
Megan Bowes
A CASCADE OF INTERVENTION? LEGISLATING MIDWIFERY IN FLORIDA, 1920-1992

By

MEGAN BOWES

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The members of the supervisory committee were:

Kristine Harper
Professor Directing Thesis

Suzanne Sinke
Committee Member

Maxine Jones
Committee Member

The Graduate School has verified and approved the above-named committee members, and certifies that the thesis has been approved in accordance with university requirements.
For my brother Matthew
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ABSTRACT

In the late-nineteenth and early-twentieth centuries, midwives in the South—generally older African-American women—maintained traditional birthing customs while assisting disadvantaged women in their communities. By the early-twentieth century, most upper-class white women were giving birth in hospitals while attended by physicians. As social reform programs began to develop during the early 1920s, social welfare agents and public health officials advocated for the regulation and education of midwives, who, the former believed, were unfit for infant and maternal care. With funds from the federal Sheppard-Towner Act of 1921, Florida began implementing programs to assess practicing midwives’ professional and moral fitness. A decade later, the Florida legislature passed the 1931 Midwife Act, which established training requirements and licensure for midwives. As a result, midwifery-training classes were established at Florida A&M College in Tallahassee and at locations in Tampa and St. Augustine. Some historians contend that the motive behind state agencies developing these programs was to eliminate midwifery as an occupation. In some instances, they may be correct. However, a further examination of how these programs—developed with the assistance of white public health nurses—trained a small number of midwives to assist women across the state with child birth needs a closer examination.

With medical advances in the twentieth century, very few Florida women sought the assistance of midwives. However, the growth of the alternative birth movement in the 1970s brought midwifery back to the forefront of discussion concerning who would provide medical services in Florida. As the alternative birth movement gained ground, Floridians who wanted to obtain midwifery licenses formed a grassroots efforts to influence the legislative process. They not only helped to craft the Midwifery Practice Act (1982), but the Midwives Association of
Florida also developed a three-year training program for women who wished to gain licensure. Using legal documents and the voices of women who participated in this movement, I argue that it was through their efforts that Florida’s 1931 midwifery law came to be revised, and midwifery once again became a legal, viable option for Florida women seeking assistance with a routine birth.
CHAPTER ONE

INTRODUCTION

For most of human history, women administered and controlled the birthing process, while men rarely ventured into birthing spaces. During the Middle Ages, European women were often healers and members of their local communities sought their medical expertise and assistance. Their presence during childbirth provided support for the mother and the gathering provided an “educative function” that allowed midwives to acquire knowledge about the processes of childbirth.¹ Most women involved in midwifery gained practical experience by observing and assisting neighbors’ births or assisting other midwives throughout the lying-in period.² During the Renaissance, new developments in scientific enquiry saw pregnancy included in studies of human anatomy. As scientific discoveries about anatomy were introduced into medical training programs, which were only available to upper-class men, male physicians began to have more contact with the birthing process. As medical schools and training programs were established throughout continental Europe during the fifteenth and sixteenth centuries, “midwives came under control of the church and were affected by the Inquisition in some parts of Europe.”³

For the English Church, the focus on controlling midwifery stemmed from two concerns: baptisms and potential witchcraft practices. Particularly in cases where infants might not survive,

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² The lying-in period was a social and cultural custom in which the mother kept to her bed for about thirty days and was only visited by female friends and relatives. For an extensive view of the lying-in period see, Adrian Wilson, “Participant or Patient? Seventeenth Century Childbirth from the Mother’s Point of View,” in *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*, ed. Roy Porter (Cambridge: The Cambridge University Press, 1985).
bishops wanted to ensure that midwives were properly instructed to perform baptisms on infants when priests were unavailable. If there were any chance that midwives might be using witchcraft and magic while assisting in a delivery, the Church wanted to keep a watchful on them.\(^4\) Church rules required midwives to take an oath swearing “to be diligent and faithful and ready to help every woman labouring with child, as well as the poor as the rich; and...in time of necessity [not to] forsake the poor woman to go to the rich.”\(^5\) Once they took the oath, midwives were legally able to practice their craft, but they could not use traditional herbs and oils.

Although midwives were unable to attend medical schools in Europe, that did not mean they were not qualified to assist births. As the population began to grow, concerns about infant mortality rates and the skills of birth attendants caused many European countries to develop midwifery courses in attempt to improve their skills.\(^6\) In Paris during the sixteenth century, authorities passed a statute regulating midwifery. As a result, midwife applicants had to pass an examination and provide a character witness.\(^7\) Similar statutes began to appear in other countries, and professional midwifery spread rapidly throughout continental Europe.

Until the eighteenth century, women dominated the birthing chamber and men held limited roles assisting childbirth due to sexual propriety. Midwives did not have a monopoly over the occupation and at times, due to medical improvements, surgeons—not necessarily physicians—assisted with childbirth. Historian Mary Lindemann argues in *Medicine and Society in Early Modern Europe*, that the improvement of midwifery education and training was not aimed at suppressing or dismantling the occupation of midwifery. On the contrary, male

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\(^5\) Ibid., 12.
physicians and surgeons only wanted to “control midwives, not displace them.” The introduction of obstetrical forceps by Peter Chamberlen in the early-seventeenth century greatly influenced the role played by males in the delivery of babies. Initially kept a secret for more than a century, forceps allowed surgeons and male-midwives to swiftly deliver the fetus during a difficult delivery, which in turn saved the lives of both mother and infant.

According to historians Richard W. Wertz and Dorothy C. Wertz, the transition from female attended deliveries to the inclusion of male physicians was a turning point in early American medicine. Women in the British colonies of North America during the eighteenth century typically relied on female midwives during labor. Female relatives and friends provided emotional support during and after the birthing process in what the Wertzes call “social childbirth.” In Lying In: A History of Childbirth in America, the Wertzes examine the social relationships between women and their midwives, the professionalization of medicine, and the shift from female-controlled experience to a male-controlled one. The representation of much of the experiences of childbirth in early America was romanticized and “birth continued to be a fundamental occasion for the expression of care and love among women.” Although birth was a social gathering, it was not always a calm and joyful experience. The Wertzes and other scholars have noted this distorted view of childbirth in early America. It is misleading to view childbirth

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8 Lindemann, Medicine and Society, 117.
9 Ibid., 114. Although the use of forceps by male-midwives and surgical physicians helped delivery, there is extensive research on how the use of forceps became a dangerous tool used on women during childbirth. See Richard W. Wertz and Dorothy C. Wertz, Lying-In: A History of Childbirth in America (New Haven, CT: Yale University Press, 1989); Donegan, Women and Men Midwives.
10 Wertz and Wertz, Lying-In, 29.
11 Ibid., 6.
as a jubilant occasion because many women feared delivery because of the very real possibilities of death or serious injury, and that fear played a role in changing traditional birthing methods.

By the mid-eighteenth century, the medical training developed in Great Britain influenced a growing number of American men. Men who went to England for medical training came back and “well-to-do families, especially the urban elite, soon came to believe that physicians provided better care than was possible with female midwives and thus offered the best hope for a successful birth.” Male midwives had already been practicing in England during the previous century and were becoming more acceptable to members of upper-class society. In the United States during the mid-nineteenth century, scientific attitudes toward women attempted to address the “woman problem” as societal norms implied that the advancement of women’s education was harmful to their health and they were no longer competent to make medical decisions. Janice Law Trecker argues in “Sex, Science, and Education” that once medicine became a science and medical knowledge became masculinized, midwives “were driven from the field by professionally educated male practitioners.” The examination of scientific attitudes of upper-class urban American women is important because it shows the gradual transition from a female-driven experience to a male-controlled one.

Historian Judith Walzer Leavitt explains that although there was a gradual shift toward physician-assisted births in the mid-nineteenth century that does not mean it was a safer alternative. Medical education in obstetrics began to expand in the nineteenth century, and the use of forceps and drugs promised women a safer and less painful childbirth experience; however, physicians continued to intervene in the birthing process. Levitt notes that “similar

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15 Ibid., 89.
maternal mortality rates for midwives and physician-attended births indicates that physicians, with all their expertise and intervention techniques, did not, as they had promised, enhance the safety of the birth experience for women.”

The promise of new obstetrics provided a minority of birthing women—usually located in major cities and of high socioeconomic stature—with childbirth alternatives, but not necessarily safer ones in the absence of aseptic procedures.

During the twentieth century, anti-midwife campaigns appeared throughout the United States, labeling midwives as ignorant and claiming that their techniques were unsanitary. Epidemiologist Judith P. Rooks notes that two “titans” of twentieth-century obstetrics, Dr. Joseph DeLee and Dr. J. Whitridge Williams, spurred the midwife debate, which lasted from 1910 until 1935. Williams participated in the American Association for the Study and Prevention of Infant Mortality (1910) to determine the standards of obstetrics in the United States. As a professor of obstetrics at Johns Hopkins University, Williams mailed a questionnaire to every four-year medical school in the United States and Canada to gather data on midwifery. After analyzing the completed and returned questionnaires, he concluded that most medical school professors lacked training in obstetrics. Dr. DeLee, head of Obstetrics at Northwestern University and author of a widely used obstetrics textbook argued, childbirth is a pathologic process from which “only a small minority of women escape damage.” Rooks argues that the existence of midwives seemed to insult obstetricians in America, noting that William believed that, “If an uneducated woman of the lowest classes may practice obstetrics, is instructed by doctors and licensed by the State, it certainly must require little knowledge and skill—surely it

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16 Leavitt, “Science Enters the Birthing Room,” 292.
17 Rooks, Midwifery and Childbirth in America, 24.
18 See Rooks, Midwifery and Childbirth in America, for all of the statistical data.
19 Ibid., 25.
cannot belong to the science and art of medicine.”  

It is within this competing view of what constitutes medicine that obstetricians such as Williams and DeLee became involved in the campaign to eliminate midwifery.

During the early Progressive Era, eugenics approaches to “social and economic reforms were popular, respectable, and widespread.”  

Eugenics principles and racial animosity fueled the blaming of midwives for high maternal mortality rates. Historical literature about black midwives contains many references to eugenics. Although the high infant and maternal mortality rates could have been attributed to the unskilled and unsanitary techniques of a midwife, economic and social status was not considered for these high rates. The debate surrounding the occupation of midwifery continued well into the twentieth century with many medical professional and public health workers advocating for the training and licensing of midwives.

As the shift from midwife to medical professional became the dominant view in society for upper-class and middle-class Americans, many began to see childbirth as a “complicated and dangerous procedure that demanded the services of highly trained medical professionals.” Although the idea of physician-assisted births became popular in the early twentieth century, many African-Americans, immigrants, and poor women still relied on midwives to attend births. According to historian Judy Barrett Litoff, most women who were not of a high economic status could “not afford to pay the high fees of physicians and they were opposed to entering lying-in

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20 Ibid., 26.
22 Ibid.
charities where they were allegedly subjected to obstetrical interference and experimentation.”

In addition, many women felt more comfortable with midwives because they were part of a birthing tradition with which they were familiar, and they provided much needed support after childbirth.

In her article, “The Midwife Throughout History,” Litoff notes that two major developments during the early-twentieth century brought significant attention to these childbirth attendants. According to Litoff, physicians grew increasingly concerned about medical education reform in regards to overcrowding within the profession, which contributed to a decrease in their income. Furthermore, physicians became aware of the disturbingly high maternal and infant mortality rates in the United States. These two developments brought the “midwife problem” to the forefront of the childbirth debate.

Historian Frances E. Kobrin developed four categories of how society perceived the “midwife problem.” These categories reflected societal and medical profession opinion on midwifery education during the Progressive Era when programs for lay midwives were developing. The first viewpoint advocated the immediate abolition of midwives with legal prosecution for any who decided to continue their practice. Second, Kobrin argues that many within the medical community agreed with the eventual abolition of midwives—with careful regulation of those who still practiced—until a sufficient number of physicians had been educated to take their place. A third group claimed that professionals wished to educate U.S. midwives until they reached the capabilities of British and European midwives; and lastly, a group that thought that if midwives could be trained to wash their hands and use silver nitrate

25 Ibid., 8.
26 Wertz, Lying-in, 5.
28 Ibid.
drops for the treatment of gonorrheal ophthalmic, then no more should be expected. These four viewpoints represent the societal perspectives of the time, with the first two appearing to be the most accurate descriptions of attempts to regulate midwives.

In “The Granny Midwife: Changing Roles and Functions of a Folk Practitioner,” Beatrice Mongeau takes a southern United States perspective as she examines older women who served as midwives. She writes:

When a practice such as midwifery is viewed on a national basis, it appears peculiar to the South. But when the focus is narrowed to the South, the practice then becomes a phenomenon-finding expression in its rural regions. If the focus is still further narrowed, the practice becomes characteristically that of rural areas to which is added the presence of non-white peoples. And then, if we examine rural southern areas in which non-whites reside, the practice is still further narrowed and becomes the dominant characteristic of rural southern areas where the number of non-white residents exceeds that of white residents.

In Chapter Two, I start my examination of midwifery by branching off from Mongeau’s assessment of southern midwifery. The controversy surrounding Florida midwives continues to be addressed in the historiography, particularly in the work of Debra Anne Susie and Mary Pugh Mathis. The debate surrounding the developments of midwife institutions by Susie argues that these education programs were not created to further the black midwives’ educations, but rather

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to gain government control and dismantle the occupation. Conversely, Mathis argues that the modernization of state policy institutionalized lay midwifery in Florida.

The large number of archival sources and interviews with lay midwives in Susie’s dissertation, “In the Way of Our Grandmothers: A Socio-Cultural Look at Modern American Midwifery,” provide an overview of the state’s role in eliminating midwifery. Susie argues that because African-American midwives compromised with the state by participating in the Florida Midwife Program, this ultimately “led to replacement of the traditional lay midwife with the modern-nurse midwife.”

32 In her dissertation, “Lay Midwifery in the Twentieth Century American South: Public Health Policy and Practice,” Mary Pugh Mathis argues that although scholars have begun to study state policy on southern midwives, they have not examined how the role of the state “may have played in the institutionalized and persistence of the practice.”

Using Florida as a case study, Mathis demonstrates that contrary to popular scholarship—specifically Susie’s assessment of Florida midwifery—that southern black lay midwifery was embedded in the demographic, economic, and political changes taking place in Florida.

34 I argue that instead of killing off midwifery, the Midwife Act of 1931 ultimately allowed it to continue to flourish—although at a reduced level and only in rural Florida areas—until the mid-twentieth century.

Chapter Three discusses the legislative measures taken by the State of Florida in 1982 as it attempted to impose new regulations on midwives seeking licensure. Providing a modern perspective on midwifery, Robbie Davis-Floyd and Elizabeth Davis offer a new theoretical framework of analysis by arguing that there had been a transformation among midwives. Using the term “postmodern midwifery,” Davis-Floyd and Davis argue that this label encompasses

34 Ibid., 36.
“midwives who are educated, articulated, organized, political, and highly conscious of both their cultural uniqueness and their global importance.”

Essentially, the postmodern midwife advocates for traditional birthing techniques while accommodating other medical systems of care. In addition, the postmodern midwife becomes “hyper-educated in the science of obstetrics so that they can both defend themselves against legal persecution by the medical establishment and work to change the laws that keep them legally marginal.” This distinct approach is relevant to this discussion of the contemporary midwives in Florida who rallied together to formally legalize midwifery. Recognizing that by being an organized political group they could inspire change, Florida midwives thus represent the “postmodern midwife.” By using this idea of the “postmodern midwife,” this chapter fits into the larger historical discourse by analyzing state intervention against the modern midwife.

Expanding on the argument of state intervention, Chapter Four focuses on the development of two midwifery schools established in north and south Florida, their eventual closing, and the reestablishment of midwifery schools under a variety of auspices in the late-twentieth century. Since that time, midwifery has seen a resurgence in Florida, as women have sought additional choices to meet their needs during routine childbirth.

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36 Ibid.
I was plowing in the field, plowing cotton, when a voice within told me he wanted me to be a midwife, to take care of mothers and babies. The Lord showed me just how it was to be done.\textsuperscript{37} 

–Northern Florida Midwife

In the late-nineteenth and early-twentieth centuries—up until approximately 1925—midwives in the South were generally drawn from among African-American women. For many of these women, the choice to become a midwife was easy; after witnessing family and friends assist others in childbirth, they saw this profession as a calling. In the late-nineteenth century, however, not all midwives looked upon their work as an occupation. Some believed that it was God’s will that called them to “catch babies” and help women through the perils of childbirth. Lay midwives—typically older black women, no longer of childbearing age—traveled throughout rural communities providing maternal services with what few resources they had available, the majority serving black and white women of low socio-economic status. Midwives accepted the role of a birth assistant for reasons beyond those tied to family or divine intervention, the social milieu of the time playing a major role in their decision as well. Disadvantaged women in the South found it extremely difficult to obtain adequate medical assistance, often due to their race or economic situation. Because medical professionals were unwilling to provide care, the midwife became a dominant force in southern society. Physicians

rarely, if ever, attended to poor women living in rural areas. According to historian Kelena Reid Maxwell, segregation laws and racial animosity made it improbable that white physicians would attend to rural black women. Therefore, medical professionals who considered granny midwives a “necessary evil” tolerated them because of the lack of—and presumably refusal of—physicians to care for poor black women. Midwives specifically tended to African-American and white women of lower-income communities, while physicians tended to wealthy and middle-class white women. As medicine became more professionalized in the early twentieth century and physician-attended births in hospitals became popular among upper- and middle-class women, the midwives were left to provide for women from the lower- and working-classes and for indigent women with no resources.

Since its founding in the mid-nineteenth century, the American Medical Association (AMA) had pushed for the professionalization of the nation’s medical education institutions, which relied on three disparate models of learning that did not share consistent standards. The three models of learning included “an apprenticeship system, in which students received hands-on instruction from a local practitioner; a proprietary school system, in which groups of students attended a course of lectures from physicians who owned the medical college; or a university system, in which students received some combination of didactic and clinical training at university-affiliated lecture halls and hospitals.”

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education reform as a public health measure.\textsuperscript{40} As medical education standards were tightened as a result, physicians actively worked to prevent “non-professionals”—including lay midwives—from providing needed medical services even when there were not enough trained physicians willing or able to fill the needs for child birth services.

While the midwives filled a vital role for many poor women in the South, predominantly white medical professionals did not welcome their efforts. As Florida’s state health officials began to ponder how they might reduce the high maternal and infant mortality rates—in 1924, Florida had 81.8 infant deaths and 12.1 maternal deaths for every 1,000 births, among the highest in the nation—they often attributed the maternal and infant deaths to the “midwife problem”: the role of uneducated black women as midwives.\textsuperscript{41} The tensions surrounding how best to curtail birth-related high mortality rates and the ongoing efforts to professionalize medical education led to the debate over educating midwives—a discussion that dominated public health discourse in the early part of the twentieth century.\textsuperscript{42}

Beatrice Mongeau’s dissertation, “The ‘Granny’ Midwives: A Study of a Folk Institution in the Process of Social Disintegration” (1973), was the first of a number of studies to tackle the controversy surrounding the roles of Florida midwives—studies that were continued by sociologists Debra Anne Susie and Mary Pugh Mathis. Extant historiography argues that midwifery educational institutions were not created to further the training of black midwives, but rather to simultaneously exert governmental control over midwifery practice and to undermine the occupation. Taking a different approach, I will examine the origin of the “midwife problem,”

\textsuperscript{40} Ibid., 2139-2140.
and how the state’s role in introducing legislative measures related to midwifery ultimately strengthened midwifery practice, thereby decreasing maternal and infant mortality rates.

**Regulating Midwifery**

Federal and state regulations played a tremendous role in establishing and implementing educational programs for black midwives. Before the early 1920s, lay midwives faced little regulation, and Florida had no laws prohibiting a midwife from practicing even if she had not registered with the state nor been properly trained. But that changed with the passage of the federal Sheppard-Towner Act. Formally known as the Federal Maternity and Infancy Act of 1921, it became the first federal matching-grant health program when the federal government matched “state expenditures on infant and maternal health programs on a one-for-one basis up to an explicit cap determined by a state’s population.” From a feminist perspective, the Sheppard-Towner Act was an important legislative measure because it was the first one that focused on women after they had secured the right to vote. Leading feminist activists, such as Montana’s Jeannette Rankin—who had been the first woman elected to Congress in 1916—as well as Julia Lathrop and Grace Abbott—social reformers who had previously worked at the Hull House—were strong supporters of the Sheppard-Towner Act, as were the League of Women Voters and the General Federation of Women’s Clubs. Appointed chief of the newly formed Federal Children’s Bureau in 1912, Julia Lathrop had worked tirelessly tackling issues regarding infant mortality and poor nutrition until 1921. Grace Abbot then replaced Lathrop as chief of the Children’s Bureau, and enforced and administered the Sheppard-Towner Act. Although the act’s


terms only lasted until 1929, the actions of these individuals and organizations on behalf of women and children demonstrated that the women’s movement remained relevant after suffrage.\(^{45}\)

Although the Sheppard-Towner Act was a permanent law, its appropriations were set to expire on June 30 1927. Proponents of the act, including social welfare activists and Florida nurses, played a pivotal role in efforts undertaken to extend the appropriations for another two years, but opponents, who labeled it as “communist,” were able to block the extension.\(^{46}\) During its short life, however, Lathrop and Abbott both played critical roles in executing the related educational programs.

Created to promote the welfare of mothers and infants through nutrition and hygiene instruction, the Sheppard-Towner Act provided funding to states for the creation of their own maternal and child health services. However, women could not receive care through its programs until their state had passed appropriate legislation, including a “plan for implementation,” that would make it eligible for funds.\(^{47}\) The United States House Committee on Appropriations agreed to support a fiscal year 1923 budget of $1,240,000 ($16.5M in 2012 dollars) for the promotion of welfare and hygiene related to maternity and infancy. The federal government distributed $240,000 (approximately $3M in 2012) among the states, each of which received $5,000 (about $66K in 2012) if it had designated a competent state authority to accept the funds.


\(^{47}\) Molly Ladd-Taylor, “Grannies and Spinsters,” 258.
The remaining one million dollars apportioned among the states covered a variety of expenses.\(^{48}\) State health agencies received funding for mothers and children in the name of the “midwife problem,” rather the economic and social conditions that ultimately led to poor health.

Numerous political groups—including “anti-suffragists, states’ rights advocates, anti-communists, and the American Medical Association (AMA)”—condemned the Sheppard-Towner Act.\(^{49}\) A letter to the editor of the *New York Times* claimed that “the supporters of the Sheppard-Towner Act were the same people who were ‘preaching birth control’ and whose mission was to ‘weaken our country.’”\(^{50}\) The AMA steadfastly argued against the act’s implementation because many within the medical community thought that the social measures it included were not within the federal government’s purview. A 1921 editorial in the *Journal of American Medicine* read: “the care of mother and child is a state and local, not a federal function…it is not the function of the federal government to provide either food or care.”\(^{51}\)

Although highly contested, the Sheppard-Towner Act brought national focus to growing maternal and infant mortality rates. Florida’s infant and maternal mortality rates prior to the implementation of the Sheppard-Towner Act do not appear in federal records; perhaps the state was not required to collect this information at the time. At the time of its passage, Florida had one of the highest maternal and infant mortality rates in the nation, and yet social reformers were unable to get a bill through the Florida legislature that would have required the training and licensing of the midwives who were delivering many of the state’s babies. For example, within a


\(^{49}\) Rodems et al., “Children’s Bureau,” 361.


decade prior to the act’s passage, Dr. C. E. Terry—the municipal health officer of Jacksonville, Florida—had expressed his disdain for granny midwives, arguing that their continued service was detrimental to the health of the community.\footnote{The term “granny” coined for the southern black midwife encompassed the stereotypes of being insane, ignorant, and uneducated. The use of this term forever followed black midwives, and they were unable to separate themselves from it.} During an American Public Health Association conference in 1912, Terry—using his own records noting mortality rates in Jacksonville—had attributed high stillbirth rates during 1910 and 1911 to the “Negro midwife.”\footnote{Dr. C. E. Terry, “The Negro: His Relation to Public Health in the South,” American Journal of Public Health 3, no. 4 (1913): 303.} Similarly, he held them responsible for “the prevalence of puerperal sepsis (uterine infections) and neonatal ophthalmia (blindness due to prenatal infection with gonorrhea).”\footnote{Barbara Ehrenreich and Deidre English, Witches, Midwives, and Nurses: A History of Women Healers (New York: The Feminist Press, 2010), 34.}

In Jacksonville between 1910 and 1911, 17.52 percent of all black births were stillbirths compared to 7.49 percent of white births. Data on birth attendants for the same period show that black midwives attended 51.7 percent and physicians attended 48.3 percent of all births. The stillbirth rate in the physicians’ practices was 8.6 percent and in the midwives’ practices it was 16.11 percent, almost twice the physicians’ rate.\footnote{Terry, “Public Health in the South,” 303.} According to Dr. Terry, this toll fell most heavily upon the “Negro babies, as they [were] nearly all attended at birth by midwives.”\footnote{Ibid.} He argued that the granny midwives deserved the blame for these statistics:

Here again, the evil of the midwife or "granny" are due notice. These women, for the most part are old and infirm and as wholly ignorant of the requirements of their avocation as they are devoid of responsibility and honesty of purpose, delight to force their way to the sick beds of their people, and ply them with worthless concoctions, entirely contented if, by hook or crook, they are able to prevent the calling of a physician. They plan successfully, upon the superstitions of their race and before even the more intelligent see
the gravity of the situation and summon a physician, the time for hope of successful intervention is too often past.\textsuperscript{57}

Rituals used by lay midwives were extremely important in the birthing process in the communities that they served, and their acceptance by mothers led professionals like Terry to question the education and professionalism of black midwives. Folk recipes and mystical experiences were part of southern black culture, especially during birth. Midwives used rituals to treat various ailments during and after childbirth, but their use of these customs exacerbated the professional medical community’s dim opinion of them.

In 1922, Florida had over 4,000 midwives, and in 1929, the state claimed that 3,000 of these women had been considered “physically unfit or of such mentality that they were incapable of receiving instruction,” and had left midwifery.\textsuperscript{58} In 1923, the State Board of Health had created a “certificate of fitness program” through which midwives from across the state were assessed by medical professionals who would declare them “fit” to practice.\textsuperscript{59} Since it was a voluntary process, midwives who did not register faced no legal repercussions. Essentially, the process was an informal procedure to screen midwives for communicable diseases.\textsuperscript{60} The following year, the State Board of Health investigated 1,834 midwives, examining their personal cleanliness, homes, and medical bags.\textsuperscript{61} This personal intrusion was necessary, according to the state, because it preserved cleanliness—the acceptance of aseptic techniques—and helped

\textsuperscript{57} Ibid.
\textsuperscript{58} Ladd-Taylor, “Grannies and Spinsters,” 264.
\textsuperscript{59} The language used to describe these programs reflects the growing acceptance of eugenic principles.
\textsuperscript{61} State Board of Health, Essays on Midwifery, Series 904, box 1, folder 1, Midwife program files, 1924-1975, State Archives of Florida, Tallahassee, Florida (hereafter State Archives of Florida).
eliminate unfit women. Indeed, some 500 midwives declined to further pursue their certification after the screening process was instituted.⁶²

The eugenics movement was a prominent social movement during the Progressive Era that affected women and their reproductive rights. Sir Francis Galton, cousin of Charles Darwin, British polymath, and eugenicist, coined the term eugenics in his 1883 book *Inquiries into Human Faculty and its Development*, having come to the conclusion that it was possible to produce a gifted race of men by weeding out undesirable traits. By the 1930s, eugenics in the United States was a “scientific process meant to promote the welfare of the individual and the public,”⁶³ although as the world would soon find out, Hitler and Nazi Germany would take it in a completely different direction in their efforts to eliminate Jews and other “undesirables.”

Historical literature about black midwives contains many references to eugenics. Social purity and eugenics approaches to “social and economic reforms were popular, respectable, and widespread”⁶⁴ during the Progressive Era. Eugenics language plagued the stereotypical descriptions of “granny midwives,” and midwife manuals described these women as dirty, ignorant, and “unfit” to deliver babies.⁶⁵ Eugenics principles of health and the “fitness” of the population helped introduce the social purity movement that ultimately transformed the black midwife into a semi-professional woman. Without further documentation, it is impossible to determine whether the midwives who refused to obtain a midwifery certificate did so as a form of resistance against the state, or because they could not meet the new medical standards.

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⁶² Ibid.
⁶⁵ During the Progressive Era, people wrestled with Galton’s idea of “fitness,” but saw eugenics as a way to improve mankind and create a superior way of life.
In 1927, Florida attempted to begin monitoring the state’s midwives. The legislature enacted section two of Chapter 12005, Acts of 1927, which required the registration of all individuals practicing medicine, and stipulated that midwives were required to pay a one dollar fee (approximately $13 in 2012) and enlist with their county’s Clerk of the Circuit Court before obtaining a license and practicing in Florida. Those who failed to register could be forced to pay a fine of no more than fifty dollars (about $650 in 2012) if convicted. Governmental control of midwives was inherent in the certification process. Registrants were required to give demographic and biographical information before being accepted into the program, and they had to be tested for syphilis and other venereal diseases. In addition, midwives could not accept a case until their prospective patients had had a thorough examination by a physician, which encouraged midwives to ensure that their patients visited their local clinic regularly. Hence, state agencies were able to keep a closer check on both the midwives and their patients. This requirement furthered the government’s role in ensuring that “clean midwives” as the last put it, were available to the public.

The certification program and the Act of 1927 represent a starting point in the regulation of midwifery, but the maternal morality rate remained significantly higher in Florida than in the rest of the United States in 1930 when the national average for maternal mortality was 6.7 per 1000 live births, while it was 10.2 per 1000 live births in Florida. However, the infant mortality rate in 1930 was 64.6 per 1000 live births in the United States, but just 61 per 1000 live births in Florida—a seeming contradiction, since one might expect the maternal and infant mortality rates to track in the same direction. A report issued after the 1930 White House Conference on

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66 State Board of Health, Midwife Licensing and Control Bill, Series 904, box 1, folder 5, Midwife program files, 1924-1975, State Archives of Florida.
67 Florida State Board of Health Annual Report 1937 (Jacksonville: Florida State Board of Health 1937), 61.
68 Curry, “Pioneer in Florida,” 19.
Child Health and Protection argued, “The midwifery problem, under [the] present economic situation cannot be relieved at once.” The midwife is a “local necessity” and “every effort should be made by the medical profession to improve her efficiency as rapidly as possible.” The report urged continued support for state boards of health and medical supervision of midwives while they worked to meet licensing requirements. Conference participants recognized that midwives catered to a large black population and thought it necessary that institutions in the South be developed to “train colored midwives.” Committee B (Prenatal and Maternal Care) also recommended post-graduate courses and continuing education to keep midwives up-to-date on current medical advances.

While acknowledging the need for midwifery institutions, Committee B also noted “the responsibility for physician education lay within medical schools and the ultimate problem of good obstetrics lies first in medical schools turning out men who are well trained in the fundamental principles and practice of obstetrics”—a statement that supports sociologist Frances E. Kobrin’s assertion that the majority of medical professionals wanted to eliminate midwives entirely, but accepted the careful regulation of existing midwives until a sufficient number of physicians were available to take their place. It also counters popular opinion at the time that physicians provided superior obstetrics care to that provided by midwives.

The Florida Legislature passed The Midwife Act of 1931 to control and license midwives for the protection of mothers at childbirth. According to the regulations contained therein, a person who was not registered and licensed as a midwife could not practice midwifery, nor call

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70 Ibid., 86.
71 Ibid.
him- or herself a midwife. The state tightened up the process of becoming a midwife as part of its attempt to reduce the state’s high maternal and infant mortality rates. Applicants had to be literate, be able to fill out a birth certificate, demonstrate cleanliness in public and in their own homes, participate in at least fifteen cases of labor and delivery, and care for at least fifteen mothers and infants during the lying-in period while under supervision.\textsuperscript{73} The most contested part of the Midwife Act of 1931 included the stipulations outlined in section eight, which forbade any type of unnatural interaction or physical assistance during labor, which meant midwives could not “use instruments of any kind, or assist labor by any artificial, forcible or mechanical manner.”\textsuperscript{74} During complicated deliveries, i.e., including a presentation that was other than head down, midwives were forced to standby until delivery was eminent or a certified physician arrived. Although midwives disagreed with the stipulation, physicians—who held that physical intervention by black midwives during childbirth was dangerous to the health of the mother and child—supported the non-intervention dictate. Regulating midwives’ interactions with the mother’s body during childbirth—a situation with which the midwives were extremely familiar—was another step toward total state intervention in midwifery practice.

**The Florida Midwife Program**

Black midwives’ practices changed as the state regulations were executed. The Florida Midwife Program grew out of the Midwife Act of 1931 and imposed a variety of guidelines on midwives, and they were required to abide by the state’s strict rules to gain certification. The midwives’ physical appearance was extremely important, as they needed to present themselves as modern, educated women. Midwives were no longer allowed to wear traditional birthing

\textsuperscript{73} The “lying-in” encompassed the period before, during, and after childbirth when a woman was essentially confined to her bed.

\textsuperscript{74} State Board of Health, The Midwife Law, Series 904, box 2, folder 14, Midwife program files, 1924-1975, State Archives of Florida.
clothes—criticized as being unsanitary, thus implying that midwives were ignorant of modern standards of cleanliness—and emerged as the new midwives in white: semi-professional women and traditional midwives accepting modernity and the professionalization of medicine.\textsuperscript{75}

Addressing the concept of midwifery as an occupation was inherent in the regulations. Some historians claim that federal and state legislative interventions had a negative effect on southern midwives.\textsuperscript{76} Certainly, legislative initiatives increased government intrusion into, and regulation of, midwifery. Debra Anne Susie’s “In the Way of Our Grandmothers: A Socio-Cultural look at Modern American Midwifery” argues that midwives were victims of industrialization, and that the professionalization of medicine led to the end of midwifery practice because the midwives’ willingness to register with the state and obtain training through midwife programs allowed state agencies to slowly phase out their craft.\textsuperscript{77} I concur in Susie’s assessment that state intervention played a major role in midwifery. But while the initial impetus behind Florida’s Midwife Program may have been to establish institutions to educate midwives to temporarily provide for needed obstetrics care, it ultimately encouraged health officials who wished to continue midwifery education.

An examination of health officials’ personal correspondence provides more insight into their views of Florida midwives. Susie argues that Florida’s plan to educate and license midwives was a temporary measure, and the state’s long-term goal was to replace midwives with modern medical services, e.g., physicians delivering babies in hospitals. Susie supports this


\textsuperscript{77} Susie, “Grandmothers,” 39.
claim by using the correspondence of Joyce Ely, Florida’s first nurse-midwife and a public health figure, which indicated that eventually midwives would no longer be allowed to practice. But Susie misinterprets this statement because Ely was only referring to midwives in Florida who were practicing illegally. Out of 1,400 midwives in the state, only 800 were licensed midwives, which left the other six hundred unaccounted for. Ely explained, “our personnel [situation] is not large enough at the present time for us to go out and search for the offenders to see whether they are offending purposely or on account of ignorance. I do believe that in the course of time we will be able to eliminate them.” Contrary to eliminating midwives entirely, Ely’s letter illustrates her desire to improve their working conditions and education.

Susie also uses the preface of the Florida Midwifery Files to bolster her argument for the temporary nature of the education program. The files’ preface claims that establishing midwifery institutions was “to improve, regulate, and—eventually—to eliminate midwifery.” However, the nurses who were essential to creating and further extending the midwife programs were not seeking to educate midwives until additional medical professionals were available. On the contrary, they saw the program as a way to further educate midwives.

Dr. Grace Whitford had established and then become the first Director of the Bureau of Child Welfare of Florida State Board of Health in 1918, and was credited with creating several classes for midwives across the state of Florida. According to Ely, Whitford claimed that the “education of the colored midwife in Florida was of great importance.”

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79 Joyce Ely, Personal Correspondence 1933, Series S 904, box 1, folder 1, Midwife program files, 1924-1975, State Archives of Florida.
80 Susie, “Grandmothers,” 46. I question Susie’s use of this source as a primary piece of evidence behind the reasons that Florida created the Midwife Program. The preface contains neither author nor date, and further examination of the document indicates that the idea of dismantling the program did not appear until the late 1950s.
81 Ely, “Correspondence,” 2.
midwifery education was so great that classes were held literally anywhere that could hold a number of people—courthouses, churches, schools—and a few were even held in undertakers’ parlors. Midwives understood the importance of attending these state certification classes, and some walked eight to ten miles to get to class. Failing to attend the certification classes would not only restrict a midwife’s ability to practice, but also meant that women living in rural areas would be left without any support during and after childbirth.

Mary Pugh Mathis’s “Lay Midwifery in the Twentieth Century American South: Public Health Policy and Practice” contends that southern lay midwifery continued because welfare policy and practice “dovetailed with the South’s cultural paternalism.” Unlike Susie, Mathis argues that midwifery among Florida’s African-American midwives continued well into the 1970s due to “institutionalized roles within the community.” However, both Susie and Mathis disregard the relationships that public health officials and public health nurses maintained with southern midwives.

Embracing modernity and the professionalization of medicine, the new Florida midwife carried a black leather bag containing soap, Lysol, blunt scissors, and other instruments that needed to be kept clean at all times. The use of the black leather bag, an important requirement for midwives, came with strict rules. In *The Midwife Manual*, midwives were instructed, “NO INSTRUMENTS OTHER THAN THOSE SPECIFIED IN THIS LIST SHOULD BE USED BY

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83 Ibid., 3

84 Mary Pugh Mathis, “Lay Midwifery in the Twentieth Century American South: Public Health Policy and Practice” (Ph.D. diss., Florida State University, 1990), iii.

85 Ibid., iv.

THE MIDWIFE.” This regulation was extremely important to health officials because midwives were known to carry traditional herbal remedies in their bags as they attended births. Some midwives refused the intrusiveness of state workers, and random bag checks led to the revocation of licenses and the non-renewal of certification for many midwives.  

The Manual for Midwives presents a unique look at the instructional methods used when teaching southern midwives, many of whom were barely literate. Based on a model of repetitive question and answers—making it relatively easy for illiterate midwives to understand and memorize the information—the midwife manual was widely used in training classes. In her

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87 Ibid., 3-4.
personal papers, Jule O. Graves (see Figure 2.1) wrote how the midwives “loved that manual and even the illiterate ones could recite it giving chapter and verse.” Questions such as “what equipment should the midwife carry” or “how would you prepare your hands for delivery in case of labor” were addressed within the text.

Figure 2.2: Manual of Instruction for Midwives. Series 904, State Archives of Florida

Jule O. Graves—a white southerner and an important figure in the nursing and midwife community in Florida—had a unique relationship with southern midwives. After Reconstruction, Florida and the rest of the U.S. South experienced extreme racial tensions. According to historian Jeffrey Alder, white Floridians believed that blacks were “prone to sudden unprovoked bursts of violence” and they were “a growing threat to social order—particularly to the safety of white

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women." Florida’s legislature subsequently created a number of laws restricting the interactions, marriage, and teaching of blacks in the state. Aware of the growing tension among the races, Graves still made it a priority to help black midwives. To gain a better understanding of and create a mutual bond with southern midwives, Graves recorded the rituals and symbolic practices of these women. Although she noted that these rituals were a “real menace to the colored mothers and babies; a contributory cause of the high maternal and infant death rate,” her attentiveness to the midwives’ customs allowed her to create a mutually beneficial relationship with them.

Along with recording the history of black midwives, Graves was a major contributor to their education. Beyond the use of the Manual for Midwives (Figure 2.2), Graves created a “midwife doll” that displayed female anatomy and was used as an educational tool when training midwives on appropriate measures to be taken during childbirth.

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91 Jule O. Graves, Data and Old Superstitions Gathered by Jule O. Graves, RN, Midwife Consultant, Florida State Board of Health, Series 904, box 1, folder 5, Midwife Program Files, 1924-1975, State Archives of Florida.

92 While working with the Works Progress Administration, Graves created two life-size dolls with mechanical features that “demonstrated the function of childbirth.” The dolls, one black and one white, were used during in-class demonstrations.
Lalla Mary Goggins, another public health nurse working with midwives in Florida, wrote, “in the midwife classes the midwives loved to return to the demonstrations. We sang a song for hand washing and they loved to sing. Everyone enjoyed the midwife classes for they were joyous occasions.”\textsuperscript{93} She also noted the significance of these classes not only for the midwives, but also for the women of Florida. Goggins recounted how she was demonstrating the number of maternal deaths for the previous three years by placing beans in a small jar. The midwives recognized the significance of the beans, and one midwife told Goggins during lunch, “some of them beans were Aunt Becky’s.”\textsuperscript{94} Goggins, realizing the potential seriousness of the situation, began to follow Aunt Becky during her visits to her patients. Worried that deaths


\textsuperscript{94} Ibid.
among Aunt Becky’s patients would continue, Goggins spoke to the only physician located in that county, and was surprised to discover that he was the one who had taught Aunt Becky how to do “vaginal examinations, give patients quinine and castor oil to begin labor.”\(^\text{95}\) In other words, the physician’s own procedure was dangerous to mothers. Goggins discussed the gravity of the situation with Aunt Becky, who soon changed her birthing methods. Goggins observed, “She was not one of the best midwives, but [she] was the only one in a very isolated section for the county.”\(^\text{96}\)

The most notable education program was created in Tallahassee, Florida, in August 1933, and its popularity led to additional programs in Tampa and Miami. Florida nurse Ruth E. Mettinger cooperated with Dr. Paul J. Coughlin and Dr. Lucille J Marsh on the Florida midwife programs, and with assistance from the then Florida Agricultural and Mechanical College they were able to create a two-month long training “program for younger Negro women” that would give them an opportunity to continue in public health nursing.\(^\text{97}\) Beyond simple certification programs and yearly registration, Florida nurses and health workers such as Joyce Ely and Jule O. Graves argued for educational programs that would further the professional preparation of black midwives.

Although funding from the Sheppard-Towner Act only lasted until 1929, the Florida Midwife Program continued well into the mid-twentieth century. Educational facilities were established to instruct midwives to counter the common perception held by medical professionals that the continuation of extant midwifery practices would continue to threaten the lives of mothers and their children. The role of a midwife was, however, like no other medical

\(^{95}\) Ibid.
\(^{96}\) Ibid.
\(^{97}\) State Board of Health, Plan For Improving the Midwife Service, Series 904, box 2, folder 21, Midwife Program Files, 1924-1975, State Archives of Florida.
professional. The professionalization of medicine gave women additional choices when considering whom to contact when they delivered their babies. Middle- and upper-class women saw male physicians as “safe” and “respectable” when compared with the average midwife.98

According to historian Judy Barrett Litoff, “blacks and other poor people almost always employed the midwife. However, unlike the roles male physicians played in obstetrics, the midwives’ role did not end after childbirth. Besides staying with the mother throughout her labor and aiding in the delivery, midwives’ duties also consisted of cooking, cleaning, and taking care of mother and child. Hence, a midwife’s role was much broader than that filled by male physicians.

Historian of science Edward Larson contends that Progressive Era reforms and increasing government regulation were two reasons why midwifery began to decline. Interventionism in the Progressive Era was based on “scientific expertise and the value of efficiency and rationality” to solve social, political, and economic problem within the country.99 According to Larson, “Individual progressive reform movements typically began with the formation of a scientific solution to a pressing problem,” proceeded to a “public education campaign to promote voluntary acceptance of the solution,” and then “concluded with the imposition of laws to compel conformity with it.”100 Larson’s analysis of Progressive Era reforms includes an examination of the social hygiene movement as it was related to the need for maternal and child health. The untrained midwife was thus the problem, contributing to high mortality rates. With the introduction of federal and state legislation, black midwives began to conform to modernity and the professionalization of medicine.

98 Wertz, Lying-In, 47.
100 Ibid.
Conclusion

Legislative measures in the twenties, thirties, and early forties spawned government intrusion into midwifery practices, whereby midwives were required to divulge demographic and biographical information that the government subsequently used to control women who practiced midwifery. The initial impetus behind these educational programs may have been to educate black midwives until medical practitioners were more readily available to fill obstetrics needs, however, those who administered these programs saw fit to expand midwifery education. Although restrictive, state regulations and training programs also provided midwives with adequate training based on aseptic techniques. While there were other factors, such as race and economic status, contributing to mortality rates, the state of Florida saw a dramatic decrease in maternal and infant mortality rates after the enactment of the midwife programs. From 1924 until 1940, Florida saw a decrease of maternal mortality rates of 46.2% while infant mortality decreased by 34.4%. Though relatively short-lived, the Florida Midwife Program trained a limited number of black midwives, who were then able to properly assist women through childbirth across the state.

CHAPTER THREE

MIDWIFERY LEGISLATION—THE 1980s

Unfortunately, the role of obstetrics has never been to help women give birth. There is a big difference between the medical discipline we call “obstetrics” and something completely different, the art of midwifery. If we want to find safe alternatives to obstetrics, we must rediscover midwifery. To rediscover midwifery is the same as giving back childbirth to women. And imagine the future if surgical teams were at the service of the midwives and the women instead of controlling them.\textsuperscript{102}

—Dr. Michael Odent

Florida’s Midwife Act of 1931 remained unmodified until 1982. Throughout the twentieth century, midwifery had steadily declined in Florida as midwives had become less publicly visible through mid-century. By 1963, there were only 191 licensed midwives, a number that dropped to 57 by 1974.\textsuperscript{103} Although no legal measures had been added to the Act since its creation, beginning in 1931 the Department of Health and Rehabilitative Services had attempted to slowly phase out midwifery, as nurse-midwives became a better alternative for providing obstetric services in the medical community. Lay midwives—also known as direct-entry midwives (DEM)—learned midwifery through informal education and obtained their skills through apprenticeship. Lacking formal training as registered nurses, midwives’ practices relied on “intense communication and human touch.”\textsuperscript{104} Direct-entry midwives were independent


\textsuperscript{103} Dolores Wennlund, \textit{Annals of Public Health Nursing in Florida} (Tallahassee, FL: Health and Rehabilitative Services, 1992), 37.

practitioners who assisted women throughout their pregnancy primarily outside a hospital setting. According to *Florida Health Notes*—a monthly journal published by the Florida Department of Health—“nurse-midwives, in addition to being registered professional nurses, are educated in the theory and practices of modern obstetrics. They are able to cope with the patient's emotional, social, and physical reactions to all phases of the maternity cycle.”

The American College of Nurse-Midwives—a professional organization founded in 1955 to assist the growth of nurse-midwifery—notes that certified nurse-midwives (CNM) conduct a variety of primary health care services such as primacy care, gynecologic and family planning services, and care during pregnancy, childbirth, and the postpartum period.

While direct-entry midwives are educated through apprenticeship and midwifery schooling, CNMs are educated in both midwifery and nursing. Beyond obtaining graduate degrees, CNMs are required to complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME), and pass a national certification examination administered by the American Midwifery Certification Board (AMCB).

In addition to the influence of newly available medical practitioners on midwifery practices, the counter-culture movement of the 1970s brought about a wide array of social changes and spawned the second-wave feminist movement, which highlighted issues concerning reproductive health.

Childbirth advocate and author Suzanne Arms’s book, *Immaculate*...
Deception, became a catalyst for the alternative birth movement. Upset by her own experiences during labor, Arms argued that women knew little about childbirth, and her book empowered them to seek alternative birthing methods. Women began to demand control over their bodies and did so by changing the way they gave birth. No longer forced to give birth lying on their backs or frightened by the pain of delivery, women sought out methods that challenged the existing medical model. Within the midwifery model of care, the midwife’s role was to help and support women with their childbirth options. The focal point of this model was to have midwives participate in “normal pregnancy” and “recognize the woman as the primary actor.” In contrast, the medical model of obstetric care focused on the treatment of pathology, managing the complications of pregnancy and the diseases affecting pregnant women. Judith Rooks argues that although pregnancy and childbirth are susceptible to pathology that “does not negate their essential normalcy and the importance of the non-medical aspects.”

The new movement toward natural home birth came with political complications. During the 1980s, the Florida Department of Health and Rehabilitative Services (DHRS)—aware that there was an existing law concerning midwifery on the books—attempted to further restrict state licensing of midwives by denying licensure to those who applied and reinterpreting the existing statute to suit their endeavors. Florida had had a long history of implementing restrictive

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Rooks, Midwifery and Childbirth in America, 2.
regulations vis-à-vis lay midwives, however the Department of Health and Rehabilitative Services and the Florida legislature were wholly unprepared for the public’s negative reaction to the restriction placed on women wishing to obtain midwifery licenses. As the alternative birth movement progressed in Florida, women who wanted to obtain midwifery licenses became actively involved in the legal process. Consequently, although the Department of Health attempted to deny midwifery licenses, women throughout the state created a grassroots movement to protest and push back against state interference. Using legal documents and the voices of women who participated in the crusade on behalf of alternative birthing methods, I argue that it was through their efforts that Florida’s original midwifery law came to be revised.\footnote{112}

In the run-up to the changes to the Midwife Act of 1931 that went into effect in 1982, legal battles ensued between health officials and midwives who wished to practice legally in the state of Florida. One notable case—\textit{State v. Baya} (1979)—pitted the State of Florida against Carol Baya, an unlicensed midwife from St. Augustine, Florida, who had been practicing midwifery illegally.\footnote{113} In October of 1979, the state attorney in St. Augustine charged Baya with practicing midwifery without a license based on the 1931 Midwife Act. According to physicians in the area, many of the women and infants who had been assisted by Baya came into the emergency room with various health problems.\footnote{114} Midwives throughout Florida won a significant victory when the judge ruled for Baya, and declared that the 1931 Midwife Act was unconstitutional. In his ruling, he stated that the law “unlawfully delegates legislative authority...”

\footnote{112}{I used oral interviews from women who were active during the revision of the Midwifery Practice Act. I queried the medical organizations that had been involved, but many either did not respond to my requests, or made a brief statement that they continue to support obstetricians for childbirth care. These organizations include the Florida Medical Association, The Florida Obstetric and Gynecologic Society, and the Florida Nurses Association.}


\footnote{114}{Wunnland, \textit{Annals}, 59.}
to DHRS control to Article II, Section 3 and Article III of the Constitution of Florida and in that it is void for vagueness in violation of Article I, Section 9 of the Florida Constitution and the amendment V and XIV of the United States Constitution.”

A case that went to trial in 1980 also resulted in a victory for women applying for midwifery licenses. In STATE of Florida, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, v. Joan MCTIGUE, Joan McTigue—a midwife from New York—had moved to Florida and then attempted to obtain a midwifery license from the Department of Health and Rehabilitative Services. Her request was denied because McTigue was unable to produce written statements from a Florida physician noting her completion of fifteen supervised births. McTigue argued that because she had obtained her education and license in New York, her previous experience was a sufficient demonstration of her proficiency to justify a license to practice midwifery in Florida. However, the Department of Health and Rehabilitative Services disagreed, defining a physician “as a person duly licensed to practice medicine or osteopathy in Florida,” though the law only required a physician’s supervision and did not specify that only a physician licensed in Florida was eligible to attest to a midwife’s skills. Reviewing the 1931 statute, the court ruled that the word physician “has a plain and ordinary meaning usually denoting a practitioner of medicine, a person duly authorized or licensed to treat diseases; a person skilled in the art of healing; specifically, a doctor of medicine.” The ruling continued: “By adding the requirement that the physician be a Florida physician, the rule is an invalid exercise of delegated

115 Florida Senate, “Staff Analysis and Economic Impact Statement,” March 29, 1982, Series 18, carton 1103, State Archives of Florida. According to the Constitution of the State of Florida, Article II §3 notes that no branch shall exercise powers over the other two branches and Article 1 § 9 notes that no person shall be deprived of life, liberty, or property.


legislative authority because it modifies the statute by adding an additional criterion to be met by the applicant.”

The Department of Health and Rehabilitative Services’ interpretation of the word “physician” to mean a “licensed Florida physician” provides insight into the department’s motivation for denying midwifery licenses. The majority of women who were applying for midwifery licenses were white middle-class women, who would be presumably examining white clientele. It is assumed that the additions to the law were made as to diminish midwifery as a birthing option, while keeping white physicians as the only viable option for white women.

Linda Wilson, a childbirth advocate and educator for women’s reproductive health, played a pivotal role in the development of the 1982 midwifery law. She holds that the original 1931 law “was created in order to keep the black people—the black women—out of the hospitals, out of the white people’s hospitals.” Wilson correctly noted the racial disparities between white women and women of color as they pertained to birthing. Based upon geographic location, race, class, and educational background, poor black women living in rural areas were typically attended to by midwives rather than doctors.

The 1931 law had allowed granny midwives minimal opportunities to intervene in dangerous situations, and as attorney Katherine Simmons Yagerman argued in “Legitimacy for the Florida Midwife: The Midwifery Practice Act,” the law was “based on the expectation that the number of midwives would decrease as more sophisticated medical resources became available to the poor.” The medical community’s view that midwifery was antiquated was a contributing factor in its diligent attempts to eliminate midwifery practice in Florida. However,

\[118\] Ibid.
based upon the rulings in these midwifery cases, the Department of Health’s actions exceeded their authority. Joan McTigue explains,

It was not their intention to give any more licenses out, but it was their intention to retire the practice of midwifery and the few granny midwives that were left in the state, and eventually, it was their intention to have the law repealed. They were very surprised to find that there were women who were interested in reviving it.\textsuperscript{121}

According to McTigue, the DHRS was shocked to receive her application for a midwifery license. After receiving her application, a DHRS staff member called her and asked, “Why on earth would somebody with your credentials want to do this?”\textsuperscript{122} McTigue had graduated from the physician’s assistant program at Stony Brook University and based on the questions asked by the DHRS staff, it seemed as if she were taking a diminished role within the medical community. As with most white women who were applying for licenses, DHRS questioned her motivation for becoming a midwife. Although the Department of Health and Rehabilitative Services was aware of the alternative birth movement and incoming applications for midwifery licenses, staff members thought the occupation was obsolete and were reluctant to support the movement. McTigue described her battle to gain a license as “long, egregious, and costly,” and compared it to the battle of David and Goliath.\textsuperscript{123}

Although the state was refusing to issue midwifery licenses that did not mean that women had not been applying for them. According to Dolores M. Wennlund, the state director of public health nursing in Florida, in her 1979 report on midwifery, “From 1977 to the middle of 1979, more than 70 inquiries were received in the nursing program office and among these were 54

\textsuperscript{121} Joan McTigue quoted in Melissa Denmark, “The Governor’s Full Support,” 216.
\textsuperscript{122} Joan McTigue interview by Megan Bowes, 12 November 2013, Reichelt.
\textsuperscript{123} Ibid.
requests for applications for lay midwife licenses.”¹²⁴ Compared to the six inquiries for licenses between 1972 and 1976, the legal initiatives—the filing of independent lawsuits against the state by these independent women fighting for legitimacy—were making waves throughout the midwife community.¹²⁵ Although the state was reluctant to issue licenses, Florida women still persisted in having home births. By 1980, there were only 25 licensed lay midwives throughout the state—the number of unlicensed midwives at the time is unknown—but that did not stop underground, unlicensed midwives from performing deliveries.¹²⁶

On the heels of the aforementioned lawsuits filed by midwives in 1982, midwives Margaret Petty-Eifert and Janice Heller sued the state of Florida because the Department of Health and Rehabilitative Services had denied their applications. Petty-Eifert and Heller had applied for licenses in 1981, however, when the Midwifery Practice Act was revised in 1982, DHRS attempted to retroactively apply the new statute to applications they had received before the changes were in place. Neither Petty-Eifert nor Heller met the new qualifications, and they argued that applying these new rules was an invalid use of DHRS’s authority.¹²⁷

The DHRS had denied Petty-Eifert’s application because she had not received positive recommendations from county medical directors and she had not “completed” numerous birth certificates. Her application was also denied because two of the births in which she had participated involved babies who “were not delivered in the hospital and … therefore [she] had not attended 15 cases of labor during the lying-in period as required by the statute and rule.”¹²⁸ Heller’s application was denied for similar reasons—she had not attended fifteen deliveries during a one-year period. The court ruled “these applicants were entitled to have the law applied

¹²⁴ Wennlund, Annals, 58.
¹²⁵ Ibid., 58.
¹²⁶ Ibid., 72.
¹²⁷ Reilley, “Midwifery in America,” 1137.
as it existed at the time they filed their applications.” Furthermore, there was no “one-year requirement” nor was there a prerequisite for a midwife to obtain a positive recommendation from the county medical director expressed within the statute. A final portion of the ruling noted that the requirement was that an “applicant be able to fill out the birth certificates legibly” not that they had to be filled out completely.\textsuperscript{129}

As the Department of Health and Rehabilitative Services continued the legal process of restricting the issuance of midwifery licenses, midwives continued to work “underground” illegally assisting women in childbirth throughout Florida. According to the Florida Vital Statistics Office, “In 1980, there were 2,225 out-of-hospital births in Florida. Licensed lay midwives reported 288 births, which means 1,837 births were unclassified. In 1981, the number of unexplained births in Florida rose to 7,360.”\textsuperscript{130} Carolyn Pardue, a government relations consultant for the Florida Nurses Association, argued that there was not “a public outcry for home births,”\textsuperscript{131} which is probably true since non-hospital births represented less than 2 percent of all births, but the difference in the number of unexplained births between 1980 and 1981 does contradict the medical community’s view that women were not interested in the alternative birth movement. For example, Wennlund claimed that “between 1973 and 1980 the percentage of reported midwife-assisted births in Florida increased from 1 percent to 2.6 percent,\textsuperscript{132} and considering that the number of births undoubtedly increased during the same period, one could safely conclude that the \textit{number} of babies born with the assistance of a midwife more than tripled in that seven year period.

\textsuperscript{129} Ibid.
\textsuperscript{130} Florida Senate, “Staff Analysis.”
\textsuperscript{131} Jill Young Miller, “Delivery Service as the Number of Licensed Midwives in Florida Dwindles, a Grass-roots Group Pushes for Change,” \textit{Sun Sentinel}, 14 March 1990.
Although a few women sued the state for licensure, as Florida midwife and founding member of the Midwives Association of Florida Justine Clegg notes, most women were not willing to go through the legal process of suing the state as individuals, and ultimately looked toward forming an organization that would represent their interests. In 1979, a group of Florida women—most of whom were mothers—founded The Midwives Association of Florida (MAF), which worked on behalf of those midwives who were unwilling or unable to sue the state to introduce and pass a revised midwifery law.

Along with assisting women—typically middle-class white women—who wanted to be licensed, the Midwives Association of Florida also represented the interests of granny midwives who were being forced to retire. The organization thus represented two different populations: “the population that had been serving Floridians for maybe fifty years” and the new wave of women from a holistic movement that encouraged them to become midwives. The white, middle-class women fighting to change the law had little interaction with the granny midwives who were still practicing within the state. After experiencing the restrictive licensing requirements from the 1930s, many granny midwives felt that they did not have a personal stake in the outcome of the Midwifery Practice Act’s revision. Those who were still “catching babies” were just happy to be continuing the practice and were fearful that the Department of Health would revoke their licenses if they spoke out against it.

One granny midwife willing to help revise the older law was Gladys Milton, who had been a midwife in the Florida Panhandle since 1959. According to Joan McTigue, Milton’s age was critical to her participation in the movement. Because she was one of the younger granny midwives, Milton was able to “bridge the cultural gap” between the older midwives and the new direct-entry midwives. Although many granny midwives were reluctant to work with a “modern

133 Ibid.
midwife,” the MAF was working for them as well. Justine Clegg recalls that they tried to tell granny midwives there was no need to retire when the Department of Health sent them their honorary certificate because in the state of Florida, everyone who held a midwifery license would be legally able to practice even if the practice of midwifery were eliminated.\textsuperscript{134} “Retiring” granny midwives was another tactic used by the DHRS to eliminate midwifery, and many granny midwives had begun to accept these certificates without fully understanding the repercussions their retirements would have on their communities and the state.

In her book, \textit{Why Not Me?}, Milton explains her experiences as a granny midwife during the transition period of midwifery regulations:

\begin{quote}
I had gotten a letter from the Florida Health and Rehabilitative Services “asking” me to retire. It was a short and sweet little letter. They told me how much they appreciated my commendable service to the community and even thanked me for my humanitarian efforts. They went on to say that, the day of the midwife was over, that Florida didn’t need us anymore, and besides, I was too old to continue working. It said things had changed since I started delivering babies, and even though I had been a real asset to the midwifery program, I was now obsolete.\textsuperscript{135}
\end{quote}

This scenario was common throughout Florida. Many granny midwives were given “a banquet and a ceremony in [their] honor” by the DHRS and were allowed to choose a nurse to assume their positions.\textsuperscript{136} This process of phasing out granny midwives in Florida was just one of the tactics county and state health departments used to promote the idea that the public’s

\begin{footnotes}
\footnotetext[134]{Ibid.}
\footnotetext[136]{Susie, “Grandmothers,” 72.}
\end{footnotes}
wellbeing superseded the need for granny midwives. Debra Susie has explored in detail the relationship between granny midwives and the Department of Health and Rehabilitative Services. Concerning the granny midwives who were still practicing, she writes:

The law’s bureaucratic technical jargon alone was enough to impel them to voluntarily turn in their licenses. The county nurse, who usually translated the state’s edicts as they came down, was no longer in place. And without interpretation, the new law appeared to be only a maze of red tape and thus yet another assault on the weary midwifery profession.\(^{137}\)

As the home birth movement began to grow, women from various social backgrounds began to use midwives. Recalling this time, Milton wrote:

My clientele had changed dramatically over the years. I no longer was helping just the poor and needy that couldn’t afford any better, the way I had been when the health department and local doctors had welcomed me into the profession. More and more I was providing my services to women who were well educated. Many of them had hospitalization insurance. I guess doctors in the state were starting to worry that once we had succeeded in providing for women that were delivering on their own, we would start taking away women that would have been their patients. Maybe they were also worried about getting into more malpractice trouble. If midwives did all the low risk deliveries, more of the doctors’ business would be riskier deliveries, increasing in the possibility that something would go wrong and the doctors would be blamed for it.\(^{138}\)

The alternative birth movement sparked an interest in public health and the new legislation attempted to make midwifery a viable option. The Midwifery Act of 1982 stressed safe education and licensing requirements, and ordered the establishment of an Advisory

\(^{137}\) Ibid., 65.
Committee. Two midwifery proponents, Senator Jack Gordon (D-District 35) and Representative Elaine Gordon (D-District 104), sponsored the 1982 legislation. The difference between the 1982 revision and the 1931 Midwife Act was the recognition of “the need for parents’ freedom in choice in the manner of cost of and setting for their children’s births.” In addition, the original law was mainly trying to establish a minimal degree of midwife competency, which was a far narrower purpose than the 1982 legislation. In addition, the District Court of Appeal of Florida, First District, had ruled that the original statute was unconstitutional, and thus the original law needed to be revised to keep midwifery as an option in Florida.

Although its duties were not explicitly outlined within the statute, the Advisory Committee of Lay Midwifery within the Department of Health and Rehabilitative Services was to advise the latter on any changes or issues regarding midwifery. The committee was a five-member body composed of one nurse midwife, one physician certified in obstetrics, two licensed lay midwives, and one state resident who had no interest—personally or financially—in the practice of midwifery. The 1982 law also authorized a three-year course of study combining classroom and clinical training in “all aspects of prenatal, intrapartum, and postpartum care.” In addition, the new statute directed that during training, the midwife trainee must participate in 25 cases of prenatal, intrapartum, and postpartum care and observe an additional 25 deliveries before applying for a license.

One of the most important parts of the Midwifery Practice Act (1982) is section 467.003 of the statute which defines key terms—such as midwifery, normal labor, and childbirth—that were ambiguous or undefined in the original 1931 act. “Midwifery,” for example, was defined as

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139 FLA. STAT. § 467.002 (Supp. 1982)
140 Yagerman, “Legitimacy of the Florida Midwife,” 125.
141 FLA. STAT. § 467.005 (Supp. 1982)
142 FLA. STAT. § 467.001 (Supp. 1982)
“the practice of supervising the conduct of a normal labor and childbirth, with the informed consent of the parent; the practice of advising the parents as to the process of childbirth; and the practice of rendering prenatal and postpartum care.”\textsuperscript{143} The ambiguous key terms and definitions in the 1931 statute had made it difficult for midwives to understand what the state considered safe practices. As defined within the 1982 revision, “normal labor and childbirth means the physiological process of a healthy woman giving birth to a healthy infant and expelling an intact placenta, without injury, complications, or undue strain to the mother.”\textsuperscript{144}

Individuals supporting lay midwifery also noted the demographic changes in clientele that Milton had reported. The 1982 revision passed through the legislature without difficulty, which Linda Wilson attributes to the “Old South mentality” of North Florida. Many legislators from North Florida grew up thinking that midwifery was a normal form of health care, and had been delivered by a granny midwife. Wilson recalled that northern legislators were “amused and puzzled by the irate positions that the Dade County doctors took down here in Miami.”\textsuperscript{145} These demographic differences within the state, and their correlation to the midwifery-related mindsets of legislators hailing from North Florida are very interesting. According to Suzanne Suarez, “legislators and other policy makers in the United States, under the influence of medical lobbyists, frequently treat birth as an event requiring the mechanisms of acute medical care.”\textsuperscript{146} However, the acceptance of midwifery as an alternative model of care by northern legislators led to wider support for the first revision of the statute.

The 1982 Midwifery Practice Act passed without significant opposition from the medical community, which was apparently focused on other matters. Looking back on this time, Joan

\textsuperscript{143} FLA. STAT. § 467.003 (Supp. 1982)
\textsuperscript{144} Ibid.
\textsuperscript{145} Linda Wilson interview by Megan Bowes, 22 October 213, Reichelt.
\textsuperscript{146} Suarez, “Midwifery,” 315.
McTigue concluded: “I think when it passed, it surprised the OB [obstetrics] community—and then once it was passed—they began to mobilize their concerns.” According to Justine Clegg—lobbyist, founding member of the MAF, and midwife applicant—time spent during 1979 lobbying legislators contributed to the bill’s successful passage. After submitting the bill in 1979 and then again in 1980 without any support from the legislature, members of the Midwives Association of Florida decided to travel around the state to educate legislators on midwifery and how the bill would benefit Floridians.

When the medical community realized that a number of women were applying for midwifery licenses, it reacted forcefully against midwifery’s proponents. Dr. Paul Gluck, president of the Florida Obstetrical and Gynecological Society, said that licensing midwives again would mean “a step backwards in health care.” The medical communities, including nurse-midwives, were uniformly unsupportive of the lay midwives’ attempts to gain licensure, but nurse-midwives were less vocal because they had the most to lose. In Florida, nurse-midwives work under the signature of physicians, and therefore they tended to refrain from speaking out on issues related to midwifery that had the potential to adversely affect their employers’ business model.

Although many physicians who opposed licensing lay midwives focused on the latter’s lack of obstetrics training, they denied that their arguments against licensure were influenced by financial considerations. Depending on where women lived within the state, choosing a midwife instead of a physician for pre-natal care and delivery made a significant financial difference. For Lisa Patullos of South Florida, the cost of having a child was her determining factor for choosing

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147 Joan McTigue interview by Megan Bowes, 12 November 2013, Reichelt.
150 FLA. STAT. § 464.003 (Supp. 1982)
a midwife in 1991. Patullos paid her midwife a total $1,600 (approximately $2,700 in 2012) for the care she received throughout her entire pregnancy, including prenatal, intrapartum, and postpartum care. The cost of having a doctor deliver the baby would have been from $1,000 to $3,000 ($1,600 to $5,000 in 2012), not including the hospital fee of $3,000 (another $5,000 in 2012).\footnote{Ibid.}

Looking back on the process, midwives who had been actively involved in the legislative fight acknowledged their naiveté vis-à-vis the process of creating a new law. Following the ruling that the 1931 law was unconstitutional, the Midwives Association of Florida attended various legislative committee meetings as they worked to create a new law that would allow lay midwives to work autonomously throughout the state. When the 1982 legislation passed, it was—they thought—a victory for women all over the state of Florida. The law required that—in coordination with the State Department of Education—a three-year midwifery education program would be developed.\footnote{FLA. STAT. § 464.009 (Supp. 1982)} However, the midwives encountered unforeseen difficulties that temporarily ended legal midwifery in Florida.

Members of the midwife community and the Department of Health needed to create and agree upon rules and regulations. As a result, the Advisory Committee of Licensed Midwifery was created to administer educational programs and enforce regulations that followed the new law. According to anthropologist Melissa Denmark, “due to the intense involvement and argument between members, it took the Advisory Committee from July 1982 until January 1984 to finish the Rules and Regulations regarding education, practice, and regulation of midwifery, which in turn delayed the process of developing midwifery schools.”\footnote{Denmark, “The Governor’s Full Support,” 224.}
During the sunset review of 1984, most legislators seemed amenable to extending the bill for another ten years.\footnote{Justine Clegg interview by Megan Bowes, 23 January 2014, Reichelt.} The Florida Legislature had enacted Florida’s Sunshine Law in 1967, which created the review process and made “recommendations to abolish, continue, or reorganize the agency under review.”\footnote{Florida Legislature, “Joint Sunset Committee,” FloridaSunsetReviews.gov; see Sandra F. Chance and Christina Locke, “The Government-in-the-Sunshine Law Then and Now: A Model for Implementing New Technologies Consistent with Florida’s Position as a Leader in Open Government,” \textit{Florida State Law Review} 35, no. 2 (2008): 245-270.} Typically, the Sunset Review process occurred every five to ten years after the creation of a statute, however, the Sunset Review attached to the 1982 Midwifery Practice Act was set to occur two years after the new law was enacted. According to Melissa Denmark, “the midwives never questioned the Sunset Review provision, as they trusted that the new law would be ‘rubber stamped’ in 1984 because their three-year education programs had not even been established yet.”\footnote{Denmark, “The Governor’s Full Support,” 223.} However, at the last moment, the Myers amendment—written and introduced by Senator William “Doc” Myers (R-District 27) of Hobe Sound—was added to the bill without objection from other legislators. The purpose of Myers’s proposed amendment was to end midwifery in Florida. It stipulated that only midwives then currently licensed or enrolled in one of the two midwifery schools in Florida would still be able to practice legally, and that the Department of Health and Rehabilitative Services would no longer issue midwifery licenses. The amendment passed by a 24-7 vote, and was added to the Midwifery Practice Act which only “allowed midwives who were licensed as of October 1 and those students enrolled in the two midwifery programs as of the beginning of May 1984 to practice midwifery.”\footnote{Ibid., 232.}

The Myers Amendment landed a serious blow on the midwife community. The only two schools that offered midwifery training—the private North Florida School of Midwifery in
Gainesville and South Florida School of Midwifery in Miami—stayed opened until their students graduated, but they could not enroll new students. Considered private postsecondary vocational programs, they fell under the purview of the Florida Department of Education Board of Postsecondary Vocational, Technical, Trade and Business Schools.  

Once the lay midwives realized that the Myers Amendment would pass, they had to make decisions about how to continue midwifery practices in Florida. Knowing that lay midwives were still serving women who depended upon them, the midwives decided to accept the amendment rather than “shut down the whole profession.”  

Thus, the North Florida and South Florida Schools for Midwifery were required to submit the names of enrolled students to the state, which gave it direct access to the students who would be the only midwives—other than the ones grandmothered in—allowed to legally practice in Florida.

**Conclusion**

Linda Wilson recalls that the Florida Midwives Association’s (MAF) ability to obtain everything that it had wanted in the new 1982 law had been miraculous. However, Wilson and the other women who had taken up the fight for the new law had been unprepared for the challenges that popped up during the 1984 Sunset Review. Although the resulting Sunset Review prevented the licensing of any new midwives in Florida, it did not stop the midwives’ approach to birthing services from developing more widely. As McTigue notes, hospitals began to market their maternity services to women interested in the alternative birth movement, advertising “home-like settings” and developing “new concepts aimed at pleasing consumers.”

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158 Ibid., 225.
159 Justine Clegg interview by Megan Bowes, 23 January 2014, Reichelt.
Understanding the new concepts that the alternative birth movement proposed, hospitals attempted to do everything in their power to keep their consumers in a hospital setting.

Many midwives believed that they had a responsibility to the women within their respective cities, towns, and small rural communities to fight for health care that was right for individual women. However, according to Reilley (1986), “Despite the existence of laws, which theoretically permit both lay and nurse-midwives to render care, lay-midwives encounter institutional obstacles inhibiting their practice. Some state legislatures directly undermine the purposes of their own statutes, refusing to provide for the issuance of licenses to lay-midwives.”

The constitutionality of the Midwifery Practice Act (1982) played a tremendous role in midwives’ ability to gain licensure. Midwives argued that because they were unable to “ascertain exactly what is prohibited, enforcement of these statutes violates the fourteenth amendment’s procedural due process requirement because the statutes are unconstitutionally vague.” Although the state of Florida attempted to deny midwifery licenses, the successful creation of a statewide grassroots movement was critical to the revision of the original midwifery law. Focusing on the vague language of the original law, midwives sued the state of Florida to obtain midwifery licenses. By helping to write their own bill and statute, the lay midwives focused on positive language that would keep midwifery as an independent and autonomous practice.

Although they were successful in revising the original midwifery law, the political struggles the MAF faced did not end with the introduction of the Myers amendment. The midwives who revised the original midwifery law would again be confronted with political obstacles as they continued to develop their private midwifery schools.

161 Reilley, “Midwifery in America,” 1126.
162 Ibid., 1133.
CHAPTER FOUR

MIDWIFERY SCHOOLS

The 1980s proved to be a critical time for midwives in Florida starting with the successful revision of Florida’s original Midwife Act of 1931. After the passage of the Midwifery Practice Act in 1982, the Midwives Association of Florida (MAF) began to propose and develop appropriate curricula. Over a two-year period, they developed two midwifery schools—North Florida School of Midwifery in Gainesville and the South Florida School of Midwifery in Miami—and began to accept students into these new licensure programs. The 1982 Midwifery Practice Act recognized “the need for parents’ freedom in choice in the manner of cost of and setting for their children’s births.”\(^{163}\) In addition to recognizing that parents had the right to decide how to give birth, the revised act also clarified vague definitions such as what it means to be a midwife and what a normal labor and birth entails. The act also outlined standards for midwifery programs training requirements, noting that clinical and classroom instruction in all aspects of prenatal, intrapartum, and postpartum care would require three years of training.\(^{164}\) During training a student midwife was also required—under the supervision of a preceptor—to care for 25 women during each of the prenatal, intrapartum, and postpartum periods, and observe an additional 25 women in the intrapartum period. The statute also made clear that the training midwives received must “differentiate between low-risk pregnancies and high-risk pregnancies.”\(^{165}\)

At almost the same time that these schools opened their doors, the Myers Amendment brought their programs to a halt in 1984. Essentially, the midwifery schools would only have one

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\(^{163}\) FLA. STAT. § 467.002 (Supp. 1982)
\(^{164}\) Ibid.
\(^{165}\) Ibid.
class of graduates—their first classes were also their last. The Midwifery Practice Act (1982) required midwives to obtain three years of education before they could become certified by the state. According to midwife Justine Clegg, soon after the act’s passage, MAF members began visiting technical schools in Florida to see if any were interested in developing a midwifery program; none were.166 Therefore, practicing midwives throughout Florida independently decided to create their own schools—the North Florida School of Midwifery in Gainesville, and the South Florida School of Midwifery in Miami. Although women who had worked together to revise the 1982 Midwifery Practice Act created these two schools and were aware of each other’s existence, they did not coordinate on their school development projects. Indeed, almost half of the women who developed and operated these schools were simultaneously enrolled as students. They handled the schools’ administrative workload in lieu of paying tuition.167

Upon contacting the Florida Department of Education, the administrative oversight of the new schools was placed under the Board of Postsecondary Vocational, Technical, Trade and Business Schools.168 Clegg, who became the Administrative Director at the South Florida School of Midwifery, worked with other midwives to create a curriculum based on three years of schooling, establish clinical sites, and hire experienced and certified faculty. Because the administrators had had little experience creating a school curriculum, they sought information from similar programs across the United States, including the Frontier Nursing Service (FNS), the Maternity Center Association (MCA), and the Seattle Midwifery School (SMS) as they developed their own programs.

The Frontier Nursing Service, originally named the Kentucky Committee for Mothers and Babies, was created in 1925 by nurse Mary Breckenridge and was the first nurse-midwifery

167 Ibid.
168 Ibid.
program in the United States. Located in Leslie County, Kentucky, Breckenridge trained midwives using the same curriculum that had been used to educate and train nurse-midwives in England and Scotland. After serving as a volunteer director of Child Hygiene and District Nursing in France after World War I, Breckenridge observed that French and British nurse-midwives were capable of providing care to rural areas.\(^{169}\) After receiving her nursing degree form St. Luke’s Hospital in New York City and studying public health at Teachers College, Columbia University, Breckenridge then went on to train in a midwifery program at the British Hospital for Mothers and Babies in London. According to registered nurse and professor of nursing Edith West, Breckenridge “expected her nurses to serve as public health and district nurses in addition to being nurse-midwives.”\(^{170}\) In operation from 1925 to 1951, the midwives with the Frontier Nursing Service attended more than 10,000 births and achieved an average maternal mortality rate of “9.1 per 10,000 births, while it was 34 per 10,000 among white women nation wide.”\(^{171}\) Hence, the FNS had a maternal mortality rate that was approximately 25 percent of the national average, a success rate that the Florida midwives wanted to emulate and a major reason behind their decision to choose the FNS curriculum as a starting point for their own programs.

The South Florida School of Midwifery also looked to the Maternity Center Association in New York City—which was founded in 1918—for curriculum ideas. Midwives who attended this school were expected to return home to “establish public health department programs for


training and supervising granny midwives.”

Since nurses and nurse-midwives played a vital role in the provision of health services within their local communities, they were given priority when entering the program. By 1920, the MCA had established 30 maternity centers throughout New York City and had begun to develop educational programs in maternity care for public and professional health personnel. The Maternity Center Association has a long history of providing maternal care to women in New York, and further developments at the facility created a free standing birthing center in Manhattan in 1975. According to Ruth Watson Lubic, a graduate and general director at the MCA, the facility opened because “women had become disenchanted with hospitals and the way they were treated there, especially [women in] the counterculture, who didn’t want to do anything the way it’d been done by Mom and Dad. There was a movement toward do-it-yourself home birth, and we felt that that was patently unsafe, and that some monitoring was required.”

Today, the MCA is known as the Childbirth Connection and it has collaborated with the National Partnership, a 41-year old organization whose “mission is to improve health for women and families, and make the nation’s workplace more fair and family friendly.”

The Maternity Center Association also created the School of the Association for the Promotion and Standardization of Midwifery, also known as the Lobenstine Midwifery School. Incorporated in 1931, the Lobenstine Midwifery School curriculum was based on the British curricula and the services provided by the clinic consisted of prenatal, intrapartum, and postpartum care in addition to patient education. From 1931 until 1958, the Lobenstine

172 Ibid.
173 Tekoa L. King et al., Varney’s Midwifery (Burlington, MA: Jones and Bartlett Learning, 2015), 10.
175 “Two Organizations Dedicated to Improving Women’s Health Join Forces,” nationalpartnership.org
Midwifery School provided care for a total of 7,099 births, 6,116 of which took place in women’s homes.\textsuperscript{176} The maternal mortality rate of the clinic was 0.9 per 1000 live births for the same geographic district as a whole, while it was 1.2 per 1000 live births for a leading hospital in New York City at the same time.\textsuperscript{177}

Drawing on a more contemporary example of midwifery schools, Florida midwives looked to the Seattle Midwifery School in Washington State. Only a few years earlier, midwives in Seattle had found themselves in a legislative predicament similar to that of the Florida midwives in the 1980s. In Washington, the original midwifery law—passed in 1917 and revised in 1975—allowed midwives within the state to develop midwifery schools for direct-entry midwives. Based upon a Dutch midwifery model, the SMS opened in 1978 and its program included “350 hours of classroom instruction and clinical experience based on the school’s home birth service.”\textsuperscript{178} Looking at these institutions as well as other midwifery and nurse-midwifery schools throughout the country, Florida midwives developed a curriculum that was accepted by the Department of Education, but with the Myers Amendment in place, it was difficult for midwifery to grow in the state of Florida. The North Florida School and South Florida School of Midwifery remained opened to graduate those who had enrolled in 1984. The North Florida School of Midwifery closed in 1986, and the South Florida School of Midwifery “kept a license with the Department of Education, but no longer accepted students.”\textsuperscript{179}

Despite the fact that the North Florida School shut its doors and the South Florida School was not enrolling new students, the MAF and other newly established midwife organizations in Florida were exploring ways to lift the Myers Amendment. Becky Martin, founder of the Florida

\textsuperscript{176} King et al., \textit{Varney’s Midwifery}, 6.
\textsuperscript{177} Ibid., 13.
\textsuperscript{178} Rooks, \textit{Midwifery and Childbirth}, 76.
\textsuperscript{179} Denmark, “Governor’s Full Support,” 233.
Friends of Midwives, joined homebirth consumer advocate Julie Snyder, who founded the Midwifery Access Project, to lobby around the state. Using State Road 60 (which runs west to east across the Florida peninsula from Clearwater to Vero Beach) as the dividing line, one group visited the legislators to the north, while the other visited the legislators who represented districts to the south. A team consisting of a midwife and a consumer of maternity services would meet with a legislator, and begin to educate him or her on the need for midwifery and the effects the alternative birthing movement had on local communities. The development of midwifery organizations such as the Friends of Midwives was not exclusive to Florida; consumer advocacy groups developed across the country where people were “interested in preserving homebirth as an option.”

In addition to visiting legislators, Becky Martin wrote a formal letter to all incoming legislators for the 1991 term asking them to consider sponsoring or cosponsoring a new piece of legislation that would remove the Myers Amendment restrictions. African-American attorney and freshman legislator Daryl Jones of Miami was interested in becoming the bill’s sponsor. However, some midwives within the MAF were torn over who should sponsor the bill. Long-time Florida House Representative Elaine Gordon, a strong supporter of midwifery, had been sponsoring midwifery bills since 1986. From the implementation of the Myers Amendment in 1984, the Florida Midwives Association had attempted to pass a bill almost every year during the legislative session to reinstate midwifery education in Florida. However, some midwives felt that Representative Gordon had not adequately lobbied for House Bill 393 in 1990, which outlined the legislative intent for midwifery and provided criteria for reviewing proposals and regulation.

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changes. A few within the midwife community feared that Jones, a newcomer to the Florida legislature, would be unable to push the bill through the necessary committees. Nonetheless, with Jones’s tenacity and persuasiveness he became the primary bill sponsor for House Bill 1513 in 1991, while Helen Gordon Davis (D-District 64) from Tampa became the primary bill sponsor for Senate Bill 1066.

House Bill 1513 modified the legislative intent regulating the licensure of midwives, definitions, and training requirements, and authorized collaboration with physicians in hospital training. Senate Bill 1066 sought to increase the minimum age of a person applying for a midwifery license from 18 to 21, added the requirement of a high school diploma or its equivalent, and required the Florida Department of Education to review programs on midwifery. Although these bills did not pass in 1991, they set the tone for the standards the MAF wanted to accomplish the following year.

Melissa Denmark argues in her article “The Governor’s Full Support,” that the 1990s “brought a breath of fresh air” to the Florida legislature with newly elected Democratic Governor Lawton Chiles and new legislators at the State Capitol. Democrats retained control of the Florida House of Representative (72 Democrats and 48 Republicans) until 1996 when Republicans became the majority in the State House. The Florida Senate maintained a Democratic majority until 1993, with 23 Democrats and 17 Republicans. This shakeup in the legislature brought in legislators who viewed midwifery as benefiting the health of mothers and their children. During the 1990 legislative session, the Senate Committee on Health and

183 Florida House of Representatives, Journal, 92nd Regular Session.
185 Denmark, “Governor’s Full Support,” 235.
186 Florida House of Representatives, Journal, 92nd Regular Session.
Rehabilitative Services completed a study called the Sunrise Report, which reviewed midwife practices between 1984 and 1990. The study attempted to determine whether the practice of midwifery should be permitted “beyond the scope of the 1984 enactment,” and concluded that with modifications in midwifery education, the practice of midwifery was not dangerous to the public and that, in fact, it would be dangerous to mothers and babies if the bill did not pass. The study further noted that almost one-third of the women in the state of Florida, particularly in rural areas, were not receiving adequate prenatal care. Florida’s population had outgrown the number of certified nurse-midwives available to provide women with access to prenatal care and the Sunrise Report recommended reinstating midwifery education in order to meet the demands for midwifery services. According to the Sunrise Report, in 1990 nurse-midwives delivered a total of 19,304 babies in Florida, 17,859 in hospitals and 1,309 in birth centers. Therefore, in 1990, lay midwives—who typically worked at birth centers or attended home deliveries—represented at least 6.7% of birth attendants in 1990. The statistical information provided by the study reinforced midwives’ claims that an alternative birth model was needed in Florida.

With a newly elected governor who supported midwifery and new bill sponsors, the MAF believed they were heading in the right direction to modify the Midwifery Practice Act (1982) and remove the Myers Amendment, but as their momentum was increasing the midwives hit another legislative roadblock. In 1991, State Senator Ben Graber, an obstetrician from Coral Springs, introduced the Graber Amendment—supported by the Florida Medical Association (FMA) and the Florida OB-GYN Society (FOGS). The Graber Amendment attempted to further regulate midwifery education by requiring “three years of a medically supervised curriculum and

189 Ibid.
191 Florida House of Representatives, “Bill Analysis.”
a one-year internship with an obstetrician.” Once certified, the midwives’ practices would fall under the oversight of the State Board of Medicine. This attempt to further restrict midwifery and render it compliant to the medical community never reached the House floor. Representative Elaine Gordon, a supporter of midwives, compromised with Representative Graber and included input from the Board of Regents, a governing board for the State University System of Florida—currently known as the Florida Board of Governors—and the State Board of Medicine concerning the training and licensure of midwives. Unlike the Myers Amendment that had sought to completely eliminate the occupation of midwifery, the Graber Amendment shifted the training received by midwives from traditional midwifery schools to medical schools where they would train and work directly under the supervision of physicians.

The passing of the Graber amendment would be a step back for midwives who wished to remain autonomous. Already dismayed by legislators’ tactics, the midwives were even more dismayed when they learned that the Florida Medical Association and the Florida OB-GYN Society had been claiming that the Midwives Association of Florida was supporting the newly drafted Graber Amendment. During summer 1991, representatives of the FMA, FOGS, and MAF met three times as they attempted to resolve their differences regarding Senate Bill 1066 and House Bill 1513. The meetings focused on developing educational curricula and training requirements, and the organizations’ representatives agreed that midwifery would be placed under the Department of Business and Professional Regulation. In addition to coming to an agreement about the bills, the MAF brought in guest speaker Ina May Gaskin to describe her experiences as a midwife to the physicians of the FMA and FOGS.

Stephen and Ina May Gaskin had created the Farm, located in Summertown, Tennessee, in the early 1970s, where they had attempted to create a spiritual community sustained by farming. After three women became pregnant while living on the Farm, Ina May acted as a midwife and supervised all deliveries. Although Gaskin studied a midwife manual, a local general practitioner who provided Gaskin and other women on the Farm with obstetrical information, assisted her. The Farm also offered prenatal care to women who were not residents in the hopes of providing alternatives to abortions.\textsuperscript{194} Women who became involved with this offer could obtain medical care and keep their child, or they had the option of leaving their baby on the Farm to be raised by the residents. In 1975, Gaskin published \textit{Spiritual Midwifery}, a book based on her experiences working on the Farm that focused on the birth experience and the spiritual health of the mother. At one of the meetings, Gaskin explained how she had performed breech deliveries vaginally. Justine Clegg, who was present at the meeting, recalled that the obstetricians were “mesmerized” by Gaskin’s explanation because most of them were taught to do Cesarean sections for breech deliveries.\textsuperscript{195} Apparently midwives knew more than the physicians thought they knew.

Although midwifery continued to face opposition well into the 1990s, 1992 was a successful legislative year for midwives. House Bill 553 to amend the Midwifery Practice Act (1982) proposed changes to the existing law that the FMA members were willing to accept. Individuals aged 21 or over who completed the three-year training program and passed the state exam would be allowed to legally practice midwifery in Florida. In addition, midwives licensed in other states and even in other countries would be able to obtain certification in Florida as long

\textsuperscript{194} Rooks, \textit{Midwifery and Childbirth}, 61.
\textsuperscript{195} Justine Clegg interview by Megan Bowes, 23 January 2014, Reichelt.
as their training met Florida standards.\textsuperscript{196} When the legislation passed in 1992, the midwifery community in South Florida had to decide whether or not to reopen the South Florida School of Midwifery, join a private vocational school—National Technical College—or create a program with Miami Dade Community College. Ultimately they decided to join Miami Dade Community College because the program would be able to accept more students, students would have access to financial aid, and being within the state system of higher education would help the occupation grow.\textsuperscript{197}

Once again, Clegg took the lead in developing a midwifery curriculum, this time one that was based upon the curriculum she had developed for the South Florida School of Midwifery and that would lead to an Associate of Science in Midwifery. Enrollment began in 1994 and students were required to “take thirty-four credits (one year) of general education and basic science courses similar to nursing prerequisites, and an additional fifty-six credits (two years) of core midwifery courses.”\textsuperscript{198} The midwifery program at Miami Dade Community College was the first direct-entry midwifery program in the country offered by a public higher education institution, and it successfully graduated students until 2008, when the high attrition rate of its students led to the program’s cancellation. The program had also faced internal opposition by Miami Dade’s Nursing Department.\textsuperscript{199} Clegg recalls that the Chair of the Nursing Department had opined that midwifery was “not a legitimate profession” and that she had stated that she was “vehemently opposed” to the midwifery program at Miami Dade Community College. When the midwifery program transitioned from the supervision of Allied Health to the Nursing Department, she was instrumental in closing the program. However, the opposition from nursing

\begin{footnotes}
\item[196] Florida House of Representatives, “Bill Analysis.”
\item[197] Justine Clegg interview by Megan Bowes, 23 January 2014, Reichelt.
\item[198] Denmark, “Governor’s Full Support,” 251.
\end{footnotes}
and nurse-midwifery to direct-entry midwifery was not unique to Miami Dade Community College, and can been seen throughout the history of midwifery in the United States.\textsuperscript{200}

While Miami Dade Community College was successful in graduating midwifery students until 2008, the education of midwives continues in Florida. The Florida School of Traditional Midwifery (FSTM), located in Gainesville, Florida, is a non-profit corporation founded in 1993, a year after the Myers Amendment was lifted. Jana Borneo, one of the midwives who was active in the revision of the Midwifery Practice Act (1982), and other women interested in maintaining midwifery practices in the state formed the FSTM’s Board of Directors and designed a program that focused on “independent practice in maternity care in an out-of-hospital setting.”\textsuperscript{201} The FTSM offers two different programs: the Direct-Entry Midwifery Program and the Licensure by Endorsement Program. The Direct-Entry Midwifery Program prepares students to become licensed Florida midwives; they earn a diploma, not a formal degree. The Licensure by Endorsement program “is a pre-licensure course for midwives certified to practice in other states, CNMs [Certified Nurse Midwives], and midwives from other countries who wish to become a licensed midwife in Florida.”\textsuperscript{202} The FTSM offers clinical training in a variety of sites—doula practices, doctor’s office, hospitals—and focuses on birth center and homebirth practices while operating as an on-site only program. In addition to the FTSM, the International Institute for Health Care Professionals (Boca Raton, Florida) and the Commonsense Childbirth School of Midwifery (Winter Garden, Florida) became approved midwifery schools in 2008 and 2009, respectively.

\textsuperscript{200} Ibid.
\textsuperscript{201} Midwifery Education Accreditation Council, MEAC Accredited Schools, http://www.meacschools.org/accredited_schools.php#SID5.
\textsuperscript{202} Ibid.
While Florida midwives were successful in creating the Midwifery Practice Act of 1982, they faced a number of legislative roadblocks along the way. The Myers Amendment essentially closed the only midwifery schools in Florida before they even began. However, the perseverance of the Midwives Association of Florida, its members, and the support of legislative sponsors, the Myers Amendment was repealed in 1992. The continued development of midwifery schools and an education curriculum focused on the midwifery model of care continued well into the twenty-first century, keeping midwifery as a viable birthing option for Florida women.
CHAPTER FIVE
CONCLUSION

The development of midwifery programs in the early-twentieth century marked a pivotal moment in Florida’s history regarding women’s health. The regulation and training programs implemented by the state followed the aims of social welfare programs that were being developed throughout the nation in an attempt to decrease the “midwife problem.” The Florida State Department of Health, and physicians more generally, viewed midwives as a necessary evil to be tolerated until sufficient numbers of professional medical personnel, i.e., physicians, were available throughout the state. Therefore, the Department of Health and Florida physicians were willing to support a regulated midwifery program as a temporary measure to meet birthing needs in the state.

The results stemming from the midwifery program based on the 1931 Midwife Act have been a subject of some debate. Sociologist Debra Anne Susie and Mary Pugh Mathis have both examined the roles of Florida midwives within these state training programs. Susie concluded that the trend to professionalize medicine in the 1920s and 1930s led to the end of midwifery practice (in particular, the practices of African-American “granny midwives”) because the midwives’ willingness to register with the state and obtain training through midwife programs allowed state agencies to regulate their practices and thereby slowly phase out midwifery.\footnote{Susie, “Grandmothers,” 39.} Mathis, however, argued that midwifery in Florida was not dismantled because of these training programs, but that in fact because of these programs, African-American midwives continued to practice well into the 1970s due to “institutionalized roles within the community.”\footnote{Mathis, “Lay Midwifery,” iii.}
both Susie and Mathis disregard the relationships that public health officials and public health nurses maintained with southern, predominantly African-American midwives.

Although state programs trained midwives in the early part of the twentieth century, medical advances combined with the increasing availability of nurse-midwives made the latter popular birth attendants, and Florida women relied less and less on lay midwives. However, the counterculture movement of the 1970s focused on a variety of social issues including women’s reproductive rights. The alternative birth movement, which developed during this period, argued against standard medical obstetric practices in the United States and urged women to take control of the birthing process. As a result of these alternative birth views, women in Florida began to apply for midwifery licenses through the State Department of Health, only to find themselves denied licensure.

Once their requests for licenses were denied, a few women decided to challenge the state by suing for licenses. As a result, the courts ruled that the original Midwife Act of 1931 was unconstitutional, and the with the bedrock of state laws on midwifery no longer in effect, the path was open to develop new legislation on midwifery practices. Realizing that they needed to take part in the legislative process if they were going to achieve their ends, a number of midwives formed the Midwives Association of Florida to represent their interests and they worked to develop the Midwifery Practice Act (1982), which resolved the vague language of the original statute and created state approved midwifery schools.

The success of the Midwifery Practice Act (1982) was short lived. The schools developed as a result of this act would only have one class of graduates due to the passing of the Myers Amendment, which ended enrollment at the North Florida School of Midwifery and the South Florida School of Midwifery. From 1984 until 1992, the Midwives Association of Florida wrote
the language for various bills in an attempt to reinstate midwifery schooling in the state of Florida. However, it was not until 1992, with the assistance of Representative Daryl Jones, that midwifery once again became a viable birthing option for women.

The opposition and displacement of midwives by the medical profession, i.e., physicians and nurse-midwives, is woven into the fabric of midwifery in the United States. Debates among historians have focused on how the professionalization of medicine and an increase in medical technology transitioned the birth process away from midwives’ traditional practices. The dramatic decrease in maternal and infant mortality rates after the enactment of the midwife programs in Florida provides evidence for the continued need for safe childbirth options. While midwifery practices waned during the mid-twentieth century, once Florida women began organizing in the 1970s and became politically active in their pursuit of midwifery as a viable birthing option, the role of midwives in serving mothers and their babies was once again strengthened, providing women with a non-medicalized choice for routine births.
# APPENDIX A

## TIME LINE

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1922</td>
<td>Laurie Jean Reid develops the <em>Manual of Instruction for Midwives</em></td>
</tr>
<tr>
<td>1931</td>
<td>The Midwife Act (Florida Statute 485) is passed</td>
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<tr>
<td>1933</td>
<td>Midwife instruction program opens in Tallahassee, FL</td>
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<tr>
<td>1963</td>
<td>191 licensed midwives in Florida</td>
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<tr>
<td>1974</td>
<td>57 licensed midwives in Florida</td>
</tr>
<tr>
<td>1979</td>
<td>Midwives Association of Florida (MAF) is formed; ruling in <em>State v Baya</em> declares the Midwife Act of 1931 unconstitutional</td>
</tr>
<tr>
<td>1980</td>
<td><em>State v. McTigue</em> court rules over vague definitions in Florida Statute 485</td>
</tr>
<tr>
<td>1982</td>
<td>The Midwifery Practice Act (Florida Statute 467) is passed</td>
</tr>
<tr>
<td>1983</td>
<td>North Florida School of Midwifery opens; <em>State v Petty-Eifert</em> ruled the guidelines stipulated by the Department of Health and Rehabilitative Services were an invalid exercise of delegated legislative authority.</td>
</tr>
<tr>
<td>1984</td>
<td>South Florida School of Midwifery opens; Myers Amendment passed and restricts further licensing of midwives in Florida</td>
</tr>
<tr>
<td>1986</td>
<td>North Florida School of Midwifery closes</td>
</tr>
<tr>
<td>1990</td>
<td>Senate Committee on Health and Rehabilitative Services (Sunrise Report) recommends reestablishing licensure for midwifery</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
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<tr>
<td>------</td>
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<tr>
<td>1992</td>
<td>New midwifery legislation (House Bill 553) is passed</td>
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<tr>
<td>1994</td>
<td>Miami-Dade Community College offers a degree for licensed midwifery</td>
</tr>
<tr>
<td>1995</td>
<td>Florida School of Traditional Midwifery opens</td>
</tr>
</tbody>
</table>
April 2, 2014

To: Manuscript Clearance Committee
   Florida State University

The American College of Nurse-Midwives is the professional organization for more than 7,000 certified nurse-midwives and certified midwives. Its leadership is staffed with volunteers like myself. The ACNM maintains organizational archives at the National Library of Medicine. A portion of those archives are sealed and require the permission of the ACNM before disclosure.

Megan Bowes, CNM, of Florida State University sought permission from the ACNM to use sealed ACNM archives at the National Library of Medicine for her dissertation and later publication. The ACNM Board of Directors authorized the Archives Committee to decide on records release for Ms. Bowes.

Ms. Bowes has the permission of the American College of Nurse-Midwives to use the requested archived material from the National Library of Medicine for her dissertation and subsequent publications. The ACNM Archives at the National Library of Medicine must be acknowledged as the source of this material. Additionally, Ms. Bowes should send a copy of her dissertation for the ACNM National Library Office.

Please contact me with any further questions.

Sincerely,

Cecilia Jevitt, CNM, PhD, FACNM
Associate Professor
Midwifery Specialty Coordinator
Archives Committee Chair American College of Nurse-Midwives
cecilia.jevitt@yale.edu
office: 203-737-5609
APPENDIX C

HUMAN SUBJECTS APPLICATION

Human Subjects Application – For Full IRB and Expedited Exempt Review

PI Name: Megan Kathleen Bowes


HSC Number: 2014.12700

Your application has been received by our office. Upon review, it has been determined that your protocol is an oral history, which in general, does not fit the definition of “research” pursuant to the federal regulations governing the protection of research subjects. Please be mindful that there may be other requirements such as releases, copyright issues, etc. that may impact your oral history endeavor, but are beyond the purview of this office.
REFERENCES

Manuscript Sources


Reichelt Program of Oral History, Florida State University, Tallahassee, Florida.

State Archives of Florida, Tallahassee, Florida. [Series 19; 18; 904]

Government Documents


Books and Articles


Miller, Jill Young. “Delivery Service as the Number of Licensed Midwives in Florida Dwindles, a Grass-roots Group Pushes for Change.” *Sun Sentinel* 14 March 1990.


BIOGRAPHICAL SKETCH

Megan Bowes is from Port Saint Lucie, Florida, and received her Bachelor’s degree in history from the University of Central Florida in spring 2011.