ORAL HISTORY INTERVIEW WITH HELEN MIKUL
Duke University Libraries and Archives
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COLLECTION SUMMARY

This collection features an oral history I conducted with Helen Mikul on September 27th, 2022. The 56-minute interview was conducted in Pittsboro, NC. Our conversation explored Mikul's role as a midwife with Duke Midwifery Service, her dedication to working with Spanish-speaking clients, and the uniqueness of midwifery as a healthcare profession. The themes of these interviews include medical training, midwifery, and family planning.

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 (credit: Josephine McRobbie)
- Scan of a signed consent form

BIOGRAPHY

Helen Mikul, CNM, worked as a midwife for the Duke Midwifery Service from 2003 to 2008. She credits this job as a critical step towards her current role as lead provider at the Siler City Community Health Center, which she calls the job she was "meant to do". As a midwife with Duke Midwifery Service, Mikul provided midwifery care to patients, worked in labor and delivery triage, attended births in Duke's labor and delivery unit, participated as a facilitator for the Centering Pregnancy prenatal care groups at Lincoln Community Health Center, and provided training and support to Duke students, residents, and fellows. Throughout her career, she has been particularly passionate about providing family planning and contraceptive care to clients.

Mikul was raised partially in Mexico, where she became fluent in Spanish. To this day, she focuses her work as a midwife on providing care to Spanish-speaking communities in North Carolina. Her interest in midwifery stems from her experiences as a recipient of both midwifery and obstetrics care while giving birth to her three children. "I was heard when I was a midwifery client," she explains. A graduate of a bible college in Dallas, Mikul went back to school at the age of 40 after her youngest child entered kindergarten. She terms herself a "late bloomer" professionally. Mikul received her Associate's Degree from Vance-Granville Community College, and her Master of Science in Nursing and Certified Nursing Midwife degrees from Eastern Carolina University (ECU). Upon her graduation from ECU in 1998, she spent five years working as a midwife at Women's Birth and Wellness Center in Chapel Hill, North Carolina.

In this interview, Mikul speaks vividly of the skills that Duke Midwifery Service midwives provided to Duke clients, and also shared with their Duke colleagues in the teaching hospital environment. She shares how she and her Duke Midwifery Service colleagues taught students and trainees the strengths of different birthing positions, maneuvers for safe birth during shoulder dystocia, strategies for postpartum care and the delivery of the placenta, as well as approaches to caring for clients experiencing stillbirth or the the loss of a pregnancy. "[The students and physicians] were very, very receptive to any teaching," she says. She describes how during her time at Duke, more trainees began encouraging clients to try hands and knees and side-lying positions for birth (as opposed to the medically-standard stirrups position). Additionally, Mikul notes that several of her colleagues ended up delivering during their residency tenure. "And they had great midwife births," she says.

INTERVIEW TOPIC LOG (helen-mikul-interview-audio-with-restriction-deleted.wav)

00:00 Introductions
00:42 Prior job at Women's Birth and Wellness Center (WBWC) in Chapel Hill; call from Amy MacDonald in 2003 related to Duke Midwifery Service opening
01:55 Career history and self-conception as a "late bloomer" professionally
02:28 First impressions of Duke; discussion in grand rounds with physician about midwifery
03:57 Relationship with physicians and students; story about teaching birth setting soft skills to resident
05:11 Relationship with residents and specific skills taught by midwives; experience of residents choosing midwifery care for their own pregnancies and births
06:46 Importance of showing how hospital midwifery functioned to those who assumed that midwives only worked in birth centers and homes
07:38 Midwifery preferences related to monitoring, "trusting the process"; story about intern identifying patient's cervix
08:33 Placenta delivery and postpartum management
09:12 Experience in nursing school and hiring at WBWC
10:03 Upbringing and early life in Mexico and later Texas
11:34 College years; birth of 3rd child at birth center; nursing school interview
12:52 Personal experiences with midwifery care; home birth of sister on commune in California
14:42 Interest in working in hospital setting and working with "whole process" of pregnancy, birth, and family planning
16:23 Interest in family planning and contraceptive care
17:10 Education at Vance-Granville Community College and later Eastern Carolina University; clinical rotation in Hickory NC; experience in driving a "triangle" of home, college, and rotations while also parenting her children
18:55 Friendships in nursing school; pelvic exam trainings
20:32 Skills-training and midwifery as "a calling": "This is what all women need"
21:56 Interest in working with Spanish-speaking clients
22:40 Work with Centering Pregnancy groups at Lincoln Community Health Center; power of group care facilitated by midwife
26:31 Facilitating Spanish-speaking Centering groups
27:09 Story about Centering client and help from other group member
28:12 Gifts and donations for groups
29:09 Facilitation conversations; discussions about birth control; importance of creating social connections
30:41 Relationship with Amy MacDonald
31:21 "Specialing" client births; working with residents; care during intrauterine fetal deaths; teaching birth position options to physicians
34:37 Maneuvers for shoulder dystocia
36:02 Story about birth occurring in triage due to cervical check error
37:01 Differences between WBWC clients and Duke clients in terms of pregnancy education; experiences with language interpretation
38:42 Teaching self-advocacy to clients, feelings about birth plans

39:38 Continuity of care and importance of prenatal education
40:23 Typical work activities with Service; work with Maternal-Fetal Medicine clients and colleagues; Mirena IUD insertion story
42:47 Relationships with colleagues in Service at Duke University Hospital; ACNM motto of "Listen to Women"
48:12 Observations about beds with stirrups, doulas, and midwife-assisted births
49:26 Move from Duke Midwifery Service to Piedmont Health
50:34 Experiences in Duke triage and recollections about work environment; working with Spanish-speaking clients as a provider and services provided by interpreter in room
53:32 Takeaways from Duke work and pride in relationships with clients

TRANSCRIPTION (helen-mikul-interview-audio-with-restriction-deleted.wav)

Josephine McRobbie 0:00
Okay, and so I'll start by saying where we are, or when it is. It's Monday, October 17th 2022. I'm Josephine McRobbie. And I'm interviewing Helen Mikul. This is part of an oral history series for the Duke University Medical Center Archives, documenting the history of the Duke Midwifery Service. So thanks for being a part of this project, Helen. And we always start oral history interviews by asking people the very basics -- their full name, their place of birth, and their date of birth.

Helen Mikul 0:33
My name is Helen Margaret Mikul. I was born in Birmingham, Alabama, on September 28th, 1958.

JM 0:42
Okay, thank you. And so to start with, just give me a quick introduction to Duke Midwifery Service and your role in the program.

HM 0:50
So, I had actually been working at the freestanding birth center in Chapel Hill [Women's Birth and Wellness Center], and I had resigned because I was fried. And I was going to get a job in a restaurant cutting vegetables. That was my goal. And I got a call from Amy MacDonald, who didn't know me. And she said, "Hi, my name is Amy, you don't know me, but I need a midwife to work with the residents here, and having somebody who speaks Spanish would be really great." And I was going to start exactly -- I gave three months notice -- and I was going to start in three months. And I thought this seems like [it is] meant to be.

JM 1:26
And how do you think Amy got a hold of your name, is the kind of birth community small?

HM 1:32
Because there's not many midwives that speak Spanish.

JM 1:36
Okay. And what year was this?

HM 1:39
2003?

JM 1:42
So this was maybe the years [when] the program was fully starting. Okay. And so you said it sounded like a good fit?

HM 1:53
Yeah, I said, "That sounds really interesting."

JM 1:55
Okay. And you had not worked at Duke previously?

HM 2:00
No, I worked -- I was a late bloomer. I didn't become a midwife till I was 40. I was a stay-at-home mom for 12 years. So I worked for a year in a private office, and then five years at the birth center, and then went to Duke for five years.

JM 2:16
Okay. And so at the birth center you had worked with UNC hospital [HM: Yes, family medicine], so you had sort of some [familiarity]. Okay. And so what were your first impressions of Duke, in that role?

HM 2:28
So this is my favorite Duke story, because I became a midwife to take care of teenagers and underserved populations. And, you know, I loved the birth center in the care that we were able to give, but that wasn't what had paid for me to get through school. Because I had Nurse Scholar[s Program] money and Office of Rural Health money to work with specific populations. And so I'm in grand rounds, with my white coat on and a stethoscope, looking around at all these doctors and going, "What in the world have I done?" And we were looking at a strip [**2 second restriction - description of case outcome**] So we were going through, you know, talking about what had happened, and how to prevent it. And one of the doctors, and I don't know who he was, I think he was retired at that point, but he was still participating. He said, "Well, I just have one question. Where was the midwife?" And I'm like, "Okay, here we go." "Where was the midwife?" And they said, "It was at night, there wasn't a midwife on." And he said, "Well, if there had been a midwife there, this would have never happened." [JM: Wow] And I was like, "Okay, that's good. I like this."

JM 3:42
That's sort of the opposite of the stereotype of these two fields sort of butting heads. [HM: That's right] Interesting. [HM: It was very, very sweet.] Okay. So that felt like an auspicious start.

HM 3:53
Another confirmation that maybe I was doing the right thing.

JM 3:57
And yeah, tell me more about that move into the -- you're wearing the white coats and in this very sort of formal medical environment. How did that feel to you?

HM 4:05
Well, it felt really -- I mean, I just felt like we were respected. There were some politics [and] things that I didn't have to deal with. Amy had to deal with [that]. But they hired us to teach the normal. And the residents were very respectful. One of the first deliveries I was with -- I think she might have been a third-year resident. And the birth was beautiful. And as soon as it was

over, she left [claps hands]. And I followed out in the hallway, and I said, "Where are you going?" She said, "To write my orders." And I said, "What was that woman's name?" And she said, "I don't know." And I said, "You just were allowed to participate in one of the most powerful parts of her life. You need to know your patients' names. You need to thank them. And you don't just split like that." And it was those kinds of things. They liked us. The residents liked having the midwives there, because we were kind to them. We were supportive. We were like moms, at your bedside, helping you do the right thing.

JM 5:11
So the residents coming in, do you feel like that was representative of how they were taught medicine? Like, they maybe wouldn't know a patient's name in the birth setting? [HM: I think so] Yeah. And how did you teach that in a way that wasn't confrontational, or allowed them to really have that learning experience?

HM 5:32
Well, I had several times -- I wear contacts now. But I used to wear reading glasses. The residents several times said "Helen, when you yell at me, please take your glasses off." And [laughs] I said "I'm not yelling. I'm teaching." So as long as I didn't have my glasses on my nose, we were okay. They were very, very receptive to any teaching, and doing things. They started doing births on hands and knees, and side-lying, and several of the residents ended up delivering during their tenure, and they had great midwife births. Like they always wanted a midwife with them at their birth.

JM 6:16
At their own births.

HM 6:21
Yeah, at Duke. We saw patients by ourselves, we didn't just supervise.

JM 6:27
I thought you were saying residents giving birth. And I was thinking, "Wow, they really, they really took that knowledge home.

HM 6:37
No, they were pregnant.

JM 6:40
Oh, my gosh! That's amazing. So they chose the midwifery model after experiencing that as professionals. I mean, that's a stamp of approval.

HM 6:46
And that was the thing that I liked, also, is that this was giving a chance for these doctors to go out into other places and have a positive experience with midwives. And not be like, "Oh, they're just having unintended home births with breech, and previous C-section deliveries and that kind of thing."

JM 7:12
Did you feel like that was the impression that some residents might have upon meeting you, or upon meeting other midwives?

HM 7:20
Not specifically. At that point I think they all knew Amy and the few others that were there already. No, they were very receptive.

JM 7:31
Okay. So you weren't having to counter stereotypes that people might have of the profession?

HM 7:36
I didn't feel that.

JM 7:38
Okay. So you said you would teach things like side-lying [and] giving birth on hands and knees? What other things did you feel like you were bringing to their education?

HM 7:50
That there wasn't a need for continuous monitoring. That was a big one. Trusting the process. You know, this is not pathology. This is physiology. Which is really different when you've gone through medical school and everything's pathology. So that was really good. There was one time it was -- she was an intern. It was her first year. And I was with her in triage, and she went to go check the patient. And I said, "So, you want to find the station, the dilation, the effacement." And I went through a list of things she needed to be checking for. And she said "Helen, if I just find the cervix, I'll be happy." [Laughs] And I was like, "Oh, yeah, sorry, honey." Just that process of watching them grow, too, was really cool.

JM 8:33
And you said "Trust the process." The process is also time. And it seems like that is something that might be challenging for people who are expected to get in there and get out quickly.

HM 8:45
Right. A great example of that is the birth of the placenta, where we did expectant management and it could take up to 45 minutes. But they were able to see that there were less issues with postpartum hemorrhages or cords breaking or whatever, if you just sat for a few minutes and let the placenta get loose by itself.

JM 9:12
And so you're teaching patience, as well -- the act of patience. [HM: Yes, right] That seems really unique, when so much of medical school and training seems very fast-paced. But I imagine your own training was fast-paced, too. So you had that experience as well?

HM 9:35

It wasn't. I was also able to get my clinical rotations anywhere I wanted, because I would call and say -- I called Maureen and I said, "Hi, my name is Helen Mikul, or it was actually Wackerhagen [married name] then, I'm needing a place to do my integration rotation." Which is where you do everything -- well-woman, and prenatal, and deliveries. And she's like, "No, I'm not taking students right now." I said, "I'm fluent in Spanish." And she's like, "Oh, we would love to have you." [Laughs]

JM 10:03
So maybe this would be a good time to go back and talk a little bit about you as a person. So, tell me about your upbringing. You learned Spanish at an early age, and English was your first language, right?

HM 10:17
Right. I started learning when I was eight. So we lived there for two years off and on. We -- some of this, you might not, I don't care -- but we were deported twice from Mexico. My dad was a hippie, and he did not like the country of the United States of America at that point. And so we just moved to Mexico in '67. But we were kind of persona non grata, because we weren't spending money. We were living poor, like the people did. And so we didn't do anything bad, we just got kicked out. And then we went back a few years later and got deported again. But we ended up in South Texas, which is 30 minutes from Matamoros, Mexico. And everybody in my class -- my graduating class, there were just 70-some of us -- spoke Spanish, and studied it. And so it was a great way to learn.

JM 11:17
And so how old were you when you moved to Mexico, and then to Texas?

HM 11:21
Nine when I moved to Mexico, and 14 when we moved to Texas. Or were escorted to Texas.

JM 11:27
Okay. And what were your kind of career aspirations when you were younger? And what were your interests?

HM 11:34
I wanted to be a go-go dancer on Laugh-In. That was my inspiration. But when I graduated high school, I didn't know what I wanted to do or anything. And I ended up going to bible college in Dallas, and then moved back to North Carolina and had three kids by the time I was 27. But my baby, who's 37, was born at a birth center in South Carolina, because we didn't qualify for Medicaid and we couldn't afford anything else. Their dad was in graduate school. So I had midwives, and we had a lovely birth center birth, and I'm like, "I'm going to be a midwife when I grow up." So I was 27 when I decided. And when Sam started kindergarten, I started nursing school. And when I interviewed for nursing school, the lady said, "So what made you want to be a nurse?" And I said, "Oh, I don't want to be a nurse." And it was, like, oops, wrong answer. And she kind of looked at me. And I said, "I want to be a nurse-midwife." She could have taken that

as a "I'm a better than a nurse" thing. But fortunately, she thought that was a great idea, too. And let me in.

JM 12:46
So, what did you mean by that?

HM 12:49
Well, I didn't want to be a nurse. I had to be a nurse to become a nurse-midwife.

JM 12:52
And so you had, kind of, your mind set on that as a specialty. What about the birth center birth was so impactful for you, on a personal level?

HM 13:04
So I had the best obstetrician in Charlotte with my middle son. And I didn't feel like anybody ever listened to me. But I was heard when I was a midwife patient. And my kids' dad was doing hypnotherapy in graduate school, taking courses. And so we had been doing progressive muscle relaxation every night before bed. And I had 10-pound babies. My babies were huge. [I had] very simple, beautiful, easy births. And the midwife and the nurse that were on that night said, "We thought you guys were on drugs." Because we were just -- we were in the zone [laughs].

JM 13:52
And not from training through a birth preparation program.

HM 14:00
Right. Also, my little sister who's 54 was an unattended home birth in a commune in Northern California. My dad [was there] and there were probably 20 people in the dome when she was born. So it was kind of like birth was always normal to me. It wasn't like a scary thing.

JM 14:20
Were you there as well for the birth, or afterwards?

HM 14:22
We were invited, but we were not interested.

JM 14:27
But it was a normal part of life?

HM 14:32
Yeah. Everybody on the communes had babies without midwives. Or doctors. Or nurses. Or sterile implements [laughs]. Yes. And the babies all survived.

JM 14:42
And so did you have any interest in home births yourself when you became a professional?

HM 14:50
Um, no. I mean, I support homebirth. I think it's wonderful if you've got somebody in the appropriate -- when precautions are taken. Like, I am not into breech home births, or vaginal birth after cesarean. You know, normal, healthy. Not hypertensive, not diabetic. Normal, healthy women should be able to birth wherever they want.

JM 15:22
Did you imagine yourself working in a birth center setting, or in a hospital setting?

HM 15:25
No, I did not want to work in a birth center. I didn't even want to do birth. I wanted to become a nurse-midwife, because I was older and I knew that it was more independent. PAs and nurse practitioners have to have their charts co-signed, and prescriptions and stuff. And midwives are directly reimbursed by Medicaid and Medicare. And I liked that. The cowgirl independence side of it. But then I didn't want to give great prenatal care to patients in a health department setting, or something, and send them off to, you know, whatever they were going into. I kind of then felt the responsibility to be part of the whole process. And like I said, I did it for five years at the birth center, and did births at UNC.

JM 16:23
So was your passion more in prenatal and well-woman care? Or was it sort of the whole life-cycle?

HM 16:32
The whole life-cycle. I'm particularly, and always have been fond of, family planning. Because over 50% of babies are not planned. There are surprises. So right now my favorite part of my job is doing the LARC, the long-acting [reversible] contraceptives. Like IUDs and Nexplanons.

JM 16:54
Do you remember when that became of interest to you?

HM 17:00
I don't think there was a specific time, I just always felt like kids should be planned.

JM 17:10
Tell me a bit about your nursing education. You went to ECU [Eastern Carolina University], is that right?

HM 17:16
I went to a community college in Vance County -- Vance-Granville Community College -- for my Associate's. So a lot of people don't realize that an Associate and a Bachelor of Nursing take the same boards, and you're a registered nurse [with both] when you're finished. It's just that the Bachelor nurses are more likely to do supervision, and that kind of thing. Associate Degree nurses, I think, make better clinicians because they have more hands-on training. So I went to the community college for two years. And then I worked every other weekend while I got my

Bachelor's at UNC. So I did it in six years. I mean, I started at 34. And I finished at 40. And I had no college before that.

JM 17:58
And your youngest was five when you started? And were all of your kids still at home? [HM: Oh, yeah.] What was that experience like?

HM 18:07
I would get up at 4:30 in the morning and study. I was always home. And one of my clinical rotations was in Hickory at a really great midwifery service up there. And that was my intrapartum rotation. I would be up for 24 hours, and drive home. So I would only miss them, for that one semester, one night. But that was hard. I put 80,000 miles on my car my last year of midwifery school.

JM 18:38
Wow. So with that rotation and other travel?

HM 18:44
Yeah, just with school. There wasn't remote learning, right? So school was at Greenville, we lived in Henderson, clinicals were in Hickory. And it was that triangle.

JM 18:55
That's a lot. And did you find that a lot of your colleagues were younger? Were you one of a few late bloomers, or many late bloomers?

HM 19:06
In the nursing program they were mostly younger. There were maybe two that were my age or older. Midwifery was a pretty eclectic group because most of them had been nurses for years, and then decided they wanted to become a midwife. I went in knowing that's what I wanted to do.

JM 19:27
And did you make friendships, or kind of gain that community in school?

HM 19:33
Oh, yeah. And we're still friends. I mean, and in midwifery school you really get to know each other. We did pelvics on each other [laughs]. There are women who come around and let students in medical schools, and nurse practitioners, and midwifery, do speculum exams on them. They're like these militant women who want women to have a good experience with their pelvic exam, and I'm sure they are reimbursed appropriately. But yeah, so one of my friends, Monique, she got to do mine. And I got to do hers. It's the same -- I got a big laugh from an oral surgeon. I said, he said, "Oh, what you do is so interesting." I'm like, "It's the same as what you do, but vaginas don't have teeth." He made everybody in the office come in. Because our culture is so hung up on body parts and the names of them.

JM 20:32
And what did you find that you took to easily when you were learning these skills, and what was challenging for you?

HM 20:41
I think because for me I felt like this was a calling [and] it wasn't a job, I really didn't struggle with any of it. I felt like I was well-prepared, and I studied hard, and I knew what I was doing. It wasn't like I was like "Is this really what I want to do?"

JM 21:07
Yeah, that's so interesting to me. Because you had not had, maybe the experience of being up close with bodies, or maybe with the science component. Or were you science-minded in school?

HM 21:19
Not at all. .

JM 21:22
But you just seemed to take to it immediately, why do you think that is?

HM 21:29
I think really my experience with having Sam [and] thinking, "This is what all women need." And that's another bumper sticker. "Every woman needs a midwife." To be heard, to be cared for. I didn't see a lot of that in health care in other situations.

JM 21:56
And when did your interest in working with Spanish-speaking populations start?

HM 22:02
When I was a kid. I mean, even the times when we were deported, there were no kitchens in the jail. The women would bring us food through the windows, and they cared for us. And the Federales, when they drove with us -- we had an old station wagon -- from Puerto Vallarta all the way to Brownsville, they were so kind and wonderful. They'd take us to restaurants they liked, and they bought my stepmom a tortilla press. And we just were treated with so much compassion there, that I kind of always felt like -- pay it back.

JM 22:40
And did you have the opportunity to focus on that area while you were doing your midwifery training? [HM: Yes, through the health department] And when you came to work with Duke Midwifery Service, you were involved with training residents, and doing births, and also the health department Centering trainings, is that correct? Can you tell me a little bit about that?

HM 23:07
Centering is amazing. The health department -- it was Durham County Health Department -- contracted with Duke to provide the prenatal care. This was when they were still meeting at Lincoln [Community Health Center]. They didn't have their new building. So I went through the

training, and I loved Centering. I would do it here except that we don't have transportation. There's no way I could get six to eight women to the clinic at the same time.

JM 23:34
It works really well in a place like Durham that has a lot of community hubs.

HM 23:42
So we've talked about it in the past, to do it here. But unless we got some grant with a van that could pick everybody, you know, that kind of thing. But yes Centering, because you have to let the women do the talking, and come up with the answers, and teach each other. And that was really powerful. When you're sitting on the mat and a woman talks about her vaginal discharge, "Are you comfortable bringing that up in the group?" "Yeah." And that would be where the focus went. It was in the moment.

JM 24:18
That kind of peer education component. Had you done that kind of group education care before?

HM 24:25
No, I was a certified childbirth educator when I was in nursing school, and I had done that. But I've never been shy, I think because we moved so much. I always just kind of like, came in. And when I graduated from UNC, I was the speaker at the graduation and everybody was like, "Weren't you nervous?" Like, no. To me, it would be the same as talking with a few people, or looking out and seeing 1,000 or however many were out there.

JM 24:58
Yeah, that's a great skill to have. So you felt comfortable working with groups in that setting. Okay. How long were you involved with the Centering program?

HM 25:07
I mean, the whole time that I was there. We didn't start it right away. I don't remember what year it started. Because also there were a lot of Spanish-speaking women in Durham County at that time, too.

JM 25:22
And you were, you were the main facilitator for those Spanish-speaking sessions, is that right?

HM 25:28
And Amy was too.

JM 25:31
And you usually had another facilitator with you, is that right?

HM 25:36
Yea, it would be either one of the nursing assistants, or one of the clinic social workers, or somebody like that.

JM 25:42
Okay. When I spoke with Ann Milligan-Barnes, who is one of the nurses, she mentioned, I think it was Monica. Is there a Monica who was an interpreter in the Health Department? She had mentioned her as being part of this. It sounds like it was a big group of facilitators, and guest instructors. How many midwives from Duke were involved with the Centering programs at the Health Department?

HM 26:08
Well, there were nine of us, but I think only three, or maybe four of us, did the Centering.

JM 26:16
And how many sessions would you do a year?

HM 26:21
Maybe four.

JM 26:25
Four groups, and those all ran for about 10 sessions. Okay, so that's pretty significant.

HM 26:29
We kept it rolling.

JM 26:31
And what were some of your strategies to get these groups to open up and be comfortable talking about things?

HM 26:37
Well, the Spanish-speaking women, in my experience, are really pretty good in a group. There's always some that are more than others. And they're very comfortable saying, even just in a regular visit, "So, how old are you? Are you married?" You know, just the curiosity and the questioning that we kind of have more boundaries and political correctness about.

JM 27:09
So you felt like the door was open? [HM: Yeah, it was very smooth] Can you tell me about any memorable sessions?

HM 27:18
Oh, a memorable couple. Men could come, too, partners could come, too. And there was this young couple, and he was there every group. And turns out he was physically abusive with her. And when she finally shared, this was right, maybe at her last Centering visit. She had become friends with an older woman in the group, who brought this young woman -- it's going to make me cry -- brought her in to live with them. And then got her partner into AA [Alcoholics Anonymous]. And, like, supported them to get back together. And last I heard they were doing really well. But that's pretty -- doesn't happen in a routine prenatal visit.

JM 28:12
You wouldn't have the opportunity to get to know other people who are going through the same experiences. Wow.

HM 28:23
That's one. The other thing that was really cool was getting people to participate. Whole Foods would donate all kinds of goodies to us -- snacks, and little baby lotions, and apricot oil, and stuff like that. So we would have little gifts and stuff for people, too.

JM 28:43
I heard there was a baby shower as part of this. There were guest instructors or guest speakers who would talk about things like dentistry, or family planning, nutrition. Were any of those particular favorites of yours? [HM: Not really.] Okay. What was your favorite part of being in that environment?

HM 29:09
The most challenging part was just like at birth. Where you've got to sit on your hands, sometimes. Just keeping your mouth shut. That was challenging, and also powerful.

JM 29:22
So what would that be like, if nobody wanted to talk?

HM 29:27
Yeah, or just when you're used to that didactic, you know, blah, blah, blah, blah, blah, blah, blah, blah, blah, blah, blah, blah.

JM 29:37
It sounds like there is this ability for the groups to sort of like problem-solve. Do you remember a time when that happened, where people were able to come to a conclusion about something together, where you didn't have to be that teacher?

HM 29:51
Yeah, birth control was a big thing. Because I remember several times where there was some thought that birth control pills cause cancer. Or hormones are bad, you know. That kind of thing. And just the older women talking with them and really helping with it. It was usually the older women helping with the younger women, in my experience.

JM 30:20
So they could be sort of mentors.

HM 30:22
It takes a village, you know. When people come here when they've been living with their grandma and their aunts and everybody right in the same little section, and here they are,

isolated, and not used to that, and not having those social connections. So it was really good that way, too.

JM 30:41
And how well did you get to know Amy during this period? Because it sounds like you were working in several different settings together.

HM 30:49
Well, Amy told one of my patients [laughs] -- it was a couple that had a baby -- they said, "Oh, do you know, Helen?" And she said, "Yes, she's my paraja." Which in Spanish means your sex partner, not your partner. And she said the couple were like [laughs], and she realized that she had used the wrong word. We were good friends. I mean, I still love Amy. I miss her. She was the midwife who attended the birth of my two oldest grandkids, too.

JM 31:21
Amazing. And you also had the unique experience, it sounds like, of being able to do this prenatal care in the clinics at the health department, or in the groups at the health department, and then also attend births with some of the women.

HM 31:37
Yeah, but I rarely had a birth where I wasn't just there with a resident. I didn't have many, like, Amy would "special" people. Like she "specialed" my daughter. That's what you call it. [JM: What does that mean?] Like, Maureen would say to somebody, "I'm going to be there at your birth, no matter what day, no matter what time."

JM 32:00
I've got dibs. Okay. Wow. And so you were often working with a resident? So would that mean that you would be kind of stepping back?

HM 32:09
Yeah. You know, or sometimes over their shoulder going, "Okay, now pull down a little bit, ok now come back up." That kind of thing. Yeah, but some of my favorite births at Duke were women who had had intrauterine fetal deaths. And we would be in the back hall, because those babies are harder to deliver, that was something I really, really appreciated being able to do. Which is to sit with somebody in that moment. And instead of it being, you know, somebody just comes in at the end and pulls the baby out. And I cry real easy.

JM 32:50
I do, too. You're in good company. Just being able to make that space for people sounds really unique. And that sounds like such an incredible skill to be able to teach residents, too. How you would teach that in the moment, while still being present yourself. Yeah. That sounds very challenging and very beautiful. When you were in this birth setting, and you were sort of taking this role of showing people how to go through the physical movements [and] maneuvers associated with birth, what was your strategy for teaching that?

HM 33:42
Well, we always had a class for the interns. And Amy was really good at organizing that kind of thing. And so each of the midwives would do either sections, or we would do one class, and then somebody would do the other class. So we always started at that point. And that was fun, because there's ways to show -- I'm going to stand up -- to show a resident about [the] pelvis. And if you're standing up, if you put your hands on the front and the back, that's how narrow it is. And if you lean back, it's even narrower. But if you come forward and squat down [it is wider]. And they were like, "Wow." You know, because what do we do traditionally? We put women flat on their backs in stirrups, which is not the ideal position to give birth in. So it's kind of counter.

JM 34:37
So you're giving these tangible examples. Can you remember other things that you were teaching in those classes beforehand?

HM 34:49
Stuff about shoulder dystocias. How to handle emergencies. And one of the best ways to deal with shoulder dystocia is to get a woman on her hands and knees, because then the pelvis opens up and the baby comes out. Because that's an obstetric emergency.

JM 35:06
And is that when the shoulders..

HM 35:10
The head comes out and the shoulder won't come out. And you can put your hand in and you can move the baby. Like, it's not comfortable. But if you can flip the woman over, get her on her hands and knees, that usually dislodges the shoulder too.

JM 35:26
But that sounds like a delicate maneuver that you have to teach, too.

HM 35:29
Little things that midwives take for granted.

JM 35:33
I'm really interested in this because it sounds like such an intimate thing to be teaching somebody, while at the same time having a patient who is probably in pain or who is nervous. So how would you sort of pay attention to all of these things at the same time?

HM 35:48
Well, the patients knew that this was a teaching class. And they were used to that model of care. So I don't know anything specific. But that made it easier.

JM 36:02

The tangible nature of it sounds really interesting. Any memorable stories of working with people in that birth setting who were medical students?

HM 36:19
So we also had the emergency room residents. And two women came in in very active labor at the same time. And so I sent one of the ER residents to go check the one lady, but when I sent him in there, I knew. Because she was going [makes a moaning sound]. And he came out and I'm like, "What's going on?" He said, "She's two centimeters." And I said "No, she's not." He felt the fontanelle. The head was coming out. That baby was being born, in triage. But he went like that [imitates cervical check] and said, "Oh, it's two centimeters." But she was giving birth when we walked back in.

JM 37:01
That's a teaching moment for them. How did this model differ from your experience at a birth center? And do you want to talk a little bit about what it was like working there?

HM 37:12
Well, I mean, it was night and day. You know, the birth center patients, they knew what they wanted. They were very well-educated. They came in, they knew their conception dates most often. So, that was a great way to come out of school. Because if somebody says "I conceived on October 10," you could go, "Oh, that's a 10 week uterus." So I got good at -- I'm really good at sizing uteri from working at the birth center. But the women, I think, that we took care of at Duke didn't have the voice and the ability to speak up for themselves like the women at the birth center did. You know, just people in health care, patients, clients, kind of thing. Well, you give over your power to this person who's going to tell you what to do. I got reported by one of the interpreters for speaking Spanish without a certificate. And so I called the interpreter's office and yelled at them for five minutes in Spanish, and they gave me a certificate. Now you have to take a test. But I'd heard the interpreter say, "No, you have to do it, because the doctor told you." And I'm like, "That's not okay. This woman is in charge of her care."

JM 38:34
So, you're in this position of trying to teach patients to self advocate?

HM 38:40
To be advocates, yep.

JM 38:42
And how were you able to do that?

HM 38:47
By teaching and discussing options. And you know, "What do you want?" Birth plans have never been one of my favorite things. One of my favorite ones I ever saw at the birth center said, "I plan to go with the flow." Because that's really all you can do [laughs]. Not like three pages of "I don't want an epidural, and I don't want an episiotomy and I don't want.." Just go with the flow. But for some people having a birth plan, you know, it's like, what do you need for these people

who are going to be taking care of you to know? You don't want your feet touched when you're in labor. Your partner does not want to be asked to cut the cord, because he'll still be a fine dad without cutting the cord. You know, just think about it, and make it personal.

JM 39:38
And then would you be having to encourage people to do these things while they're actively laboring? [HM: Usually this was prenatal]. So you would know most of your clients from their prenatal care?

HM 39:52
A good portion of them. I think in the MFM [Maternal Fetal Medicine] office with nine midwives, and I don't know, 13 attendings? It was a lot. You didn't have a whole lot of continuity of care.

JM 40:09
Did clients or patients usually have one provider who they stuck with through the course of [prenatal]? [HM: No]. Okay, so they rotated through. So you might know someone a little.

HM 40:20
Unless somebody was "specialing" them.

JM 40:23
So being with Duke Midwifery Service, what other activities were you involved with? So you had your day-to-day clients, you had attending births, you had this education, you had training with new doctors.

HM 40:43
I was often at Lincoln, occasionally in the MFM office, and often in triage, from six [a.m.] to six [p.m.]. I don't know if it ever changed. But when I was there those five years, we never had midwives after six. So it was just the 12-hour thing. Which I always thought was unfortunate that they couldn't figure out how to have 24 hours.

JM 41:11
Amy talked about that same thing. So can you tell me a little bit about each of those settings? So Lincoln, and then Maternal-Fetal-Medicine and triage, can you tell me a bit about what your activities would be in each of those spaces? Lincoln would be Centering, right?

HM 41:25
Well, Centering and also individual [care]. It wasn't just Centering. Because not everybody wanted to do it. The MFM group was often really high-risk people, you know. Twins and triplets and birth defects and diabetics. So it was a lot more complicated than just normal, healthy pregnancies. So it was not my favorite place to be. I had a patient on my schedule one day who was there for an IUD, and I had only done Paragard which are the 10-year copper [IUDs]. And she said when I went in the room and we were talking, "Oh no, I want to do the Mirena." And I'm like, "Oh, okay, well I haven't done one yet. I'll go get one of the doctors to come in and we'll

do it together." So I went out and the attending that was there -- who was a wonderful, wonderful woman. The attendings were so great. I loved those guys. I miss some of them a lot. But anyway, I went out to this attending and I said, "The patient wants a Mirena, and I've never done one." And she grabbed a sample and she said "you just go [doot doot doot noise]." I went back into the room and I said, "I've been [inaudible - inserviced?]" I should have never told her I'd not done one before. But it went in and it was all good.

JM 42:47
That's great. Good to hear, for them. So were you working at Durham or Duke Regional?

HM 42:56
I've never worked at Durham [Just Duke]. I don't know when they actually started doing birth there, but I never participated in that.

JM 43:13
Okay, that makes sense you were [working] with the school. So that is a big healthcare setting. Can you talk a little bit about some of your usual colleagues, and maybe mentors or mentees that you had during that time?

HM 43:29
Well, the group that was there -- well, Janet Fields. When I left the interview -- the interview was not an interview when I got interviewed at Duke. It was basically, "Welcome to the team." And they needed another midwife. And as soon as I got to the parking deck, I'm like, "Janet, you need to call Amy." Because she had been at the birth center with me too. So her and Barbara and Amy and Sue. We had a good little group there for a while.

JM 44:00
And can you tell me people's last names so we have them for the interview?

HM 44:04
Kim Dau, Amy MacDonald, Janet Fields, Sue [Susan Holliday], I can't remember her name, but she was retired army. Can't believe I can't think of her name. She's my friend on Facebook. I could find her on Facebook. Barbara [Roberman].

JM 44:23
And what were your working relationships like?

HM 44:27
Oh, we got along really, really well. We would have our meetings. Maria [Valentin-Welch] -- I'll have to find her last name too -- she came from Boston. She's Puerto Rican. But we'd have meetings once a month, and one time we were at Amy's house, and we've had several new midwives start. And they said something about, "The people down here can't drive." and I said, "Raise your hand if you're from here." Like, we're not on the Jersey Turnpike. And if they say it's going to snow, get you some milk and bread [laughs]. Because I'm so Southern, even though I grew up all over the place. I'm protective of it.

JM 45:17
Yeah. So you would see each other once a month?

HM 45:23
More often than that, too, but we just had bigger meetings. Part of this is a blur because it's been almost 15 years, right?

JM 45:34
Would you be at the hospital at the same time?

HM 45:39
There were usually two of us. One was on the floor, and one was in triage.

JM 45:43
So you might not see each other very much during this shift.

HM 45:49
No, we would see each other. Occasionally, we even got to have lunch together. That was Janet Fields and I. One of our sayings was, you know, when you say, "How was your day?" "I had lunch, and nobody died." Because it was a big change from the birth center.

JM 46:05
And were you able to sort of talk about your different experiences as you were going through, Like if there was a loss or something? [HM: "Oh yeah"]. What can you tell me about those kinds of conversations?

HM 46:20
I'm not sure what you mean.

JM 46:22
I'm curious, would you be talking at lunch and say, "You know, this really difficult thing happened today." Like, did you have the time and the space to really like debrief about the things that were going on that might be challenging?

HM 46:35
Probably not as often as we needed to. But definitely we spoke, or on the phone later or whatever.

JM 46:44
And did you have people that you considered mentors at this time?

HM 46:50
Well Amy, for sure was. And Sue.

JM 46:56
And what kind of advice would they give you?

HM 46:59
There wasn't really a lot of advice-giving?

JM 47:03
So listening? [HM: Yeah]. What else would make them sort of in that mentor role to you?

HM 47:16
Well, Amy, because she knew the system. And that was not something I had ever even imagined that I would be part of so watching the way she navigated the politics and stuff.

JM 47:36
And then what about you, as you started to serve a [mentor] or an encouragement to other people coming into your field. What did you try to offer to them?

HM 47:50
Well, I mean, people -- and it's mostly women that go into midwifery -- have basically the same mindset. I mean, the motto of the American College of Midwives is "listen to women". And so I never felt like I was anybody's mentor, I was just there working, and friends, and support.

JM 48:12
Okay. So maybe that word doesn't work, but it does sound like it was a community. Or that you maybe have several different communities going on at the same time in this field. So the midwifery kind of model of care within a hospital setting, how did that play out on the day-to-day with prenatal care and births and post-postpartum care?

HM 48:41
Well, just something as simple as not breaking down the bed. You know, just women giving birth in a bed that wasn't taken apart with stirrups. That was not normal when we started there. I think, and there's science that says that women who have a doula have less epidurals and less cost in their pregnancy and labor. And I know that's the same with patients who have a midwife. Because if you've got somebody there at your bedside going, "You got this, you're doing great." You know, just that encouraging. It works.

JM 49:26
And how long were you with Duke? [HM: Five years.] And then why did you decide to leave, or what moved you on to the next thing?

HM 49:36
I was 50. And I was actually at a music festival with lots of dance. And the medical director at Piedmont [Health] had known me when I worked at the birth center. And she said, "Helen, don't you want to come back?" And so it was less hours, more pay, and less stress [laughs]. And I thought "This is a good time to change." Running triage, we were really, really busy. We put a lot

of miles on our shoes. So then to come into a clinical setting and less stress, and more money and working -- it was like my dream job to come work with mostly Spanish-speaking women and low-risk [clients].

JM 50:34
Yeah. It sounds like the busyness of the previous position, was it challenging for you? [HM: "Oh yeah."] How did you make sure that you were able to give it the care that you wanted to give while also running around, frantically, maybe at times?

HM 50:53
There were enough people there, between the residents and the attendings. It didn't seem that that frantic, unless you had three people coming in pushing to triage at the same time. You probably know this, but in a hospital, if you cut your foot and you're more than 20 weeks, they send you to Labor and Delivery. And we're like, hey. Our sutures dissolve, we need sutures too. So it was really actually a great step to get to the job I'm in, because triage [includes] "Why are you here, what are we doing, let's get you out." And so when I have a patient every 20 minutes now with -- we have a lot of diabetics and hypertensives in my clinical setting now. You can't come into a clinic appointment and have 10 problems, we can deal with three of them, and then you can come back. So triage helped me a lot with that.

JM 51:51
And you mentioned earlier that you had worked with an interpreter in some of these settings at Duke, is that right?

HM 51:58
So when I first started, the interpreters were always available. And they would come, and it was mostly if the doctor had called. I never called an interpreter. But the doctors would call and I would just be there listening. That was when I would go, "That's not what the doctor just said." Or that situation where she was told she had to do it because the doctor said so. That's not interpreting.

JM 52:27
So quickly after that you called them and were able to get the certification.

HM 52:35
No, no, they called me, because I got reported.

JM 52:37
I see. And so then from then on, you were managing that role of being maybe an interpreter, as well as a provider?

HM 52:46
No, I just always communicate with my patients if they speak English or Spanish. I never used an interpreter.

JM 52:53
But if you had another provider in the room?

HM 52:57
I wouldn't do the interpreting. I would call an interpreter.

JM 53:01
Oh, okay. Thank you for explaining that.

HM 53:02
Yeah, they would overhear me talking to patients, the interpreters. Whoever the two were that reported me.

JM 53:10
So if you had a resident in the room who didn't speak Spanish, you would also have a translator there. Or would you be telling them, "this is what we're doing." [HM Yeah."] So it's sort of dependent on the person?

HM 53:22
Right, if there was a complicated consent that needed to be signed [then it was] the official interpreter, I was not an interpreter.

JM 53:32
Okay. That's helpful. Anything else about working in the Duke Midwifery Service that you feel like it's important to preserve on the record. Oftentimes, when we put the recorder off, that's when people say, "Oh, I've got this great story." But is there anything that stands out for you from your tenure there?

HM 53:51
No. I mean, my favorite story, the one I started with [**2 second restriction - description of case outcome mentioned earlier**] "Where was the midwife?" I felt personally respected by the attendings, you know? I felt like we were colleagues. And that was a really nice thing. I don't know if all the midwives that went through Duke felt that way. But that was my experience.

JM 54:17
Well, doing an oral history, it's all about your experience. Thank you for spending this time with me. Anything else that we've missed that you'd like to mention?

HM 54:30
I don't think so. I am just glad I got to work there. And I'm really grateful for how it prepared me to be in this job that I think was the job I was meant to do.

JM 54:43
That's wonderful. And as I'm looking at my questions, I did have one last thing that I wanted to ask you, what's been the most satisfying moment or experience of your career in midwifery?

HM 54:58
Oh, they're too numerous, I mean, mostly -- and this is really kind of selfish. I get so much love for my patients and always have. Even when I was a student they were like, "Where's Helen?"

JM 55:20
I think I have something like that down here. I'll read to you what Amy said from her interview she said, "Helen is a 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 she and I really got the party started with group care at Lincoln Community Health Center. Her Spanish is impeccable and she's beloved by her patients."

HM 55:46
Yeah, that'll make me cry, too [laughs].

JM 55:47
Well, thank you so much.