Nursing and the Privilege of Prescription, 1893-2000

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December 3, 1931

Dear Emily,

. . . Lest you think I simply gossip with the neighbors, I will tell you of a typical day’s work in my dispensary.

Man—(trachoma) eyes treated.

Baby—with diarrhea, diet and treatment outlined to mother.

Ute woman—aspirin for headache, cathartic—too much Yeibicai [traditional winter night ceremonial chant around a huge pinon fire].

Woman—ear irrigated to remove louse. Abdominal tumor discovered.

Man—complaining of pain in chest. Suspected nothing serious. Found he really wanted to sell me some mutton!

Child—extensive impetigo on face. Allowed the removal of scabs and the application of ointment without a murmur.

[Indian name]’s baby to hospital: Pneumonia—died later.

Hogan visited—Old man [name]—Chill last night, pain in chest, general aching, headache, temperature 101. Refuses to be taken to hospital. Visited Hogan the next day. [name of Indian] not at home—out herding sheep in the rain! Rumor later reported his complete recovery.

Man—ammoniated mercury ointment for three children with impetigo.

Woman—badly abscessed gums. Local treatment. To go to hospital for treatment.

Man—“toothache medicine”: (oil of cloves) for wife.
Like other field nurses working for the Bureau of Indian Affairs (BIA) in the first half of the twentieth century, public health nurse Elizabeth Forster had initially hoped to avoid giving medications. She wanted to distinguish the nurse's role—that of health promoter and case finder—from that of BIA physicians, who in the past had been known for dispensing pills. Public health nurses were supposed to do health teaching and assist the physicians. Instead, Forster found herself alone, making diagnoses and treating patients. Writing on December 3, 1931 to her friend Emily, Elizabeth Forster gave the brief account above of a day's work in her dispensary. She gave little explanation, writing matter-of-factly about the care she provided. It was becoming routine for her to diagnose and treat commonly occurring conditions like trachoma, ear infections, and impetigo.

Forster, an experienced public health nurse, was working as a field nurse among the Navajo Indians in Red Rock, Arizona. Red Rock, a trading post, was located in a remote area of the Navajo reservation in the Four Corners region of the United States, where Colorado, New Mexico, Utah, and Arizona meet.

The best thing about Red Rock was that it had an abandoned mission hospital that could serve as Forster's home and clinic for her eighteen-month stay. The old adobe brick hospital, previously owned by the Presbyterian church, was now government property, and the New Mexico Association of Indian Affairs superintendent, E. R. McCray, had promised that the building would be made ready for Elizabeth Forster's arrival. However, when she arrived in early November of 1931, Forster found that nothing had been done. Instead, she had to live in two tiny rooms heated only by a small stove. For the entire month of November, Foster waited for the government to deliver fuel and renovate the mission to create a clinic room. With the exception of the delivery of a small bed and dresser mid-month, nothing was done, and Forster had to treat patients in her tiny kitchen. Finally, in early December, the Indian Affairs agency delivered a supply of wood and coal, just in time for the cold winter ahead. Carpenters also renovated the mission to create a small dispensary. That month alone, Forster treated 138 Navajo patients.
The Federal Initiative

Forster’s work at Red Rock was part of an experimental public health program sponsored by the New Mexico Association of Indian Affairs. It was also part of a major federal government initiative to provide health care to American Indians on reservations throughout the United States. The initiative began in 1849 with the transfer of the Bureau of Indian Affairs from the War Department to the Department of the Interior, an act designed to emphasize the nonmilitary aspects of Indian administration, one of which was the provision of civilian medical services on the reservations. Within twenty-five years, about half of the Indian reservations had a doctor, and by 1900, there were eighty-three physicians employed on reservations. However, the number was hardly sufficient. At no time during the late nineteenth and early twentieth century were there enough doctors to meet the Indians’ needs. In fact, the available Bureau doctors, some of whom had little medical training, had such heavy case-loads that they could do little more than issue pills. Adding to that problem, there were no nurses. According to an early descriptive account of its history, the BIA did not employ nurses until the 1890s, when they hired a few to work in the Indian boarding schools.

By 1900, the BIA had built several hospitals and had increased the number of boarding schools on the reservations. In 1911, Congress appropriated $40,000 for general health services to Indians, the first significant appropriation of its kind. Then, in 1913, Congress ordered a public health survey to identify the Indians’ health care problems. According to

Figure 4.1: Elizabeth Foster with Model-T Ford, 1925. NAU-CL, BBWC
their findings, the most pressing need was for better sanitation. The report also called for more hospitals, better qualified and better paid physicians, and the employment of field nurses (RNs with public health training) to provide care for patients outside the hospitals. The major emphasis, however, according to a 1913 USPHS report, was on preventing contagious diseases that could spread to white Americans. Based on these findings, Congress appropriated $90,000 to the Bureau of Indian Affairs, mostly for the control of trachoma and tuberculosis, the Indians’ two most significant health problems.

Despite the report’s recommendations, prior to 1925 the BIA continued to hire minimally qualified field matrons rather than public health nurses to care for patients in the community. These untrained field matrons, working against overwhelming odds for minimal pay, were supposed to teach better sanitation and hygiene, provide emergency nursing services, and give medicines for minor illnesses. However, owing to their lack of health care training and minimal qualifications, the matrons’ work was often of inconsistent and often poor quality. According to a later report:

> No schooling [for field matrons] was required until 1924 when applicants were required to have the equivalent of an eighth grade education. . . . In 1916, applicants were required only to answer fully what experience, if any, they had in (a) cookery, (b) household sanitation, (c) sewing, (d) care of the sick, (e) care and feeding of infants, (f) home gardening . . . (g) social work and reform, slum, civic betterment or similar work.

The skills needed for their work far exceeded the field matrons’ capabilities. In fact, as a report on the Indian administration noted: “the types of service outlined for them would tax the most modern public health nurse, social case worker, and farm demonstration agent combined. . . .” Nonetheless, it would take several more major studies followed by Congressional appropriations of funds before the Bureau employed licensed registered nurses were employed.

The continuing problems of the Bureau of Indian Affairs were finally on a Congressional agenda in the early 1920s. In 1921, Congress passed the Snyder Act, authorizing federal funds for health services to Native American tribes. The funds were part of the peace treaty agreement made between the Indians and the US government as part of the government’s compensation for its treatment of the Indians in the nineteenth century. Instead of using the funds to set up field clinics, the BIA built more hospitals. The problem was that the Navajos did not use hospitals, as they
believed death lay within the hospital walls, and therefore the buildings were filled with evil spirits, “Ch’įndis.”

In an attempt to better meet the Indians’ needs, in 1922 the Office of Indian Affairs commissioned the American Red Cross to conduct a survey of the health needs on the reservations, and in 1924, two years after they began the study, the Red Cross recommended “the immediate establishment of an organized public health nursing service as part of the Indian health program.” As a result, three trained Red Cross nurses were assigned to be visiting nurses on the Navajo reservation in a trial program. The experiment was a success, but it would take years to get the nursing service up and running because of a lack of money. According to a 1928 report four years after the initial Red Cross recommendations, the “organization of nursing work in the Indian service” had not been “thoroughly established as yet.” In fact, numerous positions remained unfilled. That year, according to the same report, there were “25 public health nurse positions, 13 traveling surgical nurse positions and 115 hospital and sanatorium (TB) positions” available.

The Meriam Report and the Field Nurses

About the same time—in the mid-1920s—US Secretary of the Interior Hubert Work commissioned Lewis Meriam, a medical specialist employed by the Department of the Interior, to conduct a survey of the health services provided to the American Indians. Working with a prestigious staff of scientists and physicians from the Institute for Government Research, Meriam made a thorough investigation of the health services on the reservations and published the results in 1928 in a document entitled The Problem of Indian Administration, soon widely known as the Meriam Report. The report was graphic in its detail, describing extreme poverty, poor health and nutrition, and a lack of sanitation among the Indians. In addition, the Meriam report documented inadequate salaries for physicians and nurses, inadequate medical facilities, and minimal efforts toward preventive medicine. It also confirmed the fact that the two “great health problems” continued to be tuberculosis and trachoma. According to the report, the Indian death rate from tuberculosis in Arizona was “15.1, more than seventeen times as high as the general rate for the country as a whole.” Of particular importance, the document “emphasized the need for stronger central supervision, more and higher-qualified field staff, and an accelerated public health program, including public health clinics on all reservations.” Part of that recommendation included a “plan to replace field matrons with public health nurses as rapidly as possible.”
Commissioner of Indian Affairs Charles J. Rhoads endorsed Meriam’s findings. Under Rhoads’s administration (1929–33), appropriations for education, health, and welfare increased. The increased funding was key to the implementation of a nursing service. Between 1924 and 1934, the number of field nurses employed by the government grew from three to ninety-eight.  

Necessary Knowledge for Safe Care

Before nurses could be hired by the Bureau of Indian Affairs, they had to meet the civil service requirements for graduate nurse visiting duty. As of December 30, 1927, these requirements included:

(1) completion of at least two years of a standard high school course,
(2) graduation from a recognized school of nursing requiring a residence of at least two years in a hospital having a daily average of 50 bed patients or more . . . (3) not less than one year’s institutional or two years private duty post-graduate experience in nursing, (4) evidence of state registration, (5) at least 4 months of post-graduate training in public health nursing or visiting nursing at a school of recognized standing . . . or [equivalent] experience. . . .

In other words, the field nurses being hired had to have both public health educational preparation and postgraduate clinical experience.  

During this period of growth (1924–37), Elinor D. Gregg, RN, served as supervisor of nurses for the Indian Service. Her reports to the American Journal of Nursing document the fact that frequent transfers of nurses from one reservation to another were typical. The report also notes that some nurses chose to leave the service entirely.  

Transfers: To Pyramid Lake San., Nevada, Louise J. Paddock; to Eastern Navajo Agency, New Mexico, Golden Blankenship; to Fort Hall Agency, Idaho, Katherine Gribnoff; to Hopi Agency, Arizona, Naomi Tatum; to Tacoma Hospital, Washington, Josephine Heineman, and Julia Trabucco; to Southern Navajo Agency, Arizona, Mrs. Wauline H. Morse; to Sells Agency, Arizona, Mrs. Rosalie M. Vargas. 

Separations—three.
Public health nurse Ida Bahl was the exception—she began to work for the BIA in 1934 and remained with the agency for twenty-three years. Bahl was well educated. She had a diploma from Mercy Hospital School of Nursing in Dubuque, Iowa, and a BSN in public health from the University of Washington School of Nursing. She also had clinical experience, which grew during her years in the Indian Health Service. Prior to her work in the Indian service, she had worked as an x-ray technician and as a private-duty nurse in Dubuque and Chicago. During the course of her employment with the BIA, Bahl worked in Arizona, Iowa, Oklahoma, California, Wisconsin, and New Mexico. Later in her life, in the 1970s, she would survey the BIA nurses and physicians in order to document their work.

The Field Nurse

Although the public health nurses who worked for the Bureau of Indian Affairs were generally more educated than the average nurse, in many ways they represented the majority of professional nurses of the era—they were women and they were single. Middle-class cultural norms identified nurses as women. The middle-class norms also defined women’s primary role as wife and mother, creating the expectation that nurses would leave their jobs when they married or at least after they had their first child. The Bureau’s policies also affected the choice of nurses who qualified for service. Single nurses were preferred. The severe shortage of separate housing on Indian reservations, resulting in the need to house nurses in dormitory residences, and the BIA regulation that “married women must present a statement of their home obligations,” further ensured that the majority of BIA nurses would be single. However, as evidenced in the nursing supervisor’s report, occasionally a married woman enlisted.

The nurses who applied to the BIA were caucasian and middle class, not only because they represented the typical nurse of the era, but also because of the Bureau’s discriminatory policies. The BIA was not open to African-American nurses. In addition, the agency required that the nurses supply their own uniforms (“navy blue or gray, washable”), and defray their own traveling expenses to the original post (significant for those traveling long distances west by train) and to alternate posts if the assignments were made at the nurse’s request. These costs could be prohibitive for those who did not have adequate financial means. Middle-class single white women were thus the norm in the BIA nursing service. Working among the Navajo people would be a completely new and challenging experience for these young women, as they were confronted with not only
poverty and isolation, but also with exotic customs, a peculiar language, and a strange culture.\textsuperscript{33} According to the field nurses’ diaries and letters, many of those who sought employment with the BIA were seeking adventure and travel.\textsuperscript{34} Others, particularly in the early years of the Great Depression, were simply looking for salaried positions, as jobs for nurses in hospitals (as supervisors) and outside (as private-duty nurses) were scarce. Some were seeking freedom from the constraints of hospital nursing they had known as students, and they found it. Despite the agency’s attempts to ensure that the nurses would continue to work under the supervision of chief nurses and physicians, and according to its bureaucratic policies, the realities of weather, geography, epidemics, and shortages of physicians demanded changes in the way care was delivered. Meanwhile, the freedom that the BIA nurses had as they practiced in remote areas of the country was unprecedented. According to Lewis

Figure 4.2: Navajo woman and child with Ida Bahl, 1961. NAU-BBWC, call # Nav. PH.92.14.2
Meriam, although the nurses’ training “was of a specialized character, sometimes considerably in advance of the physicians”35 with whom they worked, the BIA nurses faced legal and ethical dilemmas in the reality of their practice situation. As Lewis Meriam noted, “If she [the nurse] is to function at all effectively, she must work more or less independently . . . in direct violation of all public health nursing ethics.”36

Difficult Conditions

One of the most isolated reservations to which nurses were assigned was the Navajo reservation in the Four Corners region. There, the open desert, inhabited by the nomadic, sheep-herding Navajo, was a world unlike any other. The vast, empty lands, sparsely dotted with buttes and rocks, pinion trees, and desert grasses, was home to more than 100,000 Navajos returned there in 1868 after the failure of the “Long Walk” to Fort Sumner, New Mexico in 1863.37 Bounded by the Grand Canyon on the west and extending east into New Mexico, the reservation encompassed a harsh environment with little water. There, the Navajos lived in hogans (one-room, octagonal, domed houses made of logs or mud), scattered over great distances.

One of the first complaints to surface in the field nurses’ reports was the difficulty of reaching the Navajo to provide care. Sometimes traveling alone and sometimes accompanied by Indian drivers who also served as interpreters, the nurses crossed the barren landscape from 800 to 2,500 miles per month in all types of weather.38 In the monsoon season that began each year in July, sudden, unexpected torrential downpours could cause flash floods over the “wash,” wide, dry river beds capable of carrying raging torrents of water.39 Sandstorms, high winds, and searing heat further complicated travel.40 Writing on August 1, 1932, Elizabeth Forster described the difficulties that resulted when the field nurse in a neighboring district 90 miles away was on vacation and Forster had to cover for her:

... when a rumor of a typhoid outbreak reached the hospital, I was asked to make as frequent visits as possible to the neighborhood to check on suspected cases. This I have done three times a week and in addition have been having a clinic at the Trading Post, 90 miles in another direction, once a week ... The sun blazes and no tree offers shade, the dust flies in smothering clouds, and yet we dread the coming of the seasonal rains which either cause us to stick in the mud or wait for hours on the bank of a wash while the water goes down. ...41
Winter was no better, as blizzards could close roads indefinitely. In February 1932, Elizabeth Forster complained: “Life is proving strenuous just now with a Flu epidemic in progress and every effort to reach patients made difficult and prolonged by roads and weather. . . .” Sometimes it was not the weather, but the sandy desert roads or the absence of roads that caused problems. According to field nurse Gladys Solverson’s March 1936 report to the Bureau:

This month we have had considerable illness on the reservation . . . 404 patients were visited and advised in their homes and 74 cases were seen at Trading Posts or Day Schools. We traveled 2025 miles and 110 hours over good and bad roads or more often, no road at all to reach these patients.

When the roads were impassable, scheduled clinics could not be held. Clinics could also be cancelled due to car trouble. Mary Eppich’s terse entry in her March 1936 nursing report is typical: “On March 19, the car was out of commission and no clinic was made.” Twenty years later, the field nurses were still writing about their car troubles in their monthly reports to Washington, DC. Lillian Watson complained that the 1949 Ford sedan assigned to her was proving to be her biggest problem:

It has been out of service four or five times during the month and now it is becoming routine . . . to take the car to the garage each morning before starting out to see what new trouble can be found. What a red letter day it would be if all the nurses were assigned new four wheel drive jeep station wagons.

The young female nurses had a right to complain—at least in part. The BIA officials assigned cars to male physicians, nonmedical agency superintendents, and other administrators before they allocated cars to nurses. The nurses received whichever were left. However, their situation was not all bad. Although the nurses did not get the best cars, they were assigned Indian drivers, as cultural norms required that the female nurses be accompanied when they traveled the reservation. In many instances, the fact that they had chauffeurs worked to the nurses’ advantage. The Indian male chauffeurs not only drove the cars but also served as guides and interpreters. In doing so, they gave the nurses wide access to the Navajo people, introducing them to distant tribes. In addition, the drivers provided the nurses with companionship and additional pairs of hands. Sometimes they served as mechanics. According to one nurse:
When I think back over the times we were stuck in the mud, had engine trouble, flat tires, caught in flash floods driving mountain roads in the darkest night, I feel humble and grateful for having Mike as a helper.47

Isolation and Autonomous Practice

When the Indian drivers were not available, the nurses made home visits unaccompanied. Because of the chronic physician shortage, the distances and the extreme weather conditions, doctors were frequently unavailable, and physician-nurse teams were not the norm. As a result, field nurses often found themselves alone making diagnoses and dispensing medicines.48 Several nurses wondered or complained about being left on their own. Mary Zillitas mentioned that she was “desperately lonely in Shiprock.”49 Even Mary Eppich, who reported that she had been “brought to Red Rock in January of 1935 by Dr. Stephenson to work as a field nurse with him,”50 lamented, “Have had several sick patients at the hogans and have wanted Dr. Stephenson to see them, but he has not made any clinics this month at Red Rock.”51

Meanwhile, the Navajo people, who did not differentiate between doctors and nurses, expected to be treated with medicines. As Dorothy Loope noted: “I was forever trying to teach my people that I was a public health nurse, not a doctor—that I was there to help them learn how to prevent illness, not to treat it. But we often did treat it.”52

Diagnosing and Treating Illness

Because they were frequently on their own, the field nurses became adept at diagnosing and treating patients for a multitude of illnesses, whether it was legally and professionally acceptable or not. Three prevalent conditions they saw were tuberculosis (TB), trachoma, and infantile diarrhea. After seeing numerous cases of TB, the nurses became expert at making the diagnosis. In one instance, Mary Eppich identified the illness as soon as she saw the child, noting in her report: “Upon seeing the child, all symptoms of tuberculosis were evident.”53 The BIA nurses diagnosed and treated a myriad of other conditions, including colds, diaper rash, ear infections, pneumonia, venereal disease, burns, spider bites, diabetes, meningitis, appendicitis, breast abscesses, conjunctivitis, whooping cough, measles, chicken pox, impetigo, flu, acute poliomyelitis, and malnutrition.54 Legally, their practice was covered by “standing orders” written
ahead of time by the physicians with whom they worked. Like those developed for the Frontier Nursing Service and other public health nurses, these standing orders provided specific guidelines for the treatment of various problems the nurse might encounter. However, the guidelines were not all inclusive. Frequently the field nurses had to use their own expertise and clinical judgment. Demonstrating her trust in the nurses’ ability to treat the patient appropriately, one physician made it clear that, after the fact, she would “write any order” the nurse needed. That way, the nurse could feel secure that she would have the backup she needed to treat the patient as she saw fit.

Although they had the support of the BIA physicians, the field nurses’ concerns about making medical diagnoses came through in their reports to the Bureau of Indian Affairs headquarters in Washington, DC. For example, in order to protect herself legally, Nena Seymour documented her diagnoses in her monthly report as “suspected whooping cough,” and “suspected

Figure 4.3: Ida Bahl examines Navajo girl, woman, and boy, 1955. NAU-CL, NAU.PH 92.14.5
meningitis” rather than writing the more definitive diagnoses. Diagnosing and treating patients independently was a new experience for the field nurses and clearly stretched their professional boundaries. According to Ruth Seawright, “There I was, 35 miles from the contract doctor and I had never given a patient 5 grains of aspirin without a doctor’s orders.”

Despite their concerns about legal liability, the BIA nurses did whatever they had to do to care for the Navajo people. In April 1933, Elizabeth Forster saw 397 patients in her dispensary and made 65 hogan visits. In May 1935, Nena Seymour made home visits to “76 different Hogans,” and gave “the usual treatments” for sore throats, ear infections, cuts, impetigo and other commonly occurring diseases.

In addition to visiting the hogans, the nurses conducted “nursing conferences,” the initial intent of which was health education, not treatment. The purpose of these conferences was to instruct the Navajo women about infant and child care, sanitation, nutrition, and the importance of prenatal care. The conferences were also for the purpose of giving immunizations, making baby clothes, and conducting well-baby checkups. However, in actuality, the conferences became “nurse-run” clinics, as the Navajo mothers would bring sick infants and children to the “conference” to be seen by the nurse. Reporting on her work at T eec Nos Pas in the Northern Navajo region in May 1931, Dorothy Williams described that reality. In fact, she referred to the conferences as “clinics”:

Five clinics held this week, three general and two baby clinics. Mothers bathed their babies and were given material to cut out and make gowns for baby. Preschool children were weighed, inspected and mothers advised [about] diets for underweights [sic]. . . . Fifty treatments given in dispensary.

Once she had the facilities ready, Nena Seymour opened clinics in specific localities in order to decrease her own travel and that of the Navajos who migrated to the mountains for the summer. She also organized her day in order to care for the hundreds of Navajos who came to the clinic for treatment of trachoma, a highly contagious eye infection that was widespread on the reservation.

My Mexican Springs dispensary is at last painted and I set up clinics. Routine trachoma treatments have been started. I have set aside 7:30–9:00 AM for trachoma treatments and other treatments each day . . . I have established a “Community Medical Center” up in the mountains for the summer.
The Indians did not hesitate to ask the field nurses for eye medications, bypassing any attempt by the medicine men to treat this disease. Trachoma, aggravated by the hot, dry climate, dust, and wind of the desert, caused granular bumps on the inside of a patient’s eyelids that caused excruciating pain when they scratched the cornea. Left untreated, the disease eventually resulted in blindness.

Apparently acknowledging that the white man’s medicine relieved pain and itching, and helped them preserve their eyesight, the ever-practical Navajos willingly attended clinics, demanding treatment. The nurses, encountering numerous patients with the signs and symptoms of trachoma on a daily basis, quickly learned how to diagnose and treat the condition. Sometimes they confirmed the diagnosis with the physician before treating it. In March 1935, Mary Eppich reported that four trachoma patients were treated twice a week with “Silver Nitrate 2%” and were taught to drop “zinc solution 1% into their own eyes twice a day” on the days they did not come to clinic.63 Covering herself legally in her report to Washington, Eppich also noted: “These were the orders of Dr. Johnson when I spoke to him on March 20, 1935.”64

The Nurses’ Bag and “The Bag of Tricks”

The nurses carried their medicines with them, either in their black nursing bags or in what one of them called her “Box of Tricks,” the box of medicines she carried with her in the car as she made home visits.65 In these, the BIA nurses carried standard medical therapies used by physicians, druggists, and white, middle-class Americans in cities and towns throughout the United States. Like the medications used by the Henry Street Visiting Nurses and the Frontier Nurses in the 1920s and 1930s, these drugs provided symptomatic relief. Aspirin, castor oil, cough medicine, zinc oxide, eye drops, and Vaseline, all nonprescription drugs widely available in drugstores, were typical. For example, Mary Eppich reported using both castor oil and aspirin to treat a young child:

[named child], 2 years old, a case of symptoms of Catarrhal fever with a temperature of 105, refused hospitalization was taken care of at the Hogan. Castor oil was given and aspirin Gr. 1 every four hours, plenty of water, no food for 24 hours. This child has a bad case of Otitis Media, which is carefully watched and treated in case a mastoid [sic] may result. Much improvement has been shown.66

In addition to castor oil, cod liver oil was also a favorite among BIA nurses and doctors in the Indian service during the 1920s and 1930s. The
drug was particularly useful for malnourished children and patients with tuberculosis. As Mary Eppich recorded: “In the cases of tuberculosis where hospitalization has been refused, my only treatment is cod liver oil . . . and advice about rest, diet and especially taking care of other members of the family. . . .”67 According to Lavinia Dock’s 1921 *Materia Medica*, cod liver oil was “an alternative to the general nutrition in various disease conditions and is more truly a food than a medicine as it supplies the need of the tissues for fat.”68 No doubt, it improved the Navajo children’s skin problems, because it supplied them with vitamins critically lacking in their diet, which often consisted only of “coffee and Navajo bread.”69 Because of the deficient nutrients, many of the children suffered from impetigo, an itchy, contagious skin disease characterized by blisters that gradually formed a yellow-brown crust. Because the infection was also exacerbated by poor hygiene, Mary Eppich used a combination of treatments:

Three severe cases of Impetigo were found in one Hogan. The treatment consists of washing with green soap, applying ammoniated mercury and bandaging. All three cases have shown much improvement. Also cod liver oil was given to them. . . . 70

Another frequently used medication was silver nitrate. The nurses used the antiseptic solution to treat eye conditions such as conjunctivitis or as a prophylaxis in the eyes of a newborn. Argyrol was another commonly used eye medication. Mary Eppich recorded its use in children with measles:

[two children’s names] were found to have measles. Advised to keep warm, plenty of water and liquid diet, aspirin when necessary and castor oil. Argyrol 25% put into their eyes when I go to see them. . . . 71

Eppich’s treatment was symptomatic. It was all there was to offer. According to the 1903 edition of the *Physician’s Handy Book of Materia Medica and Therapeutics*, the treatment of measles was to “follow general treatment for fevers, prescribing for symptoms as they arise.”72

Despite the propensity to treat symptoms, not all of the drugs the field nurses dispensed were over-the-counter medications used for symptomatic relief. Ammoniated mercury ointment, mentioned by Mary Eppich as the treatment for impetigo and listed in Dock’s 1921 *Materia Medica*, was a prescription drug commonly used for “treatment of skin diseases and irritations.”73 Elizabeth Forster also used it to treat impetigo. The BIA nurses also gave morphine and sleeping pills, which they carried with them for use in emergencies. In addition, after sulfanilamide and penicillin became
available, the nurses used them to treat infectious illnesses. Sulfanilamide, in particular, was excellent for treating trachoma and revolutionized the care of this disease. By the 1940s, both nurses and physicians used penicillin to treat strep throat, chronic ear infections, venereal disease, pneumonia, and nephritis. 

**Working with the Contract Doctors**

Although it may not have been often, the field nurses did work with physicians. On January 10, 1932, about eight weeks after her arrival in Red Rock, Forster wrote to her friend Laura Gilpin that she was collaborating with a physician on a weekly basis. (She also noted that she used food and shelter as a means of interesting the Navajos in attending the new clinic.)

> Have I told you that I am having clinics once a week with a doctor out from the hospital? The weather is so cold and my people have to come from such distances that I am preparing and serving soup for them, and my dispensary, warmed by a cheerful wood fire and advertising my soup in odoriferous fashion, is a popular place on clinic day. I strongly suspect many of them come for soup and not from need to see the doctor. I am, however, by means of this bait catching a good many cases which would not otherwise come to us for care: cases of trachoma, diseased tonsils, chronic appendicitis etc. . . .

Forster was not the only nurse to work with a physician. According to one of Mary Eppich’s reports, when Dr. Stephenson could make it to a clinic at Teec Nos Pas, he and Eppich treated fifty patients. Eppich also worked with Dr. Elliot and, as evidenced in her report, clearly deferred to him when she did so:

> March 16–21: Four clinics held this week, large number of Navajos in for medicine and treatment. Dr. Elliott and myself [sic] attended the farmers meeting at Teec Nos Pas and he explained to the Navajos the reason for the children being vaccinated and having inoculation etc. and answered all the questions. . . .

Other nurses worked with visiting physician specialists. Gladys Solverson, writing in April 1936, reported that she and Dr. Hancock had seen ninety-three patients in their trachoma clinic that month, and Mollie Reebel wrote that “the clinics are being kept up regularly with Dr.
Barklow in attendance.” Clearly, when the doctors were present, the nurses slipped into the much less autonomous (traditional) role of assistant.

Whether or not the nurses saw much of the physician with whom they were assigned depended on the circumstances in which they found themselves—including not only the geographic distance from the physician, the weather, the road conditions, and the availability of the physician, but also the doctor’s willingness to work with nurses. Some, like Forster, Eppich, and Reebel, worked with doctors in cooperative arrangements. Another nurse had quite the opposite experience. According to Lydia King:

... Our senior medical officer ... is not in sympathy with field nurses and to quote him “looks forward to the day when there will be no field nurses in the Navajo Area,”—it all looks pretty discouraging from where I sit."
Why this particular senior medical officer did not want nurses to work on the reservation is unclear. Evidence from the nurses’ reports supports the fact that other doctors, working at the grassroots level, welcomed the nurses and trusted their judgment.81 When conditions permitted, together they visited patients in their hogans, conducted specialty clinics and surgeries, and attended meetings on the reservations. Later, some praised the nurses’ work as they reflected on the years of collaborative practice in the Indian service. Writing to Ida Bahl in the 1970s, BIA physician Charles S. McCammon was clear about his feelings on the subject: “There has never been any question that the public health nurse . . . was and still is the back bone of Indian community health programs. . . .”82

Between the Contract Doctor and the Medicine Man

One of the most difficult tasks the nurses had to undertake in the BIA service was negotiating their role between the white American contract doctors and the Navajo medicine men. As historians Abel and Reifel have documented, the field nurses accepted without question the dominance of scientific American medicine.83 Now, understanding the Navajo culture and the importance of balance and order to the Indians was essential in fostering a collaborative relationship and a sense of trust between the nurses and the people. Although not all nurses did so, many of the BIA nurses appreciated the fact that Navajo traditional healing ceremonies were at the foundation of their society and had to be incorporated into the care if any white man’s treatment was to be accepted. According to Delores Young, who worked at a hospital in Crownpoint, New Mexico in 1945 and subsequently as a public health nurse in Tuba City, Arizona: “With the younger Indians who were undecided as to which medicine was the best, it was important to let them have both if they wanted it.”84 Another BIA nurse, Mary Zillatas, noted that she “tried to show the Indians that both cultures could be used to their advantage.”85 Both of these nurses worked according to recommendations written by Lewis Meriam: “The position taken . . . is that the work with and for the Indians must give consideration to the desires of the individual Indians.”86

Therefore, rather than force “white man’s medicine” on the Navajo, some field nurses tried to get the Indians to accept them as individuals first so that they then could introduce Anglo-American medicine, culture, health practices, and beliefs. The first step in this process was for the nurse to accept the Navajo culture. Many BIA nurses respected the Navajos’ centuries-old customs and the medicine men’s (Hataatii’s) traditional practices, even though the nurses themselves did not always agree with the
Indians’ beliefs. What the nurses could agree with was the Navajo’ holistic perspective. The Navajos believed that “the system of life is one interconnected whole” and that “the whole human creature—body, mind and spirit,” should be treated.87 This holistic perspective was at the core of what nursing as a profession had been advocating since its inception. There were some significant differences, however, that were foreign to the increasingly scientific American nursing practice in the first half of the twentieth century. A major component of the Navajo medicine men’s treatment involved “Sings,” or “chantways,” ceremonial chants that the Hataatii sang over the patient.88 One of these, called “Beauty Way,” was meant to restore balance to the patient. It was based on the Navajo belief that an imbalance or lack of harmony in any area of a person’s life could cause illness.89 Other ceremonial chantways included “Lifeway,” “Blessingway,” “Enemyway,” “the Night Chant,” “the Mountain Way,” and “Shooting Way.” Different chants were meant to cure different illnesses: a “Shooting Way” ceremony might be used to cure an illness thought to have been caused by a snake, lightning, or an arrow; a “Lifeway” was used to cure an illness caused by an accident; “Enemyway” healed an illness believed to be caused by the ghost of a non-Navajo.90 An important part of one Sing, “the Night Chant” or “Yeibechai,” was an elaborate sand-painting created by the medicine man during the day of the ceremony. Some of the nurses attended these ceremonies and recorded their impressions, including the fact that sometimes (to their surprise) a cure took place! According to Ida Bahl:

The medicine man spends days gathering materials and preparing them, and during this time a ceremonial Hogan is built by the family. The usual procedure is to clear the floor in the center . . . and cover it with clean white sand. . . . The medicine man or shaman . . . and his assistants . . . create figures of the Holy People, or the Yeis, and sacred plants in story designs. They use pulverized sandstone of various hues, charcoal, pollen, and meal, and let it slip through the fingers of the right hand . . . everything must be exactly right! . . . In the meantime, the patient prepares by taking a bath and shampooing the hair in yucca suds. Then the shaman gives an emetic. The patient sits beside a hot fire to induce profuse sweating . . . they muster the strength to go through the whole rite. . . . The patient is given a potion of herbs to drink and part of it is applied to the body. . . . Sand is transferred from each part of the painting to the same part of the patient’s body . . . to absorb the might of the supernatural forces to avert evil and ill health. All the time, the shaman chants. . . . He finishes before sundown when the painting must be
erased. . . . Then they prepare for the ceremonial dances. . . . Often a surprising and unexplained cure takes place.  

Some BIA nurses respected these beliefs and did not interfere with the traditional care, even when they disagreed. According to Dorothy Williams:

Navajos requested me to visit a sick child in a hogan one day this week. When I got there I found that the child had a broken leg—compound fracture—and I advised hospital for child [sic] but the family said they had already sent for the medicine man and would send the child to hospital in a few days if he failed to cure the leg. I visited the hogan a few days later and found they were still having a “Sing.”

Although she may have been discouraged by the parents’ refusal to send the child to the hospital, Williams did not press the issue and instead waited for the medicine men to decide to do something different. Sometimes, that delay was fatal. According to field nurse Lillian Watson, who worked among the Navajo in the 1950s under the Indian Health Service:

Attempts to persuade the mother of one two-year old boy, diagnosed as having military tuberculosis, to return him to the hospital failed and it was learned that the child died in the Hogan after receiving treatment by the grandfather who is reported to be a medicine man.

Collaborating with the Medicine Men

Not every medicine man denied white man’s medicine (or in this case, white women’s therapies) to his patients. In fact, some accepted the nurses’ therapy as adjunct treatments to the chants. According to Mary Eppich:

[name], age 1 year, also has symptoms of Catarrhal Fever. A Sing is being held over him. My treatment was Castor Oil and Aspirin Gr. 1 [grains 1] every four hours, plenty of water and not much food. . . .

Clearly, some of the field nurses recognized the legitimate power of the medicine men (Hataatii) within the community and the importance of working with them rather than undermining their authority. Solveson described the results of that collaboration, noting:
It has been gratifying to realize that we have gained the confidence of several of the better known medicine men. We have been called frequently this month by the medicine men, both to their own homes as well as to “sings,” to consult regarding their patients. Frequently the medicine man has advised the family to consider hospital care when we recommended it. We have brought in a good number of patients who had never seen the inside of a hospital before.\(^95\)

The Hataatii’s cooperation was essential to any consideration of hospitalization. And sometimes that cooperation was forthcoming. Robert Trennert, who wrote extensively on government physicians’ work with the Navajo, noted that many of the medicine men believed that white man’s medicine was better in curing what they referred to as “white men’s diseases”—for example, whooping cough, small pox, measles, tuberculosis.\(^96\) Because the Navajo community had invested the Hataatii with decision-making power, the medicine men could decide to accept the white man’s ideas about treatment if their own treatment wasn’t working. According to Gladys Solveson:

> Recently we advised an influential medicine man to hospitalize his 13 year old boy. The boy had been sick six days and had a temperature of 104 degrees. A “sing” was in progress and several medicine men were present. After a discussion of about an hour and a half, the medicine men decided to send the patient to the hospital. The father accompanied his boy and watched his progress daily as he visited him in the hospital. Recently, we sent him home well. It is to be hoped his father has become better acquainted with hospital treatment and that he has more confidence in our care of a patient.\(^97\)

Although some BIA nurses shared information about illness with the medicine men, attempting to educate them, their attempts were not always successful. In one instance, Dorothy Williams tried to teach the Hataatii the differences between chicken pox and impetigo. According to her February 1936 report:

> Several children came to school with chickenpox in Teec Nos Pas. There is quite an epidemic. . . . The Navajos think it is impetigo and come to the dispensary for ammoniated mercury to apply. . . . I tried to explain to them the symptoms of chickenpox but they are quite unable to understand contagious diseases.\(^98\)

Over time, some of the nurses’ effort paid off, particularly when they
were accepting and nonjudgmental about cultural differences, which was not always the case, as has been well documented in Emily Abel’s and Nancy Reifel’s work. In her final report to the National Association of Indian Affairs in 1933, Elizabeth Forster wrote:

I believe that the Red Rock Navajos were beginning to accept me as a friend. . . . It was gratifying to have them voluntarily invite me to their ceremonies and sand paintings and to find the Medicine Men very willing to cooperate on increasingly frequent occasions.

Working with people of a different culture and in harsh surroundings was not the only challenge the nurses and physicians faced. These professionals also had to question some of their own cultural norms, particularly the conviction—instilled in them early in their careers and reinforced by state medical practice acts—that only physicians could diagnose disease and prescribe treatment.

Maternal Services

Unlike the Frontier Nurses working in the same time period, the BIA nurses only delivered babies in emergencies, when there was no one else to do it. The public health nurses were not certified nurse-midwives, and they worked carefully within their professional boundaries. Rather than delivering patients, the field nurses frequently transported expectant mothers to hospitals. Mollie Reebel reported one case in which she went to extremes to get the patient to the hospital rather than deliver her at home:

. . . One of the most difficult trips I have ever made was in response to a call about two o’clock one afternoon to go out and see a lady reported as having been in labor for three days with no result. The man who came for me had started before daylight on foot and after reaching the highway had caught a ride. I inquired how far the hogan was, and was assured that it was not very far. Maybe six miles off the highway, and about twelve miles up the highway. . . . I took Laura Sherman with me for interpreter and with the Indian man as guide, we started out. After we left the highway we went sixteen miles. Again over places where there was not even a wagon road. Found the patient in terrible condition, put her in the car and headed for Ship Rock where we arrived at 7 PM having covered sixty-four miles from Nava. The patient was given immediate attention and is now recovering, so the trip was well worth while. . . .
For the most part, instead of serving as midwives, the BIA nurses worked as public health nurses, teaching expectant and new mothers how to sew layettes for their infants, how to bathe their babies and care for their skin, how to prevent infantile diarrhea (which was prevalent on the reservation), and how to provide a more nutritious diet for their children. The nurses also conducted prenatal clinics and followed mothers and babies after the delivery, frequently treating infected and bleeding umbilical cords.\(^{103}\)

There was one problem, however—sometimes there was no one else available to deliver babies when they arrive prematurely or precipitously. Mary Zillitas recounted delivering a baby after receiving physician instructions over the telephone,\(^{104}\) and in her July 1935 report, Nena Seymour documented: “One pre-natal hospitalized and one premature baby delivered.”\(^{105}\) As in other instances, the BIA nurses simply did what they had to do.

The 1940s

As World War II engulfed America’s energy and tapped its resources, less funding was available for the Indian programs. However, the public health services continued, albeit with shortages in personnel, as was true of hospitals and public health agencies across the country.\(^{106}\)

During the 1940s, advances in medicine brought other changes to the BIA health services. Care of infectious diseases improved as new drugs like the sulfonamides and penicillin became available. Mobile x-ray units were instituted to screen for tuberculosis, and hospitals specializing in the treatment of TB and crippled children were available in Salt Lake City.\(^{107}\)

Meanwhile, the field nurses were still de facto diagnosing. Whether or not they recognized it themselves, others with whom the nurses worked acted on their diagnoses. BIA nurse Delores Young recounted one instance in which the school superintendent trusted her judgment without question:

While at Fort Wingate, N.M., a school girl developed abdominal pain about 8 PM one evening. I advised sending her to Fort Defiance Hospital to be checked. The school superintendent called the school driver saying, “We have to take a girl to the hospital. Miss Young says she’s got appendicitis.”\(^{108}\)
The 1950s: The BIA and the United States Public Health Service

In 1955, Congress transferred medical care from the BIA to the United States Public Health Service (USPHS). By then, the entire Indian Health Service was more structured. “By 1955, the Bureau had entered into contracts for care of Indians in 65 general community hospitals, 16 tuberculosis hospitals, and 5 mental hospitals. It also was paying for care on a fee basis at more than 180 additional general or specialized non-Indian hospitals.” The policy adopted in 1952 was that the Indian Health facilities would be closed whenever “other similar facilities are available to the eligible Indians without segregation. . . .”

Despite the gradual closure of many of the Indian Health facilities, the nurses’ work in schools and clinics continued—sometimes in conjunction with hospital or specialty clinic services. In her annual report for March 1955 to July 1956, public health nurse Lillian Watson noted that PPD testing and Mantoux testing of the school children was being done, and those with active TB were “urged to come to the hospital clinic for chest x-rays.” She went on to report, “Nursing conferences were utilized not only to give health supervision and to screen the morbidity cases, but at most of them the nurse made it a point to have some planned demonstrations, such as that of preparing powdered milk, care of skin sores and bathing the baby. Although many of the mothers wondered at a nurse’s being interested in her ‘well’ children, they were coming to see the nurses in increasing numbers . . . and they seemed to be beginning to understand what we were trying to do. . . .” Watson also noted that she was able to “assist at the crippled children’s clinics held at Tuba City three times a year by Dr. Paul Pemberton from Salt Lake City.”

By the 1950s, some of the educational efforts undertaken by the BIA nurses in the 1920s and 1930s were beginning to pay off. In a September 1957 monthly narrative, one nurse (unidentified) reported that the mothers in the Window Rock area had become very “diarrhea-conscious”—aware of the “great killer of Navajo babies.” Some things did not change, however. Even with increased funding and a new bureaucratic structure, the field nurses continued to face many of the same challenges they had for decades. As Watson wrote in her 1955 annual report:

Many problems are here. We have all repeated them many times . . . about automobiles not adapted to sand dunes and mud, about our moving population, about the distances we travel, about the lack of water and sanitary facilities, about our need for more x-ray facilities, about our need for [TB] sanitoria right here on the reservation so that
families can visit . . . about the need for tonsillectomies and hearing devices for children . . . and about so many other things we hardly know where to stop. . . .

During this period, the nurses continued to hold nursing clinics throughout the reservation—often outdoors. According to Harold Foster, who worked as a chauffeur and interpreter in the 1950s: “We moved our office 5 or 6 times in one year, (no office space) and carried our family records in the car. We had our Nursing conference under a tree or in the back seat of the service car. . . .” Clearly, an underfunded public health service was still a problem. And there were other problems looming for the nurses—these from their own professional organization, the American Nurses Association (ANA). It was midcentury, and the nursing profession, working from a positivistic epistemology, was struggling to define its scientific base and the boundaries of the discipline. So, in 1955, while nurses in the Frontier Nursing Service and the newly formed Indian Health Service were diagnosing patients and initiating treatments either according to “standing orders” or on their own, the American Nurses Association developed a model definition of nursing that would constrain the professional practice of nursing for the next several decades. The definition, published in 1955 and adopted by many states shortly thereafter, emphasized the fact that nurses were neither to diagnose nor prescribe. According to the ANA:

The practice of professional nursing means the performance for compensation of any act in the observation, care and counsel of the ill . . . or in the maintenance of health or prevention of illness . . . or the administration of medications and treatments as prescribed by a licensed physician. . . . The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures. (emphasis added)

Although the ANA may simply have been seeking clarity in defining the discipline’s boundaries, its exclusion of the acts of diagnosis and prescription interrupted nurses’ autonomy in practice settings in which they were providing care to those to whom it would otherwise be denied. The ANA’s restrictive definition of nursing also set the stage for continued conflicts over the nurses’ legal authority to expand their role to include the privilege of making diagnoses and writing prescriptions. These conflicts—between medicine and nursing—would surface in the 1960s with the institution of the nurse-practitioner role in primary care. In the meantime, inside hospitals in the 1950s, other issues were being addressed.