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“A GREAT MASS OF INCOMPETENT MEN”: CONTESTED MEDICAL FRONTIERS IN OKLAHOMA, 1880-1940

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DEPARTMENT OF HISTORY

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Abstract

This thesis observes the movement of White aspiring physicians to Indian and Oklahoma Territories in the late 19th and early 20th centuries and the racial and professional interactions that ensued. Like other Whites, Oklahoma represented an opportunity to acquire economic freedom and prosperity through land runs and other settler colonial processes. In Oklahoma, aspiring physicians used the chaos and lawlessness in Oklahoma and Indian Territories along with their whiteness to jumpstart their professional careers while experimenting and enforcing orthodox forms of medicine over Oklahomans. Native, Black, and White Oklahomans resisted through various means, and White orthodox physicians largely used statehood to cement their medical vision for the state of Oklahoma. In the American West, as settler colonial policies spread, contested medical spaces emerged with various forms and understanding of health and healing practiced. In Oklahoma this is especially true. Statehood became a pivotal event that allowed doctors to reflect on the medical future of the state and utilize their recently acquired professional authority and power to enact changes to the medical profession including medical school reform and institutionalizing healthcare. This thesis centralizes national trends in the professionalization of medicine to explain how the American West and Oklahoma were unique in offering White physicians the opportunity to practice medicine, but they were met with resistance and often threatened by nontraditional practitioners.

Introduction

Isabel Cobb arrived in Indian Territory some time after 1870. Born to Joseph Benson and Evaline Cobb, Isabel's maternal family was Cherokee. She grew up in Tennessee, and when her family relocated to the Cherokee Nation, Isabel attended the Cherokee Female Seminary in Tahlequah. She would enroll in several schools until she achieved her medical degree in 1892 from the Woman's Medical College of Pennsylvania.[1] After completing internships on the east coast, she returned to the Cherokee Nation and became arguably Indian Territory's first female and Native physician. Isabel Cobb's story illuminates the movement of physicians along state and territorial borders in the late 19th century. Cobb petitioned to become the head physician at the Cherokee National Female Seminary, but she was denied, and the job was given to a male physician.[2] Cobb continued to serve her community, specializing in the care of women and children, treating Cherokees and others throughout Indian Territory. As a Cherokee Nation physician and arguably the first female doctor in Indian Territory, Cobb pushed medical boundaries and limits. She navigated the flexible medical space in Indian Territory at the end of the 19th century. "Dr. Belle" also exemplifies the hesitancy of authorities and officials to accept female, and Native physicians as leading practitioners. Cobb traversed borders with the Cherokee, Muskogee-Creek, and settlers and created her legacy when physicians were actively seeking to exclude the likes of her from their profession.

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[1] The Woman's Medical College of Pennsylvania was the second institution in the world created for training women to practice medicine. The United States led the world in its training of female physicians for a time, until schools began closing and barring female applicants in the early 20th century. See Peitzman, Steven J. *A new and untried course: Woman's Medical College and Medical College of Pennsylvania, 1850 – 1998* (New Brunswick: Rutgers University Press, 2000).

[2] Dr. Farina King created a video on Dr. Isabel Cobb's career with a detailed biography on Cobb, and her motivations as a physician utilizing archival sources and interviews with Cobb's family. See "*Loyal Countrywoman Too*", YouTube, (Museum of Native American History, 2021), https://www.youtube.com/watch?v=U8ghVGVUMxU.

The story about how physicians like Cobb got excluded from medicine in the Twin Territories and then the state of Oklahoma has largely to do with White, male, regular physicians and their medical associations. As early as 1893 in Oklahoma Territory just a year after Cobb graduated, physicians Eugene O. Barker, H. P. Halsted, and Joseph Pinquard created *The Oklahoma Medical Journal*. In their publication, they urged the formation of a medical association in Oklahoma Territory. In Indian Territory, a similar association had formed in 1881 and reorganized under a different constitution in 1890. In their March issue of *The Oklahoma Medical Journal*, the three raised this question, "Is it not about time to organize a Territorial Medical Society? Every State and Territory except Oklahoma has a successful medical society, and Oklahoma with 300, or more physicians without a Territorial Society is behind the times. We as practitioners, if we hope to keep to the front and alive to the advance of medical science, must have a place where we can meet and exchange ideas and form more friendly and closer relations."[3] Just two months later, the first meeting to organize an Oklahoma Territory society met in Oklahoma City. Together with the Oklahoma Territory physicians, the Indian Territory society anticipated statehood and used their organization to stay proactive in their medical and lobbying efforts. Their Whiteness and presence in associations allowed them to discount physicians and push their experiences to the back of the public's imagination. However, many stories emerge of alternative practitioners continuing their work despite many physicians' active efforts to exclude them from the profession altogether.

In Oklahoma, the struggle for power largely influenced decision-making. Leading Oklahoma scholars, David Baird and Danney Goble have illustrated how jurisdiction and the

[3] "History of the Oklahoma State Medical Association," *Journal of the Oklahoma State Medical Association* 49, no. 5 (January 1956): pp. 147-189.

lack of control over nontribal citizens established a lawlessness in Indian Territory.[4] I build off that scholarship by centralizing medicine to this larger history of Oklahoma. Baird and Goble successfully demonstrate Oklahoma's political history and its brief status as two territories noting each territory's economy and demographic changes at the turn of the century. Some immigrants, Native peoples, and African Americans all threatened the status of many White settlers which I use as a backdrop for my study. Historians' attention to Oklahoma's unique past has resulted in scholarship that details how race and landownership played central roles in statehood. Histories of medicine in the American West are scarce, and I use medicine as another reinforcer to this process of settler colonialism that occurred all throughout the moving frontier boundary of the American West. David Chang demonstrates that owning land in Oklahoma was central to a settler's success. He also argues that a complex triracial society emerged in Oklahoma, where race and landownership were closely tied with status. I build off his theme by grounding my study in this racialized society, where physicians treated a variety of patients with very different understandings of medicine and healing. Chang also illustrates how race created opportunity in Oklahoma. For many formerly enslaved Black Creek citizens, race, specifically Blackness, united people and created Black towns throughout eastern Oklahoma. I also demonstrate how medicine created unique opportunities for formerly enslaved Black Indians, while also being limited by the racialization of Oklahoma society. White tenant farmers like many White orthodox physicians depended on their Whiteness to lead them to success.[5] The

[4] Baird and Goble's narrative history of Oklahoma demonstrates that tribal governments could not govern nontribal citizens, resulting in chaotic space. In a similar way, doctors took advantage of the lawlessness of Indian Territory to practice medicine. I use Baird and Goble's impactful history to ground my work. Their attention to Indigenous voices and Oklahoma's political history is an important foundation to my extension of parts of their argument to the medical field. See David W. Baird and Danney Goble, *Oklahoma, A History* (Norman, OK: University of Oklahoma Press, 2008).

[5] For my thesis, I use "orthodox" or "regular" to categorize physicians that practiced a Western-centric type of medicine that most physicians utilized, with roots in western Europe and the east coast of the U.S. Leading medical schools and associations like the American Medical Association created standards and practices that I deem

pleas of White tenant farmers resembled the urgency and demands of White physicians. Both groups worked to create a sustainable professional future for themselves that relied on their race.[6] Through the lens of medicine, I demonstrate that the struggle for power over both patients and the profession resemble the power struggle depicted by previous Oklahoma historians over land and governing Oklahomans.

This thesis argues that Oklahoma and Indian Territories were contested medical spaces, where practitioners from various backgrounds struggled to obtain professional autonomy and authority. Moreover, statehood was a pivotal event that shaped the medical future of Oklahoma. While Oklahoma scholars have explored statehood implications in facets other than medicine, I offer different observations about what statehood meant for the health of Oklahomans. While other states were undergoing the process of professionalizing, I argue that for a brief moment in the historical timeline in Oklahoma, and elsewhere, alternative practitioners and nontraditional doctors threated the Western-centric system of medicine. This is especially true in states like Arizona and New Mexico, where the process of statehood in the early 20th century coincided with medical professionalization. Oklahoma was different in that its White settlement policies and rich Indigenous history created a unique space. A glimpse into this process in Oklahoma offers an important contribution into the history of medicine in the American West with

"orthodox for this thesis. I use alternative to denote any physician or practitioner that challenged Western physicians' type of medicine. This means irregular or nontraditional could mean Black physicians, Indigenous doctors, or homeopathic White doctors. I distinguish this because it is difficult to categorize practitioners because of medicine's dynamic nature during this time. I realize "orthodox" may insinuate that this form of medicine was supreme; however, in Oklahoma there was significant blending and adoption of multiple forms of medicine that meant no one way of practicing medicine was superior.

[6] David Chang's *The Color of the Land* centralizes landownership as a driving force for Oklahomans in the 19th and early 20th centuries. His book offers an understanding of how the Creek understood their land and the ways the Dawes Commission determined status based on race for settlers and Indigenous peoples alike. Moreover, the book discusses the ways Black Oklahomans viewed land and the ways landowning united races. For Whites, tenant farming drove farmers to socialism to advocate for their financial futures, and in a similar way, doctors used organization to advocate for their own professional lives. See David A. Chang, *The Color of the Land: Race, Nation, and the Politics of Landownership in Oklahoma, 1832-1929* (Chapel Hill, NC: Univ. of North Carolina Press, 2010).

implications for later states like Arizona and New Mexico. The professionalization of medicine in Oklahoma and other Western territories and states was simultaneous with trends around the country, but eastern states had established medical schools and public health departments well before Oklahoma and other Western states. The timing of this process resulted in struggles over professional authority while people debated and determined political power in these states. Oklahoma's demographics also made regular physicians' task to cement their form of medicine more difficult than other states. White physicians needed to work alongside and with Indigenous practitioners to treat Oklahomans resulting in compromise and adaptation from both sides that adds to the complexity of this story.

Scholars have depicted frontier physicians as innovative practitioners that used everything at their disposal to treat their patients with grace and competence.[7] Many historians have challenged this account since, and I add to the deconstruction of these narratives in the history of medicine. I also build off previous works on rural medicine and how settlers understood themselves through their bodies and medicine.[8] Larger syntheses of the American medical profession have generated a sweeping narrative of progress and authoritative success in the field of medicine when throughout the history of medicine, alternative practitioners have

[7] Articles like "Doctors, Druggists, and Dentists in the Oklahoma Territory, 1889-1907" situate pharmacists and pioneer doctors as innovators, having to "endure the discomforts of rural practice." (122). Other works like *Frontier Medicine, From the Atlantic to the Pacific, 1492-1941* use the frontier as an all-encompassing backdrop where medical boundaries are pushed and A triumphant narrative of the White man traveling in adverse weather with his instruments in his saddlebag departing for days at a time emerges in the oral histories and scholarship about frontier medicine, especially in Oklahoma. Finally, One vital collection for my thesis, the Oklahoma Pioneer Physicians Oral History Collection reads like this. However, through analysis, the ambiguity and uncertainty of the medical future of Oklahoma can be argued. See Johnson, B H. "Doctors, Druggists, and Dentists in the Oklahoma Territory, 1889-1907." Arizona and the West 19, no. 2 (1977): 121-34.

[8] Conevery Bolton Valencius' *The Health of the Country* makes an important contribution to the history of medicine by joining both environment and body. White settlers had to adjust to new environments, and my work builds off her argument by demonstrating that White hesitancy to medicine and worries about different diseases in Oklahoma affected the careers of physicians in Oklahoma. White settlers in Oklahoma brought with them assumptions about the land and environment that included disease and medicine. Both Valencius' and my work situate settlers' stories and medical experiences as evidence of settler colonialism. See, Valencius, Conevery Bolton, *The Health of the Country How American Settlers Understood Themselves and Their Land*, (New York, NY: Basic Books, 2002).

challenged this notion and did not simply disappear. For example, Paul Starr's *The Social Transformation of American Medicine* covers the making of an industrial profession in the United States by centralizing authority and reform as major reasons for the creation of the medical profession.[9] Although Starr, a sociologist, makes a splash in the history of medicine, other scholars have contested his work. John Harley Warner argues that Starr's synthesis imagines a collective group of privileged doctors looking to create a uniform profession.[10] In many ways, my thesis adds to this phenomenon. However, like Warner discusses, Starr's work failed to recognize the sustaining of alternative physicians in the United States beyond the professionalization process. I also hope to not reproduce the hegemonic history that others have created. Instead, I look to use Oklahoma as a view into the contestation of the medical field at the turn of the century.

Regular Oklahoma physicians, who were largely migrants, were met with resistance to their form of medicine from patients and practitioners alike. I also add to the deconstruction of traditional narratives by framing their experience as another enactment of settler colonialism. Rather than assuming the prowess of migrating doctors, I represent their assumption of power because of the privilege White male doctors had as scholars like Deidre Cooper Owens and Rana Hogarth have noted recently.[11] I add to the historiographic trends in deconstructing the Grand

[9] I do use Starr's work for background in Chapter 2, but his argument that physicians were a collective force is not necessarily true in the case of Oklahoma. While I argue statehood made professionalizing medicine easier, doctors were threatened by alternative practitioners and used statehood to cement their form of medicine for the future.
[10] Warner, John Harley. "Grand Narrative and Its Discontents: Medical History and the Social Transformation of American Medicine." Journal of Health Politics, Policy and Law 29, no. 4-5 (2004): 757-80.
[11] More recent scholarship demonstrates the means that Black bodies were used for the advancement of White medicine while reinforcing scientific racism. Deirdre Cooper Owens' *Medical Bondage* and Rana Hogarth's *Medicalizing Blackness* illustrate how scientific racism developed and was sustained by White physicians. *Medical Bondage* tells the story of American gynecology and how physicians exerted power over Black women's bodies through experimentation. Both books show how racial differences were created and how physicians used power and coercion to enhance their own careers and beliefs. In Oklahoma, through sterilization and segregated medicine, a similar story emerges where physicians reinforce racist and ableist assumptions about patients' bodies and use healthcare to demonstrate those assumptions. See Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens, GA: University of Georgia Press, 2017) and Rana A. Hogarth,

Narrative that historically depicted the history of medicine as well as the history of the American West. The influx of practitioners migrating to Oklahoma coupled with the doctors already practicing in Indian Territory created a problem of competition amongst all practitioners. Competition threatened the financial future of many physicians and prompted action. By using their professional power, traditionally Western physicians enacted what they envisioned for the future of medicine in Oklahoma. Framing the status of Oklahoma as lagging other states, physicians appealed to Oklahomans' desire to fit into the larger conversation of suitable states. While many pioneer doctors did practice good medicine with limited instruments and medications, an unchallenged romanticism excludes the experiences of the practitioners already present in Indian Territory. I provide a close analysis of the often complex motivations of White physicians and offer an alternative window into the history of medicine in Oklahoma at the turn of the century.

Scholars have also addressed contested medical spaces that I look to build off in this work. For example, Sharla Fett argues that on plantations in the antebellum South, enslaved women built healing networks that challenged both enslavers and physicians.[12] While my study is set later than Fett's, in Indian and Oklahoma Territories, women were central to medicine and nursing. I also focus on the stories of several women who directly altered the field of medicine in Oklahoma. Regina Morantz-Sanchez's work on women in medicine tells women's stories and

Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780-1840 (Chapel Hill, NC: The University of North Carolina Press, 2017).

[12] Fett's *Working Cures* illustrates the ways Black women formed complex healing networks within plantations in the United States. Black enslaved women created opportunities for themselves that sometimes challenged the interests of enslavers. In many cases, enslavers did not want to call physicians to treat enslaved people to save money, and enslaved people relied on the health networks of enslaved women for treatment. In Oklahoma, White physicians were hired to work on Native land and to treat Indigenous peoples, and in my work, this created a middle-ground of White and Native ways to approach medicine. Like *Working Cures*, this thesis demonstrates that in these contested medical spaces, opportunities for irregular practitioners were created and power was exerted. See Sharla M. Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations* (Chapel Hill, NC: University of North Carolina Press, 2002).

struggles to receive the same treatment as their male counterparts. In some ways, my work supplements her ground-breaking scholarship by demonstrating that in Oklahoma, women practiced medicine frequently, but also were excluded from education programs and medical associations. Morantz-Sanchez argued that women's place in medicine emerged because many thought women had something unique to offer patients. She argues that as medicine became more scientific and rigid, women began to lose their place in medicine.[13] In many ways, the story of Isabel Cobb exemplifies the trend Morantz-Sanchez articulates. Cobb entered the profession to help women and children like her mother and siblings, but her status as a woman hindered professional opportunities for her in Indian Territory.

This thesis is divided into two chapters. Chapter 1 begins by exploring the reasons doctors migrated to Oklahoma and the ways new, self-proclaimed physicians largely used the disorder of practicing medicine in the Twin Territories to their own advantage. With limited education and professional experience, doctors established their careers in Oklahoma with little regulation. They were quickly met with resistance and competition from nontraditional practitioners. Socialist and Populist doctors challenged orthodox physicians' authority and methods. Indigenous peoples strategically used Western medicine for their benefit while White doctors often dismissed Native traditions and healing practices. By the time of statehood, many regular physicians recommended changes to the medical profession that excluded nontraditional practitioners and established rigid requirements for future Oklahoma doctors. The disorder of the medical profession opened professional doors for White male physicians. The chapter concludes with the joint meeting of both the Indian and Oklahoma Territory Medical Associations in which

[13] See Morantz-Sanchez, Regina Markell, *Sympathy and Science: Women Physicians in American Medicine*, New York: Oxford University Press, 1985.

orthodox White physicians looked forward to statehood and the implications it posed for their profession's future.

The second chapter considers the ways statehood cleared the path to authority for White physicians. As medicine became more institutional into the 20th century, hospitals and asylums used state funding to open and grow. Using the recommendations of authorities from across the nation, medical officials in Oklahoma worked to close some medical schools and bolster others. Recommendations limited who could train in Oklahoma. Authorities then used education to improve the medical field for future generations, while also cementing the supremacy of regular physicians. The chapter concludes with Oklahoma's history with forced sterilization. Oklahoma's sterilization law, passed in the 1930s, allowed the sterilization of habitual criminals and patients with mental illness. The inclusion of habitual criminals in this legislation was certainly unique, and its constitutionality was challenged in the United States Supreme Court. However, throughout the United States, many physicians agreed that sterilizing patients with mental illness could cure patients. I argue that the newly acquired professional authority brought on by statehood allowed certain physicians to enact power over their patients in a time that doctors were just beginning to understand mental illness. Their confidence in the questionable treatments they administered often made situations much worse for their patients. In addition, their professional authority extended over other practitioners through medical association meetings.

Medical organizations like the Oklahoma State Medical Association were just one of the avenues for doctors to share their work and advocate for themselves. Legislative power emerged from their meetings. Their decisions and recommendations could be brought to state and local legislatures to establish public health systems that could not only improve the lives of

Oklahomans, but also advance doctors' own medical careers by giving them experience in public health, sanitation, and infectious disease.[14] The career of Isabel Cobb has been overshadowed by the conquering narrative of White male physicians employing their form of medicine throughout American society. Oklahoma and Indian Territories offered new starts for recently graduated physicians like Lewis Jefferson Moorman who would become an Oklahoma Hall of Fame inductee and editor of the Journal of the Oklahoma State Medical Association. Moorman toured Oklahoma Territory, settled in El Reno, and eventually became the Dean of the University of Oklahoma's medical school. He also established a sanatorium in Oklahoma City, headed state discussions about tuberculosis, and traveled to the Navajo and Hopi Nations to report back to the Department of the Interior on the conditions of Native Americans. Oklahoma fostered numerous stories like Moorman's while trying to push the likes of Cobb from the public's imagination. Doctors like Moorman saw statehood as an opportunity that would bolster their careers and purify their profession. Oklahoma grounds this story of struggle and contested medical spaces at the turn of the century in the United States, and its unique history produces a larger understanding of the history of medicine and the American West.

[14] Bernice Crockett published *The origin and development of public health in Oklahoma, 1830–1930* in which she details the history of public health systems in Oklahoma, writing about medical practices of numerous Native tribes in Oklahoma. Her statistical approach is also beneficial to understand how statistics became more important to public health officials in the 20th century. Her detailed study of Oklahoma spans Native and White medicine, the influenza epidemic, and other public health crises that were influential in grounding this work. I build off her subject by critically viewing the mechanisms and motivations for professionalization and how statehood simplified that process. See Crockett, Bernice Norman. "The Origin and Development of Public Health in Oklahoma, 1830–1930", (University of Oklahoma Press, 1953).

Chapter 1: Envisioning a Medical Future: Doctor migration and Oklahoma's territorial days

A nineteen-year-old Virgil Berry rode into Salem, Indiana one spring morning in 1886 to restock farm supplies for his family's small farm. As he gathered what his family needed, he heard songs and cheers of land hungry farmers wishing to join David L. Payne's camp of "Boomers" in Kansas. A fellow Indianan, Payne organized and led efforts to claim land in what would become Oklahoma before the official opening of the Unassigned Lands in 1889. Nicknamed "boomers" for their enthusiasm to "boom" into the Unassigned Lands without restraint or hesitation, Payne's men were arrested numerous times trying to lay claim to land prior to its opening in 1889. Despite Payne's death in 1884, his Boomers and their intentions lived on. The teenaged Berry, like many others, were captivated by the rhetoric and songs these wishful "boomers" sang. Berry believed Indian Territory, the Unassigned Lands, and eventually Oklahoma could provide a White man with economic prosperity and freedom especially for a young man with larger ambitions to practice medicine.[15]

The lure and promise of economic success Oklahoma drove scores of White farmers, Black freedmen, other settlers to the area at the end of the 19th century. Several land runs from 1889 to 1895 opened over two million acres to non-Indigenous settlement. Throughout those six years, lands of the Iowa, Sac and Fox, Potawatomi, Shawnee, Cheyenne, Arapaho, Cherokee, and Kickapoo were opened to Whites, and settlers quickly laid claim to plots of land. The railroad and mining industries also used White settlement to establish additional railroads and mines that were now not located on Native land in Indian Territory. Soon, the federal

[15] Autobiography, "Experiences of a Pioneer Doctor in Indian Territory" by Virgil Berry Folder 1, Box B-10, Virgil Berry Collection, Western History Collections and David W. Baird and Danney Goble, *Oklahoma, A History* (Norman, OK: University of Oklahoma Press, 2008).

government could begin profiting off this increased infrastructure and economic connections from Texas and Kansas. While the Five Tribes in Indians Territory had dangerous mining industries prior to the Land Runs, White settlement created new economic opportunities for settler colonialists from various backgrounds.

Not only did the Land Run of 1889 cause a fundamental shift in Oklahoma and American society, but it also drew many other types of people to Oklahoma. Aspiring physicians like Virgil Berry used Oklahoma as a jumpstart to their medical careers. Doctors settling in Oklahoma and Indian Territory largely used the chaos and lawlessness of the land to establish themselves so that when statehood came, their experience and acquired professional authority would render them esteemed professionals when by many accounts their path to practicing medicine was abnormal and not traditional. Economic promise in Oklahoma drew doctors to the area, causing competition as well as opportunities for professional development. Compared to national trends, the appeal of Oklahoma produced a greater number of physicians than the Twin Territories needed. Doctors practiced various forms of medicine as well, and patients in what would become Oklahoma were faced with varying levels of care. Oklahoma offered a physician a new start with little regulation in how they treat patients and almost no licensure and educational requirements.

The doctors who moved to Oklahoma settled in a largely disordered territory. Native Nations tried to preserve their sovereignty as an influx of White farmers flooded newly ceded land and hungrily eyed more. The federal government seemingly provided Whites a path to power through the acquisition of land at the expense of marginalized groups like Native Americans and Black migrants that Whites quickly subjected to Jim Crow laws after statehood in 1907. Physicians who migrated to Oklahoma were forced to navigate this triracial society that emerged in Oklahoma by the 20th century. As scholars such as David A. Chang have noted,

Oklahoma became a triracial space in which Whites and African Americans grasped for plots of land while Native Americans worked to retain their lands and communal ownership.[16] Nations like the Seminoles and Creek often hired White physicians to care for their people often supplementing traditional healing practices. In some cases, physicians worked closely with Native healers and adopted some Indigenous treatments. Native tribes offered the most regulation for doctors by hiring and requiring licenses for their tribe physicians since around 1879. White doctors treating Natives often encountered apprehensive patients willing to use orthodox medicine for their own gain while retaining traditional forms of healing. White physicians struggled to implement their forms of medicine while Natives applied White medicine hesitantly. White Oklahoma physicians also treated some Black patients, and White doctors brought with them their preconceived notions about racial immunities and pain tolerance.[17] In the years leading up to statehood the Black population in Oklahoma had increased from around nineteen thousand to over eighty thousand in 1907.[18] Whites in Oklahoma had increased to over half a million in the seventeen years since the first Land Run in April 1889 as well, offering physicians a demographically diverse clientele.

Influenced by these demographic compositions, Oklahoma also offered competing visions of the structure of medicine as statehood loomed. Orthodox physicians worried that the problems and rival forms of medicine threatened their profession. Absurd competition, quackery, and an underregulated profession were just some of the issues that physicians articulated and

[16] For more on landownership and race in Oklahoma see, David A. Chang, *The Color of the Land: Race, Nation, and the Politics of Landownership in Oklahoma, 1832-1929* (Chapel Hill, NC: Univ. of North Carolina Press, 2010).
[17] Scholarship like *Medical Bondage* and *Medicalizing Blackness* demonstrate the development of ideologies about racial immunities and pain tolerance. See Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens, GA: University of Georgia Press, 2017) and Rana A. Hogarth, *Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780-1840* (Chapel Hill, NC: The University of North Carolina Press, 2017).
[18] David A. Chang, *The Color of the Land*, 152.

fought to combat through their positions of power in state and territorial associations. By statehood, three major strains of medicine were practiced by men and women in Oklahoma. Homeopathy, Eclectics, and orthodox physicians worked closely with men and women employing various perspectives on medicine and treatments.[19] Not only were Black and White women important to healing and midwifery, but they also often accompanied their husbands in early years of Oklahoma. Other women were physicians themselves. White women, Black women and men, and Indigenous healers all challenged newly arrived White male physicians and those White men worked to alleviate and eradicate the issues they observed within the field of medicine in Oklahoma. Perhaps more importantly, they envisioned the future of Oklahoma through medicine. Physicians imposed their form of Western medicine over a largely tumultuous society in Oklahoma with benevolence and personal gains in mind. In the last years of the 19th and early 20th centuries, Oklahoma seemed open to competing versions of medicine considering its history of Native American tribes and acceptance for progressive reform. In many ways, Oklahoma and Indian Territories were a contested medical space, with diverse practitioners grappling for power and stability in their practices. These visions would influence state decisions and policy surrounding public health in the coming years.

When Virgil Berry returned to his family's farm in Indiana that spring morning, he could hardly contain his excitement. After hearing the optimism in the farmers' songs and conversations, he soon realized this could be his opportunity to pursue his dream of becoming a doctor. As the eldest of eight, he knew from his family's experience rural people faced medical emergencies on their own. Oftentimes country doctors did not make it to house calls for obstetrics or surgeries in time. He wanted to enter the profession so that he could help the likes

[19] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, Updated (New York, NY: Basic Books, 2017).

of his parents and others on the countryside. After unloading the farm supplies he had gathered in Salem, he went to his worn shelf of books for his geography text. He took the book to the barn, away from the distraction of his younger brothers and sisters and looked for Indian Territory. Then, as he traced his finger along the page, he found a city close to Indian Territory—Springfield, Missouri. Throughout the summer of 1886, he ensured his siblings knew the farm chores, preparing them for his departure. He also anxiously approached his mother to tell her his plan to move to Springfield and save up for medical school. After some convincing, Virgil gathered what little cash his parents had saved, packed his telescope, and began his journey to Missouri.[20]

Berry hitched rides with farmers from city to city as he traveled west to Missouri. He encountered a family with two teenage boys around twelve or thirteen years old. After explaining that he was headed to Missouri, the family welcomed Virgil aboard. As the family stopped for the night after a nearly silent journey all day, they did not offer Virgil any of their food or blankets. Berry helped make camp and ate the last of his food from home. He brought out his only belonging not related to survival, a telescope, and looked up to the sky as the family unwound for the night. He held onto his only possession from Indiana, a symbol of the wonders and discovery a successful life in Indian Territory could bring him. Gazing up at the open, dark sky, Berry dreamt and fell fast asleep, anxious for the remaining journey to his new home.

In the middle of the night, the family and wagon disappeared, taking all of Virgil's property with them. Panicked and angry, Berry chased after the wagon but could not catch the thieves. As the family left Berry behind, one of the teenage boys had broken his leg, and as Virgil pressed on, he heard a distant scream. To Berry's surprise, he encountered the family just

[20] Margaret Berry Blair and R. Palmer Howard, *Scalpel in a Saddlebag: The Story of a Physician in Indian Territory* (-- Oklahoma City, OK: Western Heritage Books, 1979), 13-15.

a mile from where they made camp the previous night. The father saw Virgil and drew his gun. Virgil explained that he was training to be a doctor, and the mother and father allowed Virgil to set their son's leg despite his lack of prior medical experience. Suddenly, Virgil Berry had treated his first patient and began his career in medicine before he attended a single lecture or dissection laboratory. When Berry arrived in Springfield three days later, he inquired about a job at a produce store where he traveled throughout the countryside purchasing eggs, meat, and hides to sell for fifty cents per day. The owner of the store was a doctor himself, and Doctor Stewart promoted Berry and increased his salary to $30 per month to sell and deliver groceries.[21] However, more important than his pay raise, Virgil could read with Stewart and live in his former servant's quarters for free. Reading books like *Gray's Anatomy*, Berry worked as Stewart's assistant while continuing to save for medical school.[22] Two years later, Berry still needed more money for tuition, and a boardinghouse keeper, "Aunt" Tillie, took Berry in and loaned him the money for his first year of medical school in Chicago. Once again, Virgil Berry packed his few belongings and traveled hundreds of miles to his next step in his medical career.

Berry would enroll at the Physio-Medical Institute in Chicago in 1889, rooming with another aspiring physician from Springfield. After finishing his first year of medical school in the spring of 1890, his roommate loaned him fifteen dollars along with train fare to get Virgil to Fort Smith, Arkansas. From there, Berry entered Wagoner, Indian Territory with fewer than five dollars in his pocket. In his later years, Berry articulated that he knew he would need to further his education and that many men read under a doctor for a year and then felt they were qualified to practice. For Berry, he entered the profession with only a year of training as well. Within days, news of another doctor in Wagoner spread, and Berry found his first case twelve miles to see a

[21] Ibid., 18.
[22] Ibid.

sick woman. The countryside enticed Berry and offered him the opportunity to treat patients with little training. Not only would Berry treat his first patient on this spring morning in 1890, but he would also meet his wife. Not only did Berry now have a romantic partner in Indian Territory, his romanticization of the land and the economic freedom it represented kept Berry in Wagoner. The irregularities of Indian Territory had allowed Berry to become a professional with only a few months of training.[23] Indian Territory would provide Berry with a variety of cases and patients, all of which added to his experience and repertoire.

Medical education in the United States at the time of Berry's enrollment was nearly as unstructured as practicing in Indian Territory. Hundreds of medical schools opened around the nation by 1900. In Missouri alone, nearly thirty-five medical schools opened in the second half of the 19th century.[24] Western schools opened to provide men with some sort of documentation that would allow him to treat patients for a standard fee.[25] Medical authorities recognized that medical education needed reform, but many institutions remained hesitant to change their programs. As the American university developed, institutions like Harvard and Johns Hopkins were among the first to reform their medical training. They lengthened programs to three years and opened hospitals to enhance clinical teachings. The Association of American Medical Colleges formed, and member schools began to succeed.[26] Commercial medical schools, however, thrived as well. Even with growing licensure requirements, exams, and educational prerequisites, commercial medical schools flourished. Lesser-known schools offered working-

[23] Ibid.
[24] Council on Medical Education of the American Medical Association, *Medical Colleges of the United States and of Foreign Countries*, 6th ed. (Chicago, IL: American Medical Association, 1918).
[25] Here I use "western" to denote schools in the American West, but elsewhere "western" typically means a Western, Euro-centric way of approaching medicine.
[26] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, Updated (New York, NY: Basic Books, 2017).

class men and agrarians the chance to pursue medicine. This had benefitted many doctors in Oklahoma like Virgil Berry, who experienced a successful career after attending the Physio-Medical Institute in Chicago. The school had only opened in 1885, just four years before Berry attended his first class. After absorbing two other medical schools, the former Physio-Medical Institute in Chicago would close its doors by 1911.[27] All throughout the United States, diploma mills were pumping out doctors at alarming rates—many of whom migrated to Oklahoma.

Newly graduated or self-proclaimed doctors that settled in Oklahoma or Indian Territory practiced a nomadic form of medicine. Many doctors were just beginning to install telephones and open offices, and as a result, word of mouth often brought cases to doctors. Doctors charged roughly a dollar per mile traveled during the day and two dollars at night. Physicians could ask for anywhere between two and four dollars for a regular visit, two dollars for an infant visit, and up to fifteen dollars for a smallpox or diphtheria vaccination. Some surgeries like appendectomies brought in over one hundred dollars, but collecting payment was often the concern.[28] Most doctors operated via horse and wagon, carting their medicines and instruments across rough terrain. They also frequently carried firearms for protection and sometimes to collect payment. Using the light from kerosene lamps, doctors operated on dining tables often accompanied by their wives who served as nurses and administered anesthetic and treatment throughout procedures.[29]

Migrating doctors pursued new careers in Oklahoma heralding from big cities like New York or Chicago and small farming communities each bringing with them a different educational

[27] Council on Medical Education of the American Medical Association, *Medical Colleges of the United States and of Foreign Countries*, 6th ed. (Chicago, IL: American Medical Association, 1918).
[28] Retrospection of a Pioneer Doctor's Wife," by Maude Barnes Ross, Folders 3-6, Box 1, Samuel Price Ross Collection, WHC.
[29] Numerous oral histories from the Physicians Oral History Collection cite the unusual conditions in which many doctors operated. In some accounts, surgeries were performed on dining room tables with limited lighting and patients often bartered meat and other goods to compensate country doctors.

background and experience. Some doctors graduated from prestigious medical schools like Rush or Vanderbilt, while others came from small towns where their only medical training might be from veterinary cases or observing a country doctor.[30] One doctor that eventually became an Oklahoma Hall of Fame inductee, arrived in Oklahoma in 1901 after graduating from Louisville School of Medicine. Lewis Jefferson Moorman, like so many others migrating to Oklahoma, grew up on a small farm in Kentucky. After attending Georgetown University, Moorman returned to Kentucky and enrolled in medical school in Louisville. Moorman saw an advertisement for a medical practice for sale in Alabama, but after traveling and citing a noticeably vast African American population, Moorman returned to Kentucky. For Moorman, his prejudices had eliminated any professional opportunity in the Deep South. Upon his return, he ran into a former classmate, J. Henry Barnes. Barnes planned to move to Oklahoma and wanted Moorman to join him. With nearly no money and some whole-sale drugs, Barnes and Moorman departed for El Reno and the latest land lottery.[31]

At first, Moorman just tagged along, but after consideration he entered the land lottery eager to win and establish a country practice. In his own words, Moorman imagined he "was serving as middleman between the wild tribes of the plains and the advance of civilization", quelling Native uprisings and violent raids.[32] Moorman and his medical school friend opened an office in Chickasha and waiting for patients; however, he and Barnes quickly moved to Jet after learning of an older doctor wishing to sell his practice. Moorman categorized the doctors in Chickasha as either "quiet, modest, generous, conscientious servant[s] of the people always in

[30] *Interview with Dr. Everett S. Lain,* Oklahoma Pioneer Physicians Oral History Collection, Western History Collections, University of Oklahoma Libraries, Norman, Oklahoma (hereafter Physicians Oral History Collection).
[31] Lewis J. Moorman, *Pioneer Doctor* (Norman, OK: University of Oklahoma Press, 1951), 35-40.
[32] Moorman, *Pioneer Doctor,* 41.

pursuit of scientific knowledge to be used in behalf of his patients and the community welfare" or "reckless, designing, dashing type in Prince Albert, high hat, and kid gloves keeping his horse in white lather to impress all spectators with the urgency of his calls whether genuine or spurious."[33] Certainly Moorman and Barnes embodied the former.

Doctors often traversed state and territory lines with their horse and buggy and treated a variety of patients. John A. Morrow began practicing medicine in February 1899 in Uniontown, Arkansas, just one mile from Indian Territory. According to Morrow, he served "illiterate but good hearted and neighborly" people suffering at the hand of quacks.[34] Thirteen years later, Morrow moved to Sallisaw, Oklahoma near Fort Smith along the Arkansas River. Doctors like Morrow thought of themselves as professional, science-based doctors, and that sense of self affected their patient interactions and treatment plans. Even with a law passed in Indian Territory that required all persons wishing to practice medicine within the territory be educated and examined in front of the medical association, the quality of care a resident might receive often varied. Lesser educated physicians would charge less for their services, but the quality of care reflected the price. The quacks Morrow referenced could take advantage of impoverished farmers and Native Americans while simultaneously taking his business. However, his assessment could also reflect the number of physicians he often competed with while establishing himself in Indian Territory. With his practice bordering Indian Territory, many of Morrow's patients were Native. Calling Native Americans illiterate and superstitious, he often dismissed their cures and treatments. Morrow, like many others, rejected alternative forms of medicine and used their prior education and experience to exhibit professional authority.

[33] Ibid., 61.
[34] Memoirs of John A. Morrow, John Morrow Collection, F1, B1, WHC.

Shortly after Oklahoma gained territorial status in 1890, territorial governor George Washington Steele and the territorial legislature established three universities in Oklahoma. In Norman, the state research university would be erected, in Stillwater the agricultural and mining school, and in Edmond a normal teaching school. A fourth university, named Epworth University after Methodist leader John Wesley's parish in England, would open fourteen years later and become influential to Oklahoma's professional training programs. As early as 1892, the idea for a Methodist college in Oklahoma had been discussed by Anton Classen. Two years earlier, Classen was insistent and supportive of the Territorial Normal School in Edmond. His vision for a Methodist college would delay a few years because of internal quarrels between Methodists, but by 1901, Classen found a way to unite the Methodists of Oklahoma and open Epworth College in Oklahoma City. In May 1901, the north and south divisions of the Methodist Church met to discuss the building of a university in Oklahoma City. By June, a joint commission was appointed from the Oklahoma and Indian Territories' conferences representing both Methodist Church North and South to build and own this newly envisioned Methodist university. This joint commission met again in December 1901 and accepted the proposal from the University Development Company of Oklahoma City to build the college. The proposal included a fifty-two-acre donation in an area known as University Addition as well as the Epworth University campus, and one hundred thousand dollars for the preliminary building, endowment, and expenses to hire a financial agent.[35]

The Epworth University building cost over forty-thousand dollars and was completed April 22, 1904. Upon completion, the board elected Rev. R. B. McSwain as their first president. McSwain relocated from his professorship at Southwestern University in Texas, and with his

[35] Todd, H. Coulter. "History of Medical Education in Oklahoma from 1904-1910." University of Oklahoma Bulletin. New Series No, 402. University Studies No. 26. (Norman: University of Oklahoma, 1928), 13.

help, the board elected their first faculty in July 1904. Within the first class of faculty, Epworth University had hired doctors to establish their own School of Medicine. Seven physicians joined Epworth in 1904, despite the lack of consultation with the state's association of physicians. The board at Epworth did not consult the medical profession for suggestions in its curriculum or recommendations for hiring. Instead, they realized the state of medical training in Oklahoma needed another institution that could offer students hospital training unlike the territorial university in Norman. When Epworth officially opened September 7, 1904, it boasted one hundred and seventy-five students--three of which were medical students.[36] By 1907, upwards of four hundred students comprised the student body, and the medical school's faculty had increased to over twenty-five paid lecturers, assistants, and professors.[37] The Epworth School of Medicine, just three years after its first class, now had professors of pediatrics, gynecology, nervous and mental diseases, ophthalmology, pathology, and even a lecturer in legal medicine. The Epworth School of Medicine certainly reflected the national trend of specialization and growth in medical education while also opening yet another school under the premise of elevating "the standard of the medical profession, provid[ing] better physicians and better facilities for practice and to assist the local profession to greater proficiency."[38] Epworth featured ample entrance requirements and an overachieving curriculum with almost four thousand hours of coursework needed to graduate.

By 1906 the Epworth School of Medicine was buzzing. By recently establishing the state's only four-year curriculum with sufficient hospital training, it drew prospective students to

[36] H. Coulter Todd, 14. None of the first class of students would go on to earn their M.D.
[37] Larry Johnson, "Epworth University," Metropolitan Library System, accessed April 14, 2022, https://www.metrolibrary.org/archives/essay/2019/07/epworth-university and H. Coulter Todd "History of Medical Education in Oklahoma from 1904-1910", 21.
[38] H. Coulter Todd, "History of Medical Education in Oklahoma from 1904-1910", 14.

Oklahoma City. Although its first three students that enrolled in 1904 never graduated, by 1907 the cohort of students filled the classrooms and laboratories in Oklahoma City. In 1907, the College of Medicine became a separate corporation with its own endowment, allowing for greater growth despite Epworth's general financial struggles. As more and more physicians migrated to the growing Oklahoma City, the College of Medicine grew and expanded. The school purchased the Angelo Hotel on 6th and Broadway for nineteen thousand dollars and refurnished it for the College of Medicine. The initial corporation featured nineteen doctors and two honorary members including Anton Classen, the man who instrumented the collaboration and founding of Epworth College a few years prior. Each member contributed one thousand dollars to both purchase and renovate the Angelo Hotel. In addition, the professors and staff of the Epworth College of Medicine allegedly were not paid with student tuition in the years immediately following the renovation. Instead, tuition and fees went towards equipment and other ways to make Epworth credible to prospective students and faculty. As such, the number of professors and adjunct lecturers rose from 1907 to 1910.[39] Oklahoma entered statehood in November 1907, and medical education in the new state of Oklahoma would look vastly different by 1910, a process facilitated by the University of Oklahoma.

David Ross Boyd became the first president of the territorial university in Norman in 1892. By 1898, the University of Oklahoma had organized four years' worth of college courses for its students along with a biology department. In 1898, about forty college students enrolled along with three hundred preparatory students. During that same academic year, four students took courses in the new Premedical Department, taking classes in anatomy, chemistry, materia

[39] H. Coulter Todd, "History of Medical Education in Oklahoma from 1904-1910", 14-25.

medica, physiology, therapeutics, and toxicology.[40] The university's School of Pharmacy had already been established by 1898 as well. Students could choose between a two-year and four-year curriculum, but it was not until 1900 that the university's School of Medicine would be established. According to the yearbook for 1899-1900, due to the territory's rapid growth and increased demand for professional departments at the University of Oklahoma, the School of Medicine was needed. Students could enter the program and after two years, be in an advantageous position at accredited medical schools around the country. Students could also couple that with other courses in route to a bachelor's degree. In one letter from Dr. Roy Stoops informed Dean Robert U. Patterson that David Ross Boyd struggled to find a man to lead the School of Medicine and wrote to Stoops while Stoops was completing his third year of medical school in Chicago. Ultimately, Boyd settled on Dr. Lawrence N. Upjohn, a graduate of the University of Michigan, paying him a salary of one thousand dollars per year.

Upjohn, just twenty-seven at the time, inherited a rough sketch of a medical department. Born into a family of doctors, he had just graduated from the University of Michigan in the spring of 1900. His father, Uriah Upjohn emigrated from England to New York in 1832. Uriah Upjohn enrolled at the College of Physicians and Surgeons in New York City. After completing his first two years of study, he acquired an apprenticeship and attended lectures given by the founder of the American Medical Association, Alden March. By 1835, Uriah and his brother had become well-known in the medical profession, and the two moved west to Michigan Territory. There, he helped establish an Anti-Slavery Society like that in New York and practiced frontier medicine. Uriah's daughter and three sons all followed Uriah's lead and became physicians. Perhaps because of his family's reputation or perhaps because all the Chicago physicians turning

[40] Everett, Mark R. *Medical Education in Oklahoma: The University of Oklahoma School of Medicine and Medical Center, 1900-1931*, (University of Oklahoma Press: Norman, OK, 1972), 6.

Boyd down, the University hired Lawrence Upjohn in 1900. However, by 1904, Upjohn resigned and joined the upstart Upjohn Company that specialized in manufacturing friable pills that were easily digestible. Founded in 1886 by Lawrence Upjohn's uncle, Upjohn experienced success in the pharmaceutical industry, even finding a way to mass produce cortisone.[41] Uriah's son, Lawrence, would not have nearly as much success in Oklahoma.

In its first year, eight students enrolled in the fledgling medical program in Norman. Students entering the program needed to pass oral exams in "English, arithmetic, algebra, physics, and Latin" or a student could "present a certificate of graduation from high school, normal school, or an academy of good standing, or evidence of having passed the entrance examination to a reputable literary or scientific college or university, or a state certificate to teach granted by a state superintendent of public instruction.[42] A student could enter the university's program in a myriad of ways. In place of a traditional medical curriculum, a student took a medical course that prepared them for professional work. Courses overlapped and were taught by professors in different departments in various places on campus. Although the School of Medicine was supposed to inhabit an entire floor in the science building, reports indicate that only a portion was used.[43] Even so, in a few years the School of Medicine at the University of Oklahoma would vastly change.

As early as 1903, Oklahoma City physicians discussed the potential for the territorial university in Norman to acquire funding to build a medical college building in Oklahoma City. The city could offer students clinical experience and mold the university's program into a

[41] Martha Lohrstorfer and Catherine Larson, "William E. Upjohn: Person of the Century 1853-1932," Local History (Kalamazoo Public Library, June 7, 2006), https://web.archive.org/web/20070928141332/http://www.kpl.gov/collections/LocalHistory/AllAbout/biography/Upjohn.aspx.
[42] Everett, Mark R. *Medical Education in Oklahoma: The University of Oklahoma School of Medicine and Medical Center, 1900-1931*,10-11.
[43] Everett, *Medical Education in Oklahoma*.

reputable four-year program. Of course, Epworth University's school of medicine was in its infancy, but both colleges recognized the potential in Oklahoma City. Dr. H. Coulter Todd arranged a conference with the territorial university in Norman, represented by Dr. Upjohn. Upjohn rejected their proposal, and President Boyd suspended the creation of a four-year clinically based program indefinitely.[44] In bulletins from the University of Oklahoma School of Medicine in the fall of 1904, the catalog "deemed best that hospital and clinical instruction should be deferred until a student enters upon his third year" of which Oklahoma did not offer.[45] In many ways, the University of Oklahoma was just a stop along a prospective doctor's journey to licensure.

Dr. Upjohn's resignation in 1904 opened the door for Roy Philson Stoops, whom Boyd reached out to four years prior. By now, Stoops graduated and began practicing medicine. He and his wife, Dr. Eunice Gertrude Rand opened a practice in Norman following the Stoops hire in 1904. Boyd added a few more faculty members in that academic session, and seven students enrolled. By 1906 sixteen students enrolled to the nine faculty members the University employed in the School of Medicine. Despite the program's duration and lack of clinical courses, the school still obtained acceptance to the Association of American Medical Colleges on March 19, 1906.[46] Just a month later in the School of Medicine Bulletin, the historical statement, that largely remained unchanged in previous years' publications, added a sentence about the school's acceptance to the AAMC. The school enhanced entrance requirements by then as well, with a detailed list of credit hours required; however, still allowed admittance of special students with

[44] Ibid., 14-15.
[45] Everett, *Medical Education in Oklahoma*, 15 and "1904 School of Medicine Bulletin", Folder 1, Box 1, College of Medicine, University of Oklahoma Archives, Health Sciences Center Publications Collection, Western History Collections.
[46] Everett, *Medical Education in Oklahoma,* 21.

passing scores on departmental screening exams. With the newly awarded accreditation, the University of Oklahoma School of Medicine, led by Roy P. Stoops, tried to establish rigid standards for their program.

At eight o'clock on a Monday morning, a student would begin their path to a degree with General Chemistry. After nearly two hours, they'd move to Embryology with Dr. Edward Marsh Williams and Physics with Dr. Major. A ninety-minute lunch left Osteology and Dissection for the afternoon finally ending their day after five in the evening. Students could be expected to pay three to four dollars a week for board along with nearly thirty dollars for textbooks in addition to other fees.[47] For Oklahoma residents, tuition was free, and many took advantage of this. The typical student would be a White male who had the option to join the Pharmo-medic society on campus. Students could try their hand at forensic medicine with Dr. Bobo or take a course in microscopic diagnosis for additional laboratory fees. The prospective student would fill out the grids on the University of Oklahoma School of Medicine application including their prior grades, class rank, and instructors. Even with the advancing of standards and prerequisites for admission, the program only covered the first half of a medical education but was "thorough instruction in chemistry, anatomy, physiology, pathology, and pharmacology" the basis for further medical training.[48] Schools like the University of Nebraska, Illinois, St. Louis University, Washington University at St. Louis, Jefferson Medical College, Cornell University, Harvard University, and Chicago University had expressed that they would admit Oklahoma graduates to their junior class as well by 1907.[49] As with Epworth University, looming statehood provided medical

[47] "1905-1906 School of Medicine Bulletin", Folder 1, Box 1, College of Medicine, University of Oklahoma Archives, Health Sciences Center Publications Collection, WHC.
[48] "1906 School of Medicine Bulletin", 19.
[49] Everett, Mark R. *Medical Education in Oklahoma: The University of Oklahoma School of Medicine and Medical Center, 1900-1931*, 29.

authorities with an inflection as to what they envisioned and wanted the medical profession to be in the 20th century, much like the first wave of White physicians did in the 1890s.

Doctors that migrated to Indian Territory in the late 19th century entered a triracial agrarian society ripe with animosity. White farmers often blamed Native tribes for their struggles and tenancy. The crop lien system plunged White and Black farmers further into debt, and the federal government continued to strip autonomy from Native nations throughout Oklahoma. Factions within nations like the Creek, Choctaw, and Chickasaw also turned issues with the federal government inward, as tribes worked through their own concerns. Southern states also stripped rights from Black farmers following Reconstruction, a leading factor in drawing African Americans to Oklahoma. Miners flooded Oklahoma, and coal companies recruited large numbers of immigrants to work in the new mines throughout eastern Oklahoma. By some accounts nearly two-thirds of the eight thousand coal miners working in Oklahoma in 1907 were foreign born immigrants.[50] Coal companies controlled and constructed towns like Krebs, Lehigh, Coalgate, and Stringtown to house their workers. In many instances, neither the federal government nor tribal governments offered workers and their families much protection from mining accidents. Oftentimes, physicians took on calls like they would their agrarian clients. Physicians encountered a variety of settlers from varying occupations, while practicing medicine in the Twin Territories.

As the lead, coal, and petroleum industries took off in Indian Territory, tribes profited from those industries, and they increased their own standard of living and revenues. At the end of the Civil War, Natives in Indian Territory numbered approximately fifty thousand. Indian Territory was also home to eight thousand freed people. By 1900, when many physicians had

[50] Baird, W. David, and Goble, Danney. *Oklahoma: A History*, 124.

begun their frontier practices, the White population in Indian Territory had increased to three hundred and two thousand and the Black population was nearly forty thousand.[51] Native Americans had quickly become outnumbered some six to one in forty years. For many years Native Nations had used White physicians, and in Indian Territory, especially, working alongside Natives offered additional professional experience for Whites, while created unique opportunities for others.

Virgil Berry began his work with the Seminole Tribe in 1898. Even though Emma Kate, his wife, liked their life in Wagoner, Oklahoma, Virgil considered that working with the Seminoles would pay more than his current practice. Wagoner's growth had slowed since Berry opened his office, and the town had no plans for a hospital. Berry decided to take Chief John F. Brown's offer. Caesar Bowlegs worked in the medical office at the Seminole capital of Wewoka for seventeen years before Berry arrived. He was bilingual and a formerly enslaved Black man. Berry and Bowlegs would often spend days away from home treating and vaccinating the Seminoles. Bowlegs, formerly enslaved by the Seminoles, now became an influential man in the Black Seminole community. A leader in the Presbyterian church, he worked with Berry as his assistant, administering anesthesia and communicating with Seminoles.[52] Bowleg's knowledge of the patients and area made Berry's transition to tribal physician seamless. With Bowleg's assistance, Virgil now cared for two thousand Indigenous Seminoles and one thousand Black Seminoles.

[51] Baird, W. David, and Goble, Danney. *Oklahoma: A History*.
[52] Bowlegs' story has also been told in the book, *The Seminole Freedmen* in which Kevin Mulroy creates a much more in-depth biography of Bowlegs and his importance to the Seminole community. See Kevin Mulroy, *The Seminole Freemen: A History* (Norman, OK: Univ. of Oklahoma Press, 2016). eCwAAQBAJ?hl=en&gbpv=1&dq=caesar+bowlegs&pg=PA209&printsec=frontcover

Berry claimed that several doctors before him with the Seminole Tribe had quit, frustrated with much of the Seminole's behavior and reluctance to adhere to their medical advice. Some Seminoles fled after the fellow Seminoles called Berry, and he often competed with Seminole medicine men.[53] In Berry's experience, when it came to gunshot wounds, Seminoles would ask for surgery to remove the bullet, but then utilize the medicinal knowledge of their healers for post-surgical treatments.[54] Many Seminoles navigated health and healing by taking desired aspects of both traditional methods and White medicine. According to Berry, by 1900 he, with the help of Bowlegs, gained the trust of many of his patients.

Caesar Bowlegs' knowledge and advice proved instrumental to Berry's success with the Seminoles. When a smallpox epidemic struck the tribe at the turn of the century, he and Bowlegs worked to vaccinate most of the Seminole population. Many were hesitant to get vaccinated. This general culture of skepticism which drove several White doctors to resign persisted well into the 20th century. In his accounts of his time with the Seminoles, Berry is condescending toward the Native Americans and criticizes their reluctance to accept and embrace Western forms of medicine. Berry, like so many others in Oklahoma at this time, expected their patients to respect their professional authority and accept their treatments without question. Bowlegs helped Berry establish a middle ground in Indian Territory, where Berry conceded some of his assumptions and pomposity to learn and adapt his style of medicine to be more effective among Seminoles. Bowleg's unique story from enslavement to an important leader in the Seminole community embody the types of opportunities available to various races in Indian Territory centered around medicine and healing.

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[53] Margaret Berry Blair and R. Palmer Howard, *Scalpel in a Saddlebag: The Story of a Physician in Indian Territory* (Oklahoma City, OK: Western Heritage Books, 1979).

[54] Autobiography, "Experiences of a Pioneer Doctor in Indian Territory" by Virgil Berry Folder 1, Box B-10, Virgil Berry Collection, Western History Collections.

Virgil Berry's work with the Seminole tribe ended in the summer of 1901. While some physicians were drawn to work with Native Americans, Berry was interested in establishing a practice and building his professional reputation. He had heard of a developing town northeast of Wewoka and that when statehood arrived, this new city of Wetumka would hold the county seat for medicine opening professional opportunities through hospitals and clinics. The Frisco Railroad passed through Wetumka, and Berry decided to move he and his family there and quit his work for the Seminoles. Berry seemed rejuvenated in his work as statehood loomed. As he parted ways with the Seminoles, he promised to visit Caesar Bowlegs often, but Bowlegs would die soon after in 1901. For Bowlegs, medicine had brought about new opportunities and experience. Even though Bowlegs was Berry's assistant, Caesar's knowledge was fundamental to Berry's practice in the Seminole Nation. Bowlegs and other similar stories would challenge and, in some ways, threaten the medicine and future Berry envisioned for Oklahoma medicine. But for now, Berry and his family moved on to Wetumka, hopeful that the regular railroad schedule would soon bring about hospitals and patients along with the staple White agrarian patient.

The lingering problems of tenant farmers in Oklahoma enabled efforts to reform commercial agriculture in the late 19th century and into the 20th century. Accompanying Oklahoma migrants were political ideologies of the Populists that contributed to a successful political movement throughout the Territories. By 1900, the Populists had largely merged with the Democratic Party, but they established the groundwork for a booming socialist movement largely built on the People's Party's ideals and goals. Disgruntled farmers in Oklahoma readily accepted the Socialist party, contributing to significant gains from 1910-1920. After other labor organizations like the Indiahoma Farmer's Union merged and endorsed the Democratic Party in

1907, socialist support at the polls jumped over 15,000 votes in 1910. Nearly doubling from 1910 to 1912, Oklahoma boasted an impressive socialist movement. In 1914 five Socialists gained seats in the state house of representatives, one into the state senate, and nearly one-fifth of voters cast their ballot for the Socialist gubernatorial candidate, Fred Holt.[55] While socialism in Oklahoma thrived after Oklahoma entered statehood, competing versions of medicine had already been established. In Oklahoma especially, the number of practitioners contributed to competing visions of medicine for the state's future. The fear of orthodox physicians was realized, even though they worked through associations and the government to exclude irregular practitioners and quacks. Tenant farmers believed statehood could solve their struggles, even though it ultimately did not. However, physicians knew the power of state legislation and following the lead of other states would ensure their version of medicine prevailed with little opposition.

In Oklahoma, socialist and populist doctors threatened the bureaucratic vision instilled by traditional practitioners. Thomas Woodrow published *Woodrow's Monthly* throughout the 1910s at the height of socialism in Oklahoma. The $3.00 subscription would give access to Woodrow's publication that berated capitalism, offered Biblical justifications for socialism, and urged pacificism. One issue from September 1915 offered readers suggested therapeutics, much less expensive than the treatments offered by orthodox physicians. Woodrow published articles and segments about the medical field's corruption. Medical fees were often collected before treatment, perhaps a measure implemented as a learned lesson from the pioneer doctors of the

[55] Chang centralizes land ownership as the defining reason Socialists succeeded in this decade. His analysis details the ways the Creek Nation understood land ownership and how those understandings affected White agrarians seeking economic freedom and prosperity in the period up to and following Allotment, David Chang, *The Color of* the Land, 180-181.

late 1880s.[56] Woodrow would go on to promote his wife, Dr. Emma Woodrow. As one of the first woman physicians in Indian Territory, Emma Woodrow stopped making country calls around 1905. Still, perhaps through *Woodrow's Monthly* promotions, her practice was full and booming. She trained at Drake University in Des Moines, Iowa until they barred women from studying there. Moving to Kansas City, Woodrow finished her training and migrated to Indian Territory. In nearly every issue of *Woodrow's Monthly*, her services were advertised as offering a "Delightful Climate" with "Fine Mountain Scenery" in Hobart, welcome to all who need health. Her health retreat rang of commoner and socialist rhetoric, offering a competing route for Oklahomans to obtain medical care. Not only was her practice welcoming and delightful, but it was also operated by a White woman, a challenge to the White men leading the medical charge in Oklahoma City and nationwide.

Woodrow's Monthly expanded its medical suggestions through various articles. One such piece advocated for magnetic healing. Dr. Daniel W. Hull, author of *Magnetic Healer's Magazine*, used Thomas Woodrow's platform to spread his unifying message. He claimed that interdependent networks of humans led society, while loneliness rendered men helpless. Tying in Biblical passages from 1 Corinthians, Hull urged cooperation and understanding of the world around him. He thought and categorized the human body as a complex system comprised of carbon, oxygen, hydrogen, and nitrogen along with other gases. For Hull, any imbalance in these gases caused disease. Hull's depiction resembled the miasmatic theory of medicine that dominated the field prior to the rise of germ theory in the 19th century. Hull argued that humans also exchanged magnetic currents when in proximity of each other. The magnetic currents, when used properly, Hull wrote, can be medicinal and cure disease.[57] Socialist periodicals like

[56] *Woodrow's Monthly* September 1915. Thomas W. Woodrow Collection, WHC.
[57] *Woodrow's Monthly* September 1915, 16-18, Thomas W. Woodrow Collection, WHC.

Woodrow's Monthly expanded and formulated public opinion about strikes, religion, and even medicine. Advertised alternative cures challenged the work of orthodox Oklahoma physicians, contributing to stereotypes and distrust in their practices. For the traditional White Western physician, socialists in Oklahoma and elsewhere threatened their vision for the future of medicine in the United States.

Years before the opening of the Unassigned Lands dating back to 1881, Indian Territory physicians met and collaborated, sharing their work and any intriguing cases. The first organization dissolved, but eight years later in 1889 the Indian Territory Medical Association reformed, operating under the American Medical Association's (AMA) code of ethics.[58] In advance of the Land Run of 1889 and subsequent lotteries, Indian Territory physicians recognized the professional threats of opening land to settlers and the challenges they could present to doctors. Not only would doctors likely increase their clientele, but more doctors would certainly follow. Members could be expelled for any violation to the AMA code of ethics or if they failed to pay their dues. One doctor was expelled for association with an "electric" doctor.[59] Original dues were $1.50, but by the third revision of the Indian Territory Medical Association (ITMA), they had dropped to $1.00 with a $1.00 initiation fee. Prospective members could join with either a diploma from a respected medical school deeming them 'regular' members, or approval from two members and the Board of Censors to become an 'honorary' member. First amendments to the constitution reflected attitudes that the disorder must be managed. ITMA members cited the fluctuation in levels of care and shear number of physicians as reasons to

[58] Historians and doctors from the OSMA presumed that ITMA reorganization was a result of the Dr. B. F. Fortner's removal from Indian Territory. Fortner was a "stalwart organizer and activator of much of the Association's activities and during his absence medicine waned." He returned to the Cherokee Nation in 1889 and the ITMA reorganized to more than 500 members in Indian Territory at the time of the ITMA and OTMA merger. https://archive.org/details/journalofoklahom4919okla/page/n158/mode/1up?view=theater

[59] *The Indian Territory Medical Association*, by John Thomas Forsythe for History 412, January 5, 1956, Indian Territory Medical Association Collection, WHC.

adopt rigid laws and further organization of the ITMA. Even though physicians were threatened by the disorder, more rural settlers could bring, settlement reinforced the need for their association as well as their profession not to mention implications for whiteness.

In a midcentury history of the Indian Territory Medical Association, John Thomas Forsythe noted that for some IT physicians, "over 90% of his patients were Indians and…the medicine man must be convinced of medical practice."[60] According to the Association, members discussed coordination with the Nations in Indian Territory through medicine but realized this would nearly be impossible. Unlike Virgil Berry with the Seminoles, many physicians were not paid for their services by Native Americans. Instead, ITMA doctors turned their efforts to the profession itself rather than many of their Indigenous patients. In 1900, ITMA President Dr. Leroy Long urged for stricter conformance to ethical practice, more laws regulating and enforcing good medicine, uniformity, and the creation of a committee dedicated to growth and prosperity of the Association. The association successfully pushed for medical practice legislation in 1904.[61] In addition, Long noted that a modern way of treating tuberculosis was necessary, especially in Indian Territory, on top of institutions to treat the "insane and feeble-minded."[62] For most like Long, Native Americans' reluctance to accept Western medicine or their counter-colonial position in taking bits and pieces of orthodox physicians' recommendations pushed Natives from the agenda of ITMA members. The population of Whites in Indian Territory had exponentially increased from roughly 6,000 in 1880 to over 300,000 by 1900 when Long addressed his colleagues and made his demands of IT.[63] After all, the Association had already set up committees to 'deal' with their Indian problem, even though they

[60] Forsythe, *The Indian Territory Medical Association*, ITMA Collection.
[61] Fred Clinton, "The Indian Territory Medical Association," *Chronicles of Oklahoma* 26, no. 1 (1948): pp. 23-55.
[62] Forsythe, *The Indian Territory Medical Association*, ITMA Collection, WHC.
[63] Ibid.

knew it was doomed to fail. But with Whites flooding Indian and Oklahoma Territories, the demographics of their clientele shifted, and in doctors' view, poor White farmers were more likely to pay or at least barter for their services.

The Indian Territory Medical Association also influenced smaller organization throughout Indian Territory. A final plea for Leroy Long was the organization of sub-societies to thoroughly organize the profession in Indian Territory. Together, if most doctors lobbied for the same rights and regulations, all traditional practitioners would benefit. However, territory and county societies were selective, and expulsions did occur. For a physician like Emma Woodrow or an "electric" doctor, their form of practice certainly constituted grounds for expulsion. However, for most White orthodox physicians, membership in the ITMA or a local organization was more important than their diploma or license issued by the territory. The Association opened the door for presentations, publications, and membership with the strongest lobbying force for physicians in Indian Territory. The exclusivity of membership shaped who could join and how they could practice. Through organization, White orthodox physicians worked to exclude nontraditional practitioners and regulate their profession for their own benefit.

Rural farmers and others remained hesitant toward vaccinations and other public health measures at the turn of the century. Albert Cook and others worked to educate the public using their medical society platforms. In Cook's reflection on his career in medicine he noted that much of the public remained hesitant towards smallpox and diphtheria vaccinations, that some doctors preached. Instead, many physicians like Cook witnessed alternative forms of medicine which they found entirely ineffective. For example, Cook named Christian Scientists, chiropractors, and osteopaths as chief culprits for misinforming society. One six-year-old girl contracted diphtheria, but because the family was Christian Scientists, they believed God would

heal their daughter without the antitoxin.[64] Cases like these persisted well into the 20th century despite Cook's and other Western physicians' efforts. Public hesitancy and lack of education allowed disease to continue as Oklahoma approached statehood; however, doctors did not fail in their efforts. Even though many physicians like Cook grew frustrated with the public, their education campaigns saved lives.

Nearly simultaneous with the reorganization of the Indian Territory Medical Association, the formation of the Oklahoma Territory Medical Association (OTMA) in 1890 served similar purposes. Inaugural members drafted a constitution and worked to create uniformity in Oklahoma Territory. Both the ITMA and OTMA grew and held annual meetings to exchange leading physicians' work and implications for the future. For many migrating physicians, joining county and territorial societies offered them new opportunities to network and showcase their work in addition to publishing their work for the remainder of the territory to view and critique. In many ways, these early associations were fraternal gatherings where doctors voiced their discontent about quacks and stubborn patients. However, by 1906, both the ITMA and OTMA knew statehood was imminent, and their merging would be imperative. A familiar face would oversee the merger.

The ITMA elected Virgil Berry as their President in 1905. At the height of statehood talks and debates, Berry inherited an Association that knew a merger with the OTMA was forthcoming. In March 1906, Berry called a special meeting of his colleagues to discuss the unification at the Masonic Hall in South McAlester, I.T. Nearly forty Indian Territory physicians met that Tuesday afternoon to lay the foundation for suggested business meetings in Oklahoma City and the combining of each Association's journal under one name—Oklahoma State Medical

[64] Interview with Dr. Albert W. Cook, Physicians Oral History Collection, WHC.

Association. Evidently, in a similar meeting, the OTMA had already adopted the name "Oklahoma State Medical Association". Nonetheless, Berry met with his constituents in preparation for May's joint meeting. According to Berry and his wife, Emma Kate, Virgil labored over the Presidential Address he gave in May. Toiling over writing his speech, he hoped to express the importance of "this closing of one era and the beginning of another, things that would express his own hopes and dreams for medicine in a new state, as well as promot[ing] harmony for working together toward the common cause of medical advancement."[65]

He began his address stating that both associations had fundraised $100 for relief efforts in San Francisco following its devastating earthquake. From there, Berry voiced the concerns of most Oklahoma and Indian Territory physicians citing a "great mass of incompetent men practicing our art in both territories" and that "it is evident there is something radically wrong." Men from nearly every part of the United States had migrated to Oklahoma by 1906 and practiced questionable medicine, more importantly Oklahoma became a haven for the mixing of all different forms of medicine. In this overcrowded and commercialized profession, Berry suggested that "by organization we can become a power that will be respected in the construction of the great state that is at hand." Moreover, physicians could become a legislative force, telling legislators "that if he is so forgetful of his duty to the commonwealth simply because he is afraid of offending some quack constituent, whether that quack be a "pathy" of some kind, or a plain, unadulterated "Christian Science" fraud we will endeavor to replace him with some one who has the interest of the common people at heart, and is not in the employ of quacks and patent medicine manufacturers." Berry's plea for unification and effort would begin with certifications only for graduates of medical school in addition to a four-year undergraduate degree—something

[65] Blair and Howard, *Scalpel in a Saddlebag*, 82-83.

Berry himself failed to acquire. In concluding, Berry offered his own token of wisdom, "The past is no guide to the future in this matter for we must look upward and onward in the march of progress along this line and keep up with the procession."[66]

Berry's address and its rhetoric exemplifies the ways older and more experienced physicians utilized Indian and Oklahoma Territories for their own benefit. Physicians failed to obtain the requirements they were now pleading for to curtail the number of men entering the profession. Through education and licensure requirements, exclusion in medicine was necessary to many at the joint meeting. Other speeches stressed the need for county societies and their registration with the American Medical Association, but no speech was as spirited and emotional as Berry's. Physicians exchanged comments and studies during the three-day conference, but Berry's pleas and vision certainly stood out. He and others recognized that statehood was the perfect opportunity to start anew. Through a unified effort, the orthodox physicians of Oklahoma could not only envision the future of medicine in Oklahoma, but they could also enact it through organization.

Following the joint meeting of the two associations, the newly formed Oklahoma State Medical Association elected A. K. West and Virgil Berry as its first delegates to the American Medical Association. Establishing his practice in Wetumka, he received his Oklahoma license to practice medicine on March 2nd, 1908, but the certificate was dated November 16th, 1907—Oklahoma's statehood day. While it seemed Berry's recommendations were taking shape, as county societies and divisions were developing his city of Wetumka failed to secure the county's seat. As Berry now understood, a new hospital would go to Holdenville, because of its seat as the county's representative for the State. The decision prompted Berry to find a permanent home

[66] *Journal of the Oklahoma State Medical Association*, May 1906, 32-33, Charles Fisk Collection, WHC.

with Emma Kate and their five children. On Christmas Eve, 1908, the *Wetumka Gazette* wrote, "Dr. V. Berry and family left the week for Okmulgee, where he will continue to practice, devoting his time principally to surgery. He expects to establish a sanitarium in Okmulgee."[67] Despite Berry's efforts as ITMA President, he was still at the hands of others lobbying for hospitals and facilities in nearby Holdenville. His pleas did manifest into reform and unification, but for his own personal benefit, Berry once again had to move and take his reputation with him.

Statehood for Oklahoma physicians proved to be an opportunity of inflection and planning. Territories began to form the framework for state public health systems, but it was not until November 1907 that these organizations and systems could join. While legislators began to enact "Progressive" laws and visions for Oklahoma, doctors used statehood as a prime opportunity to create a 'unified' version of medicine that largely excluded practitioners of color, women, and Indigenous healers. By joining forces, the physicians of Indian and Oklahoma Territories could put aside their territorial rivalries for the good of the commonwealth Berry spoke of in his Presidential address. Scores of physicians had begun practicing medicine in Oklahoma for the first time with limited educational training and experience. Oklahoma offered doctors, settlers, and others a fresh start leading to an influx of doctors with little regulation. Using the chaos, disorder, and lawlessness to their advantage, these White migrants established themselves along with booming medical practices treating a variety of diverse patients. These doctors, especially, bolstered their professional careers and were the very ones wishing to enact restrictive reform to limit the number and type of physicians that Oklahoma could support. However, unified the physicians of Oklahoma and Indian Territories seemed to be, real action and reform would take time.

[67] Blair and Howard, *Scalpel in a Saddlebag*, 85.

Chapter 2: Enacting a Medical Vision: Statehood's Power and Implications

Upon receipt of his Oklahoma license, Virgil Berry, his wife Emma Kate, and his children moved to Okmulgee, the former capital of the Muscogee-Creek Nation. Impatient and frustrated that Wetumka was not going to acquire a hospital, Berry quickly found a four-room single story brick cottage to rent at 515 South Muskogee. With the support of fellow Okmulgee doctors, Berry turned the modest cottage into a four-bed hospital with an operating room.[68] With limited bedspace, miniscule funding, and a hesitant public, the single-story cottage could not sustain itself, but it was Berry's start. He worked to fundraise to modernize his cottage with the support of Okmulgee's citizens and leaders. The wife of future U.S. Senator Edward H. Moore, Cora McComb and Fred Storm headed the hospital's Board of Directors, and Virgil even hired trained nurses for the first time. His wife, Emma Kate, no longer needed to assist Berry.

Like Virgil Berry's medical practice, Oklahoma's medical field would undergo vast changes to its structure and competence after 1908. Oklahoma no longer could hide any shortcomings in public health and attribute them to its territorial status. Instead, statehood instigated the process of bureaucratization and professionalization for physicians and cemented the professional authority and status of orthodox practitioners, namely White men. Numerous physicians and legislative authorities saw statehood as an opportunity to cement and create public health systems that excluded some while boosting the professional opportunities for others. Oklahoma physicians could learn from other states and institute programs, hospitals, and research that challenged and advanced American medicine as they saw it. Statehood also diminished the status of alternative practitioners and pushed the experiences of nontraditional doctors to the back of the public's imagination. Through constant lamenting of nontraditional

[68] Blair and Howard, *Scalpel in a Saddlebag*, 86-87.

practitioners, orthodox physicians prioritized the exclusion of irregular physicians from their profession. The experiences of Caesar Bowlegs and Isabella Cobb became less visible via the bolstering of traditional medical practice. In addition, institutionalizing medicine was easier after Oklahoma became a state. Berry's generation of doctors had built their careers in the medical chaos of the territorial years, but after statehood, they achieved authoritative status through leadership roles and professional opportunities in the state and in the field of medicine. Doctors became public health experts and authorities in fields like dermatology and otorhinolaryngology. Through hospitals, institutions, medical education reform, and specialization, Oklahoma physicians attempted to become relevant in American medicine while establishing its footing as a state.

Whatever opportunities post-statehood provided to practitioners, it limited opportunities for others. For Virgil Berry, this meant moving to a nearby developing city to advance his career in surgery. His successful practice and reputation made the relocation relatively easy. Other doctors struggled to adapt to the changes statehood brought. Oklahoma began assigning cities as county seats; those cities then drew state funding for projects like hospitals. This process excluding and limiting professional development for those outside county seats, while simplifying the process those working in them. Beyond geography, new efforts at medical education reform limited the number of physicians that could enter the field, while simultaneously trying to raise the standards of graduating doctors. These reforms included limiting the number of women physicians and doctors of color in medical schools and limiting employment opportunities for those that graduated. Oklahoma became a state at the height of national efforts to remake the profession of medicine, and it created serious implications for many Oklahoma physicians.

Nationally, concerns over medical education and training prompted the Carnegie Foundation to hire Abraham Flexner to travel to all the nation's medical schools, as well as eight in Canada, and report on their status and legitimacy. Flexner studied classics at Johns Hopkins before taking graduate coursework in psychology at Harvard and the University of Berlin. He also taught classics at Louisville where he employed a unique teaching style. He abolished grading systems, had no rigid testing, and focused on small groupwork. In 1908, he wrote in *The American College* a robust criticism of higher education in the United States, which led to his employment with the Carnegie Foundation who wanted him to conduct a study on professional schools. Flexner had never attended a medical school class or even been in a laboratory, but now he became responsible for the review of medical schools nationwide.[69]

Through his investigation, Flexner discovered that in Missouri alone twelve medical schools operated, and the state had over six thousand practitioners. That was a ratio of one doctor for every five hundred and fifty-two people—relatively close to the national average. He complimented the high school system in Missouri, but the worst medical schools were "utterly wretched."[70] According to Flexner, only two of the current colleges had sufficient resources to support a capable medical school, both of which were in St. Louis. As Flexner traveled across the country in 1909, using the influence of the Carnegie Foundation to open doors for him. He witnessed nearly every school's laboratory and coursework. In November, Abraham Flexner traveled south to Oklahoma and found two of its schools and offered his considerations for the fledgling state.

[69] Bonner, T. N. *Searching for Abraham Flexner*, Academic Medicine: February 1998 - Volume 73 - Issue 2 - p 160-66.
[70] Flexner, Abraham, Daniel Berkeley Updike, and Henry S. Pritchett. 1910. *Medical education in the United States and Canada: a report to the Carnegie foundation for the advancement of teaching*, 258.

In 1909, Flexner reported that 2,703 physicians were treating 1,592,401 Oklahomans, well above the national average. Flexner reported that medical education in Oklahoma was "at a low ebb" and that the state "lacks authority to enforce even a high school preliminary" for admission.[71] He observed modest laboratories with teachers that devoted their entire time to instructing students rather than practicing medicine. In Oklahoma City, Epworth College of Medicine exhibited minimal entrance requirements with fifty-one students enrolled, nearly double that of the University of Oklahoma's program. Forty-two faculty members worked for Epworth in "hardly more than nominal" laboratories and "all is disorderly and neglected."[72] Epworth did have thirty beds in a private hospital for clinical instruction; however, Flexner still had plenty to say about Oklahoma's future in medical training. He mostly saw potential in the state university, seeing already that the medical program had become an integral part of the University. A modest underdeveloped program could be revamped to avoid the evils that his report had outlined. He noted that migration of doctors to Oklahoma had been so rapid during its territorial years, that Oklahoma had three times the number of doctors that it needed. By Virgil Berry's count in 1906, Oklahoma and Indian Territories held twice as many physicians as England, and over six times the amount in Italy—both countries that had some sort of state-sanctioned education and licensure requirements.[73] In territories like Arizona and New Mexico, the number of practitioners were also noteworthy.[74] But, because both Arizona and New Mexico

[71] Flexner, *Medical education in the United States*, 258.
[72] Ibid., 290.
[73] Presidential address from Virgil Berry, *Journal of the Oklahoma State Medical Association*, May 1906, F2, B1, Charles W. Fisk Collection, WHC.
[74] Arizona followed a similar pattern to Oklahoma's where a Territorial Board offered little for the forthcoming state board. Public health campaigns followed, attempting to educate Arizonians on hygiene and other means to protect citizens from disease. A territorial insane asylum was built in 1887, and until 1907 few reports were received by the territorial board of health. Vital statistics bureaus opened simultaneous with Oklahoma, as well, indicating that this story in Oklahoma is indicative of a larger American West story of colonialism, medicine, and a progressive understanding of public health. See "ADHS Historical Timeline - Arizona Department of Health Services," Arizona

were not states until 1912, Flexner failed to report on conditions or numbers of physicians there. By 1909 during his infamous visit, Oklahoma had garnered Flexner's attention for its practitioner influx, and he had stern recommendations for Oklahoma's medical future.

Flexner's suggestions for Oklahoma were imperative to the state's future reputation. The state needed to "speedily define a standard such as will (1) suppress commercial schools, --as for example, that now nominally belonging to Epworth University,--and (2) by the same action exclude inferior doctors trained elsewhere," he wrote. Like H. Coulter Todd had suggested in 1903, Flexner advised opening an Oklahoma City clinical department to "obtain control of the field." A clinical department could diversify the types of patients and cases doctors in training would see and learn from, but logically, that would have to take shape in Oklahoma City. Flexner praised Oklahomans for quickly opening over twenty-five state-supported education institutions, but its medical schooling needed reform and fast. Oklahoma City was modernizing according to Flexner, and Oklahoma could easily "avoid the weary and costly errors in educational organization that the states about them have one after the other made." After all, other states were already "painfully correcting or paying for their blunders" and "should Oklahoma, to soothe the local pride of this little town or that, run up a bill of the same sort?"[75] Instead of making the same mistakes as other states by establishing diploma mills and poor curriculum, Flexner advised for Oklahoma to be proactive in remaking their medical training program.

Health Services Through the Century (Arizona Department of Health Services), accessed May 3, 2022, https://www.azdhs.gov/documents/director/history/ADHS-Historical-Timeline.pdf.
In New Mexico, midwives were essential to healthcare well into the 1930s. Nearly 800 midwives served New Mexicans in the late 1930s, and midwifery was linked to second-class practitioners and midwives were linked to the state's colonial and racialized past according to scholar Lena McQuade-Salzfass. See Lena McQuade-Salzfass, "'An Indispensable Service' Midwives and Medical Officials after New Mexico Statehood," in *Precarious Prescriptions: Contested Histories of Race and Health in North America*, ed. Laurie B. Green, John McKiernan-González, and Martin Summers (University of Minnesota Press, 2014), pp. 115-141.
[75] Flexner, 290.

Flexner's opinions facilitated change throughout the nation. Abraham Flexner's overtly racist and sexist recommendations for medical schools nationwide certainly altered attitudes toward the profession.[76] He recommended the closing of all but two African American schools in the United States. He also suggested that schools should go back to only admitting men. His findings also influenced stricter regulations and prerequisites for incoming students. Fifty schools now required one year of college-level physics, chemistry, and biology along with one modern language. Schools began closing and consolidating, reflecting the general recommendations of Flexner and other medical reformers of the era. In the immediate years after publication, *Medical Education in the United States and Canada* had influenced schools to affiliate with state universities, and universities themselves became influential in shaping education along with medical professionals. In those remade medical schools, fewer and fewer osteopathic and homeopathic students enrolled which further severed their fields from "orthodox" medicine.

Abraham Flexner missed two notable medical schools in Oklahoma because by the time of his visit they had closed. In 1900, when the territorial university in Norman first opened its medical program, another school in Guthrie opened. The Twentieth Century Physio-medical College organized and operated for four years in Oklahoma. Led by Dean H. Warner Newby, a graduate of the diploma-mill Independent Medical College in Chicago, the Physio-medical College in Guthrie had corresponding departments in Michigan and Pennsylvania that advertised

[76] Many scholars and physicians have written about the profound impacts to minority physicians and prospective doctors in recent years. While others like Barbara M. Barzansky and Norman Gevitz note that many of the reforms to medical education were already underway and the Flexner Report often gets credit for these reforms. See Barbara M. Barzansky and Norman Gevitz, *Beyond Flexner: Medical Education in the Twentieth Century* (New York, NY: Greenwood Press, 1992).
Also see Ann Steinecke and Charles Terrell, "Progress for Whose Future? The Impact of the Flexner Report on Medical Education for Racial and Ethnic Minority Physicians in the United States," *Academic Medicine* 85, no. 2 (February 2010): pp. 236-245, https://doi.org/10.1097/acm.0b013e3181c885be,

the school's diplomas for ten dollars apiece.[77] In 1904, the school's charter was revoked for fraudulence.[78] The Oklahoma Medical College also was gone by the time Flexner arrived. It had opened in Oklahoma City in 1907, but the thirty-two physicians on staff competed with those on the Epworth University and University of Oklahoma faculties. The Oklahoma Medical College never built their proposed school building, and when they applied for admittance to the Association of American Medical Colleges, their C rating did not suffice. The school disbanded. Perhaps partly due to Flexner's report along with other difficulties of operating a medical school, Epworth closed in 1910 as well. Its property sold for approximately thirty thousand dollars, opening the door the University of Oklahoma to open clinical training in Oklahoma City without serious competition across town.[79] Of course, other attempts were made like when the Postgraduate Medical College opened in 1911 in Oklahoma City, but it never became as prominent as the University of Oklahoma would following the publication of *Medical Education in the United States and Canada*.

Shortly after Epworth closed its doors, the University of Oklahoma medical program—now the only accredited program in the state—reorganized to extend its reach to Oklahoma City and extend the length of medical training. By agreeing to accept Epworth students into the University of Oklahoma (OU) program, OU officials forced Epworth to disband. Several meetings between the Epworth Board of Directors and OU's Board of Regents discussed the possible merger. In some cases, Epworth faculty paraded in the streets of Oklahoma City to

[77] Council on Medical Education of the American Medical Association, *Medical Colleges of the United States and of Foreign Countries*, 6th ed. (Chicago, IL: American Medical Association, 1918).
[78] Mark Reuben Everett, *Medical Education in Oklahoma: The University of Oklahoma School of Medicine and Medical Center 1900-1931* (Norman, OK: Univ. of Oklahoma Press, 1972).
and *Journal of American Medical Association* Vol. XLIII, 990.
[79] Mark Reuben Everett, *Medical Education in Oklahoma: The University of Oklahoma School of Medicine and Medical Center 1900-1931* (Norman, OK: Univ. of Oklahoma Press, 1972), 43.

endorse this unification of the two most successful schools in the state.[80] Many of the faculty of Epworth already worked in multiple schools in Oklahoma City at this time, and when Epworth and other Oklahoma City schools failed, they were brought on by the University of Oklahoma to teach the third and fourth years of training in Oklahoma City. Students completed their general medical coursework in Norman before moving to Oklahoma City where they received instruction in hospitals and clinics. Enrollment doubled after Epworth students were accepted, and it seemed that Oklahoma was expanding its medical training to more students. The Association of American Medical Colleges gave OU an "A" rated school following the merger/acquisition.

Many physicians worked as lecturers or faculty while also practicing medicine, especially in Oklahoma. Everett S. Lain exemplified this trend. He had worked for the Oklahoma Medical College, Epworth, and now the University of Oklahoma over the course of a decade. At OU, Lain taught courses in dermatology, electro-therapy, and radiography. Located at the American National Bank Building in Oklahoma City, Lain worked part-time teaching for the college while also operating his own practice. Lain grew up in Bolivar, Texas and attended Vanderbilt University for his medical training. After returning to Texas, Lain decided to settle in Amarillo at the turn of the century. Just twenty-six and newly married to Mollie E. Miller, Lain took a trip to Oklahoma just after he graduated in 1900. After his brief trip to Oklahoma City, Lain boarded the train bound for Amarillo. After learning that the furthest the train traveled was Weatherford, the disappointed Lain met Reverend Hill, a preacher who shared a name with his childhood friend. Eventually he learned the preacher's and his friend were one and the same; Reverend Hill tried to convince Lain to stay and open a practice in Weatherford. Lain continued on his trip to Amarillo, and when he returned to Bolivar to pack the rest of his belongings for the move to

[80] Ibid., 48.

Amarillo, several letters from Rev. Hill urged him once again to move to Weatherford. Numerous other men from Weatherford sent letters as well and Lain detoured north to Weatherford in 1902. In just five years, Lain would find his way to the faculty of several medical schools in Oklahoma, less than a decade removed from his initial training.

Everett Lain opened his first office on the second floor of the Sugden & Boyer General Store in Weatherford in 1902. He and a dentist, Dr. Fred E. Sims, shared an office space above the general store and next to the Winne & Winne Farm and Business Loans office.[81] Like most physicians beginning their career at the turn of the century, Lain reflected the national trends toward medical specialization by 1910. Doctors throughout the world had already studied specialties in medicine, but it was not until the 20th century that fields like dermatology had its own journal and offices. During his years at Vanderbilt, Lain witnessed the installation of the institution's first X-ray machine. His fascination with the new technology grew, and he knew that if he were to specialize it would be in radiography. After paying his school debt and saving fifty dollars, he obtained a three-hundred-dollar loan to purchase one of the first X-ray machines in Oklahoma.

Oklahoma City's growth brought professional opportunities for young doctors like Lain. After six years of practice Lain, his wife, and two daughters left Weatherford. After installing his X-ray machine in Weatherford, Within a few months, he had several patients referred to him from Oklahoma City. As with medical education, clinical cases and patients were abundant compared to rural Weatherford and Lain moved out of necessity it seemed. Oklahoma City offered a budding physician the variety of patients and opportunity he needed to establish himself in the medical community. Oklahoma Medical College (OMC) had opened in the

[81] Several photographs depict Lain's first and subsequent offices, including assistants and newer instruments and machines such as one of Oklahoma's first X-ray machines. Everett S. Lain Photograph Collection, WHC.

previous year in 1907 and Lain quickly found his way to the faculty of OMC and Epworth. After establishing himself in Oklahoma City, Lain focused on his new specialty, often refusing to provide his patients with routine healthcare like vaccinations. Lain carved out his place in the profession in Oklahoma through radiation. Physicians began to hone in their experience and knowledge in particular fields of medicine, catalyzing the process of professionalization in Oklahoma in its early years of statehood. For those like Lain, Oklahoma City represented the opportunity to sculpt a successful career just as Oklahoma and Indian Territories had been for the earlier generations of physicians like Virgil Berry.

As some physicians specialized in new medical subfields, other physicians and medical authorities worked to further understand the state of disease and public health in Oklahoma. Oklahoma Territory had organized a Territorial Board of Health, but as the first biennial report of the Oklahoma State Public Health Department revealed, "little serviceable material had been inherited" and the state organization had to be built from scratch.[82] The State Commissioner of Health, Dr. J. C. Mahr, began appointing county superintendents of health throughout Oklahoma and investigating health conditions throughout Oklahoma. Mahr also oversaw the creation of the Bureau of Vital Statistics, an agency that could publish health statistics given to the Bureau by county superintendents. Prior to statehood, the tracking and reporting of health statistics, births, and deaths was extremely difficult, but under the newly formed Oklahoma State Public Health Department (OSPHD) officials could use state authority in the name of public health to obtain this information. The first biennial publication of the health department urged that "the first duties of a government is to guard the health of its people, for as long as a community is greatly afflicted with disease the community makes no progress, and its people can have little

[82] Dr. J. C. Mahr, *First Biennial Report of the Oklahoma State Public Health Department for the years 1909-1910*, (Oklahoma City, OK, Printers Publishing Co, 1910), 12.

happiness." The State Public Health Department organized to safeguard the public, because they believed it was impossible for individuals to protect themselves from disease especially if citizens were careless or misinformed about disease. However, the people they worked to "safeguard" were not all Oklahomans. The department claimed that "only from one source with authority over all the people can this guarding of health come, and public health officers are absolutely necessary if sanitary measures are to be enforced."[83] The department gathered statistics and information about health in Oklahoma beginning in 1908. From then on, they exerted power over Oklahomans and the information about their health with numerous recommendations to improve public health across the state.

Throughout the first OSPHD report, Mahr and other leaders offered recommendations for a whole host of troubles plaguing Oklahomans. They made their case to lawmakers and the public using financial figures. Appealing to the state's economy stirred the most emotion for lawmakers and taxpayers historically. For example, they argued that each death from a preventable disease in Oklahoma cost the state nearly $1,700; in 1910 the State of Oklahoma lost nearly 5.8 million dollars because of death. Of the 3,406 deaths recorded in the year ending September 30, 1910, nearly three in four could have been prevented according to public health officials. Focus on preventative medicine took hold for OSPHD. They believed that "only through education can the public be brought to realize the necessity of rigid quarantine" and other preventative measures like vaccinations. Newspapers published columns from the public health department for free to educate the public. In the eyes of these physicians, the lack of understanding of germ theory increased preventable deaths. These issues were especially relevant considering the smallpox and measles epidemics in 1910, which were the most serious

[83] Mahr, *First Biennial Report of the Oklahoma State Public Health Department for the years 1909-1910,* 12-17.

outbreaks since OSPHD was organized in 1907. With sufficient funding, the OSPHD could build and execute a competent plan to educate the public. Oklahoma health officers all agreed that the establishment of a publicity bureau would be vital because, "people must be taught what the health is doing, and why it is doing it, so they may recognize its value, and be willing to sustain its acts."[84] Public health officials needed the public, lawmakers, and fellow practitioners to collaborate and agree to institute such policy, something difficult to achieve in Oklahoma.

Through its stance on public health, Oklahoma could demonstrate its competence as a state. The State Public Health Department had a multifaceted plan to target both adults as well as children in Oklahoma public schools. Oklahoma public health officials sought to model other states' health education programs in schools and used schoolchildren as representations that Oklahoma was forward-thinking in their public health efforts. By 1910, Massachusetts already sponsored compulsory medical inspection in its public schools. In Oklahoma larger cities like Oklahoma City had begun inspections; inspectors were advised to oversee the health of these schoolchildren as well as visit their homes in the event a student was absent for several days without cause. Additionally, school inspectors were hired by OSPHD, not the schools themselves, to ensure outbreaks would be cause for schools to close.[85] Public health inspectors would be less hesitant than school employees to close schools if an outbreak were found. The State Superintendent of Public Instruction, E. D. Cameron, was also on board with health education plans and strategies that would make Oklahoma a "state of up-to-date sanitarians." By focusing on the education of children, doctors could communicate innovations in their field and dynamic understandings of disease to the next generation of Oklahomans. Teachers and officials could preach quarantine measures, vaccination efforts, and overall cleanliness to the youth in

[84] Ibid., 13-16.
[85] Ibid., 14.

hopes that sanitation could thrive in their adolescence and adulthood and preventable disease in Oklahoma would fall for future generations. Not only would deaths decrease, but state costs would shrink as well. Similar strategies were enacted all throughout the United States, and Oklahoma sought to seat itself among the leaders and be able to boast about their efforts.

Another major recommendation by OSPHD was to shift the focus of public health law in the state from establishing smallpox hospitals and towards preventative medicine. In the spring and winter of 1910, there were nearly 400 cases of smallpox in Oklahoma. Almost fifty died. But, of the nearly six thousand schoolchildren who were vaccinated, only two caught smallpox. Some physicians cited a decrease in vaccine hesitancy after statehood, but the OSPHD feared they were far from conquering that problem. "The enemy contend that it is contrary to the liberty and free will of the citizens," the department wrote. Vaccine skeptics argued that vaccines would produce "syphilis, tuberculosis, and various surgical infections, and that eventually a bovinization of the human race would occur." Nonetheless, public health efforts continued.[86] Nearly fifteen thousand people received the smallpox vaccination in Oklahoma City in the winter of 1909-1910 with the help of the police department. Black Oklahomans were most susceptible to smallpox; Black people were nearly sixty percent of all smallpox cases. Death rates were higher for African Americans as well. In a Jim Crow state like Oklahoma, White doctors generally advocated for segregated medicine and helped establish Black associations modeled after their own organizations. In practice, Oklahoma medicine reflected sustained racism throughout the nation. Public health recommendations were generally tailored to affluent White communities, and providing aid and education to Black communities was often viewed as impractical to White doctors with little success attainable in those efforts. Yet, education

[86] Ibid., 69.

recommendations were still offered to African American communities, and in Tulsa especially, numerous Black physicians became valued doctors. Quarantine and vaccinations were some of the proven methods to combat preventable diseases, and Oklahoma physicians faced significant resistance from the public prompting educational and structured efforts in schools as well as cities like Oklahoma City. The public's skepticism, regardless of race created problems for physicians, but the public was leery of such individuals so certain in their work who just years ago had little experience treating anyone.

In numerous ways, Oklahoma physicians imagined a collective enemy in the uneducated public and hesitant legislature. Not only did Oklahoma's demographic composition make it difficult for doctors to convince the public of preventative health measures, but doctors also feared that noncompliant lawmakers would complicate their profession. As evidenced by vaccination efforts and school inspections, doctors often needed those outside their profession to make progress in the name of public health. In the Oklahoma State Health Association, President J. M Byrum asked lawmakers to enact laws that could place Oklahoma at the front of American public health and sanitation. Legislation like the Board of Health Act, the Pure Food and Drug Act, along with hotel inspections, pharmacy regulation, and compulsory vaccinations could propel Oklahoma to the forefront of American medicine in just its infant years in the Union. New records and medical supplies were necessary. Each January, Byrum urged county superintendents to report births and deaths (along with cause of death). Undertakers needed to cooperate; schoolteachers needed to allow and facilitate school inspections along with ensuring each student had 225 cubic feet of space in the classroom. By 1910, Oklahoma medical authorities began enacting a framework that connected the community in the name of public health. The urgent recommendations made by Byrum and others appealed to the public,

lawmakers, and fellow physicians and Byrum developed a foundation with which Oklahoma resemble the states that were leading the nation in public health efforts.

One disease received exceptional attention in the medical sphere in Oklahoma at the turn of the century. By OSPHD metrics, nearly half of the 645 reported deaths from tuberculosis could have been prevented. The bacterial disease had been historically linked to poverty and filth. Public health authorities advised that the government recognize the link between poor Oklahomans, tuberculosis, and death and perhaps more importantly, "insure protection to our other citizens from this contagious disease."[87] Practitioners advocated for the furnishing of tubercular wards and free distribution of tuberculosis antitoxin so that rural patients could attain the cure before it was too late. However, the link of tuberculosis to poverty offered authorities the opportunity to further divide economic classes. Through the Bureau of Vital Statistics, data was used to create separation and justification for programs targeted for Oklahoma's poor. OSPHD argued that the state could purchase the antitoxin for one fifth the price that practicing physicians would have to pay. In addition to tuberculosis, the smallpox vaccine should be administered for free according to the officials. Oklahoma led the nation in smallpox deaths in Oklahoma in 1909. Oklahoma's status as a state created responsibility for its legislators and public health officials to its citizens that was not entirely realized during its brief tenure as Oklahoma Territory.

Tuberculosis exposed class and racial disparities among Oklahomans. According to the biennial report from 1909-1910, tuberculosis cost the state over 1.3 million dollars. An urgent plea followed the statistic, "Is it not time for Oklahoma to WAKE UP and try and do something for the suppression and restriction of this disease?"[88] They argued that poverty was most

[87] Ibid., 20.
[88] Ibid., 28.

responsible for its spread, and proper education on hygiene could alleviate tuberculosis outbreaks in Oklahoma. Moreover, J. C. Mahr and others worked to form the State Anti-Tuberculosis Association to generate awareness and interest in combating tuberculosis. By 1910, most states had already formed similar leagues and organizations, and Oklahoma, again, was just following the lead of others. In Oklahoma, medical authorities noticed and wrote on how Black Oklahomans were affected at greater rates than Whites. Not only were death rates higher, but living conditions were contributing to the spread of disease. Tuberculosis was exposing class differences. Wealth as well as race predisposed certain Oklahomans to disease even though improved conditions could be attained from public health organizations and state authorities. Instead of advocating directly for increased funding to these areas, State Commissioner of Health, J. C. Mahr put the responsibility on Black physicians in Oklahoma.

In November 1909, Mahr helped organize a conference for Black physicians, educators, and businessmen. The result was the Colored Anti-Tuberculosis League of Oklahoma, whose purpose was to educate and combat the misinformation regarding tuberculosis, its causes, and treatments. Through educating and improving the living conditions of Black Oklahomans, medical authorities could achieve essential sanitation in the Black community. Further, Mahr and other White physicians intended to help organize local Black tuberculosis leagues at the county level; White doctors could not become members unless voted in as honorary members. Physicians like Mahr used tuberculosis to sustain segregation in the medical field. White oversight over African American organizations only stretched so far. Black Oklahomans had their own doctors, according to Mahr, but they needed the influence of White physicians to create the best plan of action to suppressing tuberculosis. The proposed organizations would also be centered around the church, and Dr. H. W. Conrad, the author of the proposal, boasted that

over three hundred Black educators and most Black physicians already endorsed his plan. Dismissal of Black physicians' knowledge and capability reverberated throughout Oklahoma and the United States as Flexner and others called for fewer African American doctors and more control over their methods of practice. Mahr, Conrad, and others used their acquired professional authority in the name of public health to impose their vision for the eradication of tuberculosis among Oklahoma's Black population.

Physicians also turned to the public schools to combat tuberculosis. Public health authorities encouraged teachers to tell their students that anyone could help prevent the spread of disease regardless of age. They suggested teachers use "Alphabet for School Children in the Prevention of Tuberculosis," by New York doctor Sigard Adolphus Knopf. Knopf published numerous books and articles about the spread and treatment of tuberculosis and even helped form the National Tuberculosis Association.[89] In Knopf's "Alphabet," the letter "B" represented breathing; children were told to do so deeply and in fresh air. The Alphabet also cautioned children not to cough in another person's face, swap apple cores, or wet pencils to make them write clearer. The tuberculosis alphabet offered children general sanitation practices and aligned with doctors' larger efforts to develop first-grade sanitarians in Oklahoma. Knopf concluded his book with "Z" for "Zeal in carrying out these rules. Knopf's school tuberculosis campaign had a coercive undertone, however. In addition to his success as a lung surgeon and tuberculosis physician, Knopf was a committed eugenicist and argued that parents who had tuberculosis should be sterilized if they continued to procreate. He even helped organize the First National Conference for Race Betterment.[90] Knopf's beliefs influenced Oklahoma doctors as well, and by

[89] Ruth C. Engs, "Adolphus Sigard Knopf," in *Progressive Era's Health Reform Movement: A Historical Dictionary* (Westport, CT: Praeger, 2003), pp. 195-197.
[90] Mahr, *First Biennial Report of the Oklahoma State Public Health Department for the years 1909-1910,* 36.

1935 Oklahoma legislature had passed laws allowing for the sterilization of patients with mental illness. Nearly two decades prior, Knopf's school campaign began in Oklahoma. Funding the campaign to educate the public on tuberculosis and other diseases associated with filth could cost over $100 per month for printing and stamps, and Oklahoma physicians relied on philanthropy as well as the state for funding its venture. By focusing on public schools, medical authorities could teach children about the harms of filth in hopes that these principles would follow them home.

Public health officials also worked hard to educate rural people about the dangers of neglecting human health and instead focusing on the health of livestock. All throughout the state, agriculture took precedence over other industries. Promise of fertile farmland drew thousands of White settlers to the area in the late 19th century with the opening of homestead plots to settlement. Due to the nature of Oklahoma's white settlement, priorities of lawmakers often revolved around farming and agriculture. Facing pressure from tenant farmers and greedy landowners, physicians noted this divide and urged for lawmakers to restructure their priorities. For years in both Oklahoma and Indian Territories, physicians had struggled to be compensated for their work, and the distrust of traveling doctors threatened the livelihood of many physicians. Not only were there three times the number of practitioners needed for Oklahoma, but the variance in compensation also created uncertainty. To combat this, physicians turned to public health systems and legislation. The territorial public health systems were essentially useless to physicians by 1907. However, the now state of Oklahoma continued to turn its attention to agriculture. Oklahoma needed to build its public health system from the ground up and needed to address tuberculosis. Doctors asked the question, "Are Our Consumptives Worth Saving?"[91] In their publications, they argued for the health and care of those battling tuberculosis no matter

[91] Ibid., 41.

how impoverished he or she was. Framing it as Oklahoma's duty and a 75% mortality rate, public health officials explained that "Oklahoma appropriates thousands of dollars for dipping vats and other methods of exterminating cattle tick" but "not a cent is specified for the battle against tuberculosis."[92] Physicians toiled to convince Oklahomans that the state's misfortunate consumptives were as important as its livestock.

In the biennial public health report from 1910, doctors reused an old anecdote about a hog and a young mother. After contracting tuberculosis, the mother was left with no options for treatment. After she contacted the State Board of Health, officials relayed the somber news that the only place she could go was a grave because the state had not a flourishing economy to afford such luxuries of tubercular sanitariums. However, a farmer had discovered one of his hogs developed hog cholera or classical swine fever. The farmer contacted the United States Agricultural Department, and a licensed veterinarian came right away. Using a government issued syringe and serum, he cured the hog. Clearly, the government could save the hog as it would soon be bacon, ham, sausage, and lard; however, the ill mother of two died, and her children were sent to the orphanage. The moral of the story was to "be a hog and be worth saving."[93] The story originated in Indiana, but the principle resonated in Oklahoma. Indiana spent $43,000 on public health, while Oklahoma spent just over $10,000. The Oklahoma State Public Health Department hoped their story and recommendations would bring change to Oklahoma's public health system.

After statehood, medical institutions grew in Oklahoma. All throughout the United States, hospitals opened at exponential rates in the last quarter of the 19th century. In 1873, 178 hospitals operated in the United States and by 1900, there were over 2,000. By the time Oklahoma entered

[92] Ibid., 41-42.
[93] Ibid., 42.

the Union, over four thousand hospitals were housing patients in America not to mention the small cottages Virgil Berry and others opened. The first hospital for civilians in Indian Territory had opened in 1895 in McAlester, partly out of necessity following a mining accident in 1892.[94] All Saints Hospital grew to over 100 beds by 1910. One of the first hospitals in Oklahoma Territory and in Oklahoma City, St. Anthony's Hospital opened in 1898 with twelve beds, and in just one year it moved to a facility double the size.[95] The days of operating on dining room tables and under the light of kerosene lamps were receding. Bed capacity in 1909 in the U.S. exceeded four hundred thousand and by 1923 nearly 7,000 documented hospitals operated in the United States with three quarters of a million-bed capacity.[96] In Oklahoma, makeshift hospitals at Fort Supply in western Oklahoma and numerous establishments in eastern Oklahoma had served Native Americans and settlers, but by 1907, hospitals and other institutions emerged throughout Oklahoma with the potential to treat numerous types of patients.

Oklahomans often viewed hospitals as last resorts. In Norman, doctors recalled that even by 1914, residents were hesitant to support funding and opening a hospital. A. C. Hirshfield, a migrant doctor from Indiana, noted that this reticence was strong even with the University and its medical school nearby.[97] Having just moved to Norman in 1909, Hirshfield bought a local physician's practice, horse, and buggy for three hundred and fifty dollars. After familiarizing himself with his predecessor's patients for a few weeks, Hirschfield took over entirely.

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[94] Gene Aldrich, "A History of the Coal Industry in Oklahoma to 1907" (Ph.D. diss., University of Oklahoma, 1952), and "History," McAlester Regional Health Center, March 28, 2018, https://www.mrhcok.com/welcome/history/#:~:text=In%201895%2C%20the%20All%20Saints,in%20an%20explosion%20in%20Krebs.

[95] Diane Clay, "'St. Anthony State's Oldest Hospital Nuns Started Care Center with Two Buildings in 1898,'" The Oklahoman (Oklahoman, February 16, 2003), https://www.oklahoman.com/story/news/2003/02/16/st-anthony-states-oldest-hospital-br-nuns-started-care-center-with-two-buildings-in-1898/62057477007/.

[96] George Rosen, *The Structure of American Medical Practice: 1875-1941* (Philadelphia, PA: University of Pennsylvania Press, 1983), 23.

[97] Interview with Dr. A. C. Hirshfield, F8, B1, Oklahoma Pioneer Physicians Oral History Collection, WHC.

Hirschfield, like the first- and second-year medical students moved to Oklahoma City to pursue other specialized fields in 1914. However, at the time of his departure a hospital for patients with mental illness had opened in Norman and struggled to secure funds throughout its tenure in Cleveland County. To open a hospital, leaders needed to either acquire funding from the government or from private shareholders interested in a business venture. Physicians often relied on governmental intervention to open hospitals while the public met doctors with hesitancy. Because of an underregulated industry, private shareholders could open hospitals, make a quick profit before the institution ultimately closed. Sustained success of hospitals and institutions depended on the territorial and eventually the state government. Doctors worked to combat rural hesitancy towards hospitals and make seeking care at hospitals the first instinct, not the fearful last resort.

A sanatorium in Norman began after the closure of yet another college in Oklahoma. While David Ross Boyd and Lawrence Upjohn developed plans for medical school curriculum at the territorial university in Norman, another local college fought to stay open and compete with the University of Oklahoma. In 1890, before the territorial governor granted Oklahoma Territory its three sanctioned universities, the Southern Methodist Church in Norman established High Gate College for women. The first college in Oklahoma Territory, High Gate's building took five years to build. As Norman grew, High Gate trustees elected the reverend J. T. Farris as its first president. In its inaugural year, over one hundred women enrolled, and classes were held at the Southern Methodist Church until the construction of the permanent building was complete. High Gate and the University of Oklahoma quickly became competitive. While the territorial university was free, High Gate charged young women three dollars monthly to attend. High Gate also restricted the activities of its students to promote Methodist ideals. By 1893, with economic

depression and competition with the University of Oklahoma decreased the number of women at High Gate.[98] By 1895, High Gate disbanded, and its new building remained empty. In less than a year, the building would be sold and converted to a sanitarium that would become controversial.

In 1895, the Oklahoma Sanitarium Company received approval from the territorial government to establish a hospital for patients with mental illness. The company purchased High Gate's forgone classroom building and opened its sanitarium in June 1895. Led by Dr. John Threadgill, the sanitarium cared for 53 patients in its first year, and by 1900 over two hundred patients with mental illness had relocated to Norman.[99] Each year, patients at the sanitarium increased, and Threadgill expanded the institution's mission. It even had a cattle herd with exceptional breeding success. Threadgill sold his sanitarium to an investment group that included the territorial governor, William Jenkins. Supported by President William McKinley, Jenkins' tenure as territorial governor was brief. Inaugurated in May, by the end of November, he was ousted. As a shareholder in the sanitarium, he allegedly sold stock to friends, and the insider trading sparked an investigation in Oklahoma as well as by the United States Department of the Interior. While the federal government found nothing, Theodore Roosevelt deemed Jenkins' behavior inappropriate and the territorial government "completely exonerated him."[100] Prior to statehood, the Oklahoma Sanitarium Company became nationally renowned through its connection to political corruption.

The Oklahoma Sanitarium Company was another option for employment for recently graduated physicians. Before Threadgill's departure, he hired Dr. David Griffin, an 1897

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[98] Suzanne H. Schrems, *Images of America: Griffin Memorial Hospital* (Charleston, SC: Arcadia Publishing, 2021), 13-16.
[99]Schrems, *Griffin Memorial Hospital*, 17.
[100] For more on Gov. William Murray, see Delmer W. Porter, "William Miller Jenkins, Governor of Oklahoma, 1891–1901," in *Oklahoma's Governors, 1890–1907: The Territorial Years*, ed. LeRoy H. Fischer (Oklahoma City: Oklahoma Historical Society, 1975), and Schrems, *Images of America: Griffin Memorial Hospital*, 18-19.

graduate of the University of Virginia's Medical School. By then, the Oklahoma Sanitarium Company (OSC) began to compete for patients with Fort Supply in western Oklahoma. In the aftermath of William Jenkins scandal, medical and legislative authorities labeled the sanitarium in Norman as unprofitable and virtually useless despite its patient growth. One advantage the Oklahoma Sanitarium Company held over the territorially funded Fort Supply was the railroad. Legislators proposed that Fort Supply should be the territory's official hospital for patients with mental illness. However, Fort Supply needed to be connected by rail to nearby Woodward before any legislation could pass. Fort Supply also needed to construct an electrical plant. The OSC continued to operate despite lousy funding while efforts at Fort Supply stalled.

Statehood transformed Oklahoma's asylums. With the Fort Supply hospital still in limbo, the state of Oklahoma passed legislation to open Eastern State Hospital in Vinita. With this, the sanitarium in Norman faced imminent closure. It was a privately owned company in central Oklahoma with little legislative leverage. The new facilities in Vinita were built using over $200,000 from the state on 160 acres purchased by the state. The Oklahoma Asylum Board even advised that nearly half a million dollars would be necessary to care for patients with mental illness in eastern Oklahoma. The Oklahoma Sanitarium Company that already experienced financial setbacks and uncertainties, now had to compete with the State of Oklahoma, rather than Oklahoma Territory. With efforts at Fort Supply and in Vinita, the state now turned to central Oklahoma where the OSC was struggling. However, it was not until 1915 that the state would buy the property. Not only was the decision to buy the sanitarium influenced by its floundering financials, conditions at the Oklahoma Sanitarium in Norman were abysmal.

Poor conditions for patients strengthened the argument for the state to purchase the Oklahoma Sanitarium, and Progressive Era reformists headed this push. In the same year that

Abraham Flexner visited Oklahoma's medical schools, a newly appointed Commissioner of Charities and Corrections paid the Oklahoma Sanitarium a visit. In 1909, Kate Barnard began touring and reporting back to the Oklahoma legislature on the poor conditions of the state's prisons and asylums. Years before women could vote, Barnard convinced the first Oklahoma legislature that a Charities and Corrections department was necessary and won the election for its commissioner. Known for her progressive principles, Barnard advocated for the abolishment of child labor at the Oklahoma Constitutional Convention and the creation of the office of charities and corrections. Throughout her political career, Barnard backed Oklahoma youths and convicts and gained national attention. During her second term as commissioner, she worked for the property rights of Native orphans, which proved unpopular.[101] But in 1909, Barnard denounced the Oklahoma Sanitarium leaders and Oklahoma physicians and helped enact some changes to the asylum. Barnard illuminated major shortcomings during her visit in 1909. Over eighty patients died at the sanitarium in 1909, and despite its ecological footprint and strong cattle herd, nutrition was lacking amongst patients. She recommended the purchase of thousands of blankets, fifty rocking chairs, and heaters for each room as well as painted rooms and windows in the buildings' hallways. Her visits to Oklahoma's prisons and institutions were reformist minded, and some of her recommendations led to action.

[101] See Suzanne J. Crawford and Lynn R. Musslewhite, "Kate Barnard, Progressivism, and the West," in *"An Oklahoma I Had Never Seen Before": Alternative Views of Oklahoma History*, ed. Davis D. Joyce (Norman: University of Oklahoma Press, 1994), Linda Edmondson and Margaret Larason, "Kate Barnard: The Story of a Woman Politician," *The Chronicles of Oklahoma* 78 (Summer 2000)., Lynn Musslewhite and Suzanne Jones Crawford, "Kate Barnard and Feminine Politics in the Progressive Era," *Mid-America* 75 (1993).
Lynn R. Musslewhite and Suzanne J. Crawford, *One Woman's Political Journey: Kate Barnard and Social Reform, 1875–1930* (Norman: University of Oklahoma Press, 2003). In addition, Connie Cronley's new book *A Life on Fire: Oklahoma's Kate Barnard* explores Barnard's reformist career and the implications for her stance on Native orphans. Exposing corruption in the oil and gas industry and advocating for Native rights led to her political downfall, but her rise to political power is significant to Oklahoma's history (Norman: University of Oklahoma Press, 2021).

Barnard's visit facilitated leadership changes that impacted the future of the Oklahoma Sanitarium. Threadgill's replacement, A. H. Clark was removed because of Barnard's visit, and David Griffin, a young physician from North Carolina, took the helm. Barnard's recommendations would attempt to improve the health of patients, but even with leadership changes and improvements, the state still purchased the sanitarium in 1915. Even if shareholders and employees wanted to retain the sanatorium's status as a private business, the state purchase was imminent. The purchase established the Central State Hospital, an institution now under the state's jurisdiction. Under Griffin's leadership, Central State Hospital grew to accommodate more and more patients. Griffin was able to practice newer psychiatric treatments that largely exploited patients.[102]

Central State's hospital began with hopes of improvement, but it still struggled to treat its patients empathetically and humanely. The state of Oklahoma bought the sanitarium for $100,000. The purchase included neighboring plots of land, and Central State Hospital would evolve into a sprawling operation that produced its own food and featured ponds and wooden areas. Central State soon erected various wards and a chapel. Generally successful in his legislative efforts, Griffin still struggled to acquire the adequate funding needed for a hospital of this size. Throughout the 20th century, Central State experienced a repetitive cycle that consisted of requesting funding, adding patients, and then needing more funding to support the increase in patients. In April 1918, Central State experienced its first of several tragedies in which a fire claimed the lives of forty men and boys.[103] The fire prompted construction for future fireproof wards and facilities paid for by the state of Oklahoma. In less than a year, Central State rebuilt

[102] Schrems briefly describes various treatments administered by Griffin and his team of medical professionals including hydrotherapy, days long hot and cold baths, and electrotherapy. Schrems, *Griffin Memorial Hospital*, 39-41.
[103] Ibid., 30.

three wards and the dining hall with $168,000 from the Oklahoma government.[104] Central State Hospital faced bankruptcy, a national political scandal, considerable growth, and a devastating fire all within two decades.

Oklahoma's power that came from statehood created a hospital complex that created jobs and gave mental health physicians like Griffin the professional space to experiment with various treatment plans while establishing their professional careers. During its territorial days, the Oklahoma Sanitarium was deplorable. But into the 20th century, it became one of the state's only mental hospitals. By 1925, five state-funded insane asylums had opened in Oklahoma. Following Barnard's visit, funding at the Norman asylum increased from $88,000 in 1908-1909 to $100,000 in 1909-1910. After the state purchased the institution in 1915, funding remained around $100,000 until the 6th Legislature approved over $450,000 for Central State Hospital. Funding would continue to oscillate through 1930 with a general increase.[105] Generally, conditions for patients did not improve, but the responsibility of treating patients at Central State was now in the hands of the state rather than private investors and physicians. Funding for Central State did increase, and necessary renovations were made. Overcrowding continued to be an issue for Griffin and his employees. Patients with varying degrees of illness were often housed together. Griffin believed that a less threatening environment could yield a more modern approach to treating mental illness.[106] The treatments Griffin and others used included continue flow baths for "delirious or exceptionally excitable women" where patients would lie in a hot water bath for up to three days to quiet them.[107] Into the 1930s, psychiatry continued to evolve and employ

[104] Ibid.
[105]Bernice Norman Crockett, "The Origin and Development of Public Health in Oklahoma, 1830-1930" (dissertation, University of Oklahoma, 1953), 241-243.
[106]Schrems, *Griffin Memorial Hospital*, 34.
[107] Ibid., 39.

obscure and allegedly proven treatments. Central State was another locale that used insulin shock therapy, hydrotherapy, and sterilization to treat patients. The treatments were accentuated by Oklahoma's and physicians' growing power over their patients.

National trends in eugenics and compulsory sterilization impacted Central State's patients as well as Oklahoma's prisoners. The first in the world, Indiana's 1907 compulsory sterilization law catalyzed the passing of similar laws in thirty other states. In 1924, Virginia passed the Virginia Sterilization Act, that legally allowed the involuntary sterilization among patients in state asylums. Issues over Virginia's legislation reached the U.S. Supreme Court in 1927, when the court heard a case about the legal sterilization of Carrie Buck. The superintendent of the Virginia State Colony for Epileptics and Feebleminded believed Buck's intellectual capacity was that of a nine-year-old. Buck's mother also was seen as having the mind of an eight-year-old with a history of prostitution.[108] The Supreme Court in a near unanimous decision ruled that "it is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for imbecility, society can prevent those who are manifestly unfit from continuing their own kind."[109] Oliver Wendell Holmes Jr.'s decision set the precedent for asylums all around the country to petition for the compulsory sterilization for patients with mental illness to prevent procreation. Just as Knopf had done with tuberculosis campaigns in schools, eugenicist rhetoric thrived through the 1930s—especially in Oklahoma.

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[108] Much of the case rested on Buck's immorality and inability to support an illegitimate child. However, new scholarship demonstrates that a family member had raped Buck, and the family's attempt to institutionalize Buck was to preserve the family's reputation, not that Buck was feebleminded. See Paul A. Lombardo, *Three Generations, No Imbeciles: Eugenics, the Supreme Court, and Buck v. Bell* (Baltimore, MD: Johns Hopkins University Press, 2022).

[109] For more on Oliver Wendell Holmes Jr.'s decision see Holmes, Oliver Wendell, and Supreme Court Of The United States. *U.S. Reports: Buck v. Bell, 274 U.S. 200. 1926*. Periodical. https://www.loc.gov/item/usrep27420, and Adam Cohen, *Imbeciles: The Supreme Court, American Eugenics, and the Sterilization of Carrie Buck* (New York, NY: Penguin Books, 2017).

Legal precedent at the Supreme Court affected patients at Central State Hospital and in Oklahoma broadly. In the state's five insane asylums, it was now legal to sterilize patients with consent from their guardians based on Holmes Jr. and the Court's decision. In some cases, non-informed consent allowed physicians to sterilize, and in other cases, promised reunification with their families influences patients' decisions to comply with sterilization efforts. Conditions at Central State and in Vinita largely meant patient neglect, and if physicians advertised sterilization as a cure to patients' illnesses, then leaving asylums seemed to be the better option for families and patients. Patients were lonely in institutions like Central State, unable to visit family and coerced into hydrotherapeutic and electric shock therapies. Using a ruling from the highest court in the United States, physicians at these asylums could now exploit and alter the bodies of their patients as sociologists, eugenicists, and doctors continued to assert that sterilization could combat social ills and prevent "feeble-minded" people from passing mental illness from generation to generation.

Asylums in Oklahoma and authorities like Dr. David Griffin took advantage of the new ruling at the height of the Great Depression. In Vinita, doctors claimed sterilization was compassionate, but many patients would have rather die than go under the knife. Oklahoma governor William "Alfalfa Bill" Murray and other lawmakers embraced the reasonings justifying sterilization and in Oklahoma many patients were sterilized. Heads of prisons and asylums complained of overcrowding, influencing sterilization laws in Oklahoma. In April 1934, Dr. Griffin presented six women to Oklahoma's Board of Affairs to decide if Griffin and his team could sterilize them. In Griffin's view, the women were incurable, all possible treatments other than sterilization had been exhausted. Griffin claimed consent was obtained in all six cases, and when presenting his patients to the three-man committee, Griffin exhibited an assumed sense of

authority and power over mental illnesses as well as his patients' bodies. The hearing was controversial, with national newspapers shedding light on the situation and precedent this would set for the future of the nation's mentally ill patients. The women advocated for themselves during the hearings as well, citing "overstudy in school" as the root of her symptoms rather than dementia praecox as Griffin would suggest. The drawn-out hearings continued to cost the state money. The Board voted to postpone hearings, but as Victoria Nourse writes, "Oklahoma's eugenics enthusiasts were impatient."[110] They turned their attention to Oklahoma's prisons, but not before David Griffin and other advocates for sterilization had made their case. Throughout the 20th century, Central State Hospital sponsored numerous compulsory sterilizations. Griffin's general legislative success in securing funding for his hospital translated to court approvals for sterilizations throughout the 1930s and 1940s.[111] In Griffin's view, not only was he helping curtail the passing of unvalued genetics to future generations, but he was also practicing relevant medicine in his underfunded asylum in Norman.

Oklahoma went a step further to ensure compulsory sterilization was implemented in the state. In 1931 and again in 1935, the Oklahoma legislature exposed their commitment to eugenics. By passing the Habitual Criminalization Sterilization Act, the State of Oklahoma could sterilize criminals convicted of two or more crimes in Oklahoma or elsewhere. Prisoners convicted of embezzlement were excluded from the law as well as political crimes. Clearly, the state was targeting a demographic that was thought to contribute to social ills, and the procreation of such criminals would pass on hereditary criminal genes to future generations. Through continuing to decide which Oklahomans were worthy of procreation, lawmakers and

[110] Victoria F. Nourse, *In Reckless Hands: Skinner v. Oklahoma and the near Triumph of American Eugenics* (New York, NY: W.W. Norton & Company, 2008), 47.
[111] Schrems, *Griffin Memorial Hospital*, 41.

physicians impeded the human rights of certain criminals as well as individuals with mental illnesses. The first utilization of the Sterilization Act did not come until May 1936. Hubert Moore had been convicted five times and incarcerated in McAlester. Prisoners rioted over the new law, and Moore managed to escape Oklahoma's State Penitentiary in June. Instead of continuing his petition to sterilize Moore, the attorney general filed one against Jack Skinner, a man who had been convicted of three separate crimes. First, the state convicted Skinner of stealing chickens, then armed robbery, and finally another robbery. Skinner would then face a jury trial to decide if he would be forced into a vasectomy. In smaller courts, the jury ruled in favor of sterilization, and when the case reached the Oklahoma Supreme Court, justices ruled five to four in favor of compulsory sterilization. Dissenting justices were still uncertain of credibility of genetic criminality, and attorneys appealed the decision to the U.S. Supreme Court.

A few years after the controversial *Buck v. Bell* decision, the Supreme Court reaffirmed its stance on sterilizing patients with mental illness, while dismissing Oklahoma's habitual criminal legislation. Skinner's case reached the Supreme Court where justices voted unanimously that Oklahoma's Habitual Criminalization Sterilization Act was unconstitutional, violating the 14th Amendment. Because the law did not include white-collar criminals, Justice William O. Douglas concluded that "the crimes of larceny and embezzlement rate the same under the Oklahoma code. Only when it comes to sterilization are the pains and penalties of the law different. The equal protection clause would indeed be a formula of empty words if such conspicuously artificial lines could be drawn."[112] Further, Douglas concluded, "the power to sterilize, if exercised, may have subtle, far-reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and

[112] Douglas, William Orville, and Supreme Court Of The United States. *U.S. Reports: Skinner v. Oklahoma., 316 U.S. 535.* 1941. Periodical. https://www.loc.gov/item/usrep316535/.

disappear. There is no redemption for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty."[113] However, *Skinner v. Oklahoma* only applied to habitual criminals. Justices avoided discussion over patients with mental illness like those Griffin presented to the Board of Affairs a few years before the Court's decision. Sterilization among patients in asylums in Oklahoma and throughout the United States continued into the 1960s, and even though *Skinner v. Oklahoma* reversed prior legal precedent for sterilizations, it only protected criminals, not the patients at Central State and elsewhere.[114]

Sterilization was another means for physicians to exert their power and authority over patients that did not always give consent or realize what sterilization would mean for their futures. Incorrect diagnoses and cruel treatments led some patients to accepted anything so long as they would get to go home to their families. Doctors like Griffin used patients' vulnerability to treat them with unproven treatments for mental illness. Eugenics and controlling reproduction meant control over a patient population that was deemed idiotic and feeble-minded. Doctors experimented and worked out eugenic theories about heredity and mental illness while enacting medical violence over their patients. Medicine in the United States was dynamic and quickly changing what it meant to be a physician in America. Specialization in fields like psychiatry or dermatology presented new opportunities to establish a successful career for doctors. Institutions like hospitals or asylums not only created jobs for these physicians, but they also created a reliance on the state for funding and approval for what went on within their facilities. Private

[113] *Skinner v. Oklahoma*, 1941.
[114] For more analysis and scholarly discussion on Skinner v. Oklahoma, see Nourse, *In Reckless Hands: Skinner v. Oklahoma and the near Triumph of American Eugenics* (New York, NY: W.W. Norton & Company, 2008).

ventures before statehood did acquire some funding. But after statehood, the now State of Oklahoma extended its reach to asylums and hospitals more easily.

The making and remaking of hospitals and medical institutions reshaped the medical geography of the state. For Virgil Berry, losing the county seat prevented any hope for a hospital, but for Griffin, statehood presented new opportunities. Oklahoma doctors sought to limit entry into their profession from both poorly educated quacks and nontraditional practitioners, but in developing fields like psychiatry and radiology, a physician could specialize and develop a respectable career in medicine using their own field. This process excluded men and women from medicine, but that was exactly what other Oklahoma physicians needed. Abraham Flexner reported that Oklahoma had three times the number of doctors it required, and the marginalization of potential candidates based on race, gender, class, and educational prerequisites made the medical profession overwhelmingly White and male.

The process of professionalization for physicians began well before statehood. However, statehood presented certain doctors with professional authority that allowed for movement both within the profession and throughout Oklahoma. Investors could support local hospital ventures, but the reaching hand of the state often shrunk private influence over healthcare. White men instituted exclusionary requirements for rising physicians and medical students as the medical field continued to evolve. Experimental treatments and pharmaceuticals could be used, enabled by the newly obtained professional authority of doctors. A few years prior, physicians were migrating to Oklahoma at unprecedented rates, developing their careers with little professional and educational experience. Older generations of physicians like Virgil Berry used their piecemeal training to travel to the countryside and practice medicine. They experimented and treated a variety of patients throughout Oklahoma when they first arrived, and by the 1930s

legalized compulsory sterilization meant state-sanctioned experimentation and eugenic policy could be enacted. Pioneer physicians now held perhaps the greatest power over their patients, the control to reproduce, and doctors used their influence to obtain "informed consent" from families of patients in favor of sterilization to cure said patients.

The history of Oklahoma medicine also exposes important racial interactions between Natives and White doctors. Seminoles were hesitant in some cases, but with the help of Seminoles like Caesar Bowlegs, Berry adapted his limited knowledge of medicine and worked with Indigenous peoples. The number of physicians and questionable care some of them provided prompted action, and statehood was the opportunity to cement their vision of medicine. Standardizing the field in Oklahoma was made significantly easier through lobbying through the State of Oklahoma rather than Oklahoma or Indian Territory. The Territorial Board of Health in Oklahoma Territory had little influence over its constituents, and public health officials like J. C. Mahr, the first commissioner of health, needed to establish a rigid bureaucratic system of public health. Vital statistics needed mandatory reporting from county officials, and the public needed to be educated. Oklahoma physicians pleaded for the legislature to make changes to their profession in a way that only a state could.

While Oklahoma followed national trends in institutionalizing and reforming its medical education program, the state represents a larger American West story; its history facilitated by the movement of scores of doctors from all around the country. Doctors with little to no experience could attain economic freedom and success in Indian and Oklahoma Territories, but they would experience unwavering competition with other doctors. In Arizona and New Mexico, states that would join the Union in four years after Oklahoma, this process also occurred. The process by which doctors migrated to evolving settler colonial spaces created power struggles

over professional authority and offered competing visions for medicine in these Western states. With these migrant doctors, came alternative forms of medicine as well. Socialist doctors, White women, and Black men and women all established practices in Oklahoma by the time the state's constitution was ratified in 1907. However, through the effort of certain doctors, the state of Oklahoma made practicing nontraditional medicine more difficult. Practitioners were ostracized from the medical community and employment opportunities were limited, all under the aegis of the state. Prior to statehood, during a brief moment in time, Oklahoma was largely a contested space where practitioners from all backgrounds grasped for power over their patients as well as their field. Through their privilege and influence at the state level, White orthodox physicians could establish themselves as medical authorities able to wield power over patients' bodies through varied treatments, quarantines, and compulsory sterilization.

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