ORAL HISTORY INTERVIEW WITH AMY MACDONALD
Duke University Libraries and Archives
Submitted November 3rd, 2022
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COLLECTION SUMMARY

This collection features an oral history I conducted with Amy MacDonald on September 27th, 2022. The 105-minute interview was conducted in Hillsborough, NC. Our conversation explored Duke Midwifery Service, hospital-based midwifery practices and nurse-led education, and the Centering Pregnancy program facilitated by Duke midwives. The themes of these interviews include midwifery; pregnancy, childbirth, and postnatal education; and medical training.

This document contains the following:

- Short biography of interviewee (pg. 2)
- Timecoded topic log of the interview recordings (pg. 3-4)
- Transcript of the interview (pg. 5-26)

The materials I am submitting also include the following separate files:

- Audio files of the interview*
    - Stereo .WAV file of the original interview audio
    - Mono .MP3 mixdown of the original interview audio for access purposes
- Photograph of the interviewee (courtesy: Amy MacDonald)
- Scan of a signed consent form

BIOGRAPHY

Amy MacDonald, CNM, MSN, founded Duke Midwifery Service in 1999. As the first nurse midwife at Duke to provide full-scope care for obstetric and gynecology patients, she grew the Service in the following years to include ten midwifery providers. In this role and throughout her career at Duke, MacDonald provided care for patients, while also mentoring and providing didactic content for Duke medical, NP and PA students, Emergency Medicine, Family Medicine and OB/GYN residents in Duke's large teaching hospital setting. MacDonald was the Director of Duke Midwifery Service until 2013, and remained at Duke as a Certified Nurse Midwife until 2021 while also serving in roles including Medical Instructor for Duke School of Medicine and Director of Duke Centering Practice Programs.

Interested in providing continuity of care for both providers and clients, MacDonald brought the Centering Pregnancy curriculum to Duke and the larger Triangle community in 2004. Centering Pregnancy, a midwifery-facilitated group care program for pregnant patients, allowed Duke Midwifery Service to provide culturally-competent care to both English and Spanish-speaking families in Durham. "I could be a skilled and caring midwife, but it was really about the cross-pollination that happened in the group," she says, reflecting on how clients experiencing systemic oppression or socioeconomic barriers could support one another in finding resources through Centering's group discussion model. The presence of Duke midwives at locations such as El Centro Hispano and Lincoln Community Health Center for Centering groups meant that patients arriving at Duke for delivery would come with high-quality education to help achieve positive birth outcomes, and would be more likely to know their providers. MacDonald was critical in ensuring the presence of Duke CNMs in multiple additional clinical settings including Southern and Hillside high schools, Franklin County Health Department, Person County Health Department, and Vance and Warren County Health Departments.

MacDonald was born in New York City and raised in South Carolina. Initially drawn to veterinary science as a child, she "found [her] people" during a college internship at the Feminist Women's Health Center in Oakland. MacDonald would take the position of Medical Director at the Feminist Women's Health Center at the age of 22 upon graduating from Antioch College, succeeding the legendary Black lesbian feminist poet and activity Pat Parker in that role. "I learned to hire, and fire, and schedule, and write protocols," she recalls of her first position. "I spent plenty a night on the couch because there were often anti-abortion protesters outside." MacDonald completed her Master of Science in Nursing from Yale University in 1991 and spent the following years establishing New River Birth Center, the first freestanding birth center in rural southern West Virginia. Throughout her career, MacDonald has had the opportunity to work with a diverse set of clients. "I've had the amazing privilege of caring for people with tremendous wealth and tremendous resource, and [also] prisoners, and immigrants who have survived unspeakable trauma," she says about midwifery. "There's this unifying thread through all of it. When we're feeling vulnerable, having another human being who sees you and who can touch you in a way that says, 'I know you're here, I know you're suffering, I know you're important, and I'm going to walk you through this,' that's really therapeutic and invaluable."

INTERVIEW TOPIC LOG (amy-macdonald-interview-audio.wav)

00:00 Introductions
00:39 Start of Duke Midwifery Service in Duke Department of Obstetrics and Gynecology
02:52 Midwifery model of care and historic relationship between OB-GYNs and midwives; Amy's introductions to doctors and students
05:54 History of midwifery as a cultural practice; history and significance of Frontier Nursing Service
09:44 Upbringing and influences; early interest in veterinary science; schooling at University of Oregon; internship at Feminist Women's Health Center in Oakland, CA; doula training at Highland General Hospital in Oakland, CA
14:41 Parents' jobs (artist, designer in fabric mill, farmer, traveling salesman for women's sportswear, log cabin builder); upbringing in New York and South Carolina.
16:46 Taking over role of Medical Director for the Feminist Women's Health Center after the departure of poet Pat Parker; experiences with anti-abortion protesters
19:28 Time at Yale's accelerated nursing graduate program
20:46 Experience operating New River Birth Center in Scarbro, West Virginia as part of National Health Service Corps loan repayment program
24:42 Move to Durham; interview at Women's Birth and Wellness Center; teaching childbirth classes at the Teer House at Duke
27:23 Positions at Kaiser Permanente and Lincoln Community Health Center; start at Duke in OB triage unit
29:10 Importance of establishing midwifery service at Duke ("Durham needed midwives")
30:25 Establishing relationships with colleagues; importance of midwifery care alongside MFM and high-risk services; value of midwifery for patients experiencing a loss
33:59 Early relationships with midwifery colleagues and other staff (residents, attendings, fellows, nurses)
36:18 Lack of 24/7 midwifery care in unit
37:27 Collaboration with Durham County Department of Public Health / Lincoln Community Health Center to provide Centering Pregnancy group-facilitated educational care to patients in the community
41:21 Initial "pushback" from health department; start of Spanish-language programs
43:12 Early success of program; structure of Centering
46:08 Importance of group structure and "cross-pollination" of groups to provide culturally-competent care; listening to experiences of health inequity
50:03 Experiences of "continuity" providing prenatal care at Lincoln and then attending births with the same patients
51:06 Gaps in healthcare in underserved communities; trauma in patients; reflections on lack of support for 24/7 care; culture of OB
53:56 "Therapeutic presence" of midwifery care; value of listening; relationships with residents; mother's work as hospice volunteer
59:15 Story about talking to medical student about communicating with patients; family history and early interest in care professions
1:03:34 Learning to facilitate a group in healthcare and translation to everyday life

1:04:58 Monty Python video and resident orientation to prenatal care and labor & delivery; midwifery maneuvers; teaching residents through "the other superpower that the midwives had … to keep the pregnant person, the pregnant woman, in the center of everything that happened"
1:11:40 Colleagues and collaborators (Janet Fields, Helen Mikul, Kim Dau); regret that training for midwifery students has not occurred
1:19:22 Service's work with 10 clinical sites (Lincoln Community Health Center, El Centro Hispano, Outrider clinics in Franklin County Health Department, Person County Health Department, Vance and Warren County Health Departments, high-risk and postpartum high-risk clinics, Southern and Hillside high school clinics)
1:22:32 Background on high school clinics
1:23:57 Current status of Duke Midwifery Service, impact of COVID on healthcare coverage and services
1:31:03 Reflections on role(s) at Duke
1:33:48 Relationship with nurses in Duke's Labor and Delivery Unit, collaborations with Duke nurse Ho-Yu Pan
1:37:36 Outcomes of midwifery care model and group care
1:41:27 Patient story related to multi-generational care

TRANSCRIPTION (amy-macdonald-interview-audio.wav)

Josephine McRobbie 0:03
Okay, so it is Tuesday, September 27th, 2022. My name is Josephine McRobbie. And I'm interviewing Amy MacDonald. This is part of an oral history series for the Duke University Medical Center Archives documenting the history of Duke Midwifery Service. So thank you for being a part of this project, Amy.

Amy MacDonald 0:22
You're welcome. Thank you.

JM 0:24
And we always start by asking people their full name, their place of birth, and their date of birth.

AM 0:30
Okay. My full name is Amy MacDonald. And I was born in New York City on August 7th, 1961.

JM 0:39
Okay, and give me a quick introduction to Duke Midwifery Service, and your role in the program.

AM 0:52
The Duke Midwifery Service started in August of 1999 when I joined the Department of OB-GYN at Duke [University]. I was the first inpatient nurse-midwife, there had been a prior nurse-midwife, 10 years prior to my coming. And the story is that she spent six months at Duke, and left. And so when I joined the Service, my primary mission was to partner with the OB-GYNs - and the residents because there was and is a large OB-GYN residency program -- I wanted to partner with the physicians and physicians-in-training to deliver excellent care, and also to really work through the hurdle of us and them as had been established [laughs] for many, many years between midwives and OB-GYNs. I really felt like it was time to deliver good care, to learn from one another, and move on. So I called it the Duke Midwifery Service. I called myself the Director. And in fact, the real truth is that it took seven years for my paycheck to reflect nurse-midwife. It actually said nurse practitioner -- Amy MacDonald, Nurse Practitioner -- because there was no category. So it was dreamed into being.

JM 2:52
And what did you see at that point as being the importance of the midwifery model of care? And tell me a little bit just about that kind of fracture between practitioners?

AM 3:08
You know, what I saw was a busy academic hospital where the nurses and the doctors were under tremendous stress. At that point, residents worked 120 hours a week. So there was very little time for eating, sleeping, family time was almost non-existent. They were running on fumes. And the nurses really picked up a lot of the slack, they were also incredibly stressed. OB is a 24/7 specialty. And so when I came in my MO was really just to be a guest, as if you were going

to someone's home. And sort of paying attention to what's happening here. Who are the characters? What are the dynamics at play? How are people engaging with one another? There was a fair amount of toxicity both in terms of how the nurses treated the residents, how the upper residents treated the junior residents, how the attendings, you know, treated the learners. And I thought that as a nurse-midwife, I really could be a good fence player. I really knew what the nurses were up against. I saw these poor young residents were absolutely exhausted. And so I knew that my work was cut out for me. But I started immediately with just a kindness protocol. You know, [saying] "Can I help you?" to the nurse. "I'm happy to take this patient to the bathroom." "I'm happy to run to the lab because the tube system is down." Let me help you, let me be of service to you. And with the residents, it was the same thing first, just like "How about if I am going down to get a sandwich, how about if I bring you one?" And then also, because no one was really teaching the residents, it was very much trial by fire. Which is medicine, right? Go figure it out. Don't kill anyone in the process. And to have someone to sit next to you and actually talk you through things, and midwife you through your learning experience, there was immediate positive uptake in that strategy. And I think I forgot the second part of your question.

JM 5:54
So the reason that midwives were well-suited to this kind of role. You are touching on that. Is that right?

AM 6:05
I guess you asked about the history of the us against them. So, I mean, this could be a 10-part series, right, the history of midwifery in the world. Because midwives, women, have been caring for other women through birth and death and everything in between, since the beginning of time, right? In this country, where obstetrics is not much more than 100 years old, midwives who were not formally trained filled that role for many, many years. And enslaved women who were brought to this country filled that role in their countries of origin and then when they landed on this soil. That was true for Indigenous women. It was true for immigrant women. And during years of racism where black women were not able to be admitted into hospitals, Black grand midwives took care of women in their communities, white and Black, when poor white women weren't able to pay for care in a hospital.

So as the field of OB-GYN grew, because OB-GYN residents - doctors in training -- needed to practice [and] needed to learn about women's health care in the hospital, there really was an active campaign to outlaw midwives, and categorize midwives as untrained, as dirty, as drunkards, as, you know, lots of pejorative terms that you're likely familiar with. And so that's kind of how we started in this country. It was 1925 when Mary Breckenridge came to the US and started Frontier Nursing Service. And the outcomes right from the beginning were exemplary in rural Kentucky. They were exemplary in inner city Los Angeles. So that fracturing happened early in our history. And sadly, because money and power run most things in the world, that fracturing -- although there are pockets where midwives and OB-GYNs have learned to respect and mutually operate together, support each other together, there are many examples of that -- our institutions, per se, have not really solved that problem. And so when I came to Duke in 1999, I saw this as a wonderful opportunity to try again, I'm an optimist.

JM 9:44
And I'd like to talk a little bit about your upbringing and influences as well, if that's all right. It sounds like you knew what kind of work you wanted to do from pretty early on. I read that you were a volunteer labor coach when you were in college. Is that right?

AM 9:59
Yes. I actually started out when I was 11 years old wanting to be a veterinarian. Although I was born in New York City and lived there until I was 10, I then moved to rural South Carolina. And I got into a motorcycle accident with the preacher's son. I was told to never ride on his motorcycle. And unfortunately, or fortunately, my mother was recovering from surgery. I jumped on -- it was actually a minibike -- with the preacher's son, and my dog, my beloved dog, followed us. A mile away from the house, we hit the dog, badly. I broke an arm, Richard, the preacher's son), broke his leg. He hobbled back home and my aunt was there delivering food. We went to the vet first before the emergency room, and there was a Black woman there [who was] a veterinarian. And it was an epiphany for me. I looked up at this woman, and I knew in that moment that I wanted to be her. And when I went to the hospital, got my cast, came back the next day to pick up my dog -- which she saved -- I asked her if I could help her. And she said yes. She and her husband ran Circle T Veterinary Clinic. And I was able to clean cages, and sweep the floor, and answer the phone, and by the time I was 14 I was assisting with large and small animal surgeries, and did this until I went to college.

I thought for sure I was going to be a veterinarian. And then one of my co-op jobs at the University of Oregon was with an OB-GYN research lab. I was able to care for the research animals, who had multiple surgeries. And then I followed the male OBs in the lab into the hospital. And I saw how they treated their patients. I was 18 years old. And I thought to myself, [whisper] "I could do a much better job." And I realized, you know, I can always have dogs. I really love dogs. I love animals. But I was a young feminist. I didn't really like what I saw in terms of communication. And so the light went on there.

And a subsequent internship in college was at the Feminist Women's Health Center in Oakland, California, where I was able to work with OB-GYNs and nurse practitioners and PAs and midwives who did home births as well as hospital births. And I found my people. It was with the midwives with whom I resonated the most. And that's when I changed course. And one of the experiences that I had while in college was to take a doula training. It was a six-week doula training, probably one of the early ones in this country, at Highland General Hospital in Oakland where they did not have 24/7 anesthesia. The anesthesiologists were on-call, but they had a team of doulas, and we were on-call. And when the midwives who ran the service at Highland deemed [that] a particular patient needed additional support, they would call the doula on-call. And I would go to the hospital and support people in labor. And I just remember looking at the midwives as just superheroes. I thought they were remarkable. And I also learned so much from the women. Because in that part of Oakland, there were women [who were] refugees, and immigrants, and people from all over the world. So seeing how different birth traditions and family relationships played out was a fantastic learning experience.

JM 14:41

And what did your parents do?

AM 14:44
My mother was an artist and worked in a studio in Greenwich Village growing up, and then later became a designer in fabric mills across the southeast after we moved down south. My dad, he's remarkable also. When I was a little girl right, before we moved to South Carolina, he had three part-time jobs. He was a bartender, a cab driver, and he sold women's bras.

JM 15:20
[Laughs] All you need!

AM 15:21
[Laughs] Yeah, that's all you really need. And then he got a great job being a traveling salesman for women's sportswear. And he did that for some time. And then we bought a peach farm in rural South Carolina. And he kind of evolved again and became a farmer, and raised cows, and learned to fix things, and put up fencing and fix small, you know, like, fix tractors and chainsaws. And his last job, he started a log cabin building company. So, yeah, they had quite varied careers themselves.

JM 16:18
And what did they think about your interest in going into nursing?

AM 16:24
They thought it was great. I think they really liked when I worked with the veterinarian growing up, because I always took care of our animals. We had horses and dogs and cats. I think they were quite proud of me.

JM 16:46
And tell me about how you made that move into your medical and healthcare training. You went to Yale?

AM 16:53
I had internships in my undergraduate education, and my last job at the Feminist Women's Health Center. They wanted me to come back after I graduated, so I did. And three weeks after I started, the medical director who was Pat Parker, famous - the famous late Pat Parker, she was a lesbian feminist poet, quite well known in the Bay Area at that time - she left and I became the Medical Director of the Feminist Women's Health Center at age 22, which had three separate clinics. Which was mind-blowing, because I was 22. But I learned to hire, and fire, and schedule, and write protocols, and spent plenty a night on the couch because there were anti-abortion protesters outside often. That is one thing I didn't tell my mother, about all the bomb threats that we would get.

JM 18:24
What do you think they saw in you at that young age, to take on a position like that?

AM 18:29
I think they saw that I was tenacious [and] that I've always had a fire in my belly for fighting for the underdog and I think [from] early on appreciating that women didn't always have the ability to advocate -- not all women had the ability to advocate -- for themselves and particularly their reproductive destinies. And I was just willing to work hard for, I think I made $3.50 an hour, that was my first salary.

JM 19:28
And so that was in the Bay Area. And then how did you end up going back to school?

AM 19:33
Because I worked with a wide group of healthcare providers, I really connected to the midwives. So I decided I wanted to be a nurse-midwife. And I applied, and I was not yet a nurse. I wound up working in women's health care from 1984 when I graduated from college, until 1988 when I started the Yale program. So Yale was one of three graduate programs that had an accelerated nursing program for people with prior degrees. And I also was able to get my master's in nursing and my specialization in midwifery in a three-year program. I think Yale, Hopkins, and Emory were the only three in the country at that time. So it made sense in terms of time. And I was very happy to be accepted.

JM 20:46
And from there, you moved to West Virginia, and let me know if I'm getting the chronology right, and you started your own freestanding birth center.

AM 20:58
When I graduated from Yale, I had substantial loans. And I learned about the National Health Service Corps, which was a loan repayment program, and I needed to commit to two years of service in an underserved area. So I chose rural West Virginia. Scarbro, West Virginia, was outside of Beckley, between Beckley and Charleston, a beautiful area right near the New River. And the New River Family Health Center was very interested in starting a birth center. And there were several women there who I became good friends with who really were citizen advocates for improved women's health because West Virginia, as you can imagine, had a terrible track record in terms of maternal health. This clinic already knew how to advocate for black lung disease and coal miners. And so it was kind of an easy fit to you know, pick up the torch for women's health. I started working there in 1991, wound up staying for three years. I gave birth to my first son there. And we started a birth center.

JM 22:42
And what did that kind of setting teach you about midwifery?

AM 22:48
Well, it taught me that there was nothing that a small group of committed citizens couldn't do. I was grateful -- on my way to West Virginia my mom grabbed an armful of clothes that she threw in the backseat of my car, and she called them my Junior Women's League clothes. And I wasn't quite sure why she was giving them to me, but she said "You will need these." And as it turned

out, as we were raising money for the birth center, I was talking to women's church groups, and actually the Junior League. And there was a whole PR circuit that I, and the other women in the community, and the leadership at the health center, went on advocating for better care for women in West Virginia. So I learned that you just can't do anything alone. That being in partnership and also that listening to women -- whether you were a poor woman and sat in a crowded waiting room in a health department and waited for hours for your five-minute visit, or if you were someone with good insurance and went to the private practice and waited for your five-minute visit -- you know that everyone was deserving of being seen, and heard, and cared for.

JM 24:36
And then from there, how did you end up making your way to the Triangle, and to Duke?

AM 24:42
My husband decided to go to grad school to become a teacher, so we moved back to the northeast. I was in a private practice in Boston then. And from there he applied for teaching jobs, and he got a job at the Emerson Waldorf School here in Chapel Hill. And so I actually moved to North Carolina with a three-month-old baby and a three-year-old toddler thinking, "certainly UNC or Duke will have large midwifery services, I'll work per diem until these little boys, you know, are in school." And I was shocked when I arrived. The only midwifery opportunities were the birth center [Women's Birth and Wellness Center]. When I was first looking for work, I interviewed with [WBWC founder] Maureen Darcey, in Siler City, when she was working there, and did not take that job. And then when I got here, I taught childbirth classes at the Teer House at Duke. And I interviewed at the birth center in Chapel Hill. And because [laughs] I had started a birth center in West Virginia and didn't sleep for three years, I did the most unprofessional thing I've ever done. I accepted the job at the birth center. And then 15 minutes later, picked up the phone and called back and said, "I am so sorry, I have made a terrible mistake, and I cannot take this job." You know, my husband was a private school teacher, not making much money at the time. And I knew energetically that I couldn't be the kind of mother that I needed to be and be the kind of midwife that I knew working in a birth center would require. So I have referred hundreds of people to the birth center, adore every midwife who's worked at the birth center, and have many friends who actually came from the birth center to Duke. But yeah, I turned down that job.

JM 27:23
And it seems like you spent a little bit of time sort of testing the waters with the different local opportunities. You worked a bit at Duke, at UNC, at the health department, and at Kaiser, is that right, which is a private practice?

AM 27:35
Yes, Kaiser had a short run here. I actually first worked as a labor and delivery nurse at UNC, because there were no midwifery jobs other than the birth center. And met a few people there. And then there was a job at Lincoln Community Health Center, and a job at Kaiser. Kaiser was closing. And then I got a call from [a doctor] who I had worked with as a nurse at UNC, who [was working] at Duke, who said, " Amy, come be the Clinical Director of the new OB Triage

Unit at Duke." [That was] in 1999. And my boys were three- and six-years-old at this point. And I said, "Okay, that sounds great. Let me see what that's about."

JM 28:33
Okay. And then after that was this position?

AM 28:38
Well, that was how I got to Duke. And in fact, when I arrived, there had never been a midwife who had done deliveries, who had done full-scope care. And those first two years, I was in the OB triage unit because the then-chairman couldn't imagine, couldn't envision, midwifery on labor and delivery at Duke. So that's how I started.

JM 29:10
And you said that you were able to give yourself your title. Is that correct? [Yes.] Okay. And why was it important for you to be able to say that you were the Director of this Service? Were you hoping at that point that you would grow it to the scale that you eventually did?

AM 29:23
Because I went in with a clear vision. I mean, from my first day, like remembering getting dressed that day, remembering walking in those double doors that I walked through for 22 years. I knew that Duke needed a midwifery service. I knew that Durham needed midwives. I knew that women deserved midwives, from the people working in that hospital to the people in the community. And I knew that I had a tremendous amount to learn [because] the last time I had worked in an academic hospital was when I was at Yale as a student. So I walked in with this clear idea that we would get there eventually.

JM 30:25
And how did you start to grow this program? You said that at the beginning, a lot of it was building these relationships.

AM 30:32
It was pretty funny. The nurses, who were overworked, they tried to get me to do their job all the time. "Can you start this IV?" "Can you do this Cath?" "Do you think you could admit that patient?" And so whereas I wanted to be a team player, and I wanted to be supportive, I wasn't a nurse. And the residents, who were also completely exhausted, we're like, "Do you think you can repair that fourth degree, because I'm getting called back to that hemorrhage?" "Do you think you can manage this patient, who just left dialysis, to get admitted for preterm labor?" Whose baby has a disease that I've never ever heard of, just super high risk. So the answer to that was also "No." And so I really had to find my way. There were plenty of patients who needed our care. And ultimately creating a service for midwives at Duke meant that yes, there were normal, healthy people who came to Duke to have their baby, but also realizing that all the high-risk patients needed midwifery also. They needed maternal-fetal medicine and all the incredible things that that medicine had to offer. But they were becoming parents, they were frightened. If they had MS, if they had cancer, if they were a double amputee, you know, they still had a uterus

and they were pushing out a baby. And they needed to really be able to feel supported and appreciated for the wonderful things that their bodies were doing.

Or if there was a loss, right? In the business of that unit, it was really the midwives who really knew what that was about. And additionally because in a big service like that you always have new people, right, new nurses coming in, or every year the residents are new, the medical students are new. They didn't know what to say to a mother, who was, you know, holding her baby who was dying. But the midwives knew what to say, right? "With women" [tenet of midwifery = "with women"], right? We knew how to be with women and how to support them. So it was a real natural extension to turn to the resident who had tears streaming down her face and whisper in her ear, "Find the beauty, find the good. You can say to this mother that her baby's lips are perfect. Or look at her feet, you know, she has the loveliest little feet." So it was pretty easy early on to see what the need was.

JM 33:59
And what was your experience, like working with residents who might have some preconceived notions about midwifery? Or maybe no framework for it at all. Was that very surprising to them to have this more holistic model?

AM 34:15
Yeah. I mean, that's why I said when I first came my attitude was like, "Well, I'm a guest, I'm going to just sort of see what the culture is and then figure out where I can be of service." And so it didn't take long, again, because being kind, being present, showing up every day, you know, that Woody Allen line about how 99% of success is just showing up every day. I just showed up every day. And as I started hiring midwives, unity was the operative word, where we would say together, "We can cry in this office, we can rage in this office. But when we're out there, caring for patients who are dealing with whatever they're dealing with, we're just always going to do the right thing. And we're going to have each other to, you know, lift each other up." And so that was kind of the group mantra to get us through. Because, yeah, the residents were not at their best because they were exhausted and their daily human needs were not being met. But it didn't take long for the residents to start to ask us to deliver their babies, the fellows, the attendings, the nurses. And then what wound up happening is because the institution really wasn't equipped to treat us as equal providers, we weren't 24/7. So, we would take call for this resident, or that attending, or that nurse. [Sigh] And it was difficult. We gave a lot.

JM 36:18
So it was sort of a patchwork of when you were able to provide that care.

AM 36:24
Yeah. And then what would happen with our patients -- I started doing [Centering Pregnancy] groups in 2004 at the [Durham County] Health Department -- and we would get very attached to our patients, who would often call and say, "No, I really want you to be there for our birth." And at a certain point we had to draw the line, as the service grew and grew and grew and the hospital leadership was never able to agree to 24/7 midwifery. Which is what patients needed. It's what the residents needed. The nurses. It's what was required to provide safe and optimal care. But for

many reasons [note from interviewee about reasons: “the hospital did not support 24/7 midwifery care] that just started to happen, as I left [last year].

JM 37:27
And when you say the groups through the Health Department, these were the Centering Pregnancy programs. So can you talk a little bit about what those were and yeah, and why you wouldn't necessarily be the midwife at the birth.

AM 37:39
Yeah. So the Durham County Department of Public Health provided maternity care for people in Durham County who were uninsured or insured by Medicaid. And historically, Lincoln Hospital was a Black hospital on Fayetteville Street in Durham. And that was the Black hospital, and then Watts Hospital was the white hospital, before Duke Regional [Hospital], otherwise known as Durham Regional [Hospital]. Durham Regional, I keep calling it Durham Regional, but it's Duke Regional now, opened in 1976. And that was the first time Black and white patients were cared for together. So until that time, Lincoln Hospital existed, and then Lincoln Community Health Center when the hospital came down became an FQHC. [JM: What is a FQHC?] A Federally Qualified Health Center that received federal funding and other funding.

And so the maternity care was delivered at Lincoln Community Health Center. There was not room at the very small Health Department on Main Street in Durham. And so, because I had worked there previously, I always had it in my mind that the Duke midwives needed to provide prenatal care there. Previously, it was very fractured. Women would go in for their pregnancy test, see a different provider for all their prenatal visits, go to the hospital and see a completely different provider, and then go back to the health department, not Lincoln, and see a different postpartum provider. And I just thought, "That's terrible care, we can do better, we can fix that." So I figured out a way for us to start doing prenatal care there. One of the midwives who I hired had done groups previously, and I heard Sharon Rising speak at a national conference. The light went on, I said, "That is sublime care, that is midwifery care, we need to do that here." It took a few years. [JM: Is that the person who founded the Centering model?] Yes, Sharon Schindler Rising founded the Centering model in this country. She's one of my best, she probably is my best mentor. She's a remarkable human being. So we applied for a grant, the March of Dimes Community Awards Grant, and didn't get it. And so I said, "Well, we're just going to do it anyway." I had a bunch of childbirth ed[ucation] stuff in my closet. And we figured it out. It was not easy, there was a lot of pushback, people thought it was crazy. I really think in the beginning, the only reason that we were able to do it is that we would bring in food, and the staff really liked eating the food.

JM 41:21
So there was pushback from within Duke, or the Health Department or both?

AM 41:25
At the health department, because it was just so other. "What? The chairs are in circles?" It was so foreign.

JM 41:36
A bit too Bay Area for them?

AM 41:40
Maybe. Maybe. They just couldn't wrap their brains around doing care in a group. Because when you looked at the group, at the room, the chairs were in the circle. We had a very kind of low mat initially before we had a proper table. But we started out doing groups in Spanish, and then groups in English. And the patients loved it. But it took a while for the administrators. And then once we started getting feedback, we had 99% of our patients who said they would recommend this to a friend, or do it again. The evaluations were just excellent. And so eventually, I appealed to the state. We were part of another larger grant, and group care was one of the parts. And the people at the North Carolina Department of Health and Human Services recognized that this was a model that would improve outcomes, because North Carolina has always been at the bottom of the list in terms of maternal child health outcomes. So anyway, it took some time. But eventually we got there.

JM 43:06
So you were able to see the data backup what you thought would happen with this kind of model?

AM 43:12
Yes. And then in 2007, the first Green Journal article was published -- this is the premier OB-GYN journal in the United States -- which showed a decrease in preterm birth, 33%, and then a 41% decrease for African American women. And once that article was published, there was no turning back. Plus increased breastfeeding rates, very high patient satisfaction, improved readiness for birth. The nurses in the hospital at that point started to say, "What are you guys doing in those circles, because these patients are different. They're coming in [and] they don't seem as fearful, they seem really prepared." So the group prenatal care, in short, is when you take a group or a cohort of pregnant people who are due in the same month, and you provide 10 prenatal visits with a health care provider, often a midwife, and a nurse, although we had lactation consultants, social workers, yoga instructors. I mean, it doesn't so much matter who that second facilitator is, as long as they're a trained facilitator. And the sessions are two hours, and this includes the actual prenatal visit, and then an hour where women, pregnant people, their families can share what they know, ask questions, and become a community of people. And it also includes a postpartum visit.

Just to skip ahead a bit, I was later able to, through my work with Centering Healthcare Institute where I was a consultant for many years, implement Centering Parenting with Oveta McIntosh-Vick who is a very well-known pediatrician at Lincoln [Community Health Center]. And the idea of doing groups at the Health Department, and then sending them down the road so that the same group of people could be in a parenting group for the first two years of that child's life, to me was the epitome of optimal community care. And sadly, the pandemic. They had just launched, and the pandemic came in and brought that to its knees, but hopefully it will resurrect itself.

JM 46:08
Yeah, I had a chance to look through some of the Centering Pregnancy curriculum. And it sounds like so much of it was peer programming, having people talk to each other about healthy food, their family planning, their emotional health. And can you tell me a little bit about what that experience was and how you saw it play out during birth or postpartum?

AM 46:35
I just, I mean, I could talk about this for years, honestly. As a midwife who got started in West Virginia, who worked really hard, you could ask my husband, I wouldn't come home until eight or nine o'clock in the evening -- of course, we were handwriting charts at that point -- I would spend all this time with my patients because I didn't want to shortchange them, and then I would sit at my desk and write notes late at night, I realized that working more, working harder, that there was just no way I could catch up. And that saying the same thing over and over to patients was exhausting. I was exhausted. So being in a group made me realize -- particularly because at the health department in Durham our Spanish-speaking groups were immigrants from Spanish-speaking countries, Mexico and Central America, some from South America, and then our English-speaking groups were largely black women from Durham but also other English-speaking people from the Durham community -- I could be a skilled and caring midwife, but it was really [about] the cross-pollination that happened in the group. I didn't know what it was like to find public housing, but other women could speak to that. I didn't know what it was like to be a brand new immigrant here and not speak the language, but other people in the group could say, "Oh, well, this is where you need to go to get papayas and plantains, and this is where you need to go to get really good quality children's clothing." So, you know, I was learning as much from them as they were from each other.

And then because racism and health equity is such an important part of really addressing the disparities in our country, the really important thing that I learned as a midwife, even though I did this for over three decades, is that I really started to understand racism from a different angle. I'm a white woman. I'm a Jewish woman, so I may know something about you know, about being othered. But I'm not a black woman. And I don't know what it means to receive health care in our system [as a Black woman]. But listening to my patients, understanding what their experiences were like, asking them in our reunions, you know, "Tell me about your birth, what was your experience in the hospital? How were you treated? What went well? What was difficult?" It gave me a whole new view of sort of understanding through my patients' eyes what their experience was like.

JM 50:03
And would there be times where you would be the person delivering these babies, too? So you would have an ability to put what you were learning into practice in some way?

AM 50:15
Absolutely. I mean, because I spoke Spanish I often would look for Spanish-speaking patients on the board. And then if I saw my patients' names from groups, I would say, "Oh, that's my patient." Or I would come in, and the nurse would say, "Amy, your patient in room four is asking

for you." And that was true for all of the midwives who did groups. And the Duke midwives would say, "This is the only experience of continuity that I have in this job. The only one."

AM 51:06
[Recording was paused here. JM: Yeah so a little bit about the gaps?] I think the big gap was that we were not 24/7. Over time, the Midwifery Service was well-known in the department and even in the hospital, because we taught residents in Family Medicine and the ED residents, PAs, NPs, nursing students, EMTs, even, right? So we got to the point where the residents in triage were referring patients to our groups. I'd get a text or an email, "My my gosh Amy, can you please? This poor woman has been through so much trauma, she really will benefit from being in a group." Or, you know, the midwives would show up in the morning, and people would say, "We have a patient for you. The patient in room seven, here's her story, she really is going to benefit from midwifery care." I think we all felt every day that we were filling a tremendous need. But because of the powers that be -- we had a chairman for many years who did not see the benefit of having us there 24/7. You know, there's a bit of sort of old school macho belief of "Because when I was a resident I worked 120 hours a week, that everyone who comes after me has to suffer as much." Or that because residency hours were cut down to 80 a week at a certain point in 2003, that was another point where the midwifery service was able to expand, but covering nights and weekends was really hard. It was going to cost more money. And the OB department was not willing to do that. And, yeah, so it was really hard. Very often, if I had been laboring with a patient all day, and we had been making progress, we had a nice way of communicating, [then I was] signing out to the night team where there's a third-year resident who likely was an incredible young physician, but was responsible for covering the entire floor, and triage, and mentoring the intern, and dealing with any other problems.

[Pause for interviewee to take call]

JM 53:56
Unless you maybe have met a lot of midwives or been under midwifery care, it might be hard to understand why it's so special. So I wonder if you could just talk a little bit more about that.

AM 54:08
Yeah, what is the secret sauce that is midwifery is the question, right? And I have thought about this a lot over the years. And obviously there are as many different kinds of midwifery as there are midwives, right? All doctors, all nurses, all midwives are not the same. But I would say that a unifying characteristic of midwives is presence, a therapeutic presence. And so really understanding the concept of therapeutic use of self. And being a good listener. Appreciating -- particularly when you're talking about birth, right, midwives can do all kinds of things in women's health care -- but if we're talking about birth for a moment, it's a physiologic state. But such a defining experience, right? You can ask any person who's ever given birth well into their 90s, "Tell me about the birth of your first child." And that person, with remarkable recall, will tell you how they felt, what other people said, will really be able to describe that remarkably important moment in their life. So midwives get that.

And for me, I think really listening deeply means that you can really address what is important to each person. And in my career I've had the amazing privilege of caring for people with tremendous wealth and tremendous resource, and prisoners, and immigrants who have survived unspeakable trauma. And there's this unifying thread through all of it, is that when we're feeling vulnerable, having a guide, having another human being who sees you who can touch you in a way that says, "I know you're here, I know you're suffering, I know you're important, and I'm going to walk you through this." You know, that's really therapeutic and invaluable.

And it's interesting, having worked with residents for most of the years of my career, they're going through a trauma of their own, you know [laughs]? And being able to hold them up, also. There is something about midwifery, it's not just the delivery of medical care, it's really understanding the human condition. Whether you're having a baby, or you're doing your first call night. I still have residents call me routinely to tell me about something beautiful, or something tragic, and what that was like for them. So being a midwife is [pause] it's a remarkable profession. And I feel like it's given me access not only to these tender, wild and wonderful, painful birth experiences, but to the remarkable range of the human spirit and what human beings are capable of, right? I mean, not only the female body and what it's capable of doing, but every person who's at a birth plays a role and you get to see human dynamics like at no other time. It's kind of like at death. My mom, one of the amazing things that she has done is volunteered for hospice in her community. So she is the kind of hospice volunteer who will crawl in bed with the dying person, or ask the daughter at the bedside, "Tell me about your mom. Tell me about her life." And so you know, it's at those moments where things tend to reveal themselves and the same thing happens at birth.

JM 59:15
Thank you for sharing that. Yeah, that ability to hold space, how did you get to be a person who could do that? Was that a skill you thought you had from a young age, or is it something you learned over time?

AM 59:31
That's a good question. Once, when I was a midwife student myself, I was sitting at the bedside of a patient. And I felt like I was being watched. And I turned toward the door and I saw a little head, you know, move out of eyeshot. And when I went outside, there was a little medical student -- I mean, I was a little midwifery student then -- it was a man wearing a jacket and his little clipboard. And he said, "Can I ask you a question?" He said, "How did you learn how to talk to people?" He said, "Because I'm not really learning that in medical school." And so I don't know the answer to that question. But I know I had a recurring dream when I was a child in New York City. If you grew up in New York City, the subways, you're on subways from the time you're really small. And so this dream that I literally had for years was being on a train and the doors would open, and children would come on board. And they were always like, dirty, they were clearly poor, they were hungry. But on the train, everyone got new pajamas and everyone got candy [laughs]. This was like, you know, I left New York City when I was 10, so I probably started this dream when I was seven or eight years old. And I remember feeling like I was in some kind of leadership role in this train, although I don't really know what it was. But just that

whoever needed new pajamas or needed candy would get it on the train. And so that was this kind of strange theme from early on.

And without going too deeply into my own family history, we all know people in our lives who are broken or suffering in some way. And I think some exposure to that in my own immediate family made me realize that people -- I think, Bryan Stevenson, this is an often quoted comment that he has made is that we're more than the worst thing we've ever done. So in my own family there are some complicated characters. And sort of seeing people's weaknesses, but also seeing their ability to rise above and work through was a theme growing up. So and lastly, I'll say I had a really difficult medical experience when I was overseas. I was traveling my third year of college and was treated really badly in an emergency room situation. I mean, I had an abortion. And did not get good care. And I think I made a vow to myself at that time, where I said, "This is unacceptable. And I deserve better than then what I received, and if I'm ever in the position to do better for someone else in the future, I will." And so that was an early seed too.

JM 1:03:34
Well, thank you for sharing that. I love the story of the little [student] asking, "How do you talk to people?" Because my understanding is maybe that is changing a little bit in medical school, but it is still this gap that a lot of people have where how do you create a connection with the patients.

AM 1:03:54
Yeah, being a good listener. And this is why doing group care has become a focal point of my life. Because it all starts with good listening. And it's important to be able to facilitate a group full of people but I have at this point trained thousands of people to become facilitators, and it's really common for people to say, "Yeah, this is a great skill for me to have with a group of patients, or sitting around a Thanksgiving table with my family, but it also impacts how I enter a patient room one-on-one." There was one nurse who said to me, "I will go around and shake everyone's hand. I want to know who everyone is, in relation to this patient, and that helps me give better care."

JM 1:04:58
In looking through the collection that you donated to the Archives, I found this document that is the Introduction to Prenatal Care and Labor and Delivery from the Midwifery Service. And I wondered if you could just kind of walk me through it a little bit. It starts with a Monty Python video.

AM 1:05:16
[Laughs] Oh, yeah. That was, oh, my goodness, this is amazing. This was a resident orientation. So our interns would come to Labor and Delivery, of course they were medical students just weeks ago. And I would kind of walk them through the essentials of what they needed to know to be successful on Labor and Delivery. And so The Meaning of Life, if you've ever seen that Monty Python movie, [JM: I haven't, shamefully] there's a segment called, I think it's called Giving Birth. And if you know Monty Python, it's quite funny. And it really exaggerates how patients are treated as things, not people, through the humor of this. And it's incredible, because

this movie was made in 1979, some time ago now, right? That's 50 years ago. It's still really true. And so, the point being that, you know, how do residents maintain -- everyone goes to medical school wanting to make a difference, wanting to do good in the world. And so this outrageously points out how to treat patients like things, not people. So it's a good entry point into, how are you going to maintain your own humanity and treat patients with the respect that they deserve?

JM 1:07:21
And is there anything else that stands out to you on this document?

AM 1:07:29
Well, the fact that probably when I wrote this, we were still handwriting history and physicals on Labor and Delivery, before the invasion of the electronic medical record. And the other thing that really stands out on this, and the thing that that Duke midwives have provided from day one, was the essential foundational obstetric skills that in my opinion over 30 years of training doctors in this role, is really not taught. So this is expertise that I think years ago was probably taught to physicians, but midwives really appreciate, you know, doing Leopold's [maneuvers], which are the hand maneuvers that can tell the presentation and the position of the baby, how large is the baby, where does the baby lie in relation to the mother's body, and how this informs the well-being of the fetus and the mother during pregnancy and of course, during labor. Doing cervical exams, figuring out what position the baby was in based on the sagittal sutures, I mean, these are all skills that take years to develop. And in the business of medical and residency education these skills are not provided. So not only were our midwives exemplary clinicians, but we were also educators and really developed a way to teach that was non-threatening to the resident.

We were kind of a safe harbor, right? They might be ashamed in front of an upper-level resident or attending to say, "I have no idea what you're talking about." But with us they really could say what they did and didn't know. And then the other superpower that the midwives had was to keep the pregnant person, the pregnant woman, in the center of everything that happened. Right? So if you were the pregnant person, you know, I might say, "Josephine, with your permission, we're going to see if we can tell what position the baby is in. Where are you feeling the kicks?" Right? So sort of saying, "What are you noticing, has your baby always been lying this way? Would it be okay if Jane, who is a first-year resident, feels this too? This is a really hard skill to learn. So first, would you be okay telling her what you're noticing? And would it be okay if she learned with your baby?" And so that way, you're feeling empowered, because I'm asking you what you know. And I'm also asking you to share your wisdom with this new doctor. Very often you see groups of doctors with white coats coming in [and] you don't know who the baby doctor is, you don't often know who the most experienced person is. A lot of mistakes get made that way. So this was expertise that we developed. And we might have the grandma, or the partner, participate in that as well. So everyone feels like they're part of something special and important.

JM 1:11:40
Thanks for describing that, and walking through an example of how it might have played out. I want to know, we only have a bit of time remaining. I wanted to ask you about some of your colleagues and collaborators. As the service grew, it eventually grew to be 10 nurse-midwives. Is

that right? And I'm going to be speaking with [some colleagues including] Kim [Dau], Helen [Mikul], and Janet [Fields] in the coming weeks. Anything you want to tell me about this group and how you all supported each other?

AM 1:12:16
Yeah, remarkable women. Helen and Janet had worked at the birth center. Janet and I first met in Alaska at an ACNM [American College of Nurse-Midwives] conference where we were so excited, we wanted to see Mount Denali more than we wanted to go to the scheduled talks. And so we decided to get in a car and drive to Denali. We had just met each other, but clearly there was some affinity there. Of course, we didn't really pay attention to how far Mount Denali was from where the conference was. So we never made it. But oh my gosh, I just loved Janet from the moment that I met her. She is a sublime midwife. I always said if I ever had another baby, I would want her there. I mean, I would want any of those midwives present with me. She is kind, funny, smart, practical. If ever we had an important meeting, Janet would come with a thermos of tea and some home-baked wonderful thing, just to break the ice and set the stage. Whenever there was conflict, and there was always conflict, I mean, there were 150 people on this unit where wild things happened. But if ever there were two nurses who were struggling, Janet would sit them down and say, "Let's talk about what's going on. We really need to be for each other here. Who wants to start?" So that's the kind of person Janet is.

Helen is another remarkable human being. She was the person who had done some group care at the birth center, and she very much has a "let's do it" attitude. And so she and I really got the party started with group care at Lincoln Community Health Center. Her Spanish is impeccable. I mean, she grew up in Mexico, so she's quite bilingual. She's beloved by her patients. So I mean, they were just really adventurous, compassionate midwives who were willing to jump through all the hoops, climb all the mountains.

And then Kim Dau was an undergrad student who -- super smart, she was at Duke -- she was leading a house course for people interested in healthcare careers. And so she found me and she said, "Oh, would you come and talk about a day in the life of the midwife." And I did, I remember I was wearing my scrubs and I had my doll and my pelvis and I told probably the birth story of the day. And she became really interested in that, got in touch with me and she said, "Are there any internship opportunities?" And I was like, "Sure." Long story short, she became an intern. She went on to go to UCSF midwifery school, learned to speak Spanish, became a real shaker and mover in terms of groups. She was the one who really started our relationship with the Duke School of Medicine, and getting medical students into our groups. And became the first new grad hire at Duke. And then she is now the Director of the UCSF Midwifery Service. Remarkable.

So, yeah, I have nothing but praise and incredible memories. One of my big regrets that I would like to say here is that after all this time, and all the care that the Duke midwives gave in terms of raising other people's children, right? Medical students, nursing students, PAs, NPs, OB GYN [and] emergency family medicine residents. We haven't been able to bring on nurse-midwifery students. Huge disparity in the Duke system. And this was really, this was really difficult for me. We tried for years, because many, many, many nurse-midwives wanted to come to Duke. There

was so much going on between the health center, and group care, and resident education, and midwives caring for high-risk patients, midwives in the high-risk clinic. We were in two different high schools at one point, doing clinics in those high schools. But unfortunately, our chairman for many years, not the current chairman, but the previous chairman, was not able to see a way forward for that to happen. And as the service is now growing, again, to meet the need, there are still barriers in place. So it always felt quite wrong, to be able to love the OB-GYN residents, and [we] loved being a big part of their growth and development. But it only makes sense to me that midwives have the same opportunity for learning and for experience in a healthcare environment like Duke.

JM 1:18:49
Yes, where is the closest place that CNM s are being trained?

AM 1:18:54
Um, every other place but Duke in North Carolina [laughs]. UNC. ECU where the only nurse-midwifery program is. But unfortunately, that is a hill that still needs to be climbed that my current colleagues are dealing with, I'm sure.

JM 1:19:22
Are you okay, if we go over time a little bit? [AM: Yes] Okay, I have a few more questions, well I have many more questions. But I did want to ask you about the clinics that you mentioned. I saw a couple listed -- Duke Resident postpartum clinic, perinatal outreach, and then these high school clinics. So could you talk a little bit about what that landscape looked like?

AM 1:19:49
At the point in the Duke Midwifery Service where we covered the most locations, if my memory serves me correctly, there were 10 different clinical sites. So in terms of prenatal care, we were at Lincoln Community Health Center. We also for a time did a pop-up clinic, for three years, at El Centro Hispano where we, literally, in two suitcases -- this was Kim Dau's genius idea, because we ran out of space at Lincoln -- we had a blow-up bed, and all our clinical tools in two suitcases that we had in a closet. And we would set up our Centering room there and do Spanish-speaking groups there. Which was fantastic, because our Spanish-speaking patients would come into a community center where if they needed legal services, or help with housing, or help with jobs, it was all right there. We also did Outrider clinic, which consisted of Franklin County Health Department, Person County Health Department, Vance and Warren County Health Departments, which were rural clinics, I believe for seven years. That was remarkable because it was rural healthcare with nurse-run clinics, and we were the primary clinicians. And then the other outpatient clinics were high-risk, the resident high-risk clinic and the postpartum high-risk clinic. There were also two high schools -- Southern and Hillside -- that had in-school clinics where we would provide care. And those two clinics, in the context of a large grant, had over 100 pregnant students a year, which is why we decided to go out and deliver prenatal care to the students right in the school, so they didn't have to miss school. And then the two different hospitals were "Big Duke" on Erwin Road, and then Durham Regional then, Duke Regional now.

JM 1:22:32

What was the experience like doing the clinics in the high schools?

AM 1:22:36
That was relatively short-lived. And honestly, I wasn't one of the primary midwives doing that. I was part of sort of the setting up. But there was already a nurse practitioner in place as a primary care provider. And so it was traditional prenatal care in the clinic in the school. And I think that grant ran for two years. And then when the grant funding left, we stopped doing it. The better experience, I think, for our pregnant teens was to be embedded in the groups, in the actual clinic at Lincoln, and then later at the Health Department. Just because that was a two-hour experience where often there were other teens in the group, but also some older people. And so the advice that they got from other pregnant women in the community, plus face-to-face time with the midwife and the nurse there, I think [that] was really valuable.

JM 1:23:57
So where does the Midwifery Service stand today?

AM 1:24:05
Well, when I left in November of 2021, the Midwifery Service was about to expand to night-time coverage at Duke Regional, which I think was quite positive. And an expansion that was a long, long time coming. Long overdue.

I have been in touch with some of my colleagues and what I understand [is that] in the wake of post-COVID, where so many nurses left, where many providers have left and looked for other opportunities, [is that] filling gaps for the various services -- for triage for labor and delivery, for the antepartum service -- is really where the Service stands now. I think my colleagues, the nurses and the advanced practice providers, the midwives and APs and the NPs, are the continuity providers. They, for the high-risk service, they're the people who are there all the time. The residents cycle through. There are some MFM attendings who spend a significant amount of time there. So, they are the fabric of providing the care. But unfortunately, because the health system has continued to grow -- the groups shut down over the pandemic, they're just restarting at the health department. I think it's been really hard to maintain continuity. I think it's been really hard to maintain a sense of investment, in terms of the institution, for the health care providers. When I left, the nurse-midwives, and the NPs were not offered faculty appointments, although, you know, it was my deep belief over many years that if I behaved as a faculty member, right, if I participated in research, if I taught residents, if I gave exemplary patient care, that of course someone in charge would see that this would make absolute sense. And that never came to pass. As far as I know, that still has not come to pass. So I would like -- my hope for the service is that as the healthcare community realizes that equity is important, both in terms of all patients getting excellent care, but it's also important for nurses, for advanced practice providers, and physicians, to share some of the same opportunities that everyone can enjoy. Not just the physicians. And I have many physician colleagues who deeply believe this as well. But medicine is a hierarchical -- there's the hierarchical infrastructure, and so that piece was difficult.

JM 1:28:20

And let me just check my timeline for this, too. So, you left Duke in 2021. Retired. Though you're not retired, you're still very busy. I had down that you left that role in 2013. Is that right? Or did your title just change?

AM 1:28:42
I stepped down from my position as the Director of the Duke Midwifery Service, but then I stayed at Duke until 2021. I became a staff midwife again. And I led the Centering groups at the health department, and also was the on-campus trainer. I had a consulting position with Centering Healthcare Institute, and trained medical students and other health professionals, nurses, APPs, in group facilitation.

JM 1:29:30
And so who led the program after you stepped down?

AM 1:29:34
No one on my team. There was a director, Michelle Schweitzer, [who] took a leadership role. And it wasn't until several years later, that a midwife was given a team lead position. And she was in that role for maybe a couple of years, and then it has since gone to two people in a team lead role. So the team went from the OB-GYN department, to the Center for, what did it used to be called? ACP. And now it's called CAP. Center for Advanced Practice providers.

JM 1:30:42
And how many nurse-midwives are there working within Duke today?

AM 1:30:50
I can't tell you. I've really kind of lost track of that number. I want to say there may be eight. There was a lot of coming and going around..

JM 1:30:55
A bit hard to tell right now.

AM 1:31:01
Yeah. I think they have a growth plan.

JM 1:31:03
At its largest, the Service was 11 people. Is that right? Okay. Got it. Thank you. Yeah, this is helpful in kind of imagining what it looked like. So in finishing, during your tenure in this role what are you most proud of?

AM 1:31:21
I am proud that I was able to be a community midwife in Durham, and in this greater area. That even though I was under the roof of a very large academic institution, that highlighting relationships with my patients was something that came easily to me. And those connections that I made were just fulfilling, as a human being. And I learned to become an educator. And the feedback that I've received from the residents and the medical students that I've trained is also

really lovely. The nurses that I've inspired. So many nurses. And this is because of all the midwives who work there. [People] decided, "Hey, I think I want to be a midwife, too." I mean, even though it wasn't perfect. We didn't have faculty appointment. Or the first two years, we were stuck in triage. But there was something that those nurses saw that we were serving people in a way that made them be able to see themselves and see possibilities for themselves. I mean, that is really satisfying. So, I guess that all of those relationships kind of weathered the storms that we went through in terms of building a service. People who I respect tremendously. That gives me a great sense of satisfaction.

JM 1:33:48
And is there anything that we haven't touched on that would be important to include in this oral history? I'm sure many things, but when we turn off the recorder, that's always when people say "And wait!"

AM 1:34:01
I do want to give a shout-out to the nurses on Duke Labor and Delivery. For nurses who work in a large, very intense unit. And oh my gosh, the Duke Birthing Center is nothing if it's not intense. And so because many of the nurses noticed years ago, I think I mentioned that our patients who had been in groups really came in with something unique. They started asking what we were doing, and we shared what group care was, and many of them said, "Well, can I volunteer? Is that something I can do on my days off?" And can you imagine working three intense days, and then volunteering to spend a day at the health department? And so over 25 nurses did that. So not only was it lovely for the nurses to kind of break out of their hospital mold, and get into the community and connect with those patients. But then when the patients would come into the hospital, if the stars lined up right, they would have those patients. And it was great for the patient, and for the nurse. Or if the nurse had heard that one of their patients in one of their groups delivered, they would see them in the postpartum area. And one of the nurses [Ho-Yu Pan] who volunteered is a nurse who had trained as a midwife in Hong Kong. She's just a remarkably skilled nurse and midwife, speaks Mandarin and Cantonese. And one day in triage, she said to me, "Amy, I believe that one day in China, we will, we will have groups." And I said, "Okay Ho-Yu, that sounds great, how are we going to do this?" And so she started doing more and more groups. And one of the [non-profits] outside of Duke that I've worked with is called Group Care Global. And its mission is to scale up group care outside the US, globally across the world. And so for the last two summers, Ho-Yu and I have done virtual group trainings with doctors, nurses, and midwives in China. And 76 people have been trained to do groups. And there are now groups in half the provinces in China, in 18 provinces. So just sort of seeing like the spark of an idea, of what if we had groups here? And then sort of imagining the impact. And just seeing how our relationship has grown. We've become remarkably close.

JM 1:37:01
Is that the Centering modality?

AM 1:37:23
Yeah, it's Centering-based group care, but it's on an international scale. So super cool.

JM 1:37:31
Well, thank you for talking with me today. I appreciate it so much.

AM 1:37:33
Thank you so much, Josephine.

[Paused recording, then Amy and I discussed a couple more topics that we wanted to add to the interview and turned the recorder back on]

JM 1:37:36
Okay, and so we wanted to talk a little bit about some of the outcomes that you see in midwifery care and in the Service in particular.

AM 1:37:44
Yeah, what's so rewarding about midwifery care is that the outcomes -- what the science says about midwifery research is that patient satisfaction is high. Preterm birth is lower. C-section rates are lower. Breastfeeding rates are higher. Preparedness for not only for birth, but for parenting, right, how to take care of your new baby, are also higher. So this is known, this is what research tells us. Regarding group care -- which is a midwifery-created and largely midwifery-led model in the US -- what was so exciting in Durham [and] in the health center where we started groups in 2004, our preterm birth rate for patients in groups, as compared to patients in our traditional clinic was half. Our C-section rate was lower for patients who participated in groups. Our breastfeeding rate for our patients, who were essentially poor women -- refugees, immigrants, Black women with Medicaid for their insurance -- our breastfeeding rate at the time of discharge for patients who had attended groups was as high as 92%. Which was really astounding to us.

So rarely in healthcare do we get the kind of feedback that drives our behavior as clinicians. So to know that by sitting in a circle, by having a facilitated conversation, by helping people share tricks [and] share strategies for being healthier, stronger, more confident pregnant women, people, parents, [it] was really satisfying. It really encouraged us to continue. It encouraged us to continue to invite learners in, because very often in the learning environment, you're going in as a lone student, and you're figuring things out on your own. In the group environment, you can listen to the questions from the patient, you can listen to the seasoned healthcare provider respond, as well as the other patients who are sharing the same experience. So as a learner, there is nothing, nothing like it. So these are some pretty standard and repeated outcomes that we experienced from our groups from 2004 until I think our last group was March of 2020. Right when the pandemic started to win. But hopefully, the groups have just started again in August. So I was excited to hear that.

JM 1:41:27
I wonder if you might want to share a patient story from your time working with the Duke Midwifery Service, something that's standing out to you today.

AM 1:41:33

Oh, my goodness, so many patient stories. Let's see. Well, one of my favorite patient stories involves a family, actually. When I first started working at Lincoln Community Health Center, I walked into a patient room and there was a woman who I had known from my time at Kaiser. And so I was able to be with her for the birth of one of her daughters, and she's a very warm and lovely person. So we were thrilled to see each other. And we were just starting groups at Lincoln. So I invited her to participate in the group. And she readily said yes. And because she had other children, she wound up being quite a leader in this group. And her two young daughters came with her to these groups to help measure her belly, and listen to the baby. I was able to attend the birth of that baby. And then because I was at Duke a very long time, a very, very long time, I was able to attend the birth of both of those daughters. In fact, one of the daughters had two babies, and I attended one of those births, her daughter was quite young, quite a young teen. And then when she had her second child, I was on vacation. But it was my first tele-midwifery experience, where we were on FaceTime with each other. And I was able to be with her in that way. And I remember her asking me, saying to me, "Amy, I need to get out of this bed! You know how I did for my first one, I need to do that right now." And I said, "Well, just do it." And she was there with two residents, who I knew, and a nurse who I knew. And so it was really -- it was just remarkable to have such longevity with this family. I still hear from them. And in fact, that young woman recently, she was a straight A student through high school, went on to get her undergraduate degree, just graduated with a master's degree in social work. And she just interviewed at the new company where I'm working. Because she was so compelled by her own birth experience, that she now, you know, wants to support young families herself. So that's a very warm memory for me.

JM 1:44:55
Thank you.