BY THEIR OWN AGENCY: A MEDICAL HISTORY OF ASHE COUNTY, NORTH CAROLINA

A Thesis

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ABSTRACT
BY THEIR OWN AGENCY: A MEDICAL HISTORY OF ASHE COUNTY, NORTH CAROLINA
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Dr. Joseph Robinson practiced medicine in Ashe County, North Carolina for over fifty years, beginning in the early 1900s. His practice exemplifies the coexistence of traditional ethnomedicine and professional biomedicine in the Appalachian region and gives clues to the myriad health strategies used in Ashe County. Instead of choosing one system of healing to the exclusion of others, the people of Ashe County rationally chose a variety of healing strategies, including traditional ethnomedical methods like midwifery, herbal remedies, home remedies, religious healing, and use of the community-based healer, while also incorporating biomedical services into their healing cache.

This thesis describes the development of a rational, culturally grounded medical system involving not only traditional ethnomedical practices but biomedicine as well. It also addresses the agency exhibited by people living in the area in both maintaining and transforming their healing system. This analysis is grounded in an examination of the history of Ashe County, North Carolina, and oral interviews with the people of the North Fork of the New River regarding traditional healing and the practice of Doc Robinson.
From 1880 to 1930, transitions occurred in the healing techniques employed by residents of Ashe County, North Carolina, as they did elsewhere. Recently, scholars including Sandra Barney (Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930, University of North Carolina Press, 2000) have focused their work on the healing practices of southern and central Appalachia. Barney and other scholars explore the impact that northern philanthropists and benevolent workers had on the transition from traditional healing methods to professional biomedicine. However, Barney's notion ignores the possibility of multiple healing strategies and assumes biomedical hegemony.

In order to counter the current assumption that biomedical practices were the dominant healing methods in Appalachia in the early twentieth century, this thesis shows that biomedicine was a completely rational healing choice within the traditional ethnomedical system already in place in Ashe County. It begins with an introduction to the traditional ethnomedical and biomedical systems used by community members. Much has been written about the variety of healing options available to people throughout time, and much has been written about the changes that healing systems have experienced; these topics are reviewed in chapter 2. With the aim of describing the healing strategies utilized by residents of Ashe County and the reasons for their use, I have included an ethnohistorical description of the county. Finally, stories about Doc Robinson show that the residents in Ashe County made deliberate, rational, culturally-grounded decisions in health care choices.
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Chapter 1: Introduction

This thesis focuses on medical practices and the physician who served the communities along the North Fork of the New River in Ashe County, North Carolina, 1900-1950. I seek to show not the uniqueness of Ashe County’s medical history, but its history in its context as an American community, as Appalachia does not exist in a vacuum separate from the rest of America. That Ashe County is a rural agrarian county has much to do with the maintenance of multiple systems of healing, as community members will deliberately choose a variety of healing strategies based upon their involvement in the rural community life and value system (Efird 1985).

People living in the North Fork area today can still remember the life and practice of one community doctor, Dr. Joseph Robinson. Doc Robinson lived and practiced in the area between 1900 and 1950. From stories told by former patients and community members, it is obvious that Doc Robinson was well received and trusted. Community members attest to having the option of using a variety of healing methods, including neighborhood healers like granny women, midwives, and Doc Robinson, and home remedies that incorporated store-bought goods such as salt and paregoric, and locally gathered herbs like lobelia, catnip, boneset, cherry bark, mint, buds, elder flower, ginseng, and burdock root (Stephens Store Records 1927-1942), and community-based religious healing involving communal prayer (Keefe 2003). As a result of Doc Robinson’s
willingness to participate in the traditional ethnomedical system that was already used in Ashe County, albeit as a biomedically trained physician, the people trusted him. This trust was solidified because of his marriage to Julia Sutherland, a member of a prominent family in the community. It was through mutual trust and respect between Doc Robinson and his community that multiple systems of healing existed simultaneously in the North Fork area.

Medical anthropologists note numerous healing systems at work in rural and urban communities including biomedicine, "the application of new technologies to now relatively old ideas about health and healing" and traditional ethnomedicine, "relatively old medical technologies that evolved as part of human cultures and societies and can now be reinterpreted in light of new ideas about health and healing" (Micozzi 2002: 398). An analysis which begins with the dominance of the study of biomedicine ignores biomedicine's foundation in ethnomedicine--biomedicine is but one among many culturally constructed systems of healing (Micozzi 2002). All healing systems are culturally viable, given the explicit, rational decisions made by people in choosing which strategy to use in order to ensure health and well-being.

A system of medicine that integrates both traditional ethnomedicine and biomedicine has been called complimentary or alternative medicine (Baer 2002). A complementary medical system provides the community with any number of health care options, thus providing individuals more control over their own well being. Medical anthropologists have sought to understand the concept of complementary and alternative medicine by observing patterns in how individuals select, combine, and apply many cultural elements in order to maintain wellness (McGuire 2002). Shelley Adler notes that
“biomedical and alternative health traditions may only appear to be irreconcilable: their apparent inconsistencies are not viewed as such or are deemed insignificant by those who engage in them either concurrently or sequentially” (Adler 2002: 413).

Medical anthropologists have recently noted the importance of examining the rationality in health care choices, the “...logic and ways of seeing that people draw upon to understand the nature of an illness and how to address it...” (Hunt and Mattingly 1998: 267). According to Hunt and Mattingly (1998), until recently there was an assumption in the field of medical anthropology that biomedical is logical and relies on scientifically tested methods while traditional ethnomedicine is grounded in cultural beliefs. Since both systems of healing are logical and culturally grounded, attempts to dichotomize health care systems in use by Appalachian people only serve to strengthen stereotypical depictions of rural people as less logical than their urban counterparts.

Scholars of the Appalachian region have often made reference to stereotypical images of Appalachian people. Through their examination of the cultural shaping of the region they have neglected to examine the possibility of multiple models of development. Sandra Barney’s landmark contribution, Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930 (2000), provides a detailed description of the advancement of biomedicine into the Appalachian region. Barney maintains that as the field of medicine became more competitive, a variety of professional and non-professional health-related societies formed, thus advancing the spread of biomedicine in Appalachia. Despite Barney’s state of the art and widely accepted presentation of health care in Appalachia, her work does not take into account the rational
decision making that occurred when people living in these areas deliberately chose a varied
healing system. Instead of viewing development within the Appalachian region as
homogenous, scholars must consider the multiplicity of development paths within
Appalachia.

Anthropologist Rhoda Halperin’s description of the multiple livelihood strategies
in rural Kentucky (1990) provides a useful model for understanding the livelihood
strategies used in Ashe County that allow for the persistence of both traditional
ethnomedicine and biomedicine in a rural agrarian setting (Efird 1985). Earlier described
as “occupational multiplicity” by Lambros Comitas in his examination of rural society in
Jamaica (see Comitas 1964), “multiple livelihood strategies” provide community members
with diversified ways of earning a living to best meet their economic needs.

Anthropologist Hans Baer has noted that “all medical systems are embedded in larger
cultural and political economic systems to which they must always respond...” (Baer 2001:
343). Ashe County residents made use of multiple healing strategies, that is, a variety of
home remedies, community-based healers like midwives and granny women, herbal
remedies, and religious healing. Additionally, biomedicine was deliberately incorporated
into the healing system in Ashe County, as the people of Ashe County chose to diversify
their health care options by maintaining some forms of traditional ethnomedical healing
while accepting the practice of local, professionally trained doctors.

Sherry Ortner’s detailed article “Theory in Anthropology Since the Sixties” (1984)
is centered around a people’s agency and provides the impetus for exploring the ability of
Ashe County residents to make their own choices regarding health care. Ortner
provides the theoretical grounding for the hypothesis of this study—that the people in Ashe County were agents of change in their own medical history. Agency, as described by Ortner, is the act of purposefully participating in a culture so far as to determine how that culture is shaped. Ortner maintains that it is important in anthropology to see any system from the actor’s point of view (Ortner 1984). Ortner marks the 1980s as a time when interest grew in cultural analysis focused “...through one or another bundle of interrelated terms: practice, praxis, action, interaction, activity, experience, performance. A second, and closely related bundle of terms focuses on the doer of all that doing: agent, actor, person, self, individual, subject” (Ortner 1984: 144). The dominant forms of action that a community participates in best explain the shape of any system in that community at any given time. Specifically for Ashe County, the community’s activities regarding the evolution of their medical systems explain the extent to which they are agents in these systems. This practice approach--examining what people do--is the method chosen for this research on the medical history of Ashe County.

The practice approach focuses particular attention on the political action of a culture. Across America in the early 1900s, the people in political control supported the standardization of medical practices and called for laws and restrictions attempting to prevent midwives from practicing and stabilizing the position of biomedicine in the community. Individuals in the communities along the North Fork of the New River chose to uphold or defy these laws based upon rational decisions, and a traditional ethnomedical system remained simultaneous to the blossoming of biomedical practices.
Ortner maintains that “actors rationally go after what they want, and what they want is what is materially and politically useful for them within the context of their cultural and historical situations” (Ortner 1984: 151).

I have chosen to describe the medical history of Ashe County because no other descriptions of the multiple healing systems of this county have been published to this date. This thesis seeks to create a new vision of the forces at work to shape the Appalachian region, and to give a little more credit to the people of the region as shapers of their own lives. The result will be a medical history of Ashe County, North Carolina, specifically focusing on the North Fork area of the New River, paying careful attention to the examples of acceptance of biomedicine in the area and examples of the maintenance of traditional ethnomedicine as well. The life of one doctor, Joseph Robinson, clearly demonstrates that the people of Ashe County accepted professional medicine in their communities by their own free will, and that neighborhood healers still existed shows that this was a deliberate and complementary act to diversify traditional ethnomedical practices already in place.
Chapter 2: A History of Healing: Review of the Literature

This chapter provides an overview of the literature pertaining to transitions in traditional ethnomedicine to include biomedical strategies in Appalachia. Since Appalachian development did not occur separate from the development of the rest of America, I incorporate information on the changes in healing across America. Medical practices in the Appalachian region have often been seen from the perspective of a biomedical hegemony. However, people across the world throughout time have rationally incorporated a variety of healing methods, including traditional ethnomedical treatments like the use of herbs, midwifery, and religious healing, and biomedically trained physicians. Most examinations of healing practices in Appalachia ignore the cultural significance of combining traditional ethnomedicine and biomedicine, furthering the stereotype of cultural change as forced by outlanders. For this reason, an examination of scholarly treatments of stereotypes and community-based studies is also included. Throughout time, people have chosen different healing methods that work best given the type of illness or seriousness of the problem, often using a combination of remedies.

Part 1: Scholarly Works on Traditional Ethnomedical Practices

Cherokee Indians inhabited and used for hunting camps the mountains of western North Carolina as of the 1500s (Arthur 1914), and there has been some indication that early settlers in the region learned much about the healing properties of local plants from Indians living in the area (Lopes 1996; Bush 1992; Cavender 1989; Alexander 1981).
According to Cherokee storyteller Davey Arch as told to historian Barbara Duncan, the Cherokee developed a cosmology which incorporated the use of plants like tobacco and ginseng as medicine (Duncan 1998). Herbal healing was a vital part of Cherokee ceremonial beliefs, combining knowledge of plants with a religious belief system (Lopes 1996). This method of combining multiple methods of healing is comparable to the traditional ethnomedical practices found in Ashe County in the first half of the twentieth century.

The Cherokee, before incorporating the ideals of scientific medicine into their own time-tested remedies after the arrival of white settlers, believed that their knowledge of the healing power of herbs was given to them through religious experience, by way of visions sent by the Creator. Cherokee historian Barbara Duncan has collected and analyzed numerous Cherokee stories, many of which indicate that some Cherokee still follow the “old way” of healing. In several different variations, Cherokee storytellers Robert Bushyhead and Freeman Owle tell of the Wolf Clan, whom the Creator taught how to heal wounds with certain herbs. Members of the Wolf Clan are traditionally the healers, but this knowledge can be taught to members of other groups. Specific formulas and prayers have been passed down over time through stories. Many of these stories involve descriptions of the plants, their location, and the spiritual importance of collecting herbs (Duncan 1998). Through the stories about their past, it is apparent that the Cherokee developed their knowledge of herbal healing from experience, empirical observation, and a religious belief system.
The Cherokee system of healing, in addition to having religious overtones, includes a belief in balance, or "whole health," so that if one's entire body is not healthy physically and spiritually then illness strikes. This differs from the reliance on the germ theory of biomedicine, in which a person becomes physically sick when a germ enters the body (Griggs 1981). The Cherokee combine this belief in balance with the idea of preventative medicine (keeping the whole body in balance before one can even get sick) and religious cleansing through ceremonies. Herbs are often employed before the onset of symptoms to prevent sickness, and this is often done in ceremonies such as sweat lodges during which the participant is spiritually cleansed through the use of herbs like sage and intense heat from steam which occurs once water is poured on the hot rocks inside the lodge (Duncan 1998). During a recent panel discussion at an Appalachian Studies Association Conference, Cherokee Amy Walker noted that running water and other natural resources are still very important for spiritual cleansing (Walker 2002). Amy Walker noted that midwives and herb doctors do not have the clientele they once had because more people rely on modern hospitals. It has been said that Indian people no longer make use of the old recipes for remedies (Walker 2002).

Despite this trend away from strictly traditional ethnomedical practices, many Cherokees are combining traditional ethnomedicine and modern resources and facilities. The spiritual overtone that was a part of religious healing in the past remains a part of the Cherokee healing system as well, as Cherokee attempt to combine Christian beliefs with traditional religious beliefs in their healing practices (Duncan 1998). Cherokee Patricia Grant in the panel discussion cited above, noted that when the first clinics were established
on the Eastern Band Reservation in North Carolina, they were designed to treat people with white middle-class values. Spiritual leaders and others began to notice that Cherokees were not responding to treatments from these clinics. In response to this, the Cherokee began to open their own clinics, more suited to their values by making use of spiritual cleansing. Grant remarked “this is validating the very essence of which we are as Indian people” (Walker 2002). In this practice of combining traditional ethnomedicine and biomedicine, the Cherokee of today are not unlike the early European settlers to the Appalachian region.

In his 1914 work on the history of western North Carolina, John Preston Arthur wrote that the Appalachian region was settled by Scots-Irish, French Huguenots, Germans, Swedish, and Danish peoples of Protestant backgrounds who flooded the area in the late 1700s to find Cherokee and Catawba Indians living in transitional hunting camps (Arthur 1914). The Appalachian region has been seen recently by scholars as overwhelmingly settled by Scots-Irish people. Historian H. Tyler Blethen has examined the extent to which the region has been shaped by its Scots-Irish heritage. Blethen notes that some policy makers and historians have used the idea of Appalachia’s Scots-Irish heritage to romanticize the cultural uniqueness of the region as an area “where time stood still.” Faced with this stereotype, Blethen explores the roots of Appalachian people and how powerfully a Scots-Irish heritage shaped the culture of the region. Pointing out that populations from other parts of the world settled the Appalachian region in addition to the Scots-Irish, Blethen discovered that Native Americans, English, German, French, Welsh, Italians, and Africans were among the first peoples to settle and influence
culture in the mountains (Blethen 1995). However, the Scots-Irish represent the largest group to settle in the region. More importantly, Blethen notes that the people of the Appalachian region see themselves as descendents of early Scots-Irish settlers (Blethen 1995). Nevertheless, Blethen was quick to point out that since the Revolutionary War, the cultural landscape of the Appalachian region has been made up of people from all over the world (Blethen 1995).

When the first waves of European settlers began to spread across America into the Appalachian Mountains of North Carolina in the 1700s, there were no professionally trained doctors living in the area. In his extensive study on folk medical practices of Appalachia, anthropologist Anthony Cavender described the medicine of Native American peoples and early European settlers as naturalistic folk medicine—that is, using plant, animal, and mineral substances to cure sickness (Cavender 1989). Early settlers brought cures from their homelands and combined this knowledge with healing practices they learned from the Native American peoples already living in the area (Lopes 1996; Cavender 1989; Alexander 1981). Florence Cope Bush, a freelance writer from Knoxville, Tennessee, has written *Dorie: Woman of the Mountains*, a memoir based upon her mother’s life in the North Carolina mountains. Dorie Cope’s family lived in Oconaluftee, North Carolina in the early twentieth century. Oconaluftee was once a township but has now been absorbed by the present-day reservation of the Eastern Band of Cherokees. Dorie recalls that her family was in close contact with Cherokee living in the area. “A doctor was never in attendance because there wasn’t one in the mountains” (Bush 1992: 14-15). A family member or a midwife from the township usually delivered
babies. Cherokee midwives delivered Dorie's brother Luther, and provided herbal remedies when the family was sick. Dorie remembers numerous occasions where Cherokee "herb doctors" or midwives would teach settlers about the healing properties of indigenous plants (Bush 1992). This demonstrates that a cultural exchange of traditional ethnomedical healing techniques was occurring between Cherokees and settlers.

In the late 1700s, immigrants to America brought knowledge of healing practices with them from their ancestral lands. Some settlers even brought seeds from healing herbs across the Atlantic Ocean, which they planted and cultivated in the New World (Lopes 1996; Crellin and Philpott 1990). An early European scientific interest in American botany prompted more of a cultural exchange of healing techniques between urban settlers and Native American populations than did necessity, and publications of the 1700s encouraged specific attention to indigenous American herbs. For example, an early medical self-help book, Gunn's Domestic Medicine (Gunn 1830), encourages settlers to seek knowledge and help from the Indians, advice that may or may not have been followed depending upon relations between the Native Americans and their new neighbors (Crellin and Philpott 1990). Despite some amount of adoption by the settlers of Native American healing techniques like the use of indigenous herbs, ethnographers like Crellin and Philpott (1990) and Duffy (1979) have downplayed the extent to which this cultural knowledge was shared in the mountains.

Traditional ethnomedical healing practices in rural areas of America developed out of necessity. Northwestern North Carolina was relatively isolated until the late 1800s, and some places remained isolated well into the 1900s. Health services did eventually exist,
but were rarely accessible or affordable for residents in more remote areas (Cozzo 1999). David Cozzo’s 1999 Master’s thesis *Herb Gatherers and Root Diggers of Northwestern North Carolina* examined specific herbs and herbal remedies used in Watauga County, Avery County, and Ashe County, North Carolina. These herbs have been used for centuries, and the uses for them were common knowledge prior to the arrival of physicians to the area. Early settlers had to make do with self-treatment, yet this did not exclusively involve the use of indigenous herbs. In the absence of doctors, chemical materials and patent medicines also made their way into the healing techniques of mountain people, including store-bought goods like salt. By the 1900s, the use of botanicals was declining in the professional medical community, sharpening the distinction between traditional ethnomedical practices and biomedical practices. Although herbs were declining in use by professionally trained physicians, herb use remained a part of home remedies well into the twentieth century (Crellin and Philpott 1990). Cratis D. Williams, considered the father of Appalachian Studies, has described in detail herbal and other home remedies that he remembers from his own Appalachian childhood in the early twentieth century. Williams recalls that as biomedicine crept into more isolated areas of Appalachia, people began to use a variety of methods when illness struck. Specifically, Williams relates how his father acted as home doctor, checking the children for the appearance of rings around their mouths which indicated worms, then treating the ailing children with a mixture of store-bought cold coffee, the steeped leaves of the vermifuge plant which grew in the family garden, and a white powder obtained from the country doctor (Williams 2003).

Many homes in the late 1890s had self-help manuals like *Gunn’s Domestic*
Medicine (1830) that were used to explain symptoms and suggest treatment (Williams 2003; Lopes 1996). According to Mountaineer Heritage, a newsletter published in Ashe County, the professional doctor was often the last resort in times of sickness. There were no hospitals in the early 1900s, and many homes had access to and had to rely on reference books like Gunn’s Domestic Medicine to heal themselves (Lewis 1986).

Community midwives often assisted in childbirth, and each neighborhood could boast of its own healer who was knowledgeable in healing practices. Cratis Williams especially describes the use of folk remedies in childbirth, including the reliance upon the local midwife even when professional doctors were available. Childbirth, as described by Williams, was a community event, in keeping with local cultural values such as neighborliness and strong familial ties. The continual use of local “granny women” in childbirth was appropriate because the local population trusted the granny women since they were part of the immediate community (Williams 2003). Midwives continued to be active well into the twentieth century because they were less expensive and more woman-centered and empathetic than biomedical physicians (Frazier 1992). While the number of practicing midwives declined with the arrival of biomedically trained physicians and laws forbidding midwifery, the use of midwives and cures concocted from natural products did not totally vanish (Efird 1985).

In addition to herbs, store-bought goods, patent medicines, and country doctors who may or may not have received professional biomedical training, religious beliefs were also incorporated into the healing systems of the Appalachian people. Anthropologist Anthony Cavender has noted that the faith healer—who, like the Cherokee, believes that
healing knowledge comes from divine intervention--is one type of folk healer found in the Appalachian region. Cavender focused on a particular form of faith healer known as a bloodstopper. Bloodstoppers have a gift for stopping excessive bleeding, which is often accomplished by placing a hand on the wound and reciting a Bible verse (Cavender 1989). Eliot Wigginton, in his work in Rabun Gap, Georgia has also noted that faith healing through the prayers of concerned community members is common throughout the region (Wigginton 1972). According to the findings of C. Horace Hamilton in Thomas Ford’s 1962 The Southern Appalachian Region: A Survey, however, faith healers “were not considered to be so popular” in the healing strategies of Appalachian residents in the mid-twentieth century, with only 2% of the people surveyed depending on faith healers “a great deal” and 8.7% “some” (Ford 1962). The use of faith healing is perhaps not as overt as the use of other methods in traditional ethnomedicine, but it is nonetheless part of the system of folk healing in use by some residents of the region.

Anthropologist Susan Keefe has noted that while professional faith healing is not used as much by Appalachian people as other healing methods, religious healing as a communal effort is used a great deal. Religious healing includes all forms of prayer within the institutional church setting and relies on stable communities, trusted personal relationships, and strong connections to people and place (Keefe 2003). Serious illness in a community provides the opportunity for community members to gather together to provide comfort and aid to the sick, often in the form of prayer vigils. Keefe recognizes that healing is done through communal rituals in the church, during Sunday services,
prayer meetings, gospel singing, and anointing. When serious illness strikes, a prayer chain is enacted by telephone, attempting to include all members of the community in the power of prayer by the social group (Keefe 2003: 18). Religious healing is strongly grounded in the concept of holistic healing—total physical body, emotional, mental, and spiritual health. By combining several healing strategies, community members ensure holistic health.

In addition to the work done by Anthony Cavender on faith healing and Susan Keefe on religious healing in Appalachia, other scholars are focusing their attention on health strategies in the region. Folklorist Richard Blaustein, former editor of Now and Then, has analyzed health care in the region, noting that too often, scholars and social activists have overlooked the complexity of Appalachian people’s healing strategies and the pervasive stereotypes that often accompany this neglect (Blaustein 1989). Echoing the work of Blaustein, Tedesco, Thomas, and Cavender have noted the importance of including folk medicine and proprietary (patent) medicine in the study of medical systems, and have reinforced the idea that Appalachian people have in the past and continue today to employ a variety of healing methods in times of sickness (Cavender 1989; Tedesco and Thomas 1989).

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1 A 1989 issue of Now and Then Magazine, subtitled Health in Appalachia, focuses on past and present methods of healing in the region and gives special attention to the complexity of health systems at work in Appalachia. The magazine is published by the Center for Appalachian Studies and Services at East Tennessee State University, home to several scholars currently looking at health strategies in Appalachia. Marie Tedesco, Norma M. Thomas, Anthony Cavender, and Richard Blaustein have done extensive research and examination of the Archives of Appalachia, the Quillen-Dishner College of Medicine Archives, and the History of Medicine Museum and Library, all housed within East Tennessee State University.
Part 2: The Development of Biomedical Practices in America

Settlers coming to the New World beginning in the 1600s found a variety of healing techniques at their disposal. Soon after the arrival of European settlers in America, a few educated physicians attempting to claim supremacy over the knowledge of healing began to set up practices in the Appalachian region. The advancement of biomedicine into rural areas of America has long been of interest to scholars. Some historians have attempted to explain the widespread transition from traditional ethnomedicine to biomedicine based upon what occurred in only a few areas, specifically eastern Kentucky (Barney 2000). Yet a variety of scholars have explored various facets of the history of medicine in America that shed light on other possible circumstances that propelled biomedicine into the Appalachian region. Professional medicine existed in remote areas of America; remote areas of Appalachia were no exception.

Journalist and long-time enthusiast of alternative medicine Barbara Griggs became interested in the history of medicine as it relates to herbal healing and compiled her research in *Green Pharmacy: A History of Herbal Medicine*. Griggs traces the history of medicine in America to its origins in medieval European healing. Through trial and error, people learned what to do with the plants they found growing in proximity to their homes. They learned what season, time of day, and phase of the moon found the plant at its most

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2 For a complete history of the development of biomedicine in Europe since the Middle Ages, see Griggs 1981. For the purposes of this thesis, it is sufficient to note that medicine was not regulated and medical training was unavailable in England until the reign of King Alfred (870-899 AD). King Alfred wanted his subjects and especially his own royal household to receive first-rate medical care. He required physicians to receive training at universities and called for the regulation of healing practices. Trained physicians were using a variety of herbal remedies for their healing, in addition to practicing the act of bleeding a patient so as to balance the blood and remove impurities that were believed to cause sickness.
potent. Griggs contends that many cultures in medieval Europe believed in the Doctrine of Signatures— that plants have been "signed" by the creator with visible clues as to their usefulness (Griggs 1981). For example, yellow plants were believed to be affective against jaundice, an ailment of the liver that causes the patient to assume a yellow skin tone. This knowledge was passed down through hundreds of years and eventually became the bulk of the material found in home remedy books.

From the Middle Ages through the sixteenth century in Europe (and later in America), most healing was done at home with herbs and the help of uneducated community healers. In the absence of doctors, the housewife often had to be the healer, and if she was an influential (i.e. trusted) member of her community, she would lend her services throughout the village. Herbs that were grown in her kitchen garden or that grew wild in the nearby countryside provided the basis of her materials. Knowledge of the healing properties of herbs would be passed on to her daughters (Griggs 1981). With the colonization of America, her medicine cabinet was soon supplemented with exotic plants that explorers shipped back across the Atlantic to England.

Griggs notes that early explorers of America were interested in the native botany they found there. When Sir Walter Raleigh's men landed off of the coast of Virginia in the seventeenth century, they studied the botany and the medical uses of the plants they found in order to supplement their trade cargo. The first settlers of the Colonies had similar interests in the plants they found in their new home, but for different reasons. English settlers were interested in the medical uses of local plants. According to Griggs, "these people had crossed the Atlantic as settlers rather than traders, and were determined to be
self-sufficient as soon as possible" (Griggs 1981:100). Early settlers observed the Native American populations using local herbs and followed their examples. Since professional physicians were rare and when they did come to America they tended not to linger, community doctors had to do the healing. In the seventeenth century, everyone was a doctor. The only aspects of professional medicine that differentiated it from lay healing were professional medicine’s reliance upon European medicine and the practice of bleeding. Community folk healers in the Colonies would use remedies that Native Americans had suggested, and professional doctors would not (Griggs 1981). This difference between professional medicine and folk medicine would not be an issue until the financial security of professional physicians came into question in the 1800s.

John Duffy’s 1979 book *The Healers: A History of American Medicine* provides a comprehensive examination of the history of medicine in the United States and complements Grigg’s work. Duffy maintains that changes in professional medicine were similar in all rural areas. Therefore, most of the changes that occurred in Appalachian medicine occurred all over the United States. As American society became more complex, so did American medicine (Duffy 1979). At its beginning in the late 1600s, American medicine was largely a product of the findings of European medicine; thus, European research prevailed. Settlers often brought knowledge of and seeds from plants in the Old World with them to the New World (Lopes 1996). However, settlers in the New World also relied on the medical knowledge of Native American populations in the absence of European trained physicians. Native Americans shared medical knowledge with European settlers in more rural or remote areas, yet European medicine was more
pervasive in colonial townships (Duffy 1979).

Within the colonial setting, colonists often had to “make do” with available medical services. At first, few medically trained doctors came to the New World. Those physicians who had been educated in medical science normally chose to remain in Europe (Duffy 1979). By the late 1700s, early American universities offered medical licenses to anyone who professed a reading knowledge of the material. Wealthier gentlemen who were able to afford medical licenses became early advocates of regulated biomedical treatment because it secured their stability as medical practitioners. The “gentlemen surgeons” regularly practicing biomedicine in America—those with spare time and money—helped to lay the foundation for an effective American medical profession by keeping abreast of scientific medical developments in Europe through subscriptions to medical journals and promoting medical education, hospitals, and professional societies in the United States.

In addition to the gentlemen surgeons of the late 1700s, other colonists were practicing medicine, either as a family tradition of healing or as a result of an interest in the emerging field of medicine. In the eighteenth century, laws did not prevent apothecaries in the colonies from practicing medicine, so unlicensed apothecaries would often diagnose ailments. Midwives and other folk healers were also common and relied upon in specific communities. No laws governed the techniques employed by folk healers until the late nineteenth century. Scientifically trained physicians were few and concentrated in the urban centers (Duffy 1979). Still, physicians were not utilized in every aspect of health
care. Throughout the Colonial Era, midwives were considered experts in child birthing methods. Midwives would be the preferred child birth attendant until significant numbers of professional physicians began to perform births (Litoff 1986).

In the early 1800s, plants were still the basis of *materia medica*, although physicians became interested in the chemical properties of the active ingredient of the plants. Local folk medicine continued, but professional physicians became wary of home remedies. Professional physicians called those untrained doctors proclaiming medical knowledge "quacks," and attempted to separate themselves from unprofessional medicine in order to ensure their stability in the industry. During the early 1800s, those physicians proclaiming professionalism used medical beliefs grounded in theory; quacks were those that used plants known to result in a useful action for the treatment of specific ailments. In order to counter competition from quacks, professional physicians proclaimed to have correct and modern ideas regarding medicine (Griggs 1981).

As of the 1830s, no reform had been attempted in the education standards of the medical community. The wealthier American physicians earned an undergraduate degree and a license to practice medicine at the same institute, then continued their medical education in Europe. Schools like the College of Physicians and Surgeons in Baltimore, Maryland, Lincoln Memorial University in Knoxville, Tennessee, and the University of Pennsylvania offered medical degrees in the late 1800s (Goss 1984). However, most physicians at this time still had only a high school education. As late as 1850, some practicing physicians had no degree. Due to the ease with which most American physicians received medical licenses, an abundance of physicians were practicing in the
late 1800s. Competition arose between doctors for patients and money, and a call came forth for the standardization of treatments for specific diseases and the amount and quality of education practicing physicians should complete. During this time the rudimentary beginnings of medical societies were formed to bring about a higher level of standardization, but they remained little more than warring factions due to their inability to regulate licensing until the 1890s (Barney 2000; Duffy 1979).

Rural doctors at the turn of the twentieth century often concocted many of their own medicines. As we will see in Ashe County, quinine and morphine were available and frequently used by rural doctors. Both rural and urban doctors were making use of substances that were proclaimed by popular medical journals of the time to be the basis of materia medica: quinine, opium, alcohol, mercury, strychnine, and arsenic were standard components of medicine (Lofton 1995). Opium became a cure-all for everything from a broken leg to appendicitis. Opium was sold wholesale as raw gum opium, laudanum, paregoric, and morphine, all of which were used as the bases for many prescription and patent medicines. Still, medicine was not standardized. Patent medicines, which were patented by the government, were sold at stores over the counter, by itinerant merchants, and through the Sears/Roebuck and Company catalogue. As there were no regulations on their use or content, most patent medicines contained well over 47% alcohol (Frazier 1992).

During the late 1850s, certain traditional ethnomedical practices were still highly preferred. Midwives were still preferred by the majority of rural people for child birth and other pregnancy-related medical situations, and residents of urban areas were beginning to
criticize the over-use of anesthesia in child birth as the leading cause of breathing difficulties among pregnant women (Litoff 1986). Even upper and middle-class women, who had previously turned to physicians in the hopes of having a safer birthing experience often returned to the services of midwives upon learning that maternal and infant mortality rates remained high despite the increasing number of physicians in use by pregnant women (Litoff 1986).

Prior to the standardization of medicine and health care education, the number of physicians exceeded the need of the people in urban areas. It became difficult for doctors to accumulate enough money to support themselves or their families. Lack of organization in the medical field and the ease of getting a medical degree hampered the individual success of physicians (Barney 2000; Lofton 1995; Duffy 1979). However, the high number of physicians was concentrated mostly in urban centers; rural doctors in the late 1800s were still few and far between. As the number of doctors in urban areas continued to increase, standardization became necessary. Professional societies formed and laws were passed to define the parameters of acceptable medical practices.

Prior to the increased professionalization of biomedicine, most rural physicians who were engaged in teaching and medical practices found that they needed supplemental income to ensure their economic stability. Those who were not too busy in their medical professions turned to politics and farming to supplement their incomes. In smaller communities, the doctors were often the best-educated members of the community, with great stature and influence in the community. Therefore, when it came time to find a
community member to represent them in political office, a doctor often filled this spot (Duffy 1979).

Sandra Barney’s significant contribution to the study of medical systems examines early attempts at the professionalization of medicine in the Appalachian region as a prime example of the shift from traditional ethnomedicine to biomedicine and the development of the conflict between the two systems of healing. Barney maintains that 1880 to 1930 represents a period of fundamental reconstruction of health care in Appalachia (Barney 2000), a time coincidental with rapid industrialization in Appalachia (Eller 1982). The Industrial Age brought standardized education to the forefront of medical training, and nowhere was this change felt more than in Appalachia. According to Sandra Barney, "with the expansion of the economy and the rapid intrusion of new physicians into the region, doctors were vulnerable to the market forces that could displace them. In order to protect themselves and guarantee their stability in the community, doctors had to capitalize on the economic expansion and create a professional identity that would unite physicians across the region" (Barney 2000: 40). Barney’s study of medical professionalization in company towns of Kentucky, Virginia, and West Virginia outlines the methods that settlement workers and women’s clubs would use in order to convince the people to adopt professional medicine as their primary medical system (Barney 2000). Barney has also described the influence of settlement workers and middle-class women on the spread of biomedicine in Appalachia. Middle-class clubwomen—those forming federations and clubs for the maintenance of their middle-class economic status—were dedicated to promoting health resources for children, and mothers and used their
maternalistic influence to gain support for their ideals. Since women did not enjoy the benefits of professionalism that male physicians did, they used expectant mothers and families to promote their maternalistic values. Likewise, settlement workers in eastern Kentucky attempted to carve out a professional place for themselves in the health care profession by promoting the ideals of scientific medicine. By maintaining the idea of Appalachian need based on stereotypes of the day, missionaries, settlement workers, and professional physicians justified their attempts to bring aid to mountain people (Barney 2000; Shapiro 1978). Professional physicians (those trained at a medical school in scientific medicine) came to mining towns in the 1890s, and were allied with the mine owners to encourage the dependency of the workers on professional medical care.

Despite the support of mining operators for biomedicine in the 1890s, professional physicians needed additional support to fully convince mining families to embrace biomedicine to the exclusion of traditional ethnomedicine. Driven by maternalistic concerns and professional class ambitions, women attempted to promote biomedicine in eastern Kentucky (Barney 1999). The wives and family members of professional physicians formed women's clubs, proclaiming loyalty to the ideals of scientific medicine, which further improved the status of professional physicians. The women's clubs mainly functioned to promote the ideas of scientific medicine to women in mining and lumber camps by convincing the women that accepting professional biomedicine would be most beneficial to their families (Barney 2000). Attempting to convince rural people to seek the help of educated physicians fit into the clubwomen's ideas of maternalism--that seeking the help of professional doctors ensured healthy children. Through their activism, the
women asserted that they would be alleviating the suffering of mothers and children. Barney notes that the activism of the clubwomen in eastern Kentucky was well within the acceptable sphere of what a woman ought to be and to do because they were constantly deferring to the judgment of medical professionals (Barney 1999). Clubwomen accepted this deferential position because they were newcomers to the area and needed a means of carving out a place for themselves in their new surroundings. Club affiliation and benevolence work allowed clubwomen to create middle-class positions for themselves and gave legitimacy to their ideals of proper healthcare. These clubwomen soon joined statewide clubs, like the Kentucky State Federation of Women’s Clubs, which organized in the 1890s to spread professional medicine through programs like healthy baby campaigns that endeavored to teach women how to properly care for infants. Thus by 1900, the position of professional physicians was established around mining and lumber camps.

Missionaries and settlement workers also began coming into the Appalachian region attempting to raise the standard of living, primarily near mining and lumber camps. Settlement workers came to remote areas of Appalachia in the late 1800s. These women were educated outsiders of the reform elite who came to the mountains to bring social services like health care and education. Settlement workers, like clubwomen, wanted to build new professional opportunities for themselves while they attempted to eradicate the poverty that they saw in the mountains. They allied themselves with physicians to provide more validity to their projects but were constantly in deference to outside physicians (Barney 1999). Settlement workers often had a different agenda from the status
aspirations of women's clubs. Settlement workers focused their attention on more rural areas of Appalachia, areas that fell outside of the "jurisdiction" of mining operators. Hoping to secure professional status themselves by modeling their practice on scientific medicine, some were trained nurses, who were nevertheless under the complete control of professional physicians (Barney 2000). Reliance on the educated decisions of physicians by both club women and settlement workers helped secure the status of professional physicians in the Appalachian region. However, this professionalization did not signify the end of traditional medicine in all rural areas. Organizations like the Frontier Nursing Service encouraged local women to become trained nurse/midwives in order to best serve their native populations. The Frontier Nursing Service began in 1925 to provide standardized infant and maternal care to the people in the mountains of Kentucky. Mary Breckenridge, founder of the FNS, was an educated nurse who wished to train others in the "proper" methods of childbirth. The FNS claimed to offer more complete care for the mother and child than an untrained midwife could give (Dammann 1982). By encouraging trained nurses to provide familiar midwifery for local people, the FNS did not alienate people who were accustomed to providing for themselves.

Other settlement workers came to the mountains in the 1890s and early 1900s to establish settlement schools. The Hindman Settlement School was founded in 1902 in Knott County, Kentucky by May Stone and Katherine Pettit. Hindman was the first rural social school in the United States to provide educational opportunities for children and to provide community services like medical care (Stoddart 1997). Pettit continued her career in settlement work by founding the Pine Mountain Settlement School in Harlan County,
Kentucky in the early 1900s. The teachers at Pine Mountain taught a variety of subjects, including crafts and nursing. In North Carolina, Dr. Mary Sloop and her physician husband came to Crossnore in the early 1900s. Dr. Sloop’s husband was a practicing physician, doing home visits, while she kept office and treated visitors. Soon, the Sloops became more interested in helping mountain children through education than through medicine. The Sloops started Crossnore School in 1913 to educate poor mountain children. In 1923, the Weaving Room was built in the hopes of teaching the students a skill that would earn money for the school, and in 1928, a hospital was established to provide care for community residents (Sloop 1953).

Settlement workers and new professional clubs most affected the rural healers including midwives, as they pushed for laws to de-legitimize the positions of folk healers in their communities. Patent medicines were also called into question. In the 1890s a tax on patent medicines made them too expensive for the rural people who would make the most use of them; in turn, the expense increased the rural population’s reliance on the town doctor who would need to prescribe the medicines instead of allowing self-medication (Barney 2000; Lofton 1995). Town doctors needed to gain further status in their communities by convincing the people to break away from traditional forms of healing. However, this successful attempt at curbing the use of home healing strategies was not the first time legislation threatened to limit the healing options of rural people.

Most medical societies were attempting to push laws regulating the practice of medicine through congress in the late 1800s, but few succeeded. A group of eclectic physicians known as Thomasonians had formed by the early 1830s and pressured
professional medical societies to change their healing practices. Thomasonians believed that medicine should rely more heavily on natural and botanical remedies than the chemical remedies that professional physicians adhered to. Most states, under pressure from the growing body of Thomasonians, repealed legislation regulating medical practice in the late 1830s (Griggs 1981). In 1846 the American Medical Association first organized in New York to police medicine through private, professional efforts and attempted to regulate traditional healing practices through the passage of laws, thereby ensuring biomedically trained physicians' status (Barney 2000). On May 7, 1847, 250 American doctors met at the Academy of Natural Science in Philadelphia, Pennsylvania, to discuss several proposals, including high and uniform standards for all medical schools and stiffer entrance requirements. Also, it was proposed that members of the newly formed AMA could not associate professionally with "quack" doctors not affiliated with professional medicine (Griggs 1981). Thus a new trend in medicine was born: the urge to regulate unlicensed practitioners so to ensure the professional status of biomedically trained physicians.

Across the Atlantic Ocean in England, a law was passed in 1854 that attempted to regulate the practice of medicine. "Mr. Brady’s Medical Reform Bill" made it illegal for doctors to practice medicine unless they had been registered with the district board of health and they were a product of a medical school (Griggs 1981). The American Medical Association continued in its push for medical regulations on American soil, and by 1858 attempted to gain support for their own "Medical Act" to make it illegal to practice medicine without a license. This attempt failed because the AMA found that it had no real authority to regulate medicine (Griggs 1981). No laws regulating medicine would be
passed in North Carolina until 1935, when the General Assembly of the State of North Carolina passed "An Act to Protect the Health of Mothers and Infants and to Regulate the Practice of Midwifery.” This law authorized the state board of health to regulate midwifery, outlawed the practice of unlicensed midwives, and stipulated a fifty-dollar fine or thirty days in jail for refusal to comply. However, another interesting clause in this act stated that any county could withdraw from the act if it so desired, suggesting that this act was not as far reaching as the medical society had hoped (Efird 1985). Midwives could receive training prior to the adoption of the North Carolina midwifery act in 1935 through the Sheppard-Towner Maternity and Infancy Protection Act of 1921 (Barney 2000). Some midwives did receive training as a result of federal funds allocated to states to improve the care of infants as dictated by the Sheppard-Towner Act, but they never enjoyed the professional status of male professionally trained physicians who decried the creation of the act due to the competition that it fostered. The Sheppard-Towner Act expired in 1929 (Litoff 1986).

During the late 1800s, the American Medical Association sought to standardize the requirements of a medical education by pushing for a four-year degree requirement in medical school (Duffy 1979). Along with stiffer education requirements, the AMA sought to legitimize the role of the professional physician in the Appalachian region. According to Lofton’s study in rural Alabama, newspapers and medical journals around the turn of

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3 The North Carolina State Board of Medical Examiners was founded in 1859, although at its beginning it was virtually powerless to ensure the professional status of doctors in any way, including attempting to regulate midwifery. North Carolina became the first southern state to attempt to alleviate its rural health problems by organizing health boards on a county basis (Campbell 1921). The Medical Society of North Carolina existed in Ashe County by 1902 (Raleigh News and Observer 1902).
the twentieth century claimed that nurses held a more esteemed position than did physicians because of their attentive care for the patient. In order to improve their status, physicians needed to treat families in their own homes in order to gain the confidence and support of the community in which they practiced (Lofton 1995).

Home care was not fully embraced by physicians during the Industrial Age because of their push to convince people that the hospital was the only appropriate place to receive medical treatment, thereby increasing the reliance people had on the professional physician. Ultimately, physicians hoped to secure their professional status by creating a monopoly over the health care options available to community members. By doing this, doctors could demand payment for services and ensure that their livelihoods be met (Barney 2000). Professional physicians found particular security in mining and logging camps, where only one doctor practiced medicine and would often times be the company doctor. Every family in the camp relied upon one doctor as the prime physician at the company's orders. Barney points to the exploitative industries of coal and timber as creating a class system of elites, comprised mainly of medical professionals (Barney 2000).

Lofton, Barney, and other scholars provide exemplary works on the subject of medicine in Appalachia and each attempts to describe the distinction between the traditional ethnomedical and biomedical systems that operate in the region. Both systems operate at different times and simultaneously due to the lack of availability of biomedicine in some areas and the restrictive costs that professional medicine often involves. The medical profession is profit motivated, while traditional ethnomedical systems attempt to keep people from even having to use healers by teaching preventative medicine (Duffy
Preventative medicine seeks to address the whole person and to maintain the person's health by keeping the immune system healthy and able to ward off illness. Prior to World War II and even afterwards in some areas, many rural communities did not have access to professional medical care due to lack of paved roads. Home remedies and community-based healers were more readily available and required less money than medical professionals (Lofton 1995). Often times waiting for a distant physician was just not an option in life-threatening situations, and community healers and self-medication provided an alternative.

In the early twentieth century, people living in the Appalachian region had more of a choice between traditional ethnomedicine and biomedicine than people living in larger urban centers who were subject to the rules and regulations of professional biomedicine. The maintenance of some forms of traditional ethnomedicine like home remedies indicates that the two systems were often times combined by rural people—they never totally excluded either system. Danielle Lopes, scholar of Appalachian folk medicine, has theorized that both medical systems were maintained because of economic necessity and a tendency by Appalachian people towards self-reliance typical of rural-agrarian cultures. Lopes maintains that the Appalachian region never experienced long-term economic stability, so that there was a low tax base for industry, and therefore a continual lack of funding for rural health care (Lopes 1996). Karen Osgood agrees with Lopes in that while midwives generally existed where a community lacks health care personnel, they were also present even when physicians were available but were used instead by the local population because of a variety of economic, social, and cultural factors (Osgood 1966).
Thus, a workable folk medical tradition prevailed, in spite of the efforts of professional societies to eradicate traditional ethnomedicine.

Judy Barrett Litoff provides an indispensable resource on the arguments surrounding midwifery in her work *The American Midwife Debate: A Sourcebook on Its Modern Origins* (1986). Litoff chronicles the quest for professionalization by the biomedical community and the consequent displacement of many community midwives in the early twentieth century. In 1910, midwives attended 50% of all births in the United States (Litoff 1986). The professionalization of biomedicine and the advancement of obstetrics as a recognized medical specialty threatened to displace midwives as experts in child birthing methods. Most midwives, however, ignored any legal attempts by physicians to monopolize medicine.

Traditional ethnomedical practices continued to provide competition for professional biomedical practices in the 1920s. Physicians attempted to professionalize medicine by displacing midwives and traditional healers in coal and lumber camps, as did settlement workers, missionaries, and social workers elsewhere (Barney 2000; Ford 1962). While some settlement workers did make use of some midwives, they preferred scientifically trained medical professionals over local traditional healers. Despite these efforts, Appalachian people maintained their healing skills due to lack of contact with professional physicians (Barney 2000; Barton 1977). Communities that were not part of coal and timber operations were by and large scattered, and nurses would usually remain in one specific community for the duration of their service. The inability of professional medical societies like the AMA to regulate medical training in the early 1920s resulted in
professional physicians who were reaching isolated mountain communities often giving the people conflicting reasons for their illnesses. Additionally, doctors would rarely explain the illness to the patient, driving some people toward reliance on traditional cures which were time-tested and trusted (Barney 2000).

Physicians were also attempting to displace midwives during the early 1920s in order to insure their professional identities. This, however, would prove to be more difficult as a result of women's reluctance to call on a male physician for the delivery of babies due to a socialized code of decency, which made childbirth a private “for women only” affair (Duffy 1979). Midwives remained strong in these communities where women were reluctant to use professional obstetricians, who were all male due to the patriarchy inherent in the biomedical system which prevented most women from studying and practicing medicine (Efird 1985; Duffy 1979).

Cathy M. Efird’s Ph. D. Dissertation (1985), The Geography of Lay Midwifery in Appalachian North Carolina 1925-1950, discusses the decline of midwifery in Allegheny, Watauga, and Ashe counties. From 1925 to 1950, midwives generally outnumbered physicians in Ashe County. However, in time, the number of midwives began to decline. Efird describes four stages of decline in midwifery: maintenance, slow decline, rapid decline, and abandonment (Efird 1985). This decline is due to greater accessibility of physicians, urbanization, and changes in public policy. Of the three-county area of study, Ashe County had the highest number of midwife attended births for the years 1925 to

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4 As of 1899, a medical degree was a requirement before one could apply to the Board of Examiners in North Carolina. However, if one wanted a medical degree, it was necessary to go to other states until the 1940s (Duffy 1979), thus the discrepancy in medical training.
1950: 4,644 out of 13,671 total, or 34%. Efird maintains that Ashe County represents a regional pattern in midwife abandonment. Of the four stages of decline previously outlined, Ashe County experienced both slow and rapid decline in midwife usage from 1925-1950. The final abandonment stage was never reached in Efird's study timeframe, a fact she dismisses: "Had data been collected on either side of the study period, it is likely that the other two stages would have been observed. The eventual abandonment of traditional midwifery after 1950 has been well documented elsewhere" (Efird 1985: 155). However, Efird is quick to point out that these patterns also suggest regional variation in midwife attendance, suggesting a variety of reasons for the abandonment (which may or may not have been total) of traditional midwifery.

Efird suggests several factors affecting the abandonment of midwifery in Ashe County. Efird asserts that public (i.e., "educated") policy towards midwives led to their certain decline. "Because they did not present the same credentials as their trained physician counterparts, they were seen as deviant practitioners operating within a traditional, non-scientific medical system. Midwives were seen as a problem from the point of view of the medical establishment" (Efird 1985: 211). Professional physicians expressed chagrin towards non-professional practitioners by encouraging increasingly restrictive legislation regulating the practice of traditional medicine. However, in North Carolina, there were not enough doctors who could deliver children, and the midwife's practice remained the only option. In turn, local boards of health attempted to train, license, and control the midwives working in their areas. This largely failed, as only 45% of the midwives in North Carolina completed this training, none from Ashe County (Efird
most midwives chose to ignore the attempts of local health departments to regulate their practices.

Changes in the legal status of midwives in Ashe County had very little impact until 1938, when a district health department was established. The health department sent public health officials to monitor the practices of midwives and to make sure legalities were maintained. However, in some cases, midwives and other folk healers ignored restrictions on their practices, a fact that Efird explains as fitting with a community’s economic patterns. Ashe County is a rural agrarian county, which influences the maintenance of a variety of healing methods (Efird 1985).

Rhoda Halperin’s research on the economics of a northeastern Kentucky community provides adequate comparison and explanation of Efird’s thesis. Rhoda Halperin has noted that rural people often combine strategies for making ends meet. In her 1990 work *The Livelihood of Kin: Making Ends Meet the “Kentucky Way”*, Halperin describes “the Kentucky way”—how working class people in her study area of eastern Kentucky have used ties to kin to maintain economic stability. According to Halperin, the Kentucky way “...has manifestations and variations all over the rural landscape [and] is, quite literally, a way of life based on ties to land and family that confers dignity and self-esteem upon rural working-class people” (Halperin 1990: 2). Soundly based in economic research, Halperin’s work suggests that the patterns of livelihood found in Kentucky can be found in other areas of Appalachia, particularly outside the coal fields.

Halperin characterized the region as a whole as consisting of three economic sectors: the agrarian sector of subsistence and small cash-crop operations, the wage labor
sector which consists primarily of factory-based work, and periodic local marketplaces which are nonetheless linked with regional and national markets. People use all three sectors, employing multiple livelihood strategies (Halperin 1990). Halperin defines Appalachian rural economies by the following features: labor intensive, small-scale subsistence farming, labor intensive food processing for storage and future consumption, the usage of seasonal food resources procured by hunting and gathering, the availability of a market for cash crops, the availability of internal and external wage labor, and reciprocal cooperative labor within an extended family (Halperin 1990: 67-8). The goal of work is that basic day-to-day needs are met. Within this economy people employ a variety of healing strategies (Efird 1985).

Studies have shown that from 1940 to 1950, health in Appalachia improved at a faster rate than that of the rest of the United States. Based on mortality rates, the health of Appalachian people is shown to be about the same as the rest of the United States as a whole from 1940-1950. In 1940, midwives attended 14.3% of the births in Appalachia. Between 1954 and 1956, 3.2% of all Appalachian births were attended by a midwife (Ford 1962). While the number of births attended by midwives decreased, the midwives were nonetheless still present in the healing system of the Appalachian people. Barney, Lofton, and Duffy each examine the effect of change on the relationship between professionals and those, like the midwives, who never secured professional legitimacy (Barney 2000; Lofton 1995; Duffy 1979). Simultaneous to the professionalization of physicians in the early 1900s, the use of botanicals rose in some areas in response to the high cost of medicine that physicians would prescribe. Home remedies were mostly free, and as early as 1860
through the 1940s, many homes had do-it-yourself guides to healing (Lofton 1995; Duffy 1979). Cost and effectiveness deterred rural Appalachian people from succumbing to the professionalism of medicine (Barney 2000; Coles 1967). Thus, two distinct medical traditions--biomedicine and traditional ethnomedicine--were maintained in the Appalachian region well into the twentieth century.

The maintenance of traditional medicine in rural Appalachian communities is due in part to the economic circumstances, relative isolation, traditions, and the set of ideological beliefs that communities share (Barney 2000; Efird 1985; Osgood 1966). Anthropologists Patricia Beaver and Rhoda Halperin have argued that historically, mountain families did not live in isolated homesteads but in proximity to kin groups for purposes of mutual support. Beaver defines community as “...a combination of elements linking geographically defined place, the daily lives and relationships of people, historical experiences, and shared values” (Beaver 1986: 1). Rural communities often have origin stories--who the founder was and the circumstances in which the community was settled--that bind the members of the community together. Community members often employ a variety of livelihood and healing techniques in order to sustain their way of life (Halperin 1990). Yet, communities are not static. Membership and ideas within a community change over time. This tends to explain how a professional physician can come to be accepted in a community that is steeped in traditional ethnomedical traditions, where the two systems of biomedicine and traditional ethnomedicine coexist. The experiences of rural physicians living in communities that embrace two systems of healing are often unique to each physician (Mathews 1980).
Rural physicians often have unique memories about practicing in a setting that embraces traditional ethnomedical practices. Professional physicians came to practice in rural areas in a variety of circumstances and often wrote about their experiences (Lofton 1995; Frazier 1992; Mathews 1980; Barton 1977). During the early 1900s, medical universities allocated money for physicians to go to rural areas to set up practices. Physicians would maintain general practices, performing all types of medicine, including delivery of babies, surgery, and treating lumber, mining, and farming accidents. General practice was necessary because there would be few physicians in remote areas and little of the sophisticated hospital equipment that urban centers enjoyed (Lofton 1995; Barton 1977). In these settings, rural professional physicians had to rely upon the knowledge of community healers when extra help was needed for heavy caseloads (Barney 2000). Rural physicians maintained their qualifications by subscribing to popular medical journals of the time, attending class reunions, and furthering their education (Barton 1977).

In rural areas of the United States during the early 1900s, people received treatment from a variety of sources (Barney 2000; Lofton 1995). Midwives and folk healers were available in most rural communities. A few community-based, scientifically trained doctors also existed in rural communities. These doctors, especially those who lived outside of the mining and logging camps of central Appalachia, were often times outside of the jurisdiction of any professional organization. Rural people not yet fully invested in the cash economy relied on these community-based doctors because the local doctors were more willing than their in-town counterparts to accept barter for services (Barney 2000). Lofton’s study of the role of healers in different communities in Alabama
reveals that rural doctors were members of their communities—the people could relate to their doctor in a personal way because they were neighbors and kin, and they participated in the daily lives of the communities in which they practiced (Lofton 1995). The effectiveness of the rural doctor depended upon his social and professional background and often times his willingness to accept the traditional healing system of the community in which he practiced (Barney 2000; Lofton 1995).

Crelin and Philpott examine the relationship of self-treatment to the availability of trusted doctors in Appalachian Georgia in their study *Herbal Medicine Past and Present: Trying to Give Ease*. Often social workers would cite a lack of facilities and a lack of desire to have medical facilities on the part of community members as prohibitive to biomedicine reaching remote areas. In one community central to their study, Crelin and Philpott discovered that it was not so much a lack of facilities as it was the philosophy of the physician and physician/patient relationships that would cause patients to choose traditional ethnomedical treatments (Crelin and Philpott 1990).

As Barney has noted, the relationship between the healer and the patient is important for success. Physicians who lived and practiced in Appalachia before large-scale industrialization may or may not have had formal educations, but depended instead upon family connections and community standing to ensure their status as community healers (Barney 2000). Physicians who were native to the area or who had managed to solidify their positions in the community by marrying in to a well-respected family often found it easier to establish long-term practices based on trust and respect than did newcomers. Non-native physicians coming to practice in the region who did not have
family or community ties to the area often found it difficult to gain the trust and therefore business of local residents. Physicians in industrialized settings often used the influence of clubwomen in an attempt to convince native Appalachians of the supremacy of biomedicine. By claiming concern for the well being of mothers and children during home visits, club women often earned the trust of local residents (Barney 2000). In communities that were not visited by club women or settlement workers, however, this trust had to be built in other ways if a professional medical practice was to prosper. C. Horace Hamilton, in Thomas R. Ford's landmark survey The Southern Appalachian Region: A Survey, notes “The number of available physicians is not always an adequate measure of their contribution to the health of a community since the utilization of their services is influenced by the way in which they are viewed by the people” (Ford 1962: 235). If the relationship between the physician and the patient is not built on trust and respect, then professional medicine will not be the primary form of health care utilized in the community. As doctors in specific communities, rural physicians often had to adjust to the habits and routines of their patients, and patients had to adjust to the habits of the physicians (Barton 1977). Ultimately, it was the choice of the community members whether or not they made use of the biomedical system.

As various scholars have pointed out, traditional ethnomedical and biomedical systems coexisted in the Appalachian region, especially in rural agrarian areas. The relationship between the two systems was not always benevolent. As professional physicians continued to vie for professional legitimacy during the 1900s, traditional ethnomedical practices often fell under scrutiny. The mountain people themselves were
often blamed for this polarity between two seemingly different healing systems. Stereotypes arose to explain the mountain people who seemed to resist the professional medical system.

Part 3: The Stereotypes in Context

Stereotypes about Appalachia took a strong hold in the first decade of the twentieth century. Early scholars characterized the Appalachian region as having a homogenous population with a common culture (Ford 1962; Campbell 1921). Cultural traits were applied to all people living in the region, despite class, ethnic, or sub-regional differences. In 1962, Thomas Ford and other scholars completed *The Southern Appalachian Region*, which was an attempt at describing the causes of the low standard of living that seemed to be characteristic of Appalachia. The Ford survey was quick to point out that “the Appalachian people have by and large experienced long isolation in an area of lesser opportunity” (Ford 1962). According to the Ford survey, this is why biomedicine had not yet reached remote areas of Appalachia. If an area did enjoy the benefits of biomedicine, it was thought to be the result of the push by benevolent groups associated with industrial areas. Yet, this still does not explain how biomedicine came to areas that did not have large-scale industrial operations, and it even assumes that remote areas did not have access to biomedicine. However, biomedicine had, by the 1960s, reached parts of Appalachia that were previously considered isolated.

To deconstruct the myth of Appalachian isolation and its link to poverty, scholars have recently focused their attention on specific mountain communities. Recent scholars like David Hsiung attempt to explain the relationship between Appalachia and America,
where the trend in the past has been to separate Appalachia from the rest of America in order to explain the supposedly inadequate healthcare system (Hsiung 1997; Shapiro 1978).

The population of the Appalachian region has never been static (Billings and Blee 2000; Jones 1999; Hsiung 1997; Beaver 1986; Shapiro 1978). People have moved in and out of the region since it was first settled. The mountain community arose from people remaining in the mountains who sought to make their lives in these places and to work with their neighbors in myriad ways. This is not to say that mountain communities were homogenous entities (Beaver 1986).

Nor were mountain communities isolated. Local merchants provided a link to the “outside” world by participating in complex trade networks. The degree to which these trade networks affected each community varied (Billings and Blee 2000; Hsiung 1997). Local merchants provided some connectedness with other regions in the United States. The early road system that existed to maintain trade networks linked neighbors (Hsiung 1997). Early roads such as the Wilderness Road, which ran through parts of Kentucky, Virginia, North Carolina, and Tennessee, linked not only the Appalachian areas of these states but non-Appalachian areas as well (Billings and Blee 2000). Recent studies agree that no basis exists in the area’s early history for modern depictions of Appalachian people as isolated from the time of first settlement (Hsiung 1997; Shapiro 1978). Henry Shapiro, who discredits the impact of both the local-color writers and missionaries in the late nineteenth century on adequately describing the character of Appalachia, contends that the myth of Appalachian isolation may have arisen because some settlers chose to be isolated,
placing agency directly in the hands of the Appalachian people. Certain populations identified with natural surroundings but did not ignore national events. Some residents of the Appalachian area made connections with the rest of the United States and some did not. Scholars who attribute to Appalachian people characteristics like “anti-progressive” and “backward” often focus on those Appalachian people who were isolated (Shapiro 1978). Local-color writers visiting the mountains on vacations assumed that if Appalachian people were isolated, they had fewer opportunities and were therefore culturally inferior to the rest of the United States.

Visitors to the area often perpetuated stereotypes about the Appalachian region. Travelers to the Appalachian region, including the former president of Berea College William Goodell Frost, would describe extremes: “strange people in a strange land.” (Shapiro 1978: 99). Travelers would gather information from a very few Appalachian residents and use this information to describe the region as a whole. Local color writers likewise made no distinction between town and country (Hsiung 1997; Shapiro 1978). Local color writer Mary Noilles Murfree knew very little of the area about which she wrote, yet she perpetuated and perhaps even created traits describing Appalachian people. Murfree came to an Appalachian resort as a young woman and spoke with wealthy people about their less prosperous neighbors. Polarization of community relations along class lines between the have and have-nots in Appalachia gave Murfree a romanticized view of Appalachia, about which she often wrote. Murfree used such language to describe the “other”, poor people in Appalachia to perpetuate the idea that poor mountain people needed outside assistance to bring them up to date with the progress that the rest of the
United States was experiencing at this time.⁵ Murfree was an extremely popular and widely read author (Shapiro 1978). According to Cratis Williams’s discussion of her work, Murfree only writes about the extreme cases of poverty and anti-progress (Williams 1961). In *Over on T’other Mounting*, Murfree does write about folk healers in the mountains, but adamantly excludes the possibility of any other system of healing at work in Appalachia. Of this story, Cratis Williams writes, “...the herb doctor, a familiar figure in most mountain communities and a minor stereotype in fiction, is presented faithfully, and the preference of mountain folk for herb doctors to medical doctors, whom they have generally mistrusted, is demonstrated...” (Williams 1961: 259). While criticizing Murfree’s narrow and distorted focus on the poor, and the stereotype generated by her writing, Williams accepts and validates her description of the folk healer. By and large, Murfree’s view of Appalachian life is what the rest of the United States took to be true.

Magazines also contributed to this view of an isolated, strange Appalachian region. *Harper’s* and *Atlantic Monthly* were designed for a middle class readership and portrayed distinct views of Appalachian people, which perpetuated common stereotypes. These distant discussions of Appalachian people, often conducted in such urban centers as New York or Boston and far from the region, promoted a distorted view of the actual conditions of mountain life (Shapiro 1978). It was this vision of conditions in the Appalachian region that prompted home missionaries to set up relief funds and establish voluntary agencies to help the less fortunate Appalachian people. During the late 1800s

⁵ This is according to popular literature of the early 1900s, which attempted to make the reader believe that the United States was rapidly progressing (Shapiro 1978).
and early 1900s, benevolent organizations built churches, established private education facilities, and attempted to promote professional medicine in the Appalachian region. Benevolent groups maintained that Appalachia was worthy of the aid, coming predominantly from the North, because they erroneously thought that during the Civil War the Appalachian people did not, by and large, support the Confederacy (Inscoe and McKinney 2000; Hsiung 1997; Shapiro 1978). Scholars have recently pointed out that there were some areas of Appalachia that did support the Confederacy, but these areas are virtually ignored or “lumped” with other areas that totally supported the Union by benevolent workers in order to justify their cause (Crawford 2001; Inscoe and McKinney 2000; Hsiung 1997). American mainline religious denominations sent hundreds of missionaries into the Southern Appalachian region to “save” those that they saw as “lost.” Missionaries strove to establish better schools, clinics, social services, and religious choice, but in order to accomplish their fundraising goals outside the region, the missionaries sometimes exaggerated conditions. Stereotypes became more prominent because missionaries focused on cultural and class distinctiveness of the lower and working classes (Jones 1999). Ironically, Mary Noailles Murfree’s In the Tennessee Mountains was used as a Mission study text in the late 1800s (Shapiro 1978). Home missionaries and local color writers needed to promote a vision of Appalachian “otherness” in order to validate their positions and their attempts to help the people in the region (Hsiung 1997).

By the turn of the century, when the local-color writers were enjoying the height of their popularity, stereotypes helped change the face of medicine in Appalachia. As a
result of the stories of local-color writers, settlement workers, benevolent groups, and professional medical societies stepped up their efforts to bring modern biomedicine to Appalachia (Barney 2000; Hsiung 1997). The images developed by the local-color writers implied that the people of Appalachia were using antiquated medical treatments and were in need of professional physicians. It was therefore a result of the stereotypes that there was such an extreme push in most of Appalachia to rid the area of traditional ethnomedicine and instill the proper biomedical doctrine.

After the Civil War, a new idea of America as a unified national entity with a unified national culture became the focus of writers and scholars (Ford 1962; Campbell 1921). After 1870 Appalachia was portrayed by local color writers as a region that lagged behind the rest of America in embracing the progressive ideals of the rest of the country (Shapiro 1978). Writers and missionaries began to create the concept of Appalachian "otherness," the idea that the mountain region was remote and untouched by the progressive and unifying forces that seemed to be at work elsewhere in the United States. Recent scholars have examined the relationship between Appalachian residents and those attempting to describe mountain people as an “us” verses “them” mentality (Hsiung 1997; Shapiro 1978). Often the very words used to describe mountain people were attempts by the media to explain the relationship between mountain people and their culture—to explain the position of the “other” people (Williamson 1995). Appalachia has been seen as an area where progress stopped (Ford 1962). The people were labeled by William Goodell Frost, President of Berea College, as “our contemporary ancestors” (Shapiro 1978: 99).
From the 1870s through the 1950s, both complimentary and derogatory stereotypes circumscribed the Appalachian region (Hsiung 1997). The derogatory stereotypes, such as “enemies of progress” and “poverty-stricken,” are based upon middle-class standards of living. Missionaries arriving in impoverished communities wrote home about the absence of sanitary provisions and the poor diet of the people (Campbell 1921). Certainly poverty existed in the Appalachian region, but this was true across the country. Matters of hygiene were thought to be best ameliorated by the influx of professional physicians to the area (Ford 1962). Philanthropists made special note of the mountaineer’s reluctance to use a professional physician. Professional medical societies arose in response to this apparent unwillingness of the Appalachian people to accept progress (Barney 2000; Jones 1999). Local color writers and “scholars” often described mountain people as fatalistic because of their reluctance to accept biomedicine (Jones 1999; Coles 1967; Weller 1965).

Appalachian people have often been described as fatalistic, a trait attributed to extreme religious beliefs and a lack of optimism toward health and living long lives (Jones 1999; Ford 1962). People who advocate such stereotypical views describe fatalistic behavior as the extreme belief in “God’s will,” preventing the believer from seeking medical care. However, Jones argues that defining Appalachian people as fatalistic based upon their religious beliefs does not explain why, when available, professional physicians are used. Jones also maintains that this definition of mountain people does not explain the economic differences between Appalachian people and the organizations that would attempt to help them (Jones 1999). Coal mining and logging have influenced the lives of
the Appalachian people beyond simply extracting natural resources. Coal and lumber camps were prime areas for professional physicians to attempt to bring biomedicine to the mountain people. Appalachian people living outside of coal and lumber camps rarely had access to professional physicians. What seemed to be fatalism actually resulted from a lack of access to professional medicine (Barney 2000). Labeling people fatalistic for not wishing to make use of biomedical treatment options completely ignores the existence of a workable traditional ethnomedical system.

Faced with the “problem” of an area such as Appalachia, social workers during the 1920s began to propose ways to bring Appalachia up to speed with the rest of America. The New Deal in the 1930s brought to Appalachia new roads and public education in the hopes that the area would prosper (Ford 1962). While roads did cut isolation, increased traffic to the area meant greater focus on the region as a pocket of poverty in an otherwise prosperous America (Hsiung 1997). Ford’s landmark survey suggested out migration as an answer to the question of regional poverty (Ford 1962). The media during the 1960s brought new attention to Appalachian poverty. Presidents Kennedy and Johnson both campaigned for the “war on poverty.” Appalachia was their poster child, based on old and familiar stereotypes. The further push for the professionalization of biomedicine is linked to the war on poverty by the idea that sickness is perpetuated by poverty (Campbell 1921). Those who would stereotype the people of Appalachia have focused on the traditional medical practices as an impediment to overcoming poverty (Barney 2000; Hsiung 1997; Shapiro 1978).
Jerry Williamson, who has documented the portrayal of Appalachian people in television and films, maintains that the television and movie images of poverty-stricken hillbillies directly influence the policies that affect the people living in the Appalachian region (Williamson 1995). Just as the local color writers in the late 1800s wrote of the anti-progressiveness of mountain people and it influenced northern benevolent societies to send help to the south, films and television of the 1960s, 1970s, and 1980s influences current policy affecting the region. In the 1960s, the image of a poverty-stricken man became the image of “Appalachia forever after” in the mass American mind (Williamson 1995: 251). According to Williamson, images of Appalachian people set into motion the trend of blaming the victims for their poverty. Organizations “...set about to minister unto them, to change them, to uplift and reconnect them to dominant economics so middle class Americans could feel good about bringing them up to speed with the rest of the nation” (Williamson 1995: 251). At the same time, the stereotypes were often maintained by this push for biomedical professionalization (Barney 2000; Jones 1999).

The role of the professional physician in Appalachia has been the subject of much recent discussion (Barney 2000; Frazier 1992; Shapiro 1978; Barton 1977). The common traits that are attributed to Appalachian people invented to explain the lack of professional physicians in Appalachia have not adequately explained why biomedicine does exist in the parts of the region that did not experience wide spread coal or timber operations. Some scholars, like Cathy Efird in her study on lay midwifery in North Carolina, maintain that both biomedicine and traditional ethnomedicine have coexisted in the Appalachian Mountains to meet the needs of the people (Efird 1985). Mountain people did not
irrationally reject medical care; a variety of situations existed where the Appalachian people would choose either biomedicine or traditional ethnomedicine (Barney 2000; Jones 1999; Coles 1967). Several historians have noted the coexistence of traditional ethnomedical and biomedical healing in Appalachian communities through specific case studies. Claude Frazier's father was a coal company doctor in the early 1900s. *Miners and Medicine* is Frazier's father's memories of practicing medicine in rural West Virginia. Dr. Frazier recalls that despite the fact that biomedical facilities existed in the mountains, people often continued to use traditional healing as a result of the lack of medical professionals in the area:

In the isolation...the grannies and midwives held their ground for many years. The establishment of a miner's hospital in the early twentieth century diminished their role, but in some areas they still did not disappear entirely. Doctors still had only these untrained, though fully experienced, women to aid them (Frazier 1992: 96).

Providing another testament of the persistence of traditional ethnomedical practices, Dr. Hugh Mathews interviewed Dr. J. L. Reeves, who had been a rural physician in Swain, Haywood, Cherokee, and Graham Counties in North Carolina in the 1930s. Dr. Reeves recalled the story of Grandpa and Grandma Hannon. The Hannons had moved into a town but still retained what Reeves referred to as "mountain ways."

Everyone--their children, their neighbors--tried to convince them to adopt modern ways, but to no avail. Dr. Reeves was called to the home to examine a cancerous sore on Grandpa's head. The weather had been rainy for several days, and the Hannons felt they would be troubling the doctor if they called him. Mr. Hannon decided to alleviate his pain
using an old remedy he had once heard of—putting maggots on the sore. Mr. Hannon accidentally told his children in a telephone conversation about the maggots, and they promptly notified Dr. Reeves. When the doctor arrived on the scene, Hannon told him that he had seen this remedy work as a child. Against his better judgment, Dr. Reeves decided to monitor this treatment for a while. Within three weeks, the maggots were gone, the pain was gone, and the sore had completely closed (Mathews 1980: 55-57).

Through these case studies, it is obvious that people choose a medical system, when given the choice, based upon the situation. Dr. Reeves also recalled that some community members found it more fitting to call upon the services of midwives. When asked by the interviewer his opinion regarding the persistence of midwives in southwestern North Carolina, Dr. Reeves was adamant: “We welcomed them. They [midwives] delivered perhaps half the babies [in Canton, North Carolina] (Mathews 1980: 130). Since he was physician to at least four counties in southwestern North Carolina, Dr. Reeves was at times undoubtedly unavailable for services. The choices patients made in regarding health care often have to do with the proximity of a healer, and the availability of funds and services, as was the situation in Ashe County.

While most studies about healing practices in Appalachia concentrate on eventual biomedical dominance to the exclusion of ethnomedicine, several scholars have recently called for a new approach to understanding the relationship between traditional ethnomedicine and biomedicine (Adler 2002; Baer 2002; McGuire 2002; Micozzi 2002; Pizzorno 2002). Hans Baer observes the importance of considering “the political economy of complementary and alternative medicine” when examining a culture’s healing
techniques (Baer 2002: 404). Complementary medicine involves the use of biomedicine within a well-established and culturally viable ethnomedical system. The use of a complementary medical system incorporating biomedicine into their ethnomedical system by Ashe County residents provides the entire population with multiple healing options, making health care available to all.

Pertaining to the study of the role that community members play in shaping their own culture is the work done by anthropologist Sherry Ortner on agency. Ortner expresses the importance of examining a culture’s activities based upon their own actions, not the actions of outside groups seeking to create change in a culture (Ortner 1984). Rhoda Halperin with her work on multiple livelihood strategies, Eliot Wigginton, editor of the *Foxfire* series, Karen Osgood in her work on lay midwifery in southern Appalachia, and East Tennessee State University scholars including Pat Arnow, Richard Blaustein, and Anthony Cavender, have echoed Ortner’s sentiments regarding a people’s choice when it comes to making health care decisions and the influences these choices have on shaping their society (Halperin 1990; Arnow 1989; Blaustein 1989; Cavender 1989; Wigginton 1972; Osgood 1966). Ultimately, Ortner maintains, “…society is a system…the system is powerfully constraining…yet the system can be made and unmade through human action and interaction” (Ortner 1984: 159). This is the case in Ashe County.

Part 4: Recent and Relevant Works Regarding Specific Community Studies

There have been several recent important studies regarding Ashe County, North Carolina, the locale of the North Fork area. Martin Crawford’s *Ashe County’s Civil War* sheds new light on Ashe County’s participation in the war, proclaiming that above all else,
community members chose to support a variety of sides—both Confederate and Union sentiments were expressed, as well as neutrality and the whim of self interest (Crawford 2001). The Appalachian south has often been seen as unified—either completely on the side of the Union or completely on the side of the Confederacy. As discussed earlier, benevolent groups assumed that the mountain people were Union sympathizers and were therefore worthy of northern aid following the Civil War. This justification by benevolence workers for their aid is inappropriate for Ashe County, whose citizens were bitterly divided during the Civil War. Both Union and Confederate loyalties were well represented in Ashe County by families of varying economic circumstances. Often times neighbors of the same economic situation, even livelihood and domestic habit, would choose to support different sides of the issue.

Doctors were present in the county well before the Civil War, although they were few and far between (Crawford 2001). These doctors did not come to the area as a result of benevolent movements or a drive by outside agencies to help the people. For example, the family of Dr. Aras B. Cox was well established in the area prior to the Civil War; no benevolent society encouraged his practice in Ashe County.

John Alexander Williams’ 2002 publication Appalachia: A History, and Donald E. Davis’ Where There are Mountains both include substantial information on Ashe County. Williams focuses on Elisha Mitchell’s early description of the physical beauty and ecological diversity of the area, noting that Ashe County residents have rallied on occasion to protect the beauty of their homeland (Williams 2002). Likewise, in his environmental history of the region, Donald Davis focuses on iron manufacturing in the Blue Ridge,
which served a vital part of the economy in Ashe County during the 1840s. Davis notes that despite the lack of industrial development, there were several iron bloomeries along the New River (Davis 2000).

Accounts of discrete communities in Ashe County include oral histories of the Pond Mountain area of northwestern Ashe County and of communities along the New River (both North and South Forks) (Cooper 2001; 1998), Martin Crawford’s study of the Civil war in Ashe County (2001), Stephen Foster’s examination of resistance in Ashe (1998), and Patricia Beaver’s study of three western North Carolina communities, one of which is in Ashe County (1986). Many of the same families who contributed their memories to these studies are still living in the area and are still consulted by scholars on various subjects. The people in the Coopers’ oral histories tell their own stories about life in rural Ashe County. Oral histories have proven invaluable to the study of life in Ashe County. Through these histories it is apparent that the people have and always had what has been called agency--creative control of their own culture (Ortner 1984).

This thesis examines the history of biomedicine and the maintenance of traditional ethnomedicine in one part of the Appalachian region. The primary goal of this paper is to add to the discussion regarding the transition from traditional ethnomedicine to biomedicine by proposing possible forces at work other than benevolence or settlement worker influence. In order to accomplish this, I have chosen to examine the history of one Appalachian community in its context as an American community. The larger goal of this study is to discover the medical history of one particular Appalachian community and thereby refute or maintain stereotypes regarding the Appalachian region and explain why
previous attempts to explain the transition from traditional ethnomedicine to biomedicine based upon what occurred in industrial camps are inadequate for the situation in the North Fork area and in similar rural places throughout southern Appalachia.
Chapter 3: Methodology

This thesis is the by-product of an earlier attempt to examine the history of healing in the area along the North Fork of the New River. I erroneously assumed that the people of the North Fork area, which lies predominantly in Ashe County in western North Carolina, until very recently used herbal remedies to cure all of their sicknesses. That was not the case, and I began to examine the history of medicine in the North Fork area as it relates to the rest of Appalachia and to the entire United States. That initial project concluded with the knowledge that the two systems of healing, biomedicine and traditional ethnomedicine, are not exclusive of one another and are in fact often used simultaneously in certain areas.

I consulted a variety of primary and secondary documents in order to develop relevant questions for my informants and to understand the basics of American medicine so that I could describe medicine in Ashe County. No other descriptions of the medical history of Ashe County have been published. Scholars have done much work on the medical history of the United States, and since Appalachia does not exist separate from the rest of America, it was to this research that I turned. An analysis of the data is included with this thesis in the literature review in chapter 2. The materials that I used to examine the history of medicine in America and Appalachia date from 1830 to 2002, and include medical histories, surveys, descriptions of professional medical societies, and other regional treatments of Appalachian communities and physicians. I also consulted materials
about traditional ethnomedical systems in Appalachia, including documents describing herbal remedies. I also investigated secondary sources including newspapers from Ashe County, medical histories of the United States, and other materials about the Appalachian region appropriate to the topic.

In examining written materials, I came across the name of one local physician who was practicing from 1900 until 1950, and decided to focus my attention on him. This was not arbitrary, as my subject was practicing medicine during the time considered by Barney to be the transition period from traditional ethnomedicine to biomedicine (Barney 2000). Dr. Joseph Robinson became the focus of my research, as I attempted to document this transition in Ashe County.

The deeper involved that I became in recording the largely unrecorded life history of “Doc” Robinson, I realized that I had all along been subjecting the people of Ashe County to a common Appalachian stereotype: that of backwardness. My research then grew to incorporate and refute common Appalachian stereotypes as they relate to the history of medicine in Ashe County.

An analysis of the available literature on the subject of medicine in Appalachia has shown that the advent and maintenance of stereotypes is connected to the professionalization of biomedicine in Appalachia. In order to see if this held true for the North Fork area of Ashe County, I interviewed several members of different communities along the river. The informants (see list at the end of this chapter) provided useful information on the life of Doc Robinson and the history of healing in Ashe County. The interviews were conducted informally in the homes or businesses of the informants, and
the events were taped-recorded. Informants were asked a series of informal questions based on the subject matter. Often times when scheduling meeting times with the informants, I would give the informants a few subject areas to be thinking over before we would actually meet.

**Anner Potter:** Mrs. Potter was a lifelong resident of the Pottertown Community in Ashe County. Before her death in January of 2001, we met to discuss her memories of Doc Robinson. Anner recalled the practice of Doc Robinson, and gave insights regarding the affects of poverty on the use of Doc Robinson by community members. Anner and I met in her home November 13, 2000.

**Joseph Robinson, Jr.:** Mr. Robinson is the son of Doc Robinson. He often helped his father on his rounds, traveling to Mountain City, Tennessee for medical supplies or driving the car to sick households. However, instead of following in his father’s footsteps, he became a schoolteacher. He still lives in the Creston community of Ashe County, at the base of Three Top Mountain. Mr. Robinson, although elderly, provided much useful information about the life of his father, which was supported by the assistance of Mr. Robinson’s home health nurse Brenda Trivett. Mr. Robinson and I met at his home on March 13, 2001.

**Dr. C. B. Jones:** Dr. Jones is the progeny of the Jones family of doctors that started the first clinic in Ashe County—the Lansing Dispensary. Currently a general practitioner at Ashe Memorial Hospital and a resident of Jefferson, Dr. Jones provided vital information on the first biomedically trained physicians in Ashe County and the means by which clinics were started here. I met Dr. Jones at Ashe Memorial Hospital March 19, 2001.
Joe Stephens: Mr. Stephens provided information on just about every aspect of my thesis, from the relationship the Doc Robinson had with community members to information regarding the changing face of healthcare in Ashe County. Mr. Stephens also turned out to be a useful connection to make, as he would point me in the direction of other informants. Mr. Stephens, like his father before him, kept Stephen’s Store in Creston, which closed in the mid-1990’s. Keeping the store allowed Mr. Stephens to come in contact with members of the community, to hear their gossip, their feelings, and their fears. Doc Robinson also frequented the store, and the Stephen’s Store records document that he made purchases there (Stepheus 1927-1942). Unfortunately, Mr. Stephens passed away in 2001. Several interviews were conducted at his home in 2001.

Nell Sutherland: Longtime resident of the Riverview area of Ashe County, Nell Sutherland has seen much change in the way that medicine has been practiced in her community. She recalls the practice of Doc Robinson, especially the role she played for him as neighborhood helper. Nell Sutherland at one time helped Doc Robinson administer ether to pregnant women, although she had never been formally trained as a nurse. I met with Nell September 6, 2001, at the Riverview Community Center and also October 29, 2001 at her home.

Joe Robinson, III: The great-grandson of Doc Robinson, Mr. Robinson recalls many stories about him. Very specific information was provided by Mr. Robinson regarding Doc Robinson’s practice and the feelings of the community about him. In Mr. Robinson’s possession are the original tools used by both Doc Robinson and Doc’s father, who was a doctor in east Tennessee. Mr. Robinson provided information which allowed me to
corroborate the information that Joe Robinson, Jr. had given me about his father. Although he currently resides in Boone, North Carolina with his wife and thirteen-month-old twins, he frequently visits and cares for his grandfather in Ashe County. A particularly informative interview was conducted in Belk Library, on the campus of Appalachian State University in Boone North Carolina, on September 10, 2001.

**Dora Wellington Horton:** Mrs. Horton, an African American woman from the Peak area of the Creston community in Ashe County, provided information about African American life in Ashe County and about Doc Robinson’s practice pertaining to African Americans. Her family were farmers in Creston for most of her life. She now lives in the Junaluska community in Boone, North Carolina, and is more than happy to recall medical practices in early twentieth century Ashe County. I met with Dora Horton on several different occasions in her home in Junaluska during 2001 and 2002.

**Minnie Sutherland:** Mrs. Sutherland has lived in the Sutherland community of Ashe County for most of her life. Doc Robinson married her Aunt Julia and became her uncle in 1903. Doc Robinson was Minnie’s primary health care provider during the first part of her life. She recalled many stories about Doc Robinson and his medical practice, and also provided useful information about the Sutherland community. We met in her home in Sutherland, October 10, 2001. Minnie died in October, 2002.

**Clara Gray:** Formerly Clara Eller of the Sutherland community, Clara Gray has moved back to Ashe County with her husband after living in Charlotte, North Carolina, Washington DC, and Atlanta, Georgia. Mrs. Gray recalled much about her early life in Ashe County. Doc Robinson was her doctor for the majority of her lifetime, but she
recalls that other doctors were also nearby for a period of time. We met at the Riverview Community Center December 6, 2001.

**Leva Reeves:** Ms. Reeves provided information about Doc Robinson’s practice. Doc Robinson was in attendance when Ms. Reeves gave birth to her children. She also recalled the healing practices of her mother, who was a community midwife. Leva Reeves and I met at Riverview Community Center December 6, 2001.

**Margie Nelson, Chester Osborne, and Robert Cornett:** These three individuals were present at other interviews at the Riverview Community Center that were conducted in October and December of 2001. Verbal permission was given by each person for me to use some of the information that they gave me in my thesis; although formal interviews were not conducted, each of these individuals provided information to substantiate information given by other community members. **Margie Nelson** recalled how busy Doc Robinson stayed, and how he needed and relied upon help from other members of the community who were not necessarily formally trained. **Chester Osborne** retold several stories that are commonly told about Doc Robinson, and provided the names of many helpful informants. **Robert Cornett** remembered the life of his mother, Rosie Cornett, who was a midwife in Creston before and during Doc Robinson’s practice.

Despite the fact that most informants recalled the same aspects of Doc Robinson’s life and work, each meeting proved valuable because of the respect and love for Doc Robinson that was apparent through their stories. The material from these interviews is discussed in chapter five.
Chapter 4: Ashe County, North Carolina

Ashe County lies in the northwestern corner of North Carolina, bordered by Tennessee to the west, Virginia to the north, and Watauga County, North Carolina to the south. This chapter explores the history of Ashe County and a small part of neighboring Watauga County, which is part of the ecological and cultural community of the North Fork of the New River. Within a traditional ethnomedical system, a developing biomedical healing system was culturally viable. Given the opportunity to choose the system of healing which best served their needs, Ashe County residents employed a variety of healing methods. Most informants relate how a variety of methods like religious healing, home remedies, including herbal remedies, patent medicines, store-bought goods in combination with herbs, and the services of local community healers like midwives formed the basis of their traditional ethnomedical healing system. Multiple healing strategies are effective for the people of Ashe County. The following chapter explores the historical and cultural context of Ashe County and its influences on the healing systems at work.

Part 1: An Ethnohistorical Description of Ashe County

The Blue Ridge Mountains form a section of the Appalachian Mountains in western North Carolina running northeast to southwest. These mountains and their associated valleys make up the 450-square mile area of Ashe County. Winding through
this county and nearby Watauga County are the North and South Forks of the New River, the headwaters of which originate in Watauga County. The North Fork begins in an area on the border of Watauga and Ashe Counties known as Pottermont. Both forks head north into Virginia through mountains with peaks higher than 5,000 feet at some places. Flowing separately for sixty miles, the two forks meet three miles south of the Virginia state line at a place known as Twin Rivers. This thesis is concerned primarily with the North Fork, where Doc Robinson lived and practiced medicine.

Legend says that the New River received its name from Peter Jefferson, father of Thomas Jefferson, who surveyed the New River valley in the 1700s. It is supposed that the New River is the first river that early European settlers came to after crossing the Blue Ridge Mountains. Historian of the New River valley Thomas Schoenbaum maintains that humans first occupied the area between 10,000 and 8,000 BC. Their primary tools were Clovis projectile points, leaf-shaped points from 2.5 to 4.5 inches long with a short flute at the base for attaching lances or spears. These ancient points have been found at several sights along the New River (Schoenbaum 1979). Tools that have been found throughout the New River valley represent the entire range of dateable projectile points. These tools, together with small occupation sites that have been found on the flood plain of the New River and on ridge crests, suggest that the New River valley was an important passageway through the Appalachian Mountains for early humans as well as the first European settlers (Schoenbaum 1979). However, sites that have been recently identified in Ashe County suggest that early human populations only stayed in the area on a seasonal basis, following game depending on the season (Whyte 2002).
Many different tribes lived, albeit seasonally, in the vicinity of the New River, notably the Cherokee, Shawnee, and Siouan-speaking peoples. The Cherokee came down from the north to hunt along the New River valley in the 1700s. Archaeologist Tom Whyte has found evidence to suggest that the Native Americans living in Ashe County during this time were Siouan speakers, related more closely to tribes on the North Carolina Piedmont and the eastern foothills, who were seasonal inhabitants exploiting the rich reservoirs of game which also attracted European hunters into the area (Whyte 2002). Native American groups were in all likelihood in Ashe County during the time of European exploration in the area, and there was contact and exchanges of information between the Natives, explorers, and later settlers.

In the late eighteenth century, Germans from Pennsylvania settled in Ashe County, including the Eller family, whose descendants still live in Ashe County (Ronald D. Eller 2000). Other families of German and Swiss descent, including “the Ellers, the Faws, the Graybeals, the Hartzogs, the Koons, the Rotens, the Tetermans, and the Younces” (Crawford 2001: 20) chose to settle in what became Ashe County because the terrain was familiar to them (being much like their native Germany) and farming was productive (Ronald D. Eller 2000). French settlers were also settling Ashe County, including the Hardin family. Simultaneously, Scots-Irish settlers came down into the New River valley along the Great Wagon Road, a route followed by Squire Boone on his way to the Yadkin Valley of western North Carolina in 1753. A group of German people known as the Moravian Brotherhood explored what is now Watauga and Ashe Counties in the 1750s and later returned to the piedmont near present-day Winston-Salem to establish Wachovia,
leaving behind the first written accounts of people in the upper-New River valley area of North Carolina. From that settlement, Moravian settler Jonathon Miller arrived in Ashe County in 1805 and established the Flatrock Church of the Brethren (Miller 2001).

In 1777, the remainder of the land belonging to the Cherokee in Ashe County was ceded to the State of North Carolina. However, the settlers in what is now east Tennessee were angered by North Carolina’s actions to control lands west of the Blue Ridge (Goss 1984). In 1785, the people of what is now Jonesboro in east Tennessee adopted their own constitution and set up a new, independent government. They called the area they lived in the State of Franklin, an area that included present-day Ashe County. Within four years, this new government collapsed. By 1789, North Carolina again ceded this area, claimed the current area of Ashe and Allegheny Counties for itself, and left Johnson and Carter Counties to the new state of Tennessee, which formed in 1799 (Arthur 1914). Because Ashe County was contested for so many years, residents have felt at times as though they belonged to both North Carolina and Tennessee.

Ashe County was formally created from Wilkes in 1799, which also included present-day Allegheny and Watauga Counties. The State of North Carolina urged settlers to homestead in Ashe County by offering land grants to veterans of the Revolutionary War and other willing participants. By 1800, there were over 70 names on the Ashe County tax roles.

In the early 1800s, the upper New River valley experienced steady population growth that continued well into the middle of the century. Native American populations by this time had left the area. There is no historical evidence of any Native American
groups moving to Ashe County after 1800 (Whyte 2002). The people that arrived in the valley developed an agrarian lifestyle, encouraged by the abundant water resources of the North and South Forks of the New River. Settlers continued to pour into the valley in the 1800s, scrambling to acquire the best land suited for farming. While plantations like those in the Deep South were not common to the North Fork area, according to Crawford, some land owners did own large tracts of land. The concentration of land in the hands of a few led to considerable class differences and disparities in wealth (Crawford 2001).

In 1807, Daniel Dougherty was granted land to set up a forge and iron works at Harbard’s Bloomery Forge along Big Helton Creek in Ashe County, making use of iron ore deposits that had been discovered there (Schoenbaum 1979). Iron manufacturing was among the earliest industries to locate in the mountains. During the early 1800s, iron works required natural resources like hematite, limonite, magnetite, limestone, and hardwood trees for producing charcoal, all to be found in Ashe County (Davis 2000). Bloomery forges required large amounts of timber to fuel fires, which Ashe County could supply in ample amounts. Prior to the Civil War, the iron industry in Ashe County impacted the county’s economy greater than agriculture (Davis 2000). The North Fork Bloomery, located eight miles northwest of Jefferson, began in 1825 (Davis 2000; Arthur 1914). Ballou’s Bloomery Forge at the Falls of the North Fork of the New River started production in 1817. However, hauling the lumber needed to fuel the fires at these bloomeries was expensive and difficult due to the poor quality of roads, and many iron works closed after only a few years. Harbard’s Bloomery Forge ended production in 1817, Ballou’s by 1832, and the North Fork Bloomery by 1829, only four years after
beginning production (Arthur 1914). Iron production in Ashe County continued to wane in the 1840s. Major iron deposits were completely exhausted in Ashe County by the late 1800s (Davis 2000). Since iron production and accompanying mining and logging operations in the Blue Ridge Mountains were never as large or widespread as they were elsewhere, industrial camps never developed in places like Ashe County as they did in other places where mining and logging were more prevalent.

While mining supported the local economy in the early 1800s, agriculture has been the major economic activity for most of Ashe County's history. Elisha Mitchell in 1828 noted in his geological survey of the Blue Ridge Mountains that Ashe County was first occupied by hunters in search of game who reported back to their kin describing the fertility of the soil in the area, leading to the establishment of Ashe County's long tradition of agricultural production (Williams 2002). Some of the wealthier families like the Worths were able to have slaves, but most families did the farming themselves.

Historian Martin Crawford has noted that in Ashe County, "family and community were representations of each other" (Crawford 2001: 1). Each community in Ashe County relied on the family household, consisting of not only husband, wife, and natural-born children, but often grandparents, orphans, and boarders, suggesting that community often entailed far more than just blood relatives. The 1820s mark a period of high birth rates, apparently to supplement the work force for the family farm. Land was often purchased or rented and passed down from father to son, pointing to the existence of a patriarchal society among landed families (Crawford 2001). Because families did their own farming, they often called upon the outside help of neighbors.
Most farms in Ashe County were 50 to 200 acres. There were some very wealthy families early on, notably the Worths and the Coxes. These families owned hundreds of acres and several brick homes, indicative of wealth and permanency (Crawford 2001; Cooper 2001). The settlers that could accumulate land had the most access to political and legal power in their communities as well (Williams 2002; Crawford 2001). As the population increased by 33% in the 1830s, access to land became more difficult. By 1860, 27% of the people in Ashe County were landless farmers. Since small-time farmers had little hope of passing land to their sons, the landless were often forced to become tenant farmers. Many who did not opt for tenantry left the county--four out of ten would leave in the late 1800s (Crawford 2001). Landholdings stayed in families through marriage and intermarriage between powerful families, and these landowners became the elite as a class system developed in Ashe County (Crawford 2001).

Ashe County has always been a hotbed of political activity. Even before the formation of the county, local residents were often divided in opinion as to the amount of control the state of North Carolina should have over lands west of the Blue Ridge, as exemplified in the argument resulting in the formation of the State of Franklin in 1785 (Goss 1984). In subsequent years, the Whigs and the Democrats argued over the extent of independence that the county should enjoy from the state and other issues that engaged state and nation. Political allegiances were formed along kin and family lines; people typically voted the way other family members did (Crawford 2001). On the eve of the Civil War, even the churches of Ashe County became heavily involved in local politics.

In the 1850s, churches throughout the South split along conservative and
progressive lines, arguing in particular the issue of state’s rights. Feeling threatened by progressive movements like temperance and evangelism as symbolic of northern influence, southern churches began to deny the effectiveness of northern benevolent and missionary societies. In 1848, Ashe County Baptists split from the larger Baptist association, forming the Jefferson Association to combat northern infringement into the belief system of the residents of Ashe County. Some aligned with evangelical churches and missionary movements, but an anti-missionary sentiment swept the county in the 1850s (Crawford 2001).

According to the 1860 Census, out of 7,956 Ashe County residents, there were 391 slaves and 142 free blacks. Slavery was clearly associated with wealth; slaveholders were 6.6% of farmers, who owned half of the available land (Crawford 2001). Most slave-owning households were in or near what Crawford calls the core: Old Fields and the Town and Village of Jefferson, which was the center of commercial activity. The North Fork area was the politically neglected periphery and did not experience the growth in prosperity of the core area with its greater commercial activity (Crawford 2001). However, slavery was not the primary issue in the county on the eve of the Civil War in either area, but particularly not the North Fork area. Ashe County was not a part of the planter society of the rest of the South, and was not as dependent upon slavery (Schoenbaum 1979). Slavery was not automatically associated with farming, although slaves were valued property and more closely associated with wealth (Crawford 2001).

The Civil War claimed the lives of many from Ashe County. Men enlisted in both the Union and Confederate armies. Early in the war, when enlisting was voluntary,
Confederate forces were in control. However, in April of 1862, Jefferson Davis called for involuntary conscription of able men, an act that caused sentiments towards him to shift later in the war. Some Ashe County residents threatened to join the Union in response to threats of conscription, and desertion became a problem (Williams 2002). A major difficulty that Ashe County residents experienced was the number of deserters and Union marauders who took shelter in the area and raided families for food. William Albert Wilson, resident of the North Fork area during the Civil War, recalls in his memoir the havoc caused by men from the Union Army and deserters from both sides, as they stole from and terrorized local families (Wilson 1951). The North Fork area, which borders Tennessee, was especially attractive to deserters and marauders because of eastern Tennessee's Union activity. The Confederacy was well represented in the county in the years during the war, and the Union maintained a small but significant presence throughout (Crawford 2001). However, after the Civil War, tensions between former Confederate and Union soldiers escalated. Union soldiers received a pension from the war, and Confederates did not, which helped to assure the elite position some former Union households. Local disagreements resulted over the struggle to acquire land and therefore gain political power in this setting. After the war, the division would take on a partisan tone: Democrats against Progressive Republicans. This division would remain throughout the early twentieth century, as both sides continued to vie for political control (Crawford 2001).

In the late 1800s, the agricultural economy began to recover from the ravages of war and to prosper. The economy gradually shifted from subsistence to cash crops like
corn, wheat, and tobacco. New industry came to Ashe County as well. In 1915, the Greer family attempted to start a commercial cheese making industry in Grassy Creek, Ashe County. The first year saw a profit of $1500, and by 1917 the factory was earning between $14,000 and $15,000 a year. The factory continued to prosper until World War II slowed the building of roads in the county. This resulted in some Greer family members leaving Ashe County for Bel Air, Maryland, to continue in the dairy business (Goss 1984). Other cheese factories also opened, including one which operated in the early 1900s at Sutherland and the Kraft Phoenix Cheese Plant of West Jefferson, which opened in 1919 (Moran 2000). Commercial industries that fared well were suited to the local economy, like the cheese factories that were supplemented by the thriving dairy industry in the early twentieth century and carding mills that made use of wool from the substantial sheep population in the area (Moran 2000; Schoenbaum 1979). By the late 1800s, another industry had already been established in Ashe County that would prove to be profitable throughout the Appalachian region: tourism.

In July of 1883, mineral springs were discovered on a farm near Crumpler off the North Fork. The farmer who discovered the springs claimed to be miraculously healed of a poison oak infection. News of this soon spread, and hundreds of people flocked to the area. In 1885, Captain Thompson of Virginia purchased the site and established a summer resort, calling it “Thompson’s Bromine and Arsenic Springs Hotel.” Thompson advertised extensively throughout the region for his resort, drawing hundreds to the area. The success of the mineral springs helped to bring the first road in the county, extending from Jefferson to Virginia (Schoenbaum 1979). Still, western Ashe County and the focus area
of this study did not enjoy the benefits of an all-weather road until much later.

Despite tourism to the county, Ashe County remained relatively isolated from other areas in the early twentieth century. There was no connection to the county from the cities of the North Carolina piedmont by rail or road. In 1900, a turnpike connecting Jefferson and North Wilkesboro in Wilkes County was built, but a flood destroyed this in 1916. In 1914, Norfolk and Western Railway built a line known as the Virginia Creeper from Abingdon, Virginia to the community of Todd in Ashe County to exploit the timber resources. A depot was established at West Jefferson, and the town grew up around it. Within the next few years, forests of oak, poplar, maple, walnut, hickory, and pine were logged and taken to Abingdon. After the timber was exhausted, the tracks between West Jefferson and Todd were removed, and passenger service was no longer provided; people no longer came to the area by way of the trains.

In the 1920s, the first all-weather highway, state route 16, was built, connecting West Jefferson and Jefferson, which became the county seat, to cities in the Piedmont. Although not paved, Highway 88 connected communities along the North Fork to Jefferson, North Carolina and Trade, Tennessee. Still, no major roads connected the North Fork area of Ashe County to the Piedmont. The Great Depression affected the County as it did everywhere, but the small family farms survived, and the Works Progress Administration helped to improve conditions by paving roads and building the hospital. The County experienced some population loss in the 1930s and 1940s, but new economic opportunities stabilized this decline by the 1960s (Schoenbaum 1979). In the 1940s and 1950s, electricity came to Ashe County as a result of President Roosevelt’s rural
electrification program. As a result, small manufacturing plants were built, adding balance to the agricultural economy of the county (Schoenbaum 1979).

Communication and transportation have been difficult in Ashe County, but the people have always participated in the larger market economy through buying and selling at local stores, like the Stephens Store in Creston, and by transporting goods and driving livestock to markets in Jefferson, Mountain City, Tennessee, and beyond. The county has never been completely isolated (Crawford 2001). Periodic contact with peddlers, preachers, local merchants, the court system in Jefferson, and participation in a nationwide voting system have ensured that the people of Ashe County were not passive victims in their economic or political destinies.

Stephen William Foster conducted research in Ashe County in the 1970s on the people living along the New River, focusing particularly on the controversy over the construction of a hydroelectric dam on the New River. In the 1960s and 1970s, residents of Ashe County were threatened by the proposal of a hydroelectric dam on the New River. This dam, if successful, would have flooded over 2000 acres of Ashe County. Nevertheless, citizens in Ashe County fought the proposed dam, and won (Foster 1998).

Changes in community members’ livelihoods, social circumstances, and environments will often challenge their sense of community cohesiveness and identity (Williams 2002). Community members in Ashe County shared a common, unspoken heritage, where their identity was defined by how well each person knew their neighbor. As historian John Alexander Williams has described Ashe County residents during the New River dam controversy, “a native’s sense of identity is derived from family and
community narratives that shaped everyday discourse without being written down or transmitted formally...an unspoken code of reciprocity governed routine interaction among neighbors and kin” (Williams 2002: 364). In response to a threatened sense of community cohesiveness from outside interests, this unspoken community identity was transformed. Ashe County residents were forced to defend their ideas of community cohesiveness by “...articulating these rules and practices and redefining local identity as Appalachian identity” (Williams 2002: 364). They rallied around pride in their history as a people in Ashe County. The local history was documented by resident Eleanor Reeves for the New River Festival in 1975 (Foster 1998). It is important that this thesis note the acceptance of this history of Ashe County by its citizenry in order to put the interview material into its appropriate historical context as it is described by the residents. By writing their history in their own words, Ashe County residents were able to vocalize the values that were of most importance to the maintenance of their lifestyle. By stressing the importance of a shared value system among community members, Ashe County residents acted as agents in the shaping of their own culture.

Descriptions of Specific Communities Along the North Fork

Post offices were established in the townships of North Fork in 1830, Jefferson in 1834, Sutherland in 1875, Creston in 1882, Lansing in 1882, Fig (Riverview) in 1888, Warrensville in 1902, and West Jefferson in 1915. The abundance of post offices and their associated towns indicates that these communities were prospering. Other communities also existed or would come to exist: Pottertown, Trout, Three Top, Ashland, and Crumpler are all communities along the New River, known as towns to the people that
live there (Goss 1984). Some of these communities consolidated into larger communities. Doc Robinson practiced medicine in all of them; however, this research focuses on Pottertown, Sutherland, Creston, and Riverview as the main areas of Doc Robinson's practice.

Pottertown, or Tamarack as it is sometimes called after the numerous Tamarack Pines growing in the area, is actually in Watauga County. This area was once a part of Ashe County, and is separated from the rest of Watauga by Snake Mountain. Pottertown is accessible from Watauga County through a gap in the mountains known as Pottertown Gap, along which several homes now stand. Around 1815, the Potter family moved into the area from Kentucky and bought land. In 1819, North Carolina granted to John Potter 100 acres of land on Hoskins Fork of the New River. In 1842, Enoch Potter acquired 120 acres on Roan’s Creek. According to Elizabeth South Storie, a resident of Boone, North Carolina with kin ties to the Potter family, “the Potters were a close-knit, mind-their-own-business, peaceful, non-aggressive family, until someone tried to impose regulation and aggressiveness of outsiders upon the Potters” (Storie 1991: 8). The Potter family did develop a history of violence, about which stories abound. Just as throughout the entire Appalachian region, poverty occurred in the community at times. Stress from various cycles of poverty often lead to incidents of violence, as would occur in any impoverished area. Any violent act that occurred fed the stereotype of the community members (and Appalachian people in general) as excessively violent people. This reputation as a violent area has led to many stories which have been woven by surrounding communities into a myth of violence. Despite the fixation about Potter family violence by the general public,
Pottertown was and still is a community of much more than just a collection of mischief-makers. The community appeared to prosper and grow, and was well populated during the early 1900s.

The institutions that make a community were certainly in existence in Pottertown in the early 1900s, and what was not available in the immediate vicinity could be accessed nearby. Most of the children attended elementary school in the summer months, since the children walked to school. Some of the children attended school for a while in a near-by Baptist Church, which also housed the election poll (Potter 2000). A post office served the community and had a mailing address of Tamarack, but everyone knew the area as Pottertown.

Several stores were in Pottertown, including the Ellison Store (closed in 1966), the Mains Store, the Nellie Gibson Store, and the Counce Potter Store. Most people sold or traded what they produced on their farms for store-bought goods, including roots and herbs they regularly dug, turkeys, chickens, and eggs. Anner Potter remarked that one often had to trade roots and herbs for bread at the store, because money was not readily available (Potter 2000). Local stores would then ship the goods to places like Wilcox Drug Company in Boone North Carolina, which would ship the products nationwide (Stephens 2001). Residents took corn and other grains they grew to the local gristmill to be ground into flour. They also kept cattle and sheep for subsistence and for market, and horses. Edgar Eller and Anner Potter both recall how the majority of the people born into the community remained in the community and worked in the area, often sharing labor on the many farms (Edgar Eller 2000; Potter 2000).
There were no doctor’s offices in Pottertown during its heyday, but each informant can recall neighborhood midwives and the services of Doc Robinson. Selena Potter was the neighborhood midwife for some time. According to Rat Mains, Selena Potter “caught” babies but did not treat people for sickness (Mains 2000). People also used their own remedies, along with seeking the help of Doc Robinson. Doc Robinson did not live in the community, but he would come from Creston or Sutherland to serve the people in Pottertown. Mains recalls that Doc Robinson would often give them pills, and he “cured a lot of people” this way (Mains 2000). Anner Potter’s grandmother, Tilda Church, was also a midwife. Tilda would come whenever someone was giving birth or if they were sick. Anner also recalls making her own remedies, particularly tea from the catnip plant. Doc Robinson also came for the birth of several of Anner’s children. However, Anner recalls doing most of her own healing (Potter 2000).

At one time, Pottertown road was lined with many different homes. In the 300 acres that make up Pottertown, 15 or 20 families lived at one time. However, today the stores are gone, the schools have consolidated and left the area, and there are no mills. Most of the families have moved elsewhere for greater economic opportunity (Edgar Eller 2000). In order to maintain a livelihood in more recent times, some residents have gained employment at Appalachian State University in nearby Boone, growing a family garden to supplement their income. Being willing to have several different jobs has allowed some family members to remain in the area.

After crossing the Ashe County line, Pottertown Road becomes Sutherland Road, and the community of Sutherland begins. According to a locally made map legend
Sutherland was settled around 1750. Original settlers survived by hunting, trapping, and selling maple sugar. Early landowners included Richard Allen, Francis Reynolds, and John Brown, who were land speculators. The state of North Carolina sold these men several land grants for five cents an acre. Later, these men sold the same land for one to five dollars per acre. In 1805, Alexander Sutherland bought 450 acres of land, and gave part of it to his son Thomas. By 1807, Tom Sutherland had married and settled on the land with his wife. By 1813 Tom was able to repay his father for the land, which suggests that some way of generating capital from farm production was possible. Tom had also by this time begun to sell parts of the land to different families. According to Minnie Sutherland, Tom sold several Potters land for a dollar an acre, helping to form what became Pottertown (Minnie Sutherland 2001).

Between 1875 and 1925, Sutherland thrived, with fourteen businesses, a church, a doctor’s office, a law office, a seminary (private school), a home for teachers, a post office, two public schools, seven tenant houses, 33 private residences, and a cheese factory (Legend for Map of Sutherland 1875-1925). Based upon the number of small businesses and community services, it is apparent that Sutherland was a very prosperous village during the late 1800s and early 1900s.

Whether purposefully or not, Sutherland did not need any push from the missionary or benevolent movement that was sweeping other parts of the south at the time in order to prosper. Sutherland Methodist Church was established in 1858, and moved to its present location by 1885 due to growth resulting from commerce and industry. The church became the center of community life, and Doc Robinson attended many of the
revivals held there (Gray 2001). In the late 1880s, the church and local community members started Sutherland Seminary. Over the next several years, the Seminary served anywhere from 50 to 150 students per year. Close by was the teacherage, the spacious brick house owned by the Sutherland family where teachers boarded. Unfortunately, the school burned in 1904 and was never reopened.

People in Sutherland, for the most part, grew much of what they needed on their family farms, and drove their livestock and garden surplus to markets in Tennessee. There were five stores at one time to provide the community with what they could not grow and which also provided local markets for some of the goods they produced, like livestock, poultry, and forest products. People often traded what they grew on their farms--grains, eggs, and livestock--for store bought goods. By 1908, only one store and the post office remained.

The community of Sutherland ends with the intersection of Sutherland Road and North Carolina State Highway 88. If one turns right onto Highway 88 from Sutherland Road following the course of the New River, Creston is the next community. Creston lies in a valley between The Peak and Three Top Mountain in western Ashe County. Jefferson, the county seat of Ashe, lies twenty-six miles away. The establishment of the North Fork post office in 1830 signified the recognition of this community. The name was later changed to Creston in 1882.

The Ellers from Germany were early residents of the Creston area. Jacob Eller had the first homestead in the area right after the Revolutionary War and operated one of the first mills (Ronald D. Eller 2000). Creston families like the Ellers farmed the land and
used the forest to gather herbs and roots. They would sell herbs like lobelia, elder flower, mint, boneset, burdock root, ginseng, cherry bark, and catnip at neighborhood stores like the Stephens Store, which operated until the late 1900s (Stephens Store Records 1927-1942). Patent medicines, those controlled by the U. S. government, were sold at general stores like the Stephens Store, suggesting that residents in Creston were self-medicating, despite the presence of Doc Robinson.

Historian Ron Eller notes that the community helped to get the roads paved in the area: “When they wanted a road, the community got together and did it” (Ronald D. Eller 2000). Creston had its own road chairman and every male between the ages of 14 and 45 had to put in a certain amount of time working on the roads during the early twentieth century. The establishment of roads helped to ensure that Creston was not isolated from trading farm products with outside communities (Stephens 2001).

The current Robinson household, the home of Doc Robinson’s son Joseph, is in the Three Top area of Creston. In the Three Top area are found the Worth Methodist Chapel and the Creston Volunteer Fire Department. The fire department was established in 1975. Before this, the closest fire department was in Warrensville, nine miles away. The Creston Volunteer Fire Department not only covers Creston, but covers Potterrton in Watauga County, as well (Lewis 2000).

In 1880, 963 African Americans lived in Ashe County. Although this number would decline to 684 by 1900, African American families lived in the area throughout the early twentieth century (Sparrow 2000). A small African American population lived along the Peak Road in Creston. African American families like the Thomases, the Wellingtons,
the Stouts, and the Maxwells survived on the Peak by subsistence farming and selling surpluses at local markets, and performing agricultural and domestic labor for their neighbors. Often times these families would go into Jefferson and sell apples, honey, beans, and tobacco. African American families lived and worked alongside their white neighbors, sharing a variety of farm labor. There was rarely any monetary exchange for the work that was done among neighbors, but rather a deep friendship between families grew, despite segregation of the day (Sparrow 2000).

In other areas of their lives along the North Fork, African American families in the Peak area were forced to deal with segregation. From the 1880s until 1940, there was a school for African American students in Creston, which was only held for a few weeks out of every year. In the 1940s, the schools in Ashe County were consolidated, and African American students attended Bristol Consolidated School, an African American school outside of West Jefferson. Most of the African American families migrated out of the Peak area by mid-century to seek better livelihood opportunities in other areas (Sparrow 2000).

Dora Horton, one of the informants for this thesis, was a member of one such African American family living in Creston at the turn of the twentieth century. Dora Horton recalls the segregation, explaining that this was a routine part of life at that time. She remembers her life in Creston as peaceful, and she especially recalls the farm help and camaraderie of her white neighbors (Horton 2001). Dora Horton attended the black school in Creston until she was 16. She also recalls with fondness the care of Doc Robinson. When her children became sick, she would call upon Doc Robinson, who
would travel on horseback to see them. Apparently, Doc Robinson never discriminated on
the basis of either class or race, and he never refused to treat the African American people
living in the area. White newcomer Jimmy Savely later rented the house of the last
African American in the community, Ethel Stout, when she was forced by age and
concerned family members to move in with her daughter in Winston-Salem, North
Carolina. Savely observed that black people at this time were “...kind of in the same boat
(as white people)--the same lifestyle. I mean they did at times mention differences, but I
never heard anything racist. They were just kinda, kindly neighbors” (Savely 2001).
This attitude is reflective of the cohesive relations that communities like Creston continue
to enjoy today.

Heading back up river on Highway 88, Riverview is the next community along the
North Fork of the New River. The Riverview School was founded in 1924 and closed in
1994. Now, the school serves as a community center, hosting weekly senior citizen
luncheons, a thrift store, Friday night music, a restaurant, a pharmacy, and a youth center.
The people living in the area near the Riverview Community Center often attend the many
functions it offers.

Many of the residents of Riverview, including Nell Sutherland, recall the practice
of Doc Robinson. Though she was not formally trained Nell acted as community healer
helping Doc Robinson administer to the sick when he was overloaded with work. Nell
Sutherland remembers “...people did use home remedies like camphor, onion poultices,
catnip tea, honey and onions...”(Nell Sutherland 2001), pointing out that often times a
combination of herbs and store bought goods were used.
Midwives, or granny women, were the only health care providers in the Creston area until the late 1800s. Each neighborhood had its own midwife. In Creston and Riverview, the midwife for a time was Rosie Cornett. Joe Stephens describes her service:

There were nine of us kids, and all but one was born at home. So a midwife, Rosie Cornett, you’ve heard her name, Rosie was the local midwife, and she lived just above the store and...when a child was being born she went. There was no doc up there...she could’ve birthed a baby just as well as anybody...

(Stephens 2001).

As evidenced by these community histories, Ashe County is a rural, agrarian county, where the economy is largely agricultural. Cathy Efird maintains that traditional medical systems are appropriate in this setting, meaning that the economy of agricultural areas will typically support traditional medical systems as opposed to professional biomedical systems where money is exchanged for services (Efird 1985). The values of an agrarian society, noted here as largely egalitarian and self-sufficient, helped to maintain traditional medical systems because the local caregivers shared the same values as their patients. As in many rural areas, Ashe County residents have often had to utilize several means of making a livelihood. In some cases, family members work two or three jobs, which might include a teaching job at one of the elementary schools, part-time work at a restaurant or factory, and small-scale farming, the products of which are mainly used for consumption in the family’s home but any surplus is sold at market. Multiple livelihood strategies, as described by Rhoda Halperin, are typical in rural areas like Ashe County (Halperin 1990). Multiple healing strategies are viable as well in this setting because they allow people to best choose which method of healing is right for them given the situation,
be it based on cost, effectiveness, or timeliness. Doc Robinson apparently made no attempt at hampering the individuals’ right to choose for themselves which method of healing to use for any given medical situation. This proves to be an important factor in the success of Doc Robinson, despite the fact that he adhered to a biomedical system of healing.

The communities along the North Fork of the New River have been called “...border communities in a border county...” as they lie on the border of Ashe County, which also forms the state border with Tennessee (Beaver 2001). Communities along the North Fork are not so much defined by strict geographical or political boundaries as they are by the people that inhabit them who share common histories and ideals (Beaver 1986). Often times the borders of these communities were fluid, and people like community doctors traversed these borders to form networks with neighboring communities. This thesis is concerned mainly with the communities of Creston (formerly North Fork), Riverview, and Sutherland in Ashe County because the bulk of Doc Robinson’s time was spent practicing medicine in these areas, but also examines information and oral histories from Pottertown in Watauga County for deeper understanding of the fluid nature of community life.

Part 2: Traditional Ethnomedical Practices in Ashe County

Prior to the widespread availability of physicians in Ashe County, the people used herbs that they found in their surroundings and incorporated their own ideas about what to do with these herbs in their healing practices. For example, catnip was made into tea and used to alleviate stomach pains (Potter 2000). Several of the informants consulted for this
study mentioned using herbs like boneset, catnip, ginseng, and bloodroot for treating ailments. Steeping the leaves of certain herbs to make tea was the typical manner in which a remedy could be made from the plants. Other substances that could be found in the household were also used as healing substances, including ashes or cobwebs for cuts (Potter 2000). Store bought goods like salt were always available, and people combined herbs with other substances for effective treatment of some ailments. The variety of herbs and other substances used for treating sickness suggests that a viable traditional ethnomedical system did exist prior to, and even after, the arrival of biomedical doctors.

Most of the informants consulted for this study were well into their 80s, and represented the oldest generation in Ashe County. Most informants do not remember the specific uses of herbs. By the mid-1900s, most herbs had been incorporated into the economic system in Ashe County, as evidenced by the Stephens Store Records (1927-1942). According to the store records, community members harvested and brought to local stores such as the Stephens Store herbs like ginseng, burdock root, lobelia, catnip, mint, and boneset with the intent to barter these herbs for other goods. This practice of incorporating herbs into the economy of mountain communities was relatively common by the mid-1900s, as David Cozzo’s research based in nearby Watauga County suggests (Cozzo 1999). While the use of herbs in their medical system may have subsided to some extent by the 1950s, community members do remember using store bought goods to concoct home remedies. Most homes had a copy of Gunn's Domestic Medicine, or a similar home remedy manual (Lewis 1986). In the North Fork area of Ashe County in the late 1800s, the local midwife was relied upon as the primary healthcare provider. This
practice continued until the 1950s. Della Bauguess of the Pond Mountain area of Ashe County recalls that a community midwife came with the birth of her first child. By the time her next two children were born, a nurse from Germany had moved to the area, and helped to deliver her children. Della’s final child was born in a hospital. Other community members living in the Pond Mountain area recall using community healers because it often took too long to reach a doctor. Several community members remarked that if they did seek the advice of a doctor, they did not always accept their suggestions (Cooper 1998). Most informants relate how a variety of methods like religious healing, home remedies, including herbal remedies, patent medicines, store-bought goods in combination with herbs, and the services of local community healers like midwives formed the basis of their traditional ethnomedical healing system. Religious healing was also used; most community members recalled praying for the sick (Gray 2001; Potter 2000).

The traditional ethnomedical system remained viable in Ashe County for a number of reasons, even after the arrival of professional physicians. Community members often site cost and time it took to get the doctor as prohibitive. Gwyn Hartsoe of Creston remembers that it once took him three hours to get Doc Robinson and bring him back to the house in need—too late for someone who needs help right away (Cooper 2001). The mountainous terrain and volatile weather conditions often made the neighborhood healer a better option than distant physicians. Cost was also a reason that people may have opted for the services of a midwife. Midwives like Rosie Cornett who practiced along the North Fork accepted barter or trade for their services (Cooper 2001). Professionally trained physicians would often only accept pay for their services. Despite the fact that Doc
Robinson often accepted barter for a job well done, many people must have assumed that he would have charged them, and chose the services of midwives instead.

Part 3: Biomedical Practices in Ashe County

Until recently, health services of professionally trained doctors were not widespread in many rural areas of western North Carolina. Most of the hospitals in the mountain counties of North Carolina were established in the 1930s as part of the Work Progress Administration's efforts to bring services to rural areas of America (Pacher and Richards 1999). In the 1880s, professionally trained doctors began to come to the area in large numbers, giving the people a choice among traditional healing, biomedicine, or a combination of the two. In some areas of Appalachia, the push to create a professional class of physicians and the influx of Northern aid and missionaries to the area tended to leave the people with little choice regarding healing practices. Outside agencies often insisted that community members use biomedical services instead of home remedies. This was especially the case in coal and timber camps, where a company doctor would perform the healing. Northern benevolent movements through clubwomen and settlement workers have often been credited for bringing professional medicine to the mountains (Barney 2000). However, this is not a sufficient explanation for the advancement of biomedicine and the maintenance of traditional ethnomedicine in Ashe County.

Mica and iron ore mines and logging operations did exist in Ashe County for over 100 years, which brought the railroad to the area by 1914 (Davis 2000). Once the timber boom was over and timber and mining were no longer economically viable, the railroad was removed. Parts of the railroad tracks that did remain were washed away by a flood in
1940. This railroad was also used as a passenger line for a while and would have brought people into the area, but there are no records of any physicians coming as a result of this. There are also no instances of extensive mining or lumber camps in the area, and no instances of physicians coming to Ashe County as a result of extractive industries or missionary work. Biomedically trained physicians were in Ashe County prior to extractive industries and independent of Northern benevolent movements that shaped the medical histories in other Appalachian communities (Fletcher 1963). Professional doctors even came to Ashe County before the push by the AMA in the late 1800s to spread professional biomedicine throughout Appalachia.

Several accounts of the Civil War in Ashe County recall the practices of early physicians. Dr. Aras B. Cox, Dr. James Wagg, and Dr. J. O. Wilcox lived in Ashe County until the 1870s. Each of these men had attended medical school and had other jobs in addition to ministering to the sick during the Civil War (Crawford 2001). These men lived around present-day Jefferson, and there is no record of them actually practicing medicine in the Creston area.

Between 1799 and 1962, no more that 75 total physicians practiced in Ashe County. Often times there was one physician for the entire county (Fletcher 1963). The earliest mentioned practicing physician in Ashe County is Dr. T. J. Jones, who opened the first clinic in Lansing (beyond Riverview) in 1882. By 1888, the Ashe County Medical Society was in existence, and Dr. Jones was a member (Ashe Historical Society 2000). The Lansing Dispensary offered biomedical care in the form of over-the-counter patent medicines, many of which contained opiates (C. B. Jones 2001). Another doctor in
Lansing, Dr. Manley Blevins, earned his medical degree in Baltimore, Maryland, and was licensed in 1885. Dr. Blevins was a native of Ashe County and had developed an early interest in medicine through the practice of his father. As a young man, he read medical books and acted as an apprentice to local doctors (Goss 1984).

In the early 1900s small, independent clinics operated throughout the county, where professionally trained doctors would fix a broken bone or give out medicines. Most of these doctors were from mountain communities and had left the mountains to attend medical school but had returned to the mountains to practice. This was true in the case of Doc Robinson, who is discussed in detail in chapter five. Around 1936, the Works Progress Administration began constructing a hospital for Ashe County. At this time there were fourteen physicians in Ashe County. Interestingly enough, the hospital only employed local physicians--no new physicians were brought into the area (C. B. Jones 2001). The District Board of Health, which was created in 1938 to provide health services throughout Ashe County, formally incorporated Ashe County Memorial Hospital in 1941 (www.ashememorial.org 2002). Prior to this, if a patient was seriously ill, Doc Robinson never hesitated to send them to medical centers outside of the community (Nell Sutherland 2001). Dora Horton recalls that when her daughter developed polio in the 1930s, she had to go to Asheville, North Carolina for treatment, provoking the family to purchase their first car, which their 16-year-old son learned to drive under the instruction of his white neighbor, Russ Brown (Horton 2001).

The District Board of Health, in collaboration with business leaders in Ashe County, requested help from the Works Progress Administration in constructing Ashe
Memorial in West Jefferson. Since its opening in 1941 Ashe Memorial has moved to Jefferson, the county seat. Some Ashe County residents, living in the North Fork, still find it more convenient to drive the shorter distance to Mountain City, Tennessee or Boone, North Carolina for medical services (www.ashememorial.org 2002).

According to Dr. C. B. Jones, there was widespread community support for Ashe Memorial. The community backed the incorporation of the hospital by collecting canned goods to raise money for the building (Fletcher 1963). Private physicians like Doc Robinson continued to practice independently of the hospital system by doing house calls, and would occasionally refer patients to the hospital.

This historical background of Ashe County is important for understanding the cultural context in which the transition from traditional ethnomedicine to biomedicine occurred. From the Native Americans who first periodically occupied areas in Ashe County and the diverse group of European and African settlers that came to live along the North Fork of the New River came a combination of traditional ethnomedical practices that helped sustain early residents of Ashe County. The county’s early reputation as a hotbed of political debate was fostered and maintained by the residents’ insistence on independence, a value that has allowed for community cohesiveness despite threats from the outside. Intense exploitation of Ashe County’s iron ore deposits and timber was short lived in the county, and as a result, no mining or logging camps existed. Clubwomen and settlement workers associated with mining and rural areas of eastern Kentucky were not a force of change in northwestern North Carolina. Because of this, residents of Ashe County were in a better position to actively shape their communities and were able to influence the
transition from traditional ethnomedicine to biomedicine. The life and practice of Doc Robinson exemplifies the forces that were at work to transform medicine in Ashe County, and how this transformation was not as complete as it might have been elsewhere in the Appalachian region.
As a result of local efforts, rather than outside benevolent movements, to encourage physicians to practice in the area through the establishment of such entities as the Seminary School in Sutherland, the transition from traditional ethnomedicine to biomedicine in Ashe County was not as complete as it may have been elsewhere. Instead, residents still living recall that they were able to use a variety of healing methods including herbal remedies like catnip tea, the local midwife, store bought remedies like paregoric, prayer, and the services of professional physicians. The initial diversity of the people settling Ashe County and their continual adaptation to daily life in the area fostered a sense of self-sufficiency, which informants spoke of often. Community members expressing, among other things, the importance of community cohesiveness and a strong sense of independence allowed for the introduction of biomedical practices into the area as long as these biomedical practices could complement, not replace the healing system in place.

Dr. Joseph “Doc” Robinson, a professionally trained biomedical physician, allowed the people of Ashe County to use a variety of healing methods. Stories by people that knew or knew of Doc Robinson are numerous, and they reflect the community’s value system and how Doc Robinson adapted his life and work to fit this value system. Excerpts from several of these stories give insight to the maintenance of two systems of healing in Ashe County and how cultural values affect the choices that people make regarding
healthcare. The following chapter outlines Doc Robinson’s life history, the community’s stories about him, and how these stories show that people in Ashe County made a deliberate choice to combine two systems of healing.

The Early Years

Dr. Joseph Robinson was born in Carter County, Tennessee, near Elizabethton, September 20, 1879. The oldest son of Joseph and Sarah Elliott Robinson, Robinson’s interest in medicine was presumably fostered by his physician father. Doc Robinson’s only son, Joseph, says that his father used to tell him stories about wanting to be a doctor “just like his father before him” (Joseph Robinson Jr. 2001). Doc Robinson, according to his obituary written by Mrs. Charles Sutherland, studied medicine at home with his father until age 19, when he began to practice alongside Dr. James Butler in Mountain City, Tennessee (Sutherland 1955). According to Joseph Robinson Jr., “when he was practicing with Dr. Butler along in the summertime, you know, when he wasn’t going to school, he was trying to make money to go to school” (Joseph Robinson Jr. 2001). Education was obviously important to Doc Robinson; he worked hard to be able to attend school.

People in Ashe County knew that Doc Robinson had worked hard to save money for school, and thus had worth to the community. Patricia Beaver has noted that in rural Appalachian areas, community members define the worth of any individual in the community based on whether or not that individual works. Work in this sense is not necessarily public work, i.e. working for a salary under the supervision of a higher
authority, but is primarily the work that is done by a community member in an effort to make ends meet within the range of available subsistence opportunities in a particular place. A person works by fulfilling economic responsibilities to any dependents. Ensuring that he or she will not unnecessarily burden other community members with economic responsibilities gives that person worth in the eyes of the community (Beaver 1986).

Knowing that Doc Robinson worked to save money for an education he so highly valued would help to establish Doc Robinson as a hard-working man, and therefore worthy of acceptance into the communities he would come to serve.

**Schooling**

Once he had saved enough money to attend school, Doc Robinson began his career at the Medical School of the University of Tennessee, Knoxville. He remained there for three years, after which he left Tennessee to attend and ultimately graduate from the Medical University of Kansas City, Missouri in 1904 (Sutherland 1955). The reasons behind Doc Robinson’s choices for medical schools are unknown, but perhaps the University of Tennessee at Knoxville was initially attractive because of the close proximity to his family home. During the early part of the twentieth century, when Doc Robinson attended medical school, the Appalachian region experienced a rise in the number of regional medical schools. Before 1925, half of all physicians practicing in the region received their education at regional medical schools (Barney 2000). However, most physicians who were seeking to further their education and thus their status in the communities where they practiced were compelled to seek education outside of the region because scientific advances in medical training were slow to reach most regional schools.
Degrees from second or third-tier institutions outside of the region helped to ensure the status of some newly arrived physicians to the area. Nevertheless, most physicians could only hope for nominal success without the advantages of having kin or community ties in the region (Barney 2000). Doc Robinson, having been born, raised, and initially educated nearby in the mountains of eastern Tennessee already enjoyed some community ties with the people he would come to serve in Ashe County. Furthering his medical education at a non-regional medical school with supposedly better training opportunities tends to support the suggestion that Doc Robinson valued a biomedical education. Doc Robinson practiced medicine in Kansas City for one year. He then relocated to the University of Chicago for post-graduate work.

Returning East

The circumstances causing Doc Robinson to return to the eastern Tennessee/western North Carolina area are unknown, but apparently at some point after he did post-graduate work at Chicago he practiced medicine under a Dr. Stoffel, in the Creston community of Ashe County. Some sources say that by 1900 he had at least visited Ashe County on a vacation. In the Sutherland community, Doc Robinson met and married resident Julia Sutherland. Joseph Robinson, Jr. says that his father “practiced medicine from the time he left Missouri and he decided to come back on a vacation, and my momma wanted to stay out there. And they hated to see him go because he was a young doctor and by God he knew what he was doing! And so he come back here, like I said, he was going to vacation, and he stayed here fifty years” (Joseph Robinson Jr. 2001).
The people of Ashe County were in need of a young doctor with current medical training to set up a practice in their area. Physicians had been in Ashe County for at least sixty years prior to Doc Robinson’s arrival. In the Sutherland community of Ashe County, a seminary (private school) had been established in 1885, but burned in 1904 and was never rebuilt. According to Minnie Sutherland, several physicians, the names of whom she could not recall and records of which do not exist, had practices in the area as a result of affiliations with the school but left after the school’s destruction, leaving the community in need of a physician. Minnie recalls that “there was a huge seminary at the time down the road and many doctors were there, it had a doctor’s office. This was a little town--lots of people came and went, especially for the seminary. Then the seminary was gone, and lots of people left. But the ones that stayed still needed treatment. We were glad to see Doc come. He was a general practitioner and we needed this. We did know about his schooling, but it was particularly important that he could do it all” (Minnie Sutherland 2001). Joe Stephens agreed that the community was in need of a physician at the time of Doc Robinson’s arrival, noting that “he was a valuable person because of his medicine, you see” (Stephens 2001). Nell Sutherland, who would eventually come to help Doc Robinson administer ether to pregnant women, believes that Doc Robinson “came to the area to be of service to mountain people. Things were real hard--there was no other doctor around, and Doc Robinson just had the calling” (Nell Sutherland 2001). It is obvious from community members’ statements that North Fork residents made an effort to encourage Doc Robinson’s permanent residency and practice in the area. Local residents in the early 1900s actively promoted the establishment of a professionally trained,
biomedical physician among them. However, this could only work in an atmosphere of trust for Doc Robinson by community members and respect for the age-old independence and adaptability of Ashe County residents on the part of the relative newcomer physician.

A Marriage that Leads to Trust

Doc Robinson married Julia Sutherland, a member of a prominent Ashe County family, around 1903. The Sutherlands settled much of western Ashe County, and their influence was far reaching. Little information is available about Doc Robinson and Julia Sutherland’s courtship and wedding, but it is obvious that marrying into a well-respected family was a major advantage to his practice in Ashe County. Numerous informants spoke of their trust for Doc Robinson based on his alliance with the Sutherland family. Despite the discrepancy in the stories regarding timing or manner, it is known that Doc Robinson married into the Creston community and began a practice which would last for over fifty years. Joseph Robinson Jr. explains that his mother “was born ten miles up the road in Sutherland. If you come down the road here [Highway 88] you will see a church up on the hill here. It is that church. Her granddaddy helped build that” (Joseph Robinson Jr. 2001). Minnie Sutherland clarified Robinson’s memories by pointing out that “Julia was born and raised in the big white house near the church [Sutherland United Methodist Church]. My husband Fred’s grandfather Red Thomas Sutherland sold off parts of his land for a dollar an acre to get people to move in. He wanted a town. This is all up this road [Sutherland Road] and into Potertown. I grew up below the Sutherland Church. The Sutherlands were the first settlers in this area. I married Fred Sutherland. Red Tom Sutherland was his grandfather, and he built the church. Julia was my husband’s aunt, and
we called Doc Robinson ‘Uncle Doc’” (Minnie Sutherland 2001). Minnie Sutherland’s statements are valuable because they tell not only of Doc Robinson’s marriage to Julia Sutherland, but also the prominent place the family held in the community. That community members trusted Doc Robinson was largely due to his marriage into a family that had done much in the way of helping to establish services like medicine, religion, and education in the area.

The Robinson family grew throughout the early 1900s to include four children. As Doc Robinson became an integral part of the community, his practice expanded as well. The services of many people were called upon as Doc’s practice became too large for one person to handle. The Robinson children often assisted their father with his house calls, although they had not been medically educated and never developed enough of an interest in medicine to attend medical school. Joseph Robinson Jr. says “I was the only boy [born to Doc Robinson]. Four younger girls after me. Yeah, I would help drive a lot of times. I had to put chains on the Model T and all and sometimes I would drive it. We went through creeks and things and the car would make ruts and we had to put chains on them” (Joseph Robinson Jr. 2001).

In most other rural Appalachian areas during the early 1900s, professional physicians followed the standards set by professional medical societies like the American Medical Association which maintained that in order to ensure their professional status, physicians should not fraternize with any individual who practiced medicine without the proper education or license (Barney 2000). Doc Robinson attended medical school but also employed the services of untrained assistants, implying his willingness to adapt to the
needs of particular situations instead of being rigidly confined by standards of the day which allowed for doctors to have supremacy over healing. Doc Robinson exhibited qualities of independence and adaptability, traits that community members valued which have indeed often been necessary for their survival.

Several Ashe County residents emphasize the importance of egalitarianism in their communities. Doc Robinson would have to limit shows of wealth in order to sustain a practice in Ashe County, a duty he willingly undertook. Informants recall that Doc Robinson willingly accepted his role as community physician, although there was a suggestion that his wife Julia might have been a bit more enthusiastic about staying in Kansas where he was offered a practice and moving away from her childhood home. Julia Robinson’s great-grandson Joseph Robinson III argues that “Grandma Rob (Julia) really wanted him to go to a big city to practice I think because you know, it would be easier, make more money and all that. But he wanted to stay around here. He did end up with a lot of land for those times, I am sure he was OK” (Joseph Robinson III 2001). Despite Julia’s occasional desire to live elsewhere, community members who know the Robinson family are adamant about their humble lifestyle. According to Clara Gray, “the Robinson family lived a simple life. And they grew a garden. But you know, [Julia] didn’t have anything extra, she had the household things that they needed and that was about it” (Gray 2001).

A village’s stability is often centered around a church, which acts as a symbolic anchor in the community (Keefe 2003). Becoming involved in a community’s religious and political life is very important in becoming fully integrated into a community (Beaver
1986), and Doc Robinson’s particular involvement in religious and political affairs in Ashe County indicated to his neighbors his willingness to respect local values, and encouraged Ashe County residents to see Doc Robinson as a trustworthy, upstanding citizen. The Robinson family attended church faithfully at Creston Methodist Church. While Doc Robinson was not known as an overtly religious man, he did take his own salvation quite seriously. Clara Gray, whose own family attended Creston Methodist Church regularly, recalls that “he would go and get saved each time they had a revival!” (Gray 2001).

Several informants have commented on Doc Robinson’s tendency to be superstitious, a trait which only served to endear him more to community members. Joseph Robinson III remembers that Doc Robinson “was very superstitious, and that was really funny. If a black cat crossed the road, one time they had to beg him to keep going to the hospital ‘cause they had somebody in there. But if he was just driving and a black cat, he would turn around and go back!” (Joseph Robinson III 2001). Clara Gray also notes Doc Robinson’s tendency towards superstition, and notes the frequency of stories relating to him. “There are many stories about Doc Robinson. One I can relate to: The time I saw a black cat cross his path, now he was driving a car that day, he pulled off his hat, spit in it, and put it back on!” (Gray 2001). Superstitions were seen as helpful in everyday life, yet they were not seen by community members as intrinsic to their healing system. Doc Robinson’s superstitious beliefs acted as a leveling mechanism in that he was seen by community members as their equal, and endeared him to the hearts of community members. Nell Sutherland explains that “superstitions helped people to look after themselves, they were more cautious” (Nell Sutherland 2001).
The trust and respect for Doc Robinson by his community members led to his eventual election to the North Carolina Senate. In 1921, Doc Robinson served Ashe, Allegheny, and Watauga counties. He served for one term. Joe Stephens suspects that community members supported Doc Robinson’s bid for state senator as a result of his medical practice. “He would go to their house and doctor their children and so on, and in turn he wanted to be a state senator. The people respected him very highly, and regardless of what their political affiliation was they supported him” (Stephens 2001). Despite the fact that most people in Ashe County were Democrats during the 1921 election, they overwhelmingly supported a very Republican Doc Robinson. Through his influence as state senator, Highway 88 was completed through Ashe County. In addition to supporting county-wide improvements, Doc Robinson wrote and lobbied for legislation to control spousal abuse in North Carolina (Stephens 2001). Joseph Robinson III speculates on his great-grandfather’s concern about spousal abuse as being the direct result of his home visits:

Yeah, well, I guess too, being a doctor, going from place to place he could see things. And it was a different time back then, people don’t realize it. There is a lot of abuse today, but back then you did what the husband told you to do and if you didn’t you would get back-slapped. I mean, it was different. And of course there were great people over there but there were also mean people. Back then if somebody was messing with you, that’s the only reason I could think, maybe he had seen some of that (Joseph Robinson III 2001).

Through stories about his term in the state legislature, it is obvious that Doc Robinson cared about the community and that the community cared about him.

Julia Robinson was also a vital part of the community throughout her life. As was
true throughout many mountain communities during the early 1920s, the victorious political party was given control of the local post office. Julia Robinson operated the post office out of the Robinson home from 1926 until 1933. It was through a window from her living room to her front porch that she served the public, and was often privy to gossip and concerns of community members (Gray 2001). Julia influenced the lives of community members through her work as postmistress, as well as her work to ensure that Doc's practice operated smoothly. Throughout Doc Robinson's years of practice in Ashe County, Julia stood by him through difficulties to support him and to assure community members of his dedication to his chosen profession.

The Practice

The earliest official documentation of Doc Robinson practicing medicine in Ashe County is 1907, as a general family practitioner (Raleigh News and Observer 1907). His practice area included all of the western part of Ashe County, which includes parts of Lansing and Pond Mountain, Todd, Warrensville, Riverview, Creston, Sutherland, Pottertown, and many other small communities. In reference to Doc Robinson's expansive practice area, Joe Stephens remarks, "I don't see how he stood it" (Stephens 2001).

While Doc Robinson spent the majority of his time making house calls out in the county, he did have an office with established hours. The office, which still stands today, is situated in the Creston community off of Highway 88. According to several community members, the office represented Doc Robinson's long-term establishment among them. The office was never locked; to community members, this was seen as a token of Doc's
constant availability. Clara Gray remembers that "the office was made up of two rooms, and the Eller children--my family--had permission to go inside and get out of the cold and wait for the school bus. You see, we lived across the river, not too far away from his office, and we moved there roughly in 1933 I'd say" (Gray 2001).

Telephones were not installed in the Creston area until the late 1950s, therefore if Doc Robinson's services were needed, another system of communication had to be developed. Community members invented a variety of methods of notifying Doc Robinson when he was needed, and the cohesiveness of the communities allowed this to work. Doc Robinson did not have office hours every day, only on Sundays from 2:00 pm until 4:00 pm. Those in need of his services could either find him by chance, or hope to catch him in his office. Noting a need for greater accessibility to Doc Robinson's services, the resourceful residents of Ashe County soon devised another way to reach Doc in times of need. Joseph Robinson III explains "they went up a holler which is just a little road up, and they knew Doc was going up there, if they wanted Doc to stop at their house they would hang a lantern outside and put a sheet over it and that meant that Doc needed to stop there" (Joseph Robinson III 2001).

Several community members enthusiastically endorse Doc Robinson's personality and practice. The fact that the entire Robinson family also helped Doc Robinson treat patients appealed to several residents' sense of familism, and led the community to trust Doc Robinson. Nell Sutherland remembered Doc Robinson as "modest, honest, and smart. Doc's family all worked with him to help him with his patients. He helped people and he loved it and so did they" (Nell Sutherland 2001).
Until the 1980s, Joe Stephens owned a general merchandise store in the Creston area, where he and his family came in frequent contact with Doc Robinson. Like other community members, Doc Robinson enjoyed the benefits of having credit at the Stephens’ Store (Stephens Store Records 1927-1942). Doc Robinson was buying whatever he needed at the store for his own personal use, but not necessarily medicinal items. Doc Robinson purchased medical supplies elsewhere, from federally approved and controlled medicinal supply companies like S. E. Masengill’s in Mountain City, Tennessee. Like most professional biomedical physicians of the time, Doc Robinson used opium-based medicines like laudanum and morphine (Joseph Robinson III 2001; Robinson 1921-1922). The Stephens Store offered patent medicinal supplies to those customers preferring to treat themselves. Paregoric was a popular ingredient in patent medicines, and Joe Stephens recalls many store patrons buying it from his shelves. Stephens remembers his own childhood use of paregoric, and claims that “paregoric had a good flavor to it! When I was small I would drink a little of it, Momma would give it to us for the stomachache or something. Had high amounts of alcohol in it. They put a stop to [selling] that” (Stephens 2001). Joseph Robinson Jr. explains the difficulty of getting medicine, and that his father often “…would get up about twelve o’clock at night [and travel somewhere to purchase] and pay sixty-eight cents a bottle for laudanum, morphine. Then they [S. E. Masengill’s] wanted forty dollars a bottle for it. He didn’t want it no more. He paid for it if he could” (Joseph Robinson Jr. 2001). Often times in situations where Doc Robinson found it necessary to travel to restock his supply of medicine, he would only charge the patient receiving the medicine what it cost him to make the trip. Furthermore, Doc
Robinson gave his patients the option of paying him with money or working for him on
the farm. His son says that Doc “would go to anybody that didn’t have money and go
ahead and doctor them and give them medicine, by God” (Joseph Robinson Jr. 2001).
Joseph Robinson, Jr. ’s explanation of the origin of his father’s medicine is also very telling
of the motives behind Doc Robinson’s practice. Instead of being profit-motivated like so
many of his contemporary professional physicians (Barney 2000), Doc Robinson cared
more for the well-being of his patients than he often did for his personal wealth or health.

Doc Robinson helped to foster North Fork community members’ new trust in
biomedicine as a cure for all ailments. Joseph Robinson III explains this as being a direct
result of Doc Robinson’s creativity. “I remember one little story that Doc and my
grandfather went to this one lady, I guess she was a hypochondriac, you know, she said,
‘Doctor I need something because I am hurting real bad,’ and he pulled out some pills and
he says, ‘Ok, you take these pills, but you only take two a day, these are really powerful
pills.’ My grandfather said ‘Daddy, are you crazy, that lady, she’s loony, she may take the
whole bottle!’ He says “well that’s OK, they were nothing but sugar tablets!’ He knew to
satisfy her she had to think she was taking something. And of course she was fine after
that! The only things I ever heard was that he was there and everybody just thought the
world of him” (Joseph Robinson III 2001).

Doc Robinson often prescribed a variety of opiates to his patients, especially
paregoric, laudanum, and morphine (Robinson 1921-1922). These drugs, derived from
the opium plant, were all the rage in the early twentieth century (Duffy 1979). As medical
science became more exact, Doc Robinson adapted his healing practices to fit the
treatment trends of the day. Doc Robinson’s education did not end upon his graduation from medical school—he kept abreast of changing treatments by constantly reeducating himself (Joseph Robinson Jr. 2001). Doc Robinson found it useful to keep a supply of medicines on hand, and he prescribed them as needed. Instead of having to go to another location like Boone, North Carolina or Mountain City, Tennessee to purchase medicines, over miles of often rugged terrain, community members could begin treatment immediately. The medicine that Doc Robinson kept in his office would be put into saddlebags and strapped to his horse when it came time to do a house call. These medicines, as Joseph Robinson Jr. stressed, were prescription medicines, not patent, and so they were subject to strict regulations by the federal government and medical societies like the AMA, who encouraged physicians to use the most advanced medicines available, which Doc Robinson had. Joseph Robinson Jr. recalls “one time his brother [from out of town] came and he said ‘I forgot my medicine, I’ve got to go back in the morning [to get it].’ He said that he would just go on back to his doctor and get his medicine. He had a certain pill to take for his heart, you see, which was not well known. Well, he got to my dad’s office and he had the same pills [my uncle] was taking!” (Joseph Robinson Jr. 2001). Robinson notes that his father stayed abreast of advancements in the medical field by reading several medical journals which he subscribed to and medical books which he would order by mail, which he often referenced in times of uncertainty. “Sometimes my father had a patient with something wrong and he would read about that patient and it would help him do more, out of that medical book; it had pictures and everything and it would tell all about that certain disease. They would mail them, mail order” (Joseph
Robinson Jr. 2001). Doc Robinson also had another valuable learning tool at his disposal: a skeleton from a 250-pound man. According to Joseph Robinson Jr., Doc Robinson received the highest grade in his class at the University of Kansas City Medical School, and was awarded the skeleton for his efforts. The skeleton was shipped to Ashe County from Kansas City, Missouri.

Several community members explained the limitations of Doc Robinson’s medicine, and the difficulty he had in treating some patients. According to several community members, Doc Robinson seemed to understand that there were situations that he was ill equipped to handle. Doc Robinson’s flexibility in difficult situations often meant that lives were saved. Several residents living along Peak Road in Creston recall an illness known locally as “fall poisoning.” According to Peak Road residents, cows grazing on the Peak were prone to eating snake root, a poisonous plant that grows at elevations of 3,000 feet. The cows’ milk would then become tainted, and the cow would die as would any human who consumed the tainted milk (Bledsoe 2000; Brown 2000). Terry Stout of the Peak Road area contracted fall poisoning from cow milk and died in the early 1920s. Stout’s neighbors Russ Brown and Ed Wellington also became ill with fall poisoning, but Doc Robinson was able to save both men as a result of his willingness to try unorthodox healing methods. Jack Brown, son of Russ Brown, explains that “Doc Robinson gave them a jug of liquor and it saved them. Then they went to Ashe Memorial Hospital. Every fall afterwards they would feel weak. We didn’t keep cows on the Peak after that!” (Brown 2000).

Despite obstacles, Doc Robinson made every effort possible to see that his patients
received the necessary treatment. Before cars were widely available to the public, Doc Robinson would transport his patients himself by horse-drawn wagon to Mountain City, Tennessee or to Damascus, Virginia, and from there they would board a train for Johnson City, Tennessee in order for the patient to have surgery (Joseph Robinson Jr. 2001). However, in some cases, traveling great distances was not possible. Especially when immediate treatment was required, Doc Robinson needed to be resourceful. Nell Sutherland remembers that “Doc Robinson always sent the really bad cases off. But one time there was no time. This was at the home of David Graybeal up on Rich Hill. They couldn’t take him to a hospital. So Doc Robinson and a nurse fixed up his dining room table and operated on him for appendicitis. Graybeal was 80 at the time and lived to be 100” (Nell Sutherland 2001).

One of Doc Robinson’s major difficulties was lack of equipment, a fact that Joe Stephens attributes to “a sign of the time.” “Well, he didn’t have no equipment. He had a little bag, little leather bag, and that’s what he carried. See, he couldn’t even X-ray. Doc Robinson was a fine doctor and well-respected and everything, but you see in 1930 a doctor’s knowledge of what he was doing wasn’t that great because everything you’ve got concerned with connected to medicine basically is about all new from 1950” (Stephens 2001).

Although he sent patients to distant hospitals for treatment, Doc Robinson was able to treat most of his patients in their homes. Home visits were often more effective than hospital visits because of the personal attention that Doc Robinson gave each of his patients. He would take the time to explain the illness and the remedy to the patient,
something Minnie Sutherland feels is lacking in today’s medical profession (Minnie Sutherland 2001).

In addition to the hardships posed by a lack of surgical equipment, Doc Robinson’s greatest challenge was overcoming the rugged terrain and sometimes harsh weather in Ashe County. Doc Robinson made all house calls on horseback until he got a car, sometime in the 1930s. Many community members recall seeing him walk a great many places to reach those in need. Having a horse, however, was a necessity for Doc Robinson. Without a horse, he simply could not have reached the majority of his patients, a testimony to the vast area covered by his practice (Gray 2001; Nelson 2001; Reeves 2001). The rugged terrain in the North Fork area often dictated that community members and Doc Robinson use a variety of transportation to reach one another, including horses, automobiles, and even bicycles. Doc Robinson went to great lengths to reach patients, often braving harsh conditions to treat someone in need. “He would get up, by God, and ride the horse through the creeks. Now we got all these bridges and the highways. A lot of times it was so bad that he couldn’t see, and he would let the reins of the horse loose and by God the horse would come home. And [the horse] would run up to the house and stop and Mama would--back then it was a fireplace, she had a hearth with a hook--bring the coals out and add an old cast iron teakettle and let the water get hot. And then my mama would go out and thaw his feet from the stirrups” explains Joseph Robinson Jr. Doc Robinson endured the difficulty of making house calls on horseback for over half of his career. Yet he was one of the first residents in Ashe County to push the county government to pave the roads (Joseph Robinson Jr. 2001). According
to Joe Stephens, Doc Robinson purchased his first car around 1925 (Stephens 2001). North Fork residents understand Doc Robinson's ability and desire to own and operate a car not as a show of wealth but as a sign of common sense, and tell many humorous stories about his unique driving methods. Joseph Robinson III says "yeah, it's funny, and when he drove he would pat the gas, he wouldn't just pat the gas and leave it. They say you could hear him come up the road and you knew it was Doc coming up, it would say BRRRUMP BRRRUMP, he would pat it, just like, he would drive up the road" (Joseph Robinson III 2001). Often times Doc Robinson would answer calls in hard-to-reach areas and treacherous conditions, and would rely upon his horse to complete the journey when his car would not make it. Joseph Robinson Jr. explains that in these instances "he would have a horse waiting for him and he would get on the horse and go on out to where the patient was" (Joseph Robinson Jr. 2001).

Doc Robinson was able to afford an automobile, but he was not considered wealthy by other North Fork residents. While he did not amass a great amount of capital as a result of his service in Ashe County, Doc Robinson never forced his patients to pay him in cash. Patients often could not pay him for services rendered, and he came to accept a variety of payment methods, including their labor. Joe Stephens explains that "they worked a lot for him [to pay medical bills]. See, he accumulated a lot of land down at Creston, up here, and a lot at the Peak" (Stephens 2001). "People paid him on credit or he charged three dollars for delivering a baby," according to Nell Sutherland. Sometimes he received farm products in exchange for his care. During the Great Depression, it was common for people to pay Doc Robinson with eggs, goats, pigs, or even land in return for
medical care. That Doc Robinson accepted barter for services illustrates the difference between him and most other medical professionals of the day: Despite the fact that Doc Robinson did belong to a professionally trained group of physicians, he did not necessarily adhere to the same value system. Joseph Robinson III explains that this is because Doc Robinson deeply cared for the people he treated. “I think for him to stay where he was at and do what he did, you’ve got to love what you do, and you are loving the profession, you are loving the people, and money is the last thing you are worried about. I mean I think as long as he could feed his family and take care of them” (Joseph Robinson III 2001).

Ashe County was a stratified society with marked differences in access to wealth and resources; the upper class was represented by wealthy and powerful families like the Worths, the moderate landowners Sutherlands, and the majority of the community represented by working-class families like the Potters, yet most community members considered themselves somewhere in between. Most families participated in some form of subsistence farming, and, just as in most rural areas, employed a variety of methods to make ends meet (Halperin 1990). That Doc Robinson adapted to the economic status of most community members showed his willingness to respect their self-sufficiency.

Self-sufficiency was highly valued in Ashe County communities, and residents often preferred to use their own time-trusted healing methods. Doc Robinson’s case load often made it difficult for him to reach potential patients in a timely manner. Instead of waiting for him to arrive, several people recall healing themselves. Using a variety of means to make ends meet financially also meant that community members were apt to use
a variety of healing methods. Despite the fact that Doc Robinson’s fee system was negotiable, several community members also commented on a preference to heal themselves because of cost. Joe Stephens elucidates: “Now it’s unreal how rough people lived. You didn’t go to the doctor, go to his office and wait or anything like that. If you could get him, he’d come. And if you couldn’t find him you had to do the best you could, you used whatever you had. If they had something to make tea out of, fine, they’d make it. But they accepted him mighty well, but you see maybe he couldn’t get there, maybe they didn’t want to bother him. Down at his place if it was two o’clock in the morning and the child—something was wrong with it and you couldn’t run and get him, you had no transportation, so you went ahead and used what you had at home” (Stephens 2001).

Community members used a variety of traditional ethnomedical practices within their healing system, including midwifery, herbal healing, and combining herbs with store-bought goods (Stephens 2001). Doc Robinson trusted community members’ ability to care for themselves, and he did not try to force his ways upon them. Nell Sutherland, who acted as an assistant to Doc Robinson in the 1930s, recalls that her neighbors were still using home remedies and neighborhood healers, despite the presence of an educated physician. “He caught the babies, I gave the women ether and cleaned the babies up. Doc told me what to do, and I did it. Also people did use home remedies like camphor, onion poultices, catnip tea, honey, and onions” (Nell Sutherland 2001). Anner Potter says that she “did a whole lot of it [doctoring]. Make some kind of tea and give it to them [the children], sweeten it and they would sleep, and not scream at night. Catnip tea, boneset tea, and stuff like that. Give it for colds” (Potter 2000).
Elsewhere across the Appalachian region during this time, professional physicians through their allies in women’s clubs were discouraging Appalachian people from using their own neighborhood healers (Barney 2000). If Doc Robinson differed from traditional ethnomedical healers in his approach to healing, he did not let it affect his respect for the methods of healing that were already in place when he arrived in the area. Neighborliness was highly valued by community members, and each neighborhood could boast of its own ready and willing healer. Neighborhood healers would provide services until Doc Robinson could arrive, sometimes even staying on to help, as Nell Sutherland came to do. Most community members used a variety of traditional ethnomedicine and biomedicine, as did Anner Potter with the births of her children. “Gramy was a midwife. We called her Ma’am, but her name was Tilda Church. She was here all but twice to see me. Doc Robinson came with two or three of them [births of her children]” (Potter 2000). Because community members by and large could not afford to pay for physician-assisted births, they often relied on the form of healthcare they knew to be free: midwifery. By all accounts, Doc Robinson never tried to put a stop to this. Joe Stephens was emphatic about Doc’s cooperation with local midwives, often resulting from the large number of people Doc treated and the fact that he simply could not treat everyone. In Stephens’ case, the neighborhood midwife, Rosie Cornett, delivered all but one of his nine siblings (Stephens 2001). Doc Robinson was usually only called in cases of emergency, after home healing had been tried, because Doc Robinson was very busy and they did not want to bother him if the illness was something they could take care of themselves (Reeves 2001).
Coping with Obstacles

Doc Robinson’s practice spread out over the entire 450 square miles of Ashe County, and included some parts of Watauga County and Tennessee (Sutherland 1955). Riding through the mountainous terrain, often in terrible weather and in all hours of the day, exhausted Doc Robinson considerably. He apparently coped with stress by tipping the bottle, and Doc’s drinking remains a subject of community gossip and humor. Joe Stephens recalls the following story, which was repeated by other community members, and was even printed in a community newsletter (Osborne 2000):

Have you heard the one about Julie, who was his wife, a-praying for him? Because he come in drunk, see, he’d get awful drunk! He’d get ungodly drunk! And I don’t know, it’s basically true, but Doc’s laying, he’s passed out drunk, he got drunk and he got to where he couldn’t go and he just fell over. And Julie was talking to him and she said, “Lord, I’ve got to pray for him.” She went to praying for him, and she said, “Oh Lord, take care of my poor old drunk up husband.” He said, “God, Julie, don’t tell him I’m drunk!” (Stephens 2001).

Stories of Doc Robinson’s drinking habit are told with humor. Joe Stephens points out that Doc Robinson always tried to put his patients first by doing follow-up visits in the instance that he was drunk on the first visit. “Over at the store across the hill, this boy got real sick, and Doc Robinson come to see him and he was on a drunk. He said, ‘Sonny, have you been eating any little green apples?’ And it was February! And that was what crossed his mind, you see. But then he come back the very next day when he got shaped up and checked the boy out. Knucklehead, there wasn’t nothing wrong with him anyway!” (Stephens 2001). Community members knew about Doc Robinson’s drinking and occasionally hesitated to utilize his services when he was under the influence.
However, as Joe Stephens relates, community members are very willing to forgive Doc Robinson’s drinking. “When one of us kids was born, Jack I think, Doc come up here drunk and he and Daddy got in a racket! He just wasn’t going to have him in there around Mom and her having a child. But Doc come back after he got sobered up and oh, they talked, oh, they sat out there and talked for an hour! But that’s just one of the things that he done, that’s just Doc for you” (Stephens 2001). Doc Robinson’s alcohol consumption was no secret to community members, who often excused his habit as a necessary means of coping with job-related stress. “He was a very valuable person to the community, because maybe somebody’d holler at him up the road, at the same time somebody was down below his house five miles or something, wanting him to come, and he just would make his rounds the best he could do. And people talk about him drinking, and he would get drunk as a skunk, but I guess he had to have a little relief” (Stephens 2001).

From other stories, it is obvious that Doc Robinson’s drinking was often excused because the community respected him and routinely benefited from his service. Community members would often care for Doc Robinson by physically taking him in, and by also protecting the family name by insisting to outsiders of his goodness and worth to the community. Joe Stephens explains that “people, they protected him. There’s always somebody in the community depending on what their standing is that that the community protects. See, he would go to somebody’s house and they’d take care of him, if he would go to somebody’s house drunk, they took care of him like he was a member of their family or anything. They knew his personal life moreso than they would just an average man, because he was at everybody’s house, he was in everybody’s home, he took care of
everybody” (Stephens 2001). Each community member willingly discussed Doc Robinson’s drinking, but each was protective of Doc Robinson, as well. All seemed to forgive his habit, as the refrain “Doc Robinson was a drinker, but he was a good man” was repeated on several occasions (Joseph Robinson III 2001; Stephens 2001; Minnie Sutherland 2001).

The End of an Era

Doc Robinson died at Ashe Memorial Medical Center in 1955 of complications due to carcinoma and heart disease. Throughout his fifty years as general practitioner in Ashe County, Doc Robinson’s role in the healing system grew. While most of the people directly affected by Doc Robinson’s practice have died, many community members continue to point out signs of his legacy. Joe Stephens pointed out a landmark and explains “that road has been Doc Robinson Road for a long time, much longer than a lot of these other ones,” a lasting legacy to Doc Robinson’s impact on the community and the respect that North Fork residents feel for him. Joseph Robinson, Jr. declares “He was a hero, yeah” (Joseph Robinson Jr. 2001). Joseph Robinson III explains that as a result of Doc Robinson’s practice, North Fork residents were more willing to add biomedicine to their cache of healing options. “I never heard anybody that said ‘oh no, so and so wouldn’t go to a new doctor or wouldn’t listen to a new doctor.’ I don’t think that people had that feeling about him. He was in here and he was welcome” (Joseph Robinson III 2001).

Dora Horton, an African American woman formerly of the Peak area of Creston, recalled with admiration that Doc Robinson never denied her family treatment based on
their skin color. “He was just the family doctor. He was awful good to come. Doc Robinson never treated us badly” (Horton 2002). Dora Horton is one of many who recall that Doc Robinson was a respected healer, despite his drinking. Joe Stephens, who presented the most information about Doc Robinson’s drinking and the most revealing information about the community’s respect for him, offered sage advice. “Tell about the drinking, but build the other parts of his life up, too. Put the best parts of his life in, too” (Stephens 2001). Certainly the “best parts of his life” were the times throughout the years when Doc Robinson was participating as a vital part of the healing system in Ashe County.
Chapter 6: Conclusions

For much of the last century, it was widely assumed that the failure of biomedicine to reach all parts of the Appalachian region was due to the isolation of remote areas and the flawed values and culture of the mountain people (Shapiro 1978; Weller 1965). Physicians and writers alike have blamed mountain people for the paucity of biomedical services, a notion which fully discredits the willingness or desire of the mountain people to have more comprehensive medical services (Barton 1977; Weller 1965). However, research in Ashe County and recollections of community members have shown that there was no marked resistance to biomedicine, just as there was no marked resistance to traditional ethnomedicine by professional physicians.

In 1847 the American Medical Association formed and began propaganda to maintain biomedicine as the professional (i.e. better) healing system. This message would be furthered by missionaries and physicians as they moved their practices into more remote areas of Appalachia (Barney 2000). Sandra Barney maintains that a great push occurred from 1880 to 1930 to professionalize biomedicine in Appalachia. As the field of medicine became professionalized by the growth of medical organizations, laws were passed restricting some of the medical practices that involved folk remedies. While most professional biomedical services that came from distant cities were forced upon Appalachian communities and were inattentive to the needs of mountain people, Ashe County physicians have largely adapted their biomedical practices to best fit the needs of
their patients. The spread of AMA propaganda by settlement workers and missionaries in the late 1800s is not the only reason that biomedicine was accepted in Appalachia.

According to the informants, AMA propaganda held little sway with the residents of Ashe County. The reason for the success of biomedicine in Ashe and surrounding counties lies in the acceptance of physicians who respected local cultural values in the communities where they practiced, and their willingness to let community members practice other forms of healing.

**Traditional Ethnomedicine: Still a Viable Choice**

By the turn of the twentieth century, Appalachia felt the full impact of the industrialization of its more resource-rich areas. Since industrialization, the Appalachian region has experienced boom and bust economic cycles, aggravated by low tax bases and limited funding from government sources for rural health care. As a result, the cost of medical insurance remains exorbitantly high (Lopes 1996).

Yet Appalachian people had and still have a choice between professional and traditional healing practices which they combine for practical and pragmatic reasons. The use of home remedies in Appalachia remains a viable option because it is cost effective and culturally viable. Working class people of Ashe County rely on a variety of jobs to “make ends meet,” often working several jobs for short periods of time. Employing multiple healing strategies makes good economic sense for people who rely on “multiple livelihood strategies” (Halperin 1990: 4). Community members may find the cost effectiveness of home remedies to be tempting, but prefer a visit to the doctor over herbal remedies for specialized cases. In fact, most of the knowledge about the uses of herbs as medicine has
faded with the passing of the last generation. As more health services became available in Ashe County, herb collection became more of a means of income rather than a source of healing (Cozzo 1999). According to the account ledger from Joe Stephen’s store circa 1930, people were selling herbs including lobelia, cherry bark, catnip, boneset, mint, buds, elder flower, burdock root, and ginseng (Stephens Store Records 1927-1942). Stephens would then take the herbs and sell them to a wholesale drug company like Wilcox Drug (Stephens 2001).

Although the use of midwives declined, midwifery never died out in Ashe County. During the last decade, there has been a rise in popularity in “alternative medicine” like midwifery and herbal remedies. Midwives in Ashe County now have the option of registering with the North Carolina Midwifery Association (Efird 1985). As always, the people of Ashe County have choices in the medical system they choose to adhere to, and will make that choice based upon the system that works best for them.

An ethnographic approach to examining the history of the healing practices of Ashe County must include comparative information about other areas in the United States. Sandra Barney’s work in the coal and lumber camps of Kentucky provides an excellent framework for investigating the forces that shaped healing practices in Appalachia (Barney 2000). Traditional ethnomedical practices prior to industrialization appear to be the same throughout the entire United States, including Appalachia, where members of rural communities developed a system of herbal and home remedies. However, differences exist throughout Appalachia in the way in which biomedicine arrived on the scene. The push by the AMA to professionalize medicine in Appalachia was strongly felt in the
industrial camps of Kentucky. However, professional physicians practiced medicine in Ashe County prior to the extractive industries. Instead of discouraging traditional ethnomedical healing practices, these professional physicians worked within the traditional ethnomedical system already in place in Ashe County. The medical ethnography of Ashe County shows the agency of the community members and the ability of mountain people to control their own lives in the acceptance of biomedical services on their own terms while simultaneously maintaining traditional ethnomedical practices.

The available literature on the professionalization of biomedicine in Appalachia does not completely explain the situation in Ashe County. Outland, professional physicians did not force biomedicine upon North Fork community members in an attempt to displace midwives. Community members were not reluctant to embrace biomedicine as a result of anti-progressive sentiments or fatalism. On the contrary, two systems of healing existed, and still exist, in North Fork area communities. Biomedicine and traditional ethnomedicine provide the medical framework within which health is maintained in Ashe County. Something more than simple progressiveness explains the acceptance of biomedicine in Ashe County. In order to get to the heart of this matter, I have examined the life history and practice of one Ashe County doctor, Dr. Joseph Robinson. The acceptance of biomedicine in the North Fork area has more to do with Doc Robinson as a person than any other factor. Doc Robinson came into the communities of Creston and Sutherland understanding the values the community members shared. These values are apparent in the way that these communities function, even today. Creston and Sutherland are each centered around community-building institutions.
Creston Methodist Church (a stone’s throw from the current Robinson family home) represents a place where the community members strengthen bonds with one another. It is a place one might go to “see about so-and-so,” a place where lasting bonds are formed and maintained. It was into this tight-knit community that Doc Robinson married, and through this marriage he built trust with the members of the community. Doc Robinson was not an outsider trying to impose his ways upon the community. The people knew him, trusted him, liked him, and above all respected him. Doc Robinson was one of “their people.”

Doc Robinson offered a system of support to the people of Ashe County. This support was reciprocated in Doc’s times of need, and it is said that members of the community often took better care of Doc Robinson when he needed them than they would their own children. Doc Robinson was so much more to the North Fork area than just a physician: he was a friend and a neighbor whose wife and children lived out their lives in the community. In this way, Doc maintained part of the value system of traditional folk healers. This is perhaps the reason why folk healing never completely died out and biomedicine was so readily embraced by the residents of Ashe County. The residents of Ashe County actively promoted and accepted biomedicine in the twentieth century. It is obvious that the people of Ashe County, not outside agencies, create their own future.
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VITA

Sarah Parker Poteete was born March 29, 1978 in Franklin, Tennessee to Terry and Stephanie Poteete. She graduated from Middle Tennessee State University in 2000 with a degree in Anthropology. Since then, her thoughts have been on the Appalachian region, and she has attempted to make her home in the mountains of North Carolina. Her great loves include talking to anyone she can, and the writing of this thesis has afforded many opportunities for her to do so. She was awarded the 2000 Cratis Williams Scholarship and a 2001 Thesis Research Grant from Appalachian State University, both of which have enabled her to complete this thesis. Sarah’s future includes further researching various topics related to the Appalachian region and attempting to use the information she gathers for some good, at the very least preserving it in a museum setting.