultural criticism of the then recent phenomenon of men getting involved in birth.

American Medical Association presently defines Obstetrics and Gynaecology as a combined specialty which "focuses on the health of women before, during, and after childbearing years, diagnosing and treating conditions of the reproductive system and associated disorders" (American Medical Association, n.d.). Before I go on to talk about the history of obstetrics and gynaecology in America, I want to take a brief pause to introduce the two terms separately. Since this is a combined medical specialty but it is important to understand what this specialty is a combination of and what these words separately represent. The word obstetric (as an adjective) is defined today as "relating to or associated with childbirth," and etymologically, it comes from the Latin word for the midwife.

Figure 4.4 A Man Mid – Wife, is an 18th-century British pamphlet criticizing the male presence in regular births.

Source: Fores, S. W., & Cruikshank (Illustrator), I. (1793). *Man-Midwifery Dissected by Samuel W Fores* [Pamphlet]. British Library. https://www.bl.uk/collection-items/man-midwifery-dissected-by-samuel-w-fores

The first recorded usage of the word in the form of an adjective (like an obstetric patient, case, nurse) dates back to 1672, while the firsts recorded usage of the word obstetrics noun, which is a medical field, date back only to 1816 (Merriam-Webster, no date, c). While the word gynaecology is derived as a scientific term to name the medical field that "deals with the diseases and routine physical care of the reproductive system of women" from the Greek word for woman, gynec (Merriam-Webster, no date, a) and its first recorded usage dates back to 1830 (Merriam-Webster, no date, b).

The medical specialty of obstetrics and gynaecology, therefore, deals with both the nonpathological, healthy pregnancy and birth as well as pathological pregnancies, births, and other reproductive issues. I will provide a deeper analysis of how this combination led to a pathologizing and medicalization of birth in chapter 4. For now, suffice it to say that the obstetrics and gynaecology doctors were surgeons who mostly dealt with the abnormal parts of the female reproductive system and thus perhaps were inclined to see problems even when there were none and due to their surgical specialty arguably, they leaned towards a more interventionist approach.

4. 2 Bedrock of American Obstetrics: Enslaved Black Women

The previous chapters demonstrated that the 19th-century scientific establishment had issues pertaining to racism. Historians of science have also established that similar problems existed concerning sexism. American doctors looked to their European counterparts for guidance on many matters until the mid-20th century, and Europe was under the influence of Unani medicine. An older western model based on humours' supposed that women had an imbalance in their humours. In other words, a natural weakness or pathology to be fixed (Brunton, 2014, p. 51-52).

Black women always sat at the intersection of these two systems of oppression due to their race and gender, and medicine was no exception. While white women were seen as the weaker sex, black women were thought to transcend this white female fragility; they were seen as capable of bearing more pain and labour, at once both more masculine and also hypersexualized (Owens, 2017, p. 44).

These notions about black women being tougher led to slave owners being particularly harsh with them. An enslaved black woman, Delia Garlic, recounted how her mistress struck her in the head with a piece of lumber and was shocked that, as a result, Delia had fallen unconscious. The slave owner white woman said, "I thought her thick skull and cap of wool could take it better than that" (Owens, 2017, p. 44). In another incident, the slaveowners forced their slaves to eat food that had killed their dogs. The master did so because he believed the woman had a stronger stomach than the dog (Owens, 2017, p. 44). These ideas about race and gender were being manufactured and maintained by doctors of this era with claims to the supposed objectivity and surety of scientific evidence.

Since the early days of slavery, America passed legislation to ensure the status of the children of slave women would be solely tied to their mother. This was done in order to make sure these children who were often conceived as a result of white slave owners raping black slave women would be tied to their mother and not their father legally. This way, slave owners saw female black slaves' fecundity as an alternative to buying slaves. A fact that became much more important with congress banning importing of slaves in 1808 (Owens, 2017, p. 15). Black women's fecundity became the only remaining way to have more slaves (Owens, 2018, p. 15). This is how white male doctors caring for the enslaved black woman for the sake of slavery beget modern obstetrics. After this point, black women's reproductive health became even more important to wealthy white men to uphold the system of slavery. Hence, they requested the services of obstetricians and gynaecologists and were willing to pay for it. Doctors also used the dead bodies of slaves for research. Both living and dead black women's bodies were profitable for white doctors who advanced their careers also by publishing their research in increasingly more popular scientific journals (Owens, 2017, p. 17). There are a few particularly important figures from this period. I will detail the lives of a few to give you a sense of the obstetrics and gynaecology field and why and how they would oppose women of colour who performed midwifery. Owens wrote that "Slavery and the rise of American gynaecology were the vessels that poured both life and death into black women's lives" (Owens, 2017, p. 44).

J. Marion Sims, who is celebrated as the father of modern gynaecology was a slave owner who established a "hospital" where he exclusively experimented on slave women between 1844 and 1849. Later in a speech, he gave he recounted how his success as a doctor was to this hospital which was "a special field of experiment" which he ran. He said, "I readily got control of these cases, all of them healthy young *negre* women" (Sims, 1858, p. 52). It is important to note that aside from Sims' little field of experimentation on enslaved healthy black women, white doctors' experimental surgeries on slave women were almost always therapeutic. This was because a slave's reproductive health was the extension of slave owner's wealth and thus, it was in their interest to protect it. Like Sims, the other physicians also used these experimental surgeries as means of practice to perfect their craft.

Early American medicine was rudimentary compared to its European counterparts, but by the time the 19th century came around, things took a different turn. Mostly due to

the unethical surgical experiments done on slaves by gynaecologists, America moved from peripheries into the centre of the medical world. A landmark event that after James Marion Sims published his treatment of vesicovaginal fistulae repair, many European royal women requested his medical expertise for their gynaecological problems (Owens, 2017, p. 6).

One of the ways these doctors made money was through acting like entrepreneurs. Sims had made himself a career mostly because he was able to (through his experiments on Anarcha and other young, healthy slave women at his clinic) treat the previously untreatable vesicovaginal fistula, and he named the position the patients had to take during the treatment surgery "Sims's position" (Owens, 2017, p 38). While Sims was perhaps the most famous, he was by no means the only white man who made a career and fortune for himself in the 19th century by researching and experimenting on enslaved black women and then publishing this research in medical journals. This was a well-paved path for many others during this time.

There is debate amongst the scholars who study racism and medical history. While some, like Harriet Washington, author of *Medical Apartheid,* believe that 19th-century physicians like Sims were intentional in their brutal and racist treatment of the enslaved patients (Owens, 2017, p. 40). Others like Deidre Cooper Owens, author of *Medical Bondage,* argue that the archival evidence does not conclusively prove Washington's thesis. Owens believes that these doctors were not particularly evil but rather part of a system that took for granted the inferiority of black people, their supposed insensitivity to pain. Moreover, they were responding to the requests of a system of slavery that demanded their medical services to fix the "broken" reproductive health of these enslaved women so that they could birth more slaves (Owens, 2017, p. 40). Another medical historian Charles Rosenberg posits that these men lived lives stuck between their two roles as human beings and as physicians, just like black women lived in the conundrum of being sometimes considered property, sometimes patients (Rosenberg, 1987, p. 89).

There is evidence, although few and far between, and hidden between the lines, that even though doctors proclaimed a belief in black women supposedly not feeling pain, they were either subconsciously or directly aware of the falsity of this belief. In his autobiography, Sims talks about how two male physicians assisted him in a surgery he

did to restrain the enslaved black women who were in (and this is the word he uses) agony (Owens, 2017, p. 112). Sims' healthy slave experiment subject also turned into his nurses when white doctors stopped supporting his work (Sims, 1884, p. 242). He could no longer get physicians to assist him, so he trained these young women as surgical nurses to assist (sometimes to restrain other black women on the operation table.) There is a famous image that became somewhat of a poster for Sims' experiments on Anarcha, Lucy, Betsey, and the remaining unnamed enslaved women who in recent years came to be known as "mothers of gynaecology" (a name that was a form of protest to those who call Sims the father of modern gynaecology.) Figure 4.5 is a painting by Robert Thom and is part of a series commissioned between 1948 and 1964 by the pharmaceutical company Parke Davies & Co for its corporate headquarters. The series of paintings is titled Great Moments in Medicine (Paintings Capture "Great Moments in Medicine, 2015).

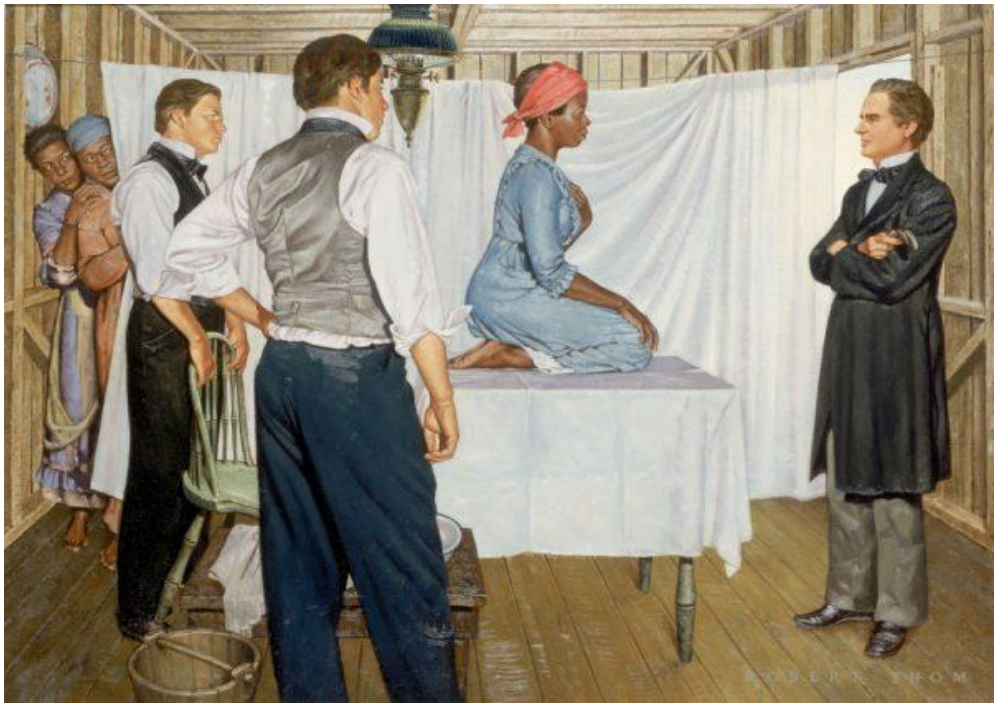

Figure 4.5 J. Marion Sims: Gynecologic Surgeon by Robert Thom, 1952 is an illustration commissioned by a pharmaceutical company as part of a series of illustrations depicting medical history. This image, in particular, shows the many experiments Sims carried out on the slave women, some young and completely healthy.

Source: Parke-Davis Pharmaceutical Company, & Thom, R. (1961). *J. Marion Sims: Gynecologic Surgeon* [Painting]. Oregon Health Science University Historical Collections and Archives. https://www.ohsu.edu/historical-collections-archives/women-power-and-reproductive-healthcare

4. 3 Professionalization of Medicine and the American Healthcare System

In order to better understand maternity care before, during, and after birth, we must first take a broader look at American medicine and the healthcare system as a whole. American medicine develops alongside the healthcare system, and the two influence each other to a great extent. There are important questions to investigate, such as the essential features and philosophy of care, the economic, and how race factors into the system. One of the ways in which doctors won the fight with the midwives was through professionalization. They used the healthcare system to lobby in their favour, pass legislation that banned midwifery. Midwives who were made up of poor, immigrant women of colour lacked the necessary political connections and economic funds to advocate for their cause in front of lawmakers.

American economic history scholar Melissa Thomasson (2018) argue that the current health care system in the U.S. grew out of a series of historical "accidents," if you will. The U.S. currently operates under a system that is voluntary, employer-based, and privately funded, where the majority of the medical services provided are paid by private insurance obtained through one's employer. Access to healthcare in America, even today largely is through employer-based insurance. America has what is called a third-party payer system, where much of the medical expense is covered by private insurance, and from very early on, black Americans were discriminated against getting these jobs. Health professionals were also largely white. Medical schools excluded black students, and most health care providers were segregated based on race. "They were denied most of the jobs that offered coverage," says David Barton Smith, an emeritus historian of health care policy at Temple University (Interlandi, 2019). "And even when some of them got health insurance, as the Pullman porters did, they couldn't make use of white facilities" (Interlandi, 2019).

Since America's founding era, all its institutions were deeply influenced by, if not completely defined by slavery, it is crucial to take a look at black people's particular history with health care. Federal health care policy was created in such a way that it was difficult for African Americans to get care. As a result, in these communities, we see shorter life expectancies and sicker people compared to white people. There is an interesting historical account behind how this peculiar system came to be. The first effort to create a system of mandatory health care coverage was organized by the

American Association for Labour Legislation (AALL) in 1915. It proposed that working people and their employers would each pay 40%, while the state covered the remaining 20%. However, this proposed bill never got passed (Chase, 1994, p. 1067). This was most likely due to the fact that people did not think of healthcare as a serious spending that needed a coverage plan. Early twentieth century was a time when medicine was rudimentary, demand for it virtually did not exist and as such there was no serious medical expenditure problem (Thomasson, 2018, p. 148). For comparison's sake, the average American in the 1900s spent a yearly amount of $5 (today's equivalent of $100) in medical spending (Blumberg, A., & Davidson, A. 2009).

In the 1920s, a brilliant marketing idea changed the course of American health care history. Baylor University Hospital in Texas wanted to create a campaign that got a lot of regular people spending money at their hospital. Instead of doing a major spending every five years, when some big medical emergency may come by, they wanted to get people to do minor spending but on a regular basis and even when there was no medical emergency at all. The promise was that if you spent 50 cents every month regardless of whether you need a visit to the doctor or not, the hospital would cover all your expenses if and when you do need a doctor's visit. This way, Baylor was able to circumvent the main problem of health insurance for the private sector: adverse selection. Thus, after this model, commercial insurance companies flocked the market (Thomasson, 2018, p. 149).

During World War II, factories facing worker shortages discovered that offering health insurance was a good way to lure people in, and the federal government encouraged employers to do so by ruling that whatever they spent on employees' health would be tax-exempt (Rosenthal, 2018, p. 20). When these developments came together with medical advances, it led to a surge in people getting private employer-based health insurance. The numbers went from a mere 9% in 1940 to almost 75% in 1957 (Thomasson, 2002, p. 2003). In the 1940s, there was another effort to set up a federal government-backed universal health care coverage plan, but it was shut down by the majority-white American Medical Association (AMA) that lobbied against it, spending $1.5 million (Shi and Singh 2008, p. 103). There was a demand in the market for health insurance, and this presented a business opportunity. Quickly new businesses were established, and they only insured young and healthy people from whom they were likely to turn a profit (Rosenthal, 2018, p. 21).

In 2008 the AMA issued a formal apology for their "history of racial inequality towards African American physicians." In order to understand this twisted history of medical education, healthcare, the AMA, and racism, we have to go back to the 1890s, which became an important era for reforms in medical education. Johns Hopkins, a leading research university in the field of medicine to this day. Hopkins was the first to require a bachelor's degree prior to going into medical school. University also structured its curriculum so that students would study theory for two years and get clinical experience at the university hospital in the remaining two years of their four-year medical education. This way, doctors did not graduate only with theoretical information, left to learn the actual practice of medicine on the job (Starr, 1982, p. 116). Other universities joined in and pushed for similarly rigorous prerequisites and curriculums. The American Medical Association (AMA) and Association of American Medical Colleges (AAMC) also joined in the effort. In 1910, Abraham Flexner published an influential report that changed the course of American medical history.

Flexner was hired by the Carnegie Foundation to do a comprehensive report on all the medical schools in the U.S. and Canada. The report was covertly backed by the American Medical Association (Miller, L., & Weiss, R., 2012, p. 217). With the level of ease and promise of making some money, there was a fast increase in the number of doctors at the turn of the century, which led to a debate among the medical community that the increased number of doctors made way for a less profitable occupation (Stevens, 1971, p.60). The AMA had a vested interest in fortifying the barrier to entry to the profession to protect the financial income of its member-physicians (who were all white and male).

The AMA, in 1870, refused to recognize a racially integrated delegation from Washington D.C., thereby contributing to the institutionalization of the racial divide in medical societies. This attitude led to the establishment of the National Medical Association (NMA), which was predominantly African American (Baker et al. 2009, p. 501). At this time, black people were not being admitted to medical schools with whites, and some hospitals also segregated patients and refused to treat black people. Therefore, there was a growing need for black physicians and other health professionals, which led to separate medical colleges for blacks. Flexner, in his report, recommended that five of the seven such schools were beyond repair and should be shut down. Only Meharry Medical College and Howard University Medical

Department were found to have met the necessary criteria. Historians retrospectively also argued that the reason for the lack of black physicians and closing of predominantly African American medical schools were in part due to the increasingly higher standards demanded by the AMA, AAMC, state licensing boards, and advances in medical knowledge coupled with the systemic racial injustices which kept the black American population disproportionately under-resourced. Ultimately the "American Medical Association used the report to advance an agenda that protected the professional and financial interests of their (white, male) membership" (Miller, L., & Weiss, R.,2012, p. 217). The effects of the Flexner report are still alive and well today: of all the practicing physicians in the U.S., only less than 4% are black, and 80% of those black physicians have been trained at the two historically black medical colleges which survived the Flexner Report: Meharry and Howard. (Miller, L., & Weiss, R., 2012, p. 217).

The early history of racial health disparities put the National Medical Association, which was the primary African American medical society at the time, into a harsh confrontation with American Medical Association during the 1930s and 40s. The AMA advocated against any nationalized health care plan on the basis that it would be "socialist and un-American," and it would allow for government intervention in the patient-physician relationship. This rhetoric was so effective in identifying core fears in the middle class white American society that to this day, the same rhetoric is used in political debates around universal health care coverage.

1964 Civil Rights Act, signed by Kennedy, outlawed racial segregation for any program that received federal funding, and introducing federally funded health coverage programs effectively would end segregation in the hospital system. Medicare and Medicaid (the complementary federal government program for those below the poverty line) were part of a broader move to end legal segregation in the medical system. Yet, they still excluded millions of Americans, those below 65, those who are above the poverty line (no matter how slightly), and those who did not have health insurance through their employer.

What does this system have anything to do with birth history and midwives? Some scholars have argued that economics has played a big role in the push for medicalization and hospitalization of birth. When we come to the modern age, at the

turn of the century, the economics of healing were increasingly important, and health became a commodity like everything else. Some scholars argued that this economic tension was at the very heart of the struggle between white male doctors and women of colour who were healers. In order to get pregnant women to spend money for childbirth, there had to have been a gradual transformation.

Ehrenreich and English, in their book *Witches, Midwives, and Nurses,* argue that "The set of healers who became the medical profession was distinguished not so much by its associations with modern science as by its associations with the emerging American business establishment. With all due respect to Pasteur, Koch, and the other great European medical researchers of the 19th century, it was the Carnegies and Rockefellers who intervened to secure the final victory of the American medical profession (Ehrenreich and English, 1973, p. 20). Mary Chamberlain argues that the professionalization of medicine has to do with economics. Because the knowledge of the "old wives" were freely distributed and there were no fees thus "no need to preserve a "closed" profession in terms of entry, training, and dissemination of knowledge" (Chamberlain, 1981, p. 3).

The late 19th, early 20th century American hospital is not the pristine, sterile place we have come to think of the hospital to be. Since medicine was not winning many battles over disease, people imagined the hospital as a place where the poor or the desperate go to die. Some historians recount that only the very bottom stratum of society would be going to the hospital during the late 19th century (Rosenberg, 1987, p. 116). Moreover, medical treatment consists mostly of doctors giving people medication, something that can just as well be done at people's homes (Temin, 1988, p. 79). With advances in medicine, physicians were able to perform surgeries with higher precision and to avoid infections; special surgical suits were set up in hospitals. With further professionalization and standardization of medicine as a profession, medical treatment and birth move swiftly into the hospital (Thomasson, 2003, p. 1373). This is important to note because it gets at the heart of the question of why most women suddenly decided to give birth at the hospital. Thomasson argues that part of what changed people's perception about hospitals and got them there to ask for medical care and thus to spend money was hospital births. The move to the hospital for the birthing mom helped change the image of the hospital as a place of hope (Thomasson, 2003, p. 1373).

To see the economic motivation behind getting pregnant women into the hospital to deliver babies further support the argument that this transition was not an inevitable one purely motivated by scientific advancements in the field of obstetrics. Feminist scholars Ehrenreich and English wrote:

> Healing was female when it was a neighbourly service based in stable communities, where skills could be passed on for generations and where the healer knew her patients and their families. When the attempt to heal is detached from personal relationships to become a commodity and a source of wealth in itself-then does the business of healing become a male enterprise. (Ehrenreich & English 1979, p. 41).

Midwives became the symbol of this tension. While Europe settled on a model of integrating midwives, training them, regulating their practice, and allowing them to attend births at the hospital alongside obstetricians, in America, they were eliminated-outlawed. Doctors were writing in medical journals, "Surely we have enough influence and friends to procure the needed legislation. Make yourselves heard in the land; and the ignorant meddlesome midwife will soon be a thing of the past." (Sablosky, 1975, p.17).

One of the ways anti midwife doctors used governmental regulation in their efforts to eliminate midwifery was to link midwives' practices to abortion, which was universally illegal in America at the time. What is more, is that it was seen as immoral by the majority of American society. Thereby the traditional practice of midwifery was placed under governmental and legal scrutiny. This was especially effective because the idea went very well with preconceived notions about immoral, urban, single, immigrant women (Warsh, 2010, p. 96). Midwives were the easy target to the problem infant and maternal mortality rates in America, which were unusually high compared to countries with similar profiles to the US. When some policy officials suggested that the midwives who operated mostly in rural areas where no physician was willing to work be trained, registered, and monitored in order to control the rates birth-related deaths, the suggestion was met with great resistance from obstetricians who feared that an improved practice of midwifery would lead to it being a permanent rival to their area of expertise (Matthews, 1992, p. 64).

5. THE SHIFT IN AMERICAN BIRTH PRACTICES AS INDICATIVE OF A BROADER CULTURAL SHIFT

The changing birth practices in 20th century America is not a simple story of scientific advancement winning battles over traditional knowledge and practice. As scholars of STS point out, these narratives of scientific triumph over older epistemologies presented in a "matter of fact" manner are cause for suspicion. Therefore, in this chapter, I will argue against a linear scientific progress narrative. Instead, I argue that the transformation of birth practices was influenced by a broader social shift about the cultural capital of science, its rising epistemological prestige, as well as the broader xenophobia and anti-black racism of the white majority American society. Walzer Leavitt writes that this transition of birth coincided with the "increasing mystification of medical knowledge," especially after the germ theory and microbes were introduced (Walzer Leavitt, 1950, p. 174). The other important social factor she argues was the women's networks that traditionally handled pregnancy and birth care were on the decline (Walzer Leavitt, 1950, p. 174), arguably because modernity, urbanization, and immigration were remodelling society.

The way science and medicine, therefore doctors, were gaining legitimacy and prestige did not happen overnight. The process united political, economic, and social forces. The aura of scientific advancement predated the actual scientific advancement in this case. In other words, people were made to believe physician-attended births were safer when that was not really the case at the time of the takeover of obstetricians from midwives. Nestel argues that what happened to American midwifery is not just about midwifery, but it is about a struggle between "traditional anthropomorphic epistemologies and the ascendency of science in Europe" (Nestel, 2006, p. 87). What is often represented as a natural move away from superstition and towards science is actually nothing but "a series of abrupt and arbitrary paradigm breaks" (Nestel, 2006, p. 87). In this story, those who represented modernity were white men while the women and the non-white other represented outmoded knowledge. This chapter will investigate this paradigm shift by looking at three components of this transition: the medicalization of birth, the infant mortality argument and image building.

5. 1 Medicalization of Birth: Analysing the Use of Tools & Chemicals

Prior to the 20th century, the birth was not something people thought of as pathological or medical, nor did they require a doctor for it. With the development of obstetrics, childbirth went from being seen as a natural process to a medical event. Medicalization can be defined as a process through which a formerly non-medical issue comes to be understood in medical terms within the medical framework (Dalton, 2009, p. 7). This includes definitions like patient, disease, pathology, cure, and more. This process opens previously inaccessible areas of social life to medical scrutiny like sleep, diet, or pregnancy & birth. In this regard, it can be interpreted as a mode of social control (Dalton, 2009, p. 9).

Is childbirth a medical event? Is it pathological, is it a malady to be treated, do women in labour need to be healed? These are interesting questions to ponder. It is true that birth with no complications, though it may be deeply uncomfortable, could, in theory, be carried out without the help of anyone, let alone anyone with medical training. It is the labouring woman who is doing most of the work, and if there are no anomalies, she is not really a patient with an illness to be treated so much as someone going through one of the most natural experiences anyone can have. I would argue that medical culture and its focus on anomaly and treatment made its way into obstetrics as well. In other words, obstetricians viewed the pregnant human female as someone who was stricken with a malady to be treated. Joseph B. DeLee, a prominent American obstetrician in the 19th century, argued that birth was a "pathologic process" and that "only a small minority of women escaped damage during labour. …So frequent are these bad effects, that I have often wondered whether Nature did not deliberately intend women should be used up in the process of reproduction, in a manner analogous to that of salmon, which dies after spawning?" (Walzer Leavitt, 1950, p. 179). This new idea that birth was not natural, but a pathological event spread from the medical community to the popular consciousness. Paul de Kruif wrote in 1936 that "human reproduction has become the same as a dangerous sickness" (de Kruif, 1936, p. 25).

It is important to note that obstetrics and gynaecology is a surgical specialty, which means that the doctors trained in this specialty are surgeons. This is an important distinction that influences the philosophy of care and contributes to the debate between the interventionist medical approach vs. the non-interventionist midwifery approach

to childbirth. The level of intervention gradually increased with the invention of anaesthetics, ways to induce (initiate birth medically), and tools to aid during childbirth. These interventions led to the most invasive birth intervention: the caesarean section, which meant you could foresee or even schedule births. This scheduling aspect is a quintessential element of the way industrialization revolutionized the understanding of time.

Another important thing to note is that obstetrics is a slightly different kind of medicine, one that deals with normal state of affairs, namely birth, as opposed to all the rest of medicine which deals with anomaly and pathology (O'Dowd and Philipp, 2000, p. 3). However, gynaecology which deals with the illnesses that have to do with the female organs such as the uterus or ovaries is in fact, a field of medicine that deals with pathology. Doctors who deal with birth are both obstetricians and gynaecologists. The philosophies of care intertwine.

Intervention requires a deeper analysis as a core tenant of the western medical philosophy of care. In some other medical systems that developed contemporaneously with western medicine, non-intervention is the underlying philosophy, so they prefer not to do surgeries or dissections but to use other less intrusive methods of intervention like herbal treatments, cupping, bloodletting, etc. Chinese medicine is a major example of such a system. Until the 1940s, almost all the doctors in China who were trained and operated with a western medical system were European missionaries; very few were trained in this way within the country. However, the traditionally trained doctors were already using herbal cures like Rauwolfia for heart problems for hundreds of years that would only be "discovered" by western medicine much later (O'Dowd & Philipp, 2000, p. 37-38).

It is important to consider widely the reasons as to why birth has come to be so medicalized. The time period during which birth did become so medicalized coincides with the rest of society becoming industrialized in the US. For centuries, pregnancy and birth are considered in many cultures a "quintessentially low-technology domestic experience" (McIntosh, 2013, p. 16). As the 20th century progresses, birth becomes increasingly more technological with the inclusion of "monitors, scans, inductions, and obstetric surgery" (McIntosh, 2013, p. 16).

Economics certainly plays a role in it, as is discussed elsewhere in this thesis. However, money is not the only non-human actor in this history. Technologies also are drivers of a particular kind of culture around birth. The most common argument for the use of these technologies is that they are for the mother and the baby and their comfort and safety. However, as the infant mortality data, which I will engage more deeply in the following pages, show this is not necessarily always the case.

There is a governmental push to medicalize birth as well. The first federal welfare program in the US, passed in 1921, aimed to "promote the use of prenatal medical care" (Barker, 2003, p. 333). There were two handbooks distributed as part of this effort. First framed pregnancy as more of a disease than a natural condition and insisted it required medical monitoring at regular intervals (Barker, 1998, p. 1067). Barker named these "the first widespread attempt to introduce women to a biomedical conception of pregnancy" (Barker, 1998, p. 1068). These efforts fit in the broader cultural shift that elevated the "status of scientific knowledge and the allure of hospitals as routes to a safer delivery" (Barker 2003, p. 333).

Critics of the medicalization of childbirth argue that the hospital environment and medical staff intervene unnecessarily, meaning they intervene in the interest of time, money, or some other factor that is not the best interest of the mother and the baby. There is a term for this phenomenon: the cascade of interventions. It means that one unnecessary intervention at the hospital leads to another, which leads to another until a perfectly normal birth turns into an expensive and unnecessary c-section. In the UK, by the 1980s, drugs were routinely used to induce labour. These drugs made contractions more painful, which led to more women asking for epidurals to take the pain away. This made them less capable of pushing their babies out, so forceps were used more often. The higher the forceps use turned out to be correlated with higher intervention rates and higher chances of getting caesarean sections. All of which diminished the role of the midwife, whose primary mission was to assist active labour (O'Dowd & Philipp, 2000, p. 28). Some argue that the reason why physicians lean more towards intervention than no intervention is because of the medical malpractice lawsuits. These doctors do not want to be charged with negligence. Such medical malpractice laws have been mentioned as early as the Code of Hammurabi in Babylon, but they became commonplace by the 1950s (O'Dowd & Philipp, 2000, p. 31).

Medical interventions come in the form of tools and chemicals that assist the birth, and these things do not exist in a social vacuum. They each come into and alter an already existing social context. One of the most famous and important medical interventions for labour is the use of anaesthetics. When it was invented, anaesthetics did not become instantly popular. There is evidence showing it was used for delivery in 1846 and 1847 in Scotland, but it was not until Queen Victoria was administered chloroform for her birth that using anaesthetics for labour became socially acceptable (O'Dowd & Philipp, 2000, p. 17). Once it was no longer taboo, anaesthetics became increasingly more popular amongst pregnant women as an option. By the time, the 1940s rolled around, the famous women's magazine *Vogue* was encouraging women to give birth at the hospital with anaesthetics ("Vogue Answers Questions on Childbirth," 1943). Anaesthetics actually became a driving force for women to prefer hospital births. Ironically though, later, when surveyed, women who experienced both home and hospital births (80%) said that they still preferred the home births (Pathak 1960, p. 111).

Another thing to keep in mind about anaesthetics and the narrative of pain is the history of racism of doctors who advanced beliefs such more *civilized* women experienced more difficult childbirth or that *less civilized* women had easy births. One doctor claimed, "it is universally admitted that labour is easier, quicker, and safer with savage than with civilized women, and my experience confirms this." (Theobald, 2019, p. 34) These beliefs had dire consequences, like the experiments done on enslaved black women without their consent and the relief of anaesthetics. Another similar consequence was observed in Native American reservations where although the federal US government was running campaigns to hospitalize birth (promising pain relief, among other things, as part of this larger campaign to move birth from home into the hospital), none of the Native women speaking about their hospital birth experiences talked about pain relief of any kind, leading us to the belief that they may have been spared this new method (Theobald, 2019, p. 88).

Another famous birth intervention of the 20th century was "scopolamine," which was commonly referred to as twilight sleep. It was said to lower the pain during birth and later delete the memory of the pain altogether. However, it also rendered the labouring woman dull. Rudolph Holmes, the doctor who introduced scopolamine to the U.S., was quoted as saying, "I wish to God I hadn't done it" (Childbirth, Nature vs. Drugs.,

year, p 32-36). Holmes said that “The basic error has crept into the obstetric field that pregnancy and labour are pathologic entities, that childbearing is a disease, a surgical malady which must be terminated by some spectacular procedure. There is too insistent preaching by those who are defending a reign of terror, of the promiscuous operative furore, on the argument that women have so degenerated that childbearing is a phase of pathologic anatomy” (Holmes, 1921, p. 225).

It is interesting to consider that some of these interventions have existed long before the medicalization of birth, just in milder forms and doses. Ergot, for instance, is a type of fungi whose spurs were discovered to cause a number of effects on the human body, including inducing labour before the baby was due. There is evidence suggesting people noticed its effects as early as the Middle Ages and started using it medicinally by the end of the 16th century (O’Dowd & Philipp, 2000, p. 151). Dr. John Stearns, who was a general practitioner in the early 19th century in New York State, published some writings explaining how his midwife co-worker told him of the effects of ergot, and they observed it speed up a labour at a very fast pace. Ergot was so powerful that the doctor voiced concern about the baby getting hurt or killed under the stress of the very forceful contractions of the uterus induced by ergot. The mother could also get seriously hurt or even die if the uterine wall were to rupture. After Dr. Stearn’s writings, ergot use went up, leading to birth tragedies exactly like the ones mentioned above (O’Dowd & Philipp, 2000, p. 152). On the other hand, when prepared right and executed in the right amount, ergot causing the uterus to contract fast and strongly also aided the uterus to extract the placentae and stop the haemorrhage (O’Dowd & Philipp, 2000, p. 151). Ergot was the precursor chemically of the induction medicines that have been used ever since.

Moving from chemical interventions to tools, perhaps the most important obstetrical tool of the 19th century was the forceps. Obstetric forceps were a major milestone for the field. Up until this tool came around, the only tool doctors used was to extract dead foetuses. There were some rudimentary tools such as hooks, fillets, bandages, or whale bones, but these posed a great danger to the unborn baby. Some scholars even argued that forceps were singlehandedly responsible for the doctors’ take over from midwives as birth attendants (O’Dowd & Philipp, 2000, p. 141). The suggestion of a forceps possibly dates back to Jacob Rueff in 1554, but the forceps is generally credited to Peter Chamberlain, who invented them in 1598, but the Chamberlain family kept the

invention a secret for 150 years (O'Dowd & Philipp, 2000, p. 11). Many blamed the family for having kept the invention a secret and claimed that this was done so in order to make large sums of money from having monopolized the obstructed birth business in their area (O'Dowd & Philipp, 2000, p. 147). After the introduction of forceps, they quickly became a routine intervention despite the not so low risk of harming the baby "Of 223 United States Hospitals surveyed in 1932, 37 percent reported their incidence of forceps deliveries to be 20 percent or higher, ranging up to 81 percent" (White House Conference on Child Health Protection, year, etc.). This rise of forceps used births, as well as other interventions, between 1918 and 25, babies that died from injuries at birth went from 39% to 44% (Frankel, 1927, p. 1909).

Another important obstetrics tool was the vacuum which is still used to this day more or less operating with the same principle. The cup catches the head of the baby, and there are a tube and a pump that establish the vacuum effect, thereby pulling on the baby's head (O'Dowd & Philipp, 2000, p. 150).

5. 2 Reconsidering Doctors' "Safer Birth Arguments" through Empirical Data

One of the ways 19th-century American obstetricians and public health officials justified the elimination of midwifery was through the use of the infant and maternal mortality argument. The infant mortality rates were uncharacteristically high for a country with the economic and social profile of the U.S., and the idea was that the shift from midwives to obstetricians as the primary birth attendants would decrease these rates. A former president of the American College of Obstetricians and Gynaecologists W.H. Pearse, wrote, "In 1940 half the deliveries in the United States were carried out at home, and the maternal mortality was 60 per 10,000 live births. In 1975, with over 99 percent of deliveries in hospitals, maternal mortality was less than 3 per 10,000 live births. This is not purely a coincidence" (Pearse, 1976, p. 611). In another incident, another past president of ACOG Dr. Keith Russell, was quoted as saying, "Home birth is child abuse in its earliest form" (Warrick, 1992). Needless to say, most doctors felt strongly about their superior care in birth assistance. The narrative of doctor-attended births being safer carried on until a more critical historical approach re-examined the actual data from this time period which presented a very different story. This section will detail the ways in which infant and maternal mortality rates did not show a steady and unidirectional decline as doctors took over from the midwives the business of

attending births. There is rather a complicated picture that shows that for most births that presented no complications (and this is an important caveat), home births with midwives were safer than physician attended births at home or at the hospital. Moreover, the gross decline in mortality rates overall is also attributed to more than one factor, such as availability of clean water, an improvement on the sewer systems, and increasing education about the importance of sanitation and hygiene (Thomasson, 2018, p. 143).

Maternal mortality has long been considered the best way to measure the success of maternity care. In the US, the rate of infant mortality was around five deaths per 1000 at the beginning of the 20th century. After 1915 it fluctuated between 7-9 per 1000. This was back to the 19th-century figures, in the rural areas where women had balanced diets and good living conditions (but less access to medical staff) were less likely to die delivering than those who gave birth at hospitals and other medical institutions (O'Dowd & Philipp, 2000, p. 22). Although surely in time maternal and infant mortality rates declined in direct relation to and further advancements in the medical field, initially during the 1900s when doctors claimed they had a better grasp of childbirth than midwives because of science, this was not necessarily true. Although the public came to view "doctors as representatives of the new and legitimately complex scientific community, a significant gap existed between the perceptions of scientific expertise and the reality" (Borst, 1995, p. 6). In the late nineteenth and early twentieth-century medicine was still very rudimentary in America. Some scholars argue retrospectively that "between 1870 and 1930, medicine struggled to achieve cultural authority, and childbirth had become an arena for demonstrating the goals of the new scientific professional" (Borst, 1995, p. 5). Getting women to choose doctors over midwives, therefore, became just as much of a cultural battle, a PR campaign of sorts. While there was certainly this pull from the medical community, Walzer-Leavitt writes that women's fears around the complications and deaths around birth provided the push for them to seek "the promise of improvements, of hope, of "science." (Walzer-Leavitt, 1950, p. 173). The important phrase here being "hope of 'science.'" Because initially, that is, in fact, what the obstetricians provided the hope of science rather than the science itself, their theoretical knowledge as well as field experience being insufficient.

The literature on birth safety in the first half of the twentieth century in the US, though not exhaustive, still substantially suggests that in the early 1900s, midwives were better at delivering babies safely than obstetricians. Given the lack of theoretical knowledge and practical skill, perhaps not surprisingly, a study by Johns Hopkins University professor in 1912 found that most American doctors were *less* competent than the midwives (Ehrenreich and English, 1973, p. 32). Office of Indian Affairs in the 1910s concluded that their campaign to "Save the Baby" on the Native American reservations by the hospitalization of birth had paid off, resulting in lower infant mortality rates, but retrospective analysis showed that the project outcome differed widely from one region to the next. While Southern Ute Reservation in Colorado saw a decline in infant mortality, in the large Navajo Reservation, mortality rates continued to rise well into the 1930s (Theobald, 2019, p. 70). While California health officials issued a report in 1924 which concluded that midwives could not be "blamed" for maternal or infant deaths. (Smith, 2005, p. 55) Some historians argued that this successful track record for midwives operating in the Western U.S. was due to the highly educated Japanese American midwives (Smith, 2005, p. 55).

In 1938 George Kosmak, editor of the *American Journal of Obstetrics and Gynaecology*, stated that although the increased number of hospital births contributed to the labouring women's comfort, it did not necessarily make birth safer. He went on to say the rise in hospital births led to more medical interventions which led to less safe results. (Kosmak, 1938, p. 2). During the 1920s and 1930s, obstetricians were divided about the degree of intervention that was necessary for most births, even the ones that did not present with any issues. Various tools and chemicals were being developed, the use and meaning of which will be discussed in more detail further down in the last section of this chapter but suffice it to say that more medical advancements led to greater numbers of interventions that were each gradually more intrusive in nature. In 1920 De Lee introduced his famous "prophylactic forceps" operations (DeLee, 1920, p. 66). These scissor-like tools were later recorded to be the cause for destructive harm to babies. Some doctors during this time argued for all babies to be delivered via c-section so that women's genitalia was not disfigures, leading supposedly to a happier marriage. (Brown, 1930, 550). There is a lot to unpack in this statement vis-a-vis gender politics. Male doctors arguing for unnecessarily performing major surgery, especially at a time when such surgeries were dangerous (much more

so than they are today) just for the sake of "marital relations" or the continued use of the female body for pleasure by the male spouse indicates the priority these doctors placed on the well-being of the labouring mothers. In a study with 1809 home births and 436 hospital births, it was found that the stillbirth rate was significantly lower at home (Hannah, 1939, p. 535). Some scholars argued that the poor track record of hospital births was due to the greater tendency of physicians to intervene unnecessarily (Devitt, 1977, p. 55). While doctors and other officials argued that hospitalization was benefiting the mothers and the babies, as evident in the declining numbers of perinatal mortality, the critics pointed out that "perinatal mortality is largely dependent on social factors, especially nutrition and standard of living, rather than birth practices" (Devitt, 1977, p. 56). The number of studies, though not conclusive, still strongly suggest that birthing at home was not less safe than birthing in the hospital in the U.S. from the 1930s to 60s (Devitt, 1977, p. 57).

Doctors' culture of care was much more interventionist and intrusive compared to that of the midwife. Walzer Leavitt writes that if birth needed medical intervention due to some complication, physician's help was surely lifesaving, but when there were no complications and no need for intervention, a much more common case statistically, unnecessarily physician interventions 'introduced dangers not otherwise present.' (Walzer Leavitt, 1950, p. 47). They induced (artificially started) labour; they used artificial hormones to hurry it along; the use of c section, forceps, and procedures like episiotomies gradually rose in popularity among physicians only for the numbers to decline as a result of the advocacy from women's rights groups (O'Dowd & Philipp, 2000, p. 26-27).

Race further complicates discussions of safety via institutions because while white women may have had births safely in the hospital setting, some women of colour were undergoing forced, coerced, or secretive sterilization procedures. Sometimes they were not informed until after their ovaries were removed or tubes were tied that these had been done to their bodies, and sometimes these procedures would be done right after they gave birth (Theobald, 2019, p. 89). This was part of a broader movement of eugenics briefly discussed earlier as part of the historical context of the century.

5. 3 Image as a Means of Legitimacy or Smear Campaign

Historian of birth in Native American communities Brianna Theobald writes, “In contrast to Europe, where public health officials typically measured mortality rates by socioeconomic position, Americans tended to view infant mortality (and so much else) through a racial prism” (Theobald, 2019, p. 47). This racial prism created a fertile ground for the rhetoric against midwives, most of whom were women of colour, many of them black. Baseless accusations that midwives were the reason for the high infant mortality rates were intertwined with a more general tension around racial purity ideology that was especially potent after the influx of immigrants—as such, painting the black or the immigrant midwife in a bad light as a dirty, ignorant, immoral person was in line with the general racist and xenophobic atmosphere of early twentieth-century America (Nelsen, 2006, p. 88).

The early twentieth century was also a time when more and more white women got into the workforce. Nursing was one such popular profession for white women. Midwives were functioning not just as birth attendants, but they also attended to minor illnesses and needs of the community. Part of their function was then replaced by trained nurses who were almost always white women. The image of nursing in the late 19th century thus came to be associated with young, single, middle-class white women. (Reverby, 1987, p. 3-5). Even after midwives were integrated into the governmental training programs, however, their image remained associated with most disenfranchised social groups of American society, immigrants, and African Americans (Borst, 1995, p. 4).

Women’s magazines which were becoming more and more prominent in the 20th century painted the midwife as an “old-fashioned crone” that the medical community was struggling against (Miller, 1977, p. 71). At the same time, doctors relied on heavily racialized language to delegitimize the traditional midwives. One doctor described the typical midwife as “old, gin, fingering, guzzling midwife with her pockets full of forcing drops, her mouth full of snuff, her fingers full of dirt and her brains full of arrogance and superstition” (Gerwin, 1906, p. 629). Dirty and ignorant were in sharp contrast to smart and sterile physicians.

In a pamphlet from this time, three midwives, one Italian, one Irish, and one black, were all wearing old dark dresses with a caption that read, “A typical Italian midwife

practicing in one of our cities. They bring with them filthy customs and practices. A ‘granny of the far south. Ignorant, superstitious a survival of the magic doctors of the west coast of Africa surely it might have been this woman of Irish American parentage who is quoted as having said I am too old to clean and too weak to wash too blind to sew but thank God I can still put my neighbours to bed” (Susie, 1988, p. 5). Here the three racial groups that are most publicly ridiculed are presented; the 19th century had a great influx of Catholic Irish, and Italian immigrants who were not considered white due to their religion and ethnicity. They were put alongside black people in the racial hierarchy created by the white supremacist ideology in America. Here the dirty, filthy stereotype is repeated.

Additionally, those of African descent are painted as superstitious, relying on magic as opposed to the rational, western practice of medicine and science. Michele Plott, in an anthology, compiles other similar accounts from the early 20th century:

> *“Filthy and ignorant and not far removed from the jungles of Africa” (Underwood 1926) A relic of barbarism (DeLee, 1915) Pestiferous (Garrigues 1898) Vicious (Titus in Huntington 1913) Often malicious (Emmons and Huntington 1911) With the overconfidence of half knowledge … unprincipled and callous of the feelings and welfare of her patients and anxious only for her fee (Emmons and Huntington 1912) Earning $5,888,888 … which should be paid to physicians and nurses for doing the work properly (Ziegler 1913) unamerican (Mabbott 1907)*
>
> (Quoted in Plott, (Ed.) 2000, p. 256)

Here we see that dirty is a running theme across many of these derogatory accounts. Use of words like barbarism or jungles of Africa also allude to a civilization's ideologies like social Darwinism or eugenics. Midwives are not just painted as ignorant but also ill-intentioned on purpose. They know they lack the necessarily knowledge yet proceed with arrogance regardless. It is pertinent that “unamerican” is also uttered about midwives as an insult. This is an era where many immigrants are coming to the U.S., and the ideas around citizenship and belonging are constantly being negotiated and renewed. Yet another important thing to note is how they are blamed for getting paid the money that is supposedly the right of the medical staff like nurses and doctors when in reality, most midwives were getting paid very little, if

anything at all, compared to the considerably higher charges of the physicians. This is another important motive doctor had to get rid of the midwives. One of the most prominent American obstetricians DeLee said, “As long as the medical profession tolerates this brand of infamy, the midwife, the public will not be brought to realize that there is high art in obstetrics and that it must pay as well for it as for surgery” (De Lee, 1915, p. 117).

These derogatory descriptions of midwives are contrasted with another account of the traditional midwives. These midwives are said to have brought bibles to read aloud to comfort the labouring women, to massage and bathe them, care for, and cook for the family and kids of the labouring women. They brought smelling salts and herbals teas, rose water, talcum powder, and a comb to pamper the birthing mother. They used ginger, mayapple, and peppers to encourage the natural progression of labour and used other herbs to ease the pain. They were described as “humble, round-shouldered women as they made their way along the side of the road in simple white aprons and heavy black shoes.” They did check-up visits days after the delivery. All of these they did for free or for very small amounts of money or gifts (Zook, 2005). Zook writes, “at a time when few Americans cared whether a black woman lived or died, midwives and mothers at least had each other. I think it would be difficult indeed for a child to come into this world in such hands and not know they were loved (Zook, 2005).

Doctors had an image problem during the era leading up to modernity as well. As I have elaborated in earlier chapters, American medicine was decentralized even after the era of lay healers; doctors were training in various systems with no national standard. This lack of a standard for training or practice led to many disagreements amongst physicians that ended in patient misery. During the 18th and 19th centuries, a common comedic trope about physicians was the phrase “Doctors differ.” This phrase became “shorthand for the futility of human knowledge, the limits of enlightenment, and the impossible choices that patients were asked to make with uncertain outcomes and no roadmap to guide them” (Gardner, 2020). In other words, these learned medical men were carrying a facade that was much more assured than they had reason to be. However, image remained (if not become even more) important for doctors well into the twentieth century. “Doctors differ” often showed up in satirical cartoons during this era. Figure 5.6 depicts such a scene of two doctors fighting each other about a treatment while their patient is left to die.

In a famous novel from 1925, we see that doctors were just as much about building up their image as they were about trying to tear down that of their perceived competitor midwife. In a passage from the novel, a seasoned older doctor instructs younger colleagues to pay attention to the image of their office.

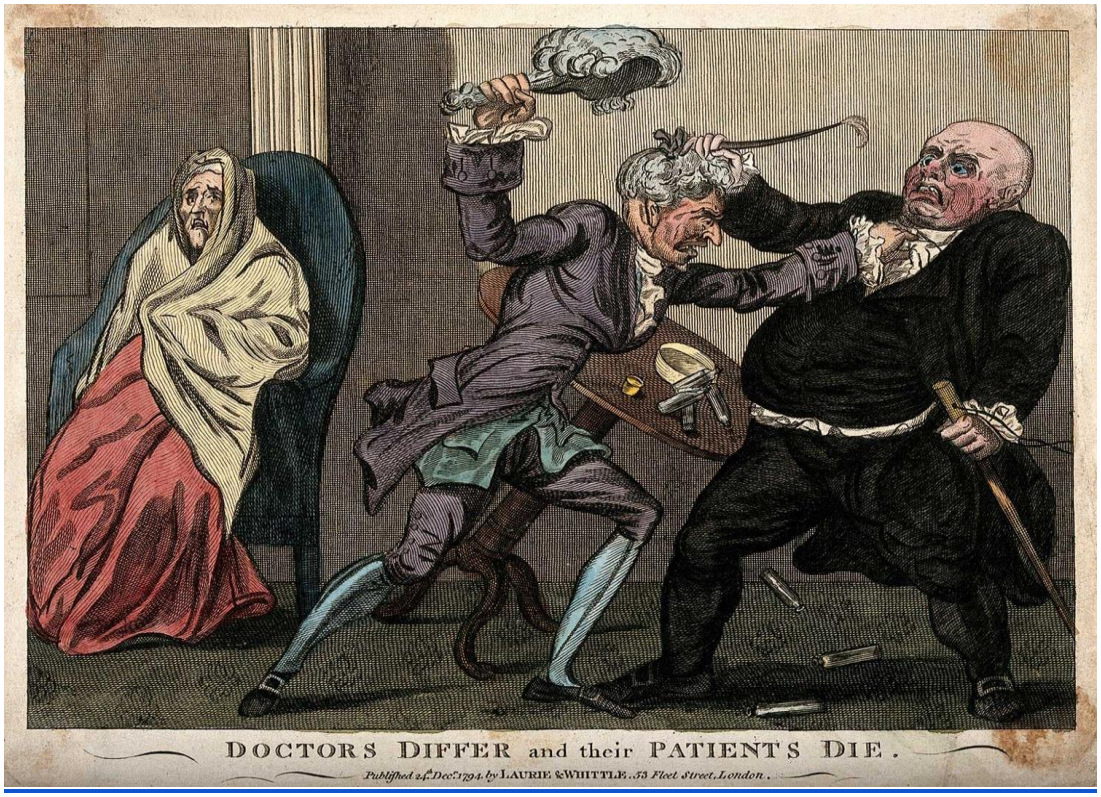

Figure 5.6. ***Doctors Differ and their Patients Die*** **(1794) by Isaac Cruikshank,** is a social commentary caricature from 18th century UK, depicting the internal disagreements and the lack of consensus amongst the medical community during this time.

Source: Cruikshank, Isaac, (1794). *Doctors Differ Patients Die* [Illustration]. U.S. National Library of Medicine Digital Collections. http://resource.nlm.nih.gov/101444045

The character goes on unto say it is irrelevant what kind of a prestigious education the doctor has if his office is dirty and worn down. In such a case, the patient will lose his trust in the doctor and "resist the treatment—and the doctor is going to have difficulty in putting over and collecting an adequate fee." He goes on unto explain that there are two options for decorating the doctors' office they should either make it look rich or make it look sterile or maybe a combination of both (Lewis, n.d). The novel *Arrowsmith* by Sinclair Lewis was a popular text during the 1920s, it won its author a Nobel and a Pulitzer. It is safe to draw the conclusion that it reflects something about the culture of its time.

6. CONCLUSION

This thesis looked at the swift shift in birthing practices during the period between 1900 and 1950s in the United States when most American women went from giving birth at home with midwives (who were mostly women of colour) to giving birth at hospitals attended by white male obstetricians. While midwifery is an ancient practice, referenced throughout time and across cultures, 19th-century industrialization brought along a new understanding of time, health, and medicine and challenged this ancient practice in many western nations. Still, many of these countries eventually found ways to professionalize midwifery and integrate the practice into the newly establishing standardized medical health care system. However, the U.S. stood as a strange example where midwives were chastised heavily, singlehandedly blamed for the high infant and maternal mortality rates. A smear campaign was run against not just their supposed inadequacy as birth attendants but the very morality of their character. This anti midwife narrative of early 20th century America had heavy racial undertones.

My research focused on these heavy racial undertones. I put the shift in birth practices and the demise of midwifery in America in the early 20th century in the broader context of white supremacy, rising xenophobia towards the growing number of immigrants, continuing legacy of antiblack racism. My research built upon an alive body of literature that challenged the notion that midwifery had lost this battle over birth assistance simply on merit. In other words, it was not medical and scientific advancements that pushed midwives into oblivion. In fact, to the contrary, for the first decades of the 20th century, doctors were not actually providing safer birth experiences. The question was then why the U.S., unlike many other industrialized nations, did not professionalize and integrate midwifery into its health care system?

American medicine was decentralized, and the healthcare system was privately funded. This was the main difference America had compared to the other industrialized nations, which implemented professional midwifery eventually within the public health system. This meant that doctors, who were often from a racially, socially, and economically privileged part of American society, being white males, could organize, access lawmakers, and lobby for their special interests. In this case, midwives were seen as a professional and financial competition that had to be eliminated. The way for them to be discredited was by accusing them of being the reason for the high infant

and maternal mortality rates. This was done not just in arguing against their craft but rather by invoking certain stereotypes about their ethnic and racial backgrounds, portraying them as dirty, ignorant, backward, uncivilized. In short, as total foils of the model that was promising to do a better job, the modern medical, professional, scientific, rational, objective, white, and male model of obstetrics and gynaecology. These narrative tools are cited in detail and further dissected throughout the chapters.

The thesis began with a section on the general historical context of the late 19th early 20th century United States. This chapter was divided into three sections, each focusing on important aspects of gender, race, and knowledge production. Here discussed were some of the issues that were the backdrop of the history of birth in America. The ultimate authority of the obstetrician was rooted in their triangular identity markers: white, male, scientist. This chapter laid out why whiteness, masculinity, and scientism were three socially advantageous positions. Next was a chapter on midwifery and its history. This chapter laid down the historical context of midwifery before obstetrics, how midwifery was affected by the spread of professionalization. Finally ending the chapter on the story of American midwifery broadly. This chapter aimed to show that midwifery was not a frivolous hobby with no basis as was portrayed by the majority of the medical community in the 20th century U.S. Midwives had produced, passed down, and built upon knowledge about female fecundity, pregnancy, birth, and abortions starting at least as early as ancient Egypt and Greece.

The fourth chapter was about obstetrics and gynaecology: how the medical field came to be, why slavery was paramount to its founding, and how the professionalization of medicine and the specific system of health care influenced obstetrics and gynaecology care. This chapter historicized the notion that doctors are also a group that has various motivations beyond patient care like personal prestige or financial gain, as well as a complicated history with scientific racism and unethical experimentation on marginalized populations. The final chapter was a deeper analysis of how the shift in birth practices was indicative of a broader cultural shift. This chapter started off with a narrative about how birth was medicalized. People's notion of birth shifted from a natural event that takes place in one's home to a pathological occurrence to be treated by a doctor at the hospital with tools and chemicals. I took an STS approach at analysing the involvement of these technics and technologies along with their histories and consequences. The second subsection delved into the empirical data on the

doctor's argument that doctor-attended births were safer for women than midwife-attended births. For the initial period of the takeover, when doctors were using this argument, it simply was not true. Data showed that for the most part, midwife-attended births were just as safe if not safer than hospital setting doctor attended births during the early decades of the 20th century in the US. Lastly, the chapter ended with a discussion of image-making, showcasing the rhetorical attacks against midwives as well as concerns for a positive image on the side of the medical community.

6. 1 Discussion of the Findings

This thesis aims to contribute to the existing body of literature on birth history by complicating the narrative of linear scientific progression. The U.S. had uncharacteristically high infant and maternal mortality rates compared to countries with similar profiles. This was seen as a public health crisis, and it was easy to scapegoat the midwives. Doctors who accused midwives often invoked racist stereotypes rather than point to actual empirical evidence about their supposed inadequacy in birth assistance. They were a good candidate to blame as they were often women of colour. In the South, there were black midwives; in the North and East of the country, there were Italian, Irish, and Jewish immigrant midwives, and in the Western states, Japanese midwives were helping women give birth. Across the nation, Native American reservations had their own indigenous community midwives. Being often poor, not white, and female put these midwives in a marginalized position in American society and made them an easy target for the medical establishment.

Studies that looked at whether it was safer for women to give birth with midwives or doctors found that during the time of this takeover, despite the exaggerated promises of obstetricians, it was not safer to give birth assisted by doctors. As discussed in section 5.2, most empirical data suggest that homebirths were equally safe if not safer than hospital births due to a few reasons. One was the infections at the hospitals. Germs were still a novel idea, and reportedly some doctors paid little attention to personal hand hygiene, going from cadavers' dissections to labours without washing their hands properly. Plus, doctors at this time lacked practical experience. Medical education focused mostly on theory, and obstetrics especially was a sensitive field due to societal concerns of modesty. Given that almost all of the medical students were male, and the obstetrical patients were women, the social norms frowned upon the gynaecological

examinations and labours being attended by men unless absolutely necessary due to a complication. Therefore, most doctors graduated not having attended an actual birth, and even vaginal examinations were done undercovers. This meant that most midwives were a lot more experienced than doctors. The one caveat here was that doctors were much more successful when there was a complication that required their intervention, but for the vast majority of births which presented no complications, their unnecessary interventions introduced risks and led to dangers otherwise not present.

It is important to clarify that this thesis is not arguing that white doctors in America intentionally behaved in racist or misogynistic ways to push midwifery out of the health care scene. The personal intentions of the white male obstetricians are not known, and any attempt to write about them would be mere speculation, and this academic work is not really the right avenue for that speculation. However, it is entirely appropriate to point out, whether they were acting on racist intentions or not, their actions collectively as a group were rooted in, burrowed from, as well as reproduced the xenophobic and racist rhetoric that was commonplace during this moment in American history. Their experiments, lectures, and writings targeting midwives were, in fact, based on racist stereotypes and had consequences that were disproportionately affecting women of colour.

Another clarification is that this thesis is not arguing that obstetrics was not benefiting women. It is a nuanced history with a complex web of motivations. For instance, in the case of experimental gynaecological surgeries done on enslaved black women, (as mentioned in chapter 4, section 2. These surgeries were experimental and successful outcomes certainly benefited to further the career of the doctor doing them. Sims is a good example; he went unto make a small fortune for himself treating European royals based on the knowledge he gained from his experiments on his slaves. However, the surgeries were designed (mostly) also to benefit these women. This was in part due to black women's fecundity being a source of "slave production." In other words, the slave owners had vested interest in employing doctors and making sure that these women were healthy enough to have babies, who in time would be the new slaves. Also consider that the women most likely were not in a position to consent to these surgeries. Plus, many times, they were not even administered anaesthetics or pain relief, despite the technology being available. This was potentially due to the

widespread belief at the time that black women (and other so called “uncivilized” people) had less sensitive pain receptors.

This is the kind of multi-layered thinking that is required in analysing a case such as this one. This is why I think that STS approach was invaluable to making sure this thesis took a holistic approach and considered the many factors in play.

6. 2 Importance of the STS Perspective

The theoretical frameworks I utilized to analyse the historical evidence were primarily science, technology, and society studies. I also burrowed useful conceptual tools from various disciplines such as critical race theory history of medicine, women’s studies, and critical media studies in taking an interdisciplinary, holistic approach to the issue at hand. I used qualitative historical document analysis as methodology. Included in my pool of documents analysed documents were official state reports, scientific journal articles from the time period at hand, oral histories, popular culture content such as novels, magazines, cartoons, paintings, and others.

The STS perspective allows one to be critical of science history and challenges notions such as the linear progression of science history. It is neither linear nor all progression. There are many factors in this history of how women gave birth and why. While infant and maternal mortality is a major concern, and it is undeniable that medical and scientific advancements in obstetrics and gynaecology have allowed for countless lives to saved and improved, it is important that we include all other factors that were at play, such as gender, race, perception of modern, western, secular science as well as the financial concerns of the medical community.

Delving a little deeper into some of these aspects shows why American midwifery is a good case study to understand the shifting dynamics of which knowledge system is valued and which is devalued. In this way, this thesis also becomes about the way knowledge is political. There are many incidents when indigenous or feminine knowledge systems are trivialized, only for western secular science to later come up with findings that confirm the practices of the older healers and midwives. To reiterate, put simply, my argument is not that science was “bad” for women, but simply that it was not and is not always all “good.” Early on writing about the theoretical framework

for the thesis, Sandra Harding's work on objectivity and situated knowledge is mentioned in the introduction of this thesis.

Harding challenges the notion of objectivity. She asserts that such notions as objectivity or rationality have been socially constructed and weaponized to undermine marginalized communities like women and people of colour. She posits an alternative. Situated knowledge is her solution to this problem, and it is the idea that one needs to write from the point of view of the marginalized. In this story, for instance, much of the narrative was controlled by doctors and state officials, two groups that were demographically almost identical being dominated by white males. Harding would suggest we reconsider this history from the point of view of the midwives and the birthing women, especially those who were non-white therefore further marginalized.

Another very interesting angle that is perhaps unique to the STS perspective is the in-depth consideration of tools and technologies. How do the medical technologies, drugs, and tools influence the culture of the scientific community, perception of birth, its medicalization, its being seen as a pathology vs. a natural life event, and the doctor-patient relationship? Many critics of the medicalization of birth talk about the unnecessary interventions that lead to dangers for the birthing mother and the baby. It is interesting to consider why doctors intervened in this way. Was it the influence of economics, as some suggested? The idea that because they were charging for much more money than midwives, people expected doctors to actually "do something" during labour. Or was it because doctors were trained to treat anomalies and therefore saw pathology even when there was none? Or was it that doctors positioned themselves higher in a hierarchy between the patient and all the other people involved, like the patient's family or other health care workers like nurses and hospital staff. Lastly, consider whether it was the mentality of intervention that led to the invention of tools and drugs or the availability of them that led to the more interventionist care approach doctors adopted compared to that of the midwives.

6. 3 Limitations of Research

As for limitations of this research, there were no conflicts of interest to be declared, though I must admit that both unwarranted selection and investigator bias may have caused some shortcomings. As is the case with any historical research project, where the researcher is only able to read a limited amount of work and chose to include

certain things and not others, although I put my best effort forward in being thorough, admittedly there is always a chance that due to the limitations of my time and access, I missed important primary and secondary sources. Plus, as a researcher who questions the very notion of objectivity and the purposes it serves, it would be ironic to claim that my work is objective and that somehow my perspective is not situated. However, allow me to add that this project is only "unobjective" due to the very nature of the impossibility of objectivity and not because of a particular viewpoint the researcher was hoping to advance.

6. 4 Possible Future Research

Future research could focus on the small but nonetheless important community of women doctors that lived and worked during this time in the U.S. Although they were an exception to a health care system dominated mostly by American-born white men, their presence was still undeniable. They were a racially diverse group; among them were former slaves who had gotten their medical training after they were emancipated from slavery. However, the literature barely ever mentioned these women. Their attitude towards ancient knowledge of birth or midwives was also not present in the literature. It would be interesting to compare their attitudes to male doctors to see if their shared gender made them more sympathetic to the cause of midwives, whether the racially diverse group of female doctors had disagreements amongst themselves regarding midwifery.

Another area of possible research may be the way birthing mother's race influenced the conversation. From time to time, briefly, some of the scholars I read made referenced how white babies were more of a concern from a public health standpoint. It would be worthwhile to pursue this question. In another incident, some historians argued perhaps counterintuitive to the general anti-black racism atmosphere black babies died at high rates actually mobilized the anti-midwifery campaign, but some scholars argue that was to not lose cheap labour in the south.

In conclusion, I argue that the swift transformation of American women's birth practices in the early 20th century was not due to doctors being better at safely delivering babies, but rather was the result of an organized effort on the part of the medical community that targeted midwives based on the racist and xenophobic assumptions of this moment in American history.

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