

“That mountain is like a drugstore:” Knowledge and Medicine in Southern Appalachia,  
1900-1933

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Thesis submitted to the faculty of the Virginia Polytechnic Institute and State University  
in partial fulfillment of the requirements for the degree of

Master of Arts  
In  
History

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May 9, 2018  
Blacksburg, Virginia

Keywords: medicine, health, knowledge, Prohibition, Appalachia



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ABSTRACT

This thesis is about how knowledge in professional medicine and folk medicine changed during the early twentieth century in Southern Appalachia. I define Southern Appalachia as the mountainous regions of Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, and the state of West Virginia. I argue that although historians of medicine tend to understand the relationship between professional medicine and folk medicine as a competition--with Appalachian folk medicine as a loser to or victim of professionalization--the two forms of medicine are best understood as systems of knowledge that collided during the first three decades of the 1900s. This collision shaped healthcare in Appalachia for the next century, as concerns over the high cost of professional medicine and accessibility to licensed doctors carried forward through the 1900s and into the twenty-first century.

Using interviews, recipes, medical society journals and administrative records, and other archival materials, I trace the changes in medicine in Southern Appalachia as shifts in how people learned, shared, and used the knowledge of folk medicine and of professional medicine and as a shift in trust. Appalachian folk medicine did not simply decline and it did not disappear. Instead, people decided to trust professional doctors as legitimate medical experts and Appalachian folk medicine transformed from a system of learned, shared, and used knowledge to a system that prioritized communication over practice.

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GENERAL AUDIENCE ABSTRACT

This thesis argues that although historians treat the relationship between professional medicine and folk medicine in Southern Appalachia as a competition and place Appalachian folk medicine as a victim of professionalization, the two forms of medicine are best understood as systems of knowledge. Through interviews, medical journals and administrative records, medical school records, and other archival sources, I trace how gender, race, and class shaped knowledge in Appalachian folk medicine and professional medicine during Prohibition and the early twentieth century. Despite the characterization of folk medicine as a victim to professionalization, I find that people in Southern Appalachia actively understood and engaged with shifting ideas of health and constant concerns over the high costs of medicine and limited accessibility to doctors throughout the twentieth century.

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## **Introduction**

During the early decades of the twentieth century in Southern Appalachia, two different systems of knowledge increasingly came into contact as people in the region navigated major changes in American health care. The first system consisted of traditional and adaptive knowledge, consolidated by people who lived in communities near the Appalachian mountains over generations, expressed through home remedies and recipes that incorporated a mix of indigenous plants and other locally available resources. My argument explores this system, popularly understood by historians and non-academics as Appalachian folk medicine, through the ways that gender, race, and class shaped how people learned, shared, and used folk medicine during the Progressive Era and especially Prohibition, which disrupted the production, distribution, and consumption of moonshine whiskey--a key ingredient for various home remedies.

The second system of medical knowledge I examine went through major changes in the late nineteenth and early twentieth century as part of a process of professionalization. In the midst of Progressive Era reform movements and industrialization in Southern Appalachia, another group of healers practiced what Paul Starr refers to as “modern medicine,” which relies on a system of specialized knowledge about disease and practices according to specific rules. These physicians pushed for public recognition and acceptance of their specialized knowledge about germs, disease, and medicine as the best, or most legitimate, form of health care in the United States. Their efforts to accomplish that goal, as my research demonstrates, revolved around learning, sharing, and using their knowledge through medical education reform, the organization of national, state, and local medical societies, and the heightened authority of medical licenses as state-sanctioned approval of professional medical knowledge.

These two worlds of medicine coexisted in Southern Appalachia--defined as the mountainous regions of Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, and the state of West Virginia--but increasingly came into contact as the professionalization of medicine took hold in the mountains. The collision between these two systems of knowledge occurred as a transition of power and trust, as people in Southern Appalachia gradually accepted the authority of professional, licensed physicians with medical degrees. The decision to trust professional doctors was not unanimous or all encompassing, and folk medicine in Appalachia persisted through professionalization and throughout the twentieth century. The system of knowledge in folk medicine, however, underwent a dramatic shift that historians typically portray as a decline or disappearance. People used folk remedies in Southern Appalachia less as the twentieth century progressed--but they also kept their system of learning and sharing folk medicine intact by passing the knowledge on to new generations.

I argue that although historians of medicine tend to understand the relationship between professional medicine and folk medicine as a competition--with Appalachian folk medicine as a loser to or victim of professionalization--the two forms of medicine are best understood as systems of knowledge that collided during the first three decades of the 1900s. This collision shaped healthcare in Appalachia for the next century, as people in the region carried concerns over the high cost of professional medicine and accessibility to licensed doctors forward throughout the twentieth century and into debates over health care in the twenty-first century.

There are three key contextual components that influenced professionalization of medicine and the shift in Appalachian folk medicine: progressivism, industrialization or modernization, and Prohibition--both the state-wide and federal legislations that criminalized the consumption of alcohol. Each of these components overlapped in terms of public health. Public

health reform came through strongly during the Progressive Era, as people navigated new ideas about medicine, hygiene, germs, and the spread of disease. With public health at the forefront of progressivism, professional doctors had popular momentum on their side in their efforts to become legitimate health experts in American society.

The industrialization of Southern Appalachia, marked by the development of railroads and the coal mining boom of the late nineteenth century, brought new opportunities for professional doctors in the region in the form of potential patients. As more licensed physicians moved into the mountains in order to set up their own practices--some as individuals, but also those hired to work for coal companies--doctors worked to gain the trust of people in Appalachian communities in order to build their number of patients. They marketed their specialized knowledge as justification for that trust and positioned themselves as the rightful stewards of public health. Physicians constructed an image of authority based around their knowledge as effective, modern, and scientifically advanced--all characteristics emphasized by industrialization by the early twentieth century.

Prohibition, though largely understood by historians as a matter of law and taxes, had a profound ramification for the professionalization of medicine and the practice of Appalachian folk medicine. I approach Prohibition--defined as state and federal legislation that criminalized the consumption, production, and distribution of alcohol during the early 1900s--as a public health reform because the Volstead Act, which outlawed alcohol at the national level, specifically granted professional doctors the right to prescribe whiskey. By granting professional doctors power over the use of a controlled, illegal substance, the Volstead Act marked the federal recognition of professional doctors as legitimate authorities over Americans' health.

Professional doctors were not the only ones who used alcohol for medicinal purposes. In Southern Appalachia, Prohibition disrupted the practice of folk medicine by criminalizing the consumption of moonshine, a form of corn-based whiskey made by individual Appalachians operating outside of regulations that taxed alcohol production. In folk remedies for a variety of ailments including coughing and yellow jaundice, Appalachians used moonshine as a basic ingredient in tinctures and teas. Though the production and distribution of moonshine were already illegal before Prohibition, enforcement of state anti-alcohol laws and the Volstead Act heightened the policing of moonshine production and distribution and therefore disrupted a local resource for Appalachian communities that used whiskey for medicinal purposes.

The professionalization of medicine rippled across the Appalachian mountains into rural communities. The people who lived in Southern Appalachia integrated professional medicine into their lives and although they used folk medicine less, they continued to communicate their knowledge throughout generations. This shift--from a system of medical knowledge that people learned, shared, and used to a system that emphasized learning and sharing over using--happened because of professional doctors' efforts to cultivate their image of authority in order to win the trust of potential patients in Appalachian communities.

### **Important Definitions and Discourse**

I use specific definitions for professionalization, professional medicine, and folk medicine derived from literature on the history of medicine and Appalachian Studies. Paul Starr defines professional medicine as “an elaborate system of specialized knowledge, technical procedures, and rules of behavior,” and my argument adheres to this definition. I emphasize that specialized knowledge informs these procedures and rules of behavior. However, Starr's definition of professional medicine does not address the context of specialized knowledge differs



from the context of knowledge in Appalachian folk medicine. Working from his definition, therefore, is not enough.

My definition of professional medicine, especially the emphasis on specialized knowledge, addresses context-based and context-free knowledge in the style of Anna Lowenhaupt Tsing, from *The Mushroom at the End of the World: On the Possibility of Life in Capitalist Ruins*. Tsing's focus on vernacular or context-based knowledge brings another dimension to Paul Starr's definition of professional medicine by looking specifically at how communities engage knowledge through their environments. In my argument, Tsing's vernacular knowledge applies to folk medicine in Southern Appalachian communities because Appalachians integrated knowledge from their environment and from each other into their system of health. Professional medical knowledge fits into Tsing's discussion of context-free knowledge, meaning knowledge applied universally or on a larger scale than local, community-based knowledge. Professional doctors in Southern Appalachia applied their knowledge--which reflected knowledge in professional medicine across the United States--to a broad range of people and places.

I use "professional" as my term to highlight the efforts licensed and collegiately educated doctors undertook to reform their field. By the emergence of the twentieth century, doctors in the United States had a model of professionalism to follow that revolved around medical licenses, medical degrees from accredited institutions, and organization as a body of peers obtained through membership to state and local medical societies. Although doctors still needed this label of "professional" to be realized by their patients and potential patients (i.e. "the public"), they already considered themselves to be in possession of specialized knowledge and experience. These men saw themselves and each other as professionals--but sought further reform,

regulation, and professionalization of their field in order to convince other people that they were indeed professionals.

Sandra Barney provides a definition of professionalization as a transformation of an occupation from a product to a service. In order to achieve the status of professional in Appalachia, Barney argues, “physicians had to consolidate and agree on an accepted body of knowledge, construct institutions and agencies to formulate and evaluate credentials, and secure recognition as the only agents who could authoritatively speak to or about their field.” In medicine, professionalization consisted of efforts to establish academic departments, professional societies, and scholarly journals--efforts centered around raising and organizing standards of knowledge for physicians.

I define folk medicine according to anthropologist Anthony Cavender’s work because historians tend to define folk medicine as an inferior form of healing. Cavender, defines folk medicine as “vernacular knowledge about the cause, prevention, and treatment of illness used by a particular social group.” John Burnham’s definition of traditional medicine encompasses Appalachian folk medicine: “The most basic [element of Euro-American traditional medicine] was a set of miscellaneous, unorganized recipes for ‘cures’ for all of the pains and miseries that constituted sickness.” Remedies in Appalachian folk medicine technically match this definition. However, Burnham demonstrates the problem with historians’ definition of folk medicine: he not only ignores the structured system of knowledge in folk medicine by describing remedies as random and disorganized, but he also diminishes the value of home remedies to the people who used them by referring to folk recipes as ‘cures.’ This definition erases the value that Appalachians invested in folk medicine during the early twentieth century. Therefore, my

research uses Cavender's definition of folk medicine but acknowledges that professional medicine worked better than folk remedies in treating disease.

My definition of knowledge depends on a system of learned, shared, and used common or information about one topic or related topics. This system is built collectively by group of people, whose shared knowledge reinforces their sense of community. In this thesis, there are two such groups: professional doctors and people in rural Appalachian communities who knew about folk medicine. Cavender rightly argues that there is a misconception about who used Southern Appalachian folk medicine knowledge and methods. The knowledge was used by people in urban or more populated areas of Appalachia as well as people in rural Appalachia. My definition of knowledge is also informed by Kenneth Ludmerer, who asserts that knowledge is not static and unchanging, but grows and evolves over time.

These definitions are not complete without understanding the connotations of the words "professional" and "folk." These two words play a major role in conceptions of both forms of medicine. "Professional" carries the weight of an image of authority that educated and licensed doctors worked so hard to cultivate during the Progressive Era. "Professional," in the context of the early twentieth century, means that this form of medicine uses the best scientific knowledge in the most effective, progressive way. Professional medicine, therefore, is at the highest tier of medical knowledge in American society.

"Folk," on the other hand, carries different connotations in the context of the early twentieth century. "Folk," a term that originated in the early twentieth century from academic studies of culture as part of scholars' efforts to define modernity and expertise, can be interpreted as a negative label, or at least one that is not taken as seriously as "professional." In order to categorize different groups of people and distinguish between systems and practices, scholars

tied “folk” as a label to people like Appalachians and their community practices as foils to what scholars understood as enlightened modernity. In this context, “folk medicine” is not as effective and therefore not as good as professional medicine.

As part of the process to enlightened modernity, scholars and reformers in the early twentieth century tied “folk” to what Barbara Kirshenblatt-Gimblett refers to as thresholds of shame. As scholars categorized culture into the archaic and the modern, “folklore” became the study of cultural practices designated as distant enough from modernity and progress-- transforming practices like folk medicine into cultural artifacts that were no longer sources of shame, but nostalgia and heritage. Kirshenblatt-Gimblett elaborates: “What one was too ashamed to do, one could study, collect, and display.” This distillation of practices like Appalachian folk medicine into static artifacts of heritage by twentieth century scholars contributed to the tension in definitions of professional medicine and folk medicine, as professional medicine became the default model of health and folk medicine in Appalachia shifted to communicated knowledge.

However problematic the terms of “professional” and “folk” may be, I use them both because they are recognizable and because both terms appear in the primary evidence and the historiography of American medicine during the twentieth century. “Professional,” as my category of choice, specifically reflects the way that doctors in the early twentieth century understood themselves and demonstrates how these men wanted other people to see them as well. Although professionalization was an ongoing process at this time, physicians of the twentieth century followed a model of professionalism, established by their predecessors in the nineteenth century. This model reinforced the path from medical educations to medical degrees to membership in medical societies.

“Folk,” as my main category for community healing in Southern Appalachia, reflects the construction of meaning linked with authority surrounding the professionalization of medicine in the region. Instead of advocating for another label, I use “folk” to highlight how historians of the professionalization of medicine developed definitions of opposing ideas in order to demonstrate that professional medicine was and remains an “enlightened” modern model of healing. In line with scholars like Anthony Cavender, I present “folk” as a label worthy of use and worthy of better definitions that incorporate emic understandings of communities.

### **Argument and Significance**

My argument depends on the different ways that professional doctors and people in Southern Appalachian communities learned, shared, and used knowledge about health, sickness, and medicine. Physicians organized the professionalization of their field around specialized knowledge by cultivating a system of medical colleges and universities, state and local medical societies, and medical licenses. Medical colleges redirected their curriculum from textbooks and lectures to focus on experiential learning in teaching hospitals and clinics. Members of medical societies at state and local levels in Southern Appalachia focused on raising boundaries around their authority through delegitimation campaigns against alternative practitioners such as chiropractors. Medical licenses gained weight as state-sanctioned symbols of professional doctors’ authority--over the course of the early 1900s, doctors increasingly needed medical degrees from accredited schools in order to acquire a license to practice. These doctors intentionally projected their expertise into an image of authority that reflected their system of learning, sharing, and using knowledge and prioritized the authority of licensed white male physicians.

Professional doctors effectively used their knowledge to claim authority through their knowledge system of schools, societies, and licenses. Their organized, vertical system was key to their campaign for legitimacy as state-approved health experts in the United States. Appalachian folk medicine, in comparison, depended on a decentralized, horizontal system of knowledge that emphasized sufficiency rather than expertise and flexibility over upward hierarchy.

In the early decades of the twentieth century, folk medicine in Southern Appalachia revolved around interactions between gender, race, and class in the process of learning, sharing, and using folk medicine knowledge. In the interviews that make up a large portion of my research, people overwhelmingly credit Cherokees in the southeastern United States as the original source of learning in Appalachian folk medicine. Several interviews point to a gendered distribution of knowledge that required men to share their knowledge of folk medicine with women and women to share what they knew about healing with men, which guaranteed access to the folk medicine system for both females and males. The constrictions of class in the early twentieth century echo throughout this system, as people in Appalachia grappled with high costs for professional treatment and limited accessibility to licensed doctors. These concerns, like the system of learning and sharing in Appalachian folk medicine, persist today.

As people in Southern Appalachia gradually accepted professional doctors as experts in the early twentieth century, the practice or use of folk medicine in the region declined. However, Appalachian folk healers and folk medicine are not victims of professionalization. Instead, people in Southern Appalachia adapted their knowledge about health to reflect professionalization and continued to pass down their knowledge to new generations throughout the twentieth century.

The changes in professional medicine and Appalachian folk medicine matter because this system of folk knowledge persists in the region today--as do concerns about the accessibility and cost of professional healthcare. However, historians define folk medicine in opposition to professional medicine by painting this system of health as an outdated mode of healing that declined in the face of professionalization. By understanding the way people in Appalachia used, shared, and learned folk medicine knowledge in the early twentieth century, historians can construct a new definition that recognizes folk medicine as part of ongoing debates about healthcare.

Rather than interpreting the acceptance of professional medicine by Appalachians as the decline of folk medicine, I find that professional doctors and Appalachians who subscribed to folk medicine engaged in a transition of power. People in Southern Appalachian communities decided to trust professional medicine and the authority of licensed doctors, yet reserved folk medicine as a system of knowledge worthy of continued communication in the face of problems with high costs and limited accessibility that stayed with professional medicine throughout the twentieth century.

### **Evidence**

In order to trace the transformation of Appalachian folk medicine during the professionalization of medicine in the early twentieth century, I use a combination of archival primary sources and oral interviews. I examine the professionalization of medicine in Appalachia through medical society journals published by and for professional doctors in the region, a case study of a local medical society in Roanoke, Virginia, education records from medical colleges whose graduates served Appalachian communities, and interviews with Appalachians treated by professional doctors during this time period. I also use state and federal legislations like the

Volstead Act and medical licensure laws to establish how professional doctors claimed authority through knowledge.

In order to demonstrate the roles of medical colleges and medical societies in the process of professionalization, I construct two case studies in professional doctors' education and organization during the early twentieth century. Through a case study of a local medical society in Roanoke Virginia, the Roanoke Valley Academy of Medicine, I examine how physicians shared specialized knowledge with their peers activities during the first three decades of the 1900s in the first chapter. I continue my study of the Academy in the second chapter as a demonstration of localized efforts to delegitimize alternative practitioners--in this case, members of the Roanoke Valley Academy of Medicine pursued multiple campaigns against local chiropractors--and the growing importance of medical licenses as proof of professional doctors' specialized knowledge. I supplement and support this case study with medical journals from states in Southern Appalachia.

The second case study, that of the medical school at the University of North Carolina in Chapel Hill, shows how professional doctors learned specialized knowledge in new ways during the early twentieth century. This study emphasizes the role of experiential learning and hospitals in medical education in the first chapter. In the second chapter, I use the University of North Carolina to expand on education's role in medical licensure and the relationship between knowledge and authority.

As for sources on folk medicine, I have approximately fifteen interviews with people in Appalachia who learned, shared, and used vernacular knowledge to treat poor health in their communities during the early twentieth century. The oral interviews make up the majority of my



primary sources on Appalachian folk medicine. I supplement them with recipes and remedies that demonstrate the consistency of this knowledge.

As people in Southern Appalachia decided to trust professional doctors, their system of knowledge in traditional healing shifted to reflect their acceptance. This acceptance, grounded in the interactions between professional medicine and folk medicine in the early twentieth century, comes through in language used by Appalachians to communicate folk medicine knowledge throughout the 1970s, 1980s, and 1990s. I analyze this language through three case studies of people interviewed about their knowledge of folk medicine--Joe Aliff from West Virginia, and Flora Youngblood and Mary Jane McCoy from northern Georgia--supplemented with fifteen other interviews with Appalachians and recipes for home remedies.

Although the interviews were not conducted in the early twentieth century, each person who contributed to the interviews learned, shared, and used Appalachian folk medicine knowledge in the context of the twentieth century. Joe Aliff, whose interviews was conducted for the Library of Congress in 1995, learned about remedies and plants from his mother, who learned and used this knowledge during the early twentieth century with Aliff's grandfather. Flora Youngblood, interviewed by Foxfire students in the 1980s, learned and used folk medicine and faith healing from her father Henry Cantrell, who was an Appalachian herb doctor at the turn of the twentieth century. Mary Jane McCoy, also interviewed by Foxfire students in 1986, learned and used folk medical knowledge passed down from her mother during the early twentieth century. The other fifteen interviews, conducted in the 1970s through the 1990s, echo the experiences and perspectives of these three people.

Although using interviews conducted decades after the 1930s--interviews that I did not conduct--appears problematic or ill-advised, these sources actually reinforce my argument that

folk medicine did not simply decline in Southern Appalachia but transformed. The memories of Flora Youngblood, Joe Aliff, and Mary Jane McCoy connect the knowledge system of Appalachian folk medicine from the early 1900s to the system that persisted after the professionalization of medicine. Not only does their knowledge matter as proof that folk medicine remained valuable to Appalachians, but their interviews are strong examples of how folk medicine operates as a system of knowledge that emphasizes learning and sharing. By participating in these interviews Youngblood, Aliff, McCoy, and others like them shared their knowledge with new people and guaranteed that the system of Appalachian folk medicine knowledge continued.

### **Historiography**

Historians tend to treat folk medicine and professional medicine during the early twentieth century as separate entities, with limited examination of interactions between the two. Scholars of Western medicine agree that there was a dramatic shift in medicine that started near the end of the nineteenth century and gained traction in the early decades of the twentieth century, resulting in the rise of professional medicine as the dominant form of healthcare in the United States.

Paul Starr centers his argument around this shift in *The Social Transformation of American Medicine*. Starr explains that for most of the nineteenth century, professional doctors were unorganized as a body and financially insecure, with no control over the standards that regulated the quality of professional care. However, as Starr demonstrates, physicians in the twentieth century turned their practice into a powerful, profitable profession that structured American medicine to consolidate their authority. As the twentieth century progressed, licensed and collegiately educated doctors followed a path to professional status. This path included

significant steps for doctors such as earning a medical degree from an accredited university or institution, passing a state exam to obtain a medical license, and joining a state or local medical society. Starr places the authority of the medical profession as dependent on knowledge. He also directly ties the rise in authority for professional doctors to the cultural triumph of Progressive Era reformers and argues that the success of professionalization is inseparable from the influence of progressivism.

Other scholars in the history of Western medicine adhere to the progressive narrative of professionalization. In *Health Care in America: A History*, John C. Burnham situates medicine and health as heavily influenced by the Progressive Era, which lasted as the backdrop to the professionalization of medicine from the end of the nineteenth century into the 1930s. According to Burnham, progressive reforms in medicine had two goals: raising minimum standards in medical education, to ensure higher-quality knowledge, and tying medical schools to university-level research in order to “make the best medical care even better.”

Kenneth Ludmerer places the professionalization of medicine in the broader context of academic professionalization, which happened in response to progressive reform. According to Ludmerer, educated, affluent Americans in almost every academic subject sought to professionalize their fields during the early twentieth century. Ludmerer traces the rise of professional medicine through medical education. He argues that American medical education evolved from the worst in industrialized civilization to the best education for professional doctors during the turn of the century. This process, from the worst education to the best, was largely a response to Abraham Flexner’s 1910 report on conditions in American medical colleges and incorporated experiential learning in hospitals and clinics as curriculum in medicine shifted away from textbooks and lectures.

Like progressivism, the related processes of industrialization and modernization are key themes in the history of medicine. John C. Burnham emphasizes the role of modernization-- which he defines as innovations in organization and technology that emerged in medicine during industrialization--as the source of fundamental changes in the professionalization of medicine that took place in the late nineteenth century. Kenneth Ludmerer traces modernization through changes in medical education, most notably the rise of the hospital as the symbol of not only medical education, but professional medicine as a whole. Hospitals, he argues, depended on modern science and technology that were tied to industrialization and modernization.

The history of medicine in Appalachia follows the trends in scholarship that focus on progressivism, industrialization, and modernization as the major contributors to the professionalization of medicine. There are two major publications on medicine in Appalachia during the early twentieth century: Sandra Lee Barney's *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930* and Anthony Cavender's *Folk Medicine in Southern Appalachia*. These two works also reflect the pattern of separation between historical studies of professional medicine and of folk medicine.

Sandra Barney traces the process of professionalization in Appalachia through the lenses of gender and class, but she situates her discussion firmly in industrialization. She argues that industrialization projected Appalachia into a new position that offered professional doctors new opportunities to establish themselves as upper middle class experts on health. Barney specifically points to industrial projects such as the development of railroads and the coal boom in Appalachia as contributors to the professionalization of medicine in the region. As coal mining profited and expanded in Southern Appalachia, coal companies essentially set up their own communities for their workers and hired professional physicians to treat them. Similarly to Paul

Starr's interpretation of physicians' social and financial anxiety, Barney explains that doctors in Appalachia had strong motivations to facilitate the professionalization of their field--motivations that revolved around making a profit and solidifying their authority. Coal communities specifically provided professional doctors with the chance not only to make money, but to "redefine their professional identity."

Cavender also grounds his study of Appalachian folk medicine in changes in American society brought about by progressive reform and industrialization. He points to a remarkable transformation in medical knowledge that took place from 1880 to 1910, a shift that emphasized germ theory over previous schools of thought in medicine such as miasmatic theory and humoral pathology. Cavender also ties this shift to changes in medical education and the growing authority of state licensing boards, illustrating the organizational nature of professional medicine. However, in Cavender's narrative, the professionalization of medicine exists in the background along with Progressive Era reforms and the major effects of industrialization in Southern Appalachia, while Sandra Lee Barney places these factors at the center of her research.

Beyond the context of progressivism, industrialization, and modernization, scholars in the history of medicine also agree that specialized knowledge about the causes and treatment of disease was the source of professional doctors' power--a power grounded in new ways of learning, through teaching hospitals and medical experience outside the classroom. Citing John Harley Warner, Sandra Barney explains that professional doctors derived legitimacy from their medical education, which centered professional doctors' authority as medical experts around the quality of their knowledge. According to Barney, young doctors in the early twentieth century were "determined to construct secure professional identities based on their possession of specialized scientific knowledge." John C. Burnham ties this specialized knowledge to

industrialization, which emphasized efficiency in a society that began to increasingly depend on experts at the turn of the century. Paul Starr argues that people in the United States accepted professional doctors as authorities on health because people were actively interested in health. By trusting doctors as experts with high-quality knowledge, patients supported the authority of professional medicine. According to Starr, professional doctors used that support and their specialized knowledge to transform their authority into “social privilege, economic power, and political influence.”

Historians also largely agree that race, gender, and class play important yet distinctly different roles in professional medicine and Appalachian folk medicine. Professional medicine reflected a homogenous body of knowledge that was taught and learned by, shared with, and used by white educated men. John C. Burnham observes that women physicians and physicians of color were rare and suffered at the hands of a society that valued white men, a value that was reflected in the socioeconomic status that white male doctors achieved during the early twentieth century. Ludmerer demonstrates that women and people of color found entrance to medical education much more difficult once progressive reforms and professionalization took hold in medicine. He also points out that members of the working class were consistently “denied a career in medicine because of the more rigid entrance requirements of the modern medical school.” Barney supports Ludmerer’s interpretation and centers her argument around the gendered nature of professional medicine in Appalachia.

In Appalachian folk medicine, however, race, gender, and class are not boundaries or obstacles the way they are in professional medicine. As Cavender demonstrates, Appalachian folk medicine in the early twentieth century depended on the intersection of three racial sources of knowledge: indigenous Americans (mainly the Eastern band of Cherokee from North

Carolina), African Americans, and Euro-Americans. He explains that the Appalachian version of Euro-American folk medicine has roots in Scots-Irish folk medicine and Cherokee medicine-- roots which influenced the strain of Euro-American folk medicine that spread across the United States in the eighteenth and nineteenth centuries. In my argument, I focus on Cherokee Indians as gatekeepers of knowledge for Appalachian folk medicine.

Gender plays an important role in the distribution of knowledge in Appalachian folk medicine that guaranteed women access to this knowledge, which I demonstrate in the next chapter. In professional medicine, however, historians agree that the role of gender played out as an imbalance of power. Professional physicians were typically white, middle to upper class, and male; the system of knowledge in professional medicine reinforced their authority as white men shaped the communication and use of medical knowledge and American health care. As Sandra Barney argues, the professionalization of medicine greatly disrupted the role of women in Appalachian medicine, especially the roles of midwives.

In terms of class, most people in rural Appalachian communities recognized the benefits of scientific medicine but faced difficulties when it came to paying professional doctors, which Paul Starr refers to as “the real cost of medicine.” While navigating the changes in healthcare during the early twentieth century, folk medicine offered a cheaper and familiar option to Appalachians with limited access to licensed physicians. Meanwhile, licensed doctors with medical degrees sought socioeconomic stability by asserting themselves as health experts who deserved a certain level of compensation from their patients. As professionals, doctors argued, their profits should be enough to achieve and maintain middle to upper class status.

When Appalachian folk medicine and professional medicine appear together in scholarly discussions, a pattern of winners and losers becomes clear: Appalachian folk medicine is

typically seen as a victim of professionalization, due to aggressive efforts taken by professional doctors to establish their authority. This argument is not without merit--my research supports that the practice of folk medicine in Appalachia lost ground to professional medicine. However, people continued to communicate their knowledge throughout the twentieth century.

Anthony Cavender argues that the way that professional medicine evolved--through industrialization and progressive reform--affected the way that folk medicine changed during the early twentieth century. He concludes that the establishment of professional medical institutions including hospitals, clinics, state public health agencies increased the presence of professional doctors in Southern Appalachia and diminished the knowledge and use of folk medicine. My research diverges from this narrative and instead portrays the decline of Appalachian folk medicine as a transformation, marked by a shift from a system of learned, shared, and used knowledge to a system that emphasized learning and sharing over practice.

I am not the only historian to argue that traditional forms of medicine persisted through professionalization. Burnham demonstrates that pre-industrial traditional systems of health in America persisted, but not without adapting to the dramatic changes in professional medicine. He also calls for historians to examine the changes in both forms of medicine at local and community levels--a call that my research answers through case studies of knowledge in both folk and professional medicine. In step with Sandra Barney, I argue that people in Southern Appalachia adapted their traditional system of health as part of their navigation of the dramatic changes in medicine. This adaptation facilitated the shift from practice to communication, which allowed professional doctors to exercise their authority in Southern Appalachia but also allowed Appalachians to continue their system of knowledge by sharing it with the next generation.

### **Structure of Chapters**



In order to trace the shift in Appalachian folk medicine from a practice to a preserved system of knowledge, I examine both Appalachian folk medicine and professional medicine in terms of knowledge and change. Chapter one examines the separate systems of folk and professional medicine as two different worlds of healing, each dependent on learning, sharing, and using medical knowledge. Through interviews and three case studies, I explore how gender, race, and class shaped folk medicine in Southern Appalachia as a horizontal or decentralized system of knowledge.

I apply the same lenses to professional medicine in this chapter and again rely on interviews, but also incorporate archival sources such as medical society journals, medical school records, and legislation such as medical licensure laws as well as newspapers that reflect twentieth century attitudes about public health and alcohol. These sources reveal the world of professional medicine as a vertical, hierarchical system of healing that professional doctors structured around specialized, expert knowledge. This system, though not empty of interactions between gender, race, and class, prioritized the authority of white, middle and upper class men.

Chapter two shows how professional doctors marketed their knowledge as expertise in order to gain trust of potential patients in Southern Appalachia. Using similar archival material from the first chapter, I trace their efforts to claim authority as health experts through delegitimization campaigns against alternative medicine, medical education reform, and the increased weight of medical licenses as tools of legitimacy. This chapter also explores how Southern Appalachian folk medicine shifted from a system of learned, shared, and used knowledge to a system that prioritized communication over use, as the efforts of professional doctors to win over potential patients in Appalachia paid off throughout the early twentieth century.

## **Conclusion**

The changes in professional medicine and Appalachian folk medicine matter because although professional medicine clearly became the dominant form of medicine in the United States, the Appalachian folk system of health persisted. People in Southern Appalachia passed down their knowledge of plants, remedies, and health through the twentieth century and into the twenty-first. However, historians typically define Appalachian folk medicine as the victim of professionalization. By examining the ways people in Southern Appalachia use, share, and learn folk medicine knowledge, historians can define folk medicine through its own system of knowledge instead of only filtering their definition through folk medicine's relationship to professional medicine. By defining folk medicine through the knowledge of people who used it, historians can also better understand why and how people in Southern Appalachia continue to pass down their knowledge of folk medicine.

Folk medicine in Appalachia was not a victim of professionalization. Instead, people in Southern Appalachia adapted their system of knowledge to focus on learning and sharing folk medicine while the use of folk remedies declined. Appalachians not only carried their knowledge of remedies forward throughout the twentieth century, but also their concerns over the costs of and accessibility to professional medicine. People persistently bring up these two major issues in professional healthcare today in the early decades of the twenty-first century. Therefore, my research places the changes in professional and folk medicine in Southern Appalachia as critical for understanding not only the contestations of knowledge and debates over health in the Progressive Era, but also critical in understanding debates over healthcare now.

## **Chapter One**

### **The Two Worlds of Medicine in Southern Appalachia**

It is hard to talk about folk medicine in Southern Appalachia during the early twentieth century without talking about it in terms of its relationship to professional medicine. In this chapter, I examine these two worlds of medicine according to the ways people learned, shared, and used knowledge in each system of health. In particular, I focus on how gender, race, and class shaped a decentralized system of Appalachian folk medicine in comparison to the linear hierarchy in professional medicine, projected through its system of medical schools, state and local medical societies, and medical licenses.

Folk medicine and professional medicine depended on different forms of knowledge that interacted but were still very distinct. However, during the Progressive Era, these two communities of knowledge increasingly came into contact due to educated and licensed doctors' efforts to legitimize and extend their authority. People in Southern Appalachia adapted their system of folk medicine as licensed doctors changed the way people thought about and attended to their health. As Appalachians began to trust professional doctors' expertise, the use of folk medicine declined but people continued to communicate their knowledge of plants, remedies, and health.

#### **Definitions of Knowledge in Appalachian Folk Medicine**

It is important to understand the definitions of knowledge in both professional medicine and folk medicine because these definitions rely on each other--in fact, these different fields are typically defined in opposition to each other. This definition by juxtaposition can be seen clearly in Anthony Cavender's definitions of "folk" and "popular" medicine, definitions which in turn formulate his idea of "official" medicine.

Cavender's definition of folk medicine is dependent on a certain kind of knowledge that he refers to as "vernacular." He defines this as, "Vernacular knowledge about the cause, prevention, and treatment of illness used by a particular social group...the term 'vernacular' in this definition refers to knowledge of health and illness shared by ordinary people, as opposed to officially sanctioned knowledge taught in medical schools, which in the United States is biomedicine...in terms of the cultural transmission process, vernacular knowledge is acquired informally by word of mouth in a variety of social settings and through the mass media." He continues from this definition to categorize Southern Appalachian folk medicine into two camps: the naturalistic domain and the magico-religious domain.

Cavender organizes his definition of folk medicine this way because, as he states, "Traditionally [in scholarly discourse], folk medicine has been organized into two knowledge domains: natural and supernatural...[this organization] is inappropriate." Therefore, Cavender organizes the knowledge into an emic model with the naturalistic domain (drawing from anthropologist George Foster) and the magico-religious domain, both of which overlap in Appalachian folk medicine. His model is an emic model because it specifically reflects how Appalachian people think about their knowledge of health, rather than how people who are not from the area might view this same knowledge as "supernatural," or superstitious. My research uses Cavender's vernacular definition of knowledge and specifically forms of knowledge that were distributed orally. The plant-based medicine I discuss in this chapter falls under the naturalistic domain, and faith healing methods fall under the magico-religious domain.

### **The World of Appalachian Folk Medicine**

During the turn of the twentieth century in the hills of Appalachia, people like Henry Cantrell were a necessity. From his home in the mountains of northeastern Georgia, Cantrell

carried with him a knowledge of remedies passed down from one generation and shaped by the next. Henry lived with and learned about folk medicine from Cherokee Indians, then later taught his daughter what he knew about medicinal plants and healing. This knowledge crossed the boundaries of race and gender--boundaries that largely informed the American social hierarchy and manifested in power differentials between women, people of color, and white men. Americans challenged these boundaries in the Progressive Era: the women's suffrage movement and African Americans' struggles against segregation are two examples.

Whether or not Henry was aware of his role in this hierarchy is unclear, but one thing is very apparent: Henry Cantrell knew about plants. He knew how to identify medicinal plants, he knew which herbs would cure or ease what ailment, and he knew people around him needed that knowledge in practice. Henry Cantrell was an Appalachian herb doctor.

Even as medicine experienced leaps and bounds in terms of scientific advancement and professionalization, people in Appalachian communities put work into consistent routines of community health. This was the routine people like Henry Cantrell subscribed to, one that emphasized locally available resources in areas with limited financial and geographic access to professional doctors. Henry's daughter, Flora Youngblood, described this routine as she saw it in an interview from 1984:

We had a little ole ox cart, two-wheel ox cart. My Daddy got down with arthritis so we would put him on that ox cart, my brother would drive the little ole ox cart and I would go with 'em to help him about digging 'em [herbs] up and we would go all back up them little roads in the mountains you know cause you could get through little biddy ole places, just two wheels. So I'd help him gather 'em... We would get it about twice in the

winter so we could—early in the fall and about one more time through the winter months. We gather it up and powder it up. He had his medicine cabinet almost as big as my hutch over there and little vial bottles you know and he would fix it all up and put it in there. Had everything labeled you know and could just go get it whenever anybody come.

She describes a labor-heavy process with a specific role for everyone involved, which typically meant family members working together. Her brother drove the ox cart on tiny roads, Flora and Henry got their hands dirty gathering plants, and once her brother got them all back home they had to process the plants into medicine. Youngblood's description points firmly to the relationship between family, labor, and medicine in the mountains.

Her words also place plants at the heart of Appalachian folk medicine. Although plants were not the only ingredients in the remedies people used, medicinal herbs dominated the knowledge behind the practice. For the most part, people in rural Appalachia did not go out looking for a licensed doctor with prescriptions once someone fell ill. They went looking for specific plants--or someone like Henry Cantrell, who had already collected the herbs and knew how to use them. Henry Cantrell's status as a community herb doctor reflects a version of authority at work in Appalachian folk medicine with similarities to authority in professional medicine. Cantrell's authority fits into Erika Brady's definition of experiential and relational authority, which emphasizes community accountability and horizontal traditions. As evidenced through his medicine cabinet, Cantrell's community and especially his family recognized his authority as a doctor. However, he did not carry the same institutional authority as professional doctors, who were accountable to credentialed boards and formal organizations and increasingly needed their own credentials-- namely medical licenses and medical degrees.

In twentieth century West Virginia, the routine of gathering herbs looked very similar to how it played out in northern Georgia. Joe Aliff, interviewed by Mary Hufford for the Library of Congress in 1995, describes the labor:

In the springtime, it was a common sight, every family. Now you folks would probably call it a sack or a paper bag but to us it was a poke. Well you get a poke that you carry groceries in, and a knife, and you go when the weeds start to grow. Every family would go to the fields and the woods and gather pokes full of these wild plants. And that was your granary that you had been without through the winter, and it was very healthy. And you drank your sassafrass tea or your spicewood tea. And you know, you were putting your body back in shape--it was equal to, you know, like the folks on the sailing ships they had to carry lemons or limes after they discovered scurvy.

Aliff builds on the same connections between family, plants, labor, and medicine that Flora Youngblood made in her interview. He goes even further than Youngblood, however, in his association between plants and health. Aliff specifically compares the process of gathering herbs to people who, centuries ago, found that citrus fruit prevented sailors from getting scurvy. The terminology he uses, like “granary,” “healthy,” and “putting your body back in shape” reflects a firm understanding of health in Appalachian communities.

The consistency between his account and Flora Youngblood’s is not coincidence. Gathering native plants for medicinal purposes was a common practice in the region, undertaken by families throughout the Appalachian mountains. The knowledge behind that practice depended on several factors, including the ones already mentioned: class, labor, family, and

plants. In this chapter, I answer why people in Appalachian communities needed folk medicine, explain plants as the primary content of this knowledge, and explain the role of family as the distribution network of knowledge. I also examine race, specifically contributions from Cherokees, in terms of its role in the sources or gatekeepers of knowledge and the role of gender in the distribution process.

### **Perspectives on Accessibility and Cost in Appalachian Folk Medicine**

Knowledge of folk remedies in Southern Appalachian communities mattered in the early twentieth century because many people had limited access to professional doctors, could not afford the high costs of their services, or both. In the interviews I collected, people pointed to accessibility and cost time and time again and demonstrated a firm understanding of the use of folk remedies as an affordable, familiar alternative.

Joe Aliff described natural resources of medicine in terms of institutional medicine, money, and knowledge in his 1995 interview: “That mountain is like a drugstore. You don’t have to have money you just need a little bit of knowledge.” His understanding of health echoed that of his peers: medicine can be found in the mountains if you know where to look and how to use what you find, and it is cheaper than going to see a licensed doctor. Aliff defines folk medicine by comparing the assortment of medicinal herbs in his locale to a drugstore, which shows how people in Southern Appalachia filtered their understanding of health to reflect professional medicine.

Mary Jane McCoy, a native of Georgia’s mountains, points directly to limited accessibility to professional medicine and how Appalachian people solved that problem through folk medicine:



“Old folks just had to kindly experiment with it themselves...Course, it was a miracle I reckon that they just experimented in getting that and it helped ‘em some. I don’t know what else. Course, you just learn things by experience sometimes. And that’s about what the old folks had to do. The doctors wasn’t so close to ‘em that they could call a doctor. They just had to learn, kindly, to doctor themselves.”

McCoy’s account brings a generational focus to the forefront. She is talking about a specific group of people, an older group of people, who had to figure out how to treat themselves because doctors were too far away. Her use of “doctor” as a verb reveals a connection between folk remedies and professional medicine in Appalachian perspectives of health. In these communities, people did not have to be a doctor in order to heal or treat someone’s health--in fact, people with experiential knowledge treat themselves.

Flora Youngblood’s perspective echoes McCoy. She points to limited accessibility to licensed doctors and, like McCoy, uses “doctor” as a verb: “Back then, you know, there wasn’t many doctors. People just sort of doctored themselves.” Based on these accounts as well as consistent echoes of these perspectives from other interviews, there is a clear link between the use of folk medicine, high costs of professional medicine, and limited access to licensed doctors. Using “doctor” as a verb also indicates a vernacular emphasis in Southern Appalachia on experience and practice as the basis for medical authority, rather than emphasizing officially recognized credentials or status identity--the foundations of authority in professional medicine. Through the language that Aliff, Youngblood, and McCoy use in their interviews, the influence from professional medicine in Appalachian knowledge of health and folk medicine is also evident.

## **Plant-Based Knowledge in Appalachian Folk Medicine**

Knowledge in Appalachian folk medicine revolved around local plants and herbs. This emphasis on available resources came from the same issues discussed above, a necessity rooted in limited access to doctors, high monetary costs, and geographic isolation. Multiple accounts from people in rural Appalachian communities describe the lack of doctors in the same breath with local knowledge on medicinal plants. Joe Aliff directly points to plants as the primary resource in Appalachian folk medicine and ties those resources to class-based necessity. In his 1995 interview, he says, “All medicines come from these plants out here anyway. And I’ve studied plants. It was a necessity with mountain folk, we didn’t have money to go to the doctors. You cured yourself or died, that’s bout the size of it.”

For example, in her Foxfire interview Amanda Turpin stated, “We didn’t use to have doctors too much. Whoever they thought had an immunity to what you had [would doctor you]. Then, just about everyone would get different herbs to make teas.” Teas with water and herbs as well as tinctures made with moonshine and herbs were common forms of remedies in Appalachian folk medicine.

Appalachians used a variety of plants and non-plant ingredients in their remedies: medicinal plants included ginseng, goldenseal, and bloodroot, and even ingredients that were technically not plants, like moonshine, were still made from plants. For example, to treat yellow jaundice--a disease marked by yellow discoloration of the eyes and skin that can be potentially fatal--people in Appalachia could drink a tea made from yellowroot (another name for goldenseal) or “soak the roots in whiskey...[and] then drink some” because the alcohol would draw out “strength from the root.”

Access to plants in Appalachian communities changed over the course of the early twentieth century, as industrial development from the late nineteenth century progressed and people born and raised in the mountains migrated out of Southern Appalachia. According to folklorist Mary Hufford, the natural landscape in the Appalachian mountains existed as a commons for people who lived in the region. Hufford defines “commons” as “an open-access area where people go to hunt, picnic and party, gather a variety of roots, herbs, nuts, and fruit, or to enjoy some solitude.” Industrialization in the early twentieth century, most notably coal, timber, and railroad developments in Southern Appalachia changed the mountain commons dramatically by physically reshaping the landscape and instilling different ideas about property rights and ownership of land.

However, Appalachians held on to their plant-based knowledge. Christine Wiginton, one of the Foxfire interview participants, recalled that when she and her mother moved out of their Appalachian community in North Carolina, her mother’s sister “that lived back in Glennville sent [my mother], I remember, sent her a little sack full of ladyslipper” to treat her neuralgia.

Informed with vernacular knowledge of plant-based medicine, people in Appalachian communities collected herbs and plants as active preparation for poor health. They did so purposefully--by acting on their knowledge, these people avoided traveling to professional doctors and paying their fees. They understood that what they were doing would have an effect on their health or someone else’s in the community. As Joe Aliff’s and Flora Youngblood’s accounts pointed out, the practices in Appalachian folk medicine often played out along the lines of family and relatives. One practice in particular depended almost entirely on a close network family: the distribution, or sharing, of knowledge about plants and remedies.

### **Networks of Knowledge in Appalachian Folk Medicine**

The Appalachian network of knowledge on health and medicine depended on oral traditions, language, and shared knowledge through communication. This hierarchy emphasized self-reliance in the face of isolation from licensed doctors and a decentralized approach to authority. Whoever had knowledge of healing was or could be a legitimate practitioner, though some people like Henry Cantrell knew more about medicinal plants and methods than others and therefore held more authority. To construct this hierarchy, I focus on family and kin networks as the distribution and preservation system for folk medicine knowledge, how that distribution guaranteed men and women access to this knowledge, and how white people in Appalachia integrated Cherokee knowledge into this hierarchy.

People in rural Appalachian communities collected and disseminated knowledge of health and medicine by communicating with kin and family and community-based oral traditions. Parents and other relatives constantly come up in interviews about folk medicine in Appalachia. For example, Mary Jane McCoy, who grew up in the Appalachian South, talks about her mother using herbs to heal: “My mother knew a lot of things about herbs. She could get some things to break a cold up on you. She got out in the fall of the year and gathered up them things and put em in paper bags and saved em up and packed em away for the winter. She knowed the roots and thangs.”

Mary Jane McCoy’s recollection of her mother’s knowledge does not reflect an isolated experience in Appalachia. In West Virginia, Joe Aliff learned about medicinal plants and healing methods through his family. In his interview, Aliff says, “[I learnt] through my mother, who learnt from my grandpa.” His experience builds on McCoy’s: while McCoy only talks about her mother’s knowledge, Aliff points to two family members that knew about folk medicine and taught other relatives.

Aliff's experience with family-centered knowledge represents a larger pattern in Appalachia. Flora Youngblood, in her interview with Foxfire students, talked about her father and his unofficial career as an herb doctor. She points exclusively to folk medicine's dependency on family networks: "from my daddy learnt my mama. Well, my mama couldn't learn me, my daddy...well, he learnt me." Youngblood's experience echoes that of Joe Aliff, although in the context of her interview she is referring to faith healing rather than plant-based remedies. However, Youngblood demonstrates the same family and kin structure around her learning expressed in other interviews. She had at least two family members with knowledge about folk medicine, both of whom taught other family members. The way that families taught each other healing methods and plant knowledge depended on gender.

### **Gendered Distribution of Knowledge**

Gender played a crucial role in how people shared of knowledge in early twentieth century Appalachian folk medicine by determining who can teach the next generation. Men typically only shared their knowledge with women, and women shared their knowledge with men--this practice was especially important when it came to faith healing. The origins of the gendered distribution of folk medicine knowledge are unclear, but according to the interviews where this practice was discussed, Appalachians believed a faith healer would lose their abilities to heal if they taught a member of their same gender. The practice appears in the distribution of plant-based folk medicine as well.

Flora Youngblood brings up the role that gender played in the distribution of folk knowledge on medicine. She says "my mama couldn't learn me" for a specific reason: men typically cannot pass down, teach, or communicate how to practice certain aspects of folk medicine to other men and women cannot do the same for other women. In Youngblood's case,

she could not learn from her mother--if she did, her mother would lose her abilities to heal through faith using her knowledge of folk medicine. This practice specifically applies to faith healing in Appalachian folk medicine but, like in Youngblood's case, can apply to knowledge of herbs and home remedies as well--she learned about plants from her father, not her mother, even though her mother learned the same knowledge from Henry Cantrell.

This practice comes out in Joe Aliff's description of how he learned about folk medicine as well: Aliff's grandfather taught his mother, and his mother taught him. Much like Youngblood, Aliff's family filtered his education in folk medicine through gender. His education was not centered around faith healing as much as Youngblood's was. Instead of focusing on faith healing, Aliff's mother taught him about native plants and traditional Cherokee knowledge of folk remedies. His experience extends the gendered distribution of knowledge in faith healing to include plant-based knowledge as well.

This gendered distribution of knowledge seems strict and rigid on its face, but the practice actually contributes to the fluidity of Appalachian folk medicine. By requiring men to teach women and vice versa, people in these communities guaranteed that their knowledge could not be restricted to one gender. The opposite is true of professional medicine at this time: licensed doctors specifically and purposefully restricted access to their profession, their authority, and to their medical knowledge from women.

### **Racialized Sources and Gatekeepers of Knowledge**

Knowledge in Appalachian folk medicine has a diverse background. White settlers and their descendents in Appalachia learned about medicinal plants and methods from American Indians and specifically Cherokees. That knowledge was incorporated into community and family oral traditions alongside knowledge that came from African slaves and Scot-Irish

tradition. In this section, I focus on the contributions of Cherokee Indians and their role as gatekeepers of knowledge in community narratives of Appalachian folk medicine.

The cross-racial communication of knowledge about health demonstrates the decentralized structure of Appalachian folk medicine in comparison to professional practices, and demonstrates one of the biggest differences between the two fields: white men shaped knowledge in professional medicine, whereas Cherokees largely shaped the knowledge used in Appalachian folk medicine. This difference presented challenges as people navigated new understandings of health presented by professional medicine, understandings that licensed doctors intended to apply universally regardless of race. In Southern Appalachia, professional doctors applied their ideas about health in communities that already had a health care system structured around a specific place and shaped largely by indigenous people.

According to interviews with people in Appalachian communities, Cherokee Indians contributed the bulk of knowledge on health and medicinal herbs to folk medicine. In her interview, Mary Jane McCoy talks about how her mother “learned from the Indians...if they didn’t and she didn’t meet them [Cherokee people] some of the people did and taught her these things. That’s the way it went.” McCoy places the basis of her mother’s knowledge in the hands of Cherokees, whether or not her mother received this knowledge directly from the Cherokees or from other people who learned about medicinal herbs from Cherokees. Her comment points to an established practice: people learned from Cherokees about medicine because “that’s the way it went.”

This pattern of instruction holds true for Flora Youngblood’s father, Henry Cantrell: “He [her father] learned all their remedies from [the Cherokee], that’s the reason he went over there...There was an Indian chief who lived in the same neighborhood that we did. He would

come out and talk with my daddy a lot in their young days...So that got him interested and wanting to know about [medicine]. So he just went and joined their tribe for a period of time.”

This cross-racial communication is embedded in family networks indirectly for people like McCoy and Youngblood--in McCoy’s interview and others, there was no mention of someone else going to live with Cherokees but learning directly from indigenous people was a common theme. In Youngblood’s case, however, she knew for a fact that her father invested his time and efforts in living with Cherokees for a period of time specifically to learn about healing with native plants. Henry’s mother and father were aware of his decision as well, and encouraged him to learn this knowledge so he could use it in his community. Their support indicates that white people valued this kind of knowledge. Henry Cantrell’s decision to live with the Cherokees demonstrates this value as well.

For Joe Aliff, who learned folk remedies passed down to his mother from his American Indian grandfather, the source of knowledge came directly from the racialized base of folk medicine in Appalachia. Originally from Cherokee, North Carolina, Aliff’s grandfather moved his family to West Virginia looking for work. In West Virginia, Aliff learned about his heritage with the Cherokees by inheriting knowledge about folk medicine from his mother. Aliff’s experience is an example of familial interactions between white Appalachians and Cherokees, which ties race into the family and kin system of learning, sharing, and using folk medicine knowledge during the early twentieth century.

Although his story looks different from Flora Youngblood’s and Mary Jane McCoy’s, whose parents were white and learned from Cherokee Indians, all three stories echo the same key conclusions: Cherokee knowledge was the foundation of Appalachian folk medicine, and white people and Cherokees integrated that knowledge into their oral traditions. Appalachians learned



about goldenseal, ginseng, bloodroot, and other plants from Cherokees who used medicinal herbs in their healing traditions. Aliff, Youngblood, and McCoy are also evidence of how people in Appalachia distributed Cherokee-based knowledge through family networks.

### **The World of Professional Medicine**

Henry Cantrell's world of medicine was not the only one at work in Appalachia. In Macon County, North Carolina, right on the border with Henry's home of northeast Georgia, a young man set off to follow his father's footsteps in medicine. Thomas Hudson Brabson traveled from his home in Macon to Atlanta College, his father's alma mater, and earned his diploma in 1911. According to census records and family lore, however, Thomas H. Brabson was not considered a "physician" until 1930--the exact year Brabson gained his medical license to practice.

Dr. Brabson's story is a strong example of the rocky road young, educated doctors had to navigate on their way through professionalization. These men took advantage of their strengths--strengths that were tied to their class, gender, and race--to pave that road by reforming medical education, organizing societies of their peers, and influencing state and federal legislation that affected their field. In doing so, educated and licensed doctors successfully cultivated an image of authority based on their knowledge of medicine and healing. That success is the reason why Appalachian folk medicine is so often defined in comparison to professional medicine.

In this section, I examine the ways that white male doctors shaped the medical field according to their changing knowledge. First, I look at how knowledge and standards of knowledge changed at medical colleges and universities like the University of North Carolina at Chapel Hill. Chapel Hill's medical school graduates often were from Appalachia or practiced in the region after receiving their diplomas. Then, I argue that professional doctors used their local

and state societies to stay informed about changing knowledge in their field and demonstrate their own expertise. Finally, I trace how medical licenses bridged authority and knowledge for professional doctors with the support of federal and state law.

### **Knowledge and Authority in the History of Medicine**

Paul Starr describes professional medicine as “an elaborate system of specialized knowledge,” a system intended to address all aspects of health in American society using a network of doctors who had different degrees of expertise in relation to different types of disease and injury. In the beginning of the twentieth century, educated and licensed doctors linked that system of knowledge to their authority. Sandra Lee Barney demonstrates how white male doctors in Appalachia contributed to the professionalization of their field by raising the standards required to practice medicine. By raising certain standards, doctors changed the way medicine was taught--changes that Kenneth Ludmerer traces throughout the twentieth century. I pull these scholars and their separate arguments together to show how people like Thomas H. Brabson navigated the professionalization of medicine.

Professional medicine did not exist as a wholly separate body of knowledge from plant-based folk medicine. In fact, in the late nineteenth century professional doctors and affiliated researchers undertook extensive research into medicinal properties of plants used by Cherokee Indians. For example, as J. T. Garrett outlines in *Cherokee Herbal*, James Mooney documented a variety of plants and recipes used in traditional healing in Cherokee during the 1880s. He was not alone--the naturalist William Bartram and playwright John Howard Payne also documented Cherokee folk medicine, often in order to determine if these plants could be used in non-traditional medicine.

### **Shifts in Knowledge and Learning in Medical Education**

Professional doctors' efforts to link their authority to their knowledge changed the way they taught medical students. At the turn of the twentieth century, medical education was in the midst of a major shift from traditional forms of learning to experiential methods of learning. This shift emphasized laboratory work and clinical clerkship over textbooks and lectures, although books and lectures did not disappear from curriculum.

Doctors and medical students were very aware of these shifts and supported Progressive Era attitudes that saw change as a positive force. In his brief history of the University of North Carolina's medical school at Chapel Hill, which trained generations of doctors from Appalachia as well as doctors who went on to practice in Appalachia, Isaac Hall Manning distinctly frames the changes in medical education as the emergence of science, reason, and progress. He also criticizes medical education's past as dependent on incomplete knowledge. According to Manning and his peers, the field not only lacked the right kind of knowledge but it hardly had any knowledge to offer students:

“It should be recalled that medical education was just beginning to emerge from medieval conceptions. The method was essentially didactic. The dawn of Medicine as a science was just beginning to break and its relation to the fundamental sciences, chemistry, physics and biology, was still largely in the realm of the imagination. Anatomy was the only subject taught in a large majority of the medical schools by the laboratory method, and actual dissection of the human body by the student outside of the large cities a rare event. This being true many of the prospective doctors began the study of Medicine in the office of some practicing physician. He was in effect an apprentice, “read medicine” under the guidance of his

preceptor or followed him around in his practice, picking up the crumbs of clinical experience as best he could.”

These “crumbs of clinical experience” became the focus of medical education in the United States, as medical schools changed their curriculums to reflect experiential learning for students through laboratory classrooms and clinical work for hospitals. Medical students spent less time reading textbooks and listening to lectures than the students who came before them. At Chapel Hill, students like Hunter McGuire Sweaney took notes from chemistry labs and pharmacy seminars and learned things like how to write a prescription and how to distill alcohol-- something that people in Southern Appalachia also knew how to do for medicinal purposes as well.

This form of learning reflected practical application of medical knowledge, but more importantly the changes in medical education represented how medical students and professional doctors emphasized their learning around the ‘best’ knowledge. During the Progressive Era, universities and colleges prepared the next generation of doctors for practice according to a knowledge-based mission of professionalization. Once the students graduated, the new generation of doctors continued this mission by joining state and local medical societies.

### **Medical Societies as Professional Knowledge Distribution Networks**

Professional doctors organized medical societies on national, state, and local levels in order to link their knowledge to their authority as health experts. In this section, I examine the ways that medical societies and associations in Kentucky, North Carolina, South Carolina, Virginia, West Virginia, Tennessee, and Georgia distributed and influenced Progressive Era knowledge about health. I use the Roanoke Valley Academy of Medicine as a localized example of how doctors in Appalachia kept in touch with changing knowledge in their field, placed

themselves in charge of educating the public on medical matters, and reinforced professionalization by setting membership requirements that depended on state-sanctioned medical degrees and licenses.

At the American Medical Association's meeting in 1904, President [of the AMA] said, "Our medical societies are the great postgraduate schools of the profession, where knowledge is increased and individual character developed." Through this comment, the President of the AMA revealed that medical societies' purpose and mission depended on distributing knowledge and establishing a network of peers for white male doctors. State and local medical societies in Appalachia embraced the AMA's mission to educate each other and the public.

In his presidential address during the same year to the Kentucky State Medical Association, Dr. Steele Bailey evaluated how effectively his association and its companion journal distributed medical knowledge. He gave the journal a positive review, stating "My opinion is that the Bulletin [Kentucky Medical Journal] has admirably subserved its purpose, that of communicating and rendering knowledge more accessible and useful." Practical and accessible knowledge mattered to Dr. Bailey's peers. White, male, educated doctors saw themselves as stewards of medical knowledge, armed with their college degrees and expertise. As stewards, they had a responsibility to educate their patients--a responsibility that doctors linked to the authority they inherited through knowledge.

In South Carolina, the state's medical society explicitly claimed the right to educate the public about health. At a 1905 meeting of the South Carolina Medical Association, President Robert Wilson Jr., M.D. told his fellow members, "Who can overcome ignorance save those who possess knowledge? We are the proper teachers of the public." Dr. Wilson referred to the association's constitution, which reflected a commitment to advancing medical science by

distributing medical knowledge to the public and elevating standards in medical education. The attitude displayed here, one that claims authority through education, echoes throughout medical journals published by doctors in Appalachia. These claims reinforced a national attitude that made professionalization dependent on knowledge and authority through expertise.

Professional doctors had to act on their claims in order to cement their authority. On a local level, doctors like members of the Roanoke Valley Academy of Medicine influenced public knowledge by organizing educational public health initiatives and gained state-sanctioned authority by bridging medical education to medical licensure. The Roanoke Valley Academy of Medicine, which its members referred to as the Academy, is a prime example of how professionalization succeeded in connecting doctors' knowledge to their authority.

### **The Bridge Between Medical Education and Professionalization**

By the late 1920s, doctors in Appalachia needed a formal medical education and a medical license in order to be socially accepted by their peers as professionals. The link between these two state-sanctioned stamps of approval is evident in the meeting minutes for the Roanoke Valley Academy of Medicine. The Academy capitalized on medical knowledge to legitimize the authority of its members in two major ways: building a pipeline to membership for local medical students and only granting membership to doctors with both medical degree and a medical license.

In 1924, the Roanoke Valley Academy of Medicine officially reached out to medical students in the area. Through a motion introduced by Academy member Dr. Graves, the society invited “the interns of the hospitals of the city...to attend the meetings and functions of the Academy, being released of dues and having all priveleges [sic] except voting, which was passed and Secretary instructed to notify each Intern of city.” Dr. Graves' motion suggests that the

Academy subscribed to the notion that there was power in numbers. The motion bridged a gap between medical colleges and the professional world and provided a pipeline from graduation to professional networks of medicine. By opening meetings to medical students, the Academy could recruit new members who were guaranteed to possess a formal education.

In 1927, the Roanoke Valley Academy of Medicine reshaped its membership requirements to reflect the bridge between medical education and state-sanctioned practice. After a suggestion from society member Dr. Powell, the Academy decided that its members “must be graduates of a regular medical college, must have been granted certificate by the Virginia Board of Examiners, and must have been a resident of the city or county of Roanoke or an adjoining county not less than six months.” This action placed proof of expert knowledge, proof that existed in the forms of medical degrees and licenses, at the center of professionalization. Without both a medical degree and a medical license to prove they possessed formal knowledge, doctors in Roanoke were not recognized by their peers as professional--and therefore legitimate--practitioners.

The Roanoke Valley Academy of Medicine’s membership requirements provide a possible answer to why Dr. Thomas Brabson went nearly twenty years with a medical degree, but no medical license. After graduating from his studies in medicine at Atlanta College in 1911, Dr. Brabson was not listed as a doctor in the 1920 census. The government considered him to be a farmer. In 1930 however, the census lists Thomas H. Brabson as a physician, living and practicing in the Appalachian county of Macon, North Carolina. Although Dr. Brabson was not a member of the Roanoke Valley Academy of Medicine, the timing of his medical license suggests that he subscribed to the same attitudes about professionalization and knowledge that medical societies across Appalachia projected to their members. Doctors like Thomas Brabson and

members of the Roanoke Academy, including Dr. Graves and Dr. Powell, cemented their authority through physical stamps of approval and acceptance: medical degrees, licenses to practice, and membership in state and local medical societies. Professional doctors in Appalachia then used that authority as justification to educate the public and shape their patients' knowledge about health.

### **Case Study of Public Health: The Roanoke Valley Academy of Medicine**

In 1926, the Academy unanimously passed a motion put forth by Dr. J. W. Preston to create a committee devoted to public health. Through this committee, the members wanted to work with public health officers in the city and county of Roanoke to develop public health initiatives “which will best serve the interests of the public and of the profession,” with public loosely defined as potential patients or clients. Roanoke doctors clearly believed they deserved to be involved in public health decisions. Not only did they deserve to be involved, but as doctors, public health was their responsibility. Furthermore, that responsibility needed to benefit doctors. Although the public takes priority in Dr. Preston's motion, the Academy specifically intended their actions to best serve the interests of their profession as well.

In the same motion, Dr. J. W. Preston requested that the public health committee also act as a local distributor of medical knowledge to the public. He suggested that the committee use specific, publicly recognized avenues of distribution, “through the Health Departments, through newspapers, and through other public agencies.” By prioritizing avenues of distribution that were already recognized as authorities on information, the Academy associated the medical knowledge of their members with their own authority. Roanoke doctors, like doctors across Appalachia, consistently linked their duty to educate the public about health to the professionalization of their field.



## **Bringing the Two Worlds into Contact**

During the beginning of the twentieth century in Appalachia, the separate worlds of folk and professional medicine collided in multiple ways. This chapter examines the ways knowledge operated in both worlds and reveals separate systems of knowledge built around race, gender, and class in different ways. Understanding ways that people learned, shared, and used knowledge in folk medicine and in professional medicine allows historians to define each according to its own system of knowledge with insight into the relationship between both worlds of medicine.

Throughout the Progressive Era, professional doctors in Appalachia changed how people in the region understood health. The formally educated, state licensed white male practitioners successfully marketed their knowledge in medicine as expertise by changing medical education to focus on experiential learning, organizing professional networks of their peers, and bridging their education and their authority through medical licenses. Appalachians gradually trusted the authority of licensed doctors with college educations. Although folk medicine did not vanish overnight, people in rural Appalachian communities subscribed to professional medicine more and more as the twentieth century progressed.

In the first three decades of the twentieth century, pieces of professional medicine bled into the system of Appalachian folk medical knowledge. Professional medical terminology crept into the language in folk medicine, which shaped perceptions of health for people in the region throughout the twentieth century--including the perspectives of Joe Aliff, Mary Jane McCoy, and Flora Youngblood. Professional medicines and drugs like aspirin and quinine appeared in recipes for folk treatments of ailments such as chills and calluses alongside traditional ingredients, including medicinal plants that contained elements of aspirin and quinine like willow and non-plant ingredients, such as tonic water. Appalachians' incorporation of professional versions of

traditional ingredients into their system of folk medicine demonstrates the adaptive nature of their knowledge.

In the next chapter, I examine the interactions between the two worlds of folk and professional medicine. I trace the shift in folk medicine during professionalization from a system of communicated and practiced knowledge to a system of communicated knowledge as a process of trust. In order to illustrate that process, I focus on strategies that physicians used to gain the trust of people in Southern Appalachia and solidify their authority as experts with legitimate medical knowledge, the effects of Prohibition on the practice and autonomy of Appalachian folk medicine.

## **Chapter Two** **The Two Worlds of Medicine ‘Collide’**

During the twentieth century in Appalachia, professional doctors used their authority as medical experts to delegitimize certain practices, require and set standards for medical licenses, and shape federal legislation including Prohibition in order to reflect their status as members of the middle and upper classes. Professional doctors channeled their efforts to draw boundaries around their field through state and local medical societies. In this chapter, I expand my argument from chapter one that linked knowledge and authority to examine how professional doctors relied on their knowledge and authority to gain the trust of Appalachians, their potential patients, and how their actions affected folk medicine in Southern Appalachia.

Progressive Era doctors drew firm boundaries around the practice of medicine. These white men shaped their profession along lines of race, gender, and knowledge. Women and people of color could not become doctors, or at least had to overcome far more obstacles than white men in order to pursue a career in medicine. Professional doctors labeled chiropractors, osteopaths, homeopaths, and other alternative practitioners as illegitimate healers, eccentrics, and quacks--their practices did not subscribe to the system of knowledge in professional medicine and professional doctors saw them as competition.

The changes that licensed doctors made to the boundaries of professional medicine worked: people in Southern Appalachia gradually trusted the expertise and specialized knowledge of licensed physicians, which contributed to the decline of folk medicine as a practice in Appalachia. People in rural communities knew that their society's knowledge of medicine and health was changing in the beginning of the twentieth century. They integrated knowledge from professional medicine into their own system of public health, as evident from the language they

used to talk about health and from new ingredients they used in home remedies, such as aspirin and quinine, which replaced ingredients like willow bark and tonic water. Even though they accepted professional medicine as the standard model of health care in the United States, people in Southern Appalachia continuously communicated their knowledge of plants, health, and remedies through oral traditions and family networks. While licensed doctors focused on discrediting immediate threats and competition like chiropractors, people in Appalachia continued to learn, share, and use folk remedies--although they used their knowledge less as the twentieth century progressed.

Professional doctors took three major initiatives in order to reinforce their authority and gain trust and legitimacy as medical experts: delegitimization campaigns, state and local medical licensure legislation, and the extent of their influence on federal legislation--specifically Prohibition. However, these are not the only factors that contributed to professionalization's effect on Appalachian folk medicine. Scholars in Appalachian Studies and historians of medicine trace a broad spectrum of changes brought about by professionalization, ranging from industrial capitalism, Progressive Era reforms in public health, and shifts in medical education.

### **Historiography of Professionalization in Appalachia**

In *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930*, Sandra Barney points to the larger forces of industrial capitalism at work in Appalachia during the Progressive Era that nudged the two worlds of medicine into contact and even collision. Barney specifically points to the roles played by the coal boom and railroad development in the region, both of which brought professionally educated and licensed doctors into rural Appalachian communities. Barney argues that rapid industrialization assigned Appalachia a new position in the national economy. This new position revolved around coal

buried deep within the mountains. Appalachian coal fueled industrialization across the United States. The rise of industrial capitalism, experienced through the coal boom and railroad expansion, also provided opportunities for expansion to professions on the rise--including the practice of medicine.

In *Health Care in America: A History*, John C. Burnham connects professionalization efforts taken by doctors to larger shifts in American society brought about by Progressive Era reformers. Burnham points to rising concerns and reforms across the United States surrounding public health, sanitation, and hygiene as the national backdrop to the professionalization of medicine. He argues that progressive reformers and professional doctors in the early twentieth century were both “inspired by the ideals of science,” and channeled their inspiration to confront poor health. Burnham emphasizes--and my research supports--that professional doctors carried out their progressive mission to ease physical suffering through local actions. Burnham also explains that during this era, professional doctors experienced social anxiety about their finances and compensation for their labors. This anxiety fueled their efforts to draw boundaries around their profession and to solidify their authority as medical experts.

Progressivism found its way into medical education as well. As professional doctors marketed their knowledge and authority to the public and their patients, the public reflected a social interest in medicine and particularly medical education. Abraham Flexner’s report to the Carnegie Foundation for the Advancement of Teaching was at the center of the relationship between medical schools, professional doctors, and the public. His report, officially titled *Medical Education in the United States and Canada* but referred to as the Flexner report, situated medical colleges as public trusts. The Flexner report rippled across Progressive circles of reform and professional medicine. Its circulation throughout American society reinforced public

attitudes that supported the advancement of medical education. As Kenneth Ludmerer argues in his book, *Time to Heal*, doctors and Progressive reformers tapped into the Flexner report's social mission: to improve the quality of health care available in the United States by improving the quality of medical education.

### **Delegitimization Campaigns At State and Local Levels**

As seen in the last chapter, professional doctors purposefully organized their social associations to distribute information and share knowledge with each other and the public. That knowledge was not limited to new advances in medical science. Professional doctors also shared information and methods to essentially exile medical practices deemed “eccentric” and practitioners they called “quacks” from their circles of expertise and authority.

State and local medical societies served as headquarters for professional doctors' campaigns against patent medicine and alternative practitioners including chiropractors, homeopaths, and osteopaths. Professional doctors in Appalachia realized that they needed the support of doctors in rural communities in order to solidify their field's boundaries. According to Dr. Steele Bailey one of the early presidents of the Kentucky Medical Association, most of the counties in his state that lacked local involvement in medical associations were in the mountains. In his 1904 Presidential Address, Dr. Bailey highlighted the significance of local medical societies in rural areas by stating that professional doctors in Appalachia “must be organized.” Professional doctors across Appalachia answered this call. They used the social momentum from their state and local medical societies to delegitimize medical practices that did not reflect the same expertise and scientific knowledge that professional doctors cherished.

State medical societies in Appalachia framed the controversy between professional medicine and alternative medicine as a contestation of knowledge, and positioned professional

knowledge as the superior foundation for medical practice. In 1900, a book review about patent medicine appeared in the annual issue of the Carolina Medical Journal and advised professional doctors in South Carolina on how to frame their knowledge in comparison to “quacks:” “Knowledge of legitimate medicine is the first requisite of the physician, but a familiarity with the means used by irregulars and quacks often aids the practitioner in putting a quietus on the ever-present busybody with reports of marvelous cure of cases.” The author’s attitude reflected how professional doctors in Appalachia prioritized their knowledge of medicine over the practices of the “other” forms of treatment for poor health, disease, and injury. There is also a call to action here, with the specific purpose of defining the boundaries of legitimacy. Not only did professional doctors need knowledge of *legitimate medicine* (meaning their own practice) but they also needed to be familiar with alternative medicine methods--for the explicit purpose of derailing their ‘marvelous cures’ as pseudo-medicine based on inferior knowledge.

### **Roanoke Valley Academy of Medicine: A Case Study in Delegitimization**

Members of local medical societies carried out delegitimization campaigns against people they identified as illegitimate doctors or practitioners in their communities. These campaigns reflected professional doctors’ commitment to legitimacy: doctors sought to delegitimize chiropractors by bringing legal charges against them. From 1920 to 1921 in Roanoke, Virginia, members of the Roanoke Valley Academy of Medicine identified and took legal action against two chiropractors in their city as threats to professional medicine. This particular local campaign in the Appalachian city of Roanoke reflects professional doctors’ perceptions of themselves as legitimate medical authorities in legal contexts and the public eye.

On October 18, 1920, Dr. J. W. Preston--head of the Academy’s new legislative committee--reported to his fellow members that a local chiropractor had been fined \$50.00 for

practicing in Roanoke. The chiropractor took an appeal, which prompted the Academy to prepare to raise funds for legal fees. The professional doctors had the support of the Commonwealth's Attorney, a Mr. Price, as well as a judge who promised to take the case up to the Supreme Court on the condition that he received one hundred dollars as compensation. Dr. Preston also reported that there was another chiropractor who recently moved to Roanoke.

The Academy brought charges against two chiropractors, who they referred to as Bristow and Stokes, and actively pursued efforts to delegitimize their practices in Roanoke through public channels as well. Members of the Academy paid fees by special assessment--\$2.50 per member--to pay for the legal fees. Mandating fees demonstrates the Academy's leaders' commitment to keep Bristow and Stokes from practicing. Dr. Preston consistently reported at the society's meetings about the two cases from October of 1920 to April of 1921, which demonstrates that professional doctors in Roanoke invested their time as well as their money in their campaign against Bristow and Stokes. Their efforts did not begin and end in the courtroom. Members of the Roanoke Academy, through the direct actions of Dr. J. W. Preston, also met with a representative for the local newspaper the *Roanoke Times* to pursue public avenues of delegitimization.

Members of the Roanoke Valley Academy of Medicine were concerned about a series of advertisements that appeared in the *Roanoke Times* and promoted chiropractors in the area. In response, Academy President George Maxwell appointed a committee to contact the newspaper and start their own series of advertisements. The Academy's advertisements would be "of a Medical and Pseudo-Medical character, with especial reference to the recent advertisements of the Chiropractors [sic] appearing in the daily papers." As part of this discussion about advertisements during an Academy meeting in December of 1920, the Academy decided to reach



out to the Ohio State Medical Society for advice on how to handle “Pseudo-Medical Quacks” such as chiropractors.

By seeking advertisements in the local Roanoke newspaper in response to chiropractors, professional doctors in the Academy brought their delegitimization campaign in the public eye. They wanted people in Roanoke to trust their professional knowledge and expertise on medicine over “quacks” like Bristow and Stokes. The Academy’s plan to reach out to the Ohio State Medical Society reinforced the relationship between state and local medical societies that professional doctors depended on to cement their authority. The combination of the Academy’s efforts with newspaper advertisement and the Ohio State Medical Society, as well as the court cases against two chiropractors in Roanoke, demonstrates the broad range of actions that contributed to delegitimization campaigns across the field of professional medicine during the early twentieth century. Although the court cases brought against Bristow and Stokes did not come up after 1921 in the Roanoke Valley Academy of Medicine’s meeting minutes, professional doctors’ concerns about chiropractors in Roanoke came to the surface throughout the 1920s.

Licensed, educated doctors in Appalachia during the Progressive Era considered any medical practitioner or medicine that did not meet their field’s education requirements and licensure standards to be ineffective at best, and harmful at its worst. Through their social organizations at state and local levels, professional doctors carried out delegitimization campaigns against chiropractors and other alternative practitioners in order to define the boundaries of acceptable medicine. They pursued legal avenues to marginalize local competition, as seen through the Roanoke Valley Academy of Medicine’s actions taken against two chiropractors in their community. These campaigns reflected other aspects of professionalization

as well: specifically the movement's emphasis on medical licenses as a gateway into professional medicine and legitimate medical authority.

### **Medical Licenses: The Guarded Entrance to Professional Medicine**

The meaning of a medical license during professionalization shifted as doctors in Appalachia linked their knowledge to their authority and redefined the boundaries of their field. Controversies over the relationship between medical diplomas and medical licenses highlighted the contestations over authority. Local medical societies like the Roanoke Valley Academy of Medicine, taking their cues from national and state organizations, increasingly required medical licenses as a condition of membership. Professionalization's emphasis on medical licenses encouraged doctors to control access to these stamps of legitimacy. By the 1930s, doctors framed medical licenses as a gateway into professional therapeutics and guarded this entrance along the lines of gender and race.

During the summer of 1897, the University of North Carolina at Chapel Hill offered a review course for its medical students who wanted to prepare for the state's medical examination. Through the review course, a medical student could obtain a medical license without a diploma if the State Board of Medical Examiners determined he had passed their test. One student would even be awarded an internship at the James Walker Memorial Hospital in Wilmington. When a student in the review class, who "had never taken a clinical course and never received a diploma," passed the state examination, "he was given a license to practice and after his internship in the James Walker settled in Wilmington to practice." This did not go over well with the college, according to Isaac Hall Manning, dean of Chapel Hill's medical school from 1905 to 1933, and "the Board saw the error of its way and returned to the requirement of a diploma" in order for medical graduates to obtain a medical license. A year later in 1898, UNC's

medical school became an accredited member of the Association of American Medical Colleges and its students were subject to the association's standards--standards that linked knowledge and authority by setting medical licenses and medical degrees as prerequisites to legitimate practice.

In the progressive atmosphere of professionalization, professional doctors in Appalachia increasingly framed medical licenses and diplomas as proof that their practices were informed by legitimate knowledge. Armed with literal stamps of approval on professional therapeutics, professional doctors reinforced their own authority by controlling who could and could not obtain a license to practice. Local medical societies operated that control beyond medical colleges into the broader world of professional medicine.

In 1924, Dr. M. A. Johnson reported back to his local medical society in Roanoke about his trip to the Virginia House of Delegates meeting in Staunton, Virginia. He told his professional peers that the representatives addressed the different meanings of medical licenses at a state and local level during their meeting. The delegates pointed to Virginia's law that required practicing doctors to have medical licenses and expressed concern that this law "seems to be ineffective," a concern reinforced by local city ordinances in Richmond and Norfolk that also required medical licenses for medical practice. The Roanoke Valley Academy of Medicine was very interested in this political discussion because it reflected internal concerns in professional medicine surrounding medical licenses.

The Roanoke Valley Academy's reaction indicated support for medical licenses as their field's standard requirement. By 1927, the Academy controlled membership based on medical licenses and medical diplomas. Dr. Johnson's attendance at the House of Delegates meeting in 1924 indicates the political role that local medical societies filled during professionalization. Not only were professional doctors in Appalachia following the politics surrounding their field, but

they were actively involved in debates over medical licenses at state levels. These men also held the same debates in their organized social circles, and then reorganized those societies to reflect the authority derived from medical licenses.

Although professional doctors' political actions typically played out at a local or state level in Appalachia, they were also involved in shaping national legislation that affected their field. Prohibition is one of the stronger examples of how professional doctors influenced federal legislation in order to reinforce the boundaries of their authority during the Progressive Era.

### **The Effects of Progressive Professionalization on Folk Medicine**

While professional doctors carried out delegitimization campaign and linked their authority to their knowledge through medical licenses, folk healers in Appalachia continued to use the same methods that had been used for generations to treat sick or hurt people. The system of knowledge in Appalachian folk medicine allowed people to integrate new information into their local systems of health. As professional medicine continued to dominate progressive dialogues surrounding health, people in rural Appalachia adapted their knowledge and methods according to these dialogues and gradually trusted licensed doctors as experts. The criminalization of the consumption of alcohol through the Volstead Act, as well as the authority granted to licensed physicians by the federal government to prescribe whiskey, magnified professionalization's effects on folk medicine.

People in Appalachian communities were aware of professional medicine and its methods of healing, and these methods crept into their language and their perceptions of health. Although the people in interviews learned and, in some cases--including Joe Aliff and Flora Youngblood--used the knowledge passed down to them from their families about Appalachian folk medicine, their discussions of folk medicine take place in the past tense. For example, McCoy states that

people “didn’t call on the doctor as much as they do now. I mean, we didn’t go to the doctor then like we do now.” Her use of the past tense to describe folk medicine demonstrates the shift in Southern Appalachian medicine from folk medicine as a prominent model of health to professional medicine as the primary or default model.

Mary Jane McCoy’s use of the past tense echoes through Flora Youngblood’s and Joe Aliff’s accounts as well. Youngblood emphasizes the past when she states, “Back then, you know, there wasn’t many doctors. People just sort of doctored themselves.” By placing folk medicine in the time of “back then” as a way that people used to “doctor” themselves, Youngblood also demonstrates the transformation in Southern Appalachian medicine that prioritized professional medicine. Joe Aliff also describes this shift: “we didn’t have money to go to the doctors. You cured yourself or died, that’s bout the size of it.” His comment highlights the transition in terms of life or death. Instead of relying on professional doctors to treat and maintain their health, Appalachians tended to their own cures. However, by using the past tense Aliff demonstrates that this life or death, self-sustaining situation is no longer the case in Appalachian medicine.

Even though people preserved folk medicine knowledge by passing it down to new generations, the professionalization of medicine contributed to a major change in Appalachian folk medicine as a practice. People used home remedies less as professional medicine became the dominant form of healthcare in twentieth century American society. Today, the remnants of folk medicine knowledge are still preserved in Appalachian communities--but the practice of folk medicine, at least in Appalachians’ own narratives, exists in the past.

Prohibition’s role in the professionalization of medicine, as well as moonshine’s role as a key ingredient for Appalachian folk remedies, are largely unexplored by historians. Scholars pay attention to moonshine as part of a cultural stereotype, its function as supplemental income for

people in both rural and urban communities in Appalachia, and its role in the history of moonshine. When historians place moonshine in the context of folk medicine, they rarely explore whiskey's medicinal value and how Prohibition disrupted that value. In the next section, Prohibition and moonshine are explored through the lens of medicine and public health.

### **Prohibition and Moonshine in Appalachian Folk Medicine**

After the Volstead Act passed and the eighteenth amendment was ratified, professional doctors were quick to project authority as medical experts and claim the right to prescribe whiskey. In the statement below, the American Medical Association--the national society for professional doctors--expressed support for the criminalization of whiskey as long as they could retain the power of prescription:

“Acting on the expressed principle that no law can establish a scientific fact, the House of Delegates of the American Medical Association voted today to prepare for submission to Congress a bill designed to remove present legal restrictions on the amount of whisky [sic] a physician may prescribe for his patients. The proposition was discussed in executive session and the vote was taken after two hours of debate, which produced a proviso [sic] that the proposed measure be framed in cooperation with prohibition enforcement authorities. A proposal that the Association send to its members a questionnaire on the medical value of alcoholic liquors was referred to the board of trustees. A statement issued at the close of the meeting said the vote was unanimous and declared it the feeling of the organization that "legislative bodies composed of laymen should not enact

restrictive laws regulating the administration of any therapeutic agent by physicians legally qualified to practice medicine."

The statement demonstrates an impressive confidence from the A.M.A. on behalf of professional doctors across the United States. These physicians were so secure in their authority by 1920 that they felt compelled to direct the leaders of their nation to follow their expert advice. As medical authorities with knowledge that alcohol had medicinal properties, licensed doctors believed they deserved the ability to prescribe an illegal substance. They were also comfortable with alcohol being illegal, no matter its medicinal uses.

Professional doctors in Southern Appalachia were comfortable with Prohibition as well and openly supported it. In an address delivered in front of the West Virginia Medical Association in 1914, Dr. C. A. Barlow expressed that "we are proud to note that the State of West Virginia has entered its protest against the use of alcoholic liquors by the adoption of the prohibition amendment, and we sincerely hope it will not be long until prohibition will become national." Dr. Barlow's statement reflected a broader attitude towards alcohol in the United States during the early twentieth century.

State by state, legislators responded to anti-alcohol sentiments with anti-alcohol laws. Ultimately, this national attitude resulted in the passing of the Volstead Act and the addition of the 18<sup>th</sup> Amendment to the United States Constitution, which criminalized the sale, production, and consumption of alcohol across the country. Although national prohibition affected all forty-eight states, people and communities in Southern Appalachia experienced the criminalization of alcohol differently than their fellow Americans.

Appalachian states were at the forefront of Prohibition debates. In 1838, Tennessee enacted the first law in the United States that criminalized the sale of alcohol, classifying the

retail act as a misdemeanor. Though the federal Volstead Act did not come into effect until 1919, every state in Southern Appalachia outlawed the distribution, production, and consumption of alcohol before national prohibition. Georgia and North Carolina passed statewide prohibition in 1908. Next came West Virginia in 1914, then Virginia and South Carolina in 1916. Kentucky was the last Southern Appalachian state to pass anti-alcohol legislation in 1919, just two months before the Volstead Act came into effect, which carried Appalachia's role in Prohibition from the start of the alcohol debate into the culmination of the national ban on alcohol.

Anti-alcohol legislation had a concentrated effect on rural communities in Southern Appalachia. Although the state and federal governments taxed, regulated, and in some cases outlawed the production of alcohol prior to statewide and then national prohibition, the Volstead Act and the preceding statewide prohibition laws criminalized the production, distribution and—perhaps most significantly—the consumption of alcohol. This criminalized Southern Appalachians' practices of making and using moonshine—a form of corn-based whiskey made by individual Appalachians operating outside of regulations that taxed alcohol production.

Moonshine served several functions in Appalachian communities, such as a source of supplemental income for Appalachians struggling to support themselves and their families. Appalachians also used moonshine for medicinal purposes in folk remedies, mostly as the base ingredient for tinctures consisting of various herbs soaking in whiskey, to be consumed at a later point. The changing nature of moonshine is an applied example of the relationship between Prohibition and the professionalization of medicine--and most significantly, the effect of this relationship on Appalachian folk medicine. This approach frames the state and federal anti-alcohol laws as a matter of public health that coincided with the professionalization of medicine.



Moonshine serves multiple cultural functions in Southern Appalachia. The distribution of moonshine was a source of economic relief for Appalachians who needed additional income. Moonshine was also a crucial ingredient in Appalachian folk remedies, which carried on a tradition of medicinal distilled alcohol that began in Europe. People who lived outside of Appalachia saw moonshine as a cultural signifier of Appalachian stereotypes put forth by the local color movement, which painted Appalachians as romantically uncivilized and, more negatively, a backwards people.

As I explained in the first chapter, people in rural Appalachian communities primarily subscribed to a tradition of home remedies influenced by Cherokee, Scot-Irish, and African medical knowledge. They frequently used moonshine for medicinal purposes. People like Henry Cantrell, a local herb doctor in White County, Georgia, used moonshine in teas to treat a skin condition called pellagra and as a preservative for medicinal herbs. Other common medicinal uses for moonshine included treating wounds or sores, coughs, and earaches, as well as a prevention for frostbite.

As states criminalized the production and consumption of alcohol as well as the practice of medicine without a license, Appalachian folk healers and moonshiners were at risk of serving jail sentences and paying hefty fines. Corn liquor was a crucial ingredient in Appalachian folk remedies, a cultural tradition that declined as professionalized medicine gained influence, legitimacy, and authority--this is the kind of medicine practiced by doctors like C. A. Barlow and his peers in the West Virginia Medical Association. The persecution of Appalachian moonshiners illustrates the most visible effect of professionalization on folk medicine. Progressive reformers, supported by the professional doctors in Appalachia, criminalized the

consumption of a key piece of Appalachian folk medicine as part of the professionalization process.

### **Shifting Knowledge in Appalachian Folk Medicine**

As the professionalization of medicine worked its way into rural Appalachian communities, bits and pieces of professional treatments for illness showed up in folk remedies. Aspirin appeared in remedies around the time of the flu epidemic in 1918. Mimi Dickerson, who lived in northeastern Georgia, remembered her mother using “medicine they give for pain” to treat what she called “grip,” a common alias for the flu. Dickerson recognized this pain medication as anacin, which is a combination of caffeine and aspirin used to treat symptoms of the common cold. Anacin was not the only thing Dickerson’s mother used to treat the flu--she also used herbal teas. This combination of folk and professional medicine demonstrates how Appalachian folk medicine adapted to professionalization and integrated new methods of treating illness into traditional knowledge of health and healing.

The integration of new medicines and knowledge into Appalachian folk medicine could be interpreted as resilience or indicate the strength of folk systems in the region’s rural communities. However, as people integrated professional methods into their system of folk medicine knowledge, they also paved the way for professional doctors to enter their communities as accepted authorities. While the demonstrating strength and resilience of how Appalachians learned and shared their knowledge of medicine, their willingness to adapt to professional knowledge contributed to the decline of folk medicine as a practice in the region.

All of the hard work that professional doctors put into establishing their authority and defining the boundaries of their field paid off before the early decades of the twentieth century were over. People in Southern Appalachia gradually accepted licensed doctors as legitimate

authorities in their communities and relied less on folk healers. According to Flora Youngblood, folk healers--especially midwives and granny women, who typically filled the role of folk healer in some communities--“quit coming out when they got the hospital built” in her home in Rabun County, Georgia. During the Progressive Era, the hospital was the ultimate symbol of professional medicine’s dominance because professional doctors were trained according to hospital practices. Now that professional doctors were locally available as health and medicine experts, folk healers were not as necessary as they had been for generations in Appalachia.

Some Appalachians preferred familiar plants and remedies to professional treatments. For example, after Christine Wiginton and her mother moved from their mountain home in North Carolina to the flatter regions in Georgia, her mother saw a doctor for neuralgia. He gave her “some kind of pain pill” but Wiginton’s mother preferred the traditional folk remedy that featured ladyslipper as the main ingredient. According to Wiginton, the pain medication did not work as well as the tea her mother made from ladyslipper. This is proof that people continued to use Appalachian folk medicine methods even after leaving the region, and after professional medicine became the dominant form of healthcare across the United States. However, folk medicine methods were more of an exception to the rule of professional doctors by the mid-twentieth century.

People in Southern Appalachia experienced this shift in trust from folk medicine to professional medicine in generational terms. According to Mary Jane McCoy, her grandmother looked down on relatives who went to see a doctor instead of learning folk medicine methods. While remembering her grandmother, McCoy said, “Ma-ma use to tell us, ‘Y’all run to the doctor too much. You ought to learn’ [laughs]. Every time anybody’d get a little bit sick, they’d run to the doctor instead of trying to take something [or] learn something” that would help treat

their ailments. McCoy's grandmother is a strong example of why folk medicine knowledge was preserved and passed down through generations of people in Appalachia throughout the twentieth century. Enough people like her grandmother insisted on the necessity of learning about folk medicine, and shared their knowledge with their children and grandchildren, who shared the same knowledge with their children.

That knowledge exists now, in the twenty-first century, because of the generational family-based distribution system. However, the actions of professional doctors during the Progressive Era solidified the success of professionalization. They successfully gained the trust of the majority of American society during the first three decades of the 1900s, including the trust of the federal government, which granted licensed doctors the sole authority to prescribe whiskey. Even though people went to see doctors more and used folk remedies less, in Southern Appalachia medicinal knowledge of things like local plants and moonshine persisted throughout the twentieth century into the lives (and interviews) of people like Joe Aliff, Flora Youngblood, and Mary Jane McCoy. Their knowledge was not the only piece of folk medicine that lasted, though: concerns over the high costs of professional health care and accessibility to doctors stuck with people in Southern Appalachia.

## Conclusion

Southern Appalachian folk medicine shifted from a system of practiced knowledge to a system of preserved knowledge during the early twentieth century, as licensed professional doctors expanded their influence and installed biomedicine at the center of American healthcare. Although most historians and anthropologists tend to understand this shift as a decline, it is better understood as a process. This process, spurred on by industrial developments and late nineteenth century modernization, spanned the early decades of the twentieth. As progressivism gained momentum, professional doctors navigated new ideas and concerns about public health by relying on their knowledge to gain public trust. The effects of that process, the answer to how much trust professional doctors won in the early 1900s, are reflected in the popular image of folk medicine as an extinct or backwards practice. People in Southern Appalachia, who subscribed to a tradition of knowledge built on adaptation, recognized the benefits of a new system spearheaded by licensed physicians with specialized knowledge.

Industrialization in the nineteenth century reshaped Southern Appalachia. In particular, railroads presented new opportunities for the region in the form of emerging markets in growing communities. This opportunity was not wasted by licensed doctors and medical school graduates, though the lack of hospitals in rural areas later discouraged professional doctors and nurses from practicing far from places with denser populations. The coal boom of the 1850s invited national interest to Southern Appalachia and instilled industrial capitalism and extractive industries at the heart of the region's economy.

At the same time, progressive reform in Appalachian states manifested in campaigns against the production, distribution, and consumption of alcohol. As state prohibition laws came into effect, the national movement gained momentum. Prohibition in Southern Appalachia

played out in a critical way that shaped the national agenda, with Tennessee as the first state to pass a prohibition law in 1838 to Kentucky's prohibition law taking effect in 1919--two months before the ratification of the Volstead Act, which outlawed alcohol consumption at a national level.

Prohibition in Southern Appalachia increased policing in rural areas, as revenue agents and marshalls chased moonshiners and bootleggers, but the Volstead Act granted professional doctors the legal authority to prescribe whiskey. This exemption from the rule reveals the national acceptance and trust in professional doctors' authority. Prohibition also changed a key element of moonshine's function in Appalachian communities: the consumption of moonshine became illegal. Before state-wide and later national prohibition, the production and distribution of moonshine was illegal because moonshiners and bootleggers evaded taxes. Moonshine was a common ingredient in Appalachian folk remedies, particularly necessary for herb tinctures. By outlawing the consumption of moonshine, Prohibition presented another challenge to folk medicine practice.

In the midst of industrialization, modernization, progressivism, and Prohibition, professional doctors with medical licenses and collegiate educations emerged as legitimate authorities on health. In order to make their legitimacy stick, these physicians needed to gain the people's--their potential patients'--trust. Professional doctors sought out trust by linking their authority to their knowledge. By reforming medical education, organizing national, state, and local medical societies, delegitimizing alternative practitioners like chiropractors, and requiring medical licenses to practice, professional physicians of the early twentieth century shaped the modern American healthcare system in place today. These men successfully established

themselves and the form of medicine they subscribed to as the dominant system of medical knowledge for their fellow Americans.

Throughout this success, professional medicine collided with existing systems of knowledge. In rural Southern Appalachia, people reassessed their system of folk medicine and gradually accepted professional medicine as a better way of treating and maintaining health. They had a lot to navigate already, as industrialization and progressivism changed the social, economic, and physical landscapes of Appalachia. High monetary costs for professional medical services and limited access to licensed doctors or hospitals in rural communities presented viable reasons not to trust physicians. However, by the 1930s people in Southern Appalachia mostly accepted professional medicine as the superior form of healthcare due to doctors' efforts to cultivate their authority.

Nonetheless, folk medicine did not fade away in the 1930s in Appalachia. People continued to learn and share their knowledge with new generations, though they used this knowledge less. Although scholars like Anthony Cavender describe this period as one of decline for Southern Appalachian folk medicine, the system actually persisted as knowledge passed down through decades. The concerns surrounding the cost of professional medicine and the questions of whether or not to trust doctors did not fade away either. These questions resurface throughout the twentieth century, as demonstrated through the interviews with Flora Youngblood, Mary Jane McCoy, and Joe Aliff. The same issues--costs and trust--carry over into the twenty-first century.

Right now in 2018, people have questions about the cost of healthcare and the authority of doctors and professionals. These questions--over high costs of drugs and surgeries and whether or not health care professionals have the patients' best interest at heart or their own--

swelled over the implementation of The Affordable Care Act and continue to follow in the wake of current efforts to undermine Medicaid and Medicare. Free clinics in Southern Appalachia are overwhelmed with patients. People wonder if they can afford insurance, or expensive hospital stays, or even an ambulance ride. People also wonder if they can trust the federal government to run a national healthcare plan, or if a national plan is the best way to combat high medical costs at all.

These problems and these questions did not go away with the rise of modern American healthcare in the early twentieth century and neither did the knowledge of Appalachian folk medicine. Both the concerns and practices of people in Southern Appalachia in regards to health evolved and persisted through the twentieth century. As long as these same concerns persist, folk medicine in Southern Appalachia will have room to persist as well.



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**Appendix**  
**“Soak the roots in whiskey:”**  
**A Demonstration of Southern Appalachian Folk Medicine Knowledge**

**Report on Presenting the Demonstration**

I presented this demonstration twice on April 24, 2018 to two separate groups of students and community members at Virginia Tech’s Newman Library in the Athenaeum. Each presentation lasted approximately 30 to 45 minutes. I covered the main points of my argument and significance of this research project. Then, I showed my audience a collection of herbs and remedies including dried roots and leaves from ginseng, pleurisy root, and boneset, as well as other common ingredients including lemons, honey, distilled alcohol, and olive oil. Throughout the presentation and after, I encouraged questions from my audience.

**Presentation Outline and Script**

Introductions, greetings, welcomes.

**Henry Cantrell story (hook)**

I’m going to start with a short story about a man named Henry Cantrell, who lived in northeastern Georgia and practiced a particular form of folk medicine. During the turn of the twentieth century in the hills of Southern Appalachia, people like Henry Cantrell were a necessity. Cantrell carried with him a knowledge passed down from one generation to the next, a knowledge that crossed the boundaries of race and gender, in a society where people consistently defined their lives and the lives of their fellow Americans by both race and gender. Whether or not Henry was aware of his role in this hierarchy is unclear, but one thing is very apparent: Henry Cantrell knew about plants. He knew how to identify medicinal plants, he knew which herbs would cure or ease what ailment, and he knew people around him needed that knowledge in practice.



## **Significance/big picture**

Real quick, let me tell you what “Appalachia” I’m talking about. Southern Appalachia, for the purposes of this demonstration, consists of the mountainous regions of North Carolina, South Carolina, Georgia, Tennessee, Kentucky, Virginia, and the entire state of West Virginia. I might refer to the region as simply, “Appalachia” out of habit.

It is hard to talk about folk medicine in Southern Appalachia during the early twentieth century without talking about it in terms of its relationship to professional medicine. When Appalachian folk medicine and professional medicine appear together in scholarly discussions, a pattern of winners and losers become clear: Appalachian folk medicine is typically seen as a victim of professionalization, due to aggressive efforts taken by professional doctors to establish their authority.

However, the stories and the interactions I’ll show you today point to a different pattern. Instead of declining, folk medicine in Appalachia transformed--from a system of practiced knowledge, to a system of preserved knowledge. People still learn(ed), share(d), and use(d) folk remedies after licensed doctors became a regular presence. They use them less, and trust licensed doctors more. But something about folk medicine, or really some important things that define folk medicine, have persisted from the early twentieth century into the present: high costs of healthcare, there is still a significant lack of hospitals in rural areas, and traditions of passing knowledge on to the next generation--in case they need it.

By understanding how knowledge operated in Southern Appalachian folk medicine during the early twentieth century, we can understand why this knowledge is still here today. People in Appalachian communities continued to distribute their knowledge of health and remedies

throughout the twentieth century and into the twenty-first, but by the 1930s professional medicine had almost entirely disrupted the practice of folk medicine.

**(introduce Flora Youngblood [Henry Cantrell's daughter], Joe Aliff, and Mary Jane McCoy)**

I trace knowledge in Southern Appalachian folk medicine primarily through the words and stories of three people: Joe Aliff, from West Virginia; Flora Youngblood, Henry Cantrell's daughter from Georgia, and Mary Jane McCoy, also from Georgia. These three people learned, shared, or used knowledge of Appalachian folk medicine in the context of the early twentieth century. For Flora Youngblood, she learned, shared, and used this knowledge during the early twentieth century. Mary Jane McCoy learned this knowledge towards the end of this period. Her mother, who learned, shared, and used folk medicine during this time, taught McCoy about home remedies and health in the mountains. Joe Aliff learned from his mother and grandfather, who learned, shared, and used folk medicine knowledge during the early twentieth century. Their stories are representative of a broader system of knowledge, supported by fifteen other interviews I used in my research.

**talk about internship at Foxfire**, researching in the archives through transcripts and audio files.

(a lot of stuff is digitized now, and Foxfire is working on digitizing their archives, but it was actually really helpful to dig through filing cabinets of folders. I never knew what names or questions or topics I would come across, and found more than one source for my thesis on accident). Talk about diversifying interview sources with interviews from Library of Congress--totally different experience because that was all digital, with only clips of interviews and no transcripts. Not as immersive as Foxfire's archives.

**talk about context of Progressivism** and professionalization--a lot of things were changing, especially things relating to physical health and hygiene: Upton Sinclair's *The Jungle*, the Pure Food and Drug Act, Prohibition--which particularly affected Southern Appalachia by increasing the policing of rural communities

### **Flora Youngblood and Henry Cantrell--plants, labor, and family**

Doctors were few and far between in rural Appalachia during the early years of the twentieth century. Even as medicine experienced leaps and bounds in terms of scientific advancement and professionalization, people in Appalachian communities put work into consistent routines of community health. This was the routine people like Henry Cantrell subscribed to, one that emphasized locally available resources. Henry's daughter, Flora Youngblood, described this routine as she saw it in an interview from 1984: (I'm going to pause here to give everyone a chance to read this quote of hers or at least look at it. Pay attention to the process that she is describing). [pause and count to five or ten].

“We had a little ole ox cart, two-wheel ox cart. My Daddy got down with arthritis so we would put him on that ox cart, my brother would drive the little ole ox cart and I would go with ‘em to help him about digging ‘em [herbs] up and we would go all back up them little roads in the mountains you know cause you could get through little biddy ole places, just two wheels. So I’d help him gather ‘em... We would get it about twice in the winter so we could—early in the fall and about one more time through the winter months. We gather it up and powder it up. He had his medicine cabinet almost as big as my hutch over there and little vial bottles you know and he would fix it all up and put it in there. Had everything labeled you know and could just go get it whenever anybody come.”

She describes a labor-heavy process with a specific role for everyone involved, which typically

meant family members working together. Her brother drove the ox cart on tiny roads, Flora and Henry got their hands dirty gathering plants, and once her brother got them all back home they had to process the plants into medicine. Youngblood's description points firmly to the relationship between family, labor, and medicine in the mountains.

Her words also place plants at the heart of Appalachian folk medicine. Although plants were not the only ingredients in the remedies people used, medicinal herbs dominated the knowledge behind the practice. For the most part, people in rural Appalachia did not go out looking for a licensed doctor with prescriptions once someone fell ill. They went looking for specific plants--or someone like Henry Cantrell, who had already collected the herbs and knew how to use them.

**Joe Aliff--plants, labor, family, focus on his language**

In twentieth century West Virginia, the routine of gathering herbs looked very similar to how it played out in northern Georgia. Joe Aliff, interviewed by Mary Hufford for the Library of Congress in 1995, describes the labor:

“In the springtime, it was a common sight, every family. Now you folks would probably call it a sack or a paper bag but to us it was a poke. Well you get a poke that you carry groceries in, and a knife, and you go when the weeds start to grow. Every family would go to the fields and the woods and gather pokes full of these wild plants. And that was your granary that you had been without through the winter, and it was very healthy. And you drank your sassafrass tea or your spicewood tea. And you know, you were putting your body back in shape--it was equal to, you know, like the folks on the sailing ships they had to carry lemons or limes after they discovered scurvy.”

Here, in these words, we need to pay attention to the language. Aliff builds on the same connections between family, plants, labor, and medicine that Flora Youngblood made in her

interview. He goes even further than Youngblood, however, in his association between plants and health. Aliff specifically compares the process of gathering herbs to people who, centuries ago, found that citrus fruit prevented sailors from getting scurvy. The terminology he uses, like “granary,” “healthy,” and “putting your body back in shape” reflects a firm understanding of health in Appalachian communities.

The consistency between his account and Flora Youngblood’s is not coincidence. Gathering native plants for medicinal purposes was a common practice in the region, undertaken by families throughout the Appalachian mountains. The knowledge behind that practice depended on several factors, including the ones already mentioned: class, labor, family, and plants.

In the interviews I collected, people pointed to two concerns about professional medicine time and time again: high costs and limited accessibility to licensed doctors. They demonstrated a firm understanding of their situations through terminology associated with health and its costs.

Joe Aliff described natural resources of medicine in terms of institutional medicine, money, and knowledge in his 1995 interview: “That mountain is like a drugstore. You don’t have to have money you just need a little bit of knowledge.” His understanding of health echoed that of his peers: medicine can be found in the mountains if you know where to look and how to use what you find, and this is cheaper than going to see a licensed doctor.

### **Mary Jane McCoy--plants, family, generations, using “doctor” as a verb**

Mary Jane McCoy, a native of Georgia’s mountains, points directly to isolation from professional medicine and the self-reliance Appalachian people found in folk medicine:

“Old folks just had to kindly experiment with it themselves...Course, it was a miracle I reckon that they just experimented in getting that and it helped ‘em some. I don’t know what else.

Course, you just learn things by experience sometimes. And that’s about what the old folks had

to do. The doctors wasn't so close to 'em that they could call a doctor. They just had to learn, kindly, to doctor themselves.”

McCoy's account brings a generational focus to the forefront. She is talking about a specific group of people, an older group of people, who had to figure out how to treat themselves because doctors were too far away. Her use of “doctor” as a verb reveals a connection between folk remedies and professional medicine in Appalachian perspectives of health. In these communities, you did not have to be a doctor in order to heal or treat someone's health.

Flora Youngblood's perspective echoes McCoy. She points to isolation, self-reliance, and uses “doctor” as a verb as well: “Back then, you know, there wasn't many doctors. People just sort of doctored themselves.” Based on these accounts as well as consistent echoes of these perspectives from other interviews, there is a clear link between money and capital, isolation, and influence from professional medicine in Appalachian knowledge of health and folk medicine.

### **Significant medicinal plants and remedies**

Knowledge in Appalachian folk medicine revolved around local plants and herbs. This emphasis on available resources came from the same class-based need discussed above, a necessity rooted in limited access to doctors, high monetary costs, and geographic isolation. Multiple accounts from people in rural Appalachian communities describe the lack of doctors in the same breath with local knowledge on medicinal plants. Joe Aliff directly points to plants as the primary resource in Appalachian folk medicine and ties those resources to class-based necessity. In his 1995 interview, he says, “All medicines come from these plants out here anyway. And I've studied plants. It was a necessity with mountain folk, we didn't have money to go to the doctors. You cured yourself or died, that's bout the size of it.”

“Well, he gathered yellow root, that’s for ulcerated stomach and queen of the meadow that is for curing Bright’s disease, any kind of kidney trouble and then he would take that, they called it butterfly root for—now they called it grip? Then, we call it flu now, about the same thing. Real bad sickness, like you’ve got the flu. That’s what he would use for that. Then he would use that burdock to soak your feet in but I done said that and I still can’t think of that, I can see it in my eyes but I can’t think of it. Now for poultices, like to draw out risens he would take walnut leaves, beat ‘em up and put salt, table salt, grind these leaves up and with table salt place it on the risen and it’ll just dry it right out.”

### **Networks of Knowledge in Appalachian Folk Medicine**

The Appalachian network of knowledge on health and medicine depended on oral traditions, language, and shared knowledge through communication. Whoever had knowledge of healing was or could be a legitimate practitioner, though some people like Henry Cantrell knew more about medicinal plants and methods than others and therefore held more authority.

People in rural Appalachian communities learned and shared knowledge of health and medicine by communicating with kin and family and community-based oral traditions. Parents and other relatives constantly come up in interviews about folk medicine in Appalachia. For example, Mary Jane McCoy, who grew up in the Appalachian South, talks about her mother using herbs to heal: “My mother knew a lot of things about herbs. She could get some things to break a cold up on uya. She got out in the fall of the year and gathered up them things and put em in paper bags and saved em up and packed em away for the winter. She knowed the roots and thangs.”

Mary Jane McCoy’s experience with her mother’s knowledge was not an isolated experience in Appalachia. In West Virginia, Joe Aliff learned about medicinal plants and healing methods through his family. In his interview, Aliff says, “[I learnt] through my mother, who learnt from

my grandpa.” His experience builds on McCoy’s: while McCoy only talks about her mother’s knowledge, Aliff points to two family members that knew about folk medicine and taught other relatives.

Aliff’s experience with family-centered knowledge represents a larger pattern in Appalachia. Flora Youngblood, in her interview with Foxfire students, talked about her father and his unofficial career as an herb doctor. She points exclusively to folk medicine’s dependency on family networks: “from my daddy learnt my mama. Well, my mama couldn’t learn me, my daddy...well, he learnt me.” Youngblood’s experience echoes that of Joe Aliff. She had at least two family members with knowledge about folk medicine, both of whom taught other family members. The way that families taught each other healing methods and plant knowledge depended on gender.

### **Gendered Distribution of Knowledge**

Gender plays a crucial role in the distribution of folk medicine knowledge in Appalachia by determining who can teach the next generation. Flora Youngblood brings up the role that gender played in the distribution of folk knowledge on medicine. She says “my mama couldn’t learn me” for a specific reason: men typically could not pass down, teach, or communicate how to practice certain aspects of folk medicine to other men and women cannot do the same for other women. In Youngblood’s case, she could not learn from her mother--if she did, her mother would lose her abilities to heal using her knowledge of folk medicine.

This practice comes out in Joe Aliff’s description of how he learned about folk medicine as well: Aliff’s grandfather taught his mother, and his mother taught him. Much like Youngblood, Aliff’s family filtered his education in folk medicine through gender. Aliff’s mother taught him about



native plants and traditional Cherokee knowledge of folk remedies--and she learned from Aliff's grandfather.

This gendered distribution of knowledge seems strict and rigid on its face, but the practice actually contributes to the fluidity of Appalachian folk medicine. By requiring men to teach women and vice versa, people in these communities guaranteed that their knowledge could not be restricted to one gender. The opposite is true of professional medicine at this time: licensed doctors specifically and purposefully restricted access to their profession, their authority, and to their medical knowledge from women.

### **Racialized Sources and Distribution of Knowledge**

Although white settlers came to Appalachia with a system of traditional medicine from Europe, they and their descendants who stayed in the mountains learned about medicinal plants and methods from American Indians--specifically Cherokees. That knowledge was incorporated into community and family oral traditions alongside knowledge that came from African slaves and Scot-Irish tradition. The cross-racial communication of knowledge about health demonstrates the fluid structure of Appalachian folk medicine, where people were expected to adapt or change their knowledge by integrating new ideas about health and medicine. In comparison to professional practices, this demonstrates one of the biggest differences between the two fields: white men shaped knowledge in professional medicine, whereas Cherokees largely shaped the knowledge used in Appalachian folk medicine.

According to interviews with people in Appalachian communities, Cherokee Indians contributed the bulk of knowledge on health and medicinal herbs to folk medicine. In her interview, Mary Jane McCoy talks about how her mother "learned from the Indians...if they didn't and she didn't meet them [Cherokee people] some of the people did and taught her these things. That's the way

it went.” Her comment points to an established practice: people learned from Cherokees about medicine because “that’s the way it went.”

This pattern of instruction holds true for Flora Youngblood’s father, Henry Cantrell: “He [her father] learned all their remedies from [the Cherokee], that’s the reason he went over there...There was an Indian chief who lived in the same neighborhood that we did. He would come out and talk with my daddy a lot in their young days...So that got him interested and wanting to know about [medicine]. So he just went and joined their tribe for a period of time.”

This cross-racial communication is embedded in family networks indirectly for people like McCoy and Youngblood. In Youngblood’s case, however, she knew for a fact that her father invested his time and efforts in living with Cherokees for a period of time specifically to learn about healing with native plants. Henry’s mother and father were aware of his decision as well, and encouraged him to learn this knowledge so he could use it in his community. Their support indicates that white people valued this kind of knowledge. Henry Cantrell’s decision to live with the Cherokees demonstrates this value as well.

For Joe Aliff, who learned folk remedies passed down to his mother from his American Indian grandfather, his knowledge came more directly from indigenous practice. Originally from Cherokee, North Carolina, Aliff’s grandfather moved his family to West Virginia looking for work. In West Virginia, Aliff learned about his heritage with the Cherokees by inheriting knowledge about folk medicine from his mother. Although his story looks different from Flora Youngblood’s and Mary Jane McCoy’s, whose parents were white and learned from Cherokee Indians, all three stories echo the same key conclusions: Cherokee knowledge was the foundation of Appalachian folk medicine, and white people and Cherokees integrated that knowledge into

their oral traditions. Joe Aliff, Flora Youngblood, and Mary Jane McCoy are also evidence of how people in Appalachia distributed Cherokee-based knowledge through family networks.

**Folk medicine “conclusion”:**

Talk about how Henry Cantrell’s world changed during Flora Youngblood’s and Mary Jane McCoy’s lifetimes, then changed again during Joe Aliff’s lifetime. Change represented by shift from mountains, to residential buildings like the maternity center that people transformed into local clinics, to hospitals and current health care infrastructure represented by the Mountain Lakes Medical Center (which wasn’t there when I was growing up, but opened during the time I’ve been in college) because this is an ongoing shift--and folk medicine persists as part of that narrative.

This essay is part of my thesis, which explores how the professionalization of American medicine during the early twentieth century influenced and changed Appalachian folk medicine. From 1900 to 1930, pieces of professional medicine slowly showed up in Appalachian folk remedies. People who lived in the mountains began to trust professional doctors and their expert knowledge over home remedies. Professional medicine’s influence grew as licensed and educated doctors cemented their image of authority in Appalachia.

The relationship between professional medicine and Appalachian folk medicine is the next step for the narrative in this essay. Before taking that step, however, it is important to understand Appalachian folk medicine separately from professional medicine. It is just as important to understand the people who used this system of knowledge, through and on their own terms. It is not enough to focus on plants, class, isolation, gender, race, or family separately--these are the necessary pieces of the puzzle in order to fully understand folk medicine in Appalachia. In an effort to bring this essay full circle, I now turn back to Henry Cantrell.

Henry Cantrell is the prime example of the interactions between plants, class, gender, race, and family at work in Appalachian folk medicine. Cherokees taught Henry Cantrell about plants. He sought out that education and learned about folk medicine because his family believed this knowledge mattered in his community--they believed it was necessary to know these things in an isolated region of the United States. Henry Cantrell distributed the knowledge he learned to his family, in a manner that depended on gender and guaranteed both men and women the chance to learn and use folk medicine in Appalachia. That knowledge is still around today because of people like Henry Cantrell, his daughter Flora Youngblood, Joe Aliff, and Mary Jane McCoy.

