Motherwork in a Community of Care: the Midwife as a Public Figure in Early America

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Abstract

Female humans manage their reproductive bodies. They find their best practices for managing periods, fertility, and childbirth. Often, they share that knowledge, formally or informally, but ultimately through the framework of care – the provision of help or aid to ensure the health, welfare, and safety of an individual who cannot or should not provide it for themselves. Childbirth is necessarily a moment of care – it is painful, long, vulnerable, and dangerous. It is done best with someone there to catch the baby, cut the cord, and hold the laboring woman. As women have always been giving birth, they have always been developing and sharing their methods to ease the pains of fertilizing, incubating, and delivering new life. Midwifery in its most basic, non-professionalized sense is the shared expert knowledge and practice between women surrounding human reproduction. Midwives birth children, deliver women, and treat maladies. In colonial and antebellum America, those medicinal interventions were the keystone to an expansive and integral social authority. Midwives oriented and enforced societal values while acting as envoys and advocates between the women they treated and the patriarchal power structures they lived in and against.

In the 1960s and 1970s, feminist scholars began reevaluating the historical role of the midwife and her demotion from birthing room authority in the Western world. This project follows the footsteps of that feminist, feminine, and female-oriented historical scholarship by analyzing colonial and antebellum American midwifery with visceral empathy. The touches, soothings, grasps, screams, writhings, encouragements, and indictments are the body of this body-centered work. When this intimate choreographic attention is enriched with social, political, and cultural analysis, the full contours and impacts of the relationships between midwife, mother and community are revealed. Ultimately, this project finds that when physicians appropriated midwifery, they expropriated midwifery’s pharmacopeia, carework, and distinct social authority to professionally authenticate their own place in America’s birthing rooms.
For Mom.
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Introduction

The white male invasion of the American birthing room was well documented – they made sure of it. The act of writing bolstered the medico-scientific institution’s supposed right to treat American women’s births. Such systematized recording sharply contrasted the oral, relational, and apprenticeship-based knowledge-transmission methods of American midwifery: the institution they usurped. I am exhausted and uninterested in the well-traveled narrative of such usurpation: it is a story of a presumptive, haphazard violence that experimentally became the modern practice of gynecology and obstetrics. I am interested in midwifery – the medical practice of Early American women. Such care centered on, but was not limited to, the birthing room and child bearing. Instead, Early American midwifery was a cultural care network bolstered by the medical practice of midwives. Midwifery was not analogous to gynecology. It was not engrained in visions of science but visions of mothering: of care, community, and cultural continuation. It was motherwork with a strong and broad socio-political impact on Early American life.

In Old English, “midwife” literally translates to “with woman.” This etymology reveals the simplest definition of midwifery: the practice of accompanying and caring for birthing women throughout their labor.¹ On a more theoretical level, archaeologist and historian Laurie A. Wilkie describes African American midwifery as an “ethnomedical tradition” which provided “experienced, patient-oriented, and inexpensive home births” alongside cultural transmission and spiritual care.² This definition echoes throughout historical and sociological work on motherhood and midwifery throughout the late 21st century. In 1988, historian Molly Ladd Taylor defined

midwifery as “an extension of maternal responsibility, passed through generations.” In 1994, the prominent sociologist Patricia Hill Collins enriched these maternal midwifery conceptions with her idea of “motherwork.” As she said, “Work for the day to come is motherwork, whether it is on behalf of one’s biological children, or the children of one’s own racial ethnic community, or to preserve the earth for those children who are yet unborn.” Wilkie’s theoretical framework defines midwifery as “the motherwork of creating mothers.” Within my own theoretical framework, midwifery was a social role that furthered and upheld community care networks among early American women. Midwives not only coordinated the generational transfer of mothering knowledge; they acted as emissaries between women and the patriarchal power structures they lived in and against.

**Foreground: Midwifery to Gynecology**

Until about 1750, all births in what would become the continental United States occurred in the home and were assisted by midwives, friends, neighbors, or relatives of the birthing mother. Birth was a social event: women gathered to care for the birthing mother, offer advice and solace, and keep house while the birthing woman was preoccupied with labor and parturition. If a midwife was present, it was she who caught the baby, cut the cord, and administered any necessary medical interventions. On Southern plantations, enslaved midwives, or “Grannys,” as they were titled, attended the enslaved birthing women on their own plantations and traveled to neighboring plantations when the community’s need arose. Some especially gifted midwives were sought by members of the white planter class for their skills. If they were paid for their work, their wages would sometimes remain their own, but most often would go

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3 Wilkie, *The Archaeology of Mothering*, 121.
5 Wilkie, *The Archaeology of Mothering*, 120.
directly to their owner. Free midwives were paid for their expertise and medicines with money, goods, or services, but their roles were not distinctly professional. Many colonial midwives received more than their typical rates from particularly grateful upper class families and waived fees for families who could not afford to pay. Weather, distance, time of day, difficulty of birth, or promised payment did not dissuade midwives from attending a needful neighbor. Early American midwives were not formally educated (indeed, many of them could not read or write). Instead, midwives were trained through their own experiences of birthing and watching births under the tutelage of other midwives or medicinally knowledgeable community members. Unlike the physicians who replaced them, midwives gained their clinical knowledge, experience, and authority from the communities of women they served.⁶

When they came into the birthing room, physicians brought the prestige of masculinity, education, and medicine. That social power was syndicated in their use of surgical instruments. In Medieval and Renaissance Europe, midwives would call barber surgeons into the birthing room when the life of the mother was in peril. Those surgeons would either cut the fetus from the womb to save the child’s life or use crochets – long, sharp hooks – to break apart the fetus’s skull and extract the child in pieces to save the mother’s life. In 1752, Dr. William Smellie published *A Treatise on the Theory and Practice of Midwifery*, a manual which popularized the use of forceps – a sort of blunt pair of tongs – in the place of crochets in difficult births. When used correctly, forceps could save the life of both mother and child from situations that would typically kill one or both of them. When used rashly or improperly, however, forceps could butcher both mother and child. Despite their unwieldiness, forceps proved essential to the growth of obstetrics because they offered a solution to dangerous births where neither mother nor child perished.⁷

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For whatever reason – be it the cost of instruments or the established custom of female medicine as herbal and tactile rather than instrumentally interventionist – European and colonial American midwives did not use forceps. Largely, they didn’t need to; midwives did not regularly encounter birth presentations that they could not treat. Between 1785 and 1812, for example, the midwife Martha Ballard attended and recorded 814 births, but only 5 maternal deaths and 14 stillbirths around her community in rural Maine. Still, birth was dangerous. Maternal mortality rates of 0.50-1% were not insignificant, and the threat of unmanageable death in birth loomed large in the minds of colonial women. Forceps, alongside the physicians who wielded them, appeared to solve that problem.

Steadily, across the 18th and 19th centuries, physicians and their instruments were increasingly invited into birthing rooms by upper and middle class women – both for dangerous and regular births. Indeed, by 1850, mortality rates of physician-assisted births had dropped enough to about equal those of midwife-assisted births, the crochet was phased out of medical practice, and most middle class American women were delivered by physicians, not midwives, in their homes. Such a progression reflects how obstetrics was essential to the actualization of American medicine as a prestigious profession.

The professional progression of physicians entering the birthing room reflects the successive institutionalization of American medicine, surgery, and obstetrics through the portal of midwifery. Around 1762, Dr. William Shippen returned from his education abroad, published his series of lectures on midwifery, and became one of the first American physicians to start delivering children (in this case, the babies of Philadelphia’s elite women). It is notable that physicians like Shippen and Smellie called their practices “midwifery.” In these beginning moments, when the United States medicine were young, physicians saw themselves as entering

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the field of midwifery with science, masculinity, and professionalism rather than creating a way of doing birth imbued with science, masculinity, and professionalism. Indeed, they began attending births because they were both interested in the physiological processes of reproduction and to earn the reliable income that midwifery brought. The term “obstetrician” was not coined until 1828.9

In 1765, Shippen and John Morgan established The Medical College of Philadelphia, the first medical college in America. King’s College Medical School in New York City (1767) and Harvard Medical College (1782) followed shortly. All three of these schools established a midwifery specialty before they established a surgical specialty.10 The doctors that these colleges produced delivered mostly the children of upper class women. But as their educations were theoretical rather than clinical in nature, physicians practiced by delivering the children of poor women in community hospitals and enslaved women on plantations. As such, inherent to the history of gynecology usurping midwifery is the intersecting histories of race, slavery, class, and gender in American society. The story of Dr. J. Marion Sims (1813-1883) synthesizes this point.

Sims received a two-year medical education in Philadelphia before opening his first practice in Montgomery, Alabama in 1845. Throughout his career, Sims invented gynecological technologies, examination positions, and surgical methods; opened the world’s first (white) women’s hospital in 1855; and broke modest Victorian tradition by actually looking at the vagina during pelvic exams. In 1845, Dr. Sims invented a vaginal speculum which remains in use today. With that speculum, Sims gained access to his subjects’ cervix and birth canal. There, he invented a surgical cure for the vesico-vaginal fistula – a hole in the wall of the vagina and urethra or rectum. Fistulas cause constant incontinence from the bladder and/or rectum through

9 Wertz and Wertz, Lying-In, 66.
10 Wertz and Wertz, Lying-In, 49.
the vagina; as a result, women with fistulas were constantly infected and malodorous. These fistulas were known as “the stumbling block of gynecology” because they were usually created by physician’s invasive instruments. Sims’s cure for the fistula, alongside others’ discoveries of anesthesia in 1846 and antisepsis technique in 1867, popularized gynecological surgery and heralded general surgery on a global scale. Dr. Sims was essential to the growth of American surgery, and the cultural proclivities of his practice have permeated gynecology and medicine since his time.

Dr. Sims made these groundbreaking surgical discoveries on the bodies of enslaved women. From 1845 to 1850, Sims housed eleven enslaved women (both women he owned and women on loan from his neighbors) behind his home for periodic surgical experimentation. We only know three of their names: Lucy, Anarcha, and Betsey. As all eleven women had gynecological conditions and were not able to reproduce, their owners allowed their absence in hope of an eventual cure at Sims’ hands. It was their torture that produced Sims’, and in turn, gynecology’s, institutional advancements. Dr. Sims is a figurehead for the entire practice of plantation medicine – experimental and routine treatment of enslaved people to ensure their productive and reproductive capabilities and devise means of systemically ensuring those capabilities for the entire enslaved population.11

Plantation medicine served the plantation economy and the medical institution, not the enslaved person. It was the medico-scientific management of chattel property for efficient production and reproduction. Like Sims, physicians experimentally treated enslaved women’s births with a simultaneous nonchalance over the value of the human lives with which they interfaced and a scientific imperative to maximize the reproductivity of the enslaved women.

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population. Such practice established those doctors as physicians and, in turn, established the institution of American medicine.

As they replaced midwifery in providing America’s health and birthing care, institutionalized medicine and obstetrics retrospectively foreground our understanding of what midwifery was and how it was practiced. The transition between the two was not easy. Quelling midwives’ practices and urging women to give birth in hospitals required legislation, a cultural medicalization of birth, and the persistent ethnicization and vulgarization of midwifery. National trends of industrialization and modernity begot, facilitated, and are reflected in this process. While the mechanics of that incremental takeover are not rehearsed in this thesis, the ways in which midwifery principles, labor, and knowledge permeated obstetrics through its inception are.

**Historiography**

Few self-proclaimed histories of American midwifery exist. Those that do stand markedly outside the realm of academic history. Both Judith Rooks’ *Midwifery and Childbirth in America* (1997) and Joyce E. Thompson and Helen Varney Burst’s *A History of Midwifery in the United States: The Midwife Said Fear Not* (2015) were written by professional nurse midwives to discuss the modern medical midwifery profession. Rooks’ anthology of the clinical history and efficacy of licensed midwives focuses heavily on the later half of the 20th century. Therein, she defines midwifery as care that focuses on pregnancy and birth’s “normalcy and potential for health” and centers the act of being *with* birthing women rather than healing birthing women. Through her history of childbirth in America, Rooks argues that physicians’ technical and

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economic prestige over midwives facilitated their takeover of birth attendance. In adherence with their title, Thompson and Burst deal more directly with the historical meanings of midwifery, though they too focus heavily on 20th century nurse midwifery. They connect the establishment of nurse-midwives as public health agents in the 1920’s to midwives’ ancient roles as shepherds of public health for their communities. To Thompson and Burst, midwives are “caretakers of life” who provide continuous, holistic, and minimally technological care to birthing women under the auspices of a conception of birth as wholly normal and natural. As such, from the perspective of modern medical nurse-midwives, midwifery is professional support for women undergoing natural childbirth.13

Another case of non-academic history of midwifery is Barbara Ehrenreich and Deirdre English’s *Witches, Midwives, and Nurses: a History of Women Healers*, a work published by the Feminist Press at City University of New York in 1973. Just like its press, this work is feminist in nature and was produced in direct response to the lack of female authority in modern health and medicine as compared to the immense heritage of women as healers. By drawing a direct line between the American and European witch hunts of the medieval period and women’s subservient roles as nurses in modern medicine, Ehrenreich and English argue that “[the medical profession] is a fortress designed and erected to exclude us [i.e. women].”14 What’s more, they posit that as women healers midwives “were the people’s doctors and their medicine was part of a people’s subculture.”15

It was into the context of this feminist discourse that Richard W. Wertz and Dorothy C. Wertz published *Lying In: A History of Childbirth in America* in 1977. Unlike the histories of

medicine that precede it, *Lying In* is a social history grounded in a theorization of birth as a distinctly social event. In colonial America, that event was marked by the gathering of family, friends, and neighbors in solidarity with the birthing women and in expectation that when their time came, the birthing woman would do the same for them. Around and within the birthing room, 17th and 18th century women exchanged labor, childcare, medicinal aid, food and drink, and psycho-emotional support. Therein, the Wertzes argue that American colonial midwives were socially revered practitioners who served not only their local communities of women, but their local legal and spiritual societies writ large in a “special social quasi-religious function.” Over the 18th and 19th centuries, however, changing meanings of childbirth begot changes in the means of childbirth. Wertz and Wertz contend that birthing women retained their authority in the birthing room across this period and authoritatively chose to be attended by physicians rather than midwives for their authority and prestige in a newfound cultural context that viewed birth as rational and de-mysticized.  

The Wertzes’ estimation of American colonial births as distinctly social and reciprocal female events is upheld and furthered in Laurel Thatcher Ulrich’s *A Midwife’s Tale: The Life of Martha Ballard, Based on her Diary, 1785-1812* (1990). Its source material - the midwife Martha Ballard’s diary recording her daily work in rural Maine - illuminates dimensions of labor, gender, aging, and law alongside the medical practices of its author. Ulrich is careful to note the magnificent rarity and value of her source material to the field of Early American women’s studies. One anecdote particularly synthesizes this value. Captain Henry Sewall and his family lived in Hallowell, Maine alongside Martha Ballard and hers. Martha delivered all eight of Captain Sewell’s children to his wife, Tabitha. Though he kept a detailed diary from 1776 to 1842, it is Martha’s diary, not Capt. Sewell’s, that tells us that Tabitha was a bonnet maker by

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trade. It is from this precious neighborly, female, and daily diary that Ulrich synthesizes Ballard’s midwifery as “one speciality in a larger neighborhood economy, as the most visible feature of a comprehensive and little-known system of early health care, as a mechanism of social control, a strategy for family support, and a deeply personal calling.” With *A Midwife's Tale*, Ulrich provides a syndicated, contextualized anthology of the many dimensions of one midwife’s life and profession; her analysis moves from the midwifery outward, towards the connections made and maintained between Martha Ballard, her family, and her community.

Unlike the sources discussed up until this point, most histories of childbearing in America do not center on the midwife but instead center on the experiences of white birthing women throughout and following the medicalization of birth. Among these titles however, Amanda Carson Banks’ *Birth Chairs, Midwives and Medicine* (1999) stands alone as a study of American and European birth through material artifacts. By analyzing the transitions from birth stones to birthing stools to hospital beds, Carson Banks analyzes the Western cultural construction of birth across time. Generally, the era of birthing stones, stools, and squatting aligns with the age of midwifery. Stools and their contemporaries allowed the midwife to face her patient and access the birth canal without sacrificing the modesty of the mother. The seat and back supported the mother while maintaining an upright position to allow gravity to aid in delivery. Hand holds and foot rests allowed the laboring mother to brace herself for contractions. And open backs allowed attendants and midwives alike to support the mother, massage her back and stomach, and hold her through her pains. The function of birth stools, Carson Banks argues, evidences the deeply social, communal, and practical birthing customs of midwives and their patients.

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Under the restrictions of her own time frame, Judith Walzer Leavitt deals exclusively in the ways in which the physician and the growing institution of gynecology affected American birthing women in *Brought to Bed: Childbearing in America, 1750 to 1950* (1986). Leavitt writes from a feminist perspective that positively centers women as actors in the birthing room. While her assertion that free birthing women held authority over their birthing rooms that was bolstered by the community of women who gathered to support them is correct, Leavitt unfortunately essentializes this “banding together” to a “feminist” “impulse embedded in women’s traditional experiences” that, to me, reads as contextually disjointed.\(^{20}\) Feminism is not a historically continuous idea, and female homosociality is not inherently feminist. In order to trace the changing birthing trends of American women, Leavitt analyzes the birth experiences of middle and upper class women from their own words and the words of their physicians and finds, conclusively, that those changes originated in American women’s desires to make birth “safer, more comfortable, and more meaningful.”\(^{21}\) Under Leavitt’s framework, those women’s decisions directly resulted in the medical institution of gynecology and obstetrics.

Conversely, Deborah Kuhn McGregor’s *From Midwives to Medicine: the Birth of American Gynecology* (1998), traces the origins of American gynecology from the scientists themselves with Dr. J. Marion Sims as the archetype of the American gynecologist. Therein, McGregor argues that the advancement of American medicine as an institution depended on success of American surgery in the latter half of the 19\(^{th}\) century. Such success was made possible by Dr. Sims’ gynecological surgery practice and pedagogy. What’s more, McGregor argues Dr. Sims operated on a hierarchical model of medicine as scientific truth-seeking with himself at the top and his patients at the bottom. Within the class of patients, however, key


distinctions emerge. As discussed in the background section above, Dr. Sims first treated enslaved women in Alabama before moving to New York City and opening The Women’s Hospital of the State of New York. As evidenced by Dr. Sims’ career, McGregor maintains the essentiality of reproductive slavery to American gynecology’s growth.22

As childbearers, enslaved women experienced a simultaneous disregard for their humanity and extractive valuing of their physical bodies and their procreative abilities. As such, much of the theoretical work surrounding childbirth and motherhood for American women has emerged from the study of enslaved women’s experiences of forced and subversive reproduction and mothering. Harriet A. Washington’s discussions of gynecology in Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present (2006) works to build a history of American gynecology that centers the experiences of enslaved Black women under the treatment of plantation physicians. Dorothy E. Roberts’ *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (1997) furthers this argument beyond the institution of slavery by comprehensively arguing that the subjugation of Black women’s reproduction from slavery through the 20th century inextricably grounds our modern conception of reproductive health and freedom. Roberts’ and Washington’s works prove that the history of American gynecology is the history of slavery and ground the theoretical understandings of medicine’s interactions with enslaved and Black American women.23

These institutions operated in tandem on systems of gender, race, and labor. In *Laboring Women: Reproduction and Gender in New World Slavery* (2004), Jennifer L. Morgan marks the resounding effect of the 1808 ban on international slave trade on those concepts of gender, race, and labor for enslaved American women. Without the ability to import enslaved people from

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Africa, Caribbean and American slave holders turned to insular reproduction to grow the slave population. Accordingly, Morgan argues that slaveholders and their plantation physicians turned their attention to the Black birthing room and enslaved women’s bodies with capitalist aims. Marie Jenkins Schwartz’s *Birthing a Slave: Motherhood and Medicine in the Antebellum South* (2006) tracks that attention explicitly after 1808 through diaries and articles published by Southern planters, planters’ wives, overseers, and plantation physicians. While she works to establish and acknowledge indigenous African and African American health practices occurring on Southern plantations, Schwartz’s primary source material necessarily tracks the incursion of the planting class on enslaved health. Throughout her narration of slavery’s contributions to gynecology, Schwartz identifies Granny midwives and elder women in general as trusted caretakers and communicators of African American healthways that operated within a large network of enslaved women and opposed the treatments of planters’ medical men.  

The above represents a litany of historical thought on Early American midwives and their places in society. In my own analysis, I carry forward Rooks and Thompson and Burst’s definition of midwifery as the non-intrusive, companionate care of birthing women and pregnancy, birth, and parturition as normal processes essential to the human experience. Ulrich and Wertz and Wertz’s definition of colonial birthing rooms as social spaces of reciprocity and care among women is essential to my framework. Additionally, Wertz and Wertz argue that midwives held powerful quasi-religious roles in their societies. While the allusion to priesthood is a helpful framework, I question the direct translation of midwifery and childbirth onto religion and salvation. Alongside Ehrenreich and English and Wertz and Wertz, however, I maintain that the misogyny, sexism, and changing religious perceptions of birth across the early colonial  

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period epitomized by the witch trials contributed to the downfall of midwives and the rise of gynecologists. What’s more, Leavitt and Wertz and Wertz’s assessment that women were authoritative agents in their own and their peers’ birthing rooms is crucial to understanding the great shift from midwives to gynecologists across the 19\textsuperscript{th} century.

With McGregor, Washington, and Roberts, I assert that the enslaved Black birthing room was an essential arena for the professional growth of gynecology. This is evidenced by the career and influence Dr. Sims and his surgical experimentation on Anarcha, Betsey, Lucy, and eight other enslaved women. Morgan and Schwartz productively deepen that narrative by asserting that the plantation physician’s role was capitalist in nature. Both the planter and the physician sought to maximize the reproductive capabilities of enslaved women with medical interventions. Within this frame of thought, I maintain alongside Schwartz that the Granny midwife acted as a caretaker and communicator of indigenous healthways against and around the imposition of physicians and gynecology in the enslaved women’s birthing room.

This thesis converses not only with the histories of American medicine and American childbirth, but also of American women writ large. With its inspection of the visceral power and influence of female cultural realms, this work takes up the feminist historical thinking of the 1960s and 1970s and merges it with modern historical approaches to histories of medicine and the body.\textsuperscript{25} Where earlier feminist scholars largely limited their study of the midwife’s authority to reproduction and birth, I extend my study to midwives’ visions of justice and community to ultimately show how medicine appropriated not just birth but also this female-accredited social authority.

Early American women were rarely literate. When they were, they were typically of the upper class. As such, collecting midwives’ own words and women’s words about midwifery is a difficult though not impossible task.

The previously discussed diary of Martha Ballard from 1785 to 1812 and the diary of Patty Bartlett Sessions from 1846 to 1888 offer two distinct insights into the daily lives of practicing American midwives trained in the early American tradition. Both diaries include daily logs of domestic tasks completed, visits and meetings attended, and births overseen. Martha recorded the births with the date, one or both names of the parents, the sex of the child, the payment asked, and the payment received. Patty recorded the dates, being “called” to a birth, and, typically, the outcome. If the child or the mother died, they recorded that as well. Such brevity hinders an analysis of their care practices, yet still allows a thorough analysis of these midwives’ connective frequencies and roles in their social networks. As the work of Laurel Thatcher Ulrich in *A Midwife’s Tale* evidences, this social analysis in turn illuminates the interpersonal texture of the midwife’s practices. Such analysis is crucial to understanding the social role of midwives within larger communities of neighborhood domestic production and reproduction.

With *The Archeology of Mothering: An African American Midwife’s Tale* (2003), Laurie A. Wilkie called in direct response to Ulrich’s seminal work *A Midwife’s Tale: The Life of Martha Ballard, Based on her Diary, 1785-1812* published in 1990. Unlike Ulrich, however, Wilkie cannot draw on a personal written account of Lucrecia Perryman to describe her life or values. Lucrecia Perryman was born into slavery in 1869 and practiced midwifery in Mobile,
Wilkie analyzes the artifacts found on the site of Perryman’s home, scant documentary evidence, and ethnographic accounts of African American midwifery to uncover a midwifery practice steeped in African American tradition, systems of community apprenticeship, and non-interventionist care. This archaeological archival method complements and contrasts historical analysis of 17th to 19th century midwife’s diaries and advocates for a material analysis of midwifery in the stead of written sources.

As so much of the midwifery practice was composed of everyday items like herbs, kitchenware, beds, chairs, and hearths, few direct artifacts of midwifery survive currently. Those that do, however, (alongside written references to midwifery’s tools) demonstrate the dynamic and intimate motions of midwifery. Most of the artifacts recovered from Lucrecia Perryman’s home are glass cosmetic and food containers like mineral water bottles, cream and oil containers, and baby food bottles. Close reading of the artifacts left at Lucrecia’s home reveals the essentiality of touch, embrace, and feeding to her midwifery practice. That same material analysis may be applied to the few birth chairs and descriptions of birth stools that survive from colonial America. As the seats upon which women birthed and midwives delivered, these structures literally framed midwifery care. By dynamically imagining the birth care that happened on, around, and through the surviving artifacts of birth, we illustrate the choreographic interpersonal textures of American midwifery.

Journals, homes and other material culture I use in this thesis are often constructed by the midwives themselves. Though the diaries offer more evidence of people, places, and births and the material culture offers more evidence of medicinal practice, both reflect a daily, intimate, and domestic personal and professional upkeep that extends to wider social worlds. As such, one may

use both diaries, homes, and material culture to uncover the deeply personal nature of a calling that requires such preparation, fortitude, and kindness.

Slave narratives are an immeasurably valuable yet complicated source on African American midwifery. The written source material available on enslaved Africans in Early America is by and large written by free white people. It was not until the Federal Writers Project of the Works Progress Administration cataloged more than 2,000 interviews of former slaves from 1936 to 1938 that we gained a substantial account of enslaved persons’ lives from their own perspectives. While most of those interviewed were children when the Emancipation Proclamation was released, their recollections hold salience to the culture, practices, and stories of African Americans in earlier periods. Many of the interviewees’ grandparents were born before 1808 or in Africa. Pharmacological horticulture and care rituals were passed down generationally. Indeed, as they caught babies, treated maladies, and trained their apprentices, Granny Midwives were bastions of that cultural exchange. As such, though mentions of Granny midwives, births, and home life are scant within these narratives, they are valuably reflective of the culturally sustaining work of Granny Midwives themselves.

That being said, these narratives were produced by white people for white people. Problems of editing, bias, and distrust between the interviewees and interviewers were abound, evident within the typewritten transcripts and their editorial notations. In the opening of Birthing a Slave, Schwartz notes that those who transcribed the WPA interviews “frequently and deliberately inserted misspellings” to imitate the speech patterns of their subjects. Such provincializing copyediting illuminates the interviewers’ and editors’ pejorative view of the people they interviewed for this project. When transcribing his interview with H.B. Holloway in

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27 Across this thesis, I refer to people who experienced enslavement not as “slaves” but as “enslaved people.” Here, I use the term “slave” because the genre of these narratives are generally called “Slave Narratives.”
Little Rock, Arkansas, S.S. Taylor added the parenthetical: “(Holloway’s mother was a midwife to Colonel Troutman’s wife and “mammy” to his boy, although a free Indian.)” The editor boxed the section and wrote “delete” in the margin. The parentheticals, combined with the editor’s directives, announce each contributor's unconcern with enslaved people’s social structures of health, let alone midwives.

What’s more, the disdain that many interviewees held for the WPA, the government, and white people at large is quite clear. Thomas Hall of Raleigh, North Carolina was quoted saying “No matter where you are from I don’t want to write my story cause the white folks have been and are now and always will be against the negro.” That Hall made this statement is telling; that the interviewer and editors included his words against his express wishes is even more so. Neither subject nor editor trusted the words or intentions of the other.

Both colonial court documents and Antebellum physicians’ case narratives offer similarly valuable yet authoritatively mediated archives of colonial and Antebellum midwifery. Both spaces – the courtroom and the physician’s birthing room – are embroiled in patriarchy, class, and race. And in both spaces, midwives were welcome or surreptitious mediators between their patients, the cultural authorities midwives occupied, and the institutional power of law and medicine.

Midwives were expected to regularly enter colonial courtrooms to mediate paternity, fornication, miscarriage, and infanticide cases with information from the birthing room. They used that distinct midwifery-based authority to arbitrate care and justice for their patients within the municipal judicial system. Court records, though mediated through a stenographer and

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physically and theoretically structured by legislative (i.e. male) authority, evidence midwife’s insistent advocacy along their own matriarchal values.

Oftentimes, it was midwives themselves who called physicians into the birthing room – physicians had instruments like crochets and forceps; midwives did not. When physicians arrived, however, midwives did not leave. They stayed to continue caring for their patients around the physician’s interventions. The archive of physicians’ obstetric case narratives document not only the midwifery care occurring in those duly occupied rooms, but also the ways in which physicians appropriated midwifery knowledge, created hierarchy between the intermediating authority of physicians and the constant nursing of midwives and attendants, and ultimately occupied the midwife’s complex social authority to gain access to the birthing room in full.

Finally, writings by contemporary colonial and antebellum Americans about childbirth and midwives themselves demonstrate the cultural meanings of childbirth and midwifery to these actors and their communities. Some, like Judge Samuel Sewall (1652-1730) and Reverend Ebenezer Parkman (1703-1782), are prominent figures in the history of colonial New England whose recordings of their wives’ births have survived within their diaries. Other diarists are women themselves. Sarah Connell Ayer (1791-1835) of Newburyport, Massachusetts, Peggy Dow (1780-1820) of Granville, Massachusetts, Mary Vial Holyoke (1737-1802) of Salem, Massachusetts, and Elizabeth Pendergast Carlisle (1747-1817) of Wayland, Massachusetts each left journals that were saved, transcribed, and published across the 19th and 20th centuries, largely by their own family members. Other women – like Mary Jackson Lee (1783-1860) of Boston, Massachusetts and Nancy Maria Hyde (1792-1816) of Norwich, Connecticut – left only letters behind. As their surnames and hometowns reveal, these women were wealthy, well connected,
and (largely) from New England. Their writings do not provide a comprehensive survey of Colonial American women’s experiences of pregnancy, childbirth, and motherhood. Their illumination of specific women’s experiences and the cultures of birth they occurred within nonetheless offer precious insight into colonial births.

Memorializations of midwives through epitaphs and mortuary notices reveal the social importance of midwives to their communities and the colonies writ large. Oftentimes, these mortuary notices simply reported the epitaphs of the deceased woman, other times, they recorded additional tidbits of the midwife’s life and work. In these celebrations, midwives are praised for their expertise at the liminal intersections of life and death. Both the words themselves and the magnitude of their publishing demonstrates the sentimental, spiritual, and authoritative meanings of midwifery for colonial Americans.

**Section Outline**

This thesis seeks a visceral understanding of the care and community inherent to Early American midwifery. How did power, community, and relationship appear and exert itself in the birthing room? How did those dynamics extend beyond the birthing room? How does the study of Early American midwives illuminate the textures of daily life for Early American women? The thesis will answer those questions through four sections of differing scopes, approaches, and archives.

The first section of the thesis analyzes colonial municipal records and court documents from the 17th and 18th centuries to first establish the centrality of the midwife to colonial municipal order, then analyze her distinct advocacy from that positional authority. Early American midwives’ familiarity with the court system, alongside their relative mobility and
respect among the families of their communities, allowed them to effectively advocate for their patients within the courtroom against and around institutional patriarchy along their own justice schemes determined by and for women and children. The midwifery work of catching babies and caring for mothers operated in tandem with the work of advocating for the justice and safety of her community’s women.

The second section inspects what the work of delivering women looked like across the entire time and geographical frames of my study by reading the motions of care throughout the entire midwifery birthing process. My analysis of carescapes and choreography follows the anatomical stages of labor: the anticipation of pregnancy, the onset of labor, calling for birth attendants, active labor, birthing the child, and caring for the newborn and parturient mother. The actions of women in the birthing room along these prescribed itineraries illuminates the midwifery health care ethic as non-intrusive, supportive, and compassionate.

The third section of the thesis expands upon the meaning of midwifery beyond the birthing room by inspecting the midwife’s social roles within her communities on plantations and in colonial and antebellum towns. Midwives entered their roles through systems of apprenticeship and spiritual calling. As motherworkers for their neighborhoods of women and children, midwives mediated the generational transfer of mothering science and culture within entire kin and social worlds. Through this role, midwives structured and upheld the institution of female domestic labor; they trained their apprentices and attendants in the art of caring, engaged and directed care networks for their patients, and distilled regional ecologies into medicine and advocacy. They were the bastions of a matriarchy that operated parallel, against, and within systems of patriarchy and enslavement for community and familial continuation. The importance of their work was honored and celebrated in their epitaphs and published memorial notices.
The final section of the thesis analyzes the transition from midwives to gynecologists as evidenced by an archive of physician articles describing obstetric cases in antebellum America. As the birthing room was a key arena of professional advancement for physicians – especially those practicing their skills on Southern plantations before delivering free patients – these articles reveal not only the insurgent and conscriptive care of midwives, but the ways in which midwifery fed gynecological knowledge, structured gynecological care practices, and defined the progression of the gynecological profession.
I. Asserting Matriarchal Justice Schemes: Midwifery, Advocacy, and the Law

In the late evening of April 2, 1677, Mrs. Hannah Sewall went into labor. Her husband, Samuel Sewall, set out to fetch the midwife. He recorded their journey in his diary:

“Father and I sitting in the great Hall, heard the child cry, whereas we were afraid ‘twould have been 12 before she would have been brought to Bed. Went home with the Midwife about 2 o’clock, carrying her Stool, whose parts were included in a Bagg. Met with the Watch at Mr. Rocks Brew house, who bad us stand, enquired what we were. I told the Woman’s occupation, so they bad God bless our labours, and let us pass.”

This midwife’s portable stool – the seat upon which she delivered each woman she attended – acted as a badge of her righteous profession and broad mobility. This badge allowed her and the man who accompanied her to not be allowed to pass but be blessed in passing a checkpoint. That man, Samuel Sewall was a judge in the Puritanical Massachusetts Bay Colony (he was, in fact, one of the judges who presided over the Salem Witch Trials in 1697); he held significant judicial and moral authority in his community. His recounting of his family’s interactions with the town’s midwife illustrates the complementary authority of the midwife within the municipal justice systems of Early America.

Across his diary, Sewall’s respect for and deference to his family’s midwife, Mrs. Elizabeth Wheeden, is apparent. When the child born from the labors described above was baptized, “Eliz. Weeden, the Midwife, brought the Infant to the third Church.” And when, eight years later, Sewall’s child Henry died and was buried, “Midwife Weeden and Nurse Hill carried the Corps by turns” to the grave in the funeral march. In Judge Sewall’s family, the midwife’s moral authority extended beyond the birthing room to the spiritual realm. The same hands that caught babies delivered them to the salvation of baptism and the afterlife. It was her role in her

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30 Samuel Sewall, Samuel Sewall’s Diary, ed. Mark Van Doren (Macy-Masius, 1927), 15.
31 Sewall, Samuel Sewall’s Diary, 16, 28-29.
community as a midwife that offered her this authority, just as it was her occupation (as evidenced by her stool) that allowed her to pass the “Watch” late at night blessed in her labors.

The judicial mobility and moral authority held by Mrs. Elizabeth Weedon was not unique to her. In fact, free Early American midwives occupied a distinct role in their communities’ justice systems as arbitrators, negotiators, advocates and representatives of the events of the birthing room and the women they treated. Furnished by the authority, respect, and municipal functionality of midwifery work, midwives were able to carve out justice claims for the women and children they tended to. In this section, I will use colonial municipal documents to illustrate not only the essentiality of midwives to municipal and judicial function for women, but the ways that three specific 17th century midwives used their positionality to care and advocate for the women they delivered. These midwives produced unique interpretations of the law and women’s rights which were grounded within and stepped beyond their authority in the birthing room to secure just public identities and experiences for the women and families in their care.

*Midwives as Written into the Colonial Municipal Framework*

Midwives were essential to the social frameworks of Early American towns. So much so that town governments ensured their professional placement. In 1657, the town of Rehoboth, Virginia heard of Mrs. Bridget Fuller’s midwifery talents and invited her to “come and dwell among us, to attend on the office of midwife, and to answer the town’s necessity, which at present is great.”32 In the municipality of Rehoboth, the “office” of midwife, like the “offices” of judge and council, had to be consistently filled and filled by the town government. The officers’ invitation to “dwell among us” articulates the total community integration required of a

functional midwifery practice. The midwife was to be among not only the women, but the men as well – she may have delivered the mothers’ babies, but she made economic exchanges with the men of the household. “Us” here could refer directly to the town council, for she would work frequently with public and political figures – part of the midwife’s duty was to represent reproductive matters in court.

In 1635, the land-owning men of New Haven, Connecticut voted to grant Widow Bradley a house and lot rent free after her husband’s passing left the midwife without means. This public arbitration of resources was appropriate to the townsmen because Bradley “hath been especially helpful to the farms and doth not refuse when called to it.”33 As such, in New Haven as in Rehoboth, the municipal operation required a midwife, and the town government was responsible for ensuring her placement. That Widow Bradley always came “when called to it” is reflective of the men’s positionality to their midwife. When labor struck, it was the husband’s duty to seek out and fetch the midwife and attendants for his wife. That moment of calling was a man’s main interface with his midwife. Widow Bradley’s proven dutiful service, her established integration in her community, and her consistent “help” all recommended her to the position and earned her recognition directly in the public law.

In Rehoboth and New Haven, midwifery was a civic investment; in all Early American municipalities, however, midwives were integral to the function and arbitration of justice in cases regarding reproduction and childbirth. To earn child support for children born out of wedlock, a mother would first have to declare her baby’s father to the court while pregnant. Then, during the final pains of birth, her midwife would again ask the name of the father and report to the court accordingly. If the names matched, paternity would be awarded and the father would be required to either marry the mother of his child or contribute to the upkeep of both mother and child.

33 Hurd-Mead, A History of Women in Medicine, 414.
Midwives were commonly impaneled for infanticide trials to inspect women’s bodies for signs of childbirth or to testify that they caught a child which was born dead or died naturally, rather than was killed. In this way, midwives acted as a legal emissary from the birthing room to the courtroom.\textsuperscript{34}

In 1716, New York City enacted a midwifery licensing law that codified these widespread expectations of the office of midwife. Therein, it was “ordained by the Mayor Recorder Aldermen and Assistants of the City of New York Convened in Common Council” that New York City’s midwives would not only be “dilligent and faithful and Ready” to deliver women rich and poor, but attend to all legal requirements of the position. As these diligent public servants, New York City midwives were expected to forbid infanticide and not administer abortions.\textsuperscript{35} They could not conceal the birth of a bastard, or any birth for that matter, nor could they report a birth that did not occur. Their reports on paternity and pregnancy were bound to truth. As such, midwives’ official duties included their status as envoys between the realms of reproduction and legal retribution.\textsuperscript{36}

The midwife’s role was enshrined and honored by the common council law that codified it. Midwives were expected to report to the council any colleagues who disobeyed their vows. When necessary, they could delegate their position to another woman in the birthing room, but only one “perfectly know[n] to be of Right honest and discreet behaviour as also Apt Able and


\textsuperscript{35} This law is, in fact, the first piece of legislature to ever comment on abortion in what would become the United States of America. Dennis J. Horan and Thomas J. Marzen, “Abortion and Midwifery: A Footnote in Legal History,” \textit{New Perspectives on Human Abortion} 2, no. 15 (1981): 199–204.

having sufficient knowledge and Experience to Exercise the said Room and Office.”  

The midwife, already sworn into her duty, was expected to discern the characters of the birthing attendants and choose correctly the woman who would take upon the “Office” of the “Room” with honor and care. Honesty and discretion were essential to the position. These matters of the birthing room were expected to be solely female, as in the word of the law: “You shall be secret and not Open any matter Appertaining to your office in the presence of any man unless Necessity or Great Urgent Cause do Constrain you so to do.”

As such, midwives were simultaneously consecrated to their female profession of the female social space and expected to act as emissaries between that space and the public male realm.

In the early 17th century, at a moment of state and city building in colonial America, midwives were codified as urban agents of public health and morality. These women were essential to the reproductive and judicial function of early American society. Analysis of midwives’ actions in that public role through court depositions offers valuable insight into the healthcare provided by midwives, the emotional tenors of the birthing room, and midwives’ advocacy and arbitration on behalf of their patients before, during, and after birth.

**The Deposition as a Source on Midwifery**

The 17th century colonial American courtroom was not a female or feminine space. In keeping the political peace, it primarily served to mediate economic and interpersonal disputes between men. Yet, women appeared to represent themselves, their friends, their families, and – for midwives – their patients, in trade disagreements, criminal charges, and cases involving children – both born and unborn. As such, among a litany of disputes over property lines and

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38 Nancy F. Cott, “A Law for Regulating Midwives,” 45.
stray livestock, with casks of tobacco, sugar, and rum traded back and forth as damage and payment, women appear and speak. Though deposition statements are brief, transcribed by a court scribe, and subjectively limited to their cases, court documents nonetheless offer a rare catalog of experiences and values from a cast of largely illiterate historical actors – Colonial American women. And, to that end, depositions offer an invaluable glimpse into the values, dynamics, and power structures within the Early American birthing room. Such inquiry is magnified by analyzing the women’s statements surrounding emotionally charged cases of stillbirth and miscarriage.

To give a deposition, one would receive a summons, then travel to and attend court, often miles away from one's home. 17th century civil and criminal cases both used depositions as their primary source of evidence. The words one spoke in court held the power to decide disputes and charges. In the stillbirth cases examined below, the threat of an infanticide charge (punishable by death) looms. As such, it was important to note – as deponents do in all of the cases analyzed below – that the child was born dead and was dead in the mother’s womb. Miscarriage and infanticide depositions are the direct paper trail of midwives’ juggling of law, care, and gender in the birthing room and the courtroom. Because appearing in court was rare for most colonial women but standard to a midwife’s career, it can be understood that experienced midwives navigated these depositions deftly. Such was the nature of their duty to the women and municipalities they served.

Depositions from three separate 17th century court cases in Maryland and Massachusetts are analyzed below. Each illuminates a unique and dynamic advocacy by a midwife for her patient. Mother Babson brought her patient community-based care and advocacy; Mary Clocker

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deftly upheld and substantiated her patient’s claims to innocence and paternity; and Rose Smith arbitrated safety and righteousness for her patient using the court’s and her own justice schemes.

**Margaret Prince Delivered by Mother Babson and Grace Duch**

In March of 1657, William Browne of Gloucester, Massachusetts was sentenced “for divers miscarriages, to lie in prison one week and be fined twenty marks and pay costs to Thomas Prince, etc.” Browne’s “divers miscarriages” were mostly directed at Margaret Prince, Thomas Prince’s wife. Indeed, the precipitating factor to this case coming to court was Goodie Prince’s dangerous stillbirth following Browne’s verbal altercations with both Thomas Prince and his wife. This court document, like the birthing room, is loud and crowded with voices, yet centered around the travail of the birthing woman. A total of twenty-one people, including Goodie Prince and her husband, produced depositions for this case. Of those twenty-one, seven were attendants in the birthing room, and of those seven, two were midwives. Ten people testified to witnessing the disputes between the Princes and the Brownes. Two people – a man and a woman – offered testimony only to the fact that Goodie Prince was lugging and laying clay three weeks before her confinement. As such, in this colonial community, the activities of pregnant women, fights between neighbors, and scenes from dangerous births all made their way to court as significant to a stillbirth case. Indeed, the care and advocacy that Mother Babson provided her patient was emotional, legal, and grounded in a community-oriented understanding of birth and disputes.

The care provided to Goodie Prince during her labor was communally sourced. Debrow Skilling deposed that “there were about a dozen women there who used all means to save the

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40 Massachusetts County Court (Essex County), *Records and Files of the Quarterly Courts of Essex County, Massachusetts: 1662-1667* (Essex Institute, 1913), 36-38.
woman’s life.” Part of the function of calling a group of women to labors and sickbeds was to amass their combined pharmacopeias of birthing knowledge. These “all means” were likely administered primarily from the midwives present, but also drawn from the dozen women there. The midwife Isabell Babson testified that “upon Goodie Prince growing worse, she sent for Grace Duch.” For Babson, then, “all means” meant seeking the aid and counsel of another midwife to bring Goodie Prince through her dangerous labor. In these accounts, community-based care was essential to both safety in childbirth and surety in legal retribution. It was the support of the collective that supported Goodie Prince through her labor.

Across their depositions, the matronly kindness between “Mother Babson” and Goodie Prince is clear; the women’s statements emphasize the emotional, not biomedical interventions of the midwife’s care. Goodie Prince testified that when Goodman Browne insulted her in her own home, “she went out weeping to an ancient woman, her neighbor” (the “ancient” woman, we infer, was Goodie Babson). Here, the adjective “ancient” testified to Babson’s entrenched stature and status in her community while the title “Mother” indicated that her stature was distinctly feminine, maternal, and caring. In her own deposition, Mother Babson not only reported Goodman Browne’s insults but recalled that she had “told [Goodie Prince] to put it out of her mind as all knew what manner of man Browne was.” By re-stating the town’s collective disdain for Browne’s character for the court and public record, Mother Babson not only offered her own indictment of Browne, but pressured the court to act on Prince’s behalf. As such, it was Mother Babson’s presence, emotional understanding of town opinion, and words that comforted her patient and advocated for the arbitration of justice.

41 Massachusetts County Court, Records and Files of the Quarterly Courts of Essex County, Massachusetts, 37.
43 Massachusetts County Court, Records and Files of the Quarterly Courts of Essex County, Massachusetts, 38.
44 Massachusetts County Court, Records and Files of the Quarterly Courts of Essex County, Massachusetts, 37.
45 Massachusetts County Court, Records and Files of the Quarterly Courts of Essex County, Massachusetts, 38.
Goodie Prince experienced a traumatic birth; twelve women experienced it with her. They supported Prince from her birthing chair to the county courtroom. It was the attendants, not the midwife, who in this case made clear that the child was born dead and thus cleared Goodie Prince of suspicion of infanticide. Mother Babson supported her as a neighbor and as a midwife. The care she provided was emotional, communally sourced, and supported by the expertise of another midwife when the birth became dire. Her advocacy, too, was communally sourced and emotionally based. Such was the nature of Mother Babson’s care.

Throughout Goodie Prince’s case, multiple voices and witnesses were drawn into the communally significant fact of birth. Yet it was the midwife’s testimony, with its maternal authority, that decided the character of those involved.

*Susanna Warren Delivered by Mary Clocker*

In June, 1651, Susanna Warren, an (presumably) white indentured servant, opened a paternity case against her master, Captain William Mitchell. He owned the largest and most grand home in St. Marys County, Maryland – the deponents refer to it as simply “the white house” – and, through contract, he owned her. The court immediately took up Susanna’s claim and ordered Captain Mitchell’s attorney to procure Susanna lodging, food, clothing, and midwifery care before, during, and after her childbirth. The court-ordered provision of a midwife not only brought Susanna maternity care, it also provided her with a legal advocate who would uphold her claim to paternity, innocence, and, ultimately, freedom throughout a years-long legal process.

The entire case was recorded in the *Archives of Maryland, Volume 10: Judicial and Testamentary Business of the Provincial Court, 1649-1657* between March 1651 and January
1653. Each deponent gave their testimony in court, under sworn oath, to the stenographer who quoted their words to the best of his ability. Each testimony amounts to about a paragraph and there is no evidence of any speaker being directly questioned. Instead, deponents arrived knowing what they wanted to say and said it.

Mary Clocker was Susanna Warren’s neighbor and midwife. In August of 1651, she delivered Susanna of a stillborn child. In June 23, 1652 she testified that the child “was dead in the Mother’s womb,” and on June 28th, 1652, she testified that while in labor, Susanna had declared Captain Mitchell the father of her child and that he had given her medicine to “destroy” the fetus. With each of these claims, Mary Clocker defended the honor and legal positionality of her patient over and against the official military power of Captain Mitchell.

When, on June 23, 1652, Mary Clocker deposed that Susanna Warren had delivered “a Child which came into the world dead,” she cleared her patient of any suspicion of infanticide. Clocker strengthened her own claims to her patient’s innocence by bringing in the male authority of Dr. Waldron. Dr. Waldron did not attend the birth – Mary Clocker and Mrs. Fenwick did – but the women called him in to inspect the dead infant. In his scientific estimation, “the Mother had gone out her full time, and that the Child had been dead as he did Suppose three weeks in its Mother’s womb.”

In bringing Dr. Waldron into both the birthing room and her own deposition, Mary Clocker strengthened but did not overshadow her authority as a woman in the social office of midwife. The physician’s ideas were supplementary to the midwife’s testimony. She, not he, spoke in court; she called him in. The distinction between the role of the physician and the role of the midwife and attendants is clear: he came in after birth to provide a scientific estimation of

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what transpired. Mary Clocker and Mrs. Fenwick held Susanna before, during, and after her labor, dressed her child for burial, and, in the case of the midwife, represented her in court.

The visceral intimacy of Mary Clocker’s testimony speaks to the visceral intimacy of the midwife’s duties. She noted that the child she caught had “hair upon it head and nails upon it fingers and toes.”47 The poignancy of the lost life is expressed in her description. This was likely not her first, nor her last stillbirth, but the wholeness of the child struck her regardless. At the end of her statement, she remarks that “the Skinn was broken to the bredth of betwixt two or 3 fingers, and about 4 inches long coming from under the Arm upon the Stomach.” The tactile description of the decay speaks to Clocker’s own close handling of the body. As she washed and dressed the infant, her fingers managed the wound. Mary Clocker’s hands caught mother and child in stillbirth, but her testimony brought that touch-based care into the realm of legal rights and retribution.48

Mrs. Clocker’s advocacy for her patient was both emotional and legal. In her first deposition, Clocker reported that about two weeks before her delivery Susanna came to her house and said that “her Child was dead within her, and that She did believe It was by the means of a fright taken by Mr. Fenwick’s Negroes.” That Susanna visited her midwife to share her concerns over her pregnancy speaks to the neighborly care established between midwife and patient. That Susanna attributed the child’s death to being scared of “Mr. Fenwick’s Negroes” instead of the abortifacient she was forced to consume, speaks to her trapped positionality: she was pregnant with her master’s child that was dead at her master’s hands. The only scapegoat available to a white female indenture is that of race and life-binding slavery. By blaming

“negroes” Susanna was able to seek care and put off questioning. In Mrs. Clocker’s second testimony, she navigated that impossible situation on behalf of her indentured patient.49

On June 28, 1652, Mary Clocker testified in open court that in the time of Susanna’s delivery, Mary “charged” her to answer as she would “to God and man,” “whether those thing that She had Spoken of Concerning Capt Mitchell that he was the father of the Child, and had given her Phisick to destroy it were true or noe, and She answered that they were all true.” When Clocker intoned “God and man” in her birthing room interrogation, she referenced the statement she would eventually make in court in front of powerful men and under a Godly oath of truth. This is the essential moment of legal advocacy between midwife and patient. As “the midwife to Susan Warren,” her word on what transpired in the birthing room reads true. And she used this moment to advocate not only for her patient’s innocence, but also her patient’s victimhood. It is this advocacy that ultimately leads to Susanna’s freedom from her indenture.50

As a neighbor, Mary Clocker cared for and comforted Susanna Warren; as a midwife, she questioned Susanna while in labor, caught her dead infant, then testified to the stillbirth, the child’s paternity and Captain Mitchell’s violence against his indenture. Clocker’s testimonies are staunch and official. She used the language of the court to deliver her testimony to the events of the birthing room. She used the masculine scientific authority of a physician’s opinion to bolster her report. And, ultimately, she used her positional authority as a midwife to bring her patient’s pain, loss, and abuse to the court record. Her actions resulted in the arrest of Captain Warren and the end of Susanna’s indenture.

Though Susanna was freed at the end of the entire legal ordeal, she was “whipped with thirty nine lashes upon her bare back” for “her lewd Course of life Soe publick and notorious.”51

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Captain Mitchell was also convicted of fornication, as well as forcing Susanna to take an abortifacient potion and thus causing the stillbirth of their child. As Susanna’s midwife, Mary Clocker arbitrated and negotiated that final knell of justice: Susanna free and Captain Mitchell jailed.

Mrs. Brooke Delivered by Rose Smith

On September 25, 1656 in Patuxent, Maryland, Ms. Elizabeth Claxton and the midwife Ms. Rose Smith, each made a deposition on behalf of their friend and patient – Mrs. Brooke – in the wake of her stillbirth and domestic abuse at the hands of her husband. The statements are emotionally charged in that they explicitly reveal the midwife as an advocate and arbitrator of justice for her patient in the face of domestic violence.\textsuperscript{52}

Like the previously analyzed depositions of Mary Clocker and Susanna Warren, the following depositions appeared in the \textit{Archives of Maryland, Volume 10: Judicial and Testamentary Business of the Provincial Court, 1649-1657}.\textsuperscript{53} At some point between their original writing and this volume’s publishing, the script was transcribed to type. As such, it is the typed transcription of a written transcription of speech. Despite these two degrees of separation from the words and actions of the deponents, the character imbued by the speakers and the stenographer remains. The court scribe wrote with commas but not periods and capitalized semi-randomly. He was careful to write down the quotes that Claxton and Smith mentioned – each begins with a capitalized “Said.” Both depositions open with the name of the deponent followed by “Sworne and/& Examined Saith, that” and ends with “and further Saith not.” Such bookending makes the choreography of the deposition clear: Claxton and Smith walked into the

\textsuperscript{52} Dayton, Cornelia Hughes. \textit{Women before the bar}.

\textsuperscript{53} Bernard Christian Steiner et al., “Archives of Maryland.” (Baltimore: Maryland Historical Society., 1883), Library of the University of Michigan, 464-465.
courtroom together. Claxton chose to or was told to speak first. She then swore an oath of truth, spoke while the stenographer transcribed her words in front of her, gave an indication that she was done. After Claxton finished, Smith stood and did the same. Unlike the other cases analyzed, there is no indication that the women were questioned or called in to testify. Instead, they came to the court together of their own accord to open a case against Mr. Brooke, said what they wished to say, and freed their friend and patient of his abusive presence.

How Claxton and Smith chose to open a case against Mr. Brooke is unknown, however Smith’s midwifery work would have allowed her the familiarity with the court system to bring this case forward, and navigate the system on her patient’s behalf. What’s more, Smith signed her name below her deposition; Claxton signed an “X.” Smith’s literacy, compared to Claxton’s illiteracy, would have strengthened her ability to navigate the written world of the county court.

Elizabeth Claxton’s deposition maps Mr. Brooke’s controlling, destructive, and gendered domestic violence alongside her own advocacy and resistance on behalf of her friend and his victim. She recounts three instances of beatings in quick succession. Mr. Brooke hit his wife with implements of the home – a cane, an oaken board, and a pair of tongs – over issues of food consumption – not letting the dog lick a pail, taking a rib of veal, and saving a sheep’s head for herself. When Mrs. Brooke laid claim to the food she had prepared, “Mr. Brooke he rising up with a bloody oath Said you whore” – thereby swearing violence and admonishing her desire for food with a gendered slur against carnal consumption. But this abuse is interrupted by Claxton: “and yo’ Depon’ Said m’ Brooke doe not Eat it for She hath a mind to it.” Despite witnessing two beatings, and perhaps treating Mrs. Brooke’s wounds afterwards, Claxton stood up to the violent man to make sure her friend got some meat. Mr. Brooke then beat his wife a third time. Claxton “followed him and asked him if he Long’d to be hanged, and he Said he did not Care if she did
Miscarry, if She were with Child it was none of his.” As Mrs. Brooke fled her attacker, Claxton followed him threatening legal action (i.e. a murder conviction that would get him “hanged”). In that moment, Claxton called the authority of the law into the room to temper Mr. Brooke’s violence. And when she recalled his response in her deposition, she drew a direct line from Mr. Brooke’s domestic violence to the miscarriage. Such connection-making was necessary, for though Mrs. Brooke fell ill after this beating, she did not fall into premature labor until “one night” following this incident. Here again Claxton advocates for her friend as she implores Mr. Brooke to “Send for women.” The men “goe for the midwife, and the Midwife came.” It is the following stillbirth that allows the midwife to enter the home, witness the abuse, deliver a still born child, and deliver a two-fold justice arbitration: in the birthing room and in the courtroom.

Midwife Rose Smith gave testimony to “reciev[ing] into the world…a man Child about three months old it was all bruised one Side of it.” Both directly following the birth and in the courtroom, Smith delivers Mr. Brooke her own sentencing - one that operates outside the public justice system but within her own woman-oriented justice scheme. When she asked her patient how the child came to be so bruised, Mrs. Brooke disclosed the beatings. Upon hearing this, the midwife “brought the Child to the Said francis Brooke and…told him that it Came soe through his Misuage, and…he would Answer it although he Scaped in this world, yet in the world to Come he Should Answer for it before a Judge that useth no partiality.” Smith assumes that Mr. Brooke would “scape” retribution in this world; she does not trust the courts to arbitrate on a woman’s behalf. Instead, she rendered her own justice from her distinct positionality as an expert in feti, wombs, and childbirth and as shepherd and caretaker to domestic reproduction. The midwife stood before this abuser, dirty with his beaten wife’s blood and birthing fluids, holding the bruised fetus he killed, and promised Hell. Smith served that sentence twice: once outside the

birthing room and once within the courtroom. By directly referencing her own Godly justice within the form and space of the court deposition, she used the patriarchal court to advance a women’s justice against domestic violence and pressures the court to do the same. In doing so, she also directly challenged the court to act on her patient’s behalf.

The court did act. Directly following Claxton and Smith’s depositions came Mr. Brooke’s sentencing: he was committed to the sheriff’s custody on bail for the suspected murder of his unborn child. For the time he was jailed (one week), Mrs. Brooke had respite from her attacker. As such, Claxton and Smith’s depositions used miscarriage to seek justice for a domestic violence victim and make extreme domestic violence legible to the 17th century colonial court.

Mrs. Brooke’s own injuries were not stated but implied through the descriptions of the child’s dead body. As the boy was battered to “bruises and the bloud black in it” through her womb, Mrs. Brooke herself must have been covered in bruises and blood. The care she likely received for those wounds, alongside the care she and her child received before, during, and after labor remains unsaid. Most stillbirths are dangerous labors. What did Smith do to treat or mitigate that peril for her patient? After a dead baby was born, the women and midwife were responsible for cleaning and dressing the child for burial. How did Claxton and Smith care for and dispose of the body? Did his mother hold him before Smith took him away to be shown to his father? What was said over that child’s body in mourning of his liminal life? While we cannot glean the interpersonal and medical intricacies of the birthing room from their depositions, we can understand the wealth of care and advocacy between and among Claxton, Smith, and Mrs. Brooke made legible to the 17th century colonial court, and, in turn, to the historical record writ large.

Elizabeth Claxton testified to her attempts at tempering her friend’s abuser, advocating for her friend’s safety, and being present for her friend’s stillbirth. Her assertive causal threading between beating and miscarriage made Mr. Brooke’s crimes visible to the court and justice possible. Within her role as midwife, Rose Smith safely delivered her patient of a dead baby and used her social and moral authority to enact justice for her patient as a victim of domestic violence both through and outside of the justice system. Claxton and Smith’s testimonies both prove that as a midwife, Smith’s voice held social and moral power. Her work catching babies and caring for mothers operated in tandem with her work advocating for justice and safety for the women she cared for. She worked within and against the colonial county court along her own justice scheme determined by and for women and children. Rose Smith theorized and enforced a justice that superseded a courtroom, and called to a “Judge who useth no paritiality” to honor the wellbeing of women in this world and “in the world to Come.”

The three women met again at least once that we know of. On September 22, 1656, Rose Smith, Elizabeth Claxton and Mrs. Brooke all testified among a jury of “able” women “impannelled to search the body of Judith Catchpole” for signs of pregnancy and birth after Judith was accused of infanticide. Together, the jury ruled that Judith Catchpole was never pregnant. As such, neighborhood bonds and county court documents enshrined Mrs. Brooke, Elizabeth Claxton, and Rose Smith’s triumvirate in continued women-centered justice projects

**Conclusion**

Midwives were essential to the public, municipal, and justice frameworks of Colonial American towns. From their distinct positionality as women respected in court rooms as well as birthing rooms, midwives advocated for the health, safety, and justice of their patients, friends,
and neighbors. Public testimonies are a transcript of all the personal intimacies surrounding birth and the matriarchal justice claims that midwives enacted on behalf of their patients. As such, in 17th and 18th century colonial America, alongside national trends of state building and expansion, American women mediated their own matriarchal polity through the midwife and her birthing room.
II. Squatting Mother, Catching Midwife: Care Choreography of the Midwife's Birthing Room

While the last section explored the crucial legal social roles midwives took on in early American society, this section turns to the root of that touch-based moral authority: the birthing room. Successive analysis of the motions and actions inherent to each step of the birthing process reveals the tenures of authority, intimacy, and kindness of midwives at work. In colonial and antebellum America, the rhythms of childbearing were woven into the rhythms of domesticity. The home operated around and among a constant cycle of reproduction. Midwives and mothers worked on both therein with familiarity and kindness.

The Daunting Time Before: Pressures on American Women to Reproduce and Do It Well

On July 24, 1846, Mrs. Mary Lee of Boston, Massachusetts wrote to her son, Henry Lee Jr., to congratulate him and his wife Elizabeth on the birth of their first child. Her coded congratulations and emotional expectations of her son and daughter-in-law demonstrate the multifaceted meanings of reproduction and childbirth for free white women in colonial and antebellum America.

“I must say one word to you and Lizzie, my dear Son, on the joyful event of the birth of your child and the safety of the mother - a dear little girl. I trust Lizzie is repaid for all her suffering and you for your care and anxiety. I rejoice with you both most sincerely, and hope Lizzie will continue as well as she now promises.”

Mary envisions this birth – one she did not attend – as simultaneously dangerous, painful, joyful, anxious, and rewarding for Lizzie. The new mother’s safety following the birth, as well as her “suffering” is notable, but the arrival of “a dear little girl” “repays” Lizzie for her sacrifice. And

at the end of the whole ordeal, Mary continued to look forward to more births and more children – she hopes Lizzie will continue reproducing “as well as she now promises.”

For Lizzie, keeping up her “promise” of sustained childbearing would involve more pain, danger, and, of course, more children. For Lizzie’s midwife, all of these expectations, the yearnings, pains, fears, and joys would need to be mediated in and around the birthing room. Indeed, as midwives delivered early and antebellum American women, they enforced, navigated, or denied all of the complex compulsions, desires, horrors, and love that structured and encumbered their patients.

Early American colonial women rarely directly referred to physical qualities of reproduction by name; instead, words like “sick” and “ill” represented pregnancy and “unwell” represented labor. Such verbage emphasizes both their modesty surrounding childbearing and their association of pregnancy and labor as conditions that brought one closer to death. In Massachusetts in 1805, Betsey Phelps Huntington, pregnant with her fourth child, confided her fears of childbearing to her mother. “I must tell you how gloomy I feel a great part of the time - my prospects for futurity are as dark as midnight…the death of Mrs Tallmadge makes me dread a certain event more than usual.”

Betsey communicated her fear of death in childbirth quite often to her mother, but her own friend’s death in the childbed heightened her fears in this case to premonitions.

The surety of death that many women felt at the face of labor heightened the religiosity of the delivery experience. As Elizabeth Pendergast Carlisle of Massachusetts reflected after her birth in September 1772, God was the one to thank for one’s safety through childbirth.

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58 Francis Rollins Morse and Ellen Hale, Henry and Mary Lee, Letters and Journals, with Other Family Letters, 1802-1860 (Boston, Mass.: Privately printed, 1926), 281.
“Gladness is put into my heart and a song of praise in my mouth; mercy and Loving Kindness has been shewn me from the Lord - the Living Mother of a Living perfect child, wonderful Deliverance.”

Elizabeth is amazed to have made it to the other side of labor a “Living Mother of a Living perfect child.” For her, then, delivery was “Deliverance” – a moment where God intervened with “mercy” and “loving kindness” to carry blessed women through their travail. Midwives brought their patients through various states of “unwell.” As deliverers of this deliverance, midwives mediated and officiated the daunting and spiritual unknown within the birthing room.

In 1809, after witnessing her sister’s labor at the age of 17, Nancy Maria Hyde of Norwich, Connecticut described the scene of childbirth as a visceral and intimate confluence of joy and fear in a poem dedicated to her new niece.

“She comes a little stranger here below,
Where mingled streams of pain and pleasure flow;
A scene, where flow’rs and thorns promiscuous rise,
And light and shade alternate veil the skies.”

In the world “below” (i.e. below one’s skirts and into the den of the birthing room), higher powers bring “streams of pain and pleasure” as well as the good tidings of “flowers” or “thorns” – i.e. children or disease and death. In her first visit to the birthing room, Nancy learned that it was a space of fear and joy; death as well as birth, but one that produced the ultimate gift – an infant with the “sweet image of a spotless soul.” This was the free white colonial midwife’s birthing room: joyous, pressured, scary, unknown, and spiritual.

Enslaved Black women too felt familial pressure to reproduce, fear at the outset of labor, and held religious associations with the processes of reproduction. But their experiences of

60 Carlisle, *Earthbound and Heavenbent*, 74.
childbearing cannot be separated from their experiences of enslavement. Enslaved women’s reproduction was promoted and controlled by enslavers. From conception, the children that enslaved women carried, birthed, and parented enriched the people who enslaved her. All of enslaved women’s births occurred in violent spaces within violent structures of simultaneous capitalization of their bodies and devaluation of their humanity and mothering.

Enslaved women were simultaneously demonized for sex, pushed to reproduce, and denied familiality. And they were markedly isolated in that process. Love bonds between men and women and men and children were not bindingly recognized by enslavers. Instead, families were consistently pulled apart by trades and sales between planters and plantations. Though their continued cohabitation was not guaranteed, mothers and their children were most likely to stay together through those sales. Yet the meanings of the mother-child connection were severed by the capitalist imperative of enslavement. Though pregnant women were frequently beaten irrespective of their condition, many overseers prioritized the health of the fetus by digging a hole in the ground, having the pregnant woman place her stomach inside, and beating her bare and exposed back. Such abuse articulated the capitalistic distinction between mother and child as independent commodities to be punished, controlled, and protected.

As they worked to retain their own familiality, enslaved women juggled love, loss, and enslavers’ demands to reproduce. At 16, Rose Williams of Bell County, Texas was forced into a “marriage:” she was moved into the cabin of her assigned husband, Rufus. When she refused his advances, her enslaver confronted her:

“De massa call me and tell me, ‘Woman, I’s pay big money for you, and I’s done dat for de cause I wants yous to raise me chilluns. I’s put you to live with Rufus for dat purpose. Now, if you doesn’t want whippin’ at de stake, yous do what I wants. I thinks ‘bout mass buyin’ me offen de block and savin’ me from bein’ separated from my folks and ‘bout

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63 Morgan, Laboring Women, 109.
64 Schwartz, Birthing a Slave, 136-137.
bein’ whipped at de stake. Dere it am. What am I’s to do? So I ‘cides to do as de massa wish and so I yields.”

To enslavers, women’s worth lay in their production and “raising” of children-workers. Rose was forced to create new biological family bonds to keep her existing ones. “Yielding” to sex, pregnancy, and childbirth meant keeping her “folks” and avoiding the overseer’s whip. Of course, childbirth and childrearing held their own torture.

It is irresponsible to assume that all enslaved women cherished pregnancy or actively loved their children. As Jennifer Morgan points out in Laboring Women, “ambivalence toward and distance from her ‘pickininies’ would have been as logical an emotion as any” for enslaved mothers of enslaved children. For one thing, 19th century “enslaved women lost at least 54% of their pregnancies to stillbirth, infant mortality, and early childhood mortality. Morgan posits that in the colonial period, those mortality rates would be even higher. The threat of watching a child die, let alone watching a child forced into an endless cycle of labor, reproduction, and loss through the slave trade made dissociating from parenting not only logical but practical.

The plantation birthing room was the physical area of these pressures and meanings of forced reproduction. The midwife, its overseer and caretaker. To “go in” for labor was to consummate the birth of a child, the growth of community, and the rebirth of enslavement.

Going In

In 1938, Ellen Cragin of Little Rock, Arkansas recalled the story of her birth to a member of the Federal Writers Project intent on recording the lives of formerly enslaved people. She

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66 Morgan, Laboring Women, 114.
67 Morgan, Laboring Women, 111.
proudly stated, “My mother was a great shouter. One night before I was born, she was at a meeting, and she said, ‘Well, I’ll have to go in, I feel something.’ She said I was walkin’ about in there. And when she went in, I was born that same night.”

Birth began when the mother felt it begin. As a “good shouter,” Ellen Cragin’s mother was good at knowing when to leave her everyday work, and withdraw into her birthing room – to “go in” to a domestic space of safety and comfort, somewhere removed from the structures of labor. She likely told another adult woman where she was going. That woman may have followed her in after calling for the midwife. In that moment, Ellen Cragin’s mother held the authority, instinct, and determination to start her birthing process.

Where was “in”? Likely, “in” was home – someplace warm and dry, where the fire was going and women could gather to support their friend, sister, daughter, or patient through the pains of birth. Judia Fortenberry of Little Rock, Arkansas recalled that she “was born in a log house with one room. It was built with a stick and dirt chimney. It had plank floors. They didn’t have nothin’ much in the way of furniture – homemade beds, stools, tables. We had common pans and tin plates and tin cans to use for dishes. The cabin had one window and one door.” In that home, Judia was born. Most enslaved Americans were cabins in homes like it. In fact, most Americans born before 1850 were born at their hearth, bedroom, or kitchen. The same structure that housed the everyday rhythms of family life welcomed little ones into the world.

**Calling the Midwife, Bringing Her In**

If the birthing woman wanted a midwife, then a man, usually the father of the child, ran out on foot, horse, or wagon to fetch the neighbor who served their community. Though free

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midwives did charge a fee (Martha Ballard typically charged 6 shillings in coin or in kind), the custom did not deter impoverished families from seeking her care. The midwife would come irrespective of her patients’ abilities to pay. In fact, most wealthy families would reliably pay the midwife double or triple her fee. As such, the midwife’s respected sliding scale of fees ensured her continued service to those who could pay less than her standard.

Martha Ballard midwifed her community in rural Maine from 1785-1812. Her diary, in its brevity and attention to logistics, centered the call, her journey, her arrival, and ultimately the outcome of the births she attended. Indeed, Martha Ballard’s diary is an immeasurably valuable and rare primary source on Early American midwifery and free colonial New England women’s lives. Martha is daily, specific, and (sometimes) emotive. Her rapt attention to reporting her chores, births, and social life, let alone her literacy itself is exceptional for early American women. As such, her diary has been used heavily by scholars studying early American women (most notably, Laurel Thatcher Ulrich), and is used heavily in this study of early American midwifery. Whereas Ulrich inspected the monograph for themes of gender, labor, and society, however, I interact with the text for evidence of Martha’s social and community-based midwifery practice.

Martha traveled on foot or riding side-saddle when she was alone through snow, muck, forest, and mire alike. Her journeys required bravery, endurance, agility, and navigational skill. When she was called “in hast” to Mr. White’s, she “took of my Shoes & walkt in my Stockins” across the muck at the bank of the summer river to “Steer as Strait a Coars as I Could and reacht mr Whites very Soon.” The journey left her “much fatagud.” Part of the duty and expertise of midwifery came through the journey – to reach their patients, midwives had to navigate the

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terrain of the colonial American frontier. When Mrs. Thomas of 18th century Marlboro, Vermont was remembered “to have traveled up to her 87th year on horseback or snowshoes through hundreds of miles of forests and river valleys, playing the part of stork” – her duty and expertise were articulated not only in her “caring for the mothers and babies,” but also in her skill and strength to bring herself to her patients.72

When they met her along common paths, roads, and neighborhoods, community members aided Martha’s travels as much as they could. She accepted rides on the carriages, sleighs, boats, and horses when they were offered to her, but even those assisted travels were not without grit. On January 19, 1792, in a “Severe Storm of Snow,” “mr Savage Came in Directly for me to go to Savage Boltons. I went on hors Back as far as mr Pollards, in a Sleigh from there…we were once over Sett once I got out & helpt push behind the Carriage. we arivd Safe at Sun Sett at Boltons…I tarried all night.”73 In extreme circumstances, then, Midwife Ballard’s neighbors worked together to bring her to a family in need. Martha’s journeys carried her to far flung families and farms; she could count on men in her community to contribute to her duty as much as they reasonably could.

The community Martha cared for straddled the Kennebec River. When it was frozen, she crossed on foot. When it was flowing, she was ferried across. During freezing and thawing, Martha risked her life to reach her waiting patients. Martha was aware and even proud of the trials she put herself through to trek to her patients’ homes. The journey was part of her duty, and she felt the necessity of her presence acutely. When, in March of 1789, Martha was delayed by two hours in her departure to Mrs. Bolton’s labor, the need she felt to reach her patient made it to

72 Hurd-Mead, A History of Women in Medicine, 411.
73 Ballard, The Diary of Martha Ballard, 19 January, 1792.
the page of the diary: “my anxiety was great for ye woman, but I found her Safe.”74 Once she arrived, she could begin her work and protect her patient from the dangers of birth.

Figure 2.1 Lucrecia Perryman, circa 1900. Historic Mobile Preservation Society via Wilkie, 136.

Like Martha Ballard, Lucrecia Perryman traveled around her community to deliver babies and treat women. Whereas Martha worked in Maine at the turn of the 19th century, however, Lucrecia worked in Alabama at the turn of the 20th. When women called Lucrecia Perryman to

74 Ballard, The Diary of Martha Ballard, 17 March, 1789.
their homes to attend their births and catch their babies, the woman pictured in figure 2.1 arrived to their homes. The picture was taken in 1900 when Lucrecia was sixty four years old and eight years into her career as a nurse and midwife to her community on the edge of Mobile, Alabama.

As well as some municipal records and this photo, Lucrecia’s home is found within the historical record. The plot was left untouched from her death in 1917 to 1993, when it was archaeologically excavated. Its archaeological record stands testament to the material existence of the Perryman family and Lucrecia’s nineteen-year-long midwifery practice.

Though she lived and worked in the 20th century, her practices and values hold salience to the legacy of enslaved midwifery. Lucrecia gave birth to three children while enslaved. Her experiences of enslavement informed her practice. What’s more, she was taught midwifery by her elders. In 1899, Sarah Taylor and Orrie Harris were both established midwives living a few blocks away from the Perrymans; Perryman was listed in the same directory as a “nurse.” In 1902, Lucrecia Perryman was the only registered midwife in her neighborhood.75 Given this information, it is likely that Mrs. Perryman was apprenticed by her neighbors before replacing their practice herself. Her designation as “nurse” may have stood in for her apprenticed position. These systems of generational transference ensured the continual salience of free Granny midwives’ spirits, theoretics, and practices across decades of emancipation and industrialization.

The image in figure 2.1 is a careful construction of a working woman on an ordinary day. Lucrecia’s placement against a line of bushes emphasizes the semi-rurality of the region she served and the intrinsic naturalness of her work – she was the skilled custodian of a biological process, not the manufacturer of babies through medicalist intervention. Her work, like the Earth around her, operated on complex natural rhythms and cycles.

75 Wilkie, An Archeology of Mothering, 34-35.
Lucrecia’s clothing is stately and functional. Her bodice is defined but not confined. Her skirt, sleeves, and headscarf bring color and personality to her uniform with their assembled Africanist patterns without sacrificing functionality. The dark patterning of her dress and the ample folds of her apron could catch blood and birth fluids easily without noticeably staining. In a pinch, she could use the clothes on her body to wipe, clean, and embrace mother and child.

Lucrecia was wearing a sunhat for her travels, but let it drop or set it down to reveal her proud and stately face. She presented the entirety of herself and her identity to the camera. Her soft smile complements her easy posture – her cocked left hip offsets the weight of her bag and her right hand lies lightly on her stomach. That large, strong hand was the focal point of this image and her practice. It was this hand that repositioned babies in their mothers’ stomachs before catching them, administered medicines, and massaged backs; these hands were her expertise, profession, and care. In her presentation, Lucrecia immortalized the main operators of her practice – her face the tool of emotional care and her hand the tool of physical care. To witness her image alongside the written and archaeological evidence of her home and her practice is distinctly special.

Lucrecia’s trade is evidenced across her body – in the functionality of her dress, the stateliness of her posture, and the dextrous strength of her hands. The most clear calling to her profession, however, is in her left hand. Laundry bags like the one Lucrecia is pictured holding were commonly used by free and enslaved Granny midwives to carry linens for their patients to birth on alongside other tools of the trade. This bag may have held Vaseline, tincture bottles, food medicines in the form of broth or jelly, store bought medicines, a syringe, a pocket knife, and a vaginal pipe. Evidence of all of these items were found and cataloged in the trash pit Perryman home.

76 Wilkie, *An Archaeology of Mothering*, 131.
Based on her diary, Martha Ballard also carried a bag. She brought her timepiece, her diary, her spectacles, her knitting or mending, and medicines to the births she attended.\textsuperscript{77} She likely relied on her patients to provide linens to birth upon, tallow or oil for lubricant, and a stool or women to hold the mother as she bore down to deliver.

Such were the ways and means that midwives arrived to the birthing room. Haggard from a harried journey, carrying a bag of tools and bringing themselves. It was her, the midwife, who offered expertise, care, and relief to mothers and loved ones awaiting the painful and dangerous arrival of a new born child.

\textit{Contractions}

Across the span of her diary, Martha mentions the many ways she filled the hours she spent at her patients’ homes both caring for the laboring mother and waiting for active labor. No other primary source offers such a comprehensive array of one midwife’s activities. Other sources, including the diary of another midwife, illuminate these dynamics as well, but no source rivals that of Martha’s 27 year long daily recording of her and her community’s lives.

Martha measured the progression of birth through her patient’s ability to move about the house and her own ability to knit, cook, or sleep. When contractions were well spaced and the woman was comfortable, Martha might help her patient complete a last round of baking, canning, or cooking. She often knit mittens or socks as she waited and recorded what projects she worked on. Another New England midwife, Mrs. Elizabeth Thomas was remembered in her obituary for “constantly knitting stockings,” “wherever she went” while she was practicing midwifery in the late 18\textsuperscript{th} century.\textsuperscript{78} These midwives’ practice of packing their knitting and

\textsuperscript{77} Ulrich, \textit{A Midwife’s Tale}, 185.
\textsuperscript{78} “Biographical Sketch,” \textit{The Eastern Herald and Gazette of Maine}, February 17, 1800.
mending reminds us that while they held responsibility to their communities as midwives, they
also held responsibilities to their families as women. Each midwife analyzed in this project
maintained her home as well as her practice. By doing their chores at their patients’ homes,
midwives could provide advice, care, and support intermittently while also staying on top of her
domestic responsibility. What Martha mentioned most in these early hours of labor, however, is
sleeping. Midwives kept the weird hours that their profession demanded – babies are not
consistently born in the day time. Martha’s diary is scattered with naps in hers and other’s
homes, in chairs, cots, and beds when allotted. Martha tended to her own and her family’s needs
as the timescapes of her patients’ birth allowed it. What’s more, her itinerant sleeping testified to
her widespread habitation; she was not only welcome in every home of her community, she was
at home in every home of her community.

In the African American midwifery tradition, the long and nervous early stages of labor
were filled with “fussing.” The term, created by public health inspectors observing and
regulating rural Black midwifery in the early 20th century, refers to a process in which a birthing
mother was braided, massaged, oiled, perfumed, and powdered to prepare her for facing the
pains of labor and meeting her child.79 The trash pit (filled in one go after Lucrecia retired) on
the Perryman compound housed numerous toilet waters, perfume, cream, and Vaseline containers
which could have been used by Lucrecia in this process. Though first described and recorded in
the 20th century, fussing holds inherent and inherited salience to the practices and ethics of
enslaved Granny midwifery. Fussing is the practice of caring touch; it is smoothing, massaging,
and soothing. The midwife’s hands – strong and wise (see figure 2.1) – impressed sweet-smelling
lotion and oil onto the birthing mother’s body. Massage on the belly, vagina, and perineum
facilitated proper birth positions and prevented tearing while enforcing the importance of the

79 Wilkie, An Archaeology of Mothering, 131.
birthing woman’s comfort, ease, and embodied well-being at the outset of a long, dangerous, and
excruciating process. A midwife who fussed and soothed was non-intrusive; she facilitated and
eased labor by working with, not against the natural process of birth.

Indeed, when the English midwife Elizabeth Nihell wrote in 1709 her “Treatise on the
Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with
Instruments” in 1709, she centered the intimate, patient, and soft touch of a midwife’s practice
over the obtrusive and hurried practices of physicians. She defended “those silly good women,
who know no better than to deliver those of their own sex with the help of their fingers and
hands.” The midwives’ use of their fingers as well as their hands sharply contrasts with the
“undextrous” instrument-wielding physicians. Nihell’s attention to the embracing softness of a
midwife’s touch illuminates the centrality of tactile comfort and caretaking to midwifery.

**Pushing**

When labor became more active and the time to push approached, the midwife instructed
the men of the house to “call the women.” On July 8, 1796, Martha reported a birth that followed
this general schedule. She “was Calld by mr Kitrick to See his wife who is in Labour. Her
women were Calld at 8h Evn, Shee was Deld at 10 of a Son, her first born.” Across Martha
Ballard’s diary, the names of these women attendants correlate most with geographic proximity
and familial connection – that is, neighbors, sisters, and mothers were most likely to come and

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80 Wilkie, *An Archaeology of Mothering*, 132.
81 The word “silly” in this context likely means “humble,” “lowly,” or “helpless.”
Elizabeth Nihell, *A Treatise on the Art of Midwifery. Setting Forth Various Abuses Therein, Especially as to the Practise with
Instruments: The Whole Serving to Put All Rational Inquirers in a Fair Way of Very Safely Forming Their Own
Judgment Upon the Question; Which It Is Best to Employ, in Cases of Pregnancy and Lying-in, a Man-Midwife; Or,
a Midwife* (A. Morley, 1709), 77-78.
help a woman deliver. Especially if they arrived early, these women would help keep house, tend to children, and care for the laboring mother with food, drink, massage, conversation, advice, and company. And at pushing time, these women would literally hold the mother upright— one on each arm— while the midwife knelt between the mother’s legs to catch her child.

The positions in which midwives’ patients give birth literally embody midwifery’s approach to birth. In the philosophy of midwifery, birth is inherently natural and is treated as such. The midwife, her instructions, and her treatments serve to facilitate, not treat or augment, birth. By giving birth upright— in a squat or on a stool or seat in the middle of the floor— women allow the force of gravity to aid them in bearing down. Indeed, in the scheme of human existence, birthing prostrate on a bed is a novel hallmark of medicalized birth. Instead, women throughout time have birthed kneeling or in squatting positions: supporting themselves, holding onto fence or bed posts, with a friend, neighbor, sister or mother holding each arm, or upon a birthing stool or chair. One physician wrote of a midwife who “delivered [her patient] on the floor, on her knees, her head resting in a woman’s lap.” That position was shocking to him, but logical to the midwife; she used whatever configuration available to her to make her patient as comfortable as possible. Mothers were asked to walk around and find a birthing position that worked for them. The woman’s comfort, not the opinion of her practitioner or ease of examination, determined her correct birthing position. So birth was not only natural, but personalized.

Midwifery’s widespread use of birthing stools and chairs physicalizes this ease-oriented approach to birth. There is no evidence that either Martha Ballard or Lucrecia Perryman used birthing stools or chairs in their practices. Many of their counterparts did, however. The furniture

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pieces were indeed emblematic of the midwifery trade in Europe and white colonial America. In his diary entry in April, 1677, Samuel Sewall mentioned his midwife’s stool “whose parts were included in a Bagg” as direct evidence of her profession and the righteous urgency of their travel past the watch house. Many stools, much like the one used by Mr. Sewall’s midwife, were small, came in parts, or folded for easy transportation between births. Most were constructed from a U-shaped seat placed on three legs, and many had backs. Handles for bracing against contractions and for transporting the stools were common, and most were foldable or deconstructable for easy transportation between births.

Figure 2.2. Birthing Stool, c. 1800. From the collection of the Lancaster Medical Heritage Museum, Lancaster, Pennsylvania.

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85 Sewall, Samuel Sewall’s Diary, 15.
86 Banks, Birth Chairs, Midwives, and Medicine, 5-9.
Most birthing stools and chairs were simply everyday seats used not only for birth but also for spinning, milking, and completing other seated domestic tasks. The chair type in figure 2.2, for example, is commonly described as both a “milking stool” and a “birthing stool.” It was the right height for milking an udder and birthing in a supported seat: about 10 inches off the ground. The stool was simultaneously designed for portability and labor. That the stool cannot be disassembled but can be easily carried from its top handle indicates that it was meant to be transported between rooms of a house rather than between homes in a community. The handles on the sides of the seat, however, indicate that the stool was built for birthing. During contractions and pushing, laboring women could brace themselves by grasping the handles beside them and bearing their feet into the ground below them. The angle of the seat back allowed the mother to ease and lean supported by her chair. Meanwhile, the small width of the back allowed birth attendants to hold and massage the birthing woman as she labored. Ultimately, the usefulness of the stool from the barn to the birthing room emphasizes the integration of birthing into the regular social fabric of the household. Birth was thus embedded in the rounds of everyday life and the tasks of everyday life were reciprocal extensions of the rituals of reproduction.

Stools like those pictured in figure 2.2 or described by Samuel Sewall rarely survive to today. They were too useful to not be used into obsolescence; too ordinary to survive.

For the midwives who transported them themselves, stools were an essential part of the theatrics of care. She would arrive in her patient’s home, enter the birthing room, and place or literally construct for her patient a structure of support and embrace. The chair, like the midwife and the women already populating the birthing room, would hold the mother through her labor. Indeed a material analysis of stools facilitates a choreographic analysis of birth. As Brigitte
Jordan states in *Birth in Four Cultures*, “the artifacts of birth, the objects and equipment…do more than deliver babies and cut cords: they are visible, practical constraints on which the shape of the system rests.”

By reading bodies in the motions of labor and caretaking onto the structures of birth chairs, we become aware of the corporeal intimacies of birth. The cries, braces, grasps, gasps, writhings, and releases as well as the touches, embraces, manipulations, and encouragements of labor are written on and around these artifacts of birth. Chairs evidence the physical tenor of birth and the choreographies of care.

![Figure 2.3 Cupola House Birth Chair, American, c. 1700. Constructed of painted yellow pine or cypress. From the collection of Cupola House, Edenton, North Carolina.](image)

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The chair in figure 2.3 was manufactured for birthing. Constructed of yellow pine or cypress, the chair is light and relatively portable. When in use, it was likely placed in front of the fire in the bedroom or kitchen. The seat is only 11.5 inches deep – long enough to support the birthing woman’s bum while leaving the birth canal open to the midwife before her. The seat is just 15.5 inches above the ground, allowing the midwife to sit or kneel on the floor below her patient to manually check dilation, massage the perineum, and catch the baby. From her lowered position and with the woman’s skirts hanging over her arms, the midwife was the only person to view and touch the vagina; the mother’s privacy was maintained. And though the midwife held generational, medicinal, and experiential authority in the birthing room, her place below the mother and her attendants is apt: the birthing woman was in charge of the birthing room. Her comfort, preferences, and desires dictated the flow of care around her. When the contractions came and she was instructed to push, she would have grabbed the knobs at the end of the chair’s arms to brace herself against the pain and work. When the pains passed, she would have eased into the tilt of the chair back. The wide slats in that chair back and the simplicity of the seat’s frame would have allowed the midwife and attendants to reach around and massage the birthing mother on her back, stomach, and sides. What’s more, the pronged chair back allowed easy hanging and sorting of linens for quick use during birth. The chair supported the weight of the birthing mother, but it was constructed to facilitate human care and support around its frame.
Figure 2.4 Windsor Style Birth Chair, American, c. 1750-1760. Constructed of elm and beech. From the collection of The National Museum of Science and Industry, London.  

Unlike the chair in figure 2.3, the chair in figure 2.4 was not constructed for birth. Rather, it was likely adapted to birthing with the removal of the seat’s center. The seat is higher than that in figure 2.3, but still low enough (13 inches from the ground), to allow the midwife to sit between the mother’s legs and catch the child. The back and seat are supportive and the arms jut out for the birthing mother to grip and brace herself against labor pains. Though the back and sides of the chair are closed off by the iconic Windsor-style posts, constructed of elm and beech, the chair is relatively light and portable. Before its seat was cut out (and perhaps after), this chair

90 Banks, Birth Chairs, Midwives, and Medicine, 19.
was used regularly – it was sat upon for meals, chores, and leisure by family, friends and guests alike. It was of the home and of the family. The adaptation for birthing neither diminished nor enhanced the everyday familiarity of the chair. Its relationship to home and hearth is continuous. Like the births that happened upon it, this chair is domestic, ordinary, and adaptive.

“Bring Her Around:” Medical Interventions at the Height of Labor

The midwife’s healing expertise was called upon most when a baby was supposed to be arriving, but was not. Medicinal interventions were used to urge labor. Oftentimes, the same herbs and roots that were used to “bring on the menses” or produce an early-term abortion, were used to invigorate labor in the birthing room. These medicines or “emmenagogues” fulfilled the same physiological purpose in both settings: to start and/or strengthen uterine contractions. As midwives cultivated and collected their medicines from the land they lived and worked on, the interventions they used depended on the region in which they were cultivated.

Martha Ballard of rural Maine, for example, grew and collected rue, tansy, mustard seeds, mugwort, and hops, all of which were known emmenagogues. She also cultivated shepherds sprouts, sanicle, burnet roots, and balm of gilead, which were all known to ease or stop painful or excessive menstruation.91 In the African American tradition, dirt dauber, dogwood berries, egg shells, sassafras, hen feathers, and castor oil were all used to ease labor and strengthen contractions.92 These herbs would be administered in teas, syrups, enemas, or poultices depending on what preparation the midwife had on hand and what treatment she deemed appropriate. When her neighbors sought gynecological advice and when they needed medicinal aid in labor, Martha Ballard, like any midwife with an herbal practice, remedied them with the

92 Wilkie, *Archeology of Mothering*, 133.
plants of her garden. Herbal medicine – the midwife’s intervention – used nature to ease nature’s problems of disease and childbearing. What’s more, just as the midwife was local, the medicine was too – the care was sourced from within the community.

Most midwives’ medicine was empiric (i.e. concerned with outcome rather than theory), spiritual, and relief-driven. In the African American tradition, the midwife placed an ax or knife under the mattress of the laboring woman to “cut” the birthing pains throughout and put the infant’s father’s hat on the laboring woman to bring an auspicious male presence to the birthing room.93 Martha Ballard talked about her interventions as giving her patients “ease” or “comfort” rather than curing their problems.94 In dire situations, midwives were trusted to administer more violent interventions. Cathartics (drugs which make one vomit) and diarrhetics (drugs which make one defecate) were used when emmenagogues failed. The use of these “pukes” and “purges,” as Martha Ballard called them, evidenced midwives' beliefs in the physiological wholeness of the human body. Cleansing the gastrointestinal system cleansed the entire body in turn.95 For birthing women, the force of expelling one’s digestive tract was thought to move the fetus and strengthen labor. Martha rarely named her medicinal interventions in her entries, but she does note cultivating mandrake, a powerful purgative and emetic, as well as rhubarb, senna, manna, mugwort, and anise seeds, all of which were known laxatives and/or emetics.96 These sickening herbs were taken by laboring mothers with faith in their midwives. The midwife was trusted to know that the gross pukes and purges the herbs brought would ultimately serve her patient.

93 Wilkie, Archeology of Midwifery, 134.
94 Ulrich, A Midwife’s Tale, 53.
95 Ulrich, A Midwife’s Tale, 54.
Some complications could not be solved medicinally. Across the span of her diary and the 814 births recorded there, Martha only saw five mothers die in her care, but she saw plenty of births she termed “dangerous” or “obstructed.”\(^\text{97}\) She handled these situations with ease and expertise. When Martha “was Calld at 5h 30m morn to See the wife of Capt Gershom Cox who is in Labour. The [foets] was in an unnatural possession but I Brot it into a proper Direction and Shee was Safe Deld at 7h morn of a fine Dagt, her Second Child, both of the Same Sex.”\(^\text{98}\) Here, Martha massaged Mrs. Cox’s stomach to manually change the position of her child. She would have had to time her manipulations with the lulls between contractions. In 1799, Martha arrived to Mrs. Branard and found that “there were Some obstructions to remove. when Performd the patient was safe Deld of her 3d Son at 5h morn. I left her and inft as well as Could be expected.”\(^\text{99}\) Here, we can infer that Martha used her hands to clear the birth canal, cervix, and crown of the child’s head of excess tissue. The eventful birth lowered her expectations for the speed of mother and child’s recovery. Both were well but apparently haggard when she left them.

Martha Ballard’s hands were her ultimate intervention. Again, Elizabeth Nihell’s 1709 *Treatise on Midwifery* provides a theoretical backing to the extended use of hands and manipulation in midwifery care. In contrast to the surgery-driven physician, the midwife, Nihell says, “will patiently, even to sixteen, to eighteen hours, where an extraordinary care requires so extraordinary a length of time, keep her hands fixedly employed in reducing and preserving the uterus in due position.”\(^\text{100}\) Here, Nihell emphasized not only the midwife’s tender and patient touch, but also her dextrous understanding of female reproductive anatomy. Her knowledge was

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98 Ballard, *The Diary of Martha Ballard*, 29 August, 1797.
100 Elizabeth Nihell, *A Treatise on the Art of Midwifery*, 90.
held in her own hands. Her faith in the ultimate action of natural birth was testified through her patient, herbal, and tactile care.

*Catching the Baby, Catching the Mother*

As it was the midwife’s job to facilitate the safety of the birth, it was the midwife’s duty to catch the child, cut the umbilical cord, and continue to care for the mother after the child was handed off. Often, this care included tending to a torn or otherwise traumatized vagina and vulva with the administration of poultices and bandages. In the African American midwifery practice, once born and caught, infants were rubbed with tallow or Vaseline and removed from the birthing room. The umbilical cord was cut and left to dry and fall off (typically in seven to ten days). Though the child was removed, the mother’s peril was not over. Many midwives considered the delivery of the afterbirth more dangerous than the delivery of the fetus. To aid in expelling the afterbirth, many midwives asked their laboring patients to drink water or buttermilk and blow into a blue glass bottle. Sixty-one blue glass bottles were recovered from the Perryman site. The placenta was burned and buried, either in an undisclosed location or with a tree planted overtop. The midwife was responsible for the proper disposal of this spiritually charged bodily structure which housed and grew the child. The health and happiness of the baby and mother were dependent on it.

The infant, if alive, was cleaned, swaddled, and placed in its mother’s arms. If it was stillborn or died following birth, the midwife and attendants would clean and dress the child for burial. Martha’s and Lucrecia’s practices around death and stillbirth cannot be exactly known.

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103 Wilkie, *An Archaeology of Mothering*, 137.
We don’t know what they said to their patients when they heard no child cry or whether they believed in a mother holding her dead child before taking it away for burial. But yet, glimpses of the care they took remain.

On February 3, 1791, Martha was called to Mrs. Welch, a recently widowed mother. “Shee was delivd at 12 of a Dagt, Dead Born, and was very ill after Delivery. I tarried with her till about 9 Evn when Shee Seemed a little more comfortable.”\(^{105}\) She called on Mrs. Welch the next day and found her “as well as Could be Expected, her Sister Cyphers with her.”\(^{106}\) On the day after, she helped Mrs. Welch out of bed. Again, she was only “as well as Could be Expected.”\(^{107}\) On the 6\(^{th}\), Mrs. Welch was “a little Easier.”\(^{108}\) Again on the 7\(^{th}\), Martha’s patient was “as well as Could be Expected.”\(^{109}\) On the fifth day, Martha sent her husband to “See that mrs Welch had wood, made her a Shovel &C.”\(^{110}\) He returned the next day to help around the Welch house.\(^{111}\) Martha tarried for Mrs. Welch for a week. She ensured her physical health and sent her husband to ensure the safety of her family, operating without a man of the house, in Maine’s midwinter. Her care was medical, social, and practical.

Martha’s use of the phrase “as well as could be expected” refers not only to Mrs. Welch’s physical condition, but her grief as well. She was as well as could be expected for a woman recovering from a difficult labor and from the loss of her dead husband’s child. Martha delivered 14 stillbirths out of 814 total births in her recorded career.\(^{112}\) Extracting a dead child was uncommon, but not rare. In her role as midwife, Martha witnessed and tended to birth as well as death. She was intimately, professionally and personally tied to this intersection of hope and loss.

\(^{105}\) Ballard, *The Diary of Martha Ballard*, 3 February, 1791.  
\(^{106}\) Ballard, *The Diary of Martha Ballard*, 4 February, 1791.  
\(^{107}\) Ballard, *The Diary of Martha Ballard*, 5 February, 1791.  
\(^{109}\) Ballard, *The Diary of Martha Ballard*, 7 February, 1791.  
\(^{110}\) Ballard, *The Diary of Martha Ballard*, 8 February, 1791.  
\(^{111}\) Ballard, *The Diary of Martha Ballard*, 9 February, 1791.  
\(^{112}\) Ulrich, *A Midwife’s Tale*, 173.
It was from that position that she caught and held her grieving parturient mothers with neighborly companionship, aid, and care.

**Lying In**

The recovery period after birth was known as the “lying in.” Therein, a mother was confined to her bedchamber with her child to rest, bond, and suckle. In Martha’s white colonial world, a mother’s recovery was measured by her ability to make her own bed and, finally, return to work in her kitchen. On August 30, 1797, Martha was surprised to find Mrs. Joy (who she had delivered just three days prior) “down in her kitchen. Shee Came out of her Chamber yesterday. Shee informs me that Shee has made her Bed this three Days. her infant is finely.”

Apparently, Mrs. Joy recovered quickly. Or, perhaps more likely, Mrs. Joy did not have relatives, neighbors, or servants available to run her kitchen for a leisurely lying in period. On plantations, enslaved women were typically afforded one to three days of recovery with their children before they were forced to hand their care to the Mammie and return to work. In the African American midwifery tradition, however, midwives stayed with their patients and their families for (typically) nine days following birth to aid the woman in healing and the infant in adjusting to life. While there, she might also keep house, tend to other children, and teach a new mother crucial parenting skills. For healthy mothers and babies, midwives did not attend the lying in. Her leaving signified the end of the birthing ordeal.

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113 Ballard, *The Diary of Martha Ballard*, 30 August, 1797.
114 Wilkie, *An Archaeology of Mothering*, 139.
Conclusion

Colonial and antebellum American birth was domestic, communal, and ecological. It was marked by the periods of expectation, going in, calling the midwife, enduring contractions, calling the women, pushing, catching the child, catching the mother, and, finally, lying in. Within these domestic cycles of reciprocal production and reproduction, women received midwifery care that was face to face and mother to mother. The midwife facilitated and eased labor as best she could; she did not change it. Her work was to care not to cure. The midwife’s activity and interventions were determined by the metronome of the woman’s labor and the barometer of the woman’s comfort. Such was the midwife’s birthing room: a place of soothing touches, comforting chatter, and new babies as well as strangled screams, arduous pain, and looming death. To this scene, the midwife orchestrated childbirth.
III. Coordinators, Foragers, Tenants, and Apostles: Midwives’ Roles in Women’s Community Care Networks

Whereas the last section attended to the interpersonal textures of midwifery care, this section attends to the generation and regeneration of that care within women’s cultures, communities, and families. Midwives were the zenith of a continuum of care for early and antebellum American women – the faces of a female heritage of herbal, communal, and reciprocal mothering. They were apostles of motherwork; midwives received a gospel of organic solicitude and touch from their elders and spread to their successors. They were remembered and honored as officials, experts, and matriarchs on a local and national scale.

Coming to the Role: Apprenticeship and Calling

Colonial and antebellum American midwifery operated on apprenticeship. Midwives were not schooled, but learned to attend births by attending births – their own, their family members’, their friends’, their neighbors’ and those which the midwife training them attended. Oftentimes, midwives trained their own family members in the art. Ebenezer Parkman’s recordings of his wife’s labors and their attendants between 1738 to 1751 in Cambridge, Massachusetts offer a valuable example of such communal familial apprenticeship. The Parkmans’ midwife, “Granny Forbush,” first attended Goodwife Parkman’s births alone, but as the years went on, she included her daughter in law, sister in law, and granddaughter in law in attendance.\footnote{Parkman, Ebenezer. “Diary, 1719-1740.” The Diary of Rev. Ebenezer Parkman. Accessed February 27, 2023.} The inclusion of these family members not only eased a midwife’s labors, they also allowed for the transference of midwifery between generations of women. In 1980, the
Virginia Granny midwife Amanda Carter recorded her matrilineal midwifery heritage for a Smithsonian researcher. She said,

“Back in the older days of the 18 hundreds, my great grandma served as a midwife on my mother side, for this community. Their transportation was an ox cart. After the passing of her, my grandma took her place as midwife. After serving many years, she took my mother with her.”

Eventually, Amanda’s mother brought her along on calls, too. Because “she wanted a midwife always to stay in the family.” As midwives’ skills, practices, and knowledge were generationally embedded, their practices were not only theirs but their family’s. To be a practicing midwife was to practice the midwifery of the cultural past, present, and future held together through the lines of apprenticeship. For many midwives, this heritage was spiritual. Marie Campbell, for example, described how during a difficult birth, Aunt Jeanie, her deceased mentor, appeared to her “in the spirit” and guided her hands “to do the right thing.”

To be trained as a midwife was an honor. In the African American tradition, the role was predetermined and showed itself through “calling” – a visceral need to midwife that caught a woman and brought her the tutelage of an elder. Many midwives felt the call as a specific moment, others knew their calling from birth. When Pauline Fakes described her work on an Arkansas plantation to a WPA interviewer around 1936, she said “I done all kinds of field work, cook and wash and iron. Midwife is my talent.” The distinction Pauline drew between labor and midwifery is crucial. Midwifery was a different kind of service, a divine aptitude that found many enslaved women through calling.

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117 Amanda Carter, “Note Handwritten by Amanda Carter about Her Family’s Midwifery Careers.”


119 Rawick, The American Slave, 8:2:263.
Many free, white, colonial midwives may have seen their midwifery as a divine duty as well. In the pioneering Mormon community in frontier Utah of the 19th century, midwifery was a spiritual vocation. Patty Bartlett Sessions’ diary, kept from February of 1846 to Friday May 4th, 1888, evidence of an intense devotion based on the teachings of Joseph Smith and midwifery.

Patty Bartlett was born in Bethel, Maine in February of 1795. In 1812, at the age of 17, she married David Sessions. Around 1834, the Sessions family joined the Church of Jesus Christ of Latter Day Saints and set out with a caravan of covered wagons traveling West. When they settled in Utah in 1846, Patty earned her money weaving and midwifing. In her journal on Saturday, May 29, 1847, she recorded spending her day attending to her income and her religion.

“Saturday 29 packed 1:86 pounds of pork for the mountains I then went to collect some debts got nothing then went to a meeting to Eliza Beamans with many of the sisters, sisters Young and Whitney laid their hands upon my head and predicted many things.”

As a woman of her household, Patty’s chores included packing salt pork for traveling, collecting debts (even when she “got nothing”), and visiting her female neighbors to praise God, discuss the scripture, and lay hands on one another. To “lay hands” is to place one's hands on another person to confer a blessing. On this Spring day, Patty received the tactile consecration from her sisters Young and Whitney, but Patty frequently laid hands on women, men and children in and out the birthing room. Both Sisters had a vision of Patty’s future salvation: “I should be blesed with that I should live to stand in a temple yet to be built.” Patty was to be blessed by Joseph Smith in the afterlife for her “great” “labours,” which were “done in order:” she would be honored for all of her dextrous deliveries as one of her community’s midwives. As well as being celebrated by her prophet, Patty was to be greeted by each child she’d caught “saying your hands

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121 Patty Bartlett Session, Mormon Midwife, ed. Donna Toland Smart (University Press of Colorado, 1997), 82.
were the first that handled me bless me.” Once she answered their calls and blessed them, all of “their mothers would rise up and bless me for they would be brought to me by Joseph himself for he loved little children and he would bring my little ones to me & C & C.”

Patty’s sisters envisioned her a heaven filled happy, healthy, grateful, and supplicant mothers and little ones. The prophet would be there, too, for it was he who brought each mother and child Patty ever midwifed to see her. All would be “blessed.” The vision “filled” Patty’s heart “with joy and rejoicing.” To Patty Bartlett Sessions and the women she served, then, midwifery was work and it was salvation.

Patty found her devotion to midwifery through familial ties, attendance, and a physician. When, around 1830, Patty and her mother-in-law were both called to attend a birth – Sister Sessions as watcher and Mother Sessions as midwife – Mother Sessions was too old and feeble to hurry to the mother in need. Patty rose to the call and put the mother to bed before Mother Sessions arrived. After a physician praised her for her natural skill, Patty began midwifing. She was in her early twenties. Her mother-in-law, as well as Molly Ockett, the native Abenaki midwife who practiced in Bethel for decades and likely delivered Patty herself, may have taught Patty her midwifery knowledge. Yet the spirituality of her midwifery was not based in apprenticeship, but Joseph Smith and the salvation he promised.

In the African American tradition, twins, seventh-borns, and those born with the caul (amniotic membrane) covering their faces were spiritually predisposed to healing work. As Clara Walker of Garland County, Arkansas stated:

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123 Patty Bartlett Session, *Mormon Midwife*, 82.
124 Patty Bartlett Session, *Mormon Midwife*, 82.
“Did you ever hear of a child born wid a veil over its face? Well I was one of dem!...It means dat you can see spirits an’ ha’nts, an all de other creatures nobody else can see.”

Clara’s ability to “see spirits an’ ha’nts might have brought her the distinction of “conjurer” – someone who not only sensed supernatural presences but called upon them to heal her patients.

Clara’s direct connection to the spiritual realm enhanced her right to officiate births – themselves liminal moments tied in new and passing lives. But she wasn’t trained in traditional midwifery, instead she was assigned the role and trained by a physician.

Most midwives are postmenopausal, but Clara was 13 when she started her midwifery career. “My ol’mistress put me wid a doctor who learned me how to midwife. Dat was cause so many on de plantation was catchin’ babies.” What does Clara mean by “Dat was cause so many on de plantation was catchin’ babies”? Were there so many pregnancies – i.e. caught babies – that more birth attendants needed to be trained; or were so many enslaved women taking up midwifery – i.e. catching babies – that enslavers felt the need to supervise and control indigenous birth practices? If it was the latter, then Clara’s caul evinces the inability of enslavers to truly sanitize enslaved midwifery. She earned her right to midwife her community through the portent of the caul and her performance as a caregiver. While she learned her obstetric expertise from a physician, she remained a midwife in her own right.

For those midwives without portents or practicing mothers, the art of midwifery found them through their own cycles of attending births not as midwives, but as watchers. For enslaved and free colonial and antebellum American women alike, marriage or the entrance into the childbearing class came with the responsibility of attending one’s peers in labor. Over decades as a watcher, women observed their local midwife work, learned her cures on top of the ones she

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129 Rawick, 117:19.
already held from her kin, and administered her own care from the side. As the interested attendant aged, she sequentially stepped further into the role of midwifery.

**Call the Women, Call the Watchers**

For Early American women, childbirth and illness were moments of reciprocal care between friends, family, and neighbors. One attended or “watched” at a neighbor’s birth stool or sick bed with care and the expectation that when her time came, one’s neighbors would do the same. Those attendants cared for the patient, kept house in a sick or laboring woman’s stead, and, literally, “watched” the progression of the illness. To watch was to hold space: to testify to care and comfort with one’s presence and nurturance. As the matriarch of the birthing room, the midwife mediated, generated and was generated by all of these communal relationships.

Elizabeth Pendergast Carlisle’s diary evidences not only the regular progression of attendance through a New England woman’s life – from attending neighbors, to birthing her children, to attending her daughters – but also the social dynamics of each phase of attendance. Like most New England women, marriage brought Elizabeth into the fold of attending births. On October 14, 1770, about four months after her wedding day, Elizabeth recorded her first watch: “Lawyer Porter’s wife taken in Travel the night before Delivered about four oclock this afternoon of a Daughter stillborn - watched with her. Saturday came home.” That Elizabeth recorded her watch “with” the parturient mother emphasizes the purpose of her presence: to hold space, community, and embrace for a birthing woman and, in this case, a grieving mother. These watches – sometimes sorrowful, sometimes “all well” – informed and instructed Elizabeth on her

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own birthing process and the meanings she would find therein of hope and strength in community. ¹³¹

Two generations later, Elizabeth’s daughter, Sarah, lived in Boston and was delivered by a male doctor, yet the female community rituals surrounding the birth remained. Elizabeth traveled into the city to be with her daughter through the end of her pregnancy, duration of her labor, and first weeks of motherhood. She summarized the birth in a letter to her other daughter:

“Sally had the warning I always had - but felt very ill - about 12 perceived herself something unwell - we sent Jack to call Dr Rand - about 2 he came - sat & chatted awhile then left us - came again before 6 - the three Aunts step’d in, - & a long time before 8 we had a fine boy…Sally appears as well as we could wish.” ¹³²

As Sarah’s (or “Sally’s”) mother, Elizabeth experienced the labor alongside her daughter. They make care decisions together – “we sent Jack to call Dr Rand” – and produce the child together – “we had a fine boy”. The doctor socially flitted in and out of the room, and “the three Aunts” were only present for the final pushes, but their amassed support brought Sarah through her labor safely. Though the physician was present to catch the child, Elizabeth did the brunt of the midwifery work by staying by her daughter to comfort, support, and guide her through her delivery.

Sarah’s graduated hierarchy of attendants illuminates the social rules of order of the birthing room. Although male physicians were, at times, invited in, the birthing room was a female-only space. For Peggy Dow of Massachusetts, that homosociality was enforced. For her first birth around 1804 to 1810, Peggy’s midwife and attendants denied her husband entry to the birthing room. As she recorded in her *Vicissitudes*, “Those that attended on me would not suffer him to come into the room where I was – which gave him much pain.” ¹³³ Lorenzo and Peggy

¹³³ Peggy Dow, *Vicissitudes; or The Journey of Life by Peggy Dow* (Philadelphia, 1815), Series 2, no. 34593, America’s Historical Imprints, 34.
were an unconventional couple – he an itinerant Methodist abolitionist preacher famous for refusing to bathe and she his companion who published her life story in her own right. Their desire to be together through Peggy’s labor directly conflicted with the prevailing belief that birth was a space for women alone. The midwife and her deputized attendants enforced that female homosociality against their patient’s wishes.

It was the women who gathered to witness the pain, danger, and joy of childbirth because it was the women who experienced it too. The gathering of the women was practical – it amassed all of their inherited pharmacological knowledge into one room – but it was also spiritual. In attending their patients, watchers and midwives held vigil to each woman’s labor. In 1809, when Nancy Maria Hyde was 17 years old, she attended her first birth – that of her older sister. Her first experience “watching” occasioned a poem in honor of the child. For the group of women gathered, she promised: “Her infant wants our watchful care attends, / From sickness guards her, and from harm defends.” For Nancy, the “watch” explicitly held protection in its witnessing, attendance, and care. She learned as much through her first venture into the midwife’s birthing room.

For Sarah Newman Connell Ayer of Portland, Maine, the presence of watchers offered a barometer of the seriousness of her illness. On March 15, 1823, she recorded in her diary:

“For three weeks before the birth of my infant I was very dangerously ill, so that my friends did not expect my life. I had watchers every night, and did not myself expect ever to recover…My life, and the life my child was spared as I do humbly believe in answer to prayer.”

No one expected her or her infant to live; they gathered at her bedside and through her birth to bear witness and bring comfort to her expected passing. Though the midwife may have stopped

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by during those three weeks and was indeed present for her dangerous delivery, Sarah received the brunt of her care from neighbors and friends. As such, the watchers operated as deputized midwives: stepping up to provide care under the same ethic when the professional midwife was otherwise occupied. According to Sarah, her watchers’ forbearance and prayer brought her and her daughter through the dangerous nights. Such was the ethic and spirit of the midwifery care system. The vigil was midwifery and midwifery was part of the vigil.

Although evidence of enslaved women’s social birthing patterns are scant, structures of watching were recognized and followed on Southern plantations. Plowden Charles Jennett Weston, a South Carolina rice planter, published his rules for the care of sick enslaved people in *De Bows Review XXII*, a popular plantation management periodical in 1857. Therein he mandated female watchers for sick patients – “A woman, beside the plantation nurse, must be put to nurse all persons seriously ill” – and for parturient women – “Lying-in women are to be attended by the midwife as long as is necessary, and by a woman put to nurse them for a fortnight.”\(^{136}\) Whether these care structures were put in place to accommodate the desires of plantation owners or bring inevitable surreptitious caretaking to the foreground cannot be known. Nonetheless, attending practices persisted and were mediated by midwives. As they described the births they attended on plantations, many physicians mention “attendants” alongside the midwife in the birthing room. Dr. Withers mentions an enslaved patient’s parents being present.\(^{137}\) One physician, Dr. Philpot, anecdotally described one woman’s birth to the readers of the *Atlanta Medical and Surgical Journal*:

> “Nancy, a negro woman, pregnant, belonging to Mr. J.P. Lenard, started off on a tramp on Sunday to see some of her dark friends on a neighboring plantation. When some four miles from home, labor commenced, and the pains increasing so fast and strong, she

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could not proceed any farther, and in a fence corner, some four miles from home, without any assistance, she gave birth to a large fine child."\textsuperscript{138}

Dr. Philpot assumes that Nancy was on a social visit to her friends when her labor overtook her. More likely, however, was that Nancy’s labor started before she left, and, since it was her day off, she was traveling in hopes of giving birth attended by her friends. As such, birth attendants were not only allotted to enslaved women, but sought after.

The collective of the women came together to witness and withhold the suffering of the laboring woman and her infant. When the patients survived, a collective sigh was exhaled. For women with time and means, that relief was marked with a “groaning” or “setting up” party – large gatherings hosted by the birthing woman and her family for all of the women attending her birth. These birthing room gatherings savored and celebrated the success of the mutual system of birthing aid among friends, family, neighbors, and midwives.

In February of 1774, Mrs. Mary Holyoke of Salem, Massachusetts opened her birthing room to married women for afternoon social visits under the banner of her “setting up week.” Among scores of household chores, visits to neighbors, and the attendees at the dinner table, Mrs. Holyoke recorded not the birth of “Judith,” but the event that came one month following. Mrs. Holyoke hosted “Mrs. Pickman, Mrs. Routh, Orne, Deblois, Lilly, Miss Caty Dowset” on the 16\textsuperscript{th} and “Mrs. Prince, Mrs. Mackey, Mrs. Bernard, Mrs. Henry Gardner” on the 17\textsuperscript{th} for tea. The separation of these visits for her actual recovery was significant. The “laying in” rarely lasted longer than a month. Likely, the “setting up” announced the health of Mrs. Holyoke and her child in anticipation of Mrs. Holyoke’s re-entrance into popular society.\textsuperscript{139}

\textsuperscript{138} Philpot, William H. “A Case of Hypertrophy of the Spleen and Post Mortem Examination.” \textit{Atlanta Medical and Surgical Journal} 2, no. 12 (August 1857): 705-8.

A “sitting up week” would not include the midwife unless she was invited. Groaning parties, however, included every attendant present. Groaning parties occurred closer to the time of birth. The “groaning” held triple meaning – the table groaned under the weight of a large supper, the women groaned with the fullness of their stomachs, and the new mother groaned to deliver her child.\footnote{Thompson, \textit{A History of Midwifery in the United States}, 9.} Therein, the early and easy hours of labor or the alleviated hours following birth were used to gather, eat, and commiserate among women, and women alone.

On November 21, 1694, Samuel Sewall recorded one such event: “My wife brought to bed of a Daughter between 9. And 10. Of the clock in the morn…Women din’d with rost Beef and minc’d Pyes, good Cheese and Tarts.”\footnote{Sewall, \textit{Samuel Sewall’s Diary}, 118.} Sewall was proud to provide the “women” such an exquisite version of a customary meal. Martha directly recorded attending at least seven such suppers. On November 18, 1793, Martha Ballard delivered Capt. Meloy’s wife of a “fine daughter:” “Her attendants Mrss Cleark, Duttun, Sewall, & myself. We had an Eelligant supper and I tarried all night.”\footnote{Ballard, \textit{The Diary of Martha Ballard}, 18 November, 1793.} Five women and one baby girl attended Mrs. Meloy’s groaning party. The midwife was the only guest to stay and “tarry” among the household through the evening. When “tarrying,” Martha watched and cared for her patients, monitored nursing, and completed necessary domestic tasks for the household. Though the elegance of these parties was reserved for the upper class, the rhythm and practice of taking food together in the birthing room was acknowledged across colonial women’s society. Midwives and guests were to be fed and thanked and births were to be celebrated among women and women only.

The birthing room literally and metaphorically held space for female gathering and female promise: of continuous neighborly support and care. As the female birth professional of
this womanly space, the midwife’s presence structured and supported these social spaces. They were there before the women arrived and stayed after they left.

The women in attendance could see their own midwife at work and at ease throughout the birth gathering. Ultimately, the midwife’s care was not so different from the attendants; the attendants were not so different from the midwives. The social purpose of the midwife and the attendant was the same – to hold and care for a mother through her labor – but the midwife’s generational authority and practiced knowledge meant that she caught the baby and stayed to care for the mother before and after the other attendants came and went. The attendants who wanted to take the midwife’s place, stepped up to learn from their elder before she stopped birthing babies and the apprentice took her place at the birthing stool.

**Midwives as Organizers and Officers of Community Care Networks**

From their positions of generational authority, midwives directed and regulated systems of caretaking and childbirth within their communities.

In Martha Ballard’s community, support was found in joyous and sorrowful moments alike: shepherded by Martha, the women of Augusta, Maine ensured the survival and mothering of their community. On March 31, 1790, Martha delivered Mrs. Cragg of her first born child – “a fine Dagt.” On April 5, Mrs. Cragg was unwell. Martha administered a “clister” (enema) of “milk, water & Salt, applyd ointment & a Bath of Tansey, mugwort, Cammomile & Hysop, which gave mrs Cragg great relief.” Martha visited again on the 9th and 11th and found her patient “Exceeding ill.” Martha “tarried & walcht” her patient finally expire on the 12th. Martha, Mrs. Pollard, and Mrs. Voce dressed Mrs. Cragg’s body for burial. Sally White, whom Martha

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144 Ballard, *The Diary of Martha Ballard*, 5 April, 1790.
had delivered in June the previous year, was fetched from down the road to “give the infant suck” and stayed to nurse the newborn for three nights. Martha “tarried” at the Craggs the next two nights. On the 15th, Mr. Cragg brought Sally White home, then called on Mrs. Hamlin, whom Martha had delivered a daughter the previous April. Mrs. Hamlin took the infant in to nurse and mother. Over the next few days, Mrs. Voce and Martha’s daughter, Dolly, both visited Mrs. Hamlin’s to help care for the infant. As midwife, Martha directed Mrs. Cragg’s delivery, her sick-care, the dressing of her body, and the care of her infant after her passing. The communal feeding of this orphan was entirely reliant on Martha’s knowledge; she knew which neighbors were breastfeeding because she herself had delivered their children. The women of the neighborhood ensured that Mrs. Cragg’s body was laid to rest and her daughter was fed. Martha led both of those charges: as an elder and a midwife, she coordinated her network of neighbors in their neighborly and womanly duties to their communities.

On Southern plantations, elders managed caretaking systems among enslaved women. Fanny Johnson’s recollection of her plantation’s childcare system illuminates not only a women’s network of covert care across plantations, but the ways in which Mammies and Grannys mediated that care.

“I helped my grandmother. She is the one who took care of the babies. All the women from the lower would bring their babies to the upper end for her to look after while they was in the field. When I got old enough, I used to help rock the cradles. We used to have lots of babes to tend. The women used to slip in and nurse their babies. If the overseer thought they stayed too long he used to come in and whip them out — out to the fields… I remember the women on the nest plantation used to slip over and get something to eat from us… The women on the next plantation, even when they was getting ready to have babies didn’t seem to get enough to eat. They used to slip off at night and come over to our place.”

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145 Ballard, *The Diary of Martha Ballard*, 21 June, 1789, 12 April, 1790.
146 Ballard, *The Diary of Martha Ballard*, 15 April, 1790, 31 April, 1789.
Fanny’s grandmother may well have been a Granny midwife, but she was certainly a Mammy – a woman past child bearing age who was assigned to nurse the children too young to work. Most enslaved mothers were only allowed to spend the first three to fourteen days of their child’s life entirely with their child. Thereafter, mothers had to entrust much of the raising of their children to Mammies, and do their own mothering in fits and spurts when able. They “slipped in” to nurse and care and “stayed too long” doing so: maneuvering around the gaze and direction of planters and overseers to tend to their babies beyond the plantation’s prescriptions. As the head of the nursery, Mammies like Fanny’s grandmother allowed and protected this care to the best of their abilities by providing food, respite, and an unevenly surveilled dwelling to new mothers.

The need to nurse, and to do so from a well-fed body, was understood among the collective of enslaved women. This practice – of taking what one believed they deserved from the plantation – was called “taking,” not “stealing.” One could not steal from someone who had already stolen their freedom. Mothering around, between, and through the desires and prescriptions of the planter meant creating space and time in the name of birth and nursing.

Women elders like Mammies and Grannys ushered and mediated this “taking” to reify the community and humanity of enslaved women.

By and large, childbearing and everyday healthcare were indigenous health practices on American plantations which occurred beyond the planter’s supervision. The ability to seek and heed the care of an elder woman aligned with African American tradition. In many African societies, midwives and women healers held respected roles in their communities as “facilitators of harmony, wellness, and order” through their work as “fertility specialists, moral counselors, and root workers.” Yet, the authority and freedom with which enslaved midwives provided

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149 Lee, *Granny Midwives and Black Women Writers*, 35.
care, advocated for rest, and protected their people was sourced within their communities but also from the institution of slavery itself. These women were responsible for reproducing the system of slavery. Within communities structured by violence and extortion, Grannys held the authority to enforce their own values of child bearing, rearing, and mothering.

Quite literally, midwives had cash value to enslavers as caretakers, healers, and birthers of their enslaved communities. Auctions and broadsides distinguished midwives and healers for sale from other elder adults. One broadside advertised “Dinah, aged about 45, good field hand, strong and valuable; can pick 350 lbs cotton; good midwife” to the businessmen of New Orleans in January, 1855. The reproductive cash value of midwives like Dinah afforded them mobility and authority. As Victoria said of her grandma Katy, “In slavery times my grandma was almost free as she was in freedom because of her work.”

In the plantation healthcare system, midwives were given the authority to regulate women’s work and rest. Plowden James Charles Weston’s rules for sick care enshrine that power. On his South Carolina rice plantation, “lying-in women [were] to be attended by the midwife as long as [was] necessary…They will remain at the negro houses for 4 weeks, and will then work 2 weeks on the highland. In some cases, however, it is necessary to allow them to lie up longer.” The midwife, as the respected birthing expert, would determine what was “necessary” for the women in her care. What’s more, Weston stated that “women are sometimes in such a state as to render it unfit to work in water.” As such, the midwife determined who could do the hard labor of the laundry and who should be excused. There was liberation in the midwife’s space to

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advocate and advance rest and freedom time. Her birthing room offered a pause from labor buffered by the midwife’s power over overseers and enslavers.

Midwives’ positions as healers offered them mobility and capability to enforce their own values within their own communities along white power structures. This is most clear in midwives’ interactions with physicians surrounding infant loss. When Dr. Larkins of Charlotte, North Carolina was called to attend a patient who appeared to be in labor, she “denied being in the family way.” But after the patient passed, the physician performed an autopsy and found that the fetus had ruptured through the uterus. In his reflections, Larkins states “We were not able to satisfy ourselves at the time what was the cause of the rupture, but I have since learned that the patient had taken something to prevent conception.” Someone intimately aware of the patient’s medicinal habits – either a friend, husband, sister, mother, or midwife – passed that information on to the physician.

Dr. Sutton was called by the coroner of Scott County, Kentucky to investigate a suspected case of infanticide in 1853. He reported the facts of the case and criminal proceedings in his article. Therein, he stated that “Matilda, a negro woman, testified that she took the child from the privy. Knew that the child was Susan’s because she took the afterbirth from her. Susan subsequently acknowledged the birth of the child.” Matilda and Susan’s relationship was immensely complicated. Supposedly, Susan called on Matilda when she was unable to deliver the placenta unassisted. Matilda delivered her, then went to collect the dead child from the vault of the toilet. Whether she intended to report the infanticide, check if the child was alive, or properly bury the child cannot be known, but her actions brought the fetus to the attention of plantation managers. In this moment, she took upon herself the onus to manage an infant and

153 Larkins, James M. “A Case of Rupture of the Uterus with the Escape of the Foetus into the Abdomen.” *The Western Journal of Medicine and Surgery* 1, no. 2 (February 1848): 110.
mother in her community. Her positionality as a matriarch and matron of reproduction allowed her that authority.

**Midwives’ Ecological Mobility and Sourcing**

Midwives used their intimate knowledge and authority to orchestrate, regulate and advocate for just reproduction. Just as they used their social connections to source patient care, they used their ecological understandings of their regions to source pharmacological care. As such, midwifery came from place as well as community.

Enslaved midwives traveled throughout their own plantation and between neighboring plantations to deliver the children of enslaved and free women. Jennie Farrell of West Memphis, Arkansas’s grandmother “was a midwife. She doctored the rich white and colored. She rode horseback, she said, far and near.” With consistent access to a horse or wagon and the ability to travel unquestioned, Granny midwives had a certain freedom of mobility. Their journeys upon roads or through the woods between plantations allowed them the space and time to forage for their herbal and root cures. What’s more, with her constant coming and going between plantations, the midwife gathered information, messages, and gossip to share between and among communities. Perhaps, on her journey between plantations Victoria McMullen’s grandma Katy gathered pine, red oak bark, and catnip from the woods alongside news of births and deaths for her home – the McClendon plantation in Lisbon, Louisiana. As such, when the midwife entered the birthing room, she did so with the ecological and social impression of a region behind her.

For Rebecca Hooks of Lake City, Florida the popular care of the plantation midwife was distinctly herbal and pharmacosmical:

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On the plantation, the doctor was not nearly as popular as the ‘granny’ or midwife, who brewed medicines for every ailment. Each plantation had its own ‘granny’ who also served the mistress during confinement. Some of her remedies follows: For Colds: Horehound tea, pinetop tea, lightwood drippings on sugar. For fever: A tea made of pomegranate seeds and crushed mint. For whooping cough: A tea made of sheep shandy (manure); catnip tea. For spasms: garlic; burning a garment next to the skin of the patient having the fit. As common horehound and catnip typically grow in disturbed, grassy soil, Rebecca’s midwife probably either cultivated the herbs herself or found them along agricultural fields or roads. Mint and water horehound are also easily cultivated in Florida’s hot and humid climate, but could be found in wet forests or along pools of fresh water. As such, Rebecca’s midwife could have collected those herbs in the same damp Florida forests in which she collected pine needles, sap, and rosin (“lightwood drippings”). Garlic and pomegranate were likely grown either by the midwife herself or in the estate’s garden. If they were the fruits of the estate, the midwife’s status as the plantation’s nurse allowed her access to the medicinals she needed. The midwife’s popularity over the physician cannot be separated from her ability to source the fruits of her own cultivation and collection into “brewed medicines for every ailment.” Her use of both garlic and “burning a garment next to the skin of the patient” emphasizes the cosmic centrality of spiritual ritual to these inherited practices. Indeed, Rebecca's report of her midwife’s cures testifies to the active generational transference of cultural health ways that midwives ensured through both their own treatments and through systems of apprenticeship.

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I would be remiss to use Rebecca Hooks’ recollections and knowledge so heavily and not share how her WPA narrative ends: “Rebecca’s husband died several years ago; she now lives with two daughters, who are very proud of her.”


Midwives sourced their knowledge from the women who came before them and their cures from the Earth around them. The same hands that delivered babies, soothed mothers, and manipulated stomachs dug through the ground for dogwood roots, chamomile, and rue. Those same hands brewed those herbs into teas, syrups, and tinctures at her own or her patient’s stove. As such, the preparatory rituals of midwifery were cultivation, collection, and distillation. Each step imbued the fruits of the Earth with the midwife’s care and attention.

The midwife was not the only enslaved woman to collect and brew gynecological medicinals, but she was the only one who could do so openly. The midwife’s medicines, unlike those of her peers’, were (albeit guardingly) approved by enslavers. Herbal knowledge was common. As Louisa Adams of North Carolina told her interviewer, “the slaves took herbs dey found in de woods.” Many enslaved women used cotton root tea to regulate menstruation and prevent pregnancy. The root could be surreptitiously collected during working hours then brewed in the privacy of home. As such, midwives were the public faces of a communal order of herbal knowledge. They were not the only ones who knew the herbs, but their personal knowledge was public knowledge.

Midwives as Community Spiritual Officials: Epitaphs and Mortuary Notices

Martha Ballard’s work was to embrace, support, and coordinate her community around their shared ethic of mutual care. Martha’s curt humility obscures any notion of gratitude given to her beyond payment, but glimpses of the love her community showed her remain. On November 27, 1795 Martha “was Calld at Sun Sett by mr Bullin to go and See the wife of Timothy Page, find her very unwell when I arivd. mrs Bullin, Adkins & white there, and mrs

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Cocks. I had a Severe turn of Cramp in my Limbs in ye night. the Author of all my Mercies heard my petition and grants me relief. the Ladies who were there used me with great kindness.” This opportunity for the women to grant “great kindness” to the one who caught their babies and embraced them in their labors was rare and special. Martha had served her community for 18 years at that point; she would serve another 17 years before passing away at the age of 77. Though her burial place is unknown and likely unmarked, this moment of reciprocated service testifies to the care and appreciation Martha’s community felt towards her. The few memorials to colonial and antebellum midwives that do survive on gravestones and in mortuary notices evidence the love and honor with which these dutiful women were laid to rest by the specific communities that held and valued them.

It is unlikely that the readers of the Norwich Courier knew Mrs. Boyer of Shenandoah, Virginia. But, on April 5, 1815, they could read of her 90 years of life and 50 years of midwifery in the paper’s section of mortuary notices. Given the geographic separation between subject and audience, the story is sentimental, not informational. “It is worthy of remark,” the Courier says, “that her first and last call was to the house of Adam Dirting, near Woodstock, where on her last visit she was taken ill and died.” Midwife Boyer delivered generations of the Dirting family. The Dirting home delivered her into her service as a midwife and onto her next life. That Mrs. Boyer’s intimate, sustained community investment was broadcasted from Shenandoah to Norwich, and beyond, testifies not only to the power of this midwife’s career, but also to a popular investment in the meanings and sentimentality of that power.

The widespread publishing of midwives’ mortuary notices and epitaphs reveals not only the intricacies of midwives’ lives and careers, but also the tender and sensational meanings of

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162 “Mortuary Notice,” Norwich Courier, April 5, 1815.
their lives to a national audience. By analyzing these notices, we may better understand the meanings and sentimentalities of midwives to their own communities and beyond.

The qualifiers with which these women are described, as well as the language surrounding midwifery in these notices, illuminates the meaning of the profession as well as their positions therein. In 1712, Mrs. Buxton was noted as an “excellent Midwife” and in 1788, Mrs. Franklin “a skilful midwife.” Each distinction told the readers of the popularly accredited expertise of these midwives. For some midwives, their excellence brought them fame: when they died in 1785 and 1796, respectively, Mrs. Burden was “a celebrated midwife” and Mrs. Hall was “a very noted midwife.”

Mrs. Elizabeth Philips, Mrs. Elizabeth Thomas, Mrs. Boyer of Shenandoah, and Mrs. Esther Franklin were all referred to having been in the “office of Midwife” or “officiated” as a midwife in their mortuary notices. The designation of an “office” being filled indicates the municipal necessity of midwifery, and the constant requirement of a region to have a midwife in service. Indeed the civic nature of midwifery is highlighted when the notices provide estimates of the numbers of births that midwives oversaw. For example, when Mrs. Hall died in 1796, she had officiated 3,000 births around Littleton – a town right on the Androscoggin river between Vermont and New Hampshire. The New Hampshire county that Littleton resides in housed 13,472 people in 1790 and Littleton itself housed 3,365 people in 1800. If Mrs. Hall really did

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deliver a population nearing that of her own town, then she caught about 20% of her region’s people. Her civic duty was to bring about her town, and she did.

Figure 3.1 Mrs. Elizabeth Phillips’ grave in Charlestown, MA.\textsuperscript{168}

What’s more, the idea of “officiating” midwifery illuminates the spiritual authoritative duty of the women therein. Priests officiated baptisms, weddings, and funerals; midwives officiated births. Their stewardship of this spiritual passing from the womb to the world linguistically aligns them with overtly religious stewards. Mrs. Elizabeth Phillips’ mortuary notice and gravestone further illuminate the religious meanings of this office. Mrs. Elizabeth

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  \includegraphics[width=\textwidth]{figure31.jpg}
  \caption{Mrs. Elizabeth Phillips’ grave in Charlestown, MA.\textsuperscript{168}}
\end{figure}

Philips “brought into this world, more than 3000 children” “by the blessing of God.” With the same blessing, she was sent to the afterlife. The ornamentation on her gravestone (figure 3.1) signifies her wealth and significance to her community, celebrates her life’s work at the confluence of life and death, and expresses a faith in her final salvation. Winged death’s skulls like the one on the top of Elizabeth Philips’ gravestone were quite common in the greater Boston area in the late 17th century. The confluence of life – wings – and death – a skull – in one symbol marks this soul’s transition into the afterlife while bluntly recognizing the cycles of life and death which allow for that salvation.169 As a midwife, Mrs. Philips was an usher and officiant to those cycles. Her gravestone celebrates and honors the Godliness of her work as a reflection of the Godliness of herself.

The obituary of Mrs. Elizabeth Thomas offers an intimate portrait of a woman and midwife of mythic personality and capacity. This biography was written and published across numerous papers in the colonial Northeast in 1800, in part for the spectacle of Mrs. Thomas’ impressive strength, anger, and masculinity. Indeed, “she was a woman of masculine size and form” who was known to, “when she has been offended, with one blow with her fist knocked a man down.” Yet, her character and connection to her community was clearly emphasized alongside her phenomenal power. She was “an industrious and useful member of society, an affectionate relative, and a kind friend and neighbor.” What’s more, she “for a considerable time,” “officiated as midwife.” Unlike her other qualities, her midwifery is not dwelled upon. Instead, her service spoke for itself among a litany of evidence to the “strength and courage” of this “extraordinary woman.” The sum of this midwife’s character, then, was power in anger and power in community – her assured punch paired with her neighborly midwifery to produce a

woman whose kindness was exercised with strength and whose strength was exercised with vindication. The power of her public role was matched by the power and strength of her physical body.\textsuperscript{170}

The publicly held recognition of a gravestone and mortuary notice were not typically available to African American women in Antebellum America. Yet, still, evidence of the communities they fostered and legacies they left behind remain. On Thursday, December 17, 1863, the \textit{Daily Picayune} of New Orleans, Louisiana reported that week’s criminal proceedings. Therein, readers learned that:

“A negro named Chss. Ross was examined on a charge of having feloniously taken possession of the vacant estate of an old colored midwife, named Maria Moore, who died on the 7\textsuperscript{th} of May last, in a home on Phillippa street. The complainant and principal prosecuting witness was a colored girl named Mary Simms, who claims to have been the adopted daughter of the deceased. According to her testimony and that of several other witnesses the accused took possession of the estate as soon as Maria Moore died.”\textsuperscript{171}

Maria Moore’s home on Phillipa Street was on the edge of the city’s commerce center for buying, selling, and trading enslaved people.\textsuperscript{172} Among and around that trade, Maria Moore amassed an “estate” that garnered the attention of Ross and a midwifery practice that earned her the respect and love of Mary Simms and the “several other witnesses” who came to her defense. Mary Simms’ position and action as Moore’s “adopted daughter” is particularly revelatory. Moore’s midwifery included extending her mothering beyond biological inheritance. Her extended kin and community wished to honor her property and stature even in death. Their court petitions testify and monument that love.

\textsuperscript{170} “Biographical Sketch,” \textit{The Eastern Herald and Gazette of Maine}, February 17, 1800.
\textsuperscript{171} “The City,” \textit{The Daily Picayune}, December 17, 1863.
Conclusion

Though its practice operated in the birthing room, early and antebellum American midwifery found spiritual, authoritative, and cultural meaning throughout generations, communities, and families of women. The midwife was an elder who generated and regulated care and community for the women in her charge. Her consistent motherwork was distinct to her home’s ecological and social landscape. She was a forager of aid, a bolster to the health of her community, and an apostle of a tactile, facilitative, and spiritual care ethic. Her work was simultaneously viscerally private and public. It was the confluence therein that gave the midwife her power.
IV. Physicians Enter the Birthing Room: The Recorded Colonization of Midwifery

The previous three sections each directly attended to what American midwifery was, what it meant, and who it impacted. In 1800, American midwives held distinct social authority in American society. They were spiritually revered, honored, and celebrated for their healing work. By 1900, physicians held that reverence in American society. This section examines how exactly physicians came to occupy not only the knowledge of midwifery, but its social meanings. Physicians colonized midwifery by performing and assigning hierarchy, appropriating midwifery’s pharmacopeia, and expropriating midwifery’s authority. The mechanics of this colonization are evident in physicians’ obstetric case narratives.

Gynecology Rises, Midwifery “Falls”

Around 1750, physicians started attending births in the American colonies. Through the mid-19th century, the mortality rates of physician-assisted births were significantly higher than those delivered by midwives. This, in part, was due to the fact that physicians were typically called into long and dangerous labors to apply instruments, ether, and calomel when the midwife’s herbal and manual interventions failed. By 1850, the forceps had usurped the crochet as the physician’s tool of choice in tricky births and most middle and upper class American women were delivered by physicians instead of midwives. By 1900, physicians delivered 50% of American births and 50% of physician-assisted births used chloroform or ether as an anesthetic. In 1950, 88% of American children were delivered in hospitals and 95% of American children were delivered by physicians. This successive transition across two

centuries from a paucity of physician-assisted births to a paucity of midwife-assisted births marks national transitions in industry, professionalism, and patriarchy as well as a cultural medicalization of birth.

The crux of this transition lies in the Antebellum era. It was then, among a litany of homeopaths, midwives, and self-taught practitioners, that physicians established themselves as an authoritative and trustworthy profession worthy of leadership in the birthing room and beyond. Standardized medical schooling and systems of accreditation were crucial to this process, but did not cement until 1904.\textsuperscript{175} In the 19\textsuperscript{th} century, then, without the scaffolding of national regulation, physicians sought to accredit themselves, both to the public and their peers, through writings in medical periodicals.

The United States’ first medical journal was \textit{The Medical Repository}, published in New York City from 1797 to 1823. Boston, Philadelphia, and Baltimore followed close behind – each had a publication by 1812. The field expanded and self-digested rapidly. By 1882, almost three quarters of the 509 journals founded in the U.S. since 1797 had ceased publication.\textsuperscript{176} Only one journal analyzed in this section is still in publication today – the \textit{Boston Medical and Surgical Journal}, founded 1828, is now the \textit{New England Journal of Medicine}. The others – \textit{Atlanta Medical and Surgical Journal, New Orleans Medical News and Hospital Gazette, The Stethoscope, The Western Journal of Medicine and Surgery, Southern Medical and Surgical Journal, and Nashville Journal of Medicine and Surgery} – were all founded between 1836 and 1856 and ceased publication between 1860 to 1900 (excluding the \textit{Western}, which ceased in 2002). The simultaneous prestige and instability of these publications mirrors that of the

\textsuperscript{176} Podolsky et. al., “The Evolving Roles of the Medical Journal,” 1457.
physicians writing for them: 19th century physicians were respected men of science, but their societal place was uncomfortably and precariously ill defined.

These rather fleeting journals were physicians’ tools of their own accreditation. As Steven Stowe has argued, 19th century medical case narratives represent a particular self-professionalization by physicians in a context of cultural doubt over their practice. Though their care was frequently called upon in times of crisis, physicians’ “heroic” (i.e. using dramatic or violent interventions) cures were not universally effective nor entirely trusted by the general public. In well-crafted case narratives, physicians could either boast their success or humbly explain their mistakes. What’s more, in well-crafted obstetrical case narratives, physicians could favorably paint themselves in contrast to the midwives they interacted with in the birthing room and professionally competed with on a national scale.

**Physician’s Articles as an Archive of Midwifery**

19th century physicians usually only attended the normal labors of upper class women. They were called into emergency births for women of all classes. The latter cases were typically written about and published. When a physician was called into such a labor, he replaced the midwife as the leader of a birthing mother’s care. As such, he necessarily interfaced with the midwife nearly every time he stepped into a birthing room. She may have reported the progress of the patient, the treatments she had administered, or, perhaps, her treatment recommendations. She then likely stayed in the room to nurse her patient through the doctor’s treatments and the rest of the labor. So, whether she was mentioned or not, the midwife was likely present for most obstetric encounters recorded by physicians. As such, it is possible to read within and between

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the lines of measurement, prognosis, and pontification to find the care provided by midwives in a crowded birthing room. What’s more, these singular transitions in birthing room authority from midwife to physician illuminate the mechanics of the national transition from the midwife’s authority to the physician’s: one that involved a conscious codification of hierarchy between physicians, midwives, and attendants; midwives’ persistent and continuous care for their patients through this period of appropriation, and physicians’ expropriation of midwifery knowledge.

Each case analyzed below contains a physician, midwife, and patient, alongside a reference to a midwife’s statements, treatments, and actions. They were chosen from an array of relatively popular and prestigious Antebellum journals. In *Birthing a Slave*, Marie Jenkins Schwartz surveys most of the available archive for evidence of the experience of childbirth for American enslaved women. Her revelations undergird my analysis, but my intervention with the archive is markedly different: I am examining these articles for the presence of midwifery and its impact on the science that usurped it.

Southern plantation physicians’ articles figure heavily into my archive and analysis of the processes of gynecology’s confiscation of midwifery. This is intentional. The enslaved birthing room was a major arena of professionalization for American medicine. Dr. J. Marion Sims, his speculum, and his surgical experiments on Anarcha, Lucy, Betsey, and eight other enslaved women epitomize physicians’ violent extraction of biomedical knowledge from Black women’s reproductive bodies. But Dr. Sims is a figurehead. He participated in a general practice of plantation medicine: using enslaved people’s bodies for experiments, education, and professional authority. As most medical schools primarily offered theoretical and anatomical medical education, most physicians entered general practice having never witnessed a live birth. The best place to gain that practice was on plantations where fees were lower, and patients’ lives were
literally expendable. Many physicians were enslavers themselves, but most enslavers invited physicians onto their plantations and into the bodies of the people they enslaved in hopes of maximizing profit through the scientific management of their chattel. The practices of plantation medicine ensured an experimental continuity between the North and South: new treatments for Northern city folk were accredited trials on enslaved people.\textsuperscript{178}

Just as physicians used enslaved women’s births to educate themselves, they used enslaved women’s bodies to professionally accredit themselves. A close reading of Dr. Manlove’s “Remarkable Case of Monstrosity,” printed in the Nashville Journal of Medicine and Surgery in 1859, illuminates the distinctly disrespectful, dehumanizing, and exploitative ways that physicians engaged with the enslaved women and children they birthed. Manlove recounted his patient Harriet’s fear that “something was wrong.” He “remonstrated with her for her anxiety and impatience,” and explicitly dismissed and disparaged Harriet’s feelings and experience – “paying but little attention to what she said.” His attention was instead on her physical body and the case it presented.\textsuperscript{179} Manlove “availed [him]self of the first pain to make an examination.” Such was the nature of his interaction: Manlove used Harriet’s body and its mechanics as a canvas on which to practice obstetrics, then record and print that practice for his own material gain – in his words, “to satisfy [himself].” Though the length of labor was “perplexing and annoying to [him]”, it ultimately produced a stillborn child with physical deformities – in Manlove’s words “a still monster” or “specimen.” Indeed, as he presented this paper to the Tennessee State Medical Society, Harriet’s child sat before him, preserved in a large glass jar for the edification of the audience and the verification of Manlove’s extraordinary story. What was an extended and traumatic birth for Harriet was educational and entertaining fodder for Manlove.

\textsuperscript{178} Schwartz, Birthing a Slave, 44. Barker-Banfield, The Horrors of a Half-Known Life, 65.

\textsuperscript{179} J.E. Manlove, “Remarkable Case of Monstrosity,” Nashville Journal of Medicine and Surgery 16, no. 6 (June 1, 1859): 481–84.
and his colleagues: “Indeed,” Manlove exclaimed to his audience, “our credulity is taxed and our wonder excited that it should have passed at all.” 180

Though he was amazed by the capabilities of Harriet’s body, Manlove distrusted his patient’s intuition, disregarded her emotional experience of birth, and extracted her anatomy and physiology for his own and his profession’s gain. Such was the process illuminated in the obstetric case narrative: a purposeful extortion of midwifery, its practices, and its prestige to define scientific medicine as targeted expertise in direct opposition to midwifery’s consistent care work. Enslaved women’s bodies were objects of that transition and articulation.

**Performing and Reiterating Hierarchy: Doctors Define the Take-Over of Midwifery**

Throughout the form, midwives and midwifery were consistently put down in favor of the formal education and gentility of physicians. What’s more, these works exist within and functionally articulate the systems of racial capitalism that upheld the enslaved plantation economy. The physicians’ use of racial and misogynistic epithets to denigrate their patients and their midwives promote the hierarchical sterility of gynecology over the communal intimacy of midwifery. As such, politics of otherness, difference, and race define the emergence of gynecology from the rooms in which midwifery was practiced to the alienated form of the scientific journal “case” article.

In his 1859 “Obstetric Letter,” Dr. Marsh blamed the work of “plantation accoucheurs and n***** midwives” for the South’s great number of prolapsed uteri and bladders for they “do not know any more of anatomy and obstetrics than law and theology.” 181 This distinction between book learning and applied learning is a crucial sticking point. In their formal education,

180 Manlove, “Remarkable Case of Monstrosity,” 481-483.
most physicians had read of law and theology as well as anatomy and obstetrics, but they came
to their profession lacking the practical education that midwives earned through their own births,
mothering and apprenticeships. Simply put, midwives knew more about birthing babies and
delivering women than doctors. Dr. J. Marion Sims – the lauded “father” of modern
gynecology picked up on the sharp difference in experience and knowledge between midwives
and physicians when he recalled around 1880 the start of his career in 1850: “[old nurses] have
an idea that young doctors don’t know a great deal, and the old nurses are not very far from
right.” In their articles, physicians accommodated these embarrassments by denigrating
midwifery and establishing a hierarchy of caretaking within the birthing room based on the
weight of scientific experimentation and book knowledge.

Cases where midwives faltered or failed were – in the words of Dr. Brickell in the New
Orleans Medical News and Hospital Gazette in 1857 – “instructive to those who advocate the
employment of midwives instead of educated physicians.” Cases where physicians failed,
however, were understandable embarrassments which were both fundamental to the scientific
process of experimentation and were made more permissible by the fact that they occurred upon
enslaved people. When Dr. Sutton admitted to the readers of the Boston Medical and Surgical
Journal in 1847 that “I was guilty of mal-practice in this case, in separating and extracting the
placenta before the uterus had properly contracted,” he unashamedly remarked on his own error
to educate his readers. The ease with which he published this “malpractice” speaks to the ease
he ultimately felt in his mistake. As such, while physicians acknowledged that the enslaved

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182 Schwartz, Birthing a Slave, 37.
183 Sims, The Story of My Life, 142.
185 W. L. Sutton, “Cases of Retained Placenta,” The Boston Medical and Surgical Journal (1828-1851) 37, no. 16
(November 17, 1847).
birthing room was their classroom, they maintained the superiority of their own bookish medicine to the racially denigrated midwives they competed with for birthing experience.

Indeed, many physicians used references to the midwifery they worked among to advance the perception of their medicine in comparison. Dr. Sutton was quite discrete in his denigration:

“About this time the pains abated very much, and scarcely made any impression on the head, that little being lost at the end of the pain. Teas, &c., failing to excite contractions, at 2, A.M., ergot was given, and the child born 3, A.M.”

“Teas, &c.” were central to herbal midwifery, but eclipsed in this case by ergot, a much stronger drug more commonly used by physicians. Sutton’s lack of an action word attached to the teas, as well as his lack of specificity as to which herbs were administered could indicate that they were given by the midwife he worked alongside. Regardless of who administered them, the progress narrative Sutton establishes from teas to ergot frames midwifery as antiquated and medicine as operative.

Physicians specified the logistics of this progress from midwives to doctors by delegating nursing to female attendants and heroic interventions to themselves. When physicians entered the birthing room, midwives did not leave. Indeed, most often, physicians would filter in and out of birthing rooms: coming in to catch or extract babies and give treatments, but spending most of their time being entertained in the big house. While he was in the birthing room, the midwife assisted the physician. When he was away, physicians delegated nursing tasks – the tedious application of medicines, tending to wounds, and rousing of patients – to midwives and attendants. This delegation and alienation of caretaking activities to women was part of gynecology’s founding schema.

186 Sutton, “Cases of Retained Placenta.”
187 Schwartz, Birthing a Slave, 153.
The hierarchy physicians established was multi-stepped. When, in 1798, Dr. Archer made incisions on his patient’s cervix to facilitate delivery, he only notified the midwife of his treatment: “Unknown to her or any of the attendants, except the midwife, who held the candle (for it was now night), with a common spear-pointed lancet, I made three incisions in the neck of the womb.”\(^{188}\) When he published these mechanics of disclosure to *The Medical Repository*, Dr. Archer not only codified the midwife’s position as surgical assistant, he stratified that assistance as marginally based in expertise, and reified her persistence to stay and monitor her birthing room. The midwife was included on the physician’s side of the cloth, but she was subordinate there.

Some physicians were explicit about the delegation of care. Dr. Overton, for example, left Mary in the custody of her midwife, nurses, and attendants after her birth in 1822: “the patient was left, with general direction for her treatment during her confinement, and a request, that should any unusual symptom occur, to send me word of it.”\(^{189}\) In recording this transfer of care, Dr. Overton defined the job of science, medicine and doctoring as hierarchy, tools, and absence. In this absence, Mary’s midwife could continue the bulk of her practice: supporting her patient with her presence, interventions, and comfort.

Other physicians were not so clear. In 1860, Dr. T.P. Bailey recorded and published his treatment of Tenah for an arm presentation in a twin delivery. When Bailey stated “the placenta soon came away and the woman was made comfortable. The child lived only about three weeks,” he marked the moment he stepped away from his patient.\(^{190}\) The women surrounding his patient stepped up to his place to make her “comfortable” and care for her sickly infant for the

\(^{188}\) Thomas Archer, “Article lii.: A Singular Case of Difficult Parturition Successfully Treated.,” *The Medical Repository of Original Essays and Intelligence, Relative to Physic, Surgery, Chemistry, and Natural History (1797-1800)* 1, no. 3 (February 1, 1798): 333.


\(^{190}\) T. P. Bailey, “Obstetrical Cases,” *Atlanta Medical and Surgical Journal* 6, no. 2 (October 1860): 87.
three weeks until it passed. Whether stated or implied, these transfers of authority and responsibility allowed midwives to continue their own care practices around the wishes of both physician and owner. Yet they also served to publicly circumscribe the physician’s role and expertise to the moments of birth and intervention alone.

The Midwives Remained Present and Practicing

An anonymous physician writing in 1857 further evidenced the relegation of midwives to care and physicians to medicine. He wrote that “the woman had a good getting up, no untoward circumstances supervening to retard her recovery,” the “untoward circumstances” he referenced were both physical and social. The “good getting up” he references is either the act of standing up after delivering upon a bed or the days-long recovery following labor. He likely delegated that physically and emotionally supportive caretaking to female attendants, but simultaneously saw that delegation as risky. To this physician, allowing autonomous midwifery allowed midwives an opportunity to assert their own “untoward” or unbecoming support and care for their patients outside of the desires and strictures of biomedicine.191 Indeed, once physicians delegated midwives to the background, many did not realize the extent of the midwifery occurring around them while they filtered in and out of birthing rooms to administer treatments.

In 1842, Dr. Frost wrote and published an obstetric case in the *Western Journal of Medicine and Surgery*. He had been called to a 25-year-old enslaved woman whose labor had progressed for 24 hours. The midwife reported that she had administered a dose of castor oil “to favor relaxation” and taken “a small quantity of blood” from the arm that morning. Dr. Frost was satisfied with her treatment, and, “finding nothing requiring my assistance, left the patient in

charge of the midwife.” He returned the next day to administer morphine and four days later to perform a craniotomy and remove the fetus from the woman. Again, the physician's decisions around the time spent with the patient and the interventions that practitioners performed defined the difference and speciality between midwives and doctors and allowed the midwife to intercede on her patient’s behalf.

Five days after the delivery, as Dr. Frost attempted to administer a vaginal enema, “the patient informed me that the vagina was filled with a substance, which prevented the introduction of the syringe.” Dr. Frost “removed a mass of hair” which baffled him to no end. Indeed, he informed his readers that it could “be seen in the museum of the Medical College of the State of South Carolina.” His article’s title – “Expulsion of a Mass of Hair from the Uterus” – frames the uterus itself as a bizarre and monstrous object of scientific intervention. Frost supposes that the hair was grown in the uterus. He does not consider (as Marie Jenkins Schwartz suggests in *Birthing a Slave*) that the midwife packed the vagina with hair to stem a hemorrhage. Frost reads this case as occurring in the moments he is present; he pays little mind to the days the midwife spent caring for his patient or her ability to act as an autonomous caretaker. But she did.\(^{192}\)

Midwives never stopped practicing midwifery; they simply moved to accommodate, evade and shape the doctoring they now neighbored.

*Presentation: The Midwife’s Case goes to the Physician*

On plantations, tending to the sick and the childbearing either occurred in homes at the hearth or in the plantation’s hospital. That space was the purview of the elder women assigned to

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the work of nursing and midwifery in their community. As Jennie Woraly of Biscoe, Arkansas recalled: “Grandma was a midwife and doctored all the babies on the place. She said they had a big room where they was and a old woman kept them.” The distinction Jennie placed between nursing and midwifery is crucial. In his rules for the sick care of slaves on his South Carolina rice plantation, published in 1857, Plowden Charles Jennett Weston codified the hierarchy between physicians, midwives, and nurses into the enslaver’s rules for health management. For nurses, “In cases at all serious the Doctor is to be sent for, and his orders are to be strictly attended to: no alteration is to be made in the treatment he directs.” Yet, under these parameters, the midwife chose how long was “necessary” for care, when a woman is “unfit” to work in the water of the laundry, and what degree of labor a pregnant woman was fit to complete. The midwife held more authority than the nurse and less than the physician. As such, the hierarchy imbued by the physicians above was solidified by the enslaver’s rules. This ranking of healers was imposed by enslavers, not African American women.

Part of the midwife’s responsibility – especially the plantation midwife – was to call for a physician when the birth got too dire. To do so was to both follow the enslaver’s orders and advocate for her patient. By the early 19th century, physicians were known as the practitioners who, unlike midwives, carried instruments like forceps and crochets that could save a birthing woman’s life in an emergency. The physician’s summons, then, is itself evidence of a midwife’s clinical decision-making and authority of admission. When, in 1847, Dr. Kollack admitted that the obstetric cases he was writing about were “pretty well advanced before I was permitted to see them” to the readers of *The Southern Medical and Surgical Journal*, he testified to the midwife’s

power to regulate who stepped into her birthing room well into the 19th century. It was when the midwife deemed the physician’s presence necessary that he was called.\textsuperscript{195}

But more can be gleaned from each case’s transfer from midwife to physician, because before the physician arrived, the birthing room, the patient, and the patient’s treatment were all explicitly the midwife’s domain. When plantation physicians wrote about treating women’s births, the rooms they described, the situations they found, and the patients they encountered were literally primed by a midwife’s work and care. By analyzing the moment of transfer between midwives and physicians, we may understand the ways in which midwives treated their patients and presented their cases to the interceding physicians.

The first paragraph of Dr. Bailey’s “Obstetrical Cases” simply summarizes the report from the attending midwife:

“June 20th, 1858. Delia, a negro woman, aged 40, the mother of several children, was taken in labor early in the afternoon. About sunset, the membranes ruptured, and she was delivered of an infant that presented in the ordinary way. In a very few minutes after, pains came on and the arm of a second child presented, which the midwife tried to extricate by traction, hoping to expedite the labor in this way, and thus wedging the arm and shoulder in the inferior straight of the pelvis, and adding to the difficulty. Finding the uterine contractions continuing with redoubled violence, and no progress being made, I was summoned in haste and found the patient in the condition above described.”\textsuperscript{196}

Through Delia’s midwife’s report to Dr. Bailey, he learned the birth history of his patient, the near exact timing and strength of her labor, the exact position of the fetus, what interventions were attempted and why, and the midwife’s estimation of the case: dire. With that in consideration, Dr. Bailey proceeded with an intervention opposite to the midwife’s: he pushed the arm back into the uterus then pulled the child out by its feet. Dr. Bailey scorned the midwife

\textsuperscript{195} P.M. Kollock and Ignatius Poulney Garvin, “Case of Traumatic Tetanus Cured by Strychnine,” \textit{Southern Medical and Surgical Journal} 3 (1847): 600.

\textsuperscript{196} T. P. Bailey, “Obstetrical Cases,” \textit{Atlanta Medical and Surgical Journal} 6, no. 2 (October 1860): 87–90.
and praised himself for the above interventions, but what he fails to recognize is that his care was built on her treatment. He did not work independently of the midwife but upon her practice.

An anonymous letter to the editor of the *New Orleans Medical News and Hospital Gazette* published in 1858 pondered the meanings and medical theory surrounding a birth presentation of the “left hand and right foot.” Here, the physician walked in on a days long labor:

“At 3, P.M., Thursday, October 3rd, 1850, I was called to visit a negro woman, the property of Mr. B. S., of Yazoo Co., Mississippi. The woman had been in labor since Sunday, the 30th September, nearly ninety-six hours. I was informed by the attending midwife, that her labor had been very hard and constant since about midnight of the 30th ult., until 10 o’clock, A.M., of the day on which I saw her. The patient was the mother of four children, and had no difficulty with any of her former labors.”

For four days, this patient and midwife had been in a room together managing a “hard and constant” labor that would not end. Whether the midwife or the patient told the physician about her past labors can’t be known, but it is quite likely that they managed those labors together. As he pontificated on the proper treatment, the physician considered that “(according to the midwife’s testimony)” the labor had been strong for three days. Though his parentheticals snidely doubt the midwife’s expertise, he used her testimony productively. It was upon the specifics of the midwife’s testimony that the physician made his clinical decisions. Her presentation dictated his practice.

Midwives not only called physicians into birthing rooms, they shaped the cases which they presented to physicians. When Dr. Overton reflected “upon the phenomena furnished by the case,” he was considering not only the physical body of his patient, but the way that her midwife had treated her and accordingly presented the facts of the case to the physician. The ephemeral “phenomena” are defined by the work, practice, clinical care, and estimations of the midwife.

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She “furnished” the birthing room with not only her medicine but also her values. Her presentation frames the physician’s understanding of the patient’s condition and personhood, the treatments with which she began the case grounded the treatments that came next, and her continued presence in the birthing room testified to her continuous care.

Dr. Withers’ published “Case of Eclampsia” further evidences the resilience of the midwife’s values in the physician’s birthing room. Dr. Withers published this case summary to the *Western Journal of Medicine and Surgery* in 1854. Despite the cool and scientific violence of Dr. Wither’s description of a mother and child’s death, the centrality of the midwife’s testimony brings her emotional care into the physician’s biomedical practice. Dr. Withers’ description of his patient is reminiscent of a slave auction advertisement: “The patient was a negro girl, aged twenty-two years, primipara, stout, athletic, and had been subject to convulsions when a child.” Her physical strength and history of seizures adds intrigue to his medical analysis. He presented the case through the midwife’s presentation to him: “I found in attendance an old lady, from whom I learned the following facts.” This “old lady’s” presentation was methodically detailed in timing and strength of contractions, but emphasized the importance and effectiveness of emotional care:

> “She was taken with premonitory labor pains about 2 o’clock, A.M., which progressed regularly and naturally, with the exception of at times an expression by the patient of impatience, restlessness, and foreboding of evil to happen during her confinement. But by diverting her attention she would become lively and talkative.”

There is pride in this midwife’s report – her ability to lighten her patient’s mood in the face of fear is as central to her practice as contraction time keeping. When the convulsions began, the midwife continued to define health in emotional terms: “about this time she was attacked with a convolution, lasting from one to two minutes, followed by a complete aberration of the mental

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faculties, not being able to recognize her parents.” This patient’s parents were in the birthing room with her. They watched her convulse with seizure and contract with pain. This midwife’s testimony brought their support and witnessing into the medical record; she brought kinship and its emotional uplift, support, and embrace into a physician’s cold clinical notes. What’s more, she re-casted her patient from an object of study and property to a person with pain and parents. The midwife’s testimony forced the physician to consider her patient’s humanity.200

Midwifery Knowledge Underwrites the Emerging Field of Gynecology

The same wonder and medical interest that physicians applied to enslaved people’s bodies was also applied to their health practices. When Dr. Morgan wrote to the Nashville Journal of Medicine and Surgery that “the remedies mostly used by the negroes to procure abortion are the infusion or decoction of tansy, rue, roots and seed of the cotton plant, pennyroyal, cedar berries, and camphor, either in gum or spirits,” he was not only reporting to planters for their policing of enslaved women’s birth control habits, but also to fellow physicians to enhance their pharmacopedic knowledge of emmenagogues. As emmenagogues stimulate uterine contractions, they can be used either as abortifacients or to strengthen or start labor. They are essential drugs for the practice of medical midwifery. Morgan was upfront about his source: “old women.” It is likely that the old women he consulted – those he expected to be knowledgeable about gynecological herbalism – were themselves midwives. He cited these women not only for the herbs used, but for the specificities of their uses – rue is a more effective emmenagogue than tansy and the cotton plant “is habitually and effectually resorted to by the slaves of the South for producing abortion, and they think it acts in this way without injury to the

general health.” Morgan corroborated these findings with experimental results from the U.S. Dispensatory; doing so added scientific weight to the women’s clinical knowledge and offered a way for Dr. Morgan to take ownership of the knowledge he shared in the name of the state.

Physicians did not practice obstetrics with a disregard for the practices of midwifery. Their use of midwifery knowledge proves as much. Indeed, the lackadaisical mining of midwifery knowledge began early. In 1798, in the third issue of *The Repository*, Dr. Archer of Harford Town, Maryland recorded not only a midwife’s full case report when handing off her patient for surgical intervention, but also the treatment she used 15 years prior for the patient’s prolapsed uterus – it “was washed in a strong decoction of white-oak bark and dusted with powdered resin” then reduced back into place. The midwife’s notes do not substantially add to the narrative of his “Case of Difficult Parturition Successfully Treated,” but they do helpfully edify his audience on medicinal treatments for “prolapsus uteri.”

Dr. Heard of Galveston, Texas similarly educated his readers when he recorded and printed a plantation midwife’s infant care practice. He offered his readers a snippet of her clinical knowledge: “I was told by the midwife…that she had given it (according to her custom) one grain of calomel.” The inclusion of the parenthetical “(according to her custom)” assures the reader of the regularity – and therefore safety and usefulness – of this midwife’s practice. By printing midwives’ clinical customs for an audience of fellow physicians, Dr. Morgan and Heard textualized a practice already in place between physicians and midwives: that of mining midwifery’s pharmacopeia and treatments for use by physicians in an aggrandized medical

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202 Thomas Archer, “Article III.: A Singular Case of Difficult Parturition Successfully Treated,” *The Medical Repository of Original Essays and Intelligence, Relative to Physic, Surgery, Chemistry, and Natural History (1797-1800)* 1, no. 3 (February 1, 1798): 333.
setting then broadly circulating that knowledge as accessible expertise pried out of its communities and traditions of origin.

As such, the practices of obstetrics were the practices of midwifery. When Dr. Overton “determined to turn and deliver the fetus” in Tennessee in 1842, he completed a manipulation that had been performed by midwives for centuries. Whether he learned it from a midwife or not, turning babies was essential to midwifery and, at some point, was transferred and taught to physicians. Obstetrics did not usurp midwifery in the birthing room; it appropriated it.

**Conclusion**

Every midwife analyzed above was an authoritative force of health and care that physicians had to contend with in order to practice on plantations and further their careers. Dr. J. Marion Sims reckoned with the power of midwives early in his career. As he stated for his memoir: “This old nurse seemed to scrutinize me, and very particularly watched everything I said and did. Nothing escaped her, and I felt very uncomfortable in her presence. I wished that she had never come there.”

This “old nurse” and her colleagues watched closely as physicians took up their inherited practices with masculine and professional authority. They saw their framings and thoughts used, reproduced, and mass produced; they watched the practices and power of midwifery bastardized onto the medical profession.

Victoria McMullen of Little Rock’s grandma Katy was a midwife in South Carolina, Louisiana, and Texas in the mid 19th century. She was known to her community for her work.

“She was a practical nurse as they call it, but she did more of what some people call midwife…That is what she was even in slavery times. She worked for colored people and white people both…She treated women and babies. They said she was a real good doctor in her day.”

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204 Sims, *The Story of My Life*, 142.
Victoria held pride in her grandmother’s status as a practitioner for “colored people and white people both.” What’s more, she qualified Katy as a “real good doctor” rather than a “real good midwife.” These distinctions evidence a generations-long understanding that much of midwifery was “doctoring” and much of doctoring was midwifery.
Conclusion

A midwife’s epitaph, published in a series of “Poetical Essays” in the *Boston Magazine* in 1786 synthesizes where I stand:

“Here lyeth a Midwife brought to bed,
Deliveress, delivered;
Her body being churched here
Her soul gives thanks in yonder sphere.”

America’s historical midwife has passed and gone, but she is “churched” in her descendants, her lineage of care, and our written celebrations of her form. Her deliverance is an ethic of community and care. Her practice was touch, expertise, support, advocacy, and embrace. Her memory is a testament to the broad social power of women’s cultures and the authority therein.

The African American midwife’s moniker, ‘Granny,’ is entirely appropriate. The midwife was, like the grandmother is, grand. She was an elder with matriarchal and matrilineal authority which emanated out of her birthing room and into her society writ large. Her motherwork generated and regenerated women’s cultures. As obstetrics took on and bastardized that grandness, we lost the formulations of birth as social and cultural and birth workers as intimate community-based practitioners who held their patients through pregnancy, birth, lactation, loss, death, justice, and joy.

As women have reckoned with their own dissatisfaction with America’s medical birthing system, the midwife has experienced a cultural resurgence – in the historical field as well as popular culture. The feminist movement of the 1960s and 1970s first begot this rebirth, and the

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use of midwives has grown steadily since then. The early 2000s and the COVID-19 Pandemic each saw spurt in the growth of institutionalized midwifery care. In 2015, of the 3,978,497 total births in the United States, 371,504, or 9.3% were delivered by a midwife of some kind.208

The practical and theoretical descendants of the midwives discussed throughout the thesis would today be called “traditional birth attendants” – those practicing without formal education, according to indigenous birth customs within their own communities. Most TBAs today are Black Granny midwives in the rural South. Although they continue to practice according to the ethics and honors illuminated in this thesis, their lack of formal accreditation excludes them from institutional medical practice and recognition.209 Certified nurse midwives are registered nurses who’ve received additional training and accreditation in perinatal care from the Accreditation Commission for Midwifery Education started in 1957.210 Certified Midwives take the same examination as Certified Nurse Midwives, but are not nurses and are instead trained in separate schools or through apprenticeships. They can only practice in a handful of states. Certified professional midwives hold a graduate-level midwifery degree; they can practice in 34 U.S. states.211 85% of all accredited midwives are white.212

Yet, the popular image of a modern midwife – a white woman with a yoga ball and kiddie pool who espouses essential oils over pharmaceutical pain management – as well as her biomedical role – an extra practitioner whose care is opted into at the end of pregnancy – is discordant with the historical figure illuminated in this thesis. Early American midwifery was not

209 Rooks, Midwifery and Childbirth in America, 7.
without faults; some midwives were quacks, not all midwives were kind advocates for their
patients, and all actors would have benefitted from antibiotics and comprehensive pain
management. But the historical midwife’s vision of care – continuously offered,
community-sourced, and women-centered – is radically and productively whole. That structure
and ethic of midwifery should instruct our current imaginations for the future of American birth
care. As this thesis proves, that structure was fundamental to all aspects of social and political
life for women in early America.
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